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Leeds CITY COUNCIL

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

Meeting to be held in Civic Hall, Leeds, LS1 1UR on
Tuesday, 26th July, 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)

Dr J Beal - Healthwatch Leeds

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

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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Head of Governance Services at least 24 hours before the meeting).	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND 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 - 28 JUNE 2016** To confirm as a correct record, the minutes of the meeting held on 28 June 2016.	1 - 8
7			**MINUTES OF EXECUTIVE BOARD - 22 JUNE 2016** To receive for information purposes the minutes of the Executive Board meeting held on 22 June 2016.	9 - 32
8			**CHAIR'S UPDATE** To receive an update from the Chair on scrutiny activity, not specifically included on this agenda, since the previous Board meeting.	33 - 34
9			**BUDGET MONITORING** To receive a report from the Head of Scrutiny introducing the Financial Health Monitoring 2016/17 report presented to the Executive Board.	35 - 42

Item No	Ward/Equal Opportunities	Item Not Open		Page No
10			**BETTER LIVES STRATEGY IN LEEDS (PROGRESS UPDATE) - DRAFT RESPONSE** To receive a report from the Head of Scrutiny introducing a draft response following more detailed consideration of the Better Lives Strategy in Leeds (progress update) presented to the Board meeting in June 2016.	
11			**LEEDS ACADEMIC HEALTH PARTNERSHIP** To receive a report from the Head of Scrutiny presenting the report on Executive Board report on Leeds Academic Health Partnership for consideration by the Scrutiny Board.	43 - 114
12			**RESPONSES TO SCRUTINY BOARD RECOMMENDATIONS** To receive a report from the Head of Scrutiny introducing responses to the Scrutiny Board recommendations following its inquiry reports relating to Cancer Waiting Times in Leeds and Bereavements.	115 - 184
13			**WORK SCHEDULE** To receive a report from the Head of Scrutiny presenting the Scrutiny Board's work schedule for the current municipal year (2016/17).	185 - 186
14			**DATE AND TIME OF NEXT MEETING** Tuesday, 4 October 2016 at 1.30pm (pre-meeting for all Board Members at 1.00pm)	

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			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)

TUESDAY, 28TH JUNE, 2016

PRESENT: Councillor P Gruen in the Chair

Councillors C Anderson, J Chapman, B Flynn, M Harland, A Hussain, G Hussain, J Pryor, A Smart, P Truswell and S Varley

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

1 Late Items

The following late information was submitted to the Board:

- Agenda item 11 – The Better Lives Strategy in Leeds.

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

2 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 for information:

- Councillor G Hussain advised that two close family members were employees within the local NHS.
- Councillor S Varley advised that she was known to families and residents of Siegen Manor Care Home.
- Councillor J Chapman advised that she was known to families and residents of Donisthorpe Hall. She also advised that her daughter had received residential care for autism.

All Councillors remained present for the duration of the meeting.

3 Apologies for Absence and Notification of Substitutes

Apologies for absence were submitted by Councillors M Dobson and B Selby. Notification had been received that Councillor G Hussain was to substitute for Councillor M Dobson and Councillor M Harland for Councillor B Selby.

4 Minutes - 18 May 2016

RESOLVED – That the minutes of the meeting held on 18 May 2016 be approved as a correct record.

5 Scrutiny Board Terms of Reference

The Head of Scrutiny submitted a report which presented the Board's terms of reference.

The Chair thanked the Adult Social Services directorate for its contribution to the Board's work during the 2015/16 municipal year. He also welcomed Councillor Charlwood to her first Board meeting in her capacity as Executive Member (Health, Wellbeing and Adults).

RESOLVED – That the Board's terms of reference be noted.

6 Co-opted Members

The report of the Head of Scrutiny sought the Board's formal consideration for the appointment of co-opted members.

The Board was informed that they could appoint the following:

- Up to five non-voting co-opted members for a term of office that does not go beyond the next Annual Meeting of the 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.

RESOLVED –

(a) That Dr John Beal representing HealthWatch Leeds be appointed as a non-voting co-opted Member of the Board for the 2016/17 municipal year.
(b) That the Board considers the appointment of co-opted members on an ad-hoc basis for any inquiries where it was deemed appropriate.

7 Chair's Update

The Chair provided a verbal update on recent scrutiny activity that was not specifically included elsewhere on the agenda.

The key updates were:

- An update on resources available to the Scrutiny Board.
- The Care Quality Commission (CQC) had completed its inspection of Leeds Teaching Hospital Trust (LTHT). The Board was awaiting publication of the report. The Chair reported that he was meeting with Julian Hartley (Chief Executive of LTHT) on 4 July 2016 for a general discussion about the work of the Trust.
- Leeds Partnerships NHS Foundation Trust (LYPFT) was awaiting its CQC inspection, which was due to commence on 11 July 2016.
- The CQC inspection of Waterloo Manor commenced on 27 June 2016.
- The Chair had met with Richard Jones, Chair of Adults Safeguarding Board, and followed up progress around BME representation on the

Board. There was also discussion about a focussed Scrutiny Board meeting in relation to Safeguarding in October.

- The Board was awaiting an update from Leeds Community Healthcare NHS Trust (LCH) regarding autism assessment and treatment times.
- In relation to Children's Epilepsy Surgery Services, requests for information and a progress update had been sent to NHSE. The Board expressed concern that the consultation closed in June 2015 and the decision had been the subject of a series of delays. The Chair acknowledged the concern and agreed to contact NHSE again.
- Sustainability and Transformation Plan – some discussion about the Leeds plan, which was the delivery mechanism for some parts of Leeds Joint Health and Wellbeing Strategy. Also, an evolving role in terms of West Yorkshire planning and decisions. This would be a key consideration for the Joint Health Overview and Scrutiny Committee (West Yorkshire).
- Work being undertaken by Scrutiny Board (Environment and Housing) in relation to Air Quality. Nominations sought from Scrutiny Board (Adult Social Services, Public Health, NHS).

RESOLVED – That the Chair's update be noted.

8 Leeds Community Healthcare NHS Trust - Response to recommendations

The Head of Scrutiny submitted a report which presented Leeds Community Healthcare NHS Trust's formal response to the Scrutiny Board's report and recommendations in relation to the Scrutiny Board Statement – 'Response to Leeds Community Healthcare NHS Trust Proposed Service Location Changes'.

The following were in attendance:

- Thea Stein (Chief Executive), Leeds Community Healthcare NHS Trust.

The key areas of discussion were:

- An update on closure of Garforth Clinic, particularly the 'pause' in disposal to ensure all considerations had been taken into account.
- Further engagement with the local community and Ward Members to address issues.
- Development of work with partners to improve equitable access to services.
- The importance of effective public involvement, engagement and consultation processes and the role of Healtwatch Leeds and the third sector.
- Confirmation of a city wide approach to the use of the built estate across the health and social care sector in Leeds. It was agreed to provide the Board with an emerging overview in September.

In addition, the Board also received an update on recent service developments leading to improved waiting times for children to be assessed for autism. The Board discussed the 'single point of access' for Child and Adolescent Mental Health Services in Leeds and requested a breakdown of referrals across Leeds.

RESOLVED –

(a) That the Board notes the response from Leeds Community Healthcare Trust.
(b) That, in September, the Board be provided with an emerging overview of the use of the built estate across the health and social care sector in Leeds.
(c) That the Board receives a breakdown of autism waiting times across Leeds.
(d) That the Board receives a breakdown of referrals into Child and Adolescent Mental Health Services across Leeds.

9 The Better Lives Strategy in Leeds

The Head of Scrutiny submitted a report which presented 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 daycentre services.

The following information was appended to the report:

- Better Lives for Older People – Day Centres for Older People – Consultation Report (June 2016)
- Better Lives for Older People – Residential Care for Older People (June 2016)
- Day Centre Service User Profiles (as at 15/06/16) and Alternatives
- Resident Profiles (as at 15/06/16) and Alternatives
- Better Lives Service Review – Potential Savings – Residential Care and Day Centres
- Summary of all centres – Post Consultation Contact 24 December to Date
- Request for scrutiny dated 19 May 2016 in relation to Siegen Manor Care Home, Morley.

The following were in attendance:

- Councillor Rebecca Charlwood (Executive Member for Health, Wellbeing and Adults)
- Cath Roth (Director of Adult Social Services) – Leeds City Council
- Shona McFarlane (Chief Officer: Access and Care Delivery) – Adult Social Services, Leeds City Council
- Anna Clifford (Programme Manager) – Adult Social Services, Leeds City Council

- Mark Phillott (Head of Commissioning (Contracts and Business Development)), Adult Social Services, Leeds City Council
- Linda Newsome, Presenting the request for scrutiny in relation to Siegen Manor Care Home
- Keith Spellman, Presenting the request for scrutiny in relation to the proposed closure of all three care homes, with a particular emphasis on Middlecross Care Home.

The Board received the requests for scrutiny in relation to Siegen Manor Care Home and the proposed closure of all three care homes, with a particular emphasis on Middlecross Care Home.

The Board considered and discussed the report from the Director of Adult Social Services.

Some of the key areas of discussion included:

- Historical practice in tender evaluations around the weighting of cost and quality.
- The need to ensure that effective commissioning of services and monitoring arrangements were in place.
- General concern about perceived poor standards of provision in the independent sector compared to Council provided care.
- The quality landscape specifically in the vicinity of the three care homes proposed for closure.
- The high level of response to the consultation and the overwhelming response not supporting the proposed closures.
- The quality of the public consultation process.
- Increased budget pressures on Adult Social Services.
- Assurances that residents who moved elsewhere would not be worse off financially, nor in terms of the quality of service provided.
- The Board was advised that while cost comparisons were based on revenue expenditure, capital expenditure was needed to refurbish Council Care homes to bring them in line with modern facilities.
- Making best use of provision, i.e. provision of dementia day care services.
- Concerns about how some CQC inspection outcomes were reported – specifically in terms of the lack of judgements around the 'impact' on services.
- Comparisons with other decisions made by the Council, with specific reference to the disposal of school buildings.
- Plans for the reuse or disposal of surplus buildings that may arise from future decisions.

Prior to the conclusion of the discussion, members of the Scrutiny Board agreed that in the main the Board had sufficient information to consider in making any statement on the proposals and consultation outcome: The exception being an outline of any plans for the reuse or disposal of surplus buildings that may arise from future decisions.

RESOLVED –

(a) That the Board establishes a sub-group to consider the information presented and issues raised in more detail address some of the issues that had been raised.
(b) That an outline of any plans for the reuse or disposal of surplus buildings that may arise from future decisions be made available and presented to the sub-group meeting of the Board.

(Councillor P Truswell left the meeting at 2.55pm during the consideration of this item.)

(The meeting was adjourned at 3.40pm and reconvened at 3.50pm.)

10 Donisthorpe Hall - update

The Head of Scrutiny submitted a report which presented an update from Adult Social Services regarding services at Donisthorpe Hall

The following information was appended to the report:

- CQC inspection report of Donisthorpe Hall dated 16 May 2016.

The following were in attendance:

- Shona McFarlane (Chief Officer: Access and Care Delivery) – Adult Social Services, Leeds City Council
- Mark Phillott (Head of Commissioning (Contracts and Business Development)) – Adult Social Services, Leeds City Council.

The Board was advised that residents' and families had been made aware about the recent inspection report and no new residents were being admitted until improvements had been made. A detailed 100 day plan of priorities had been put in place which sought to address issues from Adult Social Care / Clinical Commissioning Group (CCG) monitoring visits and CQC inspections.

The Chair expressed thanks to the provider for the open and transparent approach displayed while seeking to address the issues highlighted by the CQC inspection report.

RESOLVED – That the Board be provided with an update on progress against the improvement plan.

11 Scrutiny Inquiry Reports

The Head of Scrutiny submitted a report which sought approval of draft inquiry reports from the previous municipal year (2015/16). The Board was advised that the reports were still being finalised and it was recommended that the item be deferred.

RESOLVED – That the item be deferred.

12 Sources of Work for the Scrutiny Board

The Head of Scrutiny submitted a report which presented potential areas of work for the Scrutiny Board.

The following information was appended to the report:

- Vision for Scrutiny at Leeds
- Best Council Plan 2015-20 – Update for 2016/17
- Leeds Health and Wellbeing Strategy 2016-2021
- Leeds Beckett University – The State of Men's Health in Leeds: A Summary.

The following sources of work were put forward for consideration:

- Joint working with Scrutiny Board (Environment and Housing) regarding Air Quality Inquiry. Councillors J Pryor, P Truswell and S Varley expressed an interest in attending.
- Length of hospital stay / discharges, including the role of intermediate care services.
- CCG updates, particularly in relation to the new role as commissioners of primary care services.
- CQC inspection outcomes.
- Budget monitoring.
- Focussed work on budgets, e.g. budgetary issues likely to impact on the delivery of Child and Adolescent Mental Health Services (CAMHS) and Targeted Mental Health Services (TaMHS).
- West Yorkshire Joint Scrutiny Committee with a particular focus on the West Yorkshire Sustainability and Transformation Plan.
- Raising awareness of men's health issues.
- The use of Pre-Exposure Prophylaxis (PrEP) in preventing the spread of HIV infection.
- Development of integrated care through joint health and social care teams.

The Chair summarised the discussion by identifying the following key themes that will encapsulate the Boards work for the year:

- Quality of services
- Making a difference to service users and their families.

RESOLVED –

(a) That the above issues be incorporated into the Board's draft work schedule for the 2016/17 municipal year.

(b) That authority be given to the Chair of the Scrutiny Board (Adult Social Services, Public Health, NHS), in conjunction with officers, to draw up inquiry terms of reference for subsequent approval by the Scrutiny Board, where required.

13 Local Authority Health Scrutiny

The Head of Scrutiny submitted a report which set 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.

The following information was appended to the report:

- Department of Health, Local Authority Health Scrutiny – Guidance to support Local Authorities and their partners deliver effective health scrutiny
- Health Service Developments Working Group Terms of Reference.

The Chair advised that Board Members were to be provided with further details regarding the establishment of a Health Service Developments Working Group for 2016/17.

RESOLVED –

(a) That the Board notes the Department of Health 'Local Authority Health Scrutiny (June 2014)' guidance.
(b) That the proposed Terms of Reference for the Health Service Developments Working Group be agreed.
(c) That the Board be provided with further details regarding the standing membership of the Health Service Developments Working Group.

14 Date and Time of Next Meeting

Tuesday, 26 July 2016 at 1.30pm (pre-meeting for all Board Members at 1.00pm)

(The meeting concluded at 4.20pm)

EXECUTIVE BOARD

WEDNESDAY, 22ND JUNE, 2016

PRESENT: Councillor J Blake in the Chair

Councillors A Carter, R Charlwood, D Coupar, S Golton, J Lewis, R Lewis, L Mulherin, M Rafique and L Yeadon

1 The Chair's Opening Comments

Tribute to Jo Cox MP and those who had lost their lives in Orlando, Florida

In opening the meeting, the Chair made reference to the terrible events of last week, which had seen 49 people killed in Orlando, Florida, and also the killing of Jo Cox MP.

As a mark of respect for both Jo Cox MP and those who lost their lives in Orlando, the meeting observed a minute's silence.

Councillor Charlwood

The Chair welcomed all in attendance to the meeting, especially Councillor Charlwood, given that it was her first meeting as an Executive Board Member.

EU Referendum

The Chair highlighted that given the proximity of this meeting to the EU Referendum and the fact that we remained within the purdah period, Members would need to exercise caution, should any issues arise during the meeting which related to the referendum question.

Municipal Journal Local Government Achievement Awards

The Chair paid tribute to, and congratulated all concerned for Leeds City Council's recent success at the Municipal Journal Local Government Achievement awards. Specifically, it was noted that the Council had been voted 'Local Authority of the Year', whilst awards were also received in the areas of 'Commercialism in the Property Estate' and 'Innovation and Impact in Children's Services'.

2 Exempt Information - Possible Exclusion of the Press and Public

RESOLVED – That, in accordance with Regulation 4 of The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, the public be excluded from the meeting during consideration of the following parts of the agenda designated as exempt on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the public were present there would be disclosure to them of exempt information so designated as follows:-

(a) Appendix E to the report entitled, 'Learning Places Programme: Capital Programme Update', referred to in Minute No. 9 is designated as

exempt from publication in accordance with paragraph 10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that the information contained within the submitted appendix relates to the financial or business affairs of any particular person (including the authority holding that information) which, if disclosed to the public could or would be likely to prejudice the commercial interests of that person or of the Council. On the basis that the information provided details pre-tender estimates, there is a risk that disclosing the information could prejudice the outcome of the tenders when submitted.

(b) Appendix A to the report entitled, 'Community Hubs: Phase 2 Business Case', referred to in Minute No. 15 is designated as exempt from publication in accordance with paragraph 10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that the information contained within the submitted appendix relates to the financial or business affairs of any particular person (including the authority holding the information) and contains property valuations for Council buildings which the report proposes are disposed of. It is therefore considered that the public interest in maintaining the content of the appendix as exempt from publication outweighs the public interest in disclosing the information, as publication could prejudice potential value of asset rationalisation.

(c) Appendix 1 to the report entitled, 'The Grand Quarter', referred to in Minute No. 25 is designated as exempt from publication in accordance with paragraph 10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that the information contained within the submitted appendix relates to the financial or business affairs of a particular organisation and of the Council. It is considered that the public interest in maintaining the content of the appendix as exempt from publication outweighs the public interest in disclosing the information due to the impact that disclosing the information would have on the Council and third parties

(d) Appendices 1 and 2 to the report entitled, 'Design and Cost Report: Proposed Maintenance Works: Leeds Grand Theatre', referred to in Minute No. 26 is designated as exempt from publication in accordance with paragraph 10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that the information contained within the submitted appendix relates to the financial and business affairs of the Council and a number of third party organisations. It is considered that the public interest in treating this information as exempt from publication outweighs the public interest in disclosing it by reason of the fact that it contains information and financial details which, if disclosed, would adversely affect the business of the Council and third parties.

(e) Appendix 1 to the report entitled, 'Leeds City Region Enterprise Zone Update and Infrastructure Delivery', referred to in Minute No. 27 is designated as exempt from publication in accordance with paragraph

10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that the information contained within the submitted appendix relates to the financial or business affairs of any particular person (including the authority holding that information). It is considered that the public interest in maintaining the content of Appendix 1 as exempt from publication outweighs the public interest in disclosing the information. This report relates to a procurement exercise and as such release of detailed information about the power requirement at this time would prejudice the council's position.

(f) Appendix 1 to the report entitled, 'Design and Cost Report for the Acquisition of Properties for the Council's Investment Portfolio', referred to in Minute No. 28 is designated as exempt from publication in accordance with paragraph 10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that the information contained within the submitted appendix relates to the financial or business affairs of a particular organisation and of the Council. It is considered that the public interest in maintaining the content of the appendix as exempt from publication outweighs the public interest in disclosing the information, due to the impact that disclosing the information would have on the Council and third parties.

3 Late Items

No formal late items of business were added to the agenda, however Members were in receipt of a re-issued version of Appendix B to agenda item 16 (Welfare Reform and Council Tax Support), as although the appendix had featured within the agenda papers, the formatting of that document had led to some text within it being obscured. As such, a re-formatted version had been provided to Board Members for their consideration prior to the meeting (Minute No. 16 refers).

4 Declaration of Disclosable Pecuniary Interests

There were no Disclosable Pecuniary Interests declared at the meeting, however, in relation to the agenda items entitled, 'Learning Places Programme' and 'Outcome of Consultation to Increase Primary School Places at Hawksworth Wood Primary School', Councillor Yeadon drew the Board's attention to her position as governor of Hawksworth Wood Primary School (Minute Nos. 9 and 14 refer). In relation to the agenda item entitled, 'Design and Cost Report: Proposed maintenance works: Leeds Grand Theatre', Councillor Yeadon also drew the Board's attention to her position as Chair of the Leeds Grand Theatre and Opera House Board of Management (Minute No. 26 refers).

In addition, a further comment with regard to interests was made at a later point in the meeting. (Minute No. 16 refers).

5 Minutes

RESOLVED – That the minutes of the meeting held on 20th April 2016 be approved as a correct record.

CHILDREN AND FAMILIES

6 Children's Transport Changes - Deputation to Council

The Director of Children's Services submitted a report which was in response to the deputation presented to full Council on 23rd March 2016 representing families from East Keswick and Bardsey in respect of changes to the Children's Transport Policy. At that meeting, Council resolved that the response to the deputation be referred to Executive Board for consideration.

In considering this matter, and responding to enquiries raised, it was confirmed that the Local Government Ombudsman's (LGO's) finding was that although the school transport policy had been correctly applied, the Council had not clearly explained to parents that their nearest priority school for admissions purposes may not be their nearest qualifying school for transport purposes. When this became apparent, all parents who had unsuccessfully applied for assistance were advised in writing to appeal in line with the Council's transport policy. It was also confirmed that clearer information was now provided to parents on such matters, an issue which had already been addressed before the complaint to the LGO. In addition, it was noted that the Council is providing a refund of travel costs and free school transport for a period of time to the children of the two families concerned in line with the LGO's recommendations, and has agreed to apply the LGO's recommendations to other families in identical circumstances who had unsuccessfully appealed.

Emphasis was placed upon the importance of clarity of communication with parents, and also continuing to ensure that in such circumstances families were treated consistently and fairly and in line with the policy.

Responding to a Member's enquiry, it was requested that further detail on the specifics of this case and the finding and recommendations of the LGO be provided to the Member in question.

RESOLVED – That the contents of the submitted report be received and noted.

(Under the provisions of Council Procedure Rule 16.5, Councillor A Carter required it to be recorded that he abstained from voting on the decisions referred to within this minute)

HEALTH, WELLBEING AND ADULTS

7 Review of the Long Term Community Support Service - next steps and Progress Report

Further to Minute No. 104, 19th November 2014, the Director of Adult Social Services submitted a report presenting the outcome of the review and related consultation undertaken with respect to the Long Term Community Support Service, and in light of such outcomes, the report outlined a proposal for Adult Social Care to cease provision of the long term service.

Responding to an enquiry regarding potential new providers and their links to the city, the Board was provided with details of the criteria that such providers would need to satisfy in such areas. In addition, it was requested that the providers liaise and engage with local Ward Members when delivering services. In noting the low level of locally based providers identified for this service, it was suggested that this could potentially be a matter which could be raised with the Local Government Association for consideration on a wider basis.

Members also considered the role of the Council, as a commissioning body, and the development of that role in processes such as this.

RESOLVED –

(a) That approval be given to cease the directly provided Long Term Community Support Service (LTCSS), and that the plans for the transfer of customers to independent sector providers be noted;

(b) That the timescales for ceasing the directly provided Long Term Community Support Service (LTCSS), commencing in July 2016, be agreed, with an aim to complete closure by September 2016;

(c) That approval be given to the undertaking of continued formal consultation under Employment Legislation with Trade Unions and staff and support for staff throughout the process, including identifying any opportunities for employment within the Council;

(d) That the use of £0.656m from the savings achieved to develop the in-house Skills for Independent Living Service (SkILs) be approved, and that the opportunities which this development creates for staff, be noted;

(e) That the work which has been undertaken in carrying out the further review of the Long Term Community Support Service (LTCSS), be noted;

(f) That in approving a decision on the future of the service the outcome of the full consultation report, as detailed within Appendix 1 to the submitted report, be noted;

(g) That the development of alternative models of support, including those provided in the independent sector and the support available for existing customers to transfer to suitable alternative services within the independent sector, be noted;

(h) That it be noted that the lead officer responsible for the implementation of such matters is the Director of Adult Social Services.

CHILDREN AND FAMILIES

8 Annual Reports of the Fostering and Adoption Service & annual updates of the respective Statements of Purpose

The Director of Children's Services submitted a report which presented the Annual Reports for both the Fostering and Adoption Services. In addition, the report also sought approval of the revised Statements of Purpose for Leeds City Council's Fostering and Adoption Services.

Having received an overview of the key points detailed within the report, responding to a specific enquiry, the Board received further information on the actions being taken to care for the increasing number of adolescents which were becoming looked after in Leeds, whilst the success and cost of the 'Staying Put' scheme in the city was noted. In addition, Members also received an update regarding the current position in respect of external residential placements and also considered the Residential Review which had been undertaken.

RESOLVED – That the submitted report be received and noted, and that support continues to be provided for the work of the fostering service and the promotion of best outcomes for children.

9 Learning Places Programme - Capital Programme Update

Further to Minute No. 75, 21st October 2015, the Director of Children's Services, the Deputy Chief Executive and the Director of City Development submitted a joint report which presented an update on the three year strategy for providing sufficient school places in the city, an update on the progress of the projects currently forming the Learning Places Programme and which also sought approval for the 'authority to spend' for schemes within the 2016 Bulge Cohort Programme, which was a sub-programme of the Learning Places Programme.

Responding to a specific enquiry, officers undertook to provide the Member in question with details of the original estimated costs for those schemes, as detailed within Appendix B to the submitted report.

Following consideration of Appendix E to the submitted report, designated as exempt from publication under the provisions of Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting, it was

RESOLVED –

(a) That the following be approved:

(i) Authority to spend on the schemes identified within the 2016 Bulge Cohort Programme which have an individual cost in excess of £500k, at a total value up to £3,410,000, as detailed within the Table at exempt Appendix E of the submitted report;

(ii) The delegation of the approval of design and cost reports for the bulge cohort schemes which exceed £500k to the Director of

Children's Services, and that these approvals shall be subject to the agreement of the Director of City Development and the Deputy Chief Executive in consultation with the appropriate Executive Members in line with the September 2014 Executive Board approval for the Learning Places Programme, and as detailed in the Table in exempt Appendix E;

(iii) That the resolutions as detailed within this minute be exempted from the Call In process, for those reasons as set out within paragraph 4.5.3 of the submitted report (detailed below).

(b) That the following be noted:

(i) The projected funding deficit which currently stands at £67.5m, based on Education Funding Agency rates, together with the fact that this is likely to increase due to a number of factors, as set out within paragraph 4.4.5 of the submitted report;

(ii) That the current reporting period has seen two further requests to access the programme capital risk fund (for Castleton Primary School and Roundhay Secondary School) totalling £1,278,944, leaving a balance of £4,356,056, which were approved in accordance with the Executive Board governance arrangements.

(The Council's Executive and Decision Making Procedure Rules state that a decision may be declared as being exempt from Call In by the decision taker if it is considered that any delay would seriously prejudice the Council's, or the public's interests. In line with resolution (a)(iii) above, the resolutions contained within this minute were exempted from the Call In process due to the constricted programme required to enable delivery of Bulge Cohort schemes by September 2016 and the limited opportunity to seek authority to spend between the date when pupil preferencing data is available (April 2016) and when orders need to be placed (mid to end of June 2016). The submitted report confirmed that the latest budget estimates had only just been received and costs are higher than anticipated on some of the projects, which has meant that they now fall within the remit of Executive Board rather than general departmental delegation limits, and some orders would need to be placed as soon as the authority to spend is granted at the Executive Board meeting in order to maintain programme. If the decision is not implemented before the end of the call-in period, there is a significant risk that some projects will not be completed in time for the start of term, with the subsequent risk of disruption to the education of a number of children starting school this year).

10 Outcome of statutory notices on proposals to expand primary provision in Hyde Park/Headingley, Swarcliffe/Whinmoor and Bramley planning areas

The Director of Children's Services submitted a report regarding the proposals brought forward to meet the local authority's duty to ensure sufficiency of school places. Specifically, this report was divided into three parts, dealing with proposals to expand Bramley (Community) Primary, Brudenell

(Community) Primary and Fieldhead Carr (Community) Primary Schools and also to establish specialist provision at Bramley (Community) Primary School.

RESOLVED –

(a) That the proposal to expand Brudenell (Community) Primary School by increasing its capacity from 280 pupils to 420 pupils, increasing the admission number from 40 to 60 with effect from September 2017, be approved;

(b) That the proposal to expand Bramley (Community) Primary School by increasing its capacity from 280 pupils to 420 pupils, increasing the admission number from 40 to 60 with effect from September 2017, be approved, and also, approval be given to establishing Special Educational Needs (SEN) provision for pupils with Complex Communication Difficulties including children who may have a diagnosis of ASC (Autistic Spectrum Condition) from September 2017 for approximately 6 pupils;

(c) That the proposal to expand Fieldhead Carr (Community) Primary School by increasing its capacity from 210 pupils to 420 pupils, increasing the admission number from 30 to 60 with effect from September 2018, be approved;

(d) That it be noted that the officer responsible for the implementation of such matters is the Head of Learning Systems.

11 Outcome of consultation to increase primary school places in Hunslet

The Director of Children's Services submitted a report on proposals brought forward to meet the local authority's duty to ensure sufficiency of school places. Specifically, the submitted report detailed the outcome of consultation on proposals to expand primary school provision at Hunslet Moor Primary School and which sought permission to publish a statutory notice in respect of such proposals.

RESOLVED –

(a) That the publication of a Statutory Notice to expand Hunslet Moor Primary School from a capacity of 315 pupils to 420 pupils with an increase in the admission number from 45 to 60 with effect from September 2018, be approved;

(b) That it be noted that the responsible officer for the implementation of such matters is the Head of Learning Systems.

12 Outcome of a consultation on a proposal to cease to provide complex social, emotional and mental health provision under the West Oaks SEN Specialist School and College (Oakwood Lane site) and providing for these needs under the Wellspring Academy Trust

Further to Minute No. 153, 9th March 2016, the Director of Children's Services submitted a report on the outcome of the consultation undertaken and subsequent Statutory Notice regarding the proposal to cease to provide

complex social, emotional and mental health (SEMH) provision under the West Oaks SEN Specialist School and College (Oakwood Lane site). Specifically, the report sought approval to provide for these needs under the Wellspring Academy Trust.

RESOLVED –

(a) That the proposal to cease to provide behaviour, emotional and social difficulty (BESD) provision under the governance of The West Oaks SEN Specialist School and College (Oakwood Lane site) from 31 August 2016, be approved, with this being conditional upon the conversion of the existing BESD SILC into a 4 – 19 SEMH sponsored academy. The provision at the Oakwood Lane site would become part of the new academy from 1 September 2016. Should the academy conversion not be in place by then, then the provision would continue at Oakwood Lane under the governance of West Oaks SEN Specialist School and College.

(b) That it be noted that the officer responsible for the implementation of such matters is the Head of Learning Systems.

13 Outcome of consultation to increase primary and secondary school places in Burmantofts & Richmond Hill

The Director of Children's Services submitted a report presenting proposals brought forward to meet the local authority's duty to ensure efficiency of school places. Specifically, this report described the outcome of consultation regarding the proposals to expand primary and secondary school provision in Burmantofts and which sought permission to publish statutory notices in respect of such proposals.

Responding to a specific enquiry, officers undertook to provide the Member in question with a briefing on the proposal to expand primary places at Shakespeare Primary School.

RESOLVED –

(a) That the publication of a Statutory Notice to expand primary places at Shakespeare Primary School from a capacity of 315 pupils to 630 pupils with an increase in the admission number from 45 to 90 with effect from September 2018, be approved, which will involve the relocation of Shakespeare Primary School onto the Dolly Lane site;

(b) That the publication of a Statutory Notice to expand secondary places at The Co-operative Academy of Leeds from a capacity of 900 students to 1,200 students, with an increase in the admissions number from 180 to 240 with effect from September 2019, be approved;

(c) That it be noted that the officer responsible for the implementation of such matters is the Head of Learning Systems.

14 Outcome of consultation to increase primary school places at Hawksworth Wood Primary School

The Director of Children's Services submitted a report regarding proposals brought forward to meet the local authority's duty to ensure sufficiency of primary school places. Specifically, the report detailed the outcome of the consultation undertaken in respect of proposals to expand primary school provision at Hawksworth Wood Primary School and to publish a Statutory Notice in respect of such proposals.

RESOLVED –

(a) That the publication of a Statutory Notice to expand primary provision at Hawksworth Wood Primary School from a capacity of 210 pupils to 420 pupils, with an increase in the admission number from 30 to 60 with effect from September 2017, be approved;

(b) That it be noted that the officer responsible for the implementation of such matters is the Head of Learning Systems.

COMMUNITIES

15 Community Hubs - Phase 2 Business Case

Further to Minute No. 25, 15th July 2015, the Assistant Chief Executive (Citizens and Communities) submitted a report presenting the progress which had been made to date on the Community Hub programme, specifically the delivery of the six Priority 1a schemes. In addition, the report also sought agreement to a number of proposals in order to progress Phase 2 of the scheme. Finally, the report also sought approval for the overall funding injections and authority to spend required to enable the delivery of the Community Hub Phase 2 programme.

Responding to a concern raised with regard to proposals in Horsforth, it was highlighted that consultation would continue with local Ward Members and all other relevant parties on this matter, and it was highlighted that the related proposals remained 'in principle' whilst such consultation took place.

With regard to proposals in Pudsey, emphasis was placed upon the importance of continuing to utilise Pudsey Town Hall as a venue for public meetings.

With regard to Rothwell, a concern was raised regarding the declaration of the area office as surplus to requirements.

Following consideration of Appendix A to the submitted report, designated as exempt from publication under the provisions of Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting, it was

RESOLVED –

(a) That the contents of the submitted report, and specifically the progress made on delivering the Phase 1a Community Hubs, be noted;

(b) That the delivery of the Phase 2 of Community Hubs schemes, be supported;

(c) That the contributions of £600k from the Changing the Workplace and Corporate Property Management programmes already injected into the capital programme be noted, and that an additional injection of £4,017.4k be authorised in order to finalise the total funding needed of £4,617.4k for phase 2 of the Community Hubs programme;

(d) That expenditure of £4,617.4k for the delivery of phase 2 of the Community Hubs programme be authorised, subject to the approval of the Assistant Chief Executive (Citizens and Communities) to the individual submission of business cases for delivering each part of the Phase 2 Community Hub programme;

(e) That the disposal of the properties, as set out in the capital receipt section of exempt appendix A to the submitted report, be approved;

(f) That the use of the revenue savings expected from the proposed asset rationalisation and delivery of the Community Hubs, as set out in paragraph 6.4.9 of the submitted report, be approved, in order to contribute towards the capital repayment cost required to deliver the Phase 2 Community Hub programme.

(Under the provisions of Council Procedure Rule 16.5, Councillor A Carter required it to be recorded that he abstained from voting on the decisions referred to within this minute, whilst under the same provisions, Councillor Golton required it to be recorded that he voted against the decisions referred to within this minute)

16 Welfare Reform and Council Tax Support

The Assistant Chief Executive (Citizens and Communities) submitted a report providing analysis on the impact of local Council Tax Support schemes since 2013 on those groups who no longer received 100% Council Tax support. In addition, the report also considered the expected impacts of the Government's continuing package of welfare reforms on local Council Tax Support schemes and set out options for how the Council could respond to such changes. Overall, the purpose of providing such information was to identify where changes were being recommended to the support scheme, and, if required, to obtain approval to undertake any related public consultation exercise.

Board Members were in receipt of a re-issued version of Appendix B to this report, as although the appendix had featured within the original agenda papers, the formatting of that document had led to some text within it being obscured. As such, a re-formatted version had been provided to Board Members for their consideration prior to the meeting.

Responding to an enquiry, it was noted that the relevant Scrutiny Board was intending to undertake a piece of work on the matters raised within the submitted report.

RESOLVED –

(a) That the development of a revised Council Tax Support scheme, as set out in paragraphs 3.18 – 3.30 and Appendix C to the submitted report, be approved;

(b) That a public consultation exercise on the revised scheme be approved, with the consultation to be concluded by November 2016;

(c) That approval be given to retaining the Child Allowance for 3rd and subsequent children during the transition to any new scheme;

(d) That approval be given to retain the Family Premium during the transition to any new scheme;

(e) That the development of a hardship scheme for those in protected groups who may be worse off under a revised scheme, be approved;

(f) That the intention to offer a financial incentive for jobseekers to complete Personal Work Support Packages by offering to write off court costs, be noted.

(During the consideration of this item, Councillor A Carter drew the Board's attention to the fact that his step-daughter was in receipt of related benefits)

ENVIRONMENT AND SUSTAINABILITY

17 Meeting the Cost of Non-Urgent Tree Works

The Director of Environment and Housing submitted a report regarding the issue of non-urgent tree works on Council owned or managed land in circumstances where a resident or organisation may consider agreeing to pay for such works.

Members welcomed the proposals detailed within the submitted report, however it was highlighted that this proposal should be part of a wider approach towards the management of trees across Leeds. In response it was noted that Leeds did have a tree planting programme, and that further details of this could be provided to Members, should they wish to receive them.

RESOLVED –

(a) That approval be given to the following:-

(i) That the full cost of non-urgent works on Council trees can be met by an interested party, subject to the criteria as set out in paragraphs 3.8 and 3.9 of the submitted report, with specified works being in line with best arboricultural practice (BS 3998) by a Council approved contractor;

(ii) That where it is deemed appropriate to remove a Council tree affected by development, then this work be undertaken by a Council approved contractor where the private landowner is prepared to meet the full cost;

(b) That it be noted that the Chief Officer (Parks and Countryside) will be responsible for the implementation of such matters.

18 Cremator Replacement

The Director of Environment and Housing submitted a report presenting potential options to sustain cremation provision in the city in order to meet current and anticipated demand.

RESOLVED –

(a) That it be noted that the existing cremators at Lawnswood are coming to the end of their operational life and need replacing;

(b) That it be noted that it is not suitable to only replace cremators at Lawnswood without filtration, as this would be vulnerable to a change in legislation and contrary to statutory guidance;

(c) That approval be given to undertake a feasibility study to 'RIBA B' at Lawnswood to install 3 cremators with mercury filtration equipment;

(d) That a land search be conducted to the east of the city in order to identify suitable site locations, in accordance with the criteria as identified in paragraph 3.4.4 of the submitted report;

(e) That it be noted that the Chief Officer Parks and Countryside is responsible for the implementation of such matters, and that it also be noted that a future report is anticipated to be submitted to Executive Board before the end of 2016.

(Under the provisions of Council Procedure Rule 16.5, Councillor A Carter required it to be recorded that he abstained from voting on the decisions referred to within this minute)

ECONOMY AND CULTURE

19 Review of Discretionary Business Rate Relief Scheme

Further to Minute No. 201, 5th March 2014, the Director of City Development submitted a report which sought approval to extend the current scope of discretionary rate relief to 'for profit' organisations which met agreed criteria, as permitted under Section 69 of the Localism Act 2011.

RESOLVED –

(a) That the proposals to extend the guidelines for the award of discretionary relief for Business Rates from 2016/17 onwards, be approved;

(b) That the implementation of the scheme be delegated to the Chief Officer Economy and Regeneration, in consultation with the Executive Members for 'Economy & Culture' and 'Resources & Strategy', together with the Deputy Chief Executive.

20 Growing the Leeds Visitor Economy

Further to Minute No. 135, 17th December 2015, the Director of City Development submitted a report highlighting the success of the transition of 'VisitLeeds' to the Council from April 2015. In addition, the report also provided an overview of the current approach together with the mid to long term forward plan and how this was aligned to the core budget, looked to bring in external funding, whilst also exploiting cross boundary collaboration opportunities. Finally, the report sought approval to continue the implementation of this approach.

The work being undertaken by the Visitor Economy and Inward Investment team was welcomed, and in response to a specific enquiry, the Board received information on the actions being taken to promote Leeds as a conferencing venue, which included details of the 'Conferencing City Proposition'.

In promoting the city's tourism offer within the context of the overall objective of maximising the economic benefits of tourism, emphasis was placed upon the potential of focussing promotions on Leeds and local residents, in addition to those from further afield, an area which was supported via a number of initiatives across Council directorates and partner organisations.

RESOLVED –

(a) That the strategic approach and forward plan for the Leeds Visitor Economy function, as set out in the submitted report (including the cross-boundary, partnership based approach aimed at attracting visitors in national and international markets) be approved, and that the detailed delivery of this be delegated to the Chief Officer of Economy and Regeneration, in consultation with the relevant Executive Member;

(b) That the approach to working with other destinations and 'Welcome to Yorkshire' on joint promotional campaigns be approved, and that the focus on attracting visitors from outside Leeds City Region, who spend more and support more jobs than local visitors, be endorsed;

(c) That the approach to attracting additional funding by applying for and delivering external investment and commercial match funding, (including in-kind support), be approved, in order to ensure that Leeds is a lead destination and included where relevant, and when the function has the capacity to do so;

(d) That approval be given for VisitLeeds to continue horizon scanning for strategic developments and opportunities, new approaches to funding, mutually beneficial collaborative partnerships (including working more closely and effectively with Leeds City Region destination management

organisations) and funding opportunities, and that such opportunities be responded to appropriately, in consultation with the Chief Officer of Economy and Regeneration;

(e) That the resolutions detailed above be exempted from the Call In process, for those reasons as detailed within paragraph 4.5.2 of the submitted report (detailed below).

(The Council's Executive and Decision Making Procedure Rules state that a decision may be declared as being exempt from Call In by the decision taker if it is considered that any delay would seriously prejudice the Council's, or the public's interests. In line with resolution (e) above, the resolutions contained within this minute were exempted from the Call In process due to the time sensitivity of external funding applications the function is currently bidding for, in particular the 'Discover England' fund where if the function is successful, it would be awarded funds to commence delivery early June 2016).

21 Storm Eva - Recovery Plan Update

Further to Minute No. 157, 9th March 2016, the Assistant Chief Executive (Citizens and Communities) submitted a report which provided an update on the impact of Storm Eva in Leeds, specifically with regard to the recovery plan, flood alleviation proposals for the city, an update in respect of those who still remain affected by the floods, the ongoing discussions which continued with Government, proposals for regeneration and also the lessons which had been learned.

Responding to specific enquiries raised, the Board received an update on the progress being made on the development of the feasibility study for proposed flood alleviation measures, together with the collaborative work being undertaken with partners such as the Environment Agency. In addition, Members highlighted the need to ensure that those flood alleviation measures that the Authority could establish itself were progressed as appropriate, and were included in any wider flood alleviation proposals.

Also in response to a specific enquiry, the Board received an update on the allocation of grant scheme monies to those affected, and also received further information regarding proposals on the use of any remaining government flood response funds.

RESOLVED –

(a) That the updates detailed within the submitted report, including the details on the progress of the Strategic Recovery Plan, be noted;

(b) That the implementation of the recommendations from the lessons learned review, as detailed within section 3.7 of the submitted report, be endorsed;

(c) That the principle of using the remaining government flood response funds to assist in supporting businesses in flood affected areas through further recovery and resilience measures, supporting any outstanding

clean-up priorities, and the development of a wider regeneration strategy for the Kirkstall Road corridor and industrial areas in Hunslet, be supported, and that the Director of City Development be requested to develop detailed proposals for this, in consultation with the relevant Executive Member.

RESOURCES AND STRATEGY

22 Financial Performance - Outturn Financial Year ended 31st March 2016

The Deputy Chief Executive submitted a report presenting the Council's 2015/16 financial outturn position for both revenue and capital and which included the Housing Revenue Account together with spending on schools. In addition, the report also highlighted the position regarding other key financial health indicators including Council Tax and Business Rates collection statistics, sundry income, reserves and the prompt payment of creditors.

RESOLVED –

(a) That the Council's outturn position for the financial year ending 31st March 2016, as detailed within the submitted report, be noted, and that the creation of earmarked reserves, as detailed within paragraphs 3.6 and 5.3 of the submitted report, be agreed, and that the release of such earmarked reserves be delegated to the Deputy Chief Executive;

(b) That it be noted that the Chief Officer Financial Services will be responsible for the implementation of such matters following the conclusion of the 'Call In' period.

23 Treasury Management Outturn Report 2015/16

The Deputy Chief Executive submitted a report which provided a final update on the Treasury Management Strategy and operations for the 2015/16 financial year.

Responding to an enquiry, the Board received further information regarding the management of the Council's debt budget.

RESOLVED – That the Treasury Management outturn position for 2015/16 be noted, together with the fact that treasury activity has remained within the treasury management strategy and policy framework.

24 Financial Health Monitoring 2016/17 - Month 2 (May 2016)

The Deputy Chief Executive submitted a report which presented the projected financial health position for 2016/17, as at month 2 of the financial year.

Responding to Members' enquiries, the Board received further details of the collaborative work being undertaken across directorates in order to manage the continued budgetary challenges, with specific reference being made to the pressures on the Children's Services directorate budget.

RESOLVED – That the projected financial position of the authority, as detailed within the submitted report, be noted.

REGENERATION, TRANSPORT AND PLANNING

25 The Grand Quarter

Further to Minute No. 71, 21st October 2015, the Director of City Development submitted a report providing an update on the progress made in negotiations for the disposal and development of land at Belgrave Gardens and which also recommended that the Council exchanged an Option Agreement for the sale of such land.

Following consideration of Appendix 1 to the submitted report, together with the associated plan, designated as exempt from publication under the provisions of Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting, it was

RESOLVED –

(a) That approval be given to the Council exchanging an Option Agreement with Wade Lane Developments Limited for the sale of land at Belgrave Gardens on the terms as detailed within exempt appendix 1 to the submitted report;

(b) That approval be given for officers to negotiate the final terms for the disposal of Council owned land at Belgrave Gardens, and also for the disposal of the Council's freehold reversionary interest in Belgrave House, Commerce House and Warwick House, and that final terms for the disposals be approved by the Director of City Development under delegated powers; and

(c) That subject to an encouraging response to the Expressions of Interest by the Heritage Lottery Fund (HLF), the necessary authority be delegated to the Director of City Development, in liaison with the Executive Member (Regeneration, Transport and Planning), to submit a Stage 1 bid to the HLF in support of a heritage-led regeneration programme for the Grand Quarter.

26 Design and Cost Report: Proposed Maintenance Works: Leeds Grand Theatre

The Director of City Development submitted a report regarding proposed maintenance works in respect of the Leeds Grand Theatre and which sought approval for an injection of funding into the Capital Programme, together with 'Authority to Spend', in order to enable such maintenance works to be undertaken.

Following consideration of Appendices 1 and 2 to the submitted report, designated as exempt from publication under the provisions of Access to Information Procedure Rule 10.4(3), which were considered in private at the conclusion of the meeting, it was

RESOLVED –

(a) That an injection of funding into the Capital Programme, together with an 'Authority to Spend' on the proposed maintenance works to the

Leeds Grand Theatre, as detailed within exempt Appendix 1 to the submitted report, be approved;

(b) That in the event that the injection of funding and 'Authority to Spend', as detailed within exempt Appendix 1 proves insufficient, the Deputy Chief Executive and the Director of City Development with the concurrence of the Executive Member for Economy and Culture be authorised to approve a further injection and 'Authority to Spend', as detailed in exempt Appendix 1, in order to facilitate the proposed maintenance works to the Theatre.

27 Leeds City Region Enterprise Zone update and Infrastructure Delivery

The Director of City Development submitted a report which provided an update on the progress achieved to date in respect of the Leeds City Region Enterprise Zone and highlighted the priority areas of work moving forward. The report also sought approval to commence a procurement process and utilise Council owned land to deliver a power solution which was intended to ensure that the required infrastructure was in place to facilitate the continued delivery within the Enterprise Zone and wider Aire Valley area.

Following consideration of Appendix 1 to the submitted report, designated as exempt from publication under the provisions of Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting, it was

RESOLVED –

(a) That the progress made to secure development and occupation of new floorspace within the Enterprise Zone, be noted;

(b) That the recommendations made within the 2015 Enterprise Zone Growth Plan, be noted;

(c) That a procurement exercise by the Director City Development to deliver improved infrastructure within the Enterprise Zone, in consultation with the Executive Member for Regeneration, Transport and Planning, and subject to funding being confirmed by the Local Enterprise Partnership (LEP), be approved;

(d) That the necessary authority be delegated to the Director City Development in order to enter into negotiations and agree a contract to deliver the required infrastructure improvements;

(e) That the necessary authority be delegated to the Director City Development in order to agree terms for the use of Council owned land adjacent to the A63 to accommodate a new electricity substation;

(f) That the proposed funding mechanism to support delivery of the infrastructure improvements within the Enterprise Zone, be noted;

(g) That the necessary authority be delegated to the Director City Development in order to inject funding from the LEP into the Council's Capital Programme, in order to support infrastructure delivery within the Enterprise Zone.

28 Design and Cost Report for Acquisition of Properties for the Council's Investment Portfolio

The Deputy Chief Executive and the Director of City Development submitted a joint report regarding the terms for the acquisition of two newly constructed buildings in Leeds (3 Sovereign Square and Unit 1 Logic Leeds) which could be added to the Council's property investment portfolio.

Members welcomed the proposals to acquire the properties, as detailed within the submitted report.

It was confirmed to the Board that the name of the tenant to occupy Unit 1, Logic Leeds (Amazon) was now in the public domain. Following this, an enquiry was raised about potential concerns regarding the working practices of that company. In response, it was confirmed that regardless of whether the Council bought the property, Amazon had obtained the lease of Unit 1, Logic Leeds, and as such, should Members have concerns about the working practices of the company on their Leeds premises, then a dialogue could be had with them. In connection with this, Members also considered the possibility of establishing an ethical landlord policy for the Council.

Following consideration of Appendix 1 to the submitted report, designated as exempt from publication under the provisions of Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting, it was

RESOLVED –

(a) That the acquisition of 3 Sovereign Square as an investment on the terms as detailed within exempt Appendix 1 to the submitted report, be approved;

(b) That the acquisition of Unit 1 Logic Leeds as an investment on the terms as detailed within exempt Appendix 1 to the submitted report, be approved;

(c) That the injection into the Capital Programme, together with the associated 'Authority to Spend', for the sums as detailed within exempt Appendix 1, be approved;

(d) That the Director of City Development, under the scheme of Delegation, be authorised to approve any changes to the recommended terms which may be necessary prior to completion, and that the Director of City Development also be authorised to complete the acquisitions;

(e) That the Director of City Development be authorised to investigate the acquisition of additional investment opportunities which will further enhance the strength and performance of the Council's investment portfolio in supporting the Council's budget and stimulating economic regeneration and confidence as part of a strategic investment fund;

(f) That the resolutions, as detailed within this minute be exempted from the Call In process, for the reasons as set out within paragraph 4.5.3 of the submitted report (detailed below);

(g) That the recommendation, as detailed at paragraph 10.1 of exempt Appendix 1 be approved, and that the Director of City Development be authorised to facilitate this resolution.

(The Council's Executive and Decision Making Procedure Rules state that a decision may be declared as being exempt from Call In by the decision taker if it is considered that any delay would seriously prejudice the Council's, or the public's interests. In line with resolution (f) above, the resolutions contained within this minute were exempted from the Call In process as the Council is purchasing 3 Sovereign Square under the provision of an option agreement which requires the transaction to be exchanged within 20 days of notice being served by the vendor. By variation, the vendors have agreed to extend this to a long-stop date of the 27 June to exchange. Accordingly, if the Council does not exchange by that date it will lose its special position afforded by the option agreement. This situation would place the purchase under significant risk. Similarly, with respect to Unit 1 Logic Leeds, the price negotiated has been concluded on the basis that the sale is completed by 30 June 2016 to be before the end of the vendor's financial year. Should the sale not complete to that timescale, the Council would be at risk of the sale and the purchase price being re-opened for negotiation in open competition with other parties).

29 Holbeck, South Bank Supplementary Planning Document (SPD) - Adoption

Further to Minute No. 160, 9th March 2016, the Director of City Development submitted a report presenting feedback from the public consultation exercise undertaken on the draft Holbeck, South Bank Supplementary Planning Document (SPD) and which requested approval of the proposed changes arising from this. Specifically, the report recommended the adoption of the re-drafted SPD, which would formally replace the existing Holbeck Urban Village Revised Planning Framework, previously adopted as Supplementary Planning Guidance in 2006.

Members acknowledged and welcomed the proposal to now refer to the area as Holbeck, rather than 'Holbeck Urban Village'.

RESOLVED –

(a) That the contents of the submitted report, together with the associated formal consultation statement, be noted;

(b) That the renaming of the Holbeck Urban Village, South Bank Supplementary Planning Document to 'Holbeck, South Bank Supplementary Planning Document' be approved, and that officers commence dialogue with residents and partners in order to consider how best to market and promote this area of the city;

(c) That the Holbeck, South Bank Supplementary Planning Document be adopted in the form as appended to the submitted report, pursuant to section 23 of the Planning and Compulsory Purchase Act 2004 (as amended);

(d) That it be noted that the Chief Planning Officer will publish the Holbeck, South Bank Supplementary Planning Document (SPD) and associated documents in accordance with the Town and Country planning (Local Planning) (England) Regulations 2012 Compulsory Purchase Act 2004 (as amended).

30 Dewsbury Road: Integrated Road Safety Scheme

The Director of City Development submitted a report which sought approval of the detailed design and implementation of the Dewsbury Road integrated road safety scheme and the associated Traffic Orders.

Responding to an enquiry, the Board noted that local Ward Members had been consulted, and that further consultation would continue, as the scheme progressed.

RESOLVED –

(a) That the scheme, as detailed within the submitted report, be approved, and that the detailed design and implementation of said package of measures, as shown on drawing TM-10-2377-GA-01b, as appended to the submitted report, be authorised;

(b) That authority to incur expenditure of £600,000, comprising of £495,000 works costs, £100,000 staff fees and £5,000 legal fees, be approved, and which are all to be funded from the Local Transport Plan Transport Policy Capital Programme;

(c) That it be noted that all remaining decisions following detailed design relating to the proposed Traffic Regulation Orders, Speed Limit Order, Movement Order, Section 90c Notices and the designation of cycle tracks on the public highway will be reported to the Chief Officer (Highways and Transportation) using existing powers under the Officer Delegation Scheme (Part 3, Council Constitution) and sub-delegated by the Director of City Development.

(Under the provisions of Council Procedure Rule 16.5, Councillor A Carter required it to be recorded that he abstained from voting on the decisions referred to within this minute)

31 Design and Cost Report for the Repair of Linton Bridge and other Highway Infrastructure Assets damaged during Winter Storms of 2015

The Director of City Development submitted a report providing details regarding the cost of repairs to Council owned infrastructure as a result of the flooding in December 2015 and the grant award funding from government to effect repairs. Specifically, the submitted report detailed proposals regarding the repair of Linton Bridge and which sought support to approach Central Government to make additional funds available for broader infrastructure works.

Members received an update on the currently projected timeframe for the completion of the bridge, whilst the complexities of the project were noted. In addition, further information was also provided on the actions being taken to progress other assets which had been damaged by the 2015 winter storms.

RESOLVED –

(a) That the contents of the submitted report be noted;

(b) That the proposal not to pursue the provision of a temporary bridge between Linton and Collingham be approved;

(c) That the injection of £4.5m government grant for local road repairs into the Bridge Maintenance Capital Programme, together with associated 'Authority to Spend', be approved, for the sole purpose of expeditious repairs to Linton Bridge, with any remaining funding at the completion of the repairs to be distributed proportionally to the cost of repairs to other Leeds City Council infrastructure assets;

(d) That the Permanent Works be procured and delivered in line with the dates as identified within section 3.11 of the submitted report;

(e) That support be given to an approach being made to Central Government to make additional funds available for broader infrastructure works;

(f) That it be noted that the Chief Officer Highways and Transportation is responsible for the implementation of such matters.

32 The Future of Transport in Leeds

Further to Minute No. 72, 21st October 2015, the Director of City Development submitted a report which provided details of the Secretary of State for Transport's decision to not grant the legal powers (under the Transport and Works Act) needed to construct and operate a trolleybus system in the form that was presented through the related Public Inquiry. In addition, the report highlighted that the funding allocated for New Generation Transport (NGT), £173.5m, would remain as allocated for schemes within Leeds, whilst it also presented the proposed next steps regarding the future of transport in Leeds.

Members made reference to the way in which such matters had recently featured in the local press.

Having noted the proposal to draw up an outline strategic case for the funding by the early autumn, Members discussed such timescales and looked forward to further discussion on this matter.

RESOLVED –

(a) That the Government's decision regarding NGT, as detailed within the submitted report, be noted;

(b) That it be agreed that the Council do not make an application for a Judicial Review of the Secretary of State decision, now that the Department for Transport (DfT) has been allocated £173.5m for transport in Leeds;

(c) That it be noted that the Leader has asked for an associated scrutiny inquiry to take place, and that support be given to the proposal that the DfT and the West Yorkshire Combined Authority (WYCA) be invited to participate;

(d) That approval be given to a letter being sent to the Secretary of State for Transport which outlines concerns about the process of developing public transport schemes in order to help lessons to be learnt nationally;

(e) That officers be requested to undertake city wide engagement on developing a new long term transport vision and an associated transport plan, including for the allocation of the £173.5m;

(f) That approval be given for officers to work in partnership with WYCA and the DfT to draw up an outline strategic case for the funding by the early autumn for submission to Secretary of State for Transport with the aim that by the end of the year we will have reached a clear, transparent and concise funding agreement for the £173.5m with Government.

DATE OF PUBLICATION: FRIDAY, 24TH JUNE 2016

LAST DATE FOR CALL IN OF ELGIBLE DECISIONS: 5.00 P.M., FRIDAY, 1ST JULY 2016

(Scrutiny Support will notify Directors of any items called in by 12.00noon on Monday, 4th July 2016)

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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: 26 July 2016

Subject: Chairs Update – July 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 last meeting.

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 the Scrutiny Board was formally advised of the Chairs activities between the monthly meeting cycles. It is proposed to continue this method of reporting for the current municipal year, 2016/17.

2.3 The purpose of this report is, therefore, to provide an opportunity to formally update the Scrutiny Board on the Chair's activity and actions, including any specific outcomes, since the previous meeting in June 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. 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.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny

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

Date: 26 July 2016

Subject: Budget Monitoring

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. As part of the Scrutiny Board's consideration of its future work programme at the meeting in June 2016, the Board identified routine budget monitoring of Adult Social Services and Public Health as a regular activity.

2. To assist the Scrutiny Board in this activity, attached is the Executive Board report, '*Financial Health Monitoring 2016/17: Month 2 (May 2016)*' for consideration.

3. Appropriate representatives have been invited to the meeting to discuss the details as they relate to of Adult Social Services and Public Health, and address issues raised by the Scrutiny Board.

Recommendations

4. That the Scrutiny Board considers the attached Executive Board report (as it relates to the remit of the Scrutiny Board) and agrees any specific scrutiny actions that may be appropriate.

Background documents[1]

5. 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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Leeds CITY COUNCIL

Report author: Alan Gay/Doug Meeson
Tel: 74250

Report of the Deputy Chief Executive

Report to Executive Board

Date: 22nd June 2016

Subject: Financial Health Monitoring 2016/17 – Month 2 (May 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

Summary of main issues

1. The purpose of this report is to inform the Executive Board of the financial health of the authority in respect of the revenue budget, and the Housing Revenue Account.

2. The 2016/17 financial year is the first year covered by the 2015 Spending Review and again presents significant financial challenges to the Council. The Council to date has managed to achieve considerable savings in the order of £330m since 2010 and the budget for 2016/17 will require the Council to deliver a further £76m of savings.

3. The current and future financial climate for local government represents a significant risk to the Council's priorities and ambitions. Whilst the Council continues to make every effort possible to protect the front line delivery of services, it is clear that the position is becoming more difficult to manage and it will be increasingly difficult over the coming years to maintain current levels of service provision without significant changes in the way the Council operates. For the period 2017/18 to 2019/20, the estimated budget gap is around £90m, of which some £60m is front-loaded into 2017/18.

4. This is the first budget monitoring report of the year, and Executive Board will recall that the 2016/17 general fund revenue budget, as approved by Council provides for a variety of actions to reduce net spend by £31.5m delivering some £76m of budget action plans by March 2017. At this early stage of the financial year, it is clear that

the majority of these actions are on track to be delivered, however this report highlights a potential overall overspend/risk of £3m, although it should be noted that measures are being put into place to reduce this figure.

5. At month 2, the Housing Revenue Account is projecting a balanced budget position.

Recommendation

6. Executive Board are asked to note the projected financial position of the authority.

1. Purpose of this report

1.1 This report sets out for the Executive Board the Council's projected financial health position for 2016/17 at month 2.

1.2 Budget Monitoring is a continuous process throughout the year, and this report reviews the position of the budget and highlights potential key risks and variations after the first two months of the year.

2. Background information

2.1 Executive Board will recall that the net budget for the general fund for 2016/17 was set at £496.4m, supported by the use of £3.5m of general reserves.

2.2 Following the closure of the 2015/16 accounts, an underspend of £0.4m was achieved. This represented a marginally better position than the assumptions made when setting the 2016/17 budget.

2.3 The balance of general reserves at the end of March 2016 was £21.3m and when taking into account the budgeted use of £3.5m in 2016/17 will leave an anticipated balance at March 2017 of £17.8m.

2.4 Financial monitoring continues to be undertaken on a risk-based approach where financial management resources are prioritised to support those areas of the budget that are judged to be at risk, for example the implementation of budget action plans, those budgets which are subject to fluctuating demand, key income budgets, etc. This has again been reinforced through specific project management based support and reporting around the achievement of the key budget actions plans.

2.5 This first monitoring report in 2016/17 is intended to highlight the potential risks at an early stage in the financial year. A more detailed quarter 1 report, including financial dashboard information for all directorates, will be presented to the July meeting of the Executive Board.

2.6 Looking beyond 2016/17, the estimated funding gap for the period 2017/18 and 2019/20 is around £90m of which £60m is front-loaded into 2017/18. This estimated funding gap recognises the Government's assessment of Core Spending Power for Leeds and therefore assumes Council Tax increases of 1.99% and Adult Social Care precept increases of 2% in 2017/18, 2018/19 and 2019/20.

2.7 A report will be brought to the Executive Board in September 2016 to update the medium-term financial strategy to take into account the implications of the

government's 4-year funding offer, potential increasing funding from local taxation and income, the impact of increasing demand and cost pressures and ultimately what actions and decisions will need to be taken in order to stay within the available financial resources.

3. Main Issues

3.1 After two months of the financial year an overspend of £3m is projected, as shown in Table 1 below.

Table 1

		(Under) / Over spend for the current period			
Directorate	**Director**	**Staffing**	**Total Expenditure**	**Income**	**Total (under) /overspend**
		£000	**£000**	**£000**	**£000**
Adult Social Care	Cath Roff	(2,470)	(668)	860	192
Children's Services	Nigel Richardson	(500)	4,900	(1,300)	3,600
City Development	Martin Farrington	(100)	(140)	(70)	(210)
Environment & Housing	Neil Evans	0	0	0	0
Strategy & Resources	Alan Gay	(338)	(338)	338	0
Citizens & Communities	James Rogers	0	0	0	0
Public Health	Dr Ian Cameron	0	0	0	0
Civic Enterprise Leeds	Julie Meakin	1,185	2,392	(2,392)	0
Strategic & Central	Alan Gay	0	(114)	(487)	(601)
Total Current Month		**(2,223)**	**6,032**	**(3,051)**	**2,981**

3.2 The major variations are outlined below;

3.2.2 Adult Social Care - the directorate is currently projecting an overspend of £0.2m. Some slippage has been identified in delivering budget action plans totalling £0.5m, but at this early stage in the financial year most are projected to be achieved over the remaining months. There is some slippage in delivering specific actions for savings of £0.3m within the learning disability community care packages budget. Slippage of £0.2m relates to the ongoing Better Lives programme within older people's residential and day care services. In addition, there is a potential pressure of £1.7m (0.9%) around community care packages with the main variation relating to residential and nursing care placements which reflects the demand trends in the last quarter of 2015/16 and a higher number of residents at the start of the current financial year than was assumed when the budget was set. Also, spend on the learning disability pooled budget is higher than budgeted, which again reflects the impact of the trend in spend in the last quarter of 2015/16 and also some slippage in delivering the 2016/17 budgeted savings. These increases are partly offset by savings in the direct payments budget, which is projected to be slightly lower than budgeted.

Staffing – savings of £2.5m (around 4%) are forecast. Savings within Access and Care Delivery total some £1.3m, mainly reflecting reducing staffing numbers within the Community Support Service since the budget was set and vacancies within the care management and business support services. Savings of £1.2m are projected in commissioning services, resources and strategy and health and well-being due to ongoing vacancies.

3.2.3 Children's Services – overall at month 2 some significant pressures on the demand-led budgets means that Children's Services are projecting to spend over the budget by £3.6m. The main budget pressure is in the demand-led children in care budgets with a potential £5m risk of which £3.5m relates to externally provided residential placements and £1.5m relates to placements with Independent Fostering Agencies (IFAs). Since 2012/13 there has been a significant reduction in both numbers and costs of these placements. Currently there are 1,250 children looked after, which includes 61 external residential placements and 231 IFA placements. During the first half of 2015/16 there was a continued reduction in placements but towards the end of the year there was an increase in the number of external residential placements and so far this trend has continued into 2016/17. Part of the increase in demand results from the increased emphasis for 'Staying Put' included in the Children and Families Act which has seen an increase in the length of IFA placements. Various actions initiated by the directorate are anticipated to result in placement numbers reducing during the year although they are unlikely to fall to the level assumed in the budget.

A further pressure is around transport where a rise in the number of children and young people requiring education outside the city and in their complexity of need has resulted in a £1.7m potential pressure against the budget.

The directorate has committed to a number of actions to mitigate against these budget pressures including additional controls on recruitment, looking at opportunities to reduce staffing spend, opportunities for additional income, reviewing contracts and a line by line review of all areas of spend to mitigate against the projected overspend. Savings of £2m from these actions are included in the projection. There is a risk that this level of savings will not be realised but the position will be closely monitored.

3.2.4 Strategic & Central budgets – the potential £0.6m underspend highlighted at month 2 reflects a potential £0.4m saving against the levy payment to the business rates pool and also the transfer of £0.7m from the Capital Reserve to offset a potential pressure of £0.4m in respect of the debt budget.

3.3 Other Financial Performance

3.3.1 Council Tax

The Council Tax in-year collection rate at the end of April was 10.2% which is in line with the performance in 2015/16. At this early stage the forecast is to achieve the 2016/17 in-year collection target of 95.9% collecting some £299m of income.

3.3.2 Business Rates

The business rates collection rate at the end of April was 10.76% which is 0.89% ahead of the performance in 2015/16. The forecast is to achieve the 2016/17 in-year collection target of 97.7% collecting some £388m of income.

4. Housing Revenue Account (HRA)

4.1 At the end of month 2 the HRA is projecting a balanced position against the 2016/17 Budget.

5. Corporate Considerations

5.1 Consultation and Engagement

5.1.1 This is a factual report and is not subject to consultation

5.2 Equality and Diversity / Cohesion and Integration

5.2.1 The Council's revenue budget for 2016/17 was subject to Equality Impact Assessments where appropriate and these can be seen in the papers to Council on 24th February 2016.

5.3 Council Policies and Best Council Plan

5.3.1 The 2016/17 budget targeted resources towards the Council's policies and priorities as set out in the Best Council Plan. This report comments on the financial performance against this budget, supporting the Best Council ambition to be an efficient and enterprising organisation.

5.4 Resources and Value for Money

5.4.1 This is a revenue financial report and as such all financial implications are detailed in the main body of the report.

5.5 Legal Implications, Access to Information and Call In

5.5.1 There are no legal implications arising from this report.

6. Recommendations

6.1 Executive Board are asked to note the projected financial position of the authority.

7. Background documents[1]

7.1 None

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

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Report author: Steven Courtney
Tel: 24 74707

Report of the Head of Scrutiny and Member Development

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

Date: 26 July 2016

Subject: Leeds Health Academic Partnership

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

1.0 Purpose

1.1 The purpose of this report is to introduce the Executive Board report '*A Business Case for a Leeds Health Academic Partnership'* consider by the Executive Board at its meeting on 20 April 2016.

2.0 Summary of issues

2.1 The Executive Board report '*A Business Case for a Leeds Health Academic Partnership'* was consider by the Executive Board at its meeting on 20 April 2016 and is appended to this report.

2.2 At its meeting, the Executive Board made the following resolutions:

(a) That the Business Case for the LAHP and its programme to deliver: better Health Outcomes; reduced Health Inequality; more jobs together with the development of skills and technology; and the stimulation of investment in health and social care, be supported;

(b) That support be given to the City Council's contribution towards the delivery of the LAHP's programme of work, as set out within the business case (appended to the submitted report), including potential sources of funding and metrics identified in the document, to drive investment and create jobs in the city's health economy and that its work be developed within the city's agreed Joint Health and Wellbeing Strategy;

(c) That further reports detailing the progress being made by the LAHP be submitted to future meetings of the Board for consideration, as and when appropriate;

(d) That it be noted that the Chief Officer (interim), Health Partnerships Team, will be responsible for overseeing the implementation by the LAHP.

2.3 At its meeting on 18 May 2016, when receiving the minutes from the Executive Board meeting, the previous Scrutiny Board resolved:

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.

2.4 Appropriate representatives from Leeds City Council's Health Partnerships Team have been invited to the meeting to outline the attached report, including any progress around implementation, and address any specific questions from the Scrutiny Board.

3.0 Recommendations

3.1 The Scrutiny Board is asked to consider the details presented in attached Executive Board report and determine any further scrutiny activity..

4.0 Background Papers

None[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.

Report author: Colin Mawhinney
Tel: 0113 2474306

Report of: **Report of the Director of Public Health and Director of City Development**

Report to: **Executive Board**

Date: **20th April 2016**

Subject: **A Business Case for a Leeds Academic Health Partnership**

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

Summary of Main Issues

1. In March 2015 Leeds City Council Executive Board supported, in principle, Leeds City Council's work with the city's universities and local NHS partners to establish a Leeds Academic Health Partnership (LAHP) to help improve the health of the local population by developing skills and technology and stimulating investment in health and social care. This was subject to the development of a business case setting out its priorities, funding, structure and metrics going forward and its work being positioned within the city's agreed Joint Health and Well Being Strategy with progress updates reportable to the Leeds Health and Wellbeing Board.

2. There has never been a more a compelling time to establish the Leeds Academic Health Partnership (LAHP). The NHS Five Year Forward View and financial climate make it imperative that health and care services work more closely together. Locally, partners in Leeds are seeking to utilise their assets to realise improved health outcomes with our universities included.

3. The LAHP has a clear purpose: ***To improve the health and wellbeing of the people of Leeds by engaging the educational and research capabilities of all three universities in Leeds with the health and social care system in order to speed up the adoption of research and innovation; creating inward investment, and raising the national and international profile and reputation of the city and its statutory authorities.***

4. It will support service improvement and deliver benefits focussed on improving health and wellbeing, reducing health inequalities and creating wealth. In particular, the LAHP will make a major contribution to two important areas of work that help to realise these benefits – developing our health and care workforce and harnessing information and technology (informatics).

5. It is uniquely well placed to deliver these outcomes. Whilst other major UK cities have the equivalent of a LAHP few are as inclusive as the Leeds model and Leeds has applied learning and also maximised our unique strengths and assets to place this partnership on a viable footing

6. The LAHP will remain for now as an informal partnership but as it capabilities develop in competing for investment against other cities this may need to be reviewed. This will be a lean structure with a small team. The costs will be shared across partners according to size with the Councils share at £102K. The metrics to measure the effectiveness of this spend include improved success rates for bids, jobs created, and lives improved

Recommendations

7. Executive Board is requested to:

    i. Support the Business Case for the Leeds Academic Health Partnership and its programme to deliver better Health Outcomes, reduced Health Inequality and more jobs developing skills and technology and stimulating investment in health and social care.

    ii. Support the City Council's contribution to the delivery of the LAHP's programme of work as set out in the business case including potential sources of funding and metrics identified in the document, to drive investment and create jobs in the City's health economy and that its work should be developed within the City's agreed Joint Health and Well-being Strategy.

    iii Note that the Chief Officer (interim), Health Partnerships Team will be responsible for overseeing implementation by the LAPH of its Business Case.

1. Purpose of this report

1.1 This report explains why Leeds City Council should support the business case for a City Academic Health Partnership, summarises the business case and its purpose to act as a collaborative action. It places the role of the Leeds Academic Health Partnership in a wider strategic context of the Council's Corporate Plan priorities to create a strong economy and compassionate city. It describes the framework within which the proposed Leeds Academic Health Partnership will operate including its strategic priorities and opportunities, financial and non-financial outcomes, governance funding and fit with other partnership structures as well as some of the challenges it must address to remain successful between 2016-20.

2. Background information

2.1 In March 2015 Leeds City Council Executive Board supported, in principle, Leeds City Council's work with the city's universities and local NHS partners to establish a Leeds Academic Health Partnership to help improve the health of the local population by developing skills and technology and stimulating investment in health and social care. The LAHP Board consists of: Leeds City Council; the Leeds Teaching Hospital NHS trust; Leeds and York Partnership NHS Foundation Trust; Leeds Community Healthcare; the city's three Clinical Commissioning Groups; and three universities; University of Leeds, Leeds Trinity and Leeds Beckett. It makes provision for affiliate membership where this can add mutual value and incudes The Yorkshire and Humber Academic Health Science Network as an affiliate member. It is currently Chaired by Sir Alan Langlands VC of the University of Leeds and supported by a small team including time from Council Officers

2.2 It was proposed that this new Academic Health Partnership (LAHP), would in particular bring the city's universities into the city's wider programme of partnership driven, citizen centred transformation to deliver funding, investment, education, skills and technology to drive economic growth and deliver its ambition to be the best for health and wellbeing in the UK. In it's first year this would require support provided primarily through officer time

2.3 The Council's Executive Board also supported the development of a formal programme of work to support a funding contribution from the Council going forward including a business case, a proposed structure, sources of funding, metrics and targets to drive investment and create jobs in the City's health economy for approval by the Executive Board..

2.4 Business and Specialist Health Advisors, Ernst and Young (EY) were selected to produce a Business Case for the LAHP covering the period to 2020 following a competitive tendering process.

3. Main issues

3.1 **The Strategic Need for an Academic Partnership:** The LAHP business case sets out the key health and social care opportunities and challenges which create the need for a new Partnership arrangement. Nationally, the NHS Five Year Forward View sets out how health services in England need to change to address a mismatch between resources and patient needs of almost £30billion by 2020/21, suggesting that action will need to be taken in three areas; demand, efficiency, and funding to bridge this gap. It also argues for a more engaged relationship with patients, carers and citizens to promote well-being and prevent ill-health. These themes were further developed by the NHS Mandate which seeks to help create the safest, highest quality health and care service including support for support research, innovation and growth.

3.2 In Social Care, in the context of budget reductions, alongside the continuing rise in need and the most significant change in legislation for 60 years, the challenge is to seek to shape the future through a strong evidence base of how to promote approaches at a national and local level.

3.3 Analysis of the Public Health England health profiles for 2015 [55] illustrates areas where the city is facing significant health challenges. While there are a few exceptions, on the profile metrics the city is invariably "significantly worse than" or "in line with" the national average. Whilst the profile paints a picture of a city facing not untypical health challenges for an urban area of northern England it clearly underlines the need to a solutions with both scale and impact to effect rapid improvement. The Draft Health and Wellbeing Strategy seeks to respond to these challenges and sets out a vision to create a healthy and caring city for all ages, where people who are the poorest will improve their health fastest'.

3.4 Funding to deliver its outcomes remains a challenge. Work by the City's Health and Social Care Transformation Board indicates that, net recurrent pressures for NHS providers and the Council are accumulating deficit for health and social care to 2020.

3.5 **The LAHP as a strategic response to the above issues:** It has long been clear that the nature of the health and social care challenges are such that individual statutory organisations cannot deliver alone. They need to work not only with each other but also with others outside the sector.

3.6 Working together in the Leeds Academic Health Partnership their strategic purpose will be ***To improve the health and wellbeing of the people of Leeds by engaging the educational and research capabilities of all three universities in Leeds with the health and social care system in order to speed up the adoption of research and innovation, creating inward investment, and raising the national and international profile and reputation of the city and its statutory authorities.***

3.7 Bringing partners and their assets and capabilities together in this way to address the problems and challenges set out above will support delivery of significant outcomes to benefit the city and its population including improved health, reduced inequality and the creation of wealth. These outcomes are aligned with the Vision in the City Council's Corporate Plan for Leeds to be a compassionate city with a strong economy.

3.8 **Improving Health and Wellbeing Outcomes:** The challenge is to deliver quality care that is safe, effective and with good outcomes and which provides a good personal experience for both adults and children. Harnessing the strength of the academic sector in the current work of the health and social care sector provides both increased capacity and capability to bring skills and experience to bear. The Business Case illustrates how this can deliver benefits by citing Cardiovascular disease as a leading cause of death and disability which in turn impacts on economy including that of Leeds. The Leeds Institute of Cardiovascular and Metabolic Medicine (LICAMM) at the University of Leeds is a leading centre for research into cardiovascular disease and could potentially support partners to make significant improvements in the prevention of cardiovascular disease and reduce its incidence and effects in the population.

3.9 **Reducing Inequalities:** Given the city's aspiration to improve the health of the poorest, the fastest – the LAHP could look at how the diversity of the City's population as an important "asset" and use that to its advantage. The combination of significant local BME population groups, together with an almost uniquely inclusive set of partners from all sectors of the NHS, local government and universities, offers an opportunity for the LAHP to not only

address local health inequalities but also develop a national and potentially international reputation for addressing those issues that impact most on BME populations, for example the high levels of prevalence of cardiovascular disease and diabetes in groups from Asian backgrounds, and utilising the specific local expertise around the use of mobile digital technologies. Similarly in respect of Young People, the Leeds Children's Hospital is developing its established research portfolio, which includes early phase trials in a wide variety of paediatric specialities and promoting suitable research projects to integrate its research teams into routine clinical and community activity.

3.10 **Creating Wealth:** The city has been successful in its goal of delivering recovery across a broad range of growth platforms including financial services, professional services and the wider digital industries as well as health and wellbeing

3.11 The LAHP will also provide a means through which innovative SMEs in the industry clusters (particularly in health informatics and medical technologies) can get more rapid access to the NHS and the wider local health and care system to develop new solutions and benefit from engagement with both local health and care planning and delivery organisations. The LAHP also provides a route for these SMEs to access the skills and expertise of three diverse universities covering almost all aspects of personal and community health, care and wellbeing.

3.12 **Enablers:** Two of the critical enabling factors which will support delivery of both national and local objectives are workforce modernisation and health informatics, covering use of both data and digital technologies.

3.13 In terms of workforce, the changing demographics and needs of the population, together with changes in the way care is delivered, particularly in primary and community settings, means that the capacity, capability and competencies – and location - of the future health and care workforce will change, in some cases very significantly. The changing dynamics between patients, carers and professionals – with a greater emphasis on professionals supporting patients and carers to self-manage - will also lead to a change in the skills needed by professionals. The LAHP could provide a key co-ordinating role in the way partners train and educate the workforce of the future and the delivery of improved outcomes through an integrated approach to health and social care delivery and will offer the potential for accelerated speed in adoption of research, as well as being an opportunity for economic growth through attracting students

3.14 Health informatics also provides another huge enabling opportunity. The increasing use of advanced data analytics to identify population health needs and more effectively and efficiently target the right kind of services, the use of informatics tools to support personalised care planning, and the adoption of new technologies to enable patients to play a greater part on their own self-care and interact in new ways with health and care professionals has the potential to be truly transformational. The report illustrates this potential by noting the appointment of Leeds as a centre of excellence within the UK Precision Medicine Catapult programme which involves members of the LAHP and suggests that this asset could play a pivotal role in providing the evidence base required to support better decisions to improve the population health

3.15 **Measuring Impact**: LAHP member organisations are conscious of the need to demonstrate the value added by the LAHP and the return on their investment. Early discussions have centred on identifying a simple set of metrics, which could be derived from the three core benefits of the LAHP:

- Improving health and well being – measured by “lives saved”
- Reducing inequalities – measured by “lives improved”
- Creating wealth – measured by “jobs created” and “inward investment secured”

3.16 Other Academic Health partnerships around the country measure their impact on a project by project basis with project level metrics can be specific to each initiative and the Business Case recommends that a similar approach should be used in Leeds. The approach should be adapted to include use of two different types of success indicators

3.17 LAHP success indicators – which are “means measures” – will be measured using SMART and quantitative metrics to report how well the LAHP is performing against the use of LAHP resources. Examples include number of bids submitted, bid conversion rate, events held etc, and the LAHP is accountable to its members for delivery of these activities.

3.18 System success indicators – which are essentially “ends measures” – will be used as part of project selection process. Examples include improving health, reducing inequality, generating wealth. Although the role of the LAHP is a critical factor in identifying projects, the LAHP does not track these or hold itself to account for them as they will be the responsibility of the delivery bodies.

4. Governance

4.1 The LAHP members recognise that the current style of working has achieved much, as evidenced by the successful creation of a strong portfolio of initiatives, but it has been highly dependent on the goodwill and commitment of a number of key individuals with substantive roles within their employing organisations.

4.2 During the current phase of informal partnership the University of Leeds has been acting as the “host” organisation for the LAHP, holding funds and paying bills on behalf of members, providing accommodation and meeting facilities, and IT and financial support. The future intention, should be to establish a more flexible and agile vehicle through which to progress the aims and objectives of the LAHP, whist remaining accountable to the LAHP members. The view of the LAHP members is that while a formal vehicle is likely to be required in the future, for the short term, the LAHP should continue as an informal partnership, hosted by the University of Leeds on behalf of the others, with a view to establishing an independent vehicle from 2017/18 onwards, subject to satisfactory progress in pursuit of the initial aims and objectives. Any formal decision for the City Council to participate in an independent arm’s length vehicle or company structure would be brought back to the Executive Board for approval.

4.3 As now, the LAHP will continue to operate as an informal collaboration of eleven fee-paying members (ten core plus one associate), supported by a LAHP team made up of a small number of substantive employees drawn from the core member organisations (with appropriate salary reimbursement to their employers to account for the time they spend on LAHP activity). Necessary “host” activity (such as financial and IT support) will continue to be provided by the University of Leeds.

4.4 A paper detailing the estimated cost of the Core Team – whether through directly employment, secondment or commissioned support – was submitted to and approved by the LAHP Board in May 2015, and this is estimated to be £683k for 2016/17

4.5 All LAHP member organisations have been engaged in a process to consider equitable methods for sharing LAHP costs, bearing in mind that the member organisations are of

widely varying size. Members have committed to a percentage contribution basis with the three largest Leeds City Council, University of Leeds and Leeds Teaching Hospital Trust each contributing 15% to the total cost of running the partnership. They have also agreed that any future expenditure agreed by the LAHP Board will be apportioned on the same basis, and in the event of there being any income to return to members, the same percentage shares will be applied.

4.6 **Delivering LAHP Activity:** As well as the tasks associated with establishing the LAHP as a sustainable body, the LAHP will progress the following priorities in 2016/17:

- Growth and development of a city-wide approach to personalised medicine and care, involving all LAHP member organisations, building on the early success of securing Leeds as a Precision Medicine Catapult Centre of Excellence
- Co-ordination of LIQH with the work of Clinical Senate and the LAHP
- Reassessment of the opportunity for local funding support for implementation of the NHS Innovation Test Bed Programme proposal
- Development of a Future Health and Care Academy to support local workforce development and develop national/international education and training offers
- Continued development of technological solutions including the Integrated Health and Care Record and associated related digital technologies and telesolutions.

5. Conclusions

5.1 While the Leeds health and care system has achieved much to date, there is still a strong case for the formal establishment of the LAHP to capitalise on the substantial assets already operating within the system, and to deliver added value for the LAHP member organisations in order to make a significant and measurable impact on the health and wellbeing of those people living and working in the city of Leeds

5.2 Of the eight English members of the UK Core Cities Group Leeds is one of the largest of cities to have not formally established any form of academic health centre or partnership.

5.3 Although the work of the individual partners to date has proved successful in attracting inward investment, creation of the LAHP on a formal basis will achieve a step change in the development of the city proposition to national bodies - and international bodies - and in attracting both public and private inward investment. It will also enable a more professional and integrated approach across the city to the development of responses to national and international initiatives.

6. Corporate Considerations - Consultation and Engagement

6.1 This report includes findings based on interviews with a range of key partners represented at the most senior levels and included the City Council, local NHS organisations and all three Universities. A list of the interviews has been included as Appendix C

7. Equality and Diversity / Cohesion and Integration

7.1 The Business Case includes reducing inequality as one of its three key priorities. It specifically refers to a shared goal by partners to bring an emphasis on health and wellbeing promotion, illness prevention and early intervention as a means of reducing inequalities. It notes that the LAHP can develop analytics-based insight and an understanding of the drivers and determinants which create and perpetuate health inequalities, and then through the research and application of that research – identifies the

actions to reduce levels of inequality whether at a personal level – such as the disparity in life expectancy across the city – or in the wellbeing of communities.

8. Council Policies and Best Council Plan

8.1 This Business Case proposes three key priorities of improving health outcomes, reducing inequalities and creating wealth which are aligned directly with the Council Plan's commitment to create a **'Strong Economy and Compassionate City'** and also commitments within the existing Joint Health and Wellbeing Strategy and the emerging Draft Joint Health and Wellbeing Strategy 2016-21.

9. Resources and value for money

9.1 Resources required to support the delivery of the Business Case by the LAHP will require an annual contribution of £102,450 from Leeds City Council towards total annual running costs of £683,000. This resource will be used to lever other flows of inward investment into the city health and care system arising from a number of public sector sources such as Innovate UK programmes and funding from Health Education England, all of which contribute to improve local services as well as support to local businesses applying for funding and support from sources such as the LEP, SBRI etc.

9.2 It is therefore proposed that City Development and Adult Social Care Directorates will contribute equally to the costs of running the partnership within existing budgets.

10. Legal Implications, Access to Information and Call In

10.1 This proposal is based on establishing a partnership which will be initially based on an informal partnership structure and without significant legal implications at this stage.

11. Risk Management

11.1 A full assessment of risk has been provided. This has been split into strategic risks and tactical risks. The greatest strategic risks is that Partners fail to agree support at the level required to ensure the LAHP remains viable and sustainably capable of developing and delivering its programmes in the longer term. By providing an ordered set of priorities, and activities to deliver these the Business Case helps to provide the assurance required to command support and mitigate this risk.

12. Recommendations

12.1 Executive Board is requested to:

i. Support the Business Case for the Leeds Academic Health Partnership and its programme to deliver better Health Outcomes, reduced Health Inequality and more jobs developing skills and technology and stimulating investment in health and social care.

ii. Support the City Council's contribution to the delivery of the LAHP's programme of work as set out in the business case including potential sources of funding and metrics identified in the document, to drive investment and create jobs in the City's health economy and that its work should be developed within the City's agreed Joint Health and Well-being Strategy.

iii. Note that the Chief Officer (interim), Health Partnerships Team will be responsible for overseeing implementation by the LAPH of its Business Case.

13. Background Documents[1]

None

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 Academic Health Partnership Business Case

March 2016

Building a better working world

Table of contents

1. Executive Summary

There has never been a more compelling time to establish the Leeds Academic Health Partnership (LAHP).

Nationally, the direction is clear: NHS England's Five Year Forward View and the financial climate make it imperative that health and care services work more closely together and that health and care systems utilise their wider assets to realise improved health outcomes. In Leeds, our three universities are central to helping our local health and care system make a step change in improving health and wellbeing, bringing their vast range of skills, knowledge and expertise to bear to help make robust, evidence-based decisions and accelerate the implementation of change.

The decision for each organisation to invest in a partnership arrangement at a time of austerity will always be a strategic one. The contribution of time and focus across Leeds' health, care and university sectors in developing the LAHP over the past year demonstrates that senior leaders see significant potential in this arrangement. The LAHP has already started to deliver benefits and will continue to make a positive and important contribution across the overlapping national, and local agendas outlined above. Making a clear commitment to its continued development now is a statement of intent for the city's ambition.

The LAHP has a clear purpose:

To improve the health and wellbeing of the people of Leeds by engaging the educational and research capabilities of all three universities in Leeds with the health and social care system in order to speed up the adoption of research and innovation; creating inward investment, and raising the national and international profile and reputation of the city and the LAHP member organisations.

Whilst ensuring we use our talents to make our mark on the national and international stage, the benefits that the LAHP seeks to bring are very much about improving the lives of people in Leeds; adding years to life and life to years. The LAHP aims to:

- *Improve health and wellbeing– ensuring that we address the health challenges that Leeds faces now – such as tackling our worse than average rates of cardiovascular disease and cancer – alongside taking the action needed now to mitigate the major health risks of the future, such as those caused through increased levels of obesity caused by factors such as diet and lack of exercise*

- *Reduce inequalities – helping redress the imbalance in the health of communities across the city by improving the health of those who need it most, the fastest - a stark example being the 10-year difference in male life expectancy between the most and least deprived wards in a city measuring a mere 15 by 13 miles in size.*

- *Create wealth – bringing investment into the city, both through greater involvement in national - and international - public sector programmes, alongside encouraging more private sector investment bringing jobs into the city, recognising that a major determinant influencing good health is employment.*

Applying world-class research knowledge and insight to help service improvement and re-design will contribute to improving services and reducing inequality. However, health and care services play only a small part in addressing overall population health; increased levels of education are strongly and significantly related to improved health, as is good housing; while and economic hardship – such as that caused by the lack of employment – is highly correlated with poor health. Education, employment, environment and housing matter for good health and wellbeing.

Within the city itself, the new five year Health and Wellbeing Strategy to be published in spring 2016, and our Sustainability and Transformation Plan for health and care services to follow in the summer, will both set out a clear ambition for Leeds to be the best city for health and wellbeing. This is an ambition built on the qualities of our people. It is an ambition that aims to reduce health inequalities and build a stronger economy, an ambition that can only be realised through stronger relationships.

Whilst there are already a variety of interactions between the LAHP partners, bringing them all together as a single, formal partnership offers a unique proposition to those outside the city who are, or are considering, engaging with Leeds with the intention of investing in our health and care economy. The LAHP cuts through the complexity of a major city, presenting a united approach and offering a single point of contact - one that combines academic and research excellence, the full range of frontline practice, access to the economic assets of the city and a uniquely diverse and broad-based population.

As Leeds increasingly competes with other national and international cities for investment, the LAHP places the city on a firmer footing to present the strength and simplicity of its partnership arrangements. Several other major UK cities already have the equivalent of a LAHP - although few are as inclusive as the Leeds model - and Leeds is looking to draw on the best learning from these, whilst also maximising our unique strengths and characteristics.

These themes resonate with the new Health and Wellbeing Strategy and the wider ambition that Leeds will be the best city in the UK by 2030 and will do so in a way that creates a strong economy within a compassionate city. In particular, the LAHP will make a major contribution to two important areas of work that help to realise these benefits – developing our health and care workforce for the future and harnessing the potential of information and technology (informatics). The LAHP will build a stronger link between the way people are trained and developed and the more integrated health and care system we need to rapidly develop for the future. It will ensure that cutting-edge informatics innovation, for which Leeds is already a leader within the health and care sector, continues to be developed, tested and supported in Leeds for the benefit of our own and wider populations.

Measuring success will be critical. The LAHP will combine measures of both the 'means' it brings to improve health and care - such as the number of successful bids it secures and the events and activities it facilitates - as well the 'ends' it plays a part in achieving - for example, projects initiated or supported by the LAHP which clearly result in improvements to health outcomes, reductions in levels of inequality or increased investment in the city. It will do this by creating the culture that enables leaders from across the partnership to think and work creatively and innovatively together, underpinned by clear governance arrangements.

We have huge potential – working together to a common purpose, our universities and statutory services are a powerful combination that can attract the best ideas, talent and investment from outside the city and affect major change within it. The Leeds Academic Health Partnership provides a focal point to make that happen.

2. Introduction

This section introduces the business case, its purpose and intended readership.

2.1 Purpose of the business case

The purpose of the business case is to act as a focus for collaborative action.

It sets out the rationale for the creation of the Leeds Academic Health Partnership (LAHP), describes its purpose and benefits, and goes on to articulate the financial costs and risks associated with its creation and operation.

2.2 Intended Audience

The primary target audience for this document is the Leeds City Council Executive Board to support them in identifying the value that the LAHP will deliver for the citizens of Leeds and providing evidence to support decisions regarding funding contributions.

The secondary audience is the remaining core members of the LAHP -- the three NHS Clinical Commissioning Groups, the three NHS provider Trusts and the three universities in Leeds – and the Yorkshire and Humber Academic Health Science Network, which is an associate member. This document aims to support their understanding of how the LAHP will help these member organisations to deliver against their organisational priorities.

2.3 The starting point

Leeds has a diverse population of some 810,000, spread throughout a city of 217 square miles. A further 2.2 million people live in the wider Leeds City region, the largest city region economy outside of London, with an economic output of £60bn GVA, of which some 10 per cent comes from health and care.

Within the city, there are three universities with a total of 70,000 students, including a Medical School with 6,000 undergraduates, together with a wide range of other health, wellbeing and social care academic research and educational teams.

Over the past 24 months, the local public sector organisations active in the Leeds health and care system have demonstrated their capability to work in a collaborative fashion and created momentum across a range of health and care related initiatives.

These initiatives have been established within Leeds, either organically through joint working by city partners - for example the development of the Leeds Care Record - or through collective bidding to secure the selection of Leeds as a host for major national initiatives such as its recent selection by Innovate UK as one of five Centres of Excellence for Precision Medicine. A summary of major initiatives and other "city assets" is included at Appendix A.

As well as the local "city assets", Leeds is a major centre for the NHS outside London. The following organisations are either headquartered here or have a sizeable presence in the city:

- *NHS England, responsible for over £106bn annual healthcare spend*
- *the Health and Social Care Information Centre, which hosts national health and social care data collections,*
- *the NHS Leadership Academy, responsible for leadership development and training throughout the NHS*
- *Health Education England, the national body responsible for planning professional healthcare education and training.*

Leeds is also home to the National Coordinating Centre of the Clinical Research Network for the ***National Institute for Health Research***, the Northern regional headquarters of ***Public Health England;*** and the headquarters of ***NHS Employers.***

3. National and local context

This section summarises national and local health and social care challenges.

3.1 NHS Five Year Forward View and the NHS England Mandate

Published in October 2014, the Five Year Forward View[1] is the most recent strategy document outlining the challenges facing the NHS. It sets out how health services in England need to change to address a mismatch between resources and patient needs of almost £30m by 2020/21, suggesting that action will need to be taken in three areas -- demand, efficiency and funding -- to bridge this gap. It also argues for a more engaged relationship with patients, carers and citizens to promote well-being and prevent ill-health.

NHS England is responsible for arranging the provision of health services in England. The Government's objectives and any requirements for NHS England, as well as its budget are set out in the national Mandate for NHS England[2]. The mandate sets direction for the NHS, and helps ensure the NHS is accountable to Parliament and the public.

The mandate sets out NHS England's contribution to the Government's goals for the health and care system as a whole, in line with the manifesto commitments.

The latest version of the mandate was published in December 2015. It sets out:

- *objectives to 2020;*
- *requirements relating to the Better Care Fund;*
- *NHS England's budget for five years.*

The mandate is structured around seven objectives as illustrated in Table 1 below. All local NHS organisations will be held to account against the delivery of these objectives.

1 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

2 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/494485/NHSE_mandate_16-17_22_Jan.pdf

1. **Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.** Secure measurable reductions in inequalities in access to health services, in people's experience of the health system, and across a specified range of health outcomes.

2. **To help create the safest, highest quality health and care service.** Roll-out seven day services; significantly reduce avoidable deaths; reduce still births, neonatal and brain injuries; improve antimicrobial prescribing and resistance rates; improve patient experience; improve cancer survival rates

3. **To balance the NHS budget and improve efficiency and productivity.** Balance the books; achieve efficiency savings; improve primary care productivity

4. **To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.** Measurable reduction in childhood obesity; reduce risk of diabetes; PM's 2020 Dementia challenge

5. **To maintain and improve performance against core standards** To cover areas such as A&E waiting times, Referral to Treatment times, ambulance response times

6. **To improve out-of-hospital care.** New models of care and general practice; evening/weekend access; reduce hospital admission rates; better integration of health and social care, including fewer delayed transfers of care; parity for mental health

7. **To support research, innovation and growth.** Improve UK ranking for health research; improve in uptake of new innovations including digital technologies; deliver 100,000 genomes programme

Table 1 – NHS Mandate

3.2 The challenge for Social Care

Our ageing population, living longer but often living with long term conditions, will increasingly need co-ordinated, person centred social support services, shaped around their needs and those of their carers. The clear expressed desire from people with have such needs is for as much choice, control and independence as possible, and a consistent, joined-up service.

However, after four years of budget reductions, alongside the continuing rise in need and the requirement to meet the provisions of The Care Act[3], the most significant change in social care legislation for 60 years, the challenge facing local health and care systems is to meet these needs for a more personalised approach to social care and ensuring that shifts in the commissioning and provision of care do not have unintended consequences in terms of simply moving problems between health and social care, whilst living with an incresingly constrained financial system. The financial challenge is further exacerbated as a result of the cost pressures for social care providers to implement the national living wage, a challenge in a sector with a substanial proportion of its workforce being low paid.

The Care Act is now law and requires significant co-ordination at national and local level. The major issues are understanding the costs and being confident that not only are the provisions of the Act funded, but the overall funding for social care is sufficient. The other dimension is how many people who are currently self funders or carers will take up the offer of additional funding or help, and the extent to which removing thresholds for safeguarding impact on those needing support

As well as the underlying increasing demand for social care support for older people, safeguarding has become increasingly important. There has been an increase in safeguarding referrals as a result of increased public awareness of safeguarding in domestic and community settings and concerns about the quality of regulated care.

3 http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Furthermore Transforming Care **[63],** the post Winterbourne View programme, was a commitment to reduce the numbers of people with learning disabilities who are in specialist hospitals.

Although there has been much debate about the need for integration between health and social care, such integration must not be seen as an end in itself but simply as a step on a route to achieving better health and wellbeing outcomes. Integration in itself will not signifincatly increase the size of the resources available – although there may be opportunities for economies of scale and increased productivity – but rather provides the opportunity to take a fresh, balanced look at what servics are required to deliver maximum health and wellbeing benefit and value from across the the complete health and care system.

Social care commissioners are already engaging strongly with the Five Year Forward View, the local development of models of care and in testing partnership arrangements. The expectation is that local government will be a full and active partner in the development of the 5-year Sustainability and Transformation Plans, recognising that social care services are critical to achieving transformation of NHS services, which are seeing an increasing shift of care out of hospital settings and into the community.

Many published research reports emphasise the importance of the interdependent relationship between health and social care including those from the National Audit Office, the Kings Fund, the Nuffield Trust and the much respected Barker Commission[4]. As well as calls for the integration of health and social care budgets, the research also advocates developing strong partnership working across agencies to collectively consider how best to use their joint resources to maximise value in terms of improving health and wellbeing for a population, an approach already in train in Leeds through the concept of the "Leeds Pound" and extensive joint planning activity.

The 2015 Spending Review provided new powers for councils to raise Council Tax by up to two percent to spend on social care. While giving additional flexibility to councils, implementation of such a policy will be for local political determination and may disadvantage deprived areas with low tax bases.

Regardless of the sources of funding, the ultimate aim must be to ensure that health and care services enable `right care, right place, right time' in order to improve health and wellbeing outcomes and reduce the level of inequality. Academic research and insight has an important part to play in supporting NHS organisations and the Council to make robust evidence-based decisions which maximise the benefit from the available resources.

3.3 The Leeds health challenge

In addition to the national challenge of improving access and outcomes whilst reducing cost, Leeds has some specific health and social care issues.

In common with the rest of the UK, the Leeds health and care system is facing a combination of challenges of an ageing population living with multiple long-term conditions combined with population lifestyle factors or behaviours around diet, smoking and alcohol, all leading to a continual increasing demand for health and care services at a time when funding levels are constrained. Analysis of the Public Health England health profiles for 2015 **[55]** illustrates areas where the city is facing significant health challenges. While there are a few exceptions, on the profile metrics the city is invariably "*significantly worse than*" or "*in line with*" the national average.

The profile paints a picture of a city facing not untypical health challenges for an urban area of northern England with significant populations of mixed ethnic groups, and where lifestyle factors play a significant bearing on the overall health of the population.

[4] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Commission%20Final%20%20interactive.pdf

3.4 The Leeds financial challenge

Work undertaken in summer 2014 **[42]** indicated that – without substantial and radical transformational change – the Leeds health and care system as a whole would be facing a net collective cumulative deficit on the order of £639m by 2020/21.

More recent work **[32]** building on 2015/16 financial plans of the local partners indicated that, with net recurrent pressures for NHS providers and the Council averaging 7 per cent per annum and taking into account a range of other factors and alternative assumptions to those adopted in the earlier 2014 work, then that would equate to a total challenge of £850m.

This subsequent work has suggested that the balance between local solutions – that is solutions which are planned and delivered by the individual statutory organisations in the local health and care eco-system - and those that require collective action involving co-ordinated action by all system partners could be in the order of £607m "local" and £243m "collective".

3.5 Health and Wellbeing Strategy for Leeds

Recognising the picture painted by the health profiles, and cognisant of the current picture of health and care services, the draft Leeds H&WB strategy for 2016-21**[26]** envisages Leeds as a "*healthy and caring city for all ages, where people who are the poorest will improve their health the fastest*".

The five intended outcomes of the strategy are that:

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

Recognising that there are many more determinants to health and wellbeing than simply access to, and quality of, health and care services, the strategy seeks to achieve these outcomes through delivery of eleven priority themes, which include *maximising the benefits of information and technology*, *creating a strong economy with quality jobs for local people*, *creating a valued, well-trained, and supported workforce*, and placing a stronger *focus on prevention, especially for long-term conditions.*

4. The Case for, the Purpose and Benefits of the LAHP

This section sets out the principles of the strategic case for change, addressing the question "why does Leeds need an Academic Health Partnership?"

4.1 The case for an academic health partnership

It has long been clear that the nature of the health and social care challenges are such that individual statutory organisations cannot deliver alone. They need to work not only with each other but also with others outside the sector. The "Leeds equation", illustrating this, is shown in Figure 1 below.

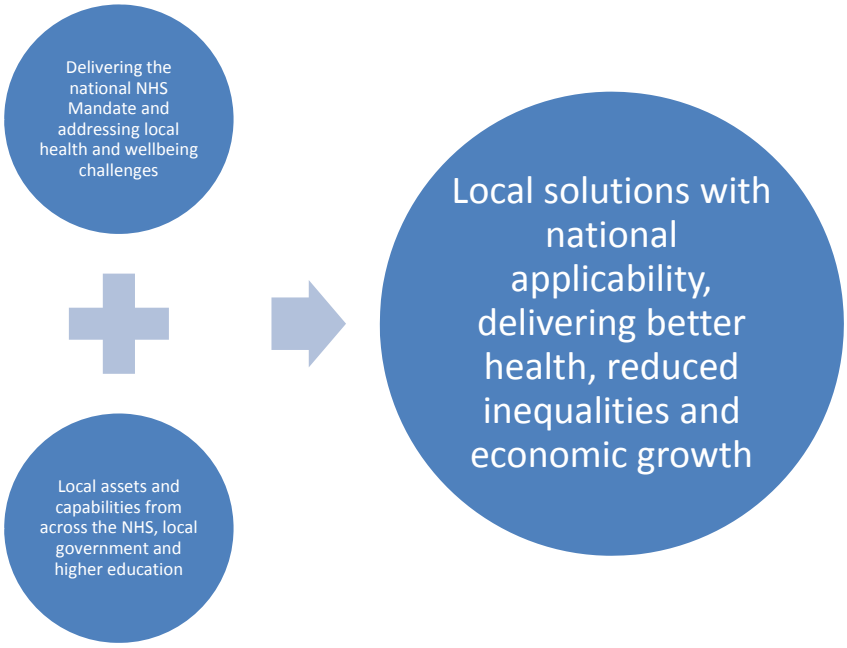

Figure 1 – The "Leeds equation"

The recent report "*Building Healthy Cities: The role of universities in the health ecosystem*" by the University Alliance [40] reinforces the important role that universities can play in their local communities as major "anchor institutions" – "providing leadership and coordination, working in partnership to co-design solutions, making services more responsive to local needs, training the health and social care workforce of tomorrow, and harnessing world-class research to make a real difference to health outcomes."

There are three universities in Leeds – the University of Leeds; Leeds Beckett University and Leeds Trinity University.

The University of Leeds, established in 1904, is one of the largest higher education institutions in the UK - a world top 100 university and renowned globally for the quality of its teaching and research.

The strength of its academic expertise combined with the breadth of disciplines it covers, provides a wealth of opportunities and has real impact on the world in cultural, economic and societal ways.

Leeds Beckett University has over 190 years of teaching experience. The Leeds Mechanics Institute, to which the University can trace its origins, was founded in 1824. Leeds Beckett has been ranked first in the UK for virtual learning, online library and technology services.

Leeds Trinity University is one of the UK's top universities for employability, and has pioneered the inclusion of professional work placements with every degree.

Each of the three universities has unique strengths and capabilities which can support the issues and challenges of the health and social care system.

Many other cities across the country – including Manchester, Liverpool, Birmingham, Newcastle and Bristol - have already established local city-wide academic health partnerships as focal points, leaving Leeds (until recently) as the largest city in England without such a partnership in place.

The LAHP has existed as an informal partnership since March 2015.

Other cities, however, have often forged their partnership simply between the local NHS acute provider(s) and the main, research intensive university, with a focus on a medical model and they have not always engaged NHS commissioners or local government. A defining characteristic of the LAHP is the active engagement of the local authority, all three NHS Trusts all three clinical commissioning groups and all local universities. The Leeds partnership reflects a broader group with a strong emphasis on population health and wellbeing[5] which helps differentiate it from most other AHPs.

4.1.1 Core Members

Leeds is a city of some 213 sq. miles with a population of over three quarters of a million, the second highest population of any local authority in the UK, covering the second greatest area of any English metropolitan district. It is the country's fourth largest urban economy, yet 65 per cent of its area is designated green belt.

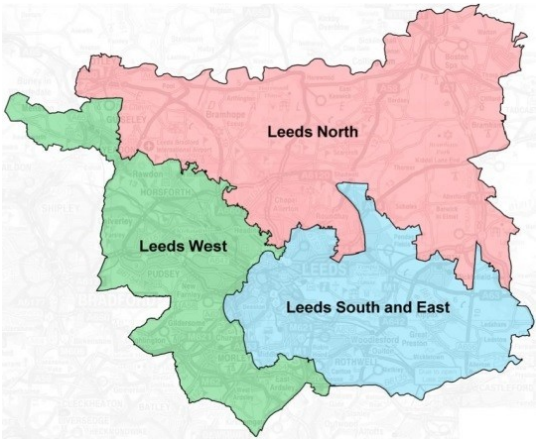

Figure 2 – Leeds and the three CCGs

Within this footprint, there are three clinical commissioning groups, three major NHS provider Trusts, one local authority, and as noted, three universities. Despite the extensive range of services, and wealth of skills, knowledge and talents represented by those working in the health, social care and academic sectors, decision making involves only ten member organisations. This contrasts at with metropolitan areas such as London, the West Midlands and Greater Manchester, which have many more statutory bodies across the health and social care landscape. The comparative simplicity and compactness of the structure allows Leeds to make fully inclusive decisions in a faster, more agile fashion than many other large cities, whilst still having the size and diversity of population, and richness of skills, capabilities and services to make the city highly attractive for inward investment.

5 For our purposes we use Kindigs 2003 definition of "Population health" as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group."

4.1.2 Associate and Affiliate Members

The value of collaboration between NHS and academic bodies and industry has long been recognised and accepted. Fifteen Academic Health Science Networks (AHSNs) were given licence to operate by NHS England in May 2013 to create partnerships between patients, health services, industry, and academic institutions.

The aim of the local Yorkshire and Humber AHSN is to create significant improvements in the health of the population by reducing service variability and improving patient experience in the health care system.

For the AHSN to realise its full potential, it needs strong, well-aligned cities that have a clear focus of local activity and which draw on the talent from across the health and care system aligned with their academic partners.

The Leeds Academic Health Partnership will not replicate the work of the wider AHSN, but acts as a key node on the AHSN network, identifying where relevant work is available, adopting and adapting it to meet local circumstances, and acting as a force to accelerate implementation of the local H&WB strategy. In turn, the LAHP will give value back to the AHSN by generating knowledge and insight, and providing an outlet for ideas and innovation generated elsewhere.

The AHSN is an associate member of the LAHP, with a seat on the Board, emphasising the closeness of this relationship.

Whilst not diluting the effectiveness of a tightly focused core group, the members of the LAHP also recognise the critical role that the voluntary and third sector organisations play in delivering health and care services for the population, and are beginning discussions about extending affiliate membership to other not-for-profit health and social care organisations based in Leeds. St Gemma's Hospice, for example, has already approached the LAHP to discuss this.

4.2 Purpose of the LAHP

Early collaborative work between the LAHP's ten core member organisations has resulted in the following definition of the LAHP's purpose:

"***To improve the health and wellbeing of the people of Leeds by engaging the educational and research capabilities of all three universities in Leeds with the health and social care system in order to speed up the adoption of research and innovation, creating inward investment, and raising the national and international profile and reputation of the city and the LAHP member organisations."***

This is represented diagrammatically in Figure 3 below, which also highlights the potential benefits of a successful academic-health partnership for the city of Leeds – improvements in health; reduction of inequalities; and the creation of wealth:

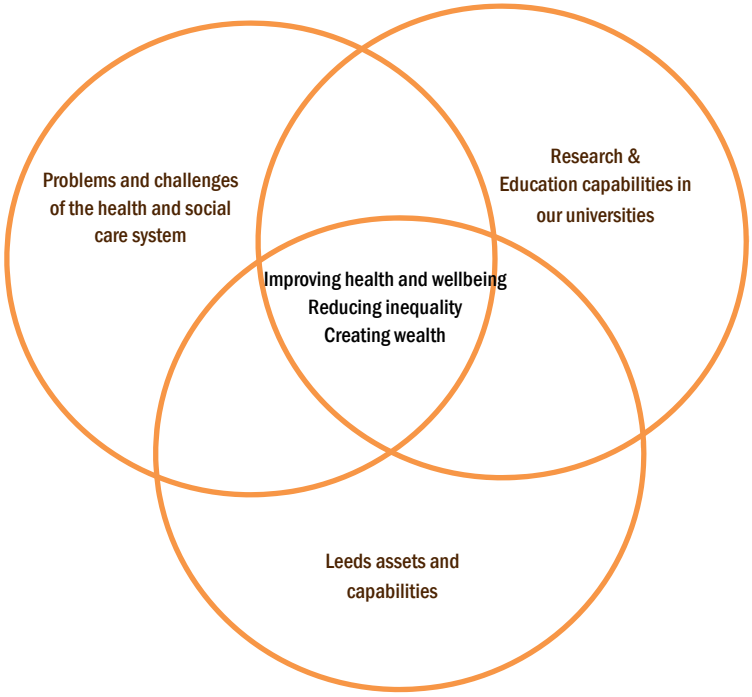

Figure 3 – Purpose and Benefits of the LAHP

The LAHP will have a key contribution to make, for example, in responding to the requirement for the NHS to produce Sustainability and Transformation Plans to set out local intentions which are "*at the forefront of science, research, and innovation"* and which articulate how "*service changes over the next five years will embrace breakthroughs in genomics, precision medicine and diagnostics."*[6]

4.2.1 Aligning the LAHP members

This purpose statement has been developed following a dialogue about the "self-interest goals" of the LAHP member organisations, because the members of the LAHP need to be assured, of course, that their involvement – and their financial contributions – will lead to the delivery of activity which supports their own individual organisational goals and objectives.

A process of discussion and sharing of individual organisational goals therefore took place over summer 2015 and provided the basis for greater awareness and understanding of both the common – and diverse – goals of all the partners. It enabled LAHP member organisations to coalesce around a set of shared goals, which have been expressed as follows:

6 https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

1.	*Emphasis on health and wellbeing promotion, illness prevention and early intervention as a means of reducing inequalities*
2.	*Improving health and wellbeing of individuals and populations*
3.	*Engaging citizens and communities in the planning and delivery of personal and population health and wellbeing, and associated decisoin making and governance*
4.	*Attracting talent (workforce) and investment associated with the planning, delivery and research in the fields of health, care and wellbeing*
5.	*Contributing to economic growth as a key factor in raising employment levels and hence improiving health*
6.	*Recognising the critical role of data and technology in improving health and wellbeing*

Table 2 – LAHP Member Shared Goals

While these shared goals have a local focus and reiterate the role of the LAHP in improving local population health and wellbeing, they are also of relevance on a national and international level, and a city that can demonstrate progress in achieving these goals will attract widespread interest and profile.

4.3 LAHP Core Themes

The intention is that the LAHP will deliver benefits by:

- *Improving health and well being*
- *Reducing inequality*
- *Creating wealth*

4.3.1 Improving Health and Wellbeing

4.3.1.1 Public Health Profiles

Analysis of the Public Health England (PHE) health profiles for 2015 [55] illustrate the areas where the city is facing significant health challenges

While the city is significantly better than the national (England) average in terms of ***statutory homelessness*** and ***violent crime***, it is significantly worse in terms of ***deprivation***, ***child poverty*** and ***long term unemployment***, all major determinants of good health, and in ***levels of GCSE attainment***, although the latter does show an improvement over the 2013-2014 period.

Children's health is significantly worse than the national position in respect of ***smoking status at time of delivery***, ***breastfeeding initiation*** and ***under 18 conceptions***.

For adults, ***smoking prevalence*** is significantly worse than the national average although the figures for ***percentages of obese adults, excess weight adults,*** and ***physically active adults*** are similar to the national average.

In terms of specific diseases, the city is significantly worse than the national average in relation to ***hospital stays for alcohol related harm, drug misuse and sexually transmitted infections***. While the ***percentage of recorded diabetes*** is significantly better than the national average, it does show a slight worsening trend.

Life expectancy at birth of both males and females is also significantly worse than the national average, as are ***smoking related deaths***, and the ***under 75 mortality rate for cardiovascular disease and cancer.***

The profile therefore paints a picture of a city facing not untypical health challenges for an urban area of northern England where lifestyle issues have a very significant bearing on the overall health of the population

4.3.1.2 Delivering quality care

In his 2008 report High Quality Care for All[7] Professor Lord Ara Darzi described quality care as being care that is safe, effective – with good outcomes - and provides a good personal experience.

There is commonality between Darzi's descriptors of quality and the Triple Aim of the US-based Institute of Health Improvement[8] which refers to the need to

- *Improve patient experience of care (including quality and satisfaction);*
- *Improve the health of populations; and*
- *reduce the per capita cost of health care*

In their distinctive areas, the three Leeds universities have much to offer in supporting the improvement of health and healthcare through their contribution towards initiatives such as the Leeds Institute of Quality Healthcare, which supports both improving health and reducing inequalities.

Harnessing the strength of the academic sector to the current work of the health and social care sector provides both increased capacity and exceptional capability to bring skills and experience to bear to pursue this ambition, although changing many of these measures will be a long-term process.

7 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf

8 http://www.ihi.org/engage/initiatives/tripleaim/Pages/default.aspx

Tackling cardiovascular disease

Cardiovascular disease is the leading cause of emergency hospitalisation in Europe, a leading cause of death and disability and has major impacts on global health economies. Throughout the world, but especially in the UK, there are substantial quantities of rich longitudinal and cross-sectional cardiovascular data available to study the quality of care and outcomes.

The Leeds Institute of Cardiovascular and Metabolic Medicine (LICAMM) at the University of Leeds is a leading centre for research into cardiovascular disease. Research in LICAMM has defined the poor prognostic combination of diabetes mellitus and heart failure – outcomes now form disease stratification for the management of heart failure patients across Leeds and beyond.

The work of the Leeds Institute of Quality Healthcare (LIQH)[9] is a collaboration between some of the LAHP member organisations which is aimed at reducing variations in health.

LIQH acts as the vehicle through which the Leeds health and care system partners can translate this leading research into the actions required to improve health in one of the key areas for which the city is rated as worse than the national average.

As well as actions which can improve the quality of the healthcare provided through the work of LIQH on addressing variation, many of the other indicators of health published by PHE illustrate the need for collaborative working to help improve the health of the population as they can only be achieved through multi-agency working. The Leeds academic community is involved in leading national research which can be drawn on for the benefit of the local population.

Tackling Obesity

Obesity is a major global health crisis and while some of the PHE indicators associated with obesity show that Leeds is not worse than the average, there is no room for complacency. Obesity and lack of exercise are major determinants of good health and without action the trend will be for an increase in the level of obesity and the consequent increase in demands on a hard pressed health and care system

Leeds Beckett University are leading a national three year programme to identify ways in which local authorities can create a whole systems approach to tackle obesities, while Leeds Trinity University is undertaking leading research into the field of exercise, health and nutrition.

Translating the knowledge and insight gained from this national research into local action, through the work of both Council and NHS partners, will benefit the local population and health and care system, as well as provide an opportunity to validate the research conclusions in practice, adding even greater value to the research programme.

4.3.2 Reducing Inequalities

The PHE report Due North **[34]** highlighted the wide disparity and levels of inequality in the UK, where, despite inner London being identified as the richest region in Northern Europe, nine of the ten poorest regions are in the UK, with the majority of these in the north of England.

Due North recognised that the burden of local government cuts and welfare reforms has fallen more heavily on the north than the south, and that there is a risk of further widening the gap of health inequalities with large proportions of children in the north of England growing up in poverty.

9 http://www.leedsqualityhealthcare.org.uk/

Improving the health and well-being of whole populations and communities, and reducing levels of inequality, cannot be achieved by health and care delivery organisations alone, but requires a co-ordinated input from across public and voluntary sector bodies as well as contributions from private sector organisations, all organised around a place-based approach.

As has been highlighted previously, one of the factors which differentiate the LAHP from many other academic health partnerships is the involvement of commissioners, the local authority and all three universities, and an emphasis on the wider factors which influence personal life satisfaction and population health including employment, housing and the environment. This reflects an increasing recognition that health cannot be measured in a simple, single dimensional way, but must reflect both the physical and mental health of individuals and the health of the communities within which they live.

By bringing together the skills and talents of its members, the LAHP can develop analytics-based insight and an understanding of the drivers and determinants which create and perpetuate health inequalities, and then – through the research and subsequent application of that research – identify the actions that can be taken to reduce levels of inequality whether at a personal level – such as the disparity in life expectancy across the city – or in the wellbeing of communities.

Personal and population health and wellbeing is also integrally bound to the economic health of the city and its communities; addressing health inequalities has to involve targeting economic and environmental inequalities. Again, this is an area that the LAHP can play a key role, in identifying opportunities and providing a welcoming environment to encourage development of new businesses which have a positive impact on improving health.

Technology also has a key role to play, helping people to retain their independence and increasingly to fit their care around their lives rather than fit their lives around their care. This will take a variety of forms, ranging from the opportunity for Leeds citizens to have access to their own health and care records, for them and their carers to be able to use technology to interact with their care professionals at a time and place more suited to them, and to be able to use technologies that empower them to manage their health conditions and lives and keep them safe and independent for longer through technology-enabled self-care.

The LAHP offers the opportunity to extend that work to bring in academic partners and to apply additional skills, knowledge and talent to address this challenge, not only locally for Leeds, but with the goal of being recognised as a national centre of excellence in the UK and a city with an international reputation for achieving a high standard of health and wellbeing and reduced levels of inequality, through providing a workforce suitably skilled to deliver future models of care and the utilisation of data and technology.

Given the city's aspiration to improve the health of the poorest, the fastest – and recognising that in many cases the poorest are those from the ethnic groups associated with the developing countries – the LAHP should recognise the diversity of its population as an important "city asset" and use that to its advantage. By looking to improve the health of the local poor many of whom are from developing countries, the LAHP can also access research funding targeted at improving the health of the poor in developing countries and thus deliver benefits at both local and international levels.

The combination of significant local BME groups, together with an almost uniquely inclusive set of partners from all sectors of the NHS, local government and universities, offers an opportunity for the LAHP to not only address local health inequalities but also develop a national and potentially international reputation for addressing those issues that impact most on BME populations, for example the high levels of prevalence of cardiovascular disease and diabetes in groups from Asian backgrounds, and utilising the specific local expertise around the use of mobile digital technologies.

Linking National and Local Programmes

Leeds Beckett University have led and supported evaluation of both national and local programmes of community health and wellbeing initiatives and programmes. The Health and Social Care Volunteering Fund (HSCVF) is an innovative programme established by the Department of Health to build organisational and community capacity for volunteering through a national and local grant scheme for Voluntary, Community and Social Enterprise (VCSE) organisations. An independent evaluation of the HSCVF was carried out by a team from Leeds Beckett University, who gathered evidence from a variety of sources.

The programme has achieved its key aim of connecting strategic health and social care goals to what projects do in communities. Valuing and supporting the contribution of volunteering is a core theme connecting national policy to local action. The team found that Volunteers gain a range of benefits from taking part; for many volunteering opens up new opportunities and leads to increased wellbeing. HSCVF volunteers have more contact with friends, families, and their own and other communities since joining their projects.

The evaluation team was able to identify opportunities for strengthening networking between projects and in supporting projects to build a case for future funding or disseminating good practice on volunteer support, and evidencing long term impact. This experience will be available to support the LAHP is delivering its aims going forward.

Early detection of lung cancer in Leeds

England has for many years lagged behind many other countries for patient survival rates for many of the leading types of cancers. Whilst recent improvements in survival rates have been achieved there is still a significant gap between England and international comparable countries. Moreover considerable variation exists between and within English Regions. Lung Cancer mortality rates in Leeds were some of the highest in the UK Early Detection is critical to reducing both regional and national survival rates.

The 'early detection of lung cancer in Leeds' is a project is focussed on early diagnosis as an essential requisite to improving detection rates. The project seeks to educate and encourage patients using social media to present symptoms to the GP earlier, use of self referral chest X- rays and the accelerated provision of treatment where this is required. The project is being run in communities with some of the highest incidences of cancer in Leeds Inner City particularly East and South Leeds. The Project is having a dramatic effect on the number of chest X-rays and is supporting improvements across the city overall in the survival rates for lung cancer

4.3.3 Creating wealth

Both economic growth and employment in the Yorkshire and Humber region have been below the national average since 2012, reflecting the underlying structure of the Yorkshire and Humber economy, with activity more weighted towards manufacturing and financial services than in the rest of the UK outside of London.

However, housing market data shows that price rises in Yorkshire and Humber in August 2015 significantly outpaced the UK average, while the region's private sector growth rate in recent months has been similar to, or above, that of the UK as a whole. These figures herald a better performance in the next few years, and in the three years to 2018 the region's GVA[10] is expected to grow at around 2.0 per cent per annum, close to the national average of 2.3 per cent **[37].**

Although the wider Yorkshire economy will grow at a steady rate over the next three years, the impact of the Chancellor's 'Northern Powerhouse' vision will be felt more in the next decade than this one **[37].**

Economic forecasts predict that Yorkshire's economy will grow by 1.9 per cent a year in GVA between 2015 and 2018, compared with a wider UK average of 2.3 per cent, while London (3.0 per cent), the South East (2.5 per cent), and the East of England (2.4 per cent) makes up the top three.

Despite the rather disappointing regional forecast, of the cities analysed, at a forecast GVA expansion of 2.3 per cent per annum, Leeds will be the second fastest growing city outside of the South of England over the next three years, just behind Manchester (2.5 per cent) **[37]**. This means that Leeds is matching the UK average and outpacing the rest of Yorkshire region thanks to expansion in its information and communications, administration and support, and professional services sectors.

10 Gross Value Added (GVA) measures the contribution to the economy of each individual producer, industry or sector in the UK. GVA is used in the estimation of Gross Domestic Product (GDP). GVA (at current basic prices; available by industry only) plus taxes on products (available at whole economy level only) less subsidies on products (available at whole economy level only) equals GDP (at current market prices; available at whole economy level only). GVA + taxes on products - subsidies on products = GDP. *Source: Office for National Statistics website – http://www.ons.gov.uk/*

This offers the city a sound basis to drive sustained economic growth through both through organic growth by supporting and developing local entrepreneurs and businesses, as well as attracting inward investment by companies seeking to locate or relocate their operations.

This in turn leads to a cycle of improvement, with employers being attracted to an area if they are confident of access to a well-skilled and appropriately educated workforce with an attractive living and working environment, and students being attracted to study and then remain in an area if there are attractive employment opportunities.

The city has been successful in its goal of delivering recovery across a broad range of growth platforms including financial services, professional services and the wider digital industries as well as health and wellbeing. However, to maintain that growth requires academic and educational establishments to ensure their courses deliver education and training that will lead to a skilled workforce fit for future requirements of the growth platforms – health and medical technology, professional services, financial services and digital industries – and in sufficient numbers to continue to support a local transformed health and care eco-system both in terms of the skills required in public service delivery and private sector support.

The positive outlook of this success has to be tempered by the report from the Centre for Cities[11] which found that in other cities where economic growth has been driven through these same growth platforms then although there is evidence of an attractor effect and this has tended to raise the wealth of those involved in these growth areas, it has had less impact on those employed in traditional areas. While the overall wealth of the area might rise, there is a relative worsening of the economic position of those not engaged in these sectors – e.g. through rising house prices – and a risk of widening inequality across the population.

Given the close links between economic prosperity and good health, the Council's clear policy objective of ensuring that the whole population benefits from economic growth is an essential one if the objective of reducing inequality - in both health and wealth terms - is to be achieved.

4.3.3.1 Industry clusters

It is estimated **[41]** that there are currently 193,000 people employed in the health and life sciences sector across the Leeds City Region with 50,000 employed in the healthcare provision sector in Leeds alone, and a further 3,500 people employed by medical sector businesses.

At present, Leeds is home to two major health-related industry clusters:

- *Digital health and analytics. The Leeds City Region is home to some of the most prominent companies in this sub - sector including TPP and EMIS, the UK's largest providers of primary care systems and patient record care services, BJSS - provider of the NHS Spine2, Immedicare, InHealthcare, Answer Consulting, Ssentif Intelligence and BT Technology.*

  Along with the national headquarters of the NHS Health and Social Care information Centre, Leeds has one of the largest concentrations of health informaticians in the UK and the wider City Region supports that cluster though initiatives such as the Digital Health Enterprise Zone supported by the University of Bradford, the Bradford Metropolitan Council and BT.

  The creation of LIDA with the presence of both the MRC Medical Bioinformatics Centre and the ESRC Consumer Data Research Centre also creates a focus of activity around data analytics.

  The development and implementation of the Leeds Care Record, containing 500,000 patient records and connecting every GP in Leeds, with secondary and social care providers also is a key attractor for the digital health industry.

11 http://www.centreforcities.org/blog/the-winners-and-losers-of-city-economic-development/

- *Medical technology. There are currently over 160 medical technology and health informatics companies in the Leeds City Region with over 100 of these based in Leeds, including Steeper, Surgical Innovation, Xiros and Brandon Medical. As with Digital health and analytics ,there are important sub-clusters in the wider city region around Bradford, Huddersfield and York*

Together these industry clusters have a combined estimated turnover of £4.33 billion and employ approximately 13,300 people across the wider Leeds City Region. **[36]**

Earlier work **[36]** recognised this strength and recommended the positioning of Leeds City Region as "a national focus for health technologies combining medical device manufacturing and related services with data and health related information technology innovation and management (health informatics)". The same report recommended "harnessing the know-how and expertise of sector champions and advocates to take ownership of the 'network' and to inform key strategic decisions and initiatives in the form of a steering group or advisory board with a short term (3 year) and long term plan (10 year)", a function which the LAHP would be well placed to adopt.

The LAHP provides a means through which innovative SMEs in the industry clusters can get rapid access to the NHS and the wider local health and care system to develop new solutions and benefit from engagement with both local health and care planning and delivery organisations. The LAHP also provides a route for these SMEs to access the skills and expertise of three diverse universities covering almost all aspects of personal and community health, care and wellbeing.

Encouraging SME development through digital health

Both national and local NHS bodies have worked with local digital health organisations to provide an outlet for their developments and help them grow and attract new talent to the city.

As well as the presence of the two largest suppliers of systems to primary care, EMIS and TPP, the work of mHabitat – a joint venture involving two of the NHS Trusts in Leeds – has created a national reputation for excellence in the field of person driven digital health applications, while Leeds based companies such as Answer Consulting – through their work on the Leeds Care Record and work with the Leeds Teaching Hospitals Trust – and BJSS - through their work on the national NHS Spine in conjunction with the Health and Social Care Information Centre – both contribute to the creation of new jobs and opportunities.

Stratifying patients with prostate cancer

Background – problem to solve

Prostate cancer is the most common cancer in men in the UK, accounting for 25% of all new male cancer cases and approximately 10,800 deaths. The majority of men diagnosed with prostate cancer present with early stage disease, which can be managed in a variety of ways. Although clinical/pathological features of the disease can guide decision-making, there remains ambiguity even among risk-stratified patients - low and intermediate risk patients represent a large subgroup (22,700) of the approximately 41,000 patients diagnosed annually in the UK. A prognostic test has been developed to address this ambiguity by directly measuring tumor biology in order to accurately stratify patients with localised prostate cancer according to disease aggressiveness and risk.

Summary of the oppportunity

The national Precision Medicine Catapult has now indicated that it wishes to work with the city to identify and develop exemplars which the Leeds PMC Centre of Excellence will take forward in the first wave of activity. Stratifying patients with prostrate cancer is an example of the type of projects which can be progressed through this new relationship.

We therefore propose to study the utility of this test to identify patients under consideration for radical therapy who do not

require aggressive management:

- *Report the test cell cycle progression (CCP – a new biomarker demonstrating improved the prediction of prostate cancer aggressiveness) scores in a NHS patient cohort and determine the correlation with routinely used risk categories, specifically the European Association of Urology (EAU) stratification.*
- *Assess the time from diagnosis of prostate cancer to availability of prognostic test.*
- *Assess the impact of the test on treatment decisions, measured in terms of the percentage of treatment decisions altered.*
- *Report the potential clinical utility and value of the CCP score in patient counselling and clinical decision making.*
- *Identify uncertain parameters in the evidence base in need of further research.*

Outcomes

Application of this test will assist in downgrading radical therapy by identifying which patients can safely be managed in active surveillance by:

- *Better differentiation of patients with similar clinical risk profiles*
- *Better assessment of the risk of prostate cancer specific mortality*
- *Improved individual patient prostate cancer treatment decision making*

4.3.4 Enablers

Two of the critical enabling factors which will support delivery of both national and local objectives are workforce modernisation and health informatics, covering use of both data and digital technologies.

In terms of workforce, the changing demographics and needs of the population, together with changes in the way care is delivered, particularly in primary and community settings, means that the capacity, capability and competencies – and location - of the future health and care workforce will change, in some cases very significantly. The changing dynamics between patients, carers and professionals – with a greater emphasis on professionals supporting patients and carers to self-manage - will also lead to a change in the skills needed by professionals.

As well as the changing demographics of the patients, the expectations of new joiners to the health and care workforce are changing in line with society's attitude to work more generally, and health and care service employers need to reflect that in order to attract and retain staff into the workforce.

Developing the new health and care workforce

Within the city there are capacity and skills shortages now, particularly in primary care and acute nursing as well as a shortage in social care. There is a local need to provide the future workforce with the roles and skills it needs to respond to the opportunities and threats that arise from the pressures to change.

Workforce development, training and education assets in Leeds are currently under-utilised and many are of poor quality. The workforce training estate is distributed with no single, high-quality place-based facility that encourages the sort of multi-disciplinary working that will be key to the future workforce needs

To address that the academic institutions, together with the local health and care partners will create a Leeds Health and Social Care 'Academy'. The Academy will be

- *A physical place and virtual space where health and social care employers can provide training and development for their current and future employees*
- *A framework for closer collaboration between health and social care employers and the three universities to deliver the single workforce plan for Leeds*

The Academy will be a place-based framework to collaborate and pool resources. In it, we will work together to deliver and sustain a system-wide workforce plan. Respecting statutory responsibilities, the Academy will ensure the effective provision of training and education and be the vehicle through which we collaborate to:

- *respond to opportunities and threats as a whole health and care system*
- *identify and develop plans to fill any gaps in training and education provision*
- *identify and act on opportunities to reduce complexity, duplication, waste and cost, and opportunities to join-up, add value and increase asset utilisation*
- *deliver new roles, skills and capacity*

It will own the Leeds vision for system-wide training and education provision;acting as a 'transmission belt' for taking adoption of innovation into practise, it will accelerate the embedding of research into education. It will also influence and be influenced by the Leeds workforce plan owned by the Transformation Board; it will have dedicated resource, staff and physical presence managed as one body with system-wide governance and oversight.

Health informatics also provides another huge enabling opportunity – the increasing use of advanced data analytics to identify population health need and more effectively and efficiently target the right kind of services, the use of informatics tools to support personalised care planning, and the adoption of new technologies to enable patients to play a greater part on their own self-care and interact in new ways with health and care professionals has the potential to be truly transformational.

Transformation through technology

New diagnostic technologies provide opportunities to re-evaluate care pathways and redesign them so that they shift the burden on the health and care system while at the same time making the lives of patients.

These technologies mean that patients are now better able to self-monitor their chronic conditions themselves, with monitoring of their readings and the ability to intervene when those readings move outside of certain key parameters.

Adopting new technologies such as this delivers improved health and care, as well as demonstrating the opportunity for medical technology innovation. A pilot with diabetes patients is underway and evaluation of the pilot will inform the options for a wider rollout across the city and potential for expansion to other long-term conditions with the opportunity for financial and quality benefits.

Transformation through data

As well as the adoption of new innovative technologies, the introduction of the Leeds Care Record and associated informatics initiatives across the city creates a wealth of linked data

The application of advanced population risk stratification and predictive modelling techniques such as those being developed through the work of the Leeds Institute of Data Analytics – bringing together talent and expertise from across the local health and care system - creates sophisticated insights into patterns of care, and identify cohorts of patients who are most likely to benefit from specific types of interventions.

These two examples are symbiotic and demonstrate the interaction between technology and data – the better the data analytics to identify cohorts of the population, the more effective the application of new technologies will be, and the greater the value of the data collected as a consequence

Creating and developing the new workforce through new forms of education and training, together with the innovative adoption of health informatics, also provides the opportunity to accelerate the adoption of research and knowledge into practice

Places that set the pace in the development of these critical enablers will both help and support their own local communities to be at the leading edge of transformational change in their own localities, and also create the potential to attract national and international talent and investment.

5. The LAHP Proposition

5.1 Assessing success

LAHP member organisations are conscious of the need to demonstrate the value added by the LAHP and the return on their investment. Early discussions have centred on identifying a simple set of metrics, which could be derived from the three core ambitions and benefits of the LAHP:

- *Improving health and well being*
- *Reducing inequalities*

} *measured by "lives saved" and "lives improved"*

- *Creating wealth – measured by "jobs created" and "inward investment secured"*

It has been difficult to uncover much detail about how other AHPs around the country measure their impact. Where there is evidence of assessing value, it is often at programme level – to judge how well a balanced portfolio of initiatives meet the objectives and goals of the partner organisations – and also on a project by project basis, where there are opportunities to develop and monitor more specific measureable objectives. UCLP and Bristol do this, for example.

Project level metrics can be specific to each initiative. It is clear that an individual project -such as Precision Medicine - may deliver against a number of dimensions **[13]** such as:

- *measureable impact and improvements to health and wellbeing of individuals and communities*
- *evidence of "lives saved" whether as a simple "lives saved" measure as adopted by University College London Partners (UCLP) in their work on stroke or more sophisticated measure to reflect quality of life improved, exploring measures such as PYLL[12] and/or QALYs[13].*
- *jobs and apprenticeships created, both in terms of the absolute "number of jobs" alongside the "quality" of jobs created.*
- *levels of inward investment secured, including research funding.*
- *enhanced levels of reputation for research and adoption of research into practice.*

There is desire amongst LAHP member organisations to keep measures as simple as possible, and an acknowledgement that it often can be difficult to measure the value added by a partnership, as its impact can often be intangible – for example, the existence of the LAHP presents Leeds as a "joined-up" city that is easy to do business with, which enhances reputation and results in improved profile, leading inevitably to more approaches from external investors and others wanting to do business here.

The LAHP can make this easier for external partners by clearly setting out a compelling proposition of why certain types of health related businesses should look to the city as a preferred place to invest in – a "best for" approach.

The LAHP will therefore adopt two relevant types of success indicators

- *LAHP success indicators – which are "means measures" – will be measured using SMART and quantitative metrics to report how well the LAHP is performing against the use of LAHP resources. Examples include number of bids submitted, bid conversion rate, events held etc., and the LAHP is accountable to its members for delivery of these activities.*

12 Potential Years of Life Lost

13 Quality Adjusted Life Year

- *System success indicators – which are essentially "ends measures" – will be used as part of project selection process. Examples include improving health and well-being, reducing inequality, generating wealth. The role of the LAHP is a critical factor in identifying projects and the LAHP will track value added on a project by project basis but responsibility for realising benefit will lie with the appropriate delivery bodies.*

As an example of a system success measure, inward investment into the city health and care system will arise from a number of public sector sources such as Innovate UK programmes, funding from Health Education England, HEFCE[14], MRC[15], ESPRC[16] - all of which contribute to city-wide developments as well as support to local businesses apply for funding and support from sources such as the LEP[17], SBRI[18] and other local, national and EU programmes such as the EU Horizon 2020 programme[19]. The LAHP will seek to use all such sources alongside private sector investment in order to deliver against its success indicators.

To avoid duplication of effort the LAHP will work closely with colleagues at the Yorkshire & Humber Academic Health Science Network (Y&HAHSN) and the Northern Health Science Alliance (NHSA) to capitalise on their work in identifying potential sources of funding and support.

5.2 The LAHP proposition

This proposition can be based on the key priorities for the city, and presented in such a way as to differentiate Leeds from other AHPs.

Fundamental to this proposition is the ability of the LAHP to be the single gateway to supporting health and care innovation and differentiating Leeds as "an easy place to do business in", whether that business is undertaking research, training and education of the current and future health and social care workforce or creating new products and services.

In effect, this becomes a differentiator for the city in the competition for resources and investment, whether in bidding for public or private investment -- it answers the "why Leeds?" question.

5.2.1 Best for applied health and wellbeing research

Section 4.3.2 identified an opportunity for Leeds to capitalise on its inclusive and integrated AHP to address the health and wellbeing issues associated with its diverse population, including the opportunity to undertake practical applied research into those issues for local, national and potentially international benefit.

Similarly addressing the needs of the frail elderly will be important priority in many parts of the country – and internationally - and so the LAHP can articulate the different approach that the city is looking to adopt by being able to support research on a system-wide basis, recognising the roles that all relevant public, private and voluntary sector parties play in caring for frail elderly people, in a way that personalises the care provided to that individual, utilising appropriate technology.

While other AHPs may emphasise the absolute number of patients recruited into clinical trials - and the scale is an important factor - the LAHP can capitalise on the performance of the generally high–performing Yorkshire and Humber Clinical Research Network (CRN), and the local Collaborations for Leadership in Applied Health Research and Care (CLAHRC) and

14 Higher Education Funding Council for England - http://www.hefce.ac.uk/

15 Medical Research Council - https://www.mrc.ac.uk/

16 Engineering and Physical Sciences Research Council - https://www.epsrc.ac.uk/

17 Leeds City Region Enterprise Partnership- http://www.the-lep.com/

18 Small Business Research Initiative - http://www.sbrihealthcare.co.uk/

19 https://ec.europa.eu/programmes/horizon2020/

focus on the quality and appropriateness of membership of practical applied health and wellbeing research programmes, having regard to the multi-faceted multi-disciplinary place-based approach of the LAHP.

5.2.2 Best for developing the new workforce

The emphasis on integrating health and social care will be another common theme across many parts of the country. The LAHP can differentiate Leeds by not only demonstrating new and effective models of integrated health and social care delivery, but also in recognising the impact that this will have on the nature of the workforce needed for the future, in terms of both capacity – the numbers of staff needed and their locations – as well as capability – the skills and competencies of those staff to work in the health and care workforce of the future.

Again the differentiator is around a city looking forwards to the future, where not only can you be educated and trained to develop the skills needed for future health and care, but you can also have the opportunity to put that learning into practice as the training and education system is so integrally linked with the local approach to health and care delivery.

Given that addressing the workforce needs of the future will be a key requirement nationally – and indeed internationally – for the LAHP to be able to demonstrate a successful link between the way it trains and educates the workforce of the future and the delivery of improved outcomes through an integrated approach to health and social care delivery will offer the potential for elevated reputation and attract research interest, as well as being an opportunity for economic growth through attracting students.

5.2.3 Best for using data and technology

Local, national and international health and care systems are increasingly recognising the crucial role that health data assets can play in identifying health and care needs – including for example cohorts such as BME groups, frail elderly and those with long term conditions - and then targeting and delivering direct care services along with other initiatives which influence personal and community health such as public health campaigns. Cross-sectoral initiatives such as Leeds Institute of Data Analytics (LIDA) demonstrate the strength of the city in terms of its resources for the capture, collation, analysis and interpretation of data while the strong local digital health eco-system - both public and private organisations – creates the climate for encouraging technological innovation. LIDA cross sectoral capabilities means, for example, consumer data and combined with health data to give many new insights into community health.

Adopting such a positioning will be attractive to private sector businesses that provide products and services that support such an approach; for example from the utilisation and analysis of data and associated processes to identify individual needs, through to the provision of technology to support that personalised form of care delivery.

The LAHP can support this approach by encouraging the advanced and innovative use of data analytics and then applying the insight gained by delivering change on the ground locally, whether through using that insight to rebalance services to meet personal and community needs or through the use of innovative technologies to deliver services in new ways, for example through in-home patient monitoring etc.

5.2.4 Best for adopting innovation

Research, product and service development only delivers maximum value when applied in practice. The LAHP is the vehicle to support the rapid adoption of innovation, translating research into action, as well as providing well designed, appropriate approaches to evaluation.

This will be cultivated in an environment which supports access to a wide range of capabilities, places for incubation growth

An example is the proposed adoption of the Sandbox approach set out in the NHS Innovation Test Bed proposal, looking to provide a technological environment which links and connects a range of technologies and devices based around the individual.

The differentiator would be not only that Leeds provides a ‘test bed’ platform to demonstrate that such integration is technologically possible with clear and measurable benefits to patients to national partners such as NHS England and the

Health and Social Care Information Centre but that these have been developed on the basis of 'interoperable' and open standards to enable rapid scaling for larger populations

Coupled with a high quality innovation business support environment, the LAHP can provide the kind of facilities and advisory services that help SMEs to grow. This would be a clear attractor both for organic growth of current Leeds-based businesses and/or university spinouts, and for other technology businesses wanting to set up in a welcoming eco-system, which provides access to the skilled people and other resources that are needed to incubate and grow their businesses.

6. Governance

6.1 Introduction

This chapter sets out the proposals for the organisational form of the LAHP both in its early years and longer term.

6.2 Current Arrangements

The LAHP currently operates as an informal partnership, with two decision making bodies:

- ***A Board, chaired by Sir Alan Langlands, with the core members and the associate member (AHSN) being represented at CEO or equivalent level***
- ***A Planning and Operational Group, chaired by the Director of Health Partnerships at the University of Leeds, with each of the core LAHP member organisations being represented at a Director or equivalent level***

The LAHP members recognise that the current style of working has achieved much, as evidenced by the successful creation of a strong portfolio of initiatives, but it has been highly dependent on the goodwill and commitment of a number of key individuals with substantive roles within their employing organisations.

During the current phase of informal partnership the University of Leeds has been acting as the "host" organisation for the LAHP, holding funds and paying bills on behalf of members, providing accommodation, and meeting facilities, and IT and financial support.

The majority of successful AHPs in England have established themselves as companies limited by guarantee for both the financial flexibility that this offers, and for the independence it gives, ensuring that no single organisation is or is perceived to be driving the agenda. It also provides investors – both public and private - with a clear entity with which to contract for services, and which is not dependent on the creation of multiple agreements across partners working in an informal relationship.

The future intention is to establish a more flexible and agile vehicle through which to progress the aims and objectives of the LAHP, whist remaining accountable to the LAHP members.

6.3 Future Options

6.3.1 Legal status

Any separate vehicle for the LAHP will require a formal status in law – as a company, a trust or an association.

The vehicle can be incorporated or unincorporated. If the organisation will take on financial risk, hold intellectual property or employ staff, it should be incorporated.

Companies are covered by Companies Act.

Limited companies can be limited by shares – that is an obligation for the members to pay the company for the shares they have taken in it – or guarantee – which requires the members to pay the company's debts up to a fixed sum.

6.3.2 Organisational forms

Many organisations may also want to be a particular kind of body in addition to having a legal status as a company – for example a Community Interest Company (CiC) has an additional status over being a limited company.

Companies have few inherent restrictions so it is possible to design almost any sort of structure and relationship within a company vehicle. For example, whilst there are common models for an Industrial Provident Society, it is possible to register a "free draft" set of rules written specifically for that society.

Whilst the organisational forms have different characteristics, they are not mutually exclusive. Theoretically, an organisation could be a Social Enterprise, a Joint Venture and a Special Purpose Vehicle.

All forms could involve sharing out all or some of any profits or surplus amongst members, raising funds by issuing shares, raising funds from public bodies, trading and protecting the assets of the organisation from distribution for private benefit.

Being a charity is neither a legal form nor an organisational form. It is a separate legal status that applies to some organisations meeting a set of criteria. Organisations that distribute profits are not eligible for charitable status.

Appendix D presents some of the organisational forms and some of their advantages and disadvantages.

6.4 Timing

The view of the LAHP members is that while a formal vehicle is likely to be required in the future, for the short term, the LAHP should continue as an informal partnership, hosted by the University of Leeds on behalf of the others, with a view to establishing an independent vehicle from 2017/18 onwards, subject to satisfactory progress in pursuit of the initial aims and objectives.

6.5 Other AHPs

Details of other UK Academic Health Science Partnerships/Centres are given at Appendix D. As mentioned previously, where it has been possible to determine their legal form they have all chosen to establish as a private company limited by guarantee, but without share capital (Anglia Ruskin, Imperial, Kings, Liverpool, Manchester, UCLP). Academic Health Science Networks have been established using a similar legal form.

As indicated in 6.3.2 above, this does not preclude declaration of the aims of the company as a social enterprise, a community interest company or as a joint venture.

Analysis of the other partnerships indicates three stages of evolution and complexity:

- *Informal partnerships – such as Bristol, Newcastle and Birmingham*
- *Established formal relationships based on a private limited company – Manchester, Cambridge, Kings, Imperial, Anglia-Ruskin*
- *Mature formal relationships - example of UCLP which has been in operation for many years [62] and which has established a range of operating units and partnerships with other bodies.*

Based on the experience of other similar city-based academic health partnerships and the AHSNs, the governance of such a company might typically involve the creation of a Board with representation from each member organisation as company directors.

Subject to its terms and powers of incorporation – which can be shaped by the partners at its inception - and its obligations under the Companies Act and related legislation, the Board will be free to take decisions in pursuit of the objects of the LAHP, with accountability to the LAHP partners through their representative governors.

If the LAHP were not to move to a Private Limited Company status and remain as an informal partnership then some LAHP initiatives are less likely to be attractive to private sector partners who will prefer to contract with one body rather than multiple organisations, or through more complicated lead provider structures.

Unlike previous initiatives to attract inward investment which involved the creation of a Private Limited Company and a large financial commitment from the City Council, the greater involvement and engagement from the NHS and university sectors shares that risk more broadly across all the partners.

6.6 Positioning of the LAHP within the wider system

A governance review of decision making structures across the Leeds Health and Social Care System has been recently undertaken and a new Governance Model which seeks to significantly improve decision making has been proposed – see Figure 4 below.

The review included within its scope the position and role of the LAHP within the wider context of other partner networks. The review concluded that the LAHP should remain as having an arms-length relationship with the System Executive Board and that any large scale programme work (not funding requests) will be delivered through the System Executive Board.

The overarching principle of the LAHP will be to act as a predominately externally facing body, in the best interests of the city and its member organisations, to pull in investment to support the health and social care system, either directly or through research funding. In this sense, the LAHP itself will not be a "delivery" organisation in the same way, for example, that UCLP is. The desire of partners is to maintain a "lean" LAHP infrastructure. The delivery of projects will therefore need to be driven through member organisations and the existing system-wide delivery infrastructure -- for example, the transformation board PMO.

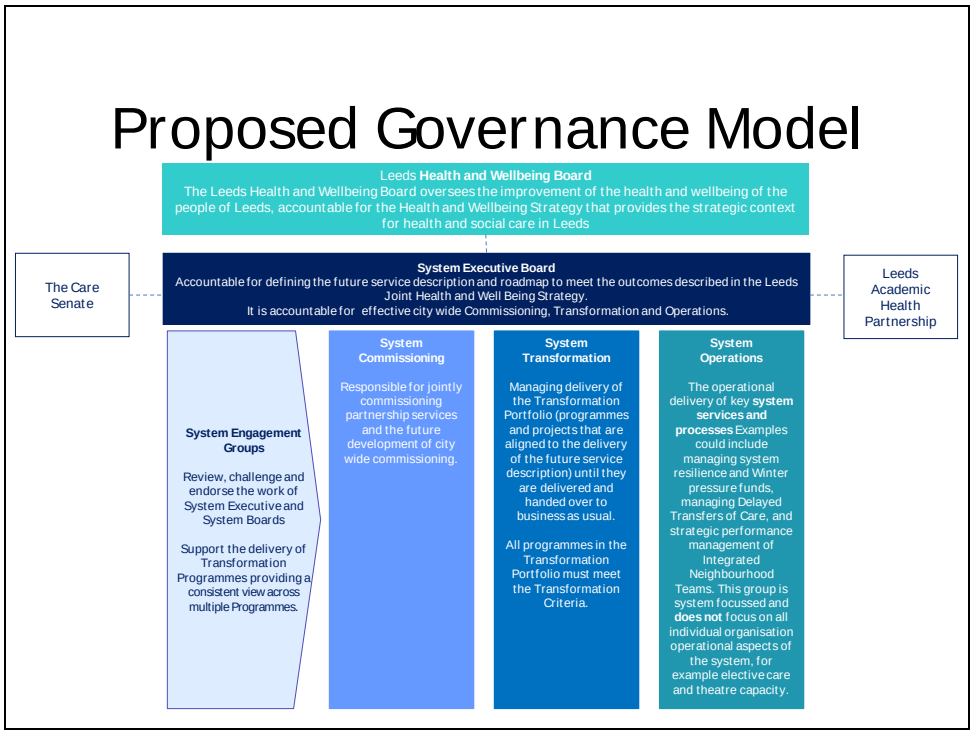

Figure 4 – Proposed Governance Model

7. Financial Impact Assessment

This section sets out the proposed costs associated with the initial early years establishment and operation of the LAHP and is based on certain assumptions about the size and organisation of the LAHP in its start-up period, and from an examination of the early years of other AHPs across the country.

7.1 The LAHP management structure

The proposal is based on the working assumptions that:

- *For 2016/17, as now, the LAHP will continue to operate as an informal collaboration of eleven fee-paying members (ten core plus one associate), supported by a LAHP team made up of a small number of substantive employees drawn from the core member organisations (with appropriate salary reimbursement to their employers to account for the time they spend on LAHP activity). Necessary "host" activity (such as financial and IT support) will continue to be provided by the University of Leeds.*

- *In the medium term - from 2017/18 at the earliest - the LAHP could operate as a private company limited by guarantee, with a Board supported by a small, lean core team (either employed by the company, or more likely seconded to the company from member organisations) focused on delivery of the aims and objectives of the LAHP and accountable to the LAHP Board.*

The Core Team will require access to a range of following capabilities. As the Core Team will remain small and focused on strategy rather than delivery, of some of these capabilities may need to be drawn either from within the LAHP members or through third parties:

- *Ability to engage with - and command the respect of - clinicians, management, politicians and civil servants*
- *Clinical and other professional leadership*
- *Strategic planning skills*
- *Programme and project planning and management*
- *Benefits identification and realisation*
- *Programme and project evaluation*
- *Stakeholder management across private/public/voluntary sector organisations and at local/national/international levels*
- *Bid writing and bid management*
- *Communications*
- *Supporting Administration*

7.2 Costs of the LAHP Core Team

A paper detailing the estimated cost of the Core Team – whether through direct employment, secondment or commissioned support – was submitted to and approved by the LAHP Board in May 2015, and this is estimated to be £683k for 2016/17. This annual running costs figure can be expected to rise in line with inflation.

In addition to the running costs of the Core Team, individual projects and initiatives will also be required to set out their objectives, costs, benefits and the risks associated with that project, as well as the metrics which they will be judged by.

While the LAHP needs to be flexible to respond quickly to in-year opportunities, the LAHP will develop an annual Business Plan setting out its intended work programme for the forthcoming year and major lines of development. This plan will act as the guideline criteria for in-year opportunity qualification.

7.3 Funding of the LAHP

All LAHP member organisations have been engaged in a process to consider equitable methods for sharing LAHP costs, bearing in mind that the member organisations are of widely varying size. Members have committed to a percentage contribution basis, as shown in Table 3 below. They have also agreed that any future expenditure agreed by the LAHP Board will be apportioned on the same basis, and in the event of there being any income to return to members, the same percentage shares will be applied.

	LTHT	UoL	LCC	LW CCG	LS&E CCG	LN CCG	LBU	L&YP	LCH	LTU	Y&H AHSN	Total
%age share	15	15	15	12	11	7	7	7	7	2	2	100
16/17 £	102,450	102,450	102,450	81,960	75,130	47,810	47,810	47,810	47,810	13,660	13,660	683,000

Table 3 – LAHP Funding Contributions for 2016/17

8. Risk Assessment and Mitigation

This section summarises some of the risks associated with the LAHP and sets out the proposed mitigation actions.

8.1 Key risks

The key risks of the LAHP can be classified as falling into one of two categories

- *strategic risks – those which impact on the overall success of the LAHP*
- *tactical risks – those risks which affect the individual initiatives overseen by the LAHP.*

8.1.1 Strategic Risks

Strategic risks are set out in Table 4 below, and represent the risks to the overall long-term sustainability and effectiveness of the LAHP.

Ref	Nature of Risk	Impact	Probability	Mitigation
S1	Failure of LAHP members to agree on aims and priorities	High	Medium	Ensure leaders and key staff within member organisations are explicitly committed to the aims and priorities of the LAHP.
S2	Failure of LAHP members to maintain commitment	High	Low	LAHP members commit to maintining senior level input to Board and Planning Group meetings. Continue to engage and communicatee with all LAHP aprtners
S3	Failure to recruit to substantive LAHP Core Team positions	High	Medium	Look for short-term secondment opportunities from across LAHP partners, and/or access third party support
S4	Perception that LAHP is not delivering value for member organisations	Medium	Medium	LAHP Core Team publish annual report setting out work undertaken, costs incurred and benefits achieved at LAHP and individual partner levels Review funding approach to ensure it is still equitable in terms of benefit to partners
S5	LAHP opportunities fail to meet goals of member organisations	Medium	Low	Opportunity qualification process and business development activity to be orientated around specific member goals LAHP Annual Report to demonstrate how projects have involved/benefited members
S6	Failing to deliver benefits from specific LAHP initiatives	High	Medium	Every LAHP initiative to have a benefits plan as part of the initiation process
S7	Failure to fund LAHP sufficiently to attract talent and resources to successfully plan, bid for and deliver initiatives	High	Medium	Members to make long-term statements of commtiment to funding.
S8	Failure to establish LAHP as credible entity at local, national and international levels	Medium	Medium	Ensure LAHP has a strong brand in terms of both content and positioning.
S9	Risk of duplication of work across LAHP and other groups	Medium	Low	Maintain active communications with other groups Establish reporting and governance arrangements to ensure LAHP activity is aligned with aims of the LAHP

Table 4 - Key strategic risks

8.1.2 Tactical risks

Tactical risks are those which relate to the day-to-day operation of the LAHP and which will impact on its effectiveness in delivery. Ultimately cumulative failures associated with tactical risks will impact on the overall sustainability of the LAHP.

Ref	Nature of Risk	Impact	Probability	Mitigation
T1	Failure to create pipeline of significant opportunities	High	Medium	Based on agreed priority areas create plan of opportunity creation and pro-actively. With advice from LAHP Board identify priority sources of opportunities to pro-actively monitor – e.g. ESIF[20] plus key organisations and programmes to proactively contact and develop relationships with – e.g. DH[21], MRC[22], Wellcome Trust, etc
T2`	Failure of LAHP members to contribute to opportunity proposal development	Medium	Low	For each proposal, develop and agree workplan with relevent members and for collective sign off at LAHP Board
T3	Failure to meet deadlines for submission of opportunities	High	Low	Create resourced workplan for any opportunity proposal, signoff by members and work to plan. Ensure sufficient resource available when qualifiying oppportunities and agreeing work plan
T4	Low opportunity conversion rate	Medium	Medium	Create and agree opportunity qualification criteria to ensure that LAHP Core Team invests time in chosen areas with high probability of success. Design and implement professional production and quality management proccesses
T5	Failure to mobilise following successful opportunity bid	Medium	Low	Every LAHP proposal to clearly set out an agreed delivery process together with roles and responsibilities of the bodies responsible for subsequent implementation.

Table 5 - Key tactical risks

In line with recognised good practice, a risk log should be created, routinely reviewed and reassessed by the LAHP Core Team and progress reported to LAHP members. New risks identified should be added to the list over time, and appropriate mitigating actions identified and implemented. Once the LAHP Core Team is in place and the risk log is established, each risk should be allocated a risk owner, responsible for ensuring that agreed mitigation actions are progressed.

20 European Structural and Investment Funds

21 Department of Health

22 Medical Research Council

9. Recommendations and next steps

This final chapter summarises the key recommendations arising from the business case and sets out the timetable for next steps

9.1 Recommendations

While the Leeds health and care system has achieved much to date, there is still a strong case for the formal establishment of the LAHP to capitalise on the substantial assets already operating within the system, and to deliver added value for the LAHP member organisations in order to make a significant and measurable impact on the health and wellbeing of those people living and working in the city of Leeds and – in due course – beyond.

Of the eight English members of the UK Core Cities Group[23] Leeds is the largest of the three not yet to have formally established any form of academic health centre or partnership, the others being Nottingham and Sheffield, although the latter does have a university-led Sheffield Healthcare Gateway.

Although the work of the individual partners to date has proved successful in attracting inward investment, creation of the LAHP on a formal basis should achieve a step change in the development of the city proposition to national bodies - and international bodies - and in attracting both public and private inward investment. It will also enable a more professional and integrated approach across the city to the development of responses to national and international initiatives.

An early task for the LAHP Core Team will be the development of a clear set of priority criteria and a robust opportunity qualification process to ensure that the efforts of the team are focused on a few key activities and not dispersed or duplicate other work.

As example of criteria, any proposed LAHP initiative should:

- *Be associated with one or more the chosen LAHP core or enabling themes*
- *Address one or more of the Health and Well-Being Board's outcomes*
- *Require collaborative working from across at least two of the three major service sectors involved in the LAHP – namely the NHS, local authority and university sectors.*

9.2 Priorities

Priorities for the coming year fall into two categories, establishing the LAHP and delivering LAHP activity.

9.2.1 Establishing the LAHP

The immediate priorities for 16/17 for establishing the LAHP are:

- *Create corporate commitment from member organisations for the formal establishment of the LAHP*
- *Reaffirm the funding commitments already made*
- *Develop and agree governance structure and delegated authorities*
- *Agree on the functions and responsibilities of the University of Leeds as the host organisation and the respective obligations (liability sharing) of the other partners to the host while the LAHP is operating as an informal partnership*

23 http://www.corecities.com/

- *Recruit or second into the LAHP Core Team to increase capability and capacity.*
- *Develop brand and establish brand awareness*

9.2.2 Delivering LAHP activity

As well as the tasks associated with establishing the LAHP as a sustainable body, the LAHP needs to make progress in delivery.

The 16/17 priority delivery areas for the LAHP have been identified as:

- *Growth and development of a city-wide approach to personalised medicine and care, involving all LAHP member organisations, building on the early success of securing Leeds as an Innovate UK Precision Medicine Catapult Centre of Excellence*
- *Co-ordinate the work of the LIQH and the Clinical Senate with the LAHP*
- *Reassessment of the opportunity for local funding support for implementation of the NHS Innovation Test Bed Programme proposal*
- *Development of a Future Health and Care Academy to support local workforce development and develop national/international education and training offers, and potentially the development of a health and social care University Technical College.*
- *Continued development of technological solutions including the Integrated Health and Care Record and associated related digital technologies and telesolutions (e.g. assisted living technologies, condition self- management apps etc.) and utilisation of data analytics.*

Additional propositions identified in the course of the development of the business case for further development and action as Innovation Accelerators include:

- *Explore opportunities to create Leeds based health, care and wellbeing "think tank" potentially though partnership with an existing relevant think tank group e.g. Health Foundation [11], Kings Fund, and Nuffield etc. Any such "think tank" should reflect the specific needs and characteristics of Leeds and similar cities, for example Northern Health Cities.*
- *Assessment of the potential creation for an Institute of Health and Care System Flow, extending the current "Improving System Flow" work programme of the Leeds Health & Social Care Transformation Portfolio, drawing on expertise of LIDA and LIQH working together and potentially with Health Foundation support, and building on work of the Y&H AHSN patient flow group.*

Table 6 below illustrates the relationship between the priority initiatives/innovation accelerators and the LAHP objectives.

	LAHP Objectives						Partner breadth
	Will the project improve health and wellbeing of people in Leeds?	Will the project reduce inequalities for the people in Leeds?	Will the project increase the wealth of the city?	Will the project develop the workforce through training and education?	Will the project join up the system further and deliver more integrated care?	Will the project improve more people's quality of life by access to quality services?	Does the project involve 1-10 partners?
Priority Initiatives							

P1 - Leeds Precision Medicine Catapult	Yes	Yes	Yes	Yes	Yes (depending on detailed definition of scope)	Yes	Yes
P2 - Integration of LIQH/ Clinical Senate	Yes	Yes	Potentially	Yes	Yes	Yes	Yes
P3 - Local Test Bed Programme	Yes	Yes	Yes	Yes	Yes	Yes	Yes
P4 - Future Health and Care Academy	Yes	Yes	Yes	Yes	Yes	Yes	Yes
P5 – Develop and adopt technical solutions	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Table 6 – Basis of project selection

9.3 Next steps

The health and care system in England is at a critical point as the vision set out in the Five Year Forward View moves into implementation with 50 Vanguard communities across the country exploring New Models of Care, including the West Yorkshire Urgent Care Vanguard.

Individual NHS organisations are required to produce individual operational plans for 2016/17 and every health and care system will be required to work together to produce – by June 2016 - a Sustainability and Transformation Plan, a separate but connected strategic plan covering the period October 2016 to March 2021.

In parallel, and to the same timescale, local health and care systems have been tasked by NHS England to develop local Digital Roadmaps setting out plans for the digitization of local services.

Locally the Leeds Health and Wellbeing Strategy are in the process of being launched, setting out the local priorities across the city for the coming [n] years.

These strategy and planning initiatives need to result in aligned plans for delivery, whether through individual organisations or by system wide bodies on their behalf, notably the Leeds Transformation Board.

The LAHP has an important contribution to make to help local organisations and the Transformation Board deliver this challenging agenda by providing a source of additional capacity and capability, helping accelerate implementation and reduce risk.

Next steps and key milestones for the LAHP are

Date	Action
Jan-March 2016	Revise business case in light of LAHP Planning Group and Board feedback Develop LAHP branding and corporate communications style pack
April 2016	Initiate LAHP Core Team recruitment process
20th April 2016	LAHP business case presentation at LCC Council Exec
	Hold inaugural meeting of formal LAHP.
	Begin to identify senior leadership for the LAHP
	Undertake launch event with associated press announcements
March – June 2016	LAHP Planning Group supporting STP/LDR development processes.
April 2016 - thereafter	Begin LAHP business development and opportunity management processes
Autumn 2016	Review option to establish LAHP as a private limited company
March 2017	Prepare first LAHP Annual report
April 2017 (earliest)	Provisional transition to private limited company

Table 7 – Next steps/milestones

Appendix A Local Initiatives

Local initiatives and "city assets" include:

- *Appointment of Leeds as one of the national Health and Social Care Integration Pioneer communities*[24]
- *Appointment of West Leeds Primary Care 2.0 project*[25] *within Wave 2 of the Prime Ministers GP Access Fund (formerly Challenge Fund)*
- *Development and operational deployment of the Leeds Care Record*[26] *and the subsequent creation of the Ripple*[27] *community as part of NHS England's Integrated Digital Care Technology Fund*[28] *supporting the deployment of Integrated Digital Care Records*
- *The development of the multi-disciplinary, multi-organisational Leeds Institute of Data Analytics (LIDA)*[29]*, building on the appointment of the University of Leeds as a centre for two major programmes for data intensive research - the MRC Centre for Medical Bioinformatics and the ESRC National Consumer Data Research Centre.*
- *The creation of the Leeds Institute of Quality Healthcare (LIQH)*[30] *as a partnership between some of the LAHP partners - and with the services delivered a relationship by the Centre for Innovation in Health Management (CIHM) of the University of Leeds in partnership with Intermountain Healthcare, USA and École Nationale d'Administration Publique (ENAP), Canada.*
- *The appointment of Leeds as a centre of excellence within the UK Precision Medicine Catapult*[31] *programme involving members of the LAHP and the Northern Health Science Alliance*[32]
- *The establishment of the EPSRC National Facility for Innovative Robotic Systems*[33] *at the University of Leeds involving research on robotic therapies, assistive robotics and surgical technologies*
- *The national programme of work being led by the Institute for Health and Wellbeing at Leeds Beckett University on the whole systems obesity challenge arising from the Foresight report "Tackling Obesity"*[34]
- *The continued development of the state-of-the-art Clinical Skills Suite*[35] *at Leeds Beckett University*

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24 https://www.england.nhs.uk/pioneers/2015/03/30/welcome/
25 https://www.england.nhs.uk/ourwork/futurenhs/pm-ext-access/wave-two/about-wave-two-pilots/%20-%2024
26 http://www.leedscarerecord.org/
27 http://rippleosi.org/
28 https://www.england.nhs.uk/digitaltechnology/info-revolution/idct-fund/
29 http://www.lida.leeds.ac.uk/
30 http://www.leedsqualityhealthcare.org.uk/
31 https://pm.catapult.org.uk/
32 http://www.thenhsa.co.uk/
33 http://robotics.leeds.ac.uk/
34 http://www.leedsbeckett.ac.uk/wholesystemsobesity/

- *The nationally and internationally recognised work of the Centre for Innovation in Health Management[36] at the University of Leeds and their reputation for co-production and enhancing social value in communities.*

- *The operation and further development of Leeds City Council's Assistive Living Centre[37]. Phase 1 of the ALC brings together a range of operational assistive technology services in a custom designed building. Phase 2 is under development and is exploring how to capitalise on the cluster of operational assistive technology services to offer new facilities such as an Assistive Technology Smart House, an Assistive Technology Retail Unit and an Assistive Technology Smart Innovation Lab.*

- *The work of the Leeds based mHabitat digital health innovation team[38]*

- *The Leeds node of the Open Data Institute[39] with its specific focus around open data for health and wellbeing*

- *The facilities for supporting innovation and growth at locations such as the Leeds Innovation Centre[40], including the Innovation Hub and the Bioincubator as well as the Tech Nation Future Labs initiative*

- *The Leeds Data Mill[41] city open data platform owned and managed by Leeds City Council and backed by the Cabinet Office's Release of Data Fund*

- *The six year "Time to Shine" project funded by the Big Lottery programme[42] which Leeds is one of 15 Ageing Better areas addressing the health and wellbeing issues created as a result of social isolation*

- *Submission of a strong and coherent multi-agency proposal for the Leeds City Region Sandbox as part of the NHS Innovation Testbed[43] programme*

This set of locally led initiatives is complemented by the major presence in the city of four of the most important UK NHS bodies

- *NHS England, responsible for over £106bn annual healthcare spend*

- *the Health and Social Care Information Centre, which hosts national health and social care data collections,*

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35 http://www.leedsbeckett.ac.uk/our-university/facilities/clinical-skills-suite/
36 http://www.cihm.leeds.ac.uk/
37 http://www.leeds.gov.uk/c/Pages/assistedliving/default.aspx
38 http://wearemhabitat.com/
39 http://leeds.theodi.org/
40 http://www.leedsinnovationcentre.co.uk/offices
41 http://leedsdatamill.org/
42 https://www.biglotteryfund.org.uk/global-content/press-releases/england/080914_yh_ab_6m-to-tackle-leeds
43 https://www.england.nhs.uk/ourwork/innovation/test-beds/

- *the NHS Leadership Academy, responsible for leadership development and training throughout the NHS*
- *Health Education England, the national body for organising healthcare education and training.*

Leeds is also home to the

- *National Coordinating Centre of the Clinical Research Network of the National institute for Health Research*
- *Northern regional headquarters of Public Health England*
- *headquarters of NHS Employers*

Appendix B Documentation Provided

Ref	Title	Date
1	LAHP Board 31/3/15 : Minutes of LAHP Board meeting 31/3/15	31/03/2015
2	LAHP Board 22/5/15 : Overview of the LAHP	22/05/2015
3	LAHP Board 22/5/15 : Resourcing issues during setup phase	22/05/2015
4	LAHP Board 22/5/15 : Minutes of LAHP Board meeting of 22/5/15	22/05/2015
5	LAHP Planning Group 2/6/15 : Public Health England – Leeds Unitary Authority Health Profile 2015	02/06/2015
6	LAHP Planning Group 26/8/15 : Individual Partner self-interest Goals.	26/08/2015
7	LAHP Planning Group 26/8/15 : Funding Model.	26/08/2015
8	LAHP Board 21/9/15 : Minutes of meeting 21/9/2015	21/09/2015
9	LAHP Board 21/9/15 : Establishment of the LAHP.	21/09/2015
10	LAHP Board 21/9/15 : IoT Cities Demonstrator Competition.	21/09/2015
11	LAHP Board 21/9/15 : Update on discussions with the Health Foundation.	21/09/2015
12	LAHP Board 21/9/15 : Precision Medicine Catapult.	21/09/2015
13	LAHP Planning Group 15/10/15 : LAHP Goals and 2015/16 Work Plan Project Selection.	15/10/2015
14	LAHP Planning Group 25/11/15 : Leeds Health and Social Care Academy	25/11/2015
15	LAHP Planning Group 25/11/15 : Precision Medicine Catapult	25/11/2015
16	LAHP Planning Group 25/11/15 : Social work education and training	25/11/2015
17	LAHP Planning Group 25/11/15 : Establishment of the LAHP	25/11/2015
18	LAHP Planning Group 25/11/15 : LAHP Contributions in Year 2 and Invoicing Procedure	25/11/2015
19	LAHP Board 27/11/15 : Opportunities for Leeds to bid for Data, Digital and Technology Enabler Care Funds	27/11/2015
20	LAHP Board 27/11/15 : Leeds Health and Social Care Academy	27/11/2015
21	LAHP Board 27/11/15 : Establishment of the LAHP	27/11/2015
22	Leeds City Council : Report to Executive Board - Review of Inward Investment in Leeds City Region - Author : Tom Bridges	17/12/2014
23	Leeds City Council : Smart Cities : Delivering a Sustainable City in the Digital Age - Author : Dylan Roberts	17/12/2014
24	Leeds City Council : Report to Executive Board – Proposal for a LAHP - Author : Rob Kenyon	18/03/2015
25	Leeds City Council : Leeds 2015 City Priority Plan 2011-2015	
26	Leeds City Council : Draft Executive Summary of Leeds JSNA 2015	07/05/2015
27	Leeds City Council : JSNA Background paper for themed CLT sessions	01/08/2015
28	Leeds City Council : Initial Summary for the 2015 Indices of deprivation	01/10/2015
29	Leeds City Council : Strong Economy, Compassionate City. Report to Executive Board. - Author : Tom Riorden	21/10/2015

Ref	Title	Date
30	Leeds City Council : A Business Case for a Leeds Academic Health Partnership - Author : Dr Ian Cameron / Martin Farrington	9/3/16
31	Inspiring Change : Leeds H&SC Transformation Portfolio Forward Look	
32	Inspiring Change : 2015/16 Local Savings Schemes and review of Financial Plans - Author Kim Gay	07/10/2015
33	Leeds City Region : Health and Innovation Hub of the UK :	04/04/2014
34	Due North : Inquiry Panel on Health Equity for the North of England - Author : University of Liverpool and Centre for Local Economic Strategies	01/09/2014
35	Presentation Pack : North Regional Tripartite Event - Author : NHS England, Monitor, TDA	04/11/2014
36	Growing science and medical technology companies in Leeds and Leeds City Region Author : Creative Space Management, Leeds City Council, University of Leeds	01/03/2015
37	EY : UK region and city economic forecast – Yorkshire and Humber EY	01/12/2015
38	Small Report of Big Impact Leeds City Region Enterprise Partnership :	
39	Innovate UK : Leeds Bid to NHS Health and Care Test Beds programme	
40	University Alliance : Building Healthy Cities	Undated
41	Presentation pack : international Economic Conference Health and Innovation panel pwc	01/07/2014
42	Leeds Health and Social Care economy - 5 year challenge. : West & South Yorkshire and Bassetlaw Commissioning Support Unit / EY	06/07/1905
43	Integration Pioneers. : https://www.england.nhs.uk/pioneers/2015/03/30/welcome/ NHS England	
44	Prime Ministers Challenge Fund Wave 2 pilots : https://www.england.nhs.uk/ourwork/futurenhs/pm-ext-access/wave-two/about-wave-two-pilots/%20-%2024 NHS England.	
45	Assisted Living Centre : http://www.leeds.gov.uk/c/Pages/assistedliving/default.aspx Leeds City Council.	
46	2015/16 Financial Plan Pressures. : Author : Inspiring Change.	
47	Proposal for a SPV - role scope and function of a SPV – a discussion paper : - Author : Colin Mawhinney	
48	Leeds Clinical Skills Strategy :	03/07/2015
49	Transformation Portfolio Board : LIQH : Framework for the Future	07/10/2015
50	“Slide for DLT” :	
51	Leeds Economy Briefing Note Issue 62 Index of Deprivation 2015 : Author : Economic Policy, Leeds City Council	01/10/2015
52	Health North : Proposals from the Northern Health Science Alliance	
53	Leeds Partnership Governance Review : Summary of Workshop 2 Model Design. Final Draft 1.3	14/09/2015
54	Realising the benefits of real-world data : Author : Marie Kane, North West EHealth	07/07/2015
55	Health Profiles Local Authority Summaries – Yorkshire & Humber : - Author : Public Health England	07/07/2015
56	City-wide informatics : the journey towards integrated health systems and intelligence in Leeds. Strategy Pack :	Undated
57	Making Leeds to best city for health and wellbeing : A one-side summary :	Undated
58	NHS Health and Care Test Beds : Initial Bid Assessment Feedback	23/11/2015

Ref	Title	Date
59	Connected Health Cities : Application Feedback	Undated
60	Leeds - A city of Health and innovation : Author Leeds and Partners	
61	City-wide Transformation Update Leeds Health & Social Care Transformation Portfolio	Oct/Nov 2015
62	UCL Partners Annual Report 2014/15	2015
63	Transforming care: A national response to Winterbourne View Hospital https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf	December 2012

Appendix C Interviews

As part of the development of the business case interviews were held with a range of local stakeholders to understand their position more clearly, and explore ideas and proposals.

Who	When	Where
Sir Alan Langlands Vice-Chancellor, University of Leeds	16 December 2015	University of Leeds
Jo Anne Wass University of Leeds	2 December 2015	University of Leeds
Councillor Lisa Mulherin Executive Board member for Health and Wellbeing and Adults, Leeds City Council	11 December 2015	Leeds Town Hall
Kim Gay Director of Finance, Leeds Transformation Board	4 December 2015	Thorp Park
Dr Simon Stockhill Chair Leeds Institute of Quality Healthcare Medical Director Leeds West CCG	16 December 2015	Harrogate
Nigel Grey Chief Officer, Leeds North CCG	16 December 2015	St Paul's House
Dr Jason Broch Clinical Chair, Leeds North CCG	16 December 2015	St Paul's House
Colin Mawhinney Healdh of Health Innovation, Leeds Health Partnerships		
Professor Paul Stewart Faculty Dean of Medicine & Health, University of Leeds.	17 December 2015	University of Leeds
Professor Ieuan Ellis Faculty Dean of Health & Social Sciences, Leeds Beckett University	27 November 2015	Leeds Beckett University
Tom Bridges Chief Economic Development Officer, Leeds City Council	11 December 2015	Leonardo Building
Andy Harris Chief Clinical Officer, Leeds South & East CCG	9 December 3105	Thorpe Park
Phil Corrigan Chief Executive, Leeds West CCG	10 December 2016	Wira House
Professor Carlton Cooke Head of School and Social and Health Sciences, Trinity University	16 December 2015	Leeds Trinity University

Appendix D Organisational Forms

This Appendix summarises three of the potential organisational forms that the LAHP could choose to adopt.

<table>
<tr><th colspan="2">Social Enterprise</th></tr>
<tr><td colspan="2">The term “social enterprise“ describes a purpose and is not a legal form. The term is typically attributable to entrepreneurial organisations with primarily social objectives and where surpluses are reinvested into the business or community.</td></tr>
<tr><td>Advantages

▶ May be more attractive to public sector organisations as several of the forms (e.g. CiC) have to satisfy a “community interest test”
▶ Trusts and Charitable Incorporated Organisations (CIOs) can achieve tax breaks (exempt from corporation tax on profits, VAT exemptions and business rates reliefs). Community Benefit Societies can also be treated as such.
▶ There are tax benefits to a charity with a commercial arm - can generate profit and gift aid it back to partners
▶ There are social enterprise models that provide protection of assets and profits alongside the potential to attract government funding and private investment
▶ A social enterprise may be simpler to manage than a joint venture and simpler to set up than a special purpose vehicle
▶ Democratic, can have a culture led by members and user</td><td>Disadvantages

▶ The forms limited by share may not be able to gain grant funding
▶ Uncertainty over the interests of communities
▶ Potential loss of influence over quality and strategy depending on particular form and voting structure selected
▶ Share ownership or guarantees would need to be negotiated for CiC form</td></tr>
</table>

Joint Venture	
A joint venture ▶ *Can be contract based or organisational (e.g. set up company with members contributing equity)* ▶ *Can involve multiple parties, private and / or public, contribute equity for the development of assets* ▶ *May have complex governance if there are differing interests amongst partners* ▶ *Requires a shareholders' agreement covering: valuation of intellectual property, control of company, number of directors and rights of founders, whether an exec board or founders manage the organisation, the transferability of shares, a dividend policy, winding up conditions, confidentiality of know how, first right of refusal on shares.* ▶ *Need for clear and strong contract management of partners*	
Advantages ▶ *Joint venture partners can provide commercial focus and funding for growth*	*Disadvantages* ▶ *Potentially complex governance* ▶ *Need for clear and strong contract management*

Publicly owned Special Purpose Vehicle	
A publicly owned SPV ▶ *Is a legal entity created to fulfil specific, time limited objectives, and isolate an organisation from financial risk* ▶ *Will have assets transferred to a "Special Purpose Vehicle" (SPV). The SPV signs a contract with the assets' owners and with subcontractors to develop the asset* ▶ *Can also have an NPD (Non-Profit Distribution model) for enhanced stakeholder involvement in management of projects, no dividend bearing equity and capped private sector returns in the event of private sector participation*	
Advantages ▶ *Can focus partners on time specific objectives and serve as a transition option* ▶ *Capped returns ensure that an 'acceptable' level of investment return is made by private sector and that returns are transparent* ▶ *Operational surpluses generated by the project company can be reinvested in the public sector* ▶ *Public interest is represented in the governance of the NPD structure*	*Disadvantages* ▶ *Requires clear contracting and effective contract management* ▶ *Potential tax implications*

Appendix E Similar partnerships

Summary details for the following

- *Anglia Ruskin Health Partners*

- *Birmingham Health Partnership*
- *Bristol Health Partners*
- *Imperial Health Partners*
- *Kings Health Partners*
- *Liverpool Health partnership*
- *Manchester Health Partners*
- *Newcastle Academic Health Partnership*
- *UCL Partners*

Anglia Ruskin Health Partnership

Status

Private company limited by guarantee without share capital (08016710). Incorporated April 2012

Mission

To work together to deliver demonstrable benefits to the health, well-being and social care of our local population, through innovation, education and research.

Composition

- *1 university*
- *1 Council*
- *6 NHS providers*
- *1 social care provider*

Finances

In 2014/15 7 of the 9 partners contributed £40,000 while 2 (Council and Social Care provider) each contributed £25,000, making a total of £330,000.

Accounts for 2014/15 indicate that the Partnership received a total income of £346,701 which was spent on £157,645 was spent on staff costs with the remainder - £189,577 - being spent on other operating costs including subscriptions figure of £50,000, possibly their contribution to UCLP. There was no surplus or loss.

Strategic Programmes

- *Quality improvement in governance*
- *Deteriorating Patient Programme*
- *Integrated Leadership Programme*
- *7 day working*

Link

www.arhpartnership.com

Birmingham Health Partnership

Status

Not clear – informal collaboration.

Purpose

The long term objectives of Birmingham Health Partners are to

- *improve healthcare;*
- *contribute to the local economy through job creation and inward investment into the biomedical sector, and*
- *increase public engagement and education about biomedicine and clinical research through increased enrolment into early and late phase clinical trials*

Its short term strategic objectives focus on the identification, adoption and spread of innovation and best practice, through the alignment of healthcare delivery, research and training

Composition

- *2 NHS Foundation Trusts*
- *University of Birmingham*

Strategic Programmes

- *Multiple*

Link

www.birminghamhealthpartners.co.uk

Bristol Health Partners

Status

Not clear – informal collaboration

Purpose

- *To improve the health of those who live in and around Bristol and the delivery of the services on which they rely*

Composition

- *3 NHS CCGs*
- *3 NHS Trusts*
- *City Council*
- *2 Universities*

Finances

In 2014/15 they reported income from 6 NHS organisations (3 CCGs, 3 providers) of £220,000 and income from 2 academic partners of £120,000 totalling £340,000. City Council are recorded as a partner but no reference to their financial contribution.

Strategic Programmes

- *Future health and care workforce*
- *Using data better*
- *Health and care leading sustainability*

Link

www.bristolhealthpartners.org.uk

Imperial College Health Partners

Status

Private company limited by guarantee without share capital (08109403). Incorporated June 2012.

Mission

- *To deliver demonstrable improvements in health and wealth for the people of North West London and beyond through collaboration and innovation, focused on:*
  - Enabling the discovery of best practice
  - Diffusing best practice systematically
  - Supporting wealth creation in the sector and beyond.

Composition

- *Six hospital trusts*
- *Two mental health trusts*
- *One community health trust*
- *Eight clinical commissioning groups*
- *Three universities*

Strategic Programmes

- *Future Neurorehabilitation*
- *Cancer*
- *COPD*
- *Medicine Optimisation*
- *Mental Health*
- *Intelligent use of data*
- *Diffusion of innovation*
- *Exploiting research*
- *Patient safety*
- *Overseas development*

Link

www.imperialcollegehealthpartners.com

Kings Health Partners

Status

Private company limited by guarantee without share capital (0733 6065). Incorporated August 2010.

Company Objects

The advancement of education health, learning and resource and in furtherance thereof

- *To pioneer better health and well-being locally and globally through integrated excellence in research education training and clinical care for the benefit for patients*
- *To improve health and well-being across ethnically and socially diverse communities and work to reduce inequalities*
- *To develop an academic health science centre that draws upon academic expertise in medical science and also in basic science, social science, law and humanities*
- *To work innovatively with stakeholders in the redesign of care pathways including the delivery of care closer to home*

Composition

- *3 NHS Foundation Trusts*
- *Kings College London University*

Finances

Accounts for 2013/14 indicate no turnover. Similar position reported for 2012/13.

Link

www.kingshealthpartners.org.uk

Liverpool Health Partnership

Status

A private company limited by guarantee without share capital (0825 9570). Incorporated in October 2012

Company Objects

- *Bring together word class researchers and clinicians to focus on preventing and treating diseases in order to translate research and teaching excellence in the most efficient way into patient benefits*
- *Apply for and maintain official recognition from the Government of its status as an Academic Health Science Centre in accordance with criteria which may be set from time to time by Government (provided that the Directors consider that such status i in the best interest of the company and its Objects)*

Composition

- *9 NHS providers (7 members and 2 affiliates)*
- *1 Clinical Commissioning Group (affiliate)*
- *2 academic bodies (both members)*

Finances

Funded by contributions from 9 members – University of Liverpool, 7 NHS providers and the Liverpool School of Tropical Medicine

In year to 31/3/15 basic subscription from 9 members of £80,000 p.a. (expect for one contributing £40,000). Additional income from 3 affiliates (2 NHS provider trusts plus Liverpool CCG) of £80,000 per annum. Total subscription income £920,000

Operational processing managed by University of Liverpool.

	2014/15	2012/14[44]
Income	£991,762	£1,435,544
Less Project Costs	£117,240	£214,144
Less Administrative Expenses	£729,470	£700,847
Operating profit / loss	£145,052	£520,533

Link

www.liverpoolhealthpartners.org.uk

Manchester Academic Health Science Centre

Status

[44] 12 March 2012 to 31 March 2014

Private Limited Company by guarantee without share capital use of 'Limited' exemption (07083059). Incorporated in March 2009

Purpose

To create a biomedical/health hub of global significance which delivers major benefits for patients and populations (7 more specific objects listed)

Composition

- *4 NHS Foundation Trusts*
- *1 Mental Health and Social Care Trust*
- *1 Clinical Commissioning Group*
- *University of Manchester*

Finances

In 2012/13 each NHS body contributed £80,000 while the University of Manchester contributed £167,900, a total of £647,900)

Funding Agreement over period August 2013 to July 2018 commits MAHSC members to increased contributions of between £286,000 and £326,000 per annum.

In 2013/14 contributions from each member ranged from £270,000 (Manchester Mental Health and Social Care Trust) to £335,900 (University of Manchester), a total of £2,073,520.

Figures for the last set of accounts (2013/14) show that running costs of the MAHSC were almost £800,000 out of a total expenditure of a £1,969,000 (40%)

	2013/14	2012/13	2011/12	2010/11
Income	£2,079,769	£647,900	£624,500	£560,750
Less Project Costs	£1,171,856	£64,218	£88,404	£1,250
Less Administrative Expenses	£796,854	£706,615	£490,764	£480,557
Operating profit / loss	£111,059	-£122,933	£45,332	£78,943

Strategic Programmes

Population health and implementation	*Mental health*
Women and children *Inflammation and repair*	*Cardiovascular* *Cancer*

Link

www.mahsc.ac.uk

Newcastle Academic Health Partnership

Status

Not clear, very recent – anticipated to be informal collaboration

Purpose

To deliver world-class healthcare through collaborative scientific research, education and patient care and mobilise the collective capabilities of the three organisations in support of economic growth.

The alliance will focus on delivering scientific advances that improve physical and mental health in common age-related chronic diseases, such as dementia and musculoskeletal disease. It will also specialise in improving understanding and treatment of cancer, diseases that affect the brain and those affecting children.

Composition

- *2 NHS Foundation Trusts*
- *Newcastle University*

Strategic Programmes

- *Age-related chronic disease*
- *Translating clinical research into practice*

Link

www.nahp.org.uk

University College Partners Limited

Status

Private company limited by guarantee without share capital (06878225). Incorporated in April 2009, although operating informally before then for about 4 years.

Company Objects

Advancement of education, health, learning and research in furtherance thereof

- *To bring together word class researchers and clinicians to focus on preventing and treating diseases in order to translate research and teaching excellence in the most efficient way into patient benefits*
- *Apply for and maintain official recognition from the Government of its status as an Academic Health Science Centre in accordance with criteria which may be set from time to time by Government (provided that the Directors consider that such status i in the best interest of the company and its Objects)*

Mission

Our members are translating cutting edge research and innovation into measurable health improvement and wealth creation for patients and populations through a portfolio of programmes and cross-cutting themes.

Achievements include

- *Saving lives - Supported the partners to reduce cardiac arrests in hospitals by up to 50%.*
- *Reducing strokes - Introducing a preventative strategy across the whole partnership could prevent 700 strokes each year and save over 200 lives.*
- *Building capability among staff - Enabled the partners to train over 13,000 staff to improve care for patients with dementia.*
- *Giving patients access to life-saving treatments and technologies - Sped up approvals for clinical trials across the partnership, attracting industry partners to invest in research in the region.*
- *Preventing disease and diagnosing early - Focused on where we can make the most impact for patients with, or at risk of, heart disease and cancer with the aim of saving over 1,000 lives each year.*

Composition

- *40 organisations covering NHS providers, academic bodies and other national bodies (NIHR, Health Education England). Note no commissioners or local government.*

Notes

UCLP provides employment for 140 members of staff, 78 direct employees the majority of whom are on fixed-term contracts, and 62 on secondment. However unlike LAHP proposition, a large number of UCLP staff are involved in project delivery.

ULP turnover for 2014/15 was £14.7m (2013/14 - £9.5m) with associated expenditure of £14.5m (2013/14 - £9.4m) creating a surplus of £0.2m.

Turnover breakdown is

- *AHSN funding - £3.9m*
- *Partner contributions - £1.26m*

- *NHS funding*[45] *- £8.4m*
- *Non-NHS funding*[46] *- £1.09m*

Link

www.uclpartners.com

45 includes NHS England, Health Education England

46 includes charities, pharmaceutical companies.

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Report author: Steven Courtney
Tel: 0113 247 4707

Report of the Head of Scrutiny

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

Date: 26 July 2016

Subject: Responses to Scrutiny Board 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 the initial responses to the Scrutiny Board recommendations following the inquiries into Cancer Waiting Times in Leeds and Bereavement.

2 Background information

2.1 During the course of the previous municipal year, the Scrutiny Board undertook inquiries into (i) Cancer Waiting Times in Leeds; and (2) Bereavement. The final report and recommendations for each inquiry area were agreed in May 2016, with relevant organisations subsequently invited to respond to the recommendations.

2.2 A summary of the desired outcomes and associated recommendations from each report is attached at Appendix 1 .

3 Response to the recommendations

3.1 The formal responses to the Scrutiny Board recommendations are attached at Appendix 2 (Cancer Waiting Times in Leeds) and Appendix 3 (Bereavements).

3.2 In providing its response to the Scrutiny Board report and recommendations, Leeds Teaching Hospitals NHA Trust also provided the following statement:

Leeds Teaching Hospitals NHS Trust welcomes the suggestions made by Leeds City Council Members and has provided responses to the specified recommendations in reports from the Scrutiny Board (Adult Social Services, Public Health, NHS), namely:

i) Bereavements: Policies and Practices; and
ii) Cancer Waiting Times in Leeds.

Members are asked to note that, given the strong requirement for strategic services to be integrated across primary, secondary and tertiary or specialist care, we have agreed our responses to the Cancer report with commissioners and key partners.

This is particularly important as the recommendations arise from consideration of waiting times but relate almost exclusively to our emergent cancer strategy.

3.3 The Scrutiny Board is asked to consider the response and proposed actions, and determine any further scrutiny activity that may be required.

4 Recommendations

4.1 That the Scrutiny Board (Adult Social Services, Public Health, NHS):

(a) Considers the responses provided to its recommendations and the associated actions and approach.

(b) Determines future monitoring arrangements of the recommendations and proposed actions.

5 Background documents[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.

Summary of desired outcomes and recommendations: Cancer Waiting Times in Leeds

Desired Outcome –The interests of patients and their families remain paramount in the commissioning and delivery of services.
Recommendation 1: That all organisations involved in the commissioning and delivery of services for the diagnosis and treatment of cancer, from across West Yorkshire, continue to work collaboratively for the benefit of patients and that organisational impacts are secondary considerations.

Desired Outcome – Ensuring cancer services remain a priority for the Scrutiny Board in 2016/17.
Recommendation 2: That commencing in the new municipal year (2016/17), the Scrutiny Board (Adult Social Services, Public Health, NHS) considers the format of future assurance on the progress associated with the early diagnosis and treatment of cancer, alongside the frequency it wishes to seek such assurance.

Desired Outcome – The work of the West Yorkshire Association of Acute Trusts achieves real patient benefits and remains open and transparent.
Recommendation 3: That by December 2016, the Chair of the West Yorkshire Association of Acute Trusts provides a further report on the achievements to date and future plans of the association.

Desired Outcome – Eradicating inequalities of access to cancer services across Leeds' health and social care economy, while tailoring services to meet local needs.
Recommendation 4: That in developing the Leeds Cancer Strategy, due consideration is given to ensuring there is a balance between providing a 'core offer' for all patients from across the City, while recognising and addressing the identified and known aspects of health inequalities across different parts of Leeds and its communities.

Desired Outcome – Greater collaboration across Leeds' health and social care economy in order to provide improved levels of patient experience data, specifically in relation to cancer services.
Recommendation 5: That by September 2016, HealthWatch Leeds, in consultation with the Director of Public Health, assesses the current level of patient experience data it holds specifically in relation to the prevention, early diagnosis and treatment of cancer, and considers its potential future role in collating such data on behalf of partners across the Leeds' health and social care economy landscape.

Desired Outcome – More effective planning and transparent decision-making, with improved and relevant patient and public involvement in the development of services.
Recommendation 6: That by December 2016, the Chair of the Leeds Cancer Strategy Group reviews its currently proposed membership to ensure this includes: (a) Appropriate patient and public representation; and, (b) Appropriate representation to reflect the diverse communities within Leeds, particularly in those areas where specific health inequalities are known to exist.
Recommendation 7: That by July 2016, the Chair of the Leeds Cancer Strategy Group reports back to the Scrutiny Board regarding the timescales associated with developing and agreeing an overall Leeds Cancer Strategy, improvement plan and associated key performance indicators, including details of where the strategy and improvement plan will be presented and agreed.
Recommendation 8: That by July 2016, and as part of the process for developing and agreeing an overall Leeds Cancer Strategy and improvement plan, the Chair of the Leeds Cancer Strategy Group: (a) Recognises the duty on NHS commissioners and providers to effectively involve and engage patients and the public, setting out plans for public and patient engagement and involvement. (b) Sets out proposals and timescales for engaging with the appropriate Overview and Scrutiny bodies.
Recommendation 9: That by September 2016, Leeds Clinical Commissioning Groups provide a joint report on the commissioning priorities and intentions for 2016/17, specifically identifying any proposed cancer prevention and early intervention initiatives, including associated timescales and budget allocations.

Summary of desired outcomes and recommendations: Bereavement – policies and practices

Desired Outcome – Ensure Leeds Teaching Hospital's NHS Trust policy reviews are well planned, adequately resourced and managed, with appropriate progress monitoring and reporting

Recommendation 1:

(a) That, when undertaking future policy reviews, Leeds Teaching Hospitals NHS Trust clearly sets out a proposed forward plan, with key milestones and timescales.

(b) That, when establishing the forward plan (referred to in (a) above), that Leeds Teaching Hospitals NHS Trust keeps progress under review and reports any anticipated and/or unexpected delays.

Desired Outcome – Ensure matters of 'best practice' highlighted in this report are reflected in Leeds Teaching Hospital's NHS Trust relevant policies and practices.

Recommendation 2:

(a) That, by September 2016, Leeds Teaching Hospitals NHS Trust reviews and compares its current process and procedures for the timely release of the deceased, with those adopted and implemented by the Heart of England NHS Foundation Trust.

(b) That, Leeds Teaching Hospitals NHS Trust reports the outcome of its review to the Scrutiny Board by November 2016.

Desired Outcome – Greater awareness and understanding of matters highlighted in this report across various stakeholder groups.

Recommendation 3: That, Leeds Teaching Hospitals NHS Trust considers extending invitations to its briefing sessions to key members of the wider community and outside the organisation, in order to help embed a shared understanding of the issues and processes associated with the timely release of deceased relatives.

Desired Outcome – Ensuring that the out of hours pathology service both reflects and meets the needs of Leeds' diverse communities.

Recommendation 4:

(a) That, by December 2016, Leeds Teaching Hospitals NHS Trust reviews its arrangements for providing out of hours pathology services and considers the potential for providing such services in partnership with neighbouring acute hospital trusts.

(b) That, by December 2016, Leeds Teaching Hospitals NHS Trust explore the potential options for offering routine access to non-invasive post mortems to all families (where appropriate), and undertake an appropriate cost benefit analysis of such options.

Desired Outcome – Greater awareness and understanding of matters highlighted in this report across the membership of Leeds' Faiths Forum.

Recommendation 5: That by September 2016, the issues and matters highlighted in this report are brought to the attention and discussed through Leeds' Faiths Forum to share any learning and experiences in respect of the timely release of the deceased, for the purpose of burial.

Desired Outcome – Ensure that matters highlighted in this report are reflected in both the consultation response and implementation of any future Medical Examiners service, regardless of the geographic footprint.

Recommendation 6

(a) That by 10 June 2016, when formally responding[1] to the Department of Health consultation on the implementation of Independent Medical Examiners, the responsible Director from Leeds City Council reflects relevant issues highlighted in this report;

(b) That, at an appropriate time, the responsible Director from Leeds City Council reflects relevant issues highlighted in this report as part of the future implementation of the Medical Examiners service, regardless of the geographic footprint.

(c) That, regardless of the geographic footprint, the responsible Director from Leeds City Council keeps the Scrutiny Board informed of any issues associated with the future implementation of the Medical Examiners service, and, as a minimum, from September 2016 provides a 6-monthly progress report for the Scrutiny Board.

[1]The response might be an individual response on behalf of Leeds City Council, or part of joint response on behalf of two

Desired Outcome – Ensure that consideration is given to relevant matters highlighted in this inquiry that specifically relate to the provision of Out of Hours primary care services.

Recommendation 7: That during the course of the 2016/17 municipal year, the Scrutiny Board (Adult Social Services, Public Health, NHS) discuss current and future arrangements for the provision of Out of Hours primary care services, specifically as they relate to death certification.

Appendix 2

Scrutiny Board (Adult Social Services, Public Health, NHS)
Scrutiny Board Recommendations: Cancer Waiting Times in Leeds
Formal Response

Scrutiny Board Recommendation	Agreed (Yes/No)	Initial Response	Recommendation Tracking
Recommendation 1: That all organisations involved in the commissioning and delivery of services for the diagnosis and treatment of cancer, from across West Yorkshire, continue to work collaboratively for the benefit of patients and that organisational impacts are secondary considerations.	Yes	The planning and implementation of the National Cancer Strategy (Achieving World Class Cancer Outcomes - a Strategy for England 2015-2020 (published June 2015) will be undertaken by the West Yorkshire Integrated Cancer Services team as part of the West Yorkshire Healthy Futures Collaborative (the Sustainability and Transformational Plan (STP) arrangement for West Yorkshire). This involves all agencies including local authorities, Public Health England, NHS England, all commissioners and all providers.	

Scrutiny Board Recommendation	Agreed (Yes/No)	Initial Response	Recommendation Tracking
Recommendation 2: That commencing in the new municipal year (2016/17), the Scrutiny Board (Adult Social Services, Public Health, NHS) considers the format of future assurance on the progress associated with the early diagnosis and treatment of cancer, alongside the frequency it wishes to seek such assurance.	Yes	To be determined by the Scrutiny Board and incorporated into the work schedule, as appropriate.	

Scrutiny Board Recommendation	Agreed (Yes/No)	Initial Response	Recommendation Tracking
Recommendation 3: That by December 2016, the Chair of the West Yorkshire Association of Acute Trusts provides a further report on the achievements to date and future plans of the association.	Yes	WYAAT has actively engaged in the development of the West Yorkshire Sustainability Transformation Plan (STP) which has identified Cancer Services as a system wide priority. Through WYAAT all acute Trusts will contribute to the development of future service models and implementing service changes which will be designed to deliver the National Cancer Strategy. In addition to the development of the Cancer workstream in the STP the WYAAT Trusts are collaborating to develop and strengthen clinical networks and improve patient flow. At this stage this includes information sharing and escalation of pathway issues through the WYAAT operational and clinical groups. The future development of WYAAT and it's workplan will be shaped by the West Yorkshire STP as well as the provider led priorities for improving sustainable services. The association therefore is focusing on developing a clear assessment of variation and developing the framework for working together to reduce this including clinical engagement in design, governance requirements, capacity and skills to deliver change at a local and system level.	

Scrutiny Board Recommendation	Agreed (Yes/No)	Initial Response	Recommendation Tracking
Recommendation 4: That in developing the Leeds Cancer Strategy, due consideration is given to ensuring there is a balance between providing a 'core offer' for all patients from across the City, while recognising and addressing the identified and known aspects of health inequalities across different parts of Leeds and its communities.	Yes	The implementation of the Leeds City Cancer Strategy will prioritise identifying and reducing the health inequalities across different parts of Leeds and its communities.	
Recommendation 5: That by September 2016, HealthWatch Leeds, in consultation with the Director of Public Health, assesses the current level of patient experience data it holds specifically in relation to the prevention, early diagnosis and treatment of cancer, and considers its potential future role in collating such data on behalf of partners across the Leeds' health and social care economy landscape.			

Scrutiny Board Recommendation	Agreed (Yes/No)	Initial Response	Recommendation Tracking
Recommendation 6: That by December 2016, the Chair of the Leeds Cancer Strategy Group reviews its currently proposed membership to ensure this includes: (a) Appropriate patient and public representation; and, (b) Appropriate representation to reflect the diverse communities within Leeds, particularly in those areas where specific health inequalities are known to exist.	Yes	The Leeds City Cancer Strategy Group will have appropriate patient and public representation and undertake to engage with the broader and diverse communities in the planning and delivery of the strategy. Representation includes third sector and Healthwatch Leeds. Patients have tested being members of strategy groups previously. They advised us that their preference is to be a partner member of specific service groups where their expertise is of greatest value by ensuring patient involvement directly influences and shapes services.	
Recommendation 7: That by July 2016, the Chair of the Leeds Cancer Strategy Group reports back to the Scrutiny Board regarding the timescales associated with developing and agreeing an overall Leeds Cancer Strategy, improvement plan and associated key performance indicators, including details of where the strategy and improvement plan will be presented and agreed.	Yes	The planning and delivery of the implementation of the National Cancer Strategy in Leeds will require stakeholder engagement which is planned for the Autumn. This will include the Scrutiny Board and the Health and Wellbeing Board. This allows the Leeds City Cancer team to align the planning of cancer services to deliver best outcomes with the Sustainability and Transformational Plans for Leeds. The Strategic Clinical Lead for Cancer will be happy to commence early discussions to inform the Scrutiny Board during the summer.	

Scrutiny Board Recommendation	Agreed (Yes/No)	Initial Response	Recommendation Tracking
Recommendation 8: That by July 2016, and as part of the process for developing and agreeing an overall Leeds Cancer Strategy and improvement plan, the Chair of the Leeds Cancer Strategy Group: (a) Recognises the duty on NHS commissioners and providers to effectively involve and engage patients and the public, setting out plans for public and patient engagement and involvement. (b) Sets out proposals and timescales for engaging with the appropriate Overview and Scrutiny bodies.	Yes	Nationally the Cancer Strategy undertook wide and detailed public and patient engagement in its production (Annex1). At local Leeds level, we have developed the Leeds Integrated Cancer Services Steering Group (LICS) to work across partner organisations to deliver the Cancer Strategy 2015-2020. Patients are involved in our work streams and will continue to be so. We also commissioned research programmes to gather insight from patients and the public which have been used to change local pathways. The Leeds Cancer Strategy will reflect our ongoing commitment to involving and engaging patients and the public. We will engage with the Health and Wellbeing Board through the Leeds STP process and can provide regular updates to the Scrutiny Board annually.	

Scrutiny Board Recommendation	Agreed (Yes/No)	Initial Response	Recommendation Tracking
Recommendation 9: That by September 2016, Leeds Clinical Commissioning Groups provide a joint report on the commissioning priorities and intentions for 2016/17, specifically identifying any proposed cancer prevention and early intervention initiatives, including associated timescales and budget allocations.	Yes	The implementation of the Leeds City Cancer Strategy will require whole system approaches where the Local Authority, all commissioners, and providers work in an integrated fashion. The concept is best described as an Accountable Care approach. To achieve the outcomes set out in the National Strategy three ambitions have to be realised: reducing cancer incidence, increasing cancer survival and ensuring patient experience has equal weight as the other clinical outcomes. To achieve this requires the whole of the system to engage and participate and make collective decisions on resources.	

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Annex 1

Engagement section from: Achieving World-Class Cancer Outcomes - A Strategy For England 2015-2020, the report of the Independent Cancer Taskforce

Our cancer strategy will deliver the aims and objectives of the national cancer strategy, in Leeds and West Yorkshire. Large numbers of organisations and individuals were involved in the creation of the national strategy.

Full membership of the Independent Cancer Taskforce:

Harpal Kumar – Chair
Shafi Ahmed – Royal College of Surgeons
Jane Allberry – Department of Health
Maureen Baker – Royal College of GPs
Juliet Bouverie – Macmillan Cancer Support
Adrian Crellin – Radiotherapy Clinical Reference Group
Sean Duffy – NHS England
Kevin Hardy – St Helens and Knowsley Teaching Hospitals NHS Trust
Anne-Marie Houlder - NHS Stafford and Surrounds CCG
Liz Hughes – Health Education England
John Newton – Public Health England
Clara Mackay – Cancer 52
Kathy McLean – NHS Trust Development Authority
Catherine Oakley - UK Oncology Nursing Society
Cally Palmer – Royal Marsden
Martin Reeves – Coventry City Council
Mike Richards – Care Quality Commission
Richard Stephens – Patient Representative
Sarah Woolnough/ Sara Hiom – Cancer Research UK

WRITTEN SUBMISSIONS
The taskforce held a call for evidence over six weeks in January and February 2015 and this was promoted by members of the secretariat to the wider cancer and health community. 226 responses were received. A full analysis has been published including details of who submitted evidence.

In addition, the taskforce secretariat has managed a taskforce email account answering queries from, and coordinating correspondence with, stakeholders and the public.

WORKSHOPS AND MEETINGS

Stakeholder workshops and meetings were hosted by the taskforce. Some of these were held with specific stakeholder groups, whereas others were held on a subject area with a cross section of interested stakeholders. A taskforce or secretariat member attended each of these events and a record of the discussion was taken.

A full list of stakeholder events is given below.

Workshops were held with the following stakeholder groups:

- Charities
- Industry
- Clinical Oncologists
- Consumer Liaison Group
- Pathologists
- Patients (Newcastle, Birmingham and London)
- Commissioners
- Primary Care
- Medical Oncologists
- Surgeons
- Nurses and AHPs
- Radiologists
- Early career clinicians and nurses

Meetings were held on the following topic areas:

- Older People
- Children and Young People
- Prevention
- Data
- Screening
- Research
- End of Life
- Living with and beyond cancer
- Information
- Digital
- Patient Experience
- Levers and incentives
- Local organisation and accountability
- Early Diagnosis

The taskforce chair, taskforce members and secretariat staff also held meetings with individual stakeholders and organisations

Appendix 3

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

Scrutiny Board Recommendations: Bereavement – policies and practices

Formal Response

Scrutiny Board Recommendation	*Agreed (Yes/No)*	*Initial Response*	*Recommendation Tracking*
Recommendation 1: (a) That, when undertaking future policy reviews, Leeds Teaching Hospitals NHS Trust clearly sets out a proposed forward plan, with key milestones and timescale; and (b) That, when establishing the forward plan (referred to in (a) above), that Leeds Teaching Hospitals NHS Trust keeps progress under review and reports any anticipated and/or unexpected delays.	Yes	LTHT has a robust process for review of all policies, and the timeframes are set out for each policy. The formal arrangements currently don't specify a model for planning consultation with stakeholders although it does specify the requirement to do so. A copy of the policy relating to the development and management of Trust-wide policies is attached at Annex A. The Trust undertakes to review this aspect during the scheduled review of this meta-policy which is due to be concluded and submitted for Executive approval by 31 October 2018. In Relation to the Care after Death and Bereavement Policy this scheduled review is due to be concluded and submitted for Executive approval by 31 January 2018 and the responsible lead officer will be the Head of Patient Experience.	

Scrutiny Board Recommendation	*Agreed (Yes/No)*	*Initial Response*	*Recommendation Tracking*
Recommendation 2: (a) That, by September 2016, Leeds Teaching Hospitals NHS Trust reviews and compares its current process and procedures for the timely release of the deceased, with those adopted and implemented by the Heart of England NHS Foundation Trust. (b) That, Leeds Teaching Hospitals NHS Trust reports the outcome of its review to the Scrutiny Board by November 2016.	Yes	The Trust will review and compare the Heart of England NHS Foundation Trust service model within the timescales requested by the Scrutiny Board and is happy to give an undertaking to complete the reviews and report back by the end of December 2016.	

Scrutiny Board Recommendation	*Agreed (Yes/No)*	*Initial Response*	*Recommendation Tracking*
Recommendation 3: That, Leeds Teaching Hospitals NHS Trust considers extending invitations to its briefing sessions to key members of the wider community and outside the organisation, in order to help embed a shared understanding of the issues and processes associated with the timely release of deceased relatives.	Yes	We understand this recommendation concerns briefing sessions for junior medical staff so that they are made aware of the importance of responding to the needs of the Muslim and Jewish communities in ensuring timely completion of the MCCD, specifically that community members should be invited to support this learning. We undertake to include briefing opportunities as part of the professional development of medical staff and our Medical Education and Patient Experience teams will work together to identify appropriate forums to which members of local communities could be invited. We also undertake to ensure there are appropriate alternative arrangements where local community members are unable to attend briefing sessions e.g. using video to relate families' experiences.	

Scrutiny Board Recommendation	*Agreed (Yes/No)*	*Initial Response*	*Recommendation Tracking*
Recommendation 4: (a) That, by December 2016, Leeds Teaching Hospitals NHS Trust reviews its arrangement for providing out of hours pathology services and considers the potential for providing such services in partnership with neighbouring acute hospital trusts. (b) That, by December 2016, Leeds Teaching Hospitals NHS Trust explore the potential options for offering routine access to non-invasive post mortems to all families (where appropriate), and undertake an appropriate cost benefit analysis of such options. .	*Yes*	The Trust is happy to accept recommendations 4(a) and 4(b) and will review its arrangements for out of hours pathology and explore the potential options for offering routine access to non-invasive post mortems. The Trust is happy to accept the timescales for the recommendations and will complete the reviews and report back by the end of December 2016. The out of hours pathology review will include 'standalone' and 'partnership with other Trusts' options and will include a review of the Heart of England Service Model. Both the out of hours and non-invasive post-mortems reviews will include cost benefit analyses of each option. The issues and recommended processes will be clearly laid out in order that all parties, including local representatives such as elected Councillors, funeral directors and community leaders have a common understanding of the Trust's decisions and the reasons behind them.	

Scrutiny Board Recommendation	*Agreed (Yes/No)*	*Initial Response*	*Recommendation Tracking*
Recommendation 5: That by September 2016, the issues and matters highlighted in this report are brought to the attention and discussed through Leeds' Faiths Forum to share any learning and experiences in respect of the timely release of the deceased, for the purpose of burial.	*Yes*	The Scrutiny Board report and recommendations to be brought to the attention of Leeds' Faiths Forum for appropriate action.	

Scrutiny Board Recommendation	*Agreed (Yes/No)*	*Initial Response*	*Recommendation Tracking*
Recommendation 6: (a) That by 10 June 2016, when formally responding[1] to the Department of Health consultation on the implementation of Independent Medical Examiners, the responsible Director from Leeds City Council reflects relevant issues highlighted in this report; (b) That, at an appropriate time, the responsible Director from Leeds City Council reflects relevant issues highlighted in this report as part of the future implementation of the Medical Examiners service, regardless of the geographic footprint. (c) That, regardless of the geographic footprint, the responsible Director from Leeds City Council keeps the Scrutiny Board informed of any issues associated with the future implementation of the Medical Examiners service, and, as a minimum, from September 2016 provides a 6-monthly progress report for the Scrutiny Board. *[1]The response might be an individual response on behalf of Leeds City Council, or part of joint response on behalf of two*	*Yes*	There are no new developments to report at this stage. The government's response to the national consultation on the future of the Medical Examiner is still awaited in September, as planned. There will be further discussions between the Chief Executives and the West Yorkshire Local Authorities following that consultation response with reports back to the Scrutiny Board. To be considered as part of the Scrutiny Board's work programme for 2016/17.	

Scrutiny Board Recommendation	*Agreed (Yes/No)*	*Initial Response*	*Recommendation Tracking*
Recommendation 7: That during the course of the 2016/17 municipal year, the Scrutiny Board (Adult Social Services, Public Health, NHS) discuss current and future arrangements for the provision of Out of Hours primary care services, specifically as they relate to death certification.	*Yes*	To be considered as part of the Scrutiny Board's work programme for 2016/17.	

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Annex A

LTHT POLICY FOR THE DEVELOPMENT AND MANAGEMENT OF TRUST-WIDE POLICIES AND PROCEDURES

Policy Title:	Policy for the Development and Management of Trust-Wide Policies and Procedures
Version:	4.2
Approved by:	Executive Team
Date of Approval:	18 April 2016
Policy supersedes	Policy for the Development and Management of Policies in Leeds Teaching Hospitals NHS Trust Version 4.1, 26 September 2013 (Updated 29 May 2014)
Lead Director:	Chief Executive
Name of policy Lead	Quality Governance Manager
Name of responsible governance committee/group:	Audit Committee
Date issued:	April 2016
Review date:	31 October 2018
Target audience:	Board Directors, Senior Managers in corporate functions and senior operational managers including Clinical Service/Support Unit Management Teams.
Associated Documents	Policy for the Development and Approval of Clinical Guidelines/Protocols and Procedures in Leeds Teaching Hospitals Trust

Key words	Policy, Policies, Guidelines, Procedure, Protocol, Approval, Development, Implementation, Monitoring, Communication, Effectiveness, Consultation, Stakeholders, Review, Register, Archive

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Annexes

Policy for the Development and Management of Policies and Procedures in Leeds Teaching Hospitals NHS Trust

Staff Summary

This Policy is relevant to all those in the Trust who are responsible for developing, reviewing and implementing Trust-wide policies or non-clinical procedures. It is not of particular relevance to other staff.

All Trust-wide policies, and non-clinical procedures, will be developed and approved in accordance with this Policy and the attached templates.

Definitions of the documents covered by this Policy can be seen in Section 3.

There will be a **Lead Board Director** with overall responsibility for each new and existing policy and non-clinical procedure. The Director will nominate an individual (the Policy or Procedure Lead) to develop and review the document. The lead is also responsible for communicating and monitoring implementation of the policy or procedure.

A Policy, within Leeds Teaching Hospitals NHS Trust is considered to be a binding statement on all employees which specifies what the Trust requires employees to do and/or how they are expected to act.

Policies will be written using a consistent style and format as set out in Appendix C. The process to follow when creating and approving a Policy is set out in figure 1 in Section 4.1

> The key requirements of a policy will be captured in a staff summary and the policy effect section. Appendices will be used for detailed policy requirements. Annexes will be used for checklists that policy users would not need to access. Guidance and toolkits can be referenced from the policy and should be held on the intranet or in a separate document to support the policy.
>
> All Trust policies, and any revisions, will be approved by the Trust Board or a Committee of the Board. Each policy will be overseen by a governance group which will receive routine reports on compliance with the Policy.

All Trust-wide **non-clinical procedures** will be developed using the format in Appendix C. The flowchart to be followed when creating and approving non-clinical procedures is set out in Figure 2 in Section 4.1. They will be approved by the Central Team or the Lead Board Director. A governance group will also oversee their implementation and effectiveness.

The flowchart for **monitoring and review of Policies, and Non-Clinical Procedures** is set out in Figure 3 in Section 4.1

Clinical guidelines, protocols and standard operating procedures must follow the relevant processes set out in the Policy for the Development and Approval of Clinical Guidelines/Protocols and Procedures in Leeds Teaching Hospitals Trust.

Local non-clinical procedures/SOPs specific to an individual specialty/service will be governed by the local governance arrangements.

1. PURPOSE

This policy and associated templates outline the process for development and approval of all clinical and non-clinical policies, and non-clinical procedures. This will ensure that a consistent approach is adopted and that consultation takes place with relevant parties.

2. BACKGROUND/CONTEXT

Policies and procedures need not be lengthy. It is important that their purpose and main principles are not obscured by detail. They may be supported by guidance, or specific toolkits outlining the precise requirements in more detail.

This Policy should be read in conjunction with the Policy for the Development and Approval of Clinical Guidelines/Protocols and Procedures in Leeds Teaching Hospitals Trust.

Local non-clinical procedures/SOPs specific to an individual specialty/service will be governed by the local governance arrangements.

3. DEFINITIONS

Policy - a binding statement on all employees that specifies what the Trust requires employees to do and/or how they are expected to act. All policies will be Trust-wide documents. These may be supported by Procedures and/or by guidance and toolkits which support staff in the implementation of a policy.

Procedure – a **Trust Procedure** sets out a standardised series of actions to be taken, with clear responsibilities, to achieve a task so that everyone undertakes it in an agreed and consistent manner to achieve a safe and effective outcome. When used as part of a policy, procedures will provide the means to fulfil the objectives of the Policy.

Clinical Guidelines, Protocols and Procedures fall under the remit of the Policy for Development and Approval of Clinical Guidelines/Protocols and Procedures . Definitions can be seen in Appendix A.

POLICY EFFECT

A summary table of governance arrangements for all Trust Policies/ Procedures/Guidelines whether local or Trust-wide can be seen in Appendix B.

This Policy covers Trust-wide Policies and Non-Clinical Procedures, as set out below.

4.1 Creating and Approving a Policy or Procedure

The process to be followed when creating and approving a Policy or Procedure are set out in Figures 1 and 2 below.

The flowchart for monitoring and review of Policies and Non-Clinical Procedures is set out in Figure 3 below.

Figure1. - Flowchart for the Creation and Approval of a Policy

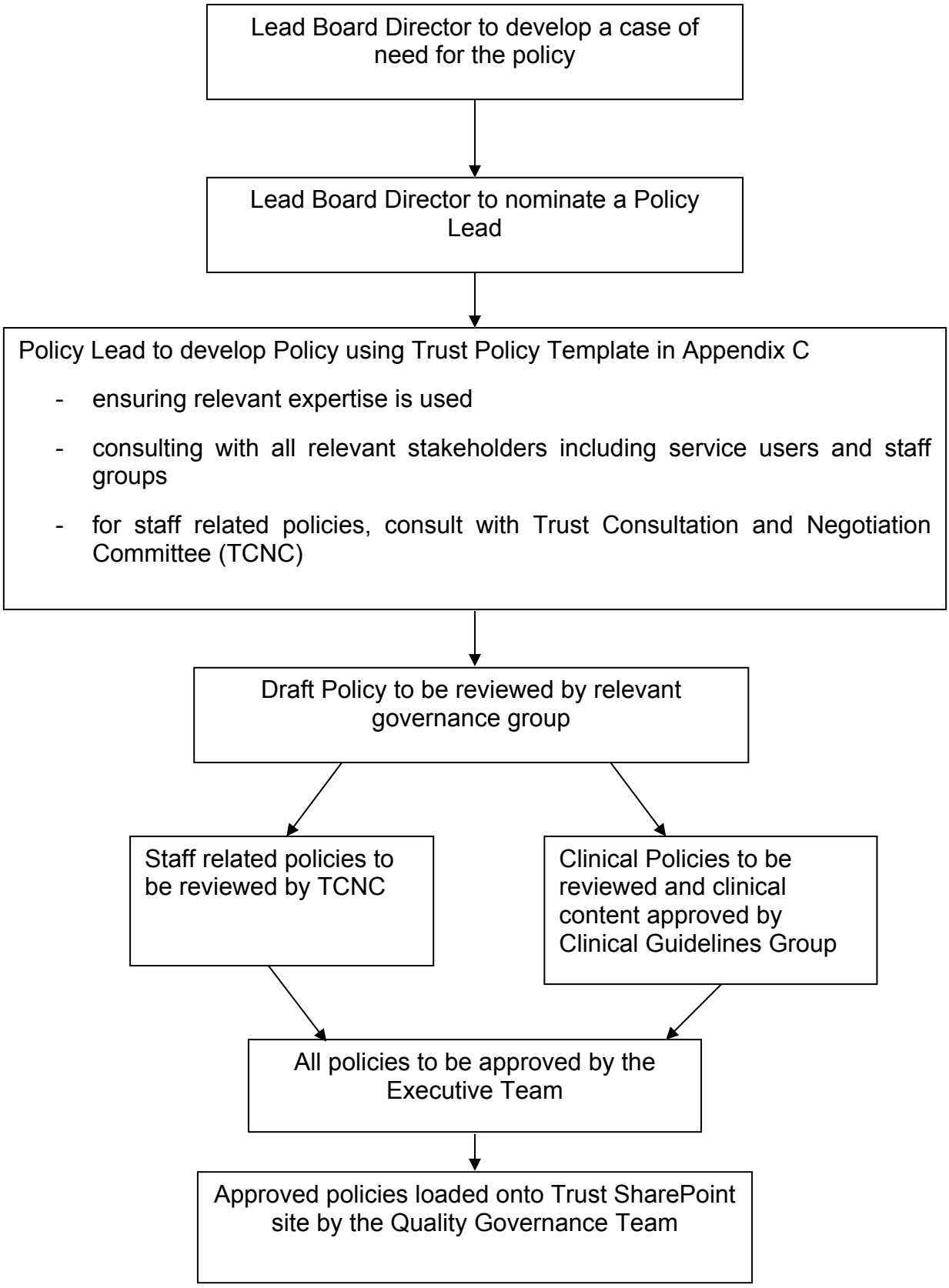


Figure 2. Flowchart for Creation and Approval of a Trust Non-Clinical Procedure

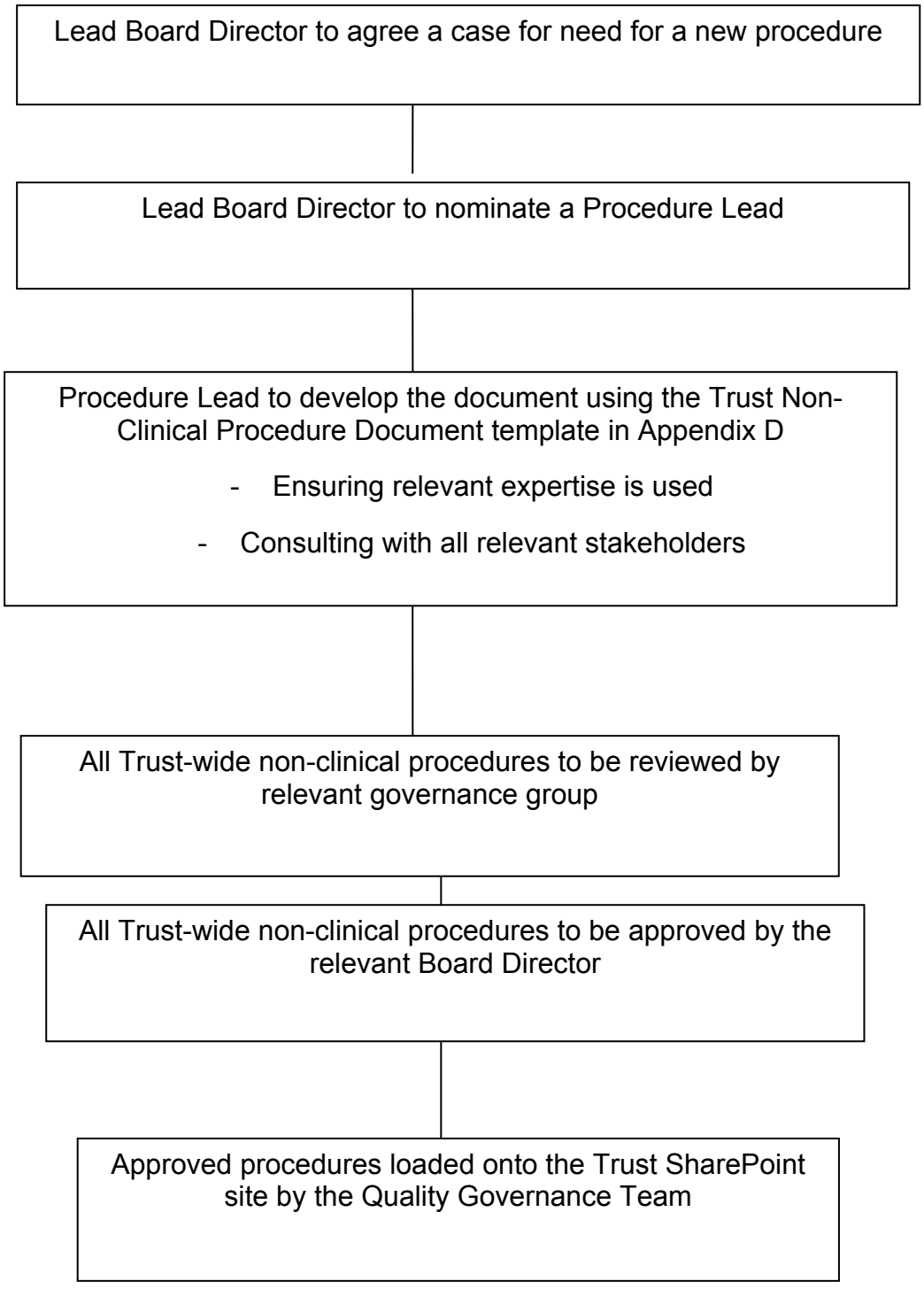
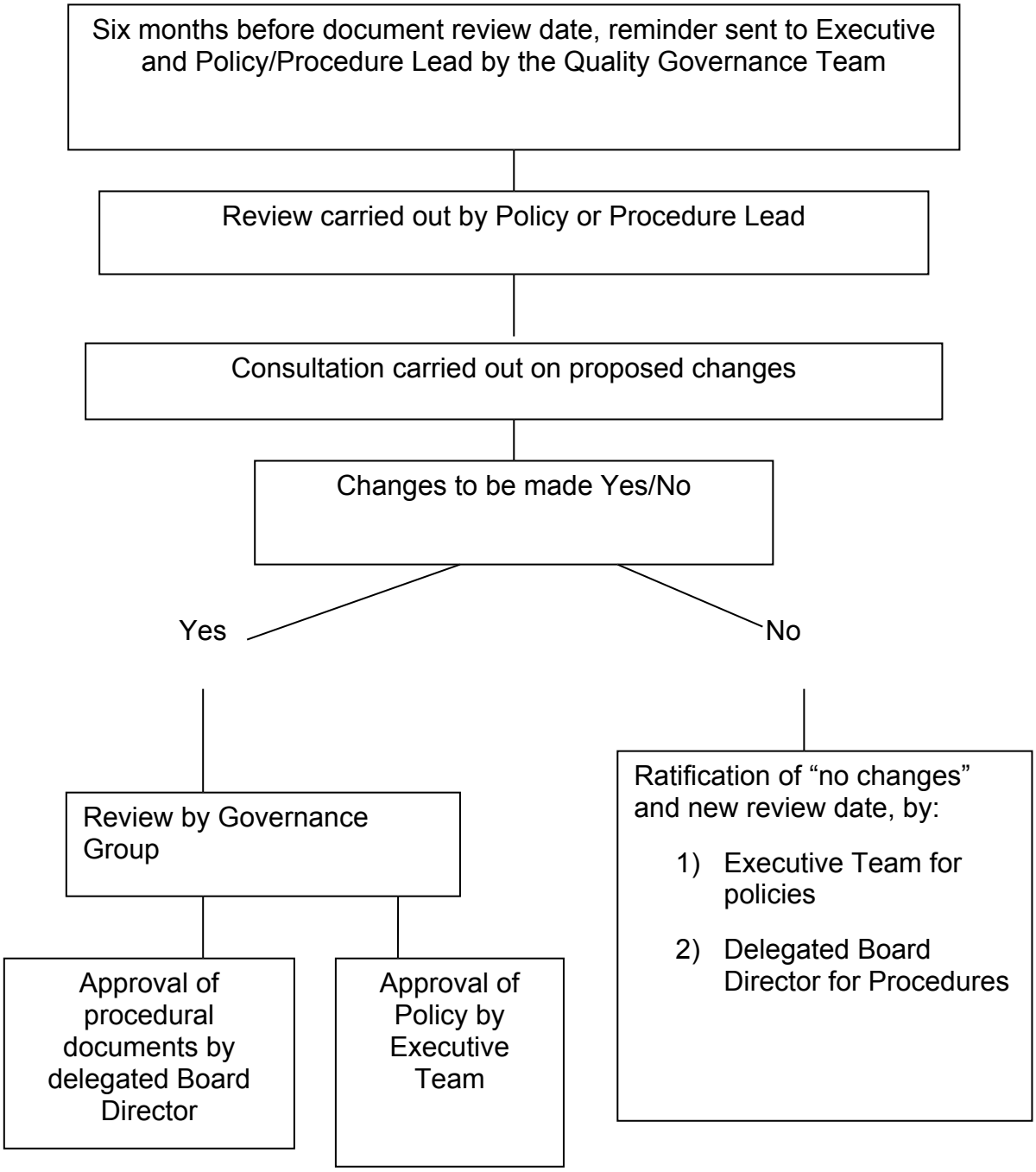


Figure 3. Review of Policies and Procedures



4.2 Style, Format and Content

All policies will be written using a consistent style and format as set out in Appendix C. The key points of the policy will be captured in a staff summary. Appendices will be used for detailed policy requirements. Annexes will be used for checklists that policy users do not need to access. Guidance, toolkits and supporting procedural documents can be referenced from the policy and should be held on the SharePoint site and linked to the policy.

All non-clinical procedures will use the format set out in Appendix D.

All policies and procedures will include a 'definitions' section giving an explanation of any key terms used.

4.3 Development Process

The process to be followed when developing or reviewing a policy or non-clinical procedure is set out below. The following sections (4.4 - 4.10) provide more detail on the process.

For any new policies, the Lead Director will:

- establish a clear justification for developing the new policy
- establish how it links with service priorities
- ensure that it is not duplicating other work.

For each document under development, the Lead Director will identify a Lead Manager who has responsibility for ensuring this policy is followed. In addition to this Policy/Procedure Lead, a steering group may also be established.

A staff side lead should also be nominated to work with the management lead for staff related policies.

4.4 Identification of Stakeholders

The Trust will seek the involvement of stakeholders in the development of new policies and procedures and any major review of existing documents. On occasion, this may include relevant staff representatives and service users. Key stakeholders outside the organisation will be informed during development or when the document has been approved, prior to implementation, at the discretion of the Lead Director.

4.5 Equality Analysis

The development of Trust policies must comply with the aim of equalities legislation which is to promote equality and eliminate unlawful discrimination. Guidance on Equality Analysis of policies is available on the Trust intranet.

An equality analysis must be undertaken on all policies and ratified prior to presentation of the policy for approval: see the equality analysis tool on the Equality and Diversity web page. This analysis must be held in an Annex to the policy.

All policies must include an equality statement such as: "The Leeds Teaching Hospitals NHS Trust is committed to reflecting individual needs, promoting equality and avoiding unfair discrimination against any particular individual or group. This applies to both the way that we provide services and the way we recruit and treat staff".

4.6 Consultation Process

All Policy/Procedural Documents

Relevant staff should be involved or consulted on the development of all policies and procedures. Where a policy or procedure is determined by a legal or regulatory requirement, Trust staff may expect to be consulted on how to implement it, rather than on the substantial requirements.

- Relevant practitioners must be involved in the development and review of clinical policies
- Where relevant, the views of people from different ethnic minority groups, of different gender, disabled people, and other groups should be sought (in accordance with the Trust's Equality and Diversity Policy)
- For policies that directly affect patients and service users, it will generally be appropriate to involve some patients, carers and public at the outset as well as consulting more widely on the drafts
- There is a statutory duty to consult with staff on all Health and Safety related policies
- Any major actions taken as result of involvement/consultation feedback should be documented on the version control sheet retained as an Annex to the Policy.

All draft documents issued during the consultation process must clearly indicate the date and draft number of the document (in the footer) to avoid confusion.

Staff Related Policies

Policies which fall into one of the categories listed below should go to either the Trust Consultation and Negotiation Committee (TCNC) or the Joint Consultation and Negotiation Committee (JCNC) for consultation

- Policies which affect terms and conditions of employment
- Policies which are authored by the HR Services
- Policies which affect (contractual and non-contractual) employee benefits
- Policies which could potentially affect all Trust employees, regardless of the job role which they are employed to do.

Where a policy falls within the remit of the TCNC/JCNC or Health and Safety Committee, the Lead Director should agree a review process with both Committees.

The consultation plan at Annex 2 of the template policy should be agreed.

When developing Staff Related Policies, due account should also be taken of the following guidelines approved by the TCNC (links are provided in Appendix C):

- Trust partnership policy

- Staff Involvement policy
- Involvement, Consultation & Negotiation Agreement

The involvement/consultation process, and major actions resulting from it, must be documented in an annex to the policy documentation (see Appendix C, Annex 3).

4.7 Approval and Ratification Process

All new or revised policies will be approved by the Executive Team.

Prior to seeking approval from the Executive Team, all new or revised policies will be reviewed by the appropriate governance group.

Staff Related Policies (as defined in Section 4.6) will normally be agreed by the TCNC/JCNC. However, where it is not possible to reach agreement, the Trust reserves the right to refer a Policy to the Executive Team for approval. In such cases the Executive Team will be advised that the TCNC/JCNC has not reached agreement in relation to the Policy.

Where a policy has been agreed by the TCNC/JCNC, the HR Service will be responsible for retaining a copy of the Policy signed by both the Director of HR and Staff Side Chair of the committee.

All Clinical policies will be reviewed and clinical content approved by the Clinical Guidelines Group, prior to approval by the Executive Team.

All draft or proposed Trust-wide policies must be submitted to the Executive Minute Secretary under a covering paper in standard Executive Team paper format. Trust policies will be approved by the Executive Team.

All new or revised non-clinical procedures will be reviewed by the appropriate governance group prior to approval by the delegated Board Director. They will then be forwarded to the Quality Governance Team for posting onto the SharePoint site.

4.8 Process for Reviewing a Policy or Procedure

Policies and Procedures will normally require a review date to be set two years from the approval date. The review date may be extended to three years if the policy requirements are unlikely to change significantly during this period. Review dates may also be brought forward if there are significant changes required, for example due to new national guidance or legislative changes. Policy/Procedure Leads must ensure they have arrangements in place to review the document at that time.

All reviews and revisions to policies and procedures must be approved according to the process described in section 4.7 of this document. Substantial changes would normally require a similar consultation process to the original policy. Changes to supporting guidance and toolkits can be made with approval from the relevant management or governance group.

Where no changes are required to a Policy following review, this will be approved by the Executive Team. A new review date will be agreed.

Where no changes are required to a non-clinical Procedure following review, this will be approved by the appropriate Board Director, and a new review date will be agreed by the Director.

4.9 Version Control

Each new 'final' version should be identified separately and distinctly with appropriate numbering on the cover sheet. Version 1 is the first published version of any policy, minor amendments may be numbered 1.1, 1.2 etc and major revisions/reviews should then become Version 2.

All Trust policy/procedural documents must include a standard section for documentation control purposes. See front page of template policy document at Appendix C for further details.

All Trust policy/procedural documents should contain a footer incorporating the title and approval date.

4.10 Communication, Dissemination and Implementation

All policies must contain a staff summary which communicates the policy succinctly.

All policies will include roles and responsibilities for ensuring staff are aware of the requirements of the policy.

All policies must include a communications and implementation plan before being submitted for formal approval. See Appendix C Annex 5.

All new policies and non-clinical procedural documents will be communicated via the 'InTouch' E-Bulletin. Substantial revisions will also be communicated via the E-Bulletin.

The governance/monitoring requirements of all policies will be summarised in the Governance Portfolio which captures the collective operational and corporate governance requirements.

4.11 Document Control including Archiving Arrangements

4.11.1 Register/Library of Policies and Procedures

The Trust has a central register/library of policies and non-clinical procedures held in SharePoint. This is an intranet-based system with search and archive functionality. To support this development, **all** policies and Trust-wide non-clinical procedures must be notified to the Quality Governance Team who will ensure they are made available on the Trust Intranet site.

The centrally-held version of the policy/procedure must be the only one actually published. If the policy/procedure is referred to within another local site on the Trust intranet it must be hyper-linked to the centrally held version on SharePoint/LHP.

4.11.2 Archiving Arrangements

The Trust will maintain a web-based archive, (via SharePoint and LHP). This will include:

- reviewed or updated policy/procedural documents

- those no longer in place, including the dates where the archived versions were extant.

Archived versions of policies and procedures must be retained in accordance with the Department of Health Code of Practice.

4.12 Monitoring Compliance and Effectiveness

All policies and non-clinical procedures will contain details of how compliance and effectiveness will be monitored including: - .

- Which governance group will oversee its implementation in conjunction with the Policy/Procedure Lead
- What monitoring arrangements for compliance and effectiveness will be adopted, e.g. audit, self-assessment, peer review, survey, or other research/evaluation
- Which specific group or named individual will have responsibility for conducting the monitoring/audit
- Reporting arrangements

Internal auditors will be asked regularly to assess awareness and compliance with Trust policies, including this policy.

4.13 References

Trust policies and procedures will provide references to show the evidence base. Policies and procedures should also reference any significant background or associated documents.

5. ROLES AND RESPONSIBILITIES

5.1 Trust Board - The Trust Board has overall responsibility for Trust policy. The Chief Executive will delegate responsibility for development of policy/procedure to nominated Lead Board Directors. The Trust Board has delegated responsibility for approval of policies to the Executive Team.

5.2 Executive Team - The Executive Team will:

- Approve all Trust Policies, and delegate approval of Trust Procedures to the appropriate Board Director

5.3 Governance Committees, Groups, and Sub-Groups - The Committees, Groups, and Sub-Groups will be responsible for:

- Receiving and reviewing minutes and assurance reports from governance groups
- Referring risks upwards to a Board Committee where appropriate
- Acting as the nominated governance group for policies and procedures for which they provide the first line of oversight.

5.4 Audit Committee - The Audit Committee will be responsible for reviewing the effectiveness of this policy on an annual basis.

5.5 Clinical Guidelines Group - The Clinical Guidelines Group will i) review new or revised clinical policies and approve the clinical content, prior to presentation to the Executive Team, and ii) approve all new or revised clinical procedures and protocols.

5.6 Nominated Governance Groups - The nominated Governance Group will:

- review new or revised policies/procedures prior to presentation to the Executive Team or Board Director, for approval
- receive routine assurance reports as required by each policy/procedure
- commission actions required to improve assurance or compliance.

5.7 Lead Directors - Lead Board Directors have overall responsibility for specific new and revised policies and procedures. This includes:

- Nominating a Policy/Procedure Lead
- Nominating the appropriate Governance Group for the Policy/Procedure
- Establishing a steering group, if required, to steer the development of a Policy, and submission for approval
- Ensuring the document is reviewed prior to its review date
- Ensuring appropriate levels and methods of patient, carer and public involvement
- Ensuring key stakeholders outside the organisation are involved or informed during policy development or when a policy has been approved, prior to implementation
- Confirming that implementation is achievable within the resources of the service/organisation
- Ensuring the document has an appropriate review date, normally two years from the approval date
- Reviewing all policies/procedures before being submitted for approval
- Ensuring that arrangements are put in place to monitor implementation of the policy/procedure, and report on compliance.

5.8 Policy Steering Group (where required) - A Steering Group, if needed, will be a time limited task and finish group with responsibility for:

- Identifying relevant stakeholders, and ensuring a consultation process takes place
- Agreeing what monitoring arrangements for compliance and effectiveness will be adopted, (e.g. audit, self-assessment, peer review, survey, or other research/evaluations) and the frequency and methodology of monitoring.
- Agreeing a communication and implementation plan

5.9 Policy/Procedure Lead -The Lead will be responsible for:

- Coordinating the development of the document
- Leading the development of a communication and implementation plan
- Carrying out consultation
- Proposing how the implementation will be monitored
- Ensuring the policy/procedure is written in plain English, is jargon-free, and follows the formatting conventions stated in Appendix C
- Ensuring the policy has been assessed for relevance to the statutory equality duties. Ensuring an equality analysis has been carried out, and approved by the Head of Equality and Diversity
- Ensuring the correct ratification process is followed
- Notifying the Quality Governance Team when the final document has been agreed and providing the approved version for posting on SharePoint**.**
- Ensure arrangements are in place to review the document at the appointed time.
- Noting when significant changes have occurred which impact on the policy/procedure and contacting the Lead Director to trigger an immediate review, if necessary
- For any policy being considered by the TCNC, the Policy Lead is responsible for providing TCNC with progress reports of the work and achievements against any agreed consultation plan. This is done by liaising with the Management Side Secretary of the TCNC in the HR directorate, who will include this on the TCNC agenda
- Ensuring that the agreed monitoring and reporting arrangements are put in place

5.10 Consultees - When draft copies of a policy/procedure are circulated and comments invited, respondents should make their comments by the date given. Failure to respond to the invitation to comment by the given date will be taken to be consent to their approval.

5.11 Quality Governance Manager - The Quality Governance Manager will be responsible for:

- Maintaining the SharePoint register of Trust Policies and Non- Clinical Procedures
- Proving an annual assurance report on the implementation of this policy to the Audit Committee.

5.12 All Staff

Failure to follow a Trust policy could result in the instigation of disciplinary procedures, in accordance with the Trust Conduct and Discipline Policy.

6. EQUALITY ANALYSIS

This Policy for the Development and Management of Policies and Procedures in Leeds Teaching Hospitals NHS Trust has been assessed for its impact upon equality. The Equality Analysis can be seen in Annex 1.

The Leeds Teaching Hospitals NHS Trust is committed to ensuring that the way that we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group.

7. CONSULTATION AND REVIEW PROCESS

Previous versions of this Policy have been the subject of consultation and discussion with staff side and Trust Consultation and Negotiation Committee.

8. STANDARDS/KEY PERFORMANCE INDICATORS

All Trust Policies and Procedures will be in the required style and format.

All Trust Policies and Procedures will include a Definitions section, explaining frequently used terms.

All Trust Policies and Procedures will reference key associated documents.

All Trust Policies and Procedures will include clear references to its drivers and evidence base.

All Trust Policies and Procedures will have been subject to consultation with identified stakeholders.

All Trust Policies and Procedures will have an identified Lead Director, and a Policy/Procedure Lead responsible for development and monitoring implementation and review.

All Trust Policies and Procedures will be ratified by the appropriate Governance Group prior to approval.

All Trust non-clinical Procedures will be approved by the Central Team, or delegated Board Director, prior to posting on SharePoint.

All Trust policies and non-clinical procedure will be held on the Trust's SharePoint site and reviewed in accordance with the agreed review date.

All superseded versions of policies and procedures will be archived.

9. PROCESS FOR MONITORING COMPLIANCE/EFFECTIVENESS

Policy element to be monitored	Standards and Performance indicators	Process for monitoring	Individual or group responsible for monitoring	Frequency or monitoring	Responsible individual or group for development of action plan	Responsible group for review of assurance reports and oversight of action plan
Style and format	All Trust Polices and non-clinical procedures will be in the required style and format.	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee
Terms used	All Trust Policies and non-clinical procedures will include a Definitions sections, explaining frequently used terms.	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee
Associated Documents and supporting references	All Trust Policies and non-clinical procedures will reference key associated documents. All Trust Policies and non-clinical procedures will include clear references to its drivers and evidence base.	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee
Consultation	All Trust Polices and non-clinical procedures will have been subject to consultation with stakeholders.	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee
Ownership and governance of	All Trust policies and non-clinical procedures will have an identified Lead Board Director, a Policy/Procedure	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee

polices	Lead, and an identified governance group to oversee ongoing implementation and review.					
Approval of Policies	All Trust policies and non-clinical procedures to be ratified by appropriate Governance Group prior to Executive Team or Board Director approval.	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee
Approval of Procedures/protocols	All Trust non-clinical procedures to be approved by the delegated Board Direcot prior to posting on SharePoint.	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee
Review of polices	All Trust policies and non-clinical procedures to be on Trust's SharePoint site and reviewed in accordance with agreed review date.	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee
Archiving of polices	All superseded versions of policies and procedures will be archived	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee

10. REFERENCES/ASSOCIATED DOCUMENTATION

NHSLA Litigation Authority Risk Management Standards 2012/13

Policy for the Development and Management of Policies and Procedures in Leeds Teaching Hospitals NHS Trust

Document Definitions

A Policy is a binding statement on all employees that specifies what the Trust requires employees to do and/or how they are expected to act.

Policies apply to all relevant staff as a 'must do' requirement, and a breach of policy may have contractual consequences for the employee. Policy is a statement of the standard to be achieved rather than how to implement the standard. Policies often arise from legislation, national policy or Trust strategy.

> A **Clinical Policy** is a Trust-wide policy, as described above, which relates to a particular clinical or patient care related issue. (A clinical policy will often have associated clinical guidelines, protocols or procedures - or possibly all three).

Procedural Documents

A Trust Procedure is a standardised series of actions to be taken to achieve a task so that everyone undertakes it in an agreed and consistent manner to achieve a safe and effective outcome. (When a procedure is part of an approved policy it provides the means to fulfil the objectives of the policy and to show how the policy statement is to be achieved).

Clinical Documents - Managed under the Trust Policy for the Development and Approval of Clinical Guidelines/Protocols and Procedures. These give guidance on direction regarding diagnosis, management and/or treatment in specific clinical areas.

A **Clinical Standard Operating Procedure (SOP**) is a step by step description of how to do something at a practical level. An example of a clinical procedure (SOP) is the procedure for insertion of peripheral venous cannula

A **Clinical protocol** is a mandatory course of action that a clinician must take when they decide that the conditions of 'specific clinical circumstances' are met. A protocol may contain procedures within it. An example of a protocol is the Immunisation Protocol for the Neonatal Unit. Clinical Protocols can be seen as more specific than guidelines and defined in greater detail. Protocols provide "a comprehensive set of rigid criteria outlining the management steps for a single clinical condition or aspects of organisation"

Clinical Guideline - A systematically developed, evidence based document that assists employees, including healthcare professionals, to make decisions concerning the appropriate course of action to take or care for specific clinical conditions.

A clinical guideline will often contain embedded protocols and/or procedures.

A Clinical Guideline does not override the individual responsibility of health professionals to make clinical decisions appropriate to the circumstances of individual patients in consultation with the patient and/or their guardian or carer. If such a decision means that a clinical guideline is not followed for an individual patient, the reasons must be fully recorded in the patients' medical records.

Local Procedures/SOPs

Local clinical procedures/SOPs specific to one specialty or service area.

Summary Table of Governance Arrangements

Appendix B

	Policies	Trust-wide Procedures		Trust-wide Clinical Guidelines	Local Clinical Guidelines	Local Procedures/SOPs	
		Clinical	Non-Clinical			Clinical	Non-Clinical
Formal Approval	Executive Team	Delegated Executive Director	Delegated Executive Director	Clinical Guidelines Group*	Clinical Guidelines Group*	CSU Governance Forum or delegated specialty group	CSU Governance Forum or delegated specialty group
Reviewed By	Relevant Governance Group, Clinical Policies also through Clinical Guidelines Group, prior to formal approval	Relevant Governance Group prior to formal approval	Relevant Governance Group, Clinical Policies and then Clinical Guidelines Group, prior to formal approval	Peer review determined by the author/specialty. LHP peer review process is available if required		Local peer review process	
Held on	SharePoint Hub	SharePoint Hub	LHP with link to SharePoint Hub	LHP	LHP	On specialty specific shared drive or on LHP	
Monitored By	Through Trust-wide mechanisms including Audit Programme, Staff and Patient Surveys, Risk and Safety Audit. Reported into governance structure as set out in Policy/Procedure Monitoring Tables			As set out in their audit section	Through specialty Audit Programme		

* Guidelines/protocols/procedures relating specifically to:

- Drugs will be approved by the Drug and Therapeutics Group and the Leeds Area Prescribing Committee for final approval.
- Antimicrobials by the Improving Antimicrobials Prescribing Group
- Other specific city-wide steering groups; Safeguarding Adults, Safeguarding Children are also able to approve their clinical guidelines/protocols and procedures through their own governance processes.
- Protocols or SOPs that are specialty specific may be approved through their own CSU governance forum.

Policy for the Development and Management of Trust Wide Policies and Procedures in Leeds Teaching Hospitals NHS Trust

Style Guide and Policy Template

STYLE GUIDE FOR TRUST POLICIES

All policies should:

- Be as concise and focused as possible
- Be fully indexed and include page numbering
- Ensure no discrimination against any groups or individuals and promote equality where possible.
- Be in plain English using short sentence, and simple vocabulary
- Be written in MS Word and use MS Word formatting conventions.

Formatting should be kept as simple as possible. Heading levels should be consistent and reflected in the index.

Tables should be used to align lists and columns of information.

The Trust's FOI Publication Scheme does not support newspaper style columns so these should be avoided.

Appendices should be attached for more detailed information. Very bulky data should be placed on the website and cross-referenced from within the paper.

Consideration should be given to also producing appropriate documents in languages other than English and in different formats dependent on the population groups served by the organisation.

Policies, especially clinical and prescribing policy, should not include abbreviations for clinical dosages or medicines. E.g. 'mcg and 'NaCl' which may lead to confusion and error. Medicines and dosage should be in full. Abbreviations used within the organisation should always be defined at the first use.

Font	Arial
Font size	All text in 12pt apart from the main heading, which should be in 14pt. (For people with visual impairments this should be increased to 16pt or 18pt and be in bold)
Headings	▪ Main section headings in **BOLD AND UPPERCASE** ▪ Sub-section headings in **Bold and Title Case** ▪ Underlining is not used within headings
Numbering Convention	▪ Main headings will be numbered sequentially ▪ Sub-heading numbering will take the format '13.1', '13.2' '13.2.1' etc ▪ All pages will be numbered at the bottom within the footer as per document template
Justification	To comply with 'Plain English' requirements, all text should be left-aligned as opposed to being justified

The Leeds Teaching Hospitals NHS
NHS Trust

Template for Trust Policies

POLICY TITLE

Policy Title	
Version:	*(see Policy Section in 4.8)*
Approved by:	Executive Team
Date of approval:	
Policy supersedes:	
Lead Board Director:	
Policy Lead (and author if different):	
Name of responsible committee/group:	*(Insert the name of the group that will oversee effectiveness of implementation)*
Date issued:	
Review date:	*(Usually 2 years from approval date)*
Target audience:	

Keywords	*(To allow searching on SharePoint)*

Contents

STAFF SUMMARY - To be on a separate page.

This gives a short **summary** (no more than one A4 side) of the policy effect (process) in simple language readily accessible to staff, and highlights key roles and responsibilities. It should be clear from this summary who the policy is of relevance to and what they can expect to find in it.

This section should signpost any flowcharts in section 4, and any other key sections of particular relevance to staff, so they can easily access key information.

1 PURPOSE

A short paragraph outlining the purpose of the policy.

It is important for policy authors to be able to state clearly in one or two short sentences the purpose of the policy and what it does. The main document is an opportunity to elaborate but this short section in bold text is a key feature that makes a policy more accessible for users.

This will be the description posted on the intranet policies A - Z and will be the first paragraph of the staff summary.

2 BACKGROUND/CONTEXT

This section can be used to explain any relevant background information or context for the policy. It should be kept as short as possible.

3 DEFINITIONS

Any key terms used within the document should be defined.

4 POLICY EFFECT

One or more sections outlining the processes covered by the policy, and what these processes aim to achieve.

These sections should lead into the “Roles and responsibilities” in section 5 by showing how the responsibilities outlined in that section fit together into a process/processes.

Wherever possible, the process(es) should be clarified in a flow chart.

It should go into sufficient detail for someone unfamiliar within the process to understand it.

Counter fraud - The Trust is required to meet the Standards for Providers on Fraud, Bribery and Corruption as set out by NHS Protect. One of these standards requires the Trust to ensure that new and existing policies and procedures are appropriately fraud proofed. Therefore, staff involved in the drafting and revising of Trust policies should, as part of the process, consider any potential risks or loopholes in the policy which may allow fraud to occur. Appropriate measures should be included in the policy to minimise this risk. For further advice, please contact the Trust’s Local Counter Fraud Specialists (LCFS’s).

Retention of Records - It is a fundamental requirement that all of the Trust’s records are retained for the appropriate period of time for legal, operational,

research and safety reasons. The length of time for retaining records will depend on the type of record and its importance to the Trust's clinical and business functions. The Trust has adopted the retention periods set out in the Records Management: NHS Code of Practice (detailed in the Trust's Retention Schedules for Health and Non-Health Records). The retention schedule will be reviewed regularly. Policy Leads should take this into consideration when developing/updating a policy

5 ROLES AND RESPONSIBILITIES

This section should set out responsibilities within the Trust: it must state clearly the requirements of staff in terms of their roles, responsibilities, and expected standards of behaviour. It must also set out who is responsible for implementing all aspects of the policy. Where it is appropriate, acceptable levels of delegation should also be stated.

It should include the responsibilities of relevant committees/groups.

Roles relating to multidisciplinary teams should be taken into account and clearly specified in this section

It should go into sufficient details for anyone at ant level of the organisation to understand their responsibilities.

6 EQUALITY ANALYSIS

This section needs to include two statements as follows:-

"This Policy has been assessed for its impact upon equality. The Equality Analysis can be seen in annex 1."

"The Leeds Teaching Hospitals NHS Trust is committed to ensuring that the way that we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group."

Guidance on Equality Impact Assessment of policies is available on the Trust intranet.

7 CONSULTATION AND REVIEW PROCESS

This section should describe the nature of the consultation process undertaken. The way in which the finalised policy will be communicated back to those involved in consultation will be included in the consultation plan in Annex 2**.** Section 4.5 of the Policy gives details of consultation requirements

"A consultation plan should be attached (See annex 2) for all new staff related Policies"

When developing Staff Related Policies, due account should also be taken of the following guidelines approved by the Trust Consultation and Negotiation Committee (links are provided below):

- Trust partnership policy

http://lthweb/departments/human_resources/Files/PartnershipPolicy.pdf

- Staff Involvement policy

http://lthweb/departments/human_resources/Files/staffinvolvement.doc

For all policies, the approving body will normally expect to see evidence of relevant staff involvement and consultation. There may be exceptions to this principle, e.g. where policy is determined by a legal or regulatory requirement, or where the policy is substantially determined by specialist professional advice. Under such circumstances, Trust staff may expect to be consulted on how to implement policy, though not in the substantial provisions of the policy

The electronic consultation forum on Leeds Health Pathways is an excellent means of consulting with named individuals within the Trust.

Prior to seeking approval from Trust Board (or Committee of the Board):

- All new or revised policies will be reviewed by the appropriate governance group
- All staff related policies will be signed off by Trust Consultation and Negotiation Committee
- All Clinical policies will also be considered by the Clinical Guidelines Committee.

The requirement for a new policy will be endorsed by the Central Team prior to work commencing on the development of the policy.

8 STANDARDS/KEY PERFORMANCE INDICATORS

This section must specify any relevant standards and KPIs which will be used to measure the impact/effectiveness of the policy e.g. how will we know if the policy is in place and being effective. Standards/indicators should only be referred to if they are measurable and there are plans referred to in Section 9 for monitoring them

9. MONITORING COMPLIANCE AND EFFECTIVENESS

This section, using the template below, must include details of how compliance and effectiveness of implementation of the policy will be monitored. This will include monitoring for any adverse impact on different groups. This should include the role of the Policy Lead and overseeing governance group in reviewing assurance. See Policy section 4.12 for further details.

Where an audit is required in order to measure compliance or effectiveness, the audit should be included in the Trust Annual Clinical Audit Programme and an audit tool should be made available.

Appendix A

Policy element to be monitored	Standards/ Performance indicators	Process for monitoring	Individual or group responsible for monitoring	Frequency or monitoring	Responsible individual or group for development of action plan	Responsible group for review of assurance reports and oversight of action plan
Include a separate row below for each element required by policy and any other aspects required by the Trust.	*How will we know if the policy is being implemented effectively?*					

10. REFERENCES/ASSOCIATED DOCUMENTATION

A list of any source documents referred to within the policy.

Policy Template Appendix A

To be included as required for the individual policy

Other appendices may be added

Policy Template Annex 1 - Equality Analysis

Use template available on Equality and Diversity web page.

Policy Template Annex 2

CONSULTATION PLAN (For new staff related policies)

This plan should be completed by the management or staff-side sponsor of a policy in advance of the consultation process. Supporting papers should be attached for information and the completed form should be sent to the relevant manager and staff-side representative and tabled at the appropriate forum for agreement.

Sponsor Name: _____ Job Title: _____ Division: _____	**Summary of Policy** e.g. *To transfer staff from ward A to ward Z as part of the Acute Service Reconfiguration*
Why is the policy necessary?	**Which staff/groups are affected?**
What is the potential impact of the policy?	**How will staff be involved in developing the policy?**
Where will formal consultation take place? With local representatives ☐ At JCNC ☐ At TCNC ☐ Other Joint Forum ☐ (Please specify) _____	**What is the target date for:** Completing consultation _____ Implementation _____ (subject to consultation) Review _____
Details of any specific constraints e.g. *Finance, Govt. requirement, etc*.	**Outline Process Agreed** Management Side _____ Staff Side _____ Date _____

Policy Template Annex 3 - Plans for Communication and Dissemination of Policy

This plan for communication and dissemination of the policy must be completed for all policies, and attached to the policy before being submitted to the Executive Team for approval.

Title of document:	
Approving Group/Committee	
Date Approved:	

Target Audience **Eg staff groups or stakeholders**	**Objective**	**Action**	**Person Responsible**	**Target date**
	Include any training requirements			
	Include removal of out of date documents, if relevant			
Narrative for InTouch:	*to highlight key changes (and why, if relevant)*			

GUIDANCE FOR DEVELOPMENT OF PLANS FOR COMMUNICATION AND DISSEMINATION OF POLICY

Objectives - State the outcomes that are required for those affected by the policy eg to: i) know of its existence, ii) understand its purpose, and iii) understand their role in implementation.

Key messages - These are the 'headlines' or key points you want people to be aware of. Readers need to understand the implications and desired effect of the policy and know whether they need to find out more details. These may already be in the Staff Summary.

Target Audience - It is important to understand the perspective of the target groups, e.g. what is their position/opinion/knowledge in relation to the policy; how do they prefer to receive important information; where are they and what are their working conditions like; what do they know already?

Do not adopt an indiscriminate, general or random approach, thinking that if you tell everyone or most people you are bound to reach the groups who need to know.

State as precisely as possible the groups who need to be informed about the policy either so that they can implement it or so that they are aware of the intended effect.

For each group there is likely to be separate information they need to know so it is helpful to segment or break up the overall target audience and specify what information each group needs. Each group may also have other characteristics or needs to distinguish it; try to identify them.

Stakeholders - These are normally people with an interest in the policy or in its impact, often external to the organisation. They may be neither subject to, nor directly affected by it. Think about how you will keep them in the picture about the things that matter to them.

Timing - Dates of communications activity that will happen? Include any key start or end dates; key milestones, anniversaries, events or opportunities to reach the target groups, including existing scheduled corporate, Trust-wide or group-specific communications.

Channels/mechanisms - It is important to select a range of effective channels or mechanisms to reach target groups. People need to see information several times before they take it in fully. It is also helpful to ensure there are multiple opportunities for any target group to see the information they need.

Do not invent new mechanisms, e.g. newsletters, intranet sites, without seeking advice from the Communications Team. This team will help you ensure whether this is likely to be the most effective means of communication with your target audience, whether there are better alternatives, and whether your aim can be supported by, or will undermine, other Trust-wide communications.

Policy Template Annex 4 - Checklist for the Review and Approval of Policy

LEEDS TEACHING HOSPITALS NHS TRUST

Approving Body Checklist for the Review and Approval of Trust Policy or Procedure

To be completed and attached to the policy when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Format and Content**		
	Is it in the correct format?		
	Is the staff summary clear and adequate?		
	Are the intended outcomes clearly described? (the Policy/Procedure Effect)		
	Is there a Definitions section giving an explanation of key terms used.		
	Is there an Equality Analysis signed off by the Head of Equality and Diversity (Policies Only)		
2.	**Consultation and Review**		
	Has there been appropriate consultation with stakeholders and users?		
	Has an appropriate governance group reviewed and supported the document prior to submission for formal approval?		
	For HR Policies only, has the TCNC approved the document?		
	If it is a clinical policy/procedure has it been reviewed by the Clinical Guidelines Group?		
	Has it been reviewed by internal audit for counter fraud?		
3.	**Dissemination and Implementation**		
	Is there a communications plan to identify how it will be communicated and implemented? The Communications Team can help you with advice.		
	Does the communications plan include a summary for InTouch?		
4.	**Process to Monitor Compliance and Effectiveness**		
	Is there a monitoring table setting out measurable standards or KPIs together with clear monitoring and reporting mechanisms (to ensure there is assurance of implementation)		
5.	**Review Date**		
	Is the review date in 2 years? If not is there a justified reason?		

If the document needs urgent approval before all of the above are satisfactorily addressed, please bring this to the attention of the appropriate committee so conditional approval can be given.

Committee Approval *(This section only required for staff- related policies)*			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	
Signature			
Name		Date	
Signature			

Policy Template Annex 5 - Version Control Sheet

This document to be maintained by the Policy/Procedure/Protocol Lead, and a copy attached to each version as it is circulated for consultation/input.

Version	Date	Author	Status	Comment (including actions taken)

Appendix D

Template for Non-Clinical Procedure

TITLE OF PROCEDURE

Date approved	
Approved by:*(Board Director)*	
Version	
Executive Lead	
Procedure Lead	
Procedure Author *(if different from Lead)*	
Governance Group	
Review Date	
Link to Policy	*Where applicable please state the policy which this procedure/protocol is governed by.*
Other Associated Documents	*Please list other documents which have direct links to this procedure.*

Contents

Staff Summary

STAFF SUMMARY - To be on a separate page.

This gives a short **summary** (no more than one A4 side) of the policy effect (process) in simple language readily accessible to staff, and highlights key roles and responsibilities. It should be clear from this summary who the policy is of relevance to and what they can expect to find in it.

This section should signpost any flowcharts in section 4, and any other key sections of particular relevance to staff, so they can easily access key information.

1. PURPOSE

This whole section should be concise and relevant. No more than a short paragraph is required

This should include;

- *the rationale for the document in a one sentence statement*
- *a brief background to the document in a one or two sentences if this helps to explain the purpose of the document; e.g Previously known as the policy on…., A new national or regional standard or guideline has been published…., New legislation regarding…. etc.*

2. SCOPE

Outline who the procedure applies to (which staff members) and the activity the procedure applies to.

3. DEFINITIONS/ ABBREVIATION

Please list any terminology frequently used throughout the document with a brief definition and any abbreviations you intend to use. Always assume the reader may not have come across terminology which you use consistently in the work environment.

4. PROCEDURE TO BE FOLLOWED

This is the body of the document and should include;

- *Who will perform the task*
- *Where the task will take place*
- *How the task will be performed*

This should be written as simply as possible, either in short sentences, numbered bullet points or clearly listed statements.

Wherever possible, please include a flow chart diagram. Please note if you cannot translate the described procedure into a flow chart it is possible it is too complex or does not provide enough detail. Always assume the person reading this does not know anything about the procedure.

5. ROLES AND RESPONSIBILITIES

This section should set out the responsibilities within the Trust. It must state clearly the requirements of staff in term of their roles, responsibilities, and expected behaviours. It must set out who is responsible for implementing all aspects of the procedure. It should also include the responsibilities of relevant groups/committees.

This presents similar information as in section 3 above, arranged under a role title so that each person can clearly see what's expected of them.

6. LINKS TO OTHER DOCUMENTS

Please list any policies, procedures or protocols this procedure or protocol is linked to.

7. MONITORING ARRANGEMENTS

This section should be set out in the attached table and must specify any standards/KPIs which will be used to measure the impact/effectiveness of the procedure ie how will we know if the procedure is in place and being effective.

Standards should be specific, measurable, achievable, realistic, and timed?

It should also state how these standards/KPIs will be monitored, how frequently, who by, and who will be responsible for reporting to the Governance Group/Committee.

If this monitoring is carried out as part of the monitoring process for a Trust Policy, this needs to be stated here.

8. REFERENCES

PROCEDURE MONITORING TABLE

Procedure element to be monitored	Standards and Performance indicators	Process for monitoring	Individual or group responsible for monitoring	Frequency or monitoring	Responsible individual or group for development of action plan	Responsible group for review of assurance reports and oversight of action plan

Procedure Template Annex 1 - Plans for Communication and Dissemination of Procedure

This plan for communication and dissemination of the policy must be completed for all Trust-wide non-clinical procedures, and attached to the policy before being submitted to the Board Director for approval.

Title of document:	
Approving Group/Committee	
Date Approved:	

Target Audience **Eg staff groups or stakeholders**	**Objective**	**Action**	**Person Responsible**	**Target date**
	Include any training requirements			
	Include removal of out of date documents, if relevant			
Narrative for InTouch:	*to highlight key changes (and why, if relevant)*			

Annex 2 - Checklist for the Review and Approval of a Procedure

LEEDS TEACHING HOSPITALS NHS TRUST

Approving Body Checklist for the Review and Approval of Trust Policy or Procedure

To be completed and attached to the procedure when submitted to Board Director for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Format and Content**		
	Is it in the correct format?		
	Is the staff summary clear and adequate?		
	Are the intended outcomes clearly described? (the Policy/Procedure Effect)		
	Is there a Definitions section giving an explanation of key terms used.		
	Is there an Equality Analysis signed off by the Head of Equality and Diversity (Policies Only)		
2.	**Consultation and Review**		
	Has there been appropriate consultation with stakeholders and users?		
	Has an appropriate governance group reviewed and supported the document prior to submission for formal approval?		
	For HR Policies only, has the TCNC approved the document?		
	If it is a clinical policy/procedure has it been reviewed by the Clinical Guidelines Group?		
	Has it been reviewed by internal audit for counter fraud?		
3.	**Dissemination and Implementation**		
	Is there a communications plan to identify how it will be communicated and implemented? The Communications Team can help you with advice.		
	Does the communications plan include a summary for InTouch?		
4.	**Process to Monitor Compliance and Effectiveness**		
	Is there a monitoring table setting out measurable standards or KPIs together with clear monitoring and reporting mechanisms (to ensure there is assurance of implementation)		
5.	**Review Date**		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Is the review date in 2 years? If not is there a justified reason?		

If the document needs urgent approval before all of the above are satisfactorily addressed, please bring this to the attention of the appropriate committee so conditional approval can be given.

Committee Approval *(This section only required for staff- related policies)*			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	
Signature			
Name		Date	
Signature			

Leeds CITY COUNCIL

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Report of Head of Scrutiny

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

Date: 26 July 2016

Subject: Work Schedule (July 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 consider the progress and development of the Scrutiny Board's work schedule for the current municipal year (2016/17).

2 Summary of main issues

2.1 At the Scrutiny Boards first meeting of the municipal year (2016/17) in June 2016, the Board identified a number of matters for consideration during the course of the year, including:

- Length of hospital stay / delayed discharges, including the role intermediate care services.
- Men's health – following publication of the State of Men's Health in Leeds report.
- CCG updates, particularly in relation to the new role as commissioners of primary care services.
- Specific activity around Adult Safeguarding
- CQC inspection outcomes – including the outcomes from inspections at Leeds Teaching Hospitals NHS Trust (LTHT) and Leeds and York Partnership NHS Foundation Trust (LYPFT).
- Budget monitoring for Adult Social Services and Public Health.
- Focussed work on budgets, e.g. budget pressure likely to impact on the delivery of Child and Adolescent Mental Health Services (CAMHS) and Targeted Mental Health Services (TaMHS) services through the single point of access, including an analysis of referrals into Child and Adolescent Mental Health Services across Leeds.

- The use of Pre-Exposure Prophylaxis (PrEP) in preventing the spread of HIV infection.
- Development of integrated care through joint health and social care teams.

2.2 Following discussions with Leeds Community Healthcare NHS Trust in response to the Board's statement on changes to service locations, the Board also agreed to consider the emerging overview of the use of the built estate across the health and social care sector in Leeds.

2.3 Other specific matters discussed included:

- Scrutiny Board (Environment and Housing) progressing an inquiry regarding Air Quality, with representatives from other relevant Scrutiny Board's invited to take part.
- The West Yorkshire Joint Health Overview and Scrutiny Committee focusing on the West Yorkshire Sustainability and Transformation Plan and the associated implications, specifically around patient flows to acute hospitals.

2.4 The Board's outline work schedule remains in development and will be presented at the meeting.

2.5 Nonetheless, it is important to retain sufficient flexibility within the Board's work schedule in order to react to any specific matters that may arise during the course of the year. As such, any work schedule presented may be subject to change and should be considered to be indicative rather than definitive.

2.6 In order to deliver the work schedule, it is likely that the Board will need to take a flexible approach and may need to undertake some activities outside the formal schedule of meetings – such as working groups, where this is deemed appropriate. Adopting a flexible approach may also require additional formal meetings of the Scrutiny Board.

3. Recommendations

3.1 The Scrutiny Board (Adult Social Services, Public Health, NHS) is asked to consider and comment on the work schedule for 2016/17, agreeing any specific priorities as deemed appropriate.

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.