APPENDIX 1

Draft Scrutiny Inquiry Final report Transformation of Health and Social Care Services in Leeds June 2012

Introduction and Scope

Introduction

1. In May 2011, the Council established six Scrutiny Boards and agreed the respective terms of reference. This included the Scrutiny Board (Health and Wellbeing and Adult Social Care).

2. Within the specific terms of reference for the Scrutiny Board (Health and Wellbeing and Adult Social Care), the following areas of review were highlighted for the municipal year 2011/12;

   - Reducing smoking in the over 18s
   - Service Change and Commissioning in Adult Social Care
   - Reducing avoidable admissions to hospital and care homes
   - The Transformation of Health and Social Care Services

3. At the first meeting of the Scrutiny Board (Health and Wellbeing and Adult Social Care), we agreed to include these areas within our annual work schedule.

4. This report seeks to summarise our work and consideration of the following areas:

   - The Transformation of Health and Social Care Services;
   - Service Change and Commissioning in Adult Social Care; and,
   - Reducing avoidable admissions to hospital and care homes;

Background and Scope of the Inquiry

5. At our meeting in July 2011, we considered the term of reference established by Full Council along with a range of background information relevant to the identified areas of review.

6. In relation to the Transformation of Health and Social Care Services we heard that the Leeds Transformation Programme was a city-wide agreement between Health and Social Care partners to work together to deliver the challenges ahead.

7. We were advised that the challenges facing the health and social care economy (both nationally and locally) included increasing quality, innovation and productivity in the context of a financially constrained environment. As such, the Leeds Transformation Programme was designed to:

   - bring together key health and social care organisations;
   - ensure partners full engagement in identifying and delivering the most appropriate ways to sustain quality;
   - substantially reduce the overall cost in the Leeds health and social care economy by the end of 2014.

8. Led by NHS Airedale, Bradford and Leeds (previously NHS Leeds), we were further advised of the wider national context, likely to impact

on the Leeds Transformation Programme, including:

- A new and evolving model of health and social care – as a result of the national NHS reforms;
- Increasing demands for services – due to the increased proportion of people aged over 65 years (and in particular aged over 85 years);
- New developments in health and social care interventions;
- Lifestyle challenges such as obesity, exercise, smoking, teenage pregnancy and drug and alcohol dependency.

9. Alongside the significant challenges presented, the benefits of the Leeds Transformation Programme were outlined to us as being:
   - More integrated services tailored to meet the needs of the large number of local people who receive both health and social care services;
   - A continued strong focus on quality and safety;
   - More health and care services delivered in the community and closer to people's homes, when and where appropriate;
   - The ability of front line health and social care services to better respond to increasing demand through a strong focus on increased productivity and the smarter use of technology in key areas;
   - More effective and targeted use of resources to better meet the needs of individuals and local communities;
   - Local people being supported to remain independent longer and empowered to take greater personal responsibility for their health and wellbeing.

10. Our intention was to undertake this work through consideration of regular updates on the work of the Leeds Health and Social Care Transformation Board, and its supporting project groups.

11. In addition, we also planned to consider a series of reports around the integration of Health and Social Care Services – outlining some of the proposed changes to services and commissioning arrangements across Health and Adult Social Services. We considered proposals at our meeting in February 2012, including how these might contribute to reducing avoidable admissions to hospital and care homes.

Anticipated Service Impact

12. Through this work, we hope to contribute to various programmes of work seeking to address some of the significant challenges facing the local health and social care economy over the coming years.

13. We recognise the significance of some of the challenges facing all the organisations involved across Leeds' local health and social care economy. We also recognise some the implications associated with the ongoing structural reform of

the NHS – not least the very challenging timescales around the transfer of responsibilities and the authorisation processes for the new Clinical Commissioning Groups.

14. Given some of the significant issues outlined, it is likely that much of the work undertaken during 2011/12 will need to continue into 2012/13 and beyond.

15. We feel it is important that the successor Scrutiny Board continues to maintain an overview of the Leeds Health and Social Care Transformation Programme and supporting workstreams during the new municipal year.

Recommendation 1

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

Conclusions and Recommendations

Overview

16. As outlined elsewhere in this report, in July 2011 we received an overview of the Leeds Health and Social Care Transformation Programme and what the programme was designed to achieve.

17. We were advised that the programme would build on the work previously undertaken through the Acute Services Strategic Review (ASSR) – albeit with a broader agenda. We did not specifically consider any outcomes from the ASSR, rather focusing our attention on the programme of work moving forward.

18. We were advised of that the programme was being led by NHS Leeds, which has the legal responsibility for improving health across the City (until April 2013).

19. We were also advised that, as key partners, the following local organisations also had an important role in guiding the programme:
    - NHS Leeds
    - Leeds City Council
    - Local GP Commissioners (now known as Clinical Commissioning Groups (CCGs))
    - Leeds Teaching Hospitals NHS Trust
    - Leeds and York Partnership NHS Foundation Trust
    - Leeds Community Health Care NHS Trust

20. Each of the above organisations are represented on the Transformation Board.

21. We recognise the significant challenges facing the local health economy – not least as a result of the constrained financial climate and significant health inequalities in some parts of the City.

22. We note that the Transformation Board is part of the emerging partnership structure under the shadow Health and Wellbeing Board arrangements and recognise the Transformation Board provides a mechanism for high level ownership of the agreed priorities and agreeing shared approaches for consideration by individual organisations.

23. As a non-statutory partnership we understand that the Transformation Board does not have formal decision-making responsibilities. However, we believe that the formation of the Board is a positive step towards meeting the local challenges and demonstrates the commitment of the partners involved.

24. Nonetheless, given the development of the Third Sector in Leeds and its likely future role in being 'part of the solution' to a number of local challenges, we would question whether the Third Sector should be more formally involved in the discussions and therefore represented on the Transformation Board – particularly given the Third Sector

representation on Leeds' shadow Health and Wellbeing Board .

Recommendation 2

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

25. As part of our work in this area, we received a series of updates on the work of the Transformation Board, the following three priority portfolios and associated projects / supporting workstreams:
    - Urgent and emergency care;
    - Older people and long-term conditions;
    - Clinical values in elective (planned) care.

26. At our February 2012 meeting – when considering a progress update on the above areas we noted that a significant aim of the Transformation Board was to make efficiency savings within the health and social care economy by the end of 2014. This aspect was not addressed and we requested a further update to address this aspect.

27. At our April 2012 meeting, we were presented with a further report intended to provide us with details of the efficiency savings generated through the work of the Transformation Board, and the associated projects / supporting workstreams.

28. However, despite the report being amended in light of concerns expressed by the Chair – and a revised report submitted on the day of the meeting, we remained frustrated by the lack of clear information demonstrating the savings achieved and where any savings had been reinvested.

29. We were advised that within the current financial environment, service providers are required to make 4% savings per year – 2½% inflationary and 1½% deflation on the financial value of contracts. We were also advised that not all savings would be measured on a 'cash releasing' basis as some savings would be around increased productivity.

30. However, we highlighted that, in the context of the national NHS reforms and the associated changing nature of NHS structures and associated funding, there was a need for a 'user friendly' report, in terms of its clarity, use of language and acronyms.

31. Given that clear advice had been repeatedly given that the report should have been written in plain English and presented in a way that could be easily understood, we were disappointed that the report did not serve the purpose it was intended for, nor did it meet our expectations.

Conclusions and Recommendations

Recommendation 3

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

Urgent and emergency care

32. This area of work initially focused on the following areas:
    - redesigning ambulatory (non-inpatient) care pathways; and,
    - front end (primary care) assessment (subsequently renamed Consult and Treat).

Ambulatory care pathways

33. We were advised that the redesigning of ambulatory care pathways aimed to improve the way that the health economy responds to patients who need assessment or treatment for conditions that do not require treatment in a hospital bed. The anticipated benefits being:
    - Avoiding unnecessary admissions to hospital;
    - Reduced lengths of hospital stays; and,
    - Emergency responses replaced with more proactive planned services.

34. In February 2012, we were advised that an assessment of the 49 (nationally defined) pathways had taken place and a prioritised review plan had been developed and was being implemented. The first phase of the review plan had focused on the management of venous thromboembolism (VTE), deliberate self harm, a surgical and urological group of pathways and a group of community pathways.

35. We noted that further review areas would be considered following completion of the first phase.

36. We are aware that the NHS Act (2006) places a duty on local NHS Trusts, to make arrangements to involve and consult patients and the public in:
    - Planning service provision;
    - The development of proposals for changes; and,
    - Decisions about changes to the operation of services.

37. We believe it would be useful to continue to provide assurance around the level of patient and public involvement and engagement when reporting progress of this area of work to the successor Scrutiny Board.

Front end assessment (Consult and Treat)

38. We were initially advised that the focus of the front end assessment project was on simplifying and improving access to urgent primary care services by exploring the options for re-procuring the urgent

care out of hours service from 2013.

39. In February 2012 we were advised that the project had been aligned to the re-procurement of the out of hours service and the NHS 111 Programme – which aims to provide a single model of out of hours care throughout West Yorkshire.

Urgent care services in Leeds

40. Part of the front end assessment (Consult and Treat) project also examined the potential risks and benefits of integrating urgent care out of hours services with an Accident and Emergency department – and formed the basis of one of three options included in the public consultation undertaken between December 2011 and March 2012.

41. We considered the options put forward at our Board meeting in January 2012. The options put forward were:
    - Option A – retaining the current configuration of urgent care services;
    - Option B – reconfiguration of provision, with potential use of current A&E sites;
    - Option C – reconfiguration of provision, with potential use of a new urgent care centre in or near to the city centre and in the east of the City.

42. Despite our discussion around the advantages and disadvantages of each of the options, there was no clear consensus on a preferred option and therefore we were unable to submit a formal consultation response.

43. At our meeting in April 2012 we examined the outcome of the engagement work around urgent care services in Leeds and how this had informed the subsequent decision of NHS Airedale, Bradford and Leeds Board.

44. We were advised that 463 written responses were received and while the analysis showed the majority of respondents preferred Option B (41%) many respondents appeared not to like any of the three options proposed.

45. We were provided with the following summary of findings:
    - The location of Lexicon House was poor overall but the facilities there were adequate or good;
    - Some people thought it was a good idea to move the services to hospital sites, but there was some concern about parking;
    - Some people were unsure if it was a good idea for extra money to be spent on new urgent care centres, although it was felt that a centre in the East of the City may be useful;
    - Some people were keen for consideration to be given to using the Seacroft Hospital site for new services;
    - Overall most people selected option B and the proportions were; option A 27%, option B 41%, option C 32%.

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46. We were advised that a range of key stakeholders responded to the engagement including Clinical Commissioning Groups, Leeds Local Medical Committee and Leeds Community Healthcare NHS Trust. We were further advised that these stakeholders had all indicated their preference for retaining services on the existing sites at the current time (Option A).

47. Taking account of the outcome of the engagement work and after considered the advantages and disadvantages of each option, the NHS Airedale, Bradford and Leeds Board concluded that the case for changing the existing service delivery locations was not made at the current time.

48. However, we were advised that the NHS Airedale, Bradford and Leeds Board had supported proposals to address concerns around signage, exterior lighting and security at Lexicon House and, subject to any necessary planning consents, improvements in these areas should be made.

49. We were also advised that, in order to reflect any future changes in the trends of accessing urgent care facilities in Leeds, the NHS Airedale, Bradford and Leeds Board had agreed that every effort should be made to provide flexibility in future estates and service provider contracts.

50. We noted the decision of the NHS Airedale, Bradford and Leeds Board and the basis of the decision – not least any potential implications associated with the local introduction of the national 111 service, which is aimed at making it easier for patients to access local healthcare services in urgent, but non-life threatening, circumstances.

51. With the implementation of the 111 service in mind, to ensure the local urgent care services continue to meet the needs of the people of Leeds, we believe it is important for appropriate NHS bodies to keep such services under review.

52. Nonetheless, in terms of the public consultation we noted with some concern that the majority view expressed by public respondents had not been reflected in the decision.

Recommendation 4

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

53. While we welcomed the proposed improvements to the signage to Lexicon House, we believed this would be enhanced by using appropriate language on any signs. For example, making it clear that Lexicon House is a doctors facility rather than a Primary Care Centre, which many people may not necessarily understand or relate to.

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We also felt that the signage should be placed carefully to ensure it was not diminished by existing signage and consideration should be given to placing signs further away, for example along York Road (the A64).

54. We also suggested a 'mystery shopper' approach be undertaken for the journey from the East of Leeds to Lexicon House to better understand the travel routes and where the placing of road signs could have the greatest impact for people approaching Lexicon House from the East of the City.

55. Another issue we considered related to the provision of postcode information by those responding to the consultation. With only 31% of respondents voluntarily providing postcode data, this had not helped in the analysis of consultation responses and we suggested that future consultation exercises should require people to provide (at least) partial postcode information (i.e. LS1, LS17 etc.).

56. We also highlighted that some Leeds residents had Bradford (BD) and Wakefield (WF) postcodes and therefore should not be discounted from the analysis of consultation responses.

Recommendation 5

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

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

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

Recommendation 6

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

Conclusions and Recommendations

Older people and long-term conditions

57. Focusing on key long-term conditions was identified as presenting the greatest opportunity for improvements and potential integration of services. We were advised this would focus on:

- Risk stratification – a process that can help to identify patients who are most at risk of hospital admission and would therefore benefit from a more proactive approach to diagnosis and management of disease.
- Integrated health and social care teams – to improve support for older people and people with long-term conditions outside of hospital by reducing duplications and gaps in care.
- Strengthening current arrangements for patients with type 2 diabetes.
- Improving home oxygen services

Risk stratification

58. We were advised that work around risk stratification would help identify those people most likely to benefit from a more proactive approach to diagnosis and management of disease. In February 2012, it was reported that the John Hopkins University ACG® (Adjusted Clinical Groups) risk stratification tool had been selected for use across the City.

59. Reference to risk stratification has been made at a number of our meetings and we understand that the initial work will be focused in those areas identified as integrated health and social care demonstrator sites (detailed elsewhere in this report). However, in terms of demonstrating benefits for local patients and across the local health economy, we recognise that work in this area is at a very early stage. Nonetheless, we look forward to monitoring progress in this specific area.

Recommendation 7

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

Integrated health and social care teams

60. In September 2011 it was reported to us that Leeds had become one of only six UK areas to secure funding from the National Endowment for Science Technology and the Arts (NESTA) for an innovative project aimed at putting patients with long term conditions in control of their own health.

61. We were advised that the project would involve a range of organisations (NHS staff, Clinical Commissioning Groups, Leeds

Local Involvement Network (LINk) and Leeds City Council) and would benefit from a financial grant and non financial support from leading experts.

62. In February 2012, we considered an overview of the principal integration initiatives currently underway between Leeds City Council (predominantly through Adult Social Services) the family of NHS organisations within the City. We also considered a report from The King's Fund relating to integrated care for patients and populations.

63. We were advised that integration of health and social care services was something being considered by local authorities and NHS Trusts across the country, which sought to address the following fundamental issues:

    - Improving patient/ service user experience – reducing duplication and providing seamless interactions with a number of different health and social care professionals.
    - Making better use of public money – through more integrated working arrangements, making better and more efficient use of available resources.

64. It was emphasised that alongside the desire for better patient care and experiences, the current financial circumstances facing a number of public organisations was acting as a significant driver, leading to greater focus on public funding and how this could be made to work better for patients and reduce duplication.

65. While we recognise there are likely to be different levels of integration, we believe one of the key challenges for the future Scrutiny Board (and elected members in general) will be around the associated governance and accountability arrangements – including the role of Councillors (as democratically elected representatives) within different organisational structures.

66. We specifically considered a report from the Director of Adult Social Services that set out the proposals to develop integrated health and social care teams across Leeds – initially focused on three demonstrator sites based around current GP practices in Kippax/Garforth, Pudsey and Meanwood. We were advised that these areas provided a demonstrator site within each of the three Clinical Commissioning Groups (CCGs) in Leeds – in preparation for the roll out of integrated teams over the following 15 months (i.e. by May 2013).

67. We were advised that the demonstrator sites would bring together a full range of health and social care staff and services at a practice / neighbourhood level. We were further advised that the demonstrator sites offered different practice populations in a mix of inner and outer city areas and

would 'test out' new ways of working. While it was intended to base the integrated teams in local communities, as close to the GP practices as possible, we were advised that there were some challenges in terms of finding suitably sized premises in the right locations.

68. We also heard from representatives from Leeds Teaching Hospitals NHS Trust who confirmed support of the proposals, stating the integrated team approach supported the Trust's own strategy.

69. We recognised the need to progress work in this area at pace and on a large scale and welcomed the ambition associated with the proposals. We also welcomed the partnership approach that appeared to be evident, while recognising the proposed timescales were challenging.

Recommendation 8

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

Type 2 diabetes

70. The main objective of this project was to create an improved model of care to allow patients to access care at appropriate levels and closer to home. We were also advised that other benefits would include:
    - a reduction in secondary care costs;
    - increased productivity within the community diabetes team; and,
    - a reversal of the upward trend of the cost of prescribing diabetes drugs

71. In February 2012, we were advised that the improved model of care was nearly complete and reductions in associated secondary care costs had been achieved. However, as outlined elsewhere in this report, despite our request for an additional report (which was submitted to us in April 2012) we have been unable to established the level of reductions in secondary care costs and overall savings to the local health economy, or increase in patients served associated with this specific project.

Home oxygen services

72. Enabling people to more effectively manage their own health was a main focus of the work around home oxygen services by:
    - reducing the number of hospital-based reviews;
    - increasing visits to peoples homes where oxygen use can be monitored more effectively.

73. We were advised that this would lead to fewer patients inappropriately being given long-term oxygen therapy, freeing them from the routine of using home oxygen. We were also advised that the change of approach would deliver some financial savings.

74. In February 2012 we were advised that, following the success of the long-term oxygen therapy reviews, the scope of the project has been extended to include patients with Chronic Obstructive Pulmonary Disorder (COPD). However, similar to the type-2 diabetes project and despite receiving an additional report in April 2012 we have been unable to established the level of financial savings or increase in patients served associated with this specific project.

Clinical value in elective (planned) care

75. We were advised that the aim of this area of work was to identify efficiencies through different ways of working and recognised best practice. The three main projects were identified as:
    - redesign of some clinical pathways;
    - clinical value in prescribing; and,
    - outpatient follow-ups.

76. By reducing unnecessary follow-up appointments or by finding more innovative ways to deliver follow-up care, we were advised that this area of work will improve the patient journey and make the health economy streamlined and more efficient.

Redesign of clinical pathways

77. In February 2012 we were advised that the project had successfully worked across organisations to implement a number of redesigned pathways, including:
    - new guidance for the management of a male specific urology pathway;
    - the adoption of NICE guidance in relation to direct access endoscopy services; and,
    - the redesign of musculoskeletal clinical pathways.

<u>Urology pathway</u>

78. The project will deliver a consistent approach to the management of the condition with telephone follow-ups (rather than face to face) and conservative management in primary care. We were advised that streamlining the pathway will reduce waiting times and improve patient experience as patients will be clear about the management of the condition and what they will receive from the service.

<u>NICE guidance in relation to direct access endoscopy services</u>

79. We were also advised that implementing the NICE guidance for Dyspepsia will result in patients being managed in primary care rather than initially being referred to secondary care for a diagnostic test (endoscopy). This approach

will deliver additional capacity into the system to enable more urgent patients to be seen quicker, reduce the overall numbers of patients having an endoscopy test and provide care closer to the patient's home through their own GP.

Redesign of musculoskeletal (MSK) clinical pathways

80. We were advised that the redesigned hand/wrist and hip pathways were due to be implemented from July 2012, with the removal of triage for four remaining pathways being planned from 1 April 2013 – following an evaluation of the first stage.

81. We were also advised that, in order to facilitate the changes to the pathways, additional IT resources had been purchased and training delivered to GP practices to help ensure a high level of awareness and therefore implementation.

82. Following the removal of triage for the first two pathways from July 2012, GPs will be able to refer patients directly to secondary care rather than through the existing MSK service. We were advised that the streamlining of pathways will improve the patient experience and create additional capacity for the MSK service to focus on patients requiring treatment and care.

83. We welcomed the developments as described to us, but as outlined elsewhere in the report we believe more detailed information around the increased capacity/ productivity needs to be provided to the successor Scrutiny Board.

Clinical value in prescribing

84. We were advised that this project area consisted of the following primary workstreams:

- Improved shared management of medicines – including the use of drugs with limited clinical value and the prescribing care of patients who use multiple health and wellbeing services;
- The development of a centralised supply chain to reduce unnecessary prescribing costs; and,
- Two workstreams looking to reduce medicines waste in the city through. , for example, unnecessary repeat ordering and stockpiling.

85. At our September 2011 meeting, we sought assurance from NHS Airedale, Bradford and Leeds that generic medicines would not be prescribed where this may have an adverse impact on a patients condition, e.g. in epilepsy. Assurance was given by the Associate Director of Commissioning that this would not be the case.

86. In February 2012, we were advised that the citywide prescribing formulary had been updated and a new traffic light system implemented – aimed at providing clinicians with guidance to deliver a consistent approach to prescribing.

87. We were also advised that following the completion and roll-out of a centralised clinical verification service, an assessment of potential alternative supply routes was being undertaken.

88. At our February 2012 meeting, we heard of a planned awareness campaign aimed at reducing medicine waste, improving safety and effectiveness and reducing unnecessary prescribing costs.

89. However, despite the assurance that the projects were progressing well and delivering what was expected, we believe that more detailed information on any financial savings and/or improved productivity needs to be more clearly reported to the successor Scrutiny Board.

Outpatient follow-ups

90. We were advised that the project had delivered a reduction of 12,000 (approx.) face-to-face follow-ups since April 2011. This had been achieved through more appropriate and innovative follow-up care, including telephone follow-ups and primary care intervention.

91. We were assured of safeguards in the revised approach and advised that a blanket approach was not being adopted, rather it was for clinically led teams to consider the most appropriate follow-up care based upon the needs of individual patients.

92. Reductions in the level of face-to-face follow-ups will undoubtedly increase capacity across secondary care, however we believe more detailed information on the impact of the reduced level of face-to-face follow-ups – in terms of financial savings and/or increased productivity and patient feedback, needs to be more clearly reported to the successor Scrutiny Board.

Integration of Health and Social Care Services

93. As outlined elsewhere in this report, in February 2012 we considered a series of reports around the integration of Health and Social Care Services in Leeds, including establishing integrated health and social care teams across the City. These reports outlined some of the proposed changes to services and commissioning arrangements across Health and Adult Social Services.

94. In some instances, we also considered how the proposals might contribute to reducing avoidable admissions to hospital and care homes.

Supporting working age adults with enduring mental health problems

95. In February 2012 we considered a report that provided an update on progress since the Scrutiny Inquiry undertaken in 2009/2010.

96. We were advised that in December 2011 the Council's Executive

Board had agreed to delegate the specialist mental health social work function to Leeds and York Partnership NHS Foundation Trust (LYPFT) and that Council staff from Adult Social Care would be seconded to LYPFT, with integrated management structures to ensure clear lines of accountability.

97. With the first phase due to commence on 1 April 2012, we were advised that the strength of the approach was around bringing together professional staff from separate organisations and eliminating areas of duplication.

98. We were advised that the core elements of the proposed service model included a single point of access into secondary mental health, leading to an initial assessment to determine the parts of the service individuals may need to access.

99. We were also advised that with the secondment of staff and, over time, the pooling of the adult placement budget, Adult Social Services were proposing to delegate the full management of statutory social care responsibilities to LYPFT. We were assured that a partnership agreement was being developed to underpin the relationship.

100. We sought assurance that patients' interests would always come first and queried whether or not there could be any possible conflict of interests for Social Workers embedded in a team managed by a health professional, particularly around the Approved Mental Health Professional (AMHP) role. Assurance in this regard was given by the Council's Chief Officer (Access and Inclusion).

101. We considered the potential risks around governance arrangements, finance, human resources and performance and noted how these will be managed in the phased approach to implementation.

102. We recognised that the information presented to us represented 'work in progress' and agreed to maintain a general overview of progress and to consider any specific matters that may arise in the future.

Recommendation 9

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

103. In addition, as integrated service solutions develop and are likely to become more common place across Leeds health and social care economy, we believe further work

is required around the general principles for future governance arrangements.

Recommendation 10

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

Harry Booth House

104. In February 2012, we also considered a report from the Director of Adult Social Services that provided an overview of the development of the City's first intermediate care facility.

105. Currently functioning as a 40 bed residential home, it was reported to us that greater potential for the building had led to discussions and agreement with NHS Airedale, Bradford and Leeds (formerly NHS Leeds) to establish an intermediate care facility.

106. Providing care in this way will see residential and nursing intermediate care beds jointly commissioned by NHS Airedale, Bradford and Leeds and Adult Social Services, and delivered in an innovative partnership with the Leeds Community Healthcare NHS Trust.

107. We were advised that intermediate nursing care is currently provided at a number of independent sector homes across the city on a 'spot purchase' basis. However, with beds tending to be spread over a wide geographical area in non-specialist homes, it was recognised that this was not the most efficient way of delivering services.

108. We understand that the proposed provision will comprise, 30 specialist nursing care beds and 10 residential intermediate care beds and were advised that the benefits of intermediate care included the provision of intensive rehabilitation services in a non-hospital setting, with the aim of providing care closer to home.

109. The development of Harry Booth House will see the development of a continuum of care – with acute services at one end, intermediate care in the middle and reablement and support service at home at the other end of the spectrum.

110. It was reported to us that the new facility would operational from 1 October 2012 and we were advised that, depending on the success of the Harry Booth House project and identifying suitable accommodation in the correct location, three hubs could eventually be established across the City.

111. We were advised that one of the main aims of having an integrated service is to reduce the length of time people needed to stay in hospital, while providing a supportive environment preparing individuals to return to their own home and maintain their

independence for as long as possible.

112. We also understand that the new facility will help to address winter bed pressures at Leeds Teaching Hospitals NHS Trust. As such, to ensure the full benefits of the new facility are realised across the health and social care economy as soon as possible, it is essential that the new facility at Harry Booth House is operational by 1 October 2012

113. We believe that the proposed facility at Harry Booth House provides an opportunity to deliver integrated intermediate care services using an innovative model of care. As such, not only do we wish to maintain an overview of progress – including being advised of any significant delays that may result in the project not being operational by 1 October 2012 – but following a suitable period of operation we would request a further report that presents a review of the project, its achievements and benefits to the local health and social care economy.

Recommendation 11

By September 2012, the Director of Adult Social Services provides a report to the successor Scrutiny Board on the progress of the Harry Booth House project.

Recommendation 12

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

Evidence

Monitoring arrangements

Standard arrangements for monitoring the outcome of the Board's recommendations will apply. Decision-makers to whom the recommendations are addressed will be asked to submit a formal response to the recommendations, including an action plan and timetable, normally within two months.

The Scrutiny Board will determine any further detailed monitoring, over and above the standard quarterly monitoring of all scrutiny recommendations.

Reports and Publications Submitted

- Leeds Health and Social Care Transformation Programme – Programme Overview (February 2011) – reported to the Scrutiny Board in July 2011.
- Leeds Health and Social Care Transformation Programme – Programme Update (September 2011) – reported to the Scrutiny Board in September 2011.
- Urgent Care Services (NHS Airedale, Bradford and Leeds Consultation Document (December 2011)) – reported to the Scrutiny Board in January 2012.
- Leeds Health and Social Care Transformation Programme – Programme Update (February 2012) – reported to the Scrutiny Board in February 2012.
- Extract from the House of Commons Health Committee report – Public Expenditure (Thirteenth report of session 2010-12, published 24 January 2012) – reported to the Scrutiny Board in February 2012 and available at: http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1499/1499vw.pdf
- Health and Social Care Service Integration: An Overview (February 2012) (including The Kings Fund report – Integrated care for patients and populations: improving outcomes by working together) – reported to the Scrutiny Board in February 2012.
- Health and Social Care Service Integration: Harry Booth House (February 2012) – reported to the Scrutiny Board in February 2012.
- Health and Social Care Service Integration: Proposal To Develop Integrated Health And Social Care Teams (February 2012) – reported to the Scrutiny Board in February 2012.
- Health and Social Care Service Integration: Supporting Working Age Adults With Enduring Mental Health Issues (February 2012) – reported to the Scrutiny Board in February 2012.
- Leeds Health and Social Care Transformation Programme – Programme Update (revised report) (April 2012) – reported to the Scrutiny Board in April 2012.

Evidence

Witnesses Heard

- Richard Clayton (Programme Manager) – Leeds and York Partnership NHS Foundation Trust
- Philomena Corrigan (Executive Director for Delivery and Service Transformation) – NHS Airedale, Bradford and Leeds
- Martin Ford (Head of Commissioning – Urgent Care Lead) – NHS Airedale, Bradford and Leeds
- Pip Goff (Manager) – Volition
- Nigel Gray (Deputy Director of Commissioning) – NHS Airedale, Bradford and Leeds
- Dennis Holmes (Deputy Director) – Leeds City Council, Adult Social Services
- John Lawlor (Chief Executive) – NHS Airedale, Bradford and Leeds (formally NHS Leeds)
- John Lennon (Chief Officer (Access and Inclusion)) – Leeds City Council, Adult Social Services
- Karl Milner (Director of Communications and External Affairs) – Leeds Teaching Hospitals NHS Trust
- Paul Morrin (Director of Integration) – Leeds Community Healthcare NHS Trust
- Lynn Parkinson (Associate Director – Adult Service) – Leeds and York Partnership NHS Foundation Trust
- Al Sheward (Divisional Nurse Manager (Medicine)) – Leeds Teaching Hospitals NHS Trust
- Claire Walker (Programme Management Officer (Transformation Board)) – NHS Airedale, Bradford and Leeds
- Richard Wall (Head of Commissioning (Mental Health and Learning Disabilities) – NHS Airedale, Bradford & Leeds
- Matt Ward (Associate Director of Commissioning) – NHS Airedale, Bradford and Leeds

Dates of Scrutiny

- 22 July 2011 – Scrutiny Board (Health and Wellbeing and Adult Social Care)
- 21 September 2011 – Scrutiny Board (Health and Wellbeing and Adult Social Care)
- 29 February 2012 – Scrutiny Board (Health and Wellbeing and Adult Social Care)
- 18 April 2012 – Scrutiny Board (Health and Wellbeing and Adult Social Care)

Scrutiny Board (Heath and Wellbeing and Adult Social Care)
Reducing Smoking in Leeds
June 2012
Report author: Steven Courtney

www.scrutiny.unit@leeds.gov.uk

Leeds CITY COUNCIL