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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE)

Meeting to be held in the Civic Hall, Leeds on Monday, 18th September, 2006 at 10.00 am

A pre-meeting will take place for ALL Members of the Board in the Civic Hall at 09.30 a.m.

MEMBERSHIP

Councillors

S Bentley	-	Weetwood
D Coupar	-	Middleton Park
Mrs R Feldman	-	Alwoodley
S Hamilton	-	Chapel Allerton
J Illingworth	-	Kirkstall
J Jarosz	-	Pudsey
G Kirkland	-	Otley and Yeadon
B Lancaster (Chair)	-	Moortown
J Lewis	-	Kippax and Methley
L Russell	-	Farnley and Wortley
A Shelbrooke	-	Harewood

Co-opted Members

J Fisher	-	Service Users and Carers Alliance Group
E Mack	-	Leeds Voice Health Forum Co-ordinating Group
B Smithson	-	Leeds PPI Forums City Wide Group

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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)	
2			**EXCLUSION OF THE PUBLIC** To identify items where resolutions may be moved to exclude the public	
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			**DECLARATIONS OF INTEREST** To declare any personal / prejudicial interests for the purpose of Section 81(3) of the Local Government Act 2000 and paragraphs 8 to 13 of the Members Code of Conduct.	
5			**APOLOGIES FOR ABSENCE**	
6			**MINUTES** To approve as a correct record the minutes of the Scrutiny Board (Health and Adult Social Care) meeting held on 24th July 2006.	1 - 8
7			**EXECUTIVE BOARD MINUTES** To note the minutes of the Executive Board meeting held on 16th August 2006.	9 - 16

8			**CONSULTATION ON THE RECONFIGURATION OF RENAL SERVICES IN LEEDS - UPDATE REPORT** To receive a verbal update from the Leeds Teaching Hospitals NHS Trust following the recent consultation process on the reconfiguration of Renal Services in Leeds.	17 - 18
9			**MEMBERS QUESTIONS** To receive a report from the Head of Scrutiny and Member Development on Members' Questions.	19 - 20
10			**ACTION LEARNING PROJECT - COMMUNITY DEVELOPMENT IN HEALTH AND WELLBEING** To consider a report from the Head of Scrutiny and Member Development presenting evidence in line with session two of the Board's action learning project.	21 - 74
11			**LEEDS MENTAL HEALTH TEACHING NHS TRUST - CONSULTATION FOR FOUNDATION TRUST STATUS** To consider and respond to the Leeds Mental Health Teaching NHS Trust's consultation for Foundation Trust Status.	75 - 104
12			**DIGNITY IN CARE FOR OLDER PEOPLE INQUIRY - DRAFT TERMS OF REFERENCE** To consider draft terms of reference for the Board's forthcoming Inquiry into Dignity in Care for Older People.	105 - 110
13			**WORK PROGRAMME** To receive a report from the Head of Scrutiny and Member Development on the Board's work programme for the forthcoming municipal year.	111 - 124
14			**DATE AND TIME OF NEXT MEETING** Monday, 23rd October 2006 at 10.00 a.m. (Pre-meeting at 9.30 a.m.)	

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SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE)

MONDAY, 24TH JULY, 2006

PRESENT: Councillor B Lancaster in the Chair

Councillors S Bentley, Mrs R Feldman, S Hamilton, J Lewis and L Russell

CO-OPTEES: J Fisher – Alliance of Service Users and Carers
E Mack – Leeds Voice Health Forum Co-ordinating Group
B Smithson – Leeds PPI Forum City Wide Group

12 Declarations of interest

There were no declarations of interest.

13 Apologies for Absence

Apologies for absence were received on behalf of Councillors Coupar, Illingworth, Jarosz, Kirkland and Shelbrooke.

14 Minutes

RESOLVED – That the minutes of the meeting held on 19th June 2006 be approved as a correct record.

15 Executive Board Minutes

RESOLVED – That the minutes of the Executive Board meetings held on 14th June 2006 and 5th July 2006 be noted.

16 Action Learning Project - Community Development in Health and Wellbeing

The Head of Scrutiny and Member Development submitted a report regarding the Action Learning Project – Community Development in Health and Wellbeing. Appended to the report was a document from the Healthy Leeds Partnership which provided background information on community development and community health development work in Leeds along with the draft terms of reference for the Board's Action Learning Project. Members were reminded that Leeds had been one of only nine authorities nationwide to successfully bid for funds from the Centre for Public Scrutiny for this Action Learning Project.

The Chair welcomed Mike Simpkin, Public Health Strategy Manager, Christine Farrar, Programme Manager and Rachel Swindells, Joint Health Programme Manager of the Healthy Leeds Partnership to the meeting.

It was reported that there was currently no strategic approach for community development and community health development in Leeds and the successful Scrutiny Action Learning bid would help to address this. Community health workers were often isolated without support and links to policy areas. They also lacked opportunities for networking and sharing best practice advice. There were however, some examples of well established community health development projects such as the Healthy Living Centres and Health for All projects. Members were informed that community development had a key role to play in reducing health inequalities and contact had been made with various organisations and projects to promote this.

Further issues discussed and comments made included the following:

- How to measure health outcomes (evidence based) of the Action Learning Project.
- The development of a steering group for the project.
- The links to the forthcoming Local Government White Paper around empowering communities.
- A successful community development strategy could attract investment.

The Chair thanked Mike Simpkin, Christine Farrar and Rachel Swindells for their attendance.

RESOLVED –

(a) That the report from the Healthy Leeds Partnership be noted.

(b) That the terms of reference for the Action Learning Project be agreed.

(c) That facilitation meetings take place following the Scrutiny Board (Health and Adult Social Care) meetings held on the following dates:

- Monday, 23rd October 2006
- Monday, 18th December 2006
- Monday, 19th February 2007

17 Inquiry into Childhood Obesity Prevention and Management - Formal Response

The Head of Scrutiny and Member Development submitted a report which detailed the Board's formal response following the Inquiry into Childhood Obesity Prevention and Management.

The Chair welcomed Rosemary Archer, Director of Children's Services and Frank O'Malley, Leeds Play Network to the meeting.

Rosemary Archer informed the Board that all their recommendations had been accepted by Children Leeds and thanked the Board for their input into the Leeds Childhood Obesity Strategy.

Frank O'Malley addressed the meeting and reported on the play strategy and links to tackling childhood obesity. Matters raised included the need to highlight children's play in the localities and transport issues including traffic calming measures.

It was reported that the Board would receive a further progress report on the implementation of the Leeds Childhood Obesity Strategy in January 2007.

The Chair thanked Rosemary Archer and Frank O'Malley for their attendance.

RESOLVED – That the report be noted.

18 Adult Day Services Review - Formal Response

The Head of Scrutiny and Member Development submitted a report detailing the formal response to the Board's review of Adult Day Services.

The Chair welcomed John Davies, Director of Adult Services and Mike Evans, Chief Officer, Adult Services, to the meeting.

The work of the Scrutiny Board was welcomed and this was reflected in the Action Plan for the Review of Adult Day Services. Issues discussed included the following:

- The role of the voluntary and community sector.
- The role of the Learning and Leisure Department.
- Mapping of voluntary sector day services.
- That following Executive Board agreement in July 2006, the Department would now proceed to detailed planning of re-designed services for people with a learning disability. This would involve each location in conjunction with service users, carers and staff..

The Chair thanked John Davies and Mike Evans for their attendance.

RESOLVED –

(a) That the report be noted.

(b) That a further update report be brought back to the Board's January 2007 meeting.

19 Inquiry into Older People's Mental Health Services in Leeds - Formal Response

The Head of Scrutiny and Member Support submitted a report which detailed the formal responses following the Board's Inquiry into Older People's Mental Health Services in Leeds.

The Chair welcomed the following to the meeting:

- Mike Evans, Chief Officer, Adult Services
- Mick Ward, Modernisation Manager
- Jenny Thornton, City Wide lead on Older People Mental Health
- Michele Moran, Director of Service Delivery, Leeds Mental Health Teaching NHS Trust

The following issues were discussed:

- In line with the Board's recommendation to receive a copy of the POPPs Risk Assessment and Management Strategy, it was highlighted that this should be available in October 2006.
- That a Programme Manager for the POPPs programme had been appointed.
- The Leeds PCTs had adopted the protocols and guidelines for the Treatment of Depression in Older People and would receive refresher sessions on the guidelines in September 2006.
- Mental Health would remain a priority under the framework of the new PCT.
- That Modernisation Leeds would be raising the issue of physical activity within the Older People's Mental Health Strategy Group and pursuing this within the 'Older Better' Strategy and Local Area Agreement.
- Meetings had been held with Housing Associations regarding the provision of additional extra care sheltered housing units, as the Department of Health had recently announced that there would be a further opportunity to submit bids to the Extra Care Housing Fund. However, the bidding criteria was yet to be published. It was reported that developments in South, North East and North West Leeds were at the planning stage and would provide a choice between rented, shared equity and full leasehold options.
- The Board's Inquiry had raised the profile of Mental Health issues for Older People in Leeds.
- That services developed as part of the POPPs programme would need to be sustained in the long term and have the commitment of commissioners.

The Chair thanked Mike Evans, Mick Ward, Jenny Thornton and Michelle Moran for their attendance.

RESOLVED –

(a) That the report be noted.

(b) That a further update report on the POPPs programme be brought back to the Board's October 2006 meeting.

20 Leeds Mental Health NHS Trust - Fire Safety Standards Review

The Head of Scrutiny and Member Development submitted a report regarding Fire Safety Standards within the Leeds Mental Health Teaching NHS Trust. Attached to this report was a letter received from the Department of Health in response to the Board's final Inquiry report.

The Chair welcomed the following to the meeting:

- Michele Moran, Director of Service Delivery, Leeds Mental Health Teaching NHS Trust
- David Brown, Contracts Manager, Leeds Mental Health Teaching NHS Trust
- John Kitchen, Managing Director, Accent Project Solutions
- Ian Germain, Strategy and Marketing Director, Accent Project Solutions

David Brown reported that a comprehensive and thorough review of the Trust's 3 PFI buildings had been carried out by an independent fire safety engineering consultant. The principal conclusion was that the design and construction of all 3 buildings provided for acceptable levels of fire safety, subject to the upgrading of 6 fire doors at The Mount. There was no further work needed in relation to the design or construction of the buildings. Regular meetings had also been held with the West Yorkshire Fire Service. Both the Trust and Accent had been reassured by the results of the review and hoped that the matter could be brought to a close.

The following issues were discussed and further comments made:

- All upholstered furniture met fire safety standards although not necessarily of the highest specifications. It had been recommended that a risk assessment be undertaken to establish whether the standard provided was appropriate for the risk.
- That the letter received from the Department of Health acknowledged that the Firecode suite of documents does not explicitly include or exclude Mental Health premises, but is aimed primarily at the acute health care sector. A revision was currently underway to ensure that guidance does not cover fire safety across the full range of healthcare facilities.
- In relation to a previous query about the use of break glass alarms, it was reported that these had now been replaced with key operated systems to reduce the incidences of unwanted signals.
- Staff training – it was reported that staff had received evacuation training, but no evacuations had been carried out. Members were informed that a practice evacuation would be undertaken and documented.

The Chair thanked, Michele Moran, David Brown, Ian Germain and John Kitchen for their attendance.

RESOLVED –

(a) That the report be noted.

(b) That the Board be further updated at its December meeting and that a representative of the independent fire safety engineering consultants be invited to attend.

(c) That the Board provides a response to the Department of Health's letter.

Councillor Lewis left the meeting at 12.10 p.m. at the conclusion of this item.

21 Draft Leeds Oral Health Strategy

The Head of Scrutiny and Member Development submitted a report on the Draft Leeds Oral Health Strategy.

The Chair welcomed Dr John Beal, Consultant in Dental Public Health, South Leeds PCT to the meeting.

It was reported that the Oral Health Strategy would cover the following 5 areas:

- Levels of oral health
- Causes of poor oral health
- How to prevent poor oral health
- Dental Services – new contract
- Action List

The following issues were discussed:

- Comparisons of 5 year old children from different ethnic groups in Leeds showed that children form Pakistani and Bangladeshi backgrounds had the highest levels of filled, missing and decayed primary teeth – reasons for this were linked to the fact that it was not uncommon for these children to be given 'sweetened' drinks in bottles until a comparatively late age and they also tended to start brushing their teeth at a later age.
- Members praised the non-offensive approach used within the Strategy to highlight dental health issues across the different ethnic groups and suggested that it would be helpful to use the charts within the Strategy to help promote the messages to the different ethnic groups.
- In relation to orthodontic treatment, it was highlighted that further work was needed to look at the referral pathway to ensure only patients prioritised by clinical need are referred for treatment in line with commissioning criteria.
- That the funding from the Department of Health aimed at improving dental estates would be made available to the Strategic Health Authority and was likely to be allocated on a weighted capitation basis.
- Problems for special needs patients, particularly those with physical disabilities, had been encountered due to problems with access to

dental surgeries – many of which were situated in old buildings and not at ground floor level.

- Members welcomed the section on special needs within the Strategy. However, a recommendation was made to find out whether dental practices were covered by the new Disability Discrimination Act 2005 and whether funding could me made to help dental practices adhere to the DDA.
- That the Strategic Health Authority would be responsible for any consultation around the fluoridation of water and would be asked to work with Yorkshire Water on this matter prior to consultation. It was highlighted that the water networks in Yorkshire were complex and that this may have cost implications.
- Members recommended that where figures/data were quoted within the Strategy, references should be made to the source of this information.
- Members recommended that following any screening programmes, it would be helpful to give parents the contact details for NHS dentists in order for them to access treatment easily. It was suggested that PCTs should also consider providing dental services at schools and liaise more closely with Education Leeds in line with the Healthy Schools Initiative.

The Chair thanked John Beal for his attendance.

RESOLVED –

(a) That the report and information presented be noted.

(b) That the comments of the Board be fed into the consultation process.

22 Inquiry into the NHS Dental Contract - Draft Terms of Reference

The Head of Scrutiny and Member Development submitted a report which included the draft terms of reference for the inquiry into the new NHS Dental Contract.

It was agreed at the June meeting to carry out an Inquiry into the new NHS Dental Contract and it was suggested that it could be considered by a Scrutiny Commission. However, it was now felt that a Working Group of the Board could be established to carry out preliminary research into this matter.

RESOLVED –

(a) That the terms of reference be agreed.

(b) That a Working Group consisting of Councillors Lancaster, J Lewis, Kirkland and Shelbrooke and B Smithson (Co-optee) be convened.

23 Work Programme

The Head of Scrutiny and Member Development submitted a report which contained an updated copy of the Board's Work Programme for the 2006/07 Municipal Year. Appended to the report was an extract from the Forward Plan of Key Decisions which related to the Board's portfolio area.

RESOLVED – That the report be noted.

24 Date and Time of Next Meeting

Monday, 18th September 2006 at 10.00 a.m. in the Civic Hall. (pre-meeting at 9.30 a.m.)

EXECUTIVE BOARD

WEDNESDAY, 16TH AUGUST, 2006

PRESENT: Councillor M Harris in the Chair

Councillors D Blackburn, R Brett, A Carter, J L Carter, R Harker, J Procter and K Wakefield

33 Substitute Member

Under the terms of Executive Procedure 2.3 Councillor R Lewis was invited to attend the meeting on behalf of Councillor Blake.

34 Exclusion of Public

RESOLVED – That the public be excluded from the meeting during consideration of Appendix 1 to the report referred to in minute 37 and Appendix 1 to the report referred to in minute 50 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 or confidential information, defined in Access to Information Rules as indicated in the minute.

35 Declaration of Interests

Councillor J L Carter declared a personal and prejudicial interest in the item relating to Adel Primary School (minute 38) as a governor of the school.

Councillors D Blackburn, J L Carter and Harker declared personal interests in the item relating to Leeds Grand Theatre (minute 45) as members of its board of management.

36 Minutes

RESOLVED – That the minutes of the meeting of the Board held on 6th July 2006 be approved and that those of the Access to Information Appeals Committee held on 19th and 20th June 2006 be noted.

DEVELOPMENT

37 Deputation to Council - Disposal of Drighlington Old School and Land

The Director of Development submitted a report in response to the deputation to Council by the Drighlington Conservation Group regarding lack of consultation on the disposal of Drighlington Old School and land.

Following consideration of Appendix 1 to the report designated exempt under Access to Information Procedure Rule 10.4(1) and circulated at the meeting, it was

RESOLVED – That the Board notes:

(a) the concerns expressed in the deputation from Drighlington Conservation Group

(b) the consultation which has taken place to date

(c) that the petition from Drighlington residents did receive due consideration from officers and the Executive Member for Development, but that on balance the view was taken that it was necessary to progress the disposal in order to deliver the Primary School Review programme

(d) that representatives of Drighlington Parish Council will have a further formal opportunity to submit any objections on the development of the school upon submission of a planning application by the successful purchaser of the site

(e) that discussions are underway to secure the rebuilding of the clock tower, the clock face and mechanism, and the weather vane in appropriate locations within the community

(f) that the Council is the legal owner of the site and buildings and therefore does have the right to dispose of them

(g) that Development Department will continue to progress the disposal of the school to meet the targets of the Primary School Review, and maintain an ongoing dialogue with Local Ward Members.

CHILDREN'S SERVICES

38 Deputation to Council - Adel Primary School

The Chief Executive of Education Leeds submitted a report in response to the comments made by the deputation to Council by parents of pupils at Adel Primary School with regard to building works at the school.

RESOLVED – That the Board supports the recommendations which Education Leeds have made to the school as follows:

(a) That the modified project be completed.

(b) That the school review the success of the scheme during the next academic year and prioritise any potential alterations, to be funded by the school, through a premises development plan.

(c) That the school fully consult staff, pupils, parents and the local community prior to any future projects.

(d) That the authority use the issues raised by this project as a case study to highlight the importance of stakeholder consultation on Capital schemes to other schools.

(Having declared a personal and prejudicial interest Councillor J L Carter left the meeting during consideration of this matter)

39 Deputation to Council - Proposals for Meanwood Primary Planning Area

The Chief Executive of Education Leeds submitted a report in response to the deputation to Council about the Executive Board's decision to publish statutory notices proposing the amalgamation of Miles Hill Primary and

Potternewton Primary with a new primary school occupying the Potternewton site.

RESOLVED – That the concerns expressed by the deputation and the next steps in the process, as described in the report, be noted.

40 School Clothing Allowances

The Director of Children's Services submitted a report on action taken following a Council decision to increase the School Clothing Allowance budget.

RESOLVED – That the action taken as a result of the Council decision to increase the School Clothing Allowance budget by £400,000 be noted.

NEIGHBOURHOODS AND HOUSING

41 Office Accommodation - Neighbourhoods and Housing Department

The Director of Neighbourhoods and Housing submitted a report highlighting the outcomes of the Option Appraisal and business case for the demolition and disposal of South Point and the consequent relocation of Neighbourhoods and Housing staff into alternative accommodation within the Departmental Portfolio.

The report outlined the following options:

1 Remain in existing site with basic remedial works and essential maintenance only
2 Major refurbishment of South Point
3 Demolish and rebuild at South Point
4 Dispose of South Point and purchase alternative accommodation
5 Dispose of South Point and lease alternative accommodation
6 Dispose of South Point and new build on alternative sites
7 Dispose of South Point and refurbish one of two existing Council properties

The report detailed alternative courses of action in pursuit of the preferred Option 5.

RESOLVED –

(a) That approval be given to the disposal of the site at South Point
(b) That staff from South Point be decanted into existing sites within the Neighbourhoods and Housing Departmental portfolio (Housing Services, Environmental Health and Community Safety), involving the overall rationalisation of Neighbourhoods and Housing Departmental office accommodation portfolio and the best placing of staff to deliver services to their client groups.
(c) That a new site be leased which will allow for all of the current Property Management Service to occupy one 'fit for purpose' site –the site identified for potential relocation being at View Point in Bramley

(d) That the early negotiations for heads of terms in respect of View Point at Bramley and, as a fall back position, Temple Point at Colton be noted

42 Former Royal Park Primary School

Further to minute 152 of the meeting held on 12th November 2003 the Director of Neighbourhoods and Housing and the Director of Development submitted a joint report seeking approval for the marketing of the Royal Park property for refurbishment or redevelopment as a mixed use development with the Council retaining an operational presence in the form of a library and some community space and retaining the freehold in the property but with no restriction as to the make up of the scheme other than would be required through the planning process.

The report outlined the following options:

1 To seek approval for a further £904,000 in mainline Capital Programme funding for the original scheme.
2 The retention of the building by the Council and its preservation and protection until such time as a sufficient range of Council and community uses and funding streams can be identified
3 To dispose of the building for refurbishment, through the grant of a long leasehold interest, with the Council retaining the freehold interest and having the use of a library and some community space.
4 To market the site for refurbishment or redevelopment, with the retention of Council interest through the freehold of the land, with guidance as to the general form of redevelopment required, including the incorporation of a library and other community space.

The report concluded that best consideration would be achieved through option 4 with any other option being likely to represent a less than best disposal.

RESOLVED –

(a) That the work undertaken to test the viability of implementing the proposals considered at the November 2003 Executive Board meeting be noted.
(b) That the decision made at the meeting of 12th November 2003 be rescinded.
(c) That the property be marketed in accordance with option 3 above.
(d) That the Board notes that the pursuance of any proposal resulting from this decision will require the Council to use its powers under the 2003 General Consent to dispose of the property at less than best consideration.

43 The Golden Triangle Partnership - Private Equity Model

The Director of Neighbourhoods and Housing submitted a report on proposed expenditure of £1,000,000 in 2006/07 in respect of a scheme to assist local people who are first time buyers, low income workers and households in need

to purchase properties in the area defined as the Golden Triangle in the Leeds, Harrogate and York districts.

RESOLVED – That authority be given for the injection into the Capital Programme of £1,000,000 fully funded by Regional Housing Board grant and that expenditure in the same amount be authorised.

44 Ombudsman's Report - Adaptations to a Council House

The Director of Legal and Democratic Services and the Director of Neighbourhoods and Housing submitted a joint report on a recent finding of maladministration and injustice by the Local Government Ombudsman with regard to a complaint about adaptations to a Council house to meet the needs of the disabled tenant.

RESOLVED –

(a) That the Ombudsman's report and findings be received and noted.
(b) That the fundamental changes to procedure and policy instituted as a result of the case be noted.
(c) That the Council's response to the Ombudsman as set out in paragraph 4 of the report be approved.

LEISURE

45 Leeds Grand Theatre Refurbishment Works

The Directors of Learning and Leisure and Development submitted a joint report on the latest position in respect of phase 1 of the Leeds Grand Theatre refurbishment scheme, proposals for phase 2 of the scheme and the proposed heads of terms for the lease of the theatre to the Leeds Grand Theatre Company.

RESOLVED –

(a) That authority be given for an injection of £193,566 into the Capital Programme to be funded by £150,000 from Opera North Trust and £43,566 from Leeds Grand Theatre.
(b) That the bringing forward of the £300,000 Arts Council England grant from phase 2 works into phase 1 be authorised subject to the ACE formal approval currently being sought.
(c) That £1,294,881 of Leeds City Council funding be brought forward from phase 2 into phase 1.
(d) That authority be given to incur additional expenditure of £1,788,447 on costs associated with the phase 1 refurbishment works at Leeds Grand Theatre (Capital Scheme Number 03611/PH1/000).
(e) That the Board notes expenditure of £175,000 on fees on phase 2 of the Grand Theatre (Capital Scheme Number 03611/PH2/000) for the preparation and submission of applications to the Heritage Lottery Fund and Arts Council England for grant aid towards the phase 2 works involving the selective refurbishment of the Grand Theatre and the restoration of the Assembly Rooms.
(f) That the potential funding of £9.124m as outlined in detail within paragraphs 3.8 and 3.9 of the report be noted, and that a further report

be brought to this Board when both costs and funding have been subject to further determination.

(g) That approval be given to the Heads of Terms that have been provisionally agreed with the Leeds Grand Theatre and Opera House Ltd for their lease of the Leeds Grand Theatre.

46 Deputation to Council - Swimming Pool Horsforth

The Director of Learning and Leisure submitted a report in response to the comments made by the deputation to Council by local residents for the provision of a swimming pool in north west Leeds.

RESOLVED –

(a) That the request to support a feasibility study into the provision of a new swimming pool in Horsforth be part supported by the City Council up to a maximum of £2,500.

(b) That recognised, bona fide consultants be engaged to undertake the feasibility study should match funding be found, and that the consultants' brief be drawn up in consultation with the Director of Learning and Leisure.

ADULT HEALTH AND SOCIAL CARE

47 Commissioning Plan for Mental Health Day Services

The Director of Adult Services submitted a report setting out proposals for the modernisation of mental health day services, based on a more person centred service model meeting an individual's assessed needs flexibly, in their local communities and wherever possible, within mainstream services rather than in settings catering only for people with mental health problems.

RESOLVED –

(a) That the plan for day services as outlined in the report be approved.

(b) That the implementation of the agreed service model within the time scales contained in the report be agreed.

(c) That further reports be brought to this Board as the new service is implemented and further briefings be offered to Members through the course of the project.

CENTRAL AND CORPORATE

48 Capital Programme Monitoring Update

The Director of Corporate Services submitted a report providing quarterly monitoring information on the Capital Programme and highlighting the continuing investment made by the Council in the city, explaining the pressures on future schemes and providing details on the latest resources and expenditure estimates for the capital programme.

RESOLVED – That the report be noted and endorsement given to the measures being taken by the Director of Corporate Services, in liaison with the other directors to ensure the affordability and sustainability of the Capital Programme.

DEVELOPMENT

49 Deputation to Council - Withdrawal of Bus Services from Wetherby to Tadcaster via Boston Spa

The Director of Development submitted a report in response to the deputation received by Council at the meeting on the 21st June 2006 in connection with the withdrawal of the 780 bus service between Wetherby and Tadcaster via Boston Spa.

RESOLVED –That the Director of Development write to North Yorkshire County Council and Metro informing them of this Council's support for the retention of this bus service.

50 Deputation to Council - Former Blackgates School at Tingley

The Director of Development submitted a report in response to the deputation to Council by local residents against the sale, demolition and redevelopment of the redundant Blackgates School at Tingley.

Following consideration of Appendix 1 to the report designated exempt under Access to Information Procedure Rule 10.4(1), and circulated at the meeting, it was

RESOLVED – That the concerns of the deputation be noted but that the disposal of the former Blackgates Infants School, Bradford Road, Tingley be progressed as detailed in the submitted report.

DATE OF PUBLICATION: 18TH AUGUST 2006
LAST DATE FOR CALL IN : 25TH AUGUST 2006

(Scrutiny Support will notify relevant Directors of any items called in by 12.00 noon on Wednesday 30th August 2006)

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Leeds CITY COUNCIL

Agenda Item 8

Originator:	A Brogden
Tel:	247 4553

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health and Adult Social Care)

Date: 18th September 2006

Subject: Consultation on the reconfiguration of Renal Services in Leeds – update report

Electoral Wards Affected:	**Specific Implications For:**	
	Ethnic minorities	☐
	Women	☐
	Disabled people	☐
	Narrowing the Gap	☐

1. Introduction

1.1 In March 2006, the Scrutiny Board (Health and Wellbeing) considered the proposals of Leeds Teaching Hospitals NHS Trust to reconfigure renal services in Leeds following concerns raised by the LGI Kidney Patients Association on the proposals. Such proposals involved centralising inpatient beds and acute dialysis on the St James's site and providing satellite dialysis units on the LGI and Seacroft Hospital sites.

1.2 Representatives from the Leeds Teaching Hospitals NHS Trust, LGI Kidney Patients Association, Royal College of Nursing and UNISON attended the Board's meeting in March to discuss these proposals. In conclusion, the Board identified the need for further consultation to be carried out with patients and the public on these proposals. The Chair therefore wrote to the Chief Executive of the Trust setting out the Board's recommendation.

1.3 In April 2006, the Trust agreed to carry out further consultation on this matter. The consultation process was led by North East Leeds Primary Care Trust as lead commissioners for renal services on behalf of the 5 Leeds PCTs. Consultation began on 31st May 2006 and ended on 31st August 2006.

1.4 Representatives from the Leeds Teaching Hospitals NHS Trust have been invited to today's meeting to provide a verbal update report on the consultation process. However, the final results of the consultation may not be available in time for this meeting.

1.5 The Chair of the LGI Kidney Patients Association has also been invited to the meeting to contribute to the Board's discussions.

2. Recommendation

2.1 Members are asked to note the update report from the Leeds Teaching Hospitals NHS Trust.

Agenda Item 9

Leeds CITY COUNCIL

Originator:	A Brogden
Tel:	247 4553

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health and Adult Social Care)

Date: 18th September 2006

Subject: Members Questions

Electoral Wards Affected:	**Specific Implications For:**	
	Ethnic minorities	☐
	Women	☐
	Disabled people	☐
	Narrowing the Gap	☐

1.0 Introduction

1.1 Last year, each scrutiny board was required to include a standard item on its agenda to enable members to ask topical questions of the relevant senior officers, without the need for a full inquiry or written reports.

1.2 Members' questions is no longer a required item for each scrutiny board meeting. However, the facility remains available for those boards that wish to do so to ask questions of the relevant director(s) at board meetings.

1.3 It is proposed by the Chair that members' questions would be included as an agenda item only if prior notice of questions has been received by the time that the agenda for the meeting is published (normally eight days before the meeting).

1.4 The Scrutiny Support Unit has received prior notice of questions for this meeting, and the Director of Adult Social Services and Chief Officer Adult Services will be attending the meeting to respond.

2.0 Recommendation

2.1 That the board identifies any issues for further scrutiny arising from the members' questions session.

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Leeds CITY COUNCIL

Originator: A Brogden

Tel: 247 4553

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health and Adult Social Care)

Date: 18th September 2006

Subject: Action Learning Project – Community Development in Health and Wellbeing

Electoral Wards Affected:	**Specific Implications For:**	
	Ethnic minorities	☐
	Women	☐
	Disabled people	☐
	Narrowing the Gap	☐

1.0 Introduction

1.1 This is the second session of the Board's action learning project on Community Development in Health and Wellbeing.

1.2 In line with the Board's terms of reference, the purpose of this session is to:

- gain an understanding of the principles underpinning Community Development;
- consider examples of community health development work on the ground across the city;
- receive information from Leeds Voice on their role in Community Development.

1.3 During the meeting, the following individuals will be providing presentations to the Board covering the above issues:

- Mary Green, Principal Lecturer, Faculty of Health, Leeds Metropolitan University;
- Corrina Lawrence, Co-ordinator for Feel Good Factor Healthy Living Centre;
- Tatum Yip, Co-ordinator for MEMHO Healthy Living Centre;
- Pat McGeever, South Leeds Health for All;
- Lisa Parkin, Participation Manager, Leeds Voice.

1.4 Particular reference will be made to the role of Healthy Living Centres. An evaluation of the seven Healthy Living Centres in Leeds was carried out last year and a copy of the evaluation report has been attached as background information for Members.

1.5 Also attached for Members' consideration is a copy of the draft 'Effective Community Participation Strategy: Community Development Section'.

2.0 Recommendation

2.1 The Board is asked to note the presentations and the attached reports.

EVALUATION OF LEEDS HEALTHY LIVING CENTRES

December 2005

Georgina Webster

Labyrinth
CONSULTANCY & TRAINING

The seven Healthy Living Centres in Leeds are funded by the Big Lottery Fund.

This evaluation was commissioned jointly by all seven Healthy Living Centres

CONTENTS

FORWARD

Seven Healthy Living Centres were set up in Leeds in 2002/3. Their bids for funding to the New Opportunities Fund were rigorously supported by the Leeds Health Action Zone, who saw this as an opportunity to tackle health inequalities in the most deprived neighbourhoods of the city, and to develop some sustainable structures for community involvement in health.

Each of the healthy living centres is *different*, and that is part of their strength. Each has developed in ways appropriate to its own communities, while illustrating core values of equity, flexibility and responsiveness, and a holistic view of health.

This evaluation shows they have been *successful* in meeting those original aims. They have tackled health inequalities and developed effective structures for community involvement. The health of the large number of individuals who have used their services has improved, and those individuals have become active participants in improving their own health and that of their communities.

Within this variety, their success has been due to their use of both *community development and organisation development approaches*. That is, they have acted as facilitators and innovators, providing community support and health promotion activities to local people in ways that they have appreciated and responded to. They have helped them to use these experiences as a springboard to further positive development. At the same time, they have facilitated partnerships between agencies and groups, so that they can work together to achieve more than they could on their own. They have brought these messages into mainstream organisations and encouraged them to change. Their success has also been due to their understanding of the crucial link between supporting socially excluded groups to engage in healthy activity, and building the capacity of communities to sustain this change.

The healthy living centres are now *well placed to act as key vehicles* to drive forward the priorities of the Leeds Initiative, especially those associated with health and wellbeing, and with building the capacity of the most deprived communities. It is timely for the healthy living centres, with their particular expertise, to get together with public health professionals from the PCTs and local authority, in order to decide how this effective partnership development can be sustained into the future. At the same time they need to, and can be, more tightly linked to the structures and priorities that are working to improve the city as a whole, and the most deprived groups within it.

1. BACKGROUND

1.1 Policy and Funding Context

In January 1999 the *New Opportunities Fund* (NOF) launched its healthy living centres grant programme. Funded by the National Lottery, it aimed to ensure that by the end of 2002, at least 20% of the population of the UK were within the catchment area of a healthy living centre. NOF sought applications which:

- Targeted the most disadvantaged areas and groups
- Responded to community needs and built upon community strengths
- Encouraged community involvement at every stage, from design to delivery
- Involved organisations from the private, public and voluntary sectors
- Would provide a diverse and innovative range of facilities, services and activities
- Reflected local health priorities as set out in local health plans

Organisations across the city of Leeds seized this opportunity to tackle disadvantage and improve health and wellbeing. A variety of voluntary organisations worked with NHS primary care groups (which later became primary care trusts – PCTs) to develop healthy living projects and bids to this new programme. This development activity was supported by the then Leeds *Health Action Zone* (HAZ), a government initiative which was itself concerned with bringing about health improvement through partnership work and community involvement. The dedicated time of a HAZ development worker, along with a development budget, was allocated to support healthy living centre bids within priority neighbourhoods from each of the five localities. In addition two city wide bids were developed: one focusing on mental health within the black and minority ethnic (BME) communities, and one bringing together the community of Armley Prison with its neighbourhood.

These seven bids proved successful and, following a period of intensive developmental work, by the middle of 2003 all seven projects had begun operations. NOF funding was agreed for five years, which commitment has been maintained by the Big Lottery which took over from NOF. In addition the five PCTs between them have committed a small amount of revenue to each healthy living centre (HLC). Following the demise of the HAZ national programme, the work of the HLCs is now positioned within the national agendas of tackling health inequalities, neighbourhood renewal and regeneration, and choosing health.[1] At the same time the HAZ coordinator post has been lost.

1.2 Local Context

The *Leeds Initiative* was established as the Local Strategic Partnership for Leeds. It is required by government to be the overarching partnership of the public, private and voluntary sectors which develops and delivers a joined up community strategy and local neighbourhood renewal strategy. The Leeds Initiative has

[1] For a discussion of these policies please see Section 4.2 on Strategic Opportunities

developed a Vision for Leeds 2004 – 2020 which embodies these priorities. It is led by a partnership board, working through two parallel executives: the 'Narrowing the Gap' Executive and the 'Going up a League' Executive. Linked to this are six theme strategy groups, one of which is the *Healthy Leeds Partnership*, and five district partnerships. Voluntary and community sector involvement in designing and delivering this structure and its strategies is coordinated by Voice, the community empowerment network for Leeds.

Structurally, the seven HLCs are positioned within the voluntary sector. Two are members of the city wide voluntary sector Health Forum, which is coordinated by Voice through a facilitator funded by the PCTs. The two representatives of the Health Forum which sit on the Healthy Leeds Partnership happen to be from two HLCs, but this is not by design. At district level some district partnerships have developed a voluntary and community sector subgroup, and/or a health subgroup, to which the local HLC will belong.

Strategically, the work of the HLCs is positioned within the Health and Wellbeing Strategy developed by the Health Partnership of Leeds Initiative. Their work may also feature in the district plans of the district partnerships, which cover the full range of themes, but these are new and are in the early stages of development.

In terms of relationships, the HLCs all have strong connections to the five PCTs which provide support, reciprocal membership of PCT and HLC groups, and funding, although there is a concern that this may change with PCT amalgamation into one Leeds wide PCT. There are equally strong relationships with the broader voluntary and community sector, and to individual voluntary organisations and community groups within their area, in terms of support, joint work and networking. Their connection to the *local authority* is the most fragile of these three sectors, although this may change as the district partnerships develop; these are led by the local authority and are still in their early stages.

1.3 Structure and Focus of Projects

Each of the seven HLCs is distinct from each other. They vary in terms of their particular focus and structure, while each meets the requirement of the NOF as described above. Two are city wide, while five cover a particular neighbourhood. Two have developed their own centres from which their activities are run, while five develop or support activities run at partners' premises. Two have independent management committees, while five are run as a separate project with its own steering group, but managed by a lead agency.

The *variety* is largely dependant on the state of the *community infrastructure* for each catchment area, at the time of the development of the project. For example:

- *Jigsaw* – a poor visitor centre building, combined with a lack of connection between the local community and the prison based within it, helped to inform the decision to bid for a new visitors centre and a programme of activities within it which would impact on local groups and prisoners' families, as well as on prison staff and prisoners themselves

- *Memho* – this grew out of a recognition that the many smaller BME communities and groups across Leeds were not accessing mental health services, and so this project focuses on building the confidence and capacity of these groups so that they can engage more effectively with their communities, and provide activities within their own premises which improve mental health and wellbeing

- *Hamara* – this large NOF funded centre grew out of the ambitions of the South Leeds Elderly and Community Group to provide a centre which would regenerate the area – this community based BME organisation was able to use a health focus to kickstart a bigger infrastructure project for the community, with a particular focus on the needs of young people and isolated elderly

- *West Leeds Healthy Living Network* – this was an area of a number of small community organisations and underused community buildings, with little outside support, and so this HLC prioritised supporting these small organisations to deliver healthy living outcomes, as well as the development of a stand alone, large, new voluntary organisation to support those organisations

- *Feel Good Factor* – the Chapeltown and Harehills area of North East Leeds had a number of active independent community and voluntary organisations, each supporting their own community; this HLC brings them together to focus on health, by supporting activities at community centres which are run in ways appropriate to that particular community.

- *Healthy Living* – this project was set up in inner East Leeds, in an area which had few community or voluntary organisations; the project has focused on running simple activities which draw people, who are not used to involvement, into activities which promote health and wellbeing; and on creating new links between individual statutory and voluntary organisations in the area

- *Active 4 Life* – this project has used three host centres to provide added value to community based services and facilities that already existed in the area; it has focused on activities promoting healthy bodies and minds, and healthy families, as well as developing a new network to coordinate health promoting activity and information from all sectors

Within this variety, there are some activities which are *common to all* HLCs. For instance all seven support activities which focus directly and explicitly on increasing physical exercise and activity for priority groups; all have a focus on encouraging and supporting healthy eating and diet; and all support activity designed to improve mental health and wellbeing. All work within a holistic approach and social model of health. At the same time, all seven have found it necessary to carry out work which explicitly builds the capacity of the community to run its own affairs, and develops community infrastructure; this latter has a broader focus than health and wellbeing, but each project has found it necessary in order to sustain improvements and developments in that area.

The table below provides an outline of the structure and focus of each project.

HLC Name	Catchment	Structure	Focus/ Objectives	Typical activities	Activities run at…	Staff
Jigsaw	City wide (prison); local neighbourhood in West Leeds	HLC joined with families team to form 1 organisation	4 communities – prisoners, prison staff, prisoner families, local neighbourhood 5 themes – family, mental health, physical health, welfare rights, health information and referral	Salsa, massage, yoga, CAB sessions, counselling, alcohol awareness, anger management	Visitors Centre	2 full time 4 part time
Memho	City wide	Managed by Touchstone. Steering Group of partner/ member agencies	2 functions – mental health; capacity building of BME community 5 themes – healthy eating, exercise, social/recreational, information/advice, complementary therapy	Healthy eating workshops, walking groups, Tai Chi, reminiscing activities, art/craft sessions, eating out, benefit advice, domestic violence support, counselling, homeopathy	Community centres run by member/partner organisations	2 full time 1 part time
Hamara	South Leeds – Beeston Hill & Holbeck	Independent Board runs HLC and Youth Access Point	Aims to break cycle of poor health & social disadvantage by using a holistic approach to build confidence, involvement & capacity 9 strands - information & advocacy, primary care, health promotion, physical activities, learning/ training, older people, community safety, women, youth	CHD sessions on secondary prevention, cardiac rehabilitation, tackling obesity, GP referral scheme, training in employment skills, walking groups, aerobics, tai chi, after school activities	Hamara Centre	9 full time 10 part time
West Leeds Healthy Living Network	Armley, Bramley, Wortley & Swinnow	Independent Board	5 themes – capacity building, physical activity, food work, environmental work, training & community health education	Community health educators programme, community development with small groups, development of food work, growing & environmental projects,	Community venues	2 full time 15 part time

				work with BME communities		
Feel Good Factor	Chapeltown & Harehills within North East Leeds	Managed by Unity Housing Association. Steering Group of partners	Aims to improve health through improved opportunities for and promotion of healthy living, physical and mental wellbeing 5 themes – food, dance art & exercise, access, walking, young people	Healthy eating sessions, dance and art classes, newsletter, benefits advice, walking groups, training walk leaders, information on sexual health, radio plays on health issues	Community centres in area	2 full time 3 part time
Healthy Living Project	Inner East Leeds	Managed by East Leeds Health For All; Management Group of 5 key partners	Aims to improve health and wellbeing 5 themes – healthy homes, healthy eating, families & communities, over 60s, mental health	Workshops on safety issues, home maintenance, healthy eating, supporting café, physical & leisure activities, stop smoking sessions, money management, support groups, advocacy	Premises of partner agencies	2 full time 4 part time
Active 4 Life	Inner North West Leeds	Managed by Cardigan Centre Steering Group of partners	Aim to develop healthier lifestyles, enabling self responsibility individually & collectively, supported by a coordinated network 3 themes – healthy minds & bodies, healthy families, information & networking	Physical activity sessions e.g. yoga & Pilates, support groups, massage, arts & craft sessions, walking groups, health network & directory	Community venues across area	3 full time 2 part time

2. EVALUATION FRAMEWORK

2.1 Purpose of Evaluation

All seven HLCs have made plans for the evaluation of their own projects, and provision for this has been made within the NOF allocation.[2] In addition, the projects decided as a whole that it would be useful to have a joint interim evaluation of how well the HLCs are working in meeting the health and wellbeing agenda. The purpose of this joint evaluation is:

- To evaluate the *cumulative impact* of 7 healthy living centres in Leeds on delivering the public health agenda
- To look at examples of *best practice* from the different HLCs and to highlight lessons that could be learnt by others
- To investigate how well placed HLCs in Leeds are to deliver public health initiatives in light of national and local policies in the *short, medium and long term*

The original lottery funding for healthy living centres comes to an end in 2007 (the precise date varying with the different start times of the projects). This joint evaluation is timely in terms of considering the strategic implications and sustainability issues of this work for the future.

2.2 Strategic Approach

This evaluation uses a strategic framework to focus the discussions and analysis. The framework combines a grassroots community development approach with a strategic organisation development approach; this approach is followed by all seven HLCs.

Community development has a *long history* within the UK. It is a process which brings about the involvement of people in taking action regarding the issues which affect their lives and their well-being. It is about helping people define their own needs and how they can best be met, individually or collectively. It is usually about helping people to set up and run their own groups and organisations, and network with others in their area, in ways that are open, participative and encourage the involvement of all.

Traditionally community development has taken place at the '*grass roots*' - in neighbourhoods, or within communities of interest. However, it is also about

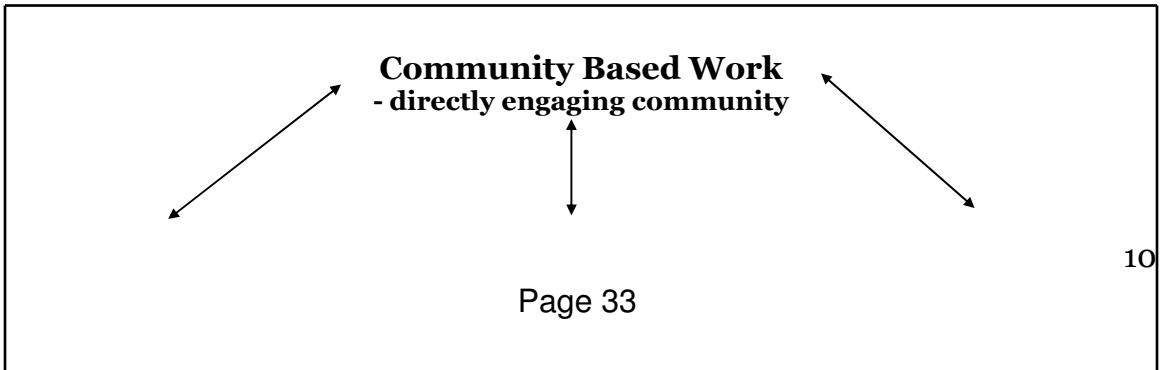
[2] Evaluation reports for each of the HLCs are available from each project. Each project evaluation has been or is being carried out by a different evaluator. This joint evaluation does not attempt to duplicate that work, but rather to look at the overall impact of the HLCs for Leeds and strategic implications for the future.

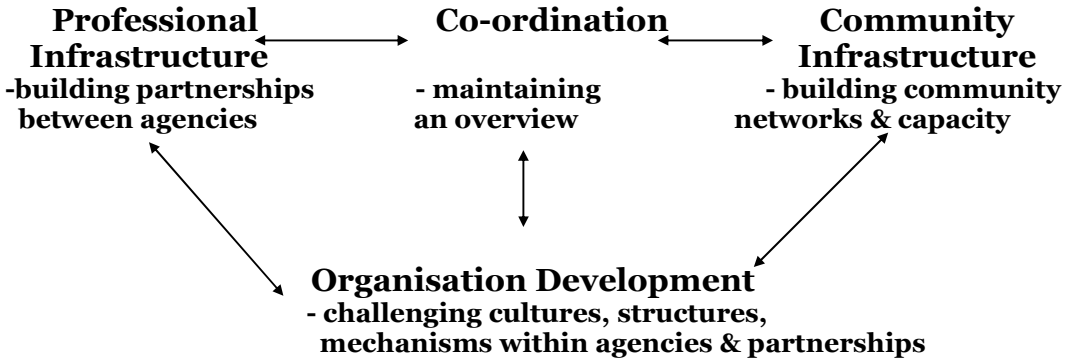
helping people build and acquire the skills, knowledge and confidence so that they can enter into partnership with other groups and organisations, and influence the policies and decisions taken by those organisations which affect their lives - what is currently called 'capacity building' and 'sustainability'. Therefore it is not just about working at local level. It also needs the involvement of those who work *strategically* and at decision making levels, across statutory and voluntary organisations and partnerships, so that they can work to open up decision making structures and develop strategies which enable, rather than inhibit, the involvement of communities. Thus it is a complex process and the involvement of all these people, at different levels, necessitates a strategic and organisation development approach.

Within a health context, a community development approach to health emphasises the *holistic nature of health*, and a positive approach to health, well-being and its promotion. It is an approach ideally suited to gain community involvement in health and to build partnerships with and between organisations. It operates within a view of health improvement which focuses on addressing *inequalities in health*. Community development is an effective method in reaching and helping people articulate hitherto 'silent' or marginalised voices, as it prioritises their views and opinions and their empowerment, rather than those of the agencies which affect them.

In an organisational context it has an obvious link to *public health* because of the role it plays in defining health needs from a local perspective. Local people invariably have a wide definition of health and the factors which influence their health. Equally, community development plays a facilitative and enabling role in bringing together local people and local agencies to take collaborative action on meeting those needs. Thus community development and health has a clear link into many of the core functions provided by health trusts and local authorities, as these functions are seen as influential in improving health and well-being. Community development and health has a clear role in health *commissioning* and in health promotion; but it also has a providing and *delivery* role, helping primary health and social care services and other agencies to work with local people to plan and improve services. It also supports the establishment of community based and/or community run health and health care services.

Therefore a community development and health project can operate at many *different levels*. The diagram below shows how the five different elements of a community development and organisation development approach to health and wellbeing, can work together to deliver change. It is particularly suitable in this context as each HLC operates at all five levels.





This evaluation also draws on nationally developed and recognised good practice in community participation health projects. [3]

2.3 Methodology

This evaluation was carried out between August and December 2005. A list of material studied and of participants interviewed is found within appendices I and II.

August 2005	Briefing meeting and refining of focus of evaluation
September 2005	Study of written material from each HLC, including monitoring and evaluation reports
October 2005	Group interviews at each HLC with members of steering groups & relevant agencies
	Individual interviews with key city wide players
November2005	Draft report prepared
December 2005	Presentation of draft report & working up next steps
	Final report prepared

[3] 'Community participation for health: A review of good practice in community participation health projects and initiatives', published by the Health Education Authority (England), 2000, and researched and written by Labyrinth Consultancy

3. EVALUATION FINDINGS

3.1 Community and Partnership Involvement and Development

The Leeds HAZ took the decision to support these seven HLC bids to NOF because it saw them as playing two key roles; tackling health inequalities in deprived areas, which is pursued in the next section of this report, and developing structures for community involvement in those areas, which is explored here. All seven HLCs are especially strong in both community involvement and partnership development. They see these processes as key to bringing about improvements in health and wellbeing of groups who are especially disadvantaged in this regard. As such both community involvement and strong partnerships are products or *outcomes* of the HLCs work. In turn, these provide the HLCs with important drivers for delivering additional *outcomes* in health and wellbeing.

HLCs deliver *community involvement in health and wellbeing* in a number of different ways:

- *adding value* to the community involvement work carried out by existing community groups and voluntary organisations in the area (including the development of local volunteers)

- *developing new community groups/services/facilities* for and with communities in their area

- *developing community networks* between communities in their area

- *building community capacity* of groups and individuals within their area

All HLCs have *developed strong partnerships* which are helping to deliver improved health and wellbeing, in terms of prevention, health promotion and service development. Each HLC is itself an example of a partnership, and has worked to develop that partnership into an effective structure for change, in order to deliver new improvements in health and wellbeing for priority groups. Partnership development is carried out in the following ways:

- *development of HLC* into a real and effective partnership

- *developing other local partnerships* to deliver change in health and wellbeing

- *supporting new* and existing partnerships for change

- *linking statutory bodies with communities* for consultation on services and strategies

Some examples are described in the tables below[4]

		COMMUNITY	INVOLVEMENT
adding value	**developing new groups & facilities**	**developing community networks**	**building community capacity**
• link worker signposts groups to wider initiatives & resources *ME* • support activities in a number of community centres *A4L* • bring together large number of separate community groups & centres to network & focus on health *FGF*	• visitors centre used as new community resource *JP* • established families forums to put concerns to prison governor *JP* • set up new self help groups & helped with funding bids *A4L* • new community radio station spreads healthy messages *FGF*	• service users forum *ME* • community cohesion subgroup *HA* • act as voluntary sector network as none other exists in area *WL*	• produced pack & guidance on how to get involved *ME* • focal point for community to respond to events of July05 *HA* • secured ERDF bid for New Wortley Development Board*WL* • provide training in community development *HL*

		PARTNERSHIP	DEVELOPMENT
developing HLC	**developing other partnerships**	**supporting partnerships**	**linking organisations with communities**
• steering group comprises all BME members & PCT *ME* • work with partner agencies to	• uniquely brings together 4 sectors; prison, health, Leeds Council, residents associations	• new health promoting prisons group with 3 way focus on prisoners, staff, families *JP*	• enabled community participation in health & environmental projects *WL* • residents move

[4] Key for tables on community involvement and partnership development: *A4L* is Active 4 Life; *FGF* is Feel Good Factor; *HA* is Hamara; *HL* is Healthy Living; *JP* is the Jigsaw Project; *ME* is Memho; and *WL* is the West Leeds healthy living network.

deliver joint services *HA* • annual consultation with users to draw up next year's programme *HL* • new Partnership Forum for networking & developing HLC work *HL*	e.g. through Community Safety event *JP* • exploring working together with Parents Resource Centre *HA* • new environmental network *WL* • new district health & social care partnership *FGF*	• key member of faith partnership of 2 churches, 1 mosque, 4 voluntary groups *HA* • key player in district & city wide partnerships e.g. Area Partnership Board; Leeds Health Forum *WL*	on to involvement with other organisations *HL* • set up new Health Network to bring groups & organisations together *A4L* • linked NHS consultant with African Caribbean communities re: spreading information on glaucoma *FGF*

3.2 Ways of Working: What Works and Why

The seven HLCs in Leeds share a number of approaches which work in terms of targeting the most disadvantaged groups in their area, and engaging priority 'hard to reach' groups in healthy activities in ways that are most appropriate to those groups. At the same time they have all been successful in drawing in local agencies to form partnerships, which are effective in supporting these new activities. Examples of both of these processes are given in the section above.

In addition. key to these successes are a number of supporting systems developed by the projects:

- *Evaluation* was built into HLCs from the beginning. This is supported by a budget. It includes ongoing monitoring and evaluation of individual project activities and events, as well as evaluating the effectiveness of the project overall. Some evaluation is carried out internally, while some involves an external, independent evaluator. It has helped to ensure a planned, evidence based approach to project development.

  For example, *Active 4 Life* has monitored individual activities and initiatives from the beginning, and then brought in an external evaluator to evaluate and inform the final three years of its work. In this process both internal and external evaluations were brought together to inform each other and the project's ongoing programme of work. This has proved a key vehicle for informing stakeholders of the outcomes of the work of the HLC.

Also the *Healthy Living Project* in East Leeds commissioned an external evaluation in the third year of its life. This evaluation found that the project has met many of its short, medium and long term outcomes and has built good networks with local people and agencies. It is responsive to the local population and it consults appropriately. The evaluation argued that the core purpose of the HLC, of achieving sustainable change in individuals and communities, needs to be brought explicitly into all its work, through enabling participants to make a step change to take the impact of a particular HLC activity into the rest of their lives. This recommendation has now been taken forward.

- All HLCs work through *partner organisations*. Sometimes this is about supporting and/or resourcing activities which are provided by other organisations, or provided at their premises. Sometimes this involves the HLC in directly providing a service themselves, but with the support of a partner body. It has helped to ensure that successes and lessons learnt are cascaded through and embedded within a variety of local organisations.

  For example, *MEMHO* explicitly focuses on delivering improvements in BME mental health by funding small groups and agencies, who then become partners, to deliver services appropriate to their particular BME community. Each group is given the same funding of £6k to develop and provide an activity, so that equality is encouraged between groups. They also then become members of the HLC steering group, and so involved in activities which strengthen their capacity to develop, with support from the HLC Link Worker. In this way smaller BME groups are given a place and a voice; barriers are broken down between individual communities; and groups are strengthened to improve their work.

- All HLCs facilitate *networking* between community groups and with statutory and voluntary organisations. This is a planned and structured approach which results in shared information, decisions to provide joint services or activities, and new creative approaches to meeting health and wellbeing needs. The HLCs also network between themselves via the seven coordinators.

  For example, the *Jigsaw Project* uses an explicit, planned and structured approach to network development so that their work impacts on life inside the prison (bringing the outside in, through providing health facilities for prisoners and staff) as well as better relationships with both prisoners and families (bringing the inside out, through support to families). Health and wellbeing is the focus of the work with all four groups (prisoners, staff, families, neighbourhood) and this provides an equality which breaks down barriers to access.

- A *holistic approach to health* is followed by all HLCs. This allows them the flexibility to act on the broader determinants of health as well as on health and health care services

For example, *West Leeds Healthy Living Network* began by targeting the general population of the area, and thus built credibility and trust with the community. It has worked to develop local community venues, and supported groups to use volunteers. It was then able to focus down on health, always stressing the social connections of activities. People may come to a walking group for the social support it provides to tackle isolation, but because of the nature of the activity on offer, it also increases the amount of regular physical exercise participants carry out.

Also the *Hamara Centre* was funded by NOF, as well as Neighbourhood Renewal, SRB, Leeds City Council and a number of charitable trusts, as a new, bold community resource. It acts as a centre where a holistic range of services are provided, which tackle the barriers of language, access, cultural and religious sensitivity, and ensure a broad takeup of services. Some of these are explicitly health focused, such as the CHD sessions which are supported by the PCT; but others are wider, such as the training courses in employment skills.

- The Leeds HLCs work within a *strategic framework* which utilises community and organisation development approaches. This allows them to focus on work which influences mainstream organisations, as well as work which impacts directly on individuals and communities themselves.

  For example, the *Feel Good Factor* sets up a working group for each strand of its work, which brings partners together to develop a needed initiative; the mobile crèche was created in this way by bringing together the college, surestart and local women. It has prioritised participation in the healthy activities it runs by the most excluded and thus built up trust with those groups. They used this relationship to link African Caribbean people with an NHS glaucoma consultant, to disseminate health promoting and prevention information on this theme.

Appendix III contains seven case studies as examples of best practice within each HLC. They describe what works and why in great detail. They are:

Active 4 Life	*Sahara Women's Refuge*
Feel Good Factor	*Fit and Fab Weight Management Programme*
Healthy Living	*Working with Over 60s*
Jigsaw	*Individual Support Across Traditional Boundaries*
West Leeds HLN	*Community Health Educators*
MEMHO	*Service Users Forum*
Hamara	*South Asian Community Based Cardiac Rehabilitation Service*

3.3 Impact on Inequalities [5]

The work of the seven HLCs has been especially strong in tackling inequalities. Their original focus was on tackling *health inequalities*. This has been achieved by a three pronged approach:

- *reaching* the most excluded groups, with the poorest health, in their areas, especially from the BME communities
- *involving* those people in activities which are health enhancing
- forming relationships with local statutory and voluntary *partners* to support and provide services for groups previously excluded.

In this way the HLCs have successfully tackled many of the *risk factors* that impinge on health and wellbeing, especially those connected with physical exercise, food and diet, and mental wellbeing. They also provide information and support to help people *choose health*.

In doing so, HLCs have also served to tackle wider inequalities which are themselves *determinants of health*, such as education, community safety, employment, liveability and involvement in public life.

The following table gives a few examples of the different groups reached, and the initiatives resourced to tackle inequalities, by each of the HLCs

Jigsaw Project	**MEMHO**	**Hamara Centre**	**West Leeds**
• Prisoners e.g. drugs & alcohol work which reduced reoffending • Prison staff e.g. stress reducing sessions • Families e.g. money/benefit advice, access to children's health services • Local young people – youth club sessions	• African women asylum seekers, blind Asian, elderly African Caribbean, Chinese community (& others) e.g. walking, homeopathy • Raise expectations about what is possible re: choosing health	• South Asian communities e.g. CHD prevention, rehabilitation, tackling obesity • Isolated elderly BME communities e.g. aerobics, tai chi • Young people e.g. after school clubs, youth access point, training in employability skills	• Travellers, refugees, asylum seekers, gypsies • Community health educators spreading healthy messages to peers • Identifying & supporting people from deprived estates who want to make a difference
Feel Good Factor	**Healthy Living**	**Active 4 Life**	
• South Asian men & women, Vietnamese community,	• Over 60s – exercise, trips, socialising • Target those not	• Parents e.g. craft classes, stress management, acupressure	

[5] For detailed information on outcomes for each of the HLCs, see the case studies described in Appendix III of this report, and the individual evaluation reports from each project.

African Caribbean groups, young people (& others) • Activities which help to prevent & manage heart disease, stroke, diabetes e.g. smoking cessation 1:1 sessions	yet involved • Impact on risk factors e.g. involvement in physical exercise has boosted confidence & lead to stop smoking classes; also tackle social isolation & mental health	• Children e.g school cooking clubs • Older people e.g. walking groups & leaders training course • Women's refuge e.g. meditation, reflexology, massage	

3.4 Capacity for Sustainability

All seven HLCs are currently and individually considering this issue, and developing forward strategies. This is in respect of mainstreaming current work, as well as looking towards new resources for developing the work once Big Lottery funding ceases.

A number of *common issues* connected with sustainability have emerged in this process:

- The *individual evaluations* of each of the HLCs are/will be useful tools in highlighting which aspects of the work of the HLCs are key to delivering current and future priorities for health and wellbeing for Leeds

- The capacity of each HLC for drawing in *other funding and resources in kind* since 2002, which is considerable, is a key factor in considering future support and ensuring this additional support for these initiatives is not lost

- *Strategically* the focus of the debate lies within the priorities of the Leeds Initiative as a whole, and the Healthy Leeds Partnership in particular. Yet structural linkage between the HLCs and city wide policy arenas is currently poor

- The five district *PCTs*, and the planned single city wide PCT are leading partners in this debate, because of the focus on health. They are strong supporters of all HLCs, giving some funding as well as partnership, strategic and operational support. This relationship needs to be continued after the forthcoming amalgamation into one city wide PCT.

- The five *district partnerships*, and the local authority which leads these partnerships, are potential key players in this discussion, because of the broader district wide implications concerning neighbourhood renewal, regeneration, community capacity building and infrastructure, and the wider

determinants of health. These partnerships are new so linkage with them needs to be strengthened.

- The *voluntary sector* at both local and city wide levels are key players across the board. This presents some problems. The HLCs are positioned within this sector yet they could, more accurately, be seen as voluntary/statutory partnerships in themselves, crossing both sectors. A positioning which is solely within the voluntary sector is problematic as this sector has a much bigger agenda than health, and so the specific issues developing from the work of the HLCs cannot get adequately represented or tackled here.

- Other key players are particular to each HLC. For example, discussions about the sustainability of the work of the *Jigsaw Project* are also taking place with the prison and with the new National Offender Management Service

- Some HLCs are working towards *independence* as an organisation, while others may stay within an existing *lead organisation*

- There is a debate concerning the *city wide versus neighbourhood* focus of HLCs. Some of the district based HLCs are considering taking on some city wide functions. There is also an argument for seeing the whole of inner city Leeds as one catchment area, as the wards within it are the most deprived across Leeds.

- The seven HLCs have focused on both health improvement and wellbeing, as well as on building community capacity and infrastructure. They have found that, in order to tackle health issues faced by the most deprived groups, they have had to carry out work, and resource activities, under both of these strands. This *dual approach* does not necessarily sit easily within current funding streams as they are played out across Leeds. This issue needs to be tackled within a strategy for sustainability

Each HLC is tackling these issues in ways appropriate to its current structure and the infrastructure of support in its area. For example:

The *Jigsaw Project* is now an integral part of the Armley Prison Visitors Centre, which is in the process of setting up as an charitable company limited by guarantee. It recognises that it is meeting key agendas around health, preventing reoffending, prison obligations to families, and local youth provision. It is meeting these agendas through joining up all four sectors, which gives added value to the achievements of each; yet no one agency is responsible for all. They feel they must address this in their forward strategy.

MEMHO has set up a working group to look at strategic planning and sustainability. While they are working intensively with their small BME partners to develop the capacity of those groups to be sustainable (e.g. helping with funding applications and development work), they feel that many of those BME

communities are not yet strong enough to enter into the tendering/commissioning processes themselves. They see a need to continue their work and feel they must represent themselves more strongly with their PCT and link into other partnerships, such as the Learning Disabilities Partnership Board.

The *Hamara Centre* is developing a new three year Business Plan with its Board of Trustees. This will focus on three areas of work: health and wellbeing (linked to the Choosing Health agenda), older people, and young people (linked to the Every Child Matters agenda). It is interested in being commissioned to provide services within these three areas. It will also work on developing its internal infrastructure so it is not so dependant on the Director. It is exploring the possibility of operating beyond its current catchment area, at least for some services, and developing a trading arm as a social enterprise.

The work of the *West Leeds Healthy Living Network* is included in the local health plan of the West Leeds PCT, and in the Strategy for Success for West Leeds District. It wants to become more involved in service delivery for the NHS (e.g. expanding the Community Health Educators initiative to city wide) and to target services at priority groups. It also wants to keep its broad community development approach, and to link more strongly to the new West Leeds District Partnership to support its community capacity building work. Its board is currently preparing a forward strategy which it will put to the PCT and local authority . It feels strongly that the HLC needs stability to continue in order to deliver lasting change in health inequalities within 10-15 years.

The steering group of the *Feel Good Factor* is working towards independence from Unity Housing by June 2006. It wants to market its work in appropriate ways, illustrating where it sits within the bigger policy agenda. It wants to continue to provide appropriate services and is also considering social enterprise. It has a good profile with the PCT which supports its work and acknowledges its achievements in reducing health inequalities and delivering health improvement. It needs to raise its profile with the new North East Leeds District Partnership. It wants to keep the balance between the involvement of statutory partners, and its local community identity, and feels this must be explained within a forward strategy

Healthy Living is currently discussing its future, and looking for facilitation to explore this further. Currently it feels it would like to be funded in the future by a mixture of grant funding and commissioning by the statutory sector. Given the fragility of community groups in the area, it feels there must be a strong voluntary sector voice in the area. It is considering a possible merger between three initiatives in East Leeds – Healthy Living, East Leeds Health For all, and Ebor Health Matters.

The steering group of *Active 4 Life* has a subgroup working on its forward strategy. It has just lost one of its three key partners in the area, as the local

future of the Family Service Unit is uncertain. It is exploring other partners for its work on 'healthy families' which provide opportunities for clearer strategic links to the Every Child Matters agenda, and structural links to the developing Children's Trust. It sees part of its future in being commissioned to undertake work for the PCT which delivers parts of the Choosing Health agenda. It feels it must get better at publicising what it does, what it achieves and how it achieves it. These themes will be pursued through its ongoing evaluation.

4. CONCLUSIONS

4.1 Added Value of Projects

All seven HLCs operate as partnerships between individual organisations and groups. What is the added value of their work; what is achieved which would not be achieved by those organisations acting alone, or without the HLC?

- The HLCs give added value to the *work of the PCTs* in tackling health inequalities. The HLCs provide access to priority hard to reach groups, and innovations in ways of involving those groups in health promoting activities. They provide a small but capable workforce with community development backgrounds. The PCTs provide public health and service development expertise. Working together, they can develop new, and use existing, models of good practice in tackling health inequalities

  For example they have influenced the food strategy for Leeds. They have provided a strategic community development input into discussions on service issues for health and social care.

- The HLCs add the value of a *focus on health and wellbeing* to the community involvement work carried out by groups and organisations in their area, and city wide. These groups already engage some people in a range of activities. The HLC provides a health dimension to their work, and also builds their capacity to deliver health promotion and health services.

  For example they introduce health services (such as the Womens Therapy and Counselling Service) to groups who have no history of access to those type of services (such as Dosti, the Asian women's group)

- The HLCs develop the *capacity of local organisations* to act more effectively and to network with each other to deliver a stronger community infrastructure for change. This gives added value to existing work, making groups stronger and more sustainable, so that they can respond to local challenges more effectively. This impacts on such priorities as community cohesion, educational attainment, community safety, liveability and employability, which in turn are determinants of improved health.

For example they have supported the district partnerships to operate more effectively by facilitating a district wide voluntary and community sector network, or a health network to feed into those district partnerships. HLCs who operate from a single centre provide a single point of access for a range of services and support

This evaluation has identified issues which need to be tackled in order for this added value to continue to be realised. HLCs are flexible and can respond quickly to community needs, which helps to maintain the trust and involvement of the community in their activities. PCTs and local authorities must follow a government agenda, albeit allied to local priorities, and are more inflexible in how they respond to local challenges. In order to safeguard the sustainability of this added value, these different organisational cultures need to be reconciled within a resourcing/commissioning/funding context.

4.2 Strategic Opportunities

These opportunities lie within:

- the *priorities* set within local policy agendas, particularly in relation to tackling inequalities, choosing health, regeneration and neighbourhood renewal

- the *structures* set up to deliver those priorities

- use of *advocacy* to build a recognition of the place of HLCs in seizing those opportunities.

Local Policy Agendas

Health policy for Leeds is influenced by a number of government policies, allied to local priorities. While just a few are referenced here, as being the most central to the mission of HLCs, others include the same requirements, albeit linked to different themes. For example the 'Every Child Matters' agenda, and the regeneration agenda, all insist on partnership development, community involvement, tackling inequalities especially in provision and access, and joined up thinking and delivery.

The aim of the government's action programme on *tackling health inequalities,* is to reduce inequalities in health outcomes by 2010 by 10% as measured by infant mortality and life expectancy at birth. It is a national Public Service Agreement for both the health service and local government.

The programme of action designed to achieve that target is based on four themes:

- Supporting families, mothers and children
- Engaging individuals and communities
- Prevention of illness and treatment and care
- Addressing the underlying determinants of health

As part of the programme for action, government gave a commitment to deliver services for hard to reach groups through 257 healthy living centres clustered around areas of deprivation. Leeds HLCs deliver activities and initiatives which impact directly on each of these themes. They also provide examples of operationalising at least two of the five discrete principles which should guide how health inequalities are tackled in practice:

- Targeting specific interventions through new ways of meeting need, particularly in areas resistant to change
- Delivering at a local level and meeting national standards through diversity of provision

The programme of action gave the lead locally to PCTs in driving forward health inequalities work with a range of partners, while for local authorities tackling health inequalities has become a priority.

This programme was taken further forward in the more recent government publication '*Choosing Health*'[6]. This sets out 'how government will work to provide more of the opportunities, support and information people want to enable them to choose health. It aims to inform and encourage people as individuals, and to help shape the commercial and cultural environment we live in so that it is easier to choose a healthy lifestyle.'

It reiterates the commitment to tackling health inequalities described above, and it is clear to see how Healthy Living Centres make a direct contribution to this agenda by supporting disadvantaged people, in disadvantaged neighbourhoods, to make healthy choices in the communities where they live. They develop and support local partnerships to make health everybody's business.. They have developed new approaches which have worked to engage and support local people around health improvement.

Another key theme of this publication is local communities leading for health. It aims to 'maximise the positive impact of the local community setting with measures that include:

- investment and new initiatives in disadvantaged and deprived communities
- promoting partnership between the public and voluntary sectors with business to develop national and local champions for health and extend opportunities for people to take up healthy lifestyles in local communities.

[6] 'Choosing Health: making healthier choices easier', Department of Health, 2004

HLCs have a clear role to play here, and can illustrate how they are helping to develop 'well ordered and stable communities, with good access to services, clear leadership, cohesion and strong partnerships between local government, business, the voluntary sector, health services and community organisations, to provide an environment that helps people make healthy choices'. They are also examples of voluntary organisations which are 'much better than the statutory sector at engaging with groups of people who face most difficulties or who do not access traditional sources of advice on health'. They have 'increased opportunities for healthy choices' through the initiatives and activities they have set up. They have helped to 'deliver equity by targeting groups and areas with the worst health outcomes'.

The government's strategy on *neighbourhood renewal* reiterates these themes. This requires local strategic partnerships to demonstrate how they are narrowing the gap between the most disadvantaged neighbourhoods and groups and the rest within their area, in terms of health, educational attainment, employment, crime and community safety, and liveability.

The local strategic partnership for Leeds has developed a strategy for health and wellbeing which is consistent with national strategies on tackling health inequalities and on choosing health. The Leeds strategy has a vision that 'Leeds will be a healthy city for everyone who lives, visits or works here, promoting fulfilling and productive lives for all. We will reduce inequalities in health between different parts of the city, between different groups of people and between Leeds and the rest of the country.'[7]

There are a number of ways in which the approach adopted and developed by the HLCs closely reflects the focus and priorities described within this strategy. For example, in clarifying the local connection between health and wellbeing, the strategy notes that:

'the health and wellbeing of communities and individuals depends on a complex interplay of social, economic, environmental, psychological, biological, cultural and spiritual factors. Health contributes to wellbeing by enabling us to make the most of our lives, at home, at work and at play. It affects the opportunities available to us, our income, social life, comfort and happiness. So we need to take direct action to improve health, prevent ill-health and to provide care and treatment for those who need it at the time they need it.'[8]

The stated aim of all healthy living centres in Leeds is to improve, and impact on, both the health and the wellbeing of its local residents. In this connection the HLCs have developed work which has impacted directly on all five priorities of the health and wellbeing strategy. For example:

[7] 'Framework for Action', Healthy Leeds Partnership, February 2005
[8] ibid

- *Priority 1; make sure that social, economic and environmental conditions promote a healthy, positive and sustainable society* – HLCs work to address poverty and housing issues, such as providing welfare rights advice and home heating improvements to priority groups

- *Priority 2: protect people's health, support people to stay healthy and promote equal chances of good health* – HLCs work to promote health in ways appropriate to different groups, such as physical activity groups for elderly Asian men

- *Priority 3: provide high quality, sustainable and accessible services for those who need them and when they need them at home, in treatment centres or in hospitals* – HLCs work to promote access to health and social care services for disengaged groups, such as access to mainstream services by prisoners and their families

- *Priority 4: make sure that everyone can play as full a part in society as they want by reducing barriers which prevent people from being involved in everyday life* – HLCs work to make it as easy as possible for people to become involved in their local community, such as work on community capacity building and training with priority groups

- *Priority 5: establish effective partnership working to improve health and wellbeing in Leeds* – HLCs work to involve community and service user groups in partnerships, such as service users forum established by MEMHO

These HLC initiatives and activities have added value to mainstream work on tackling health inequalities. They impact particularly on the 'narrowing the gap' stream of Leeds Initiative, especially regarding the 'differential takeup of preventive measures' and carrying out the 'community development and capacity building' without which 'our priorities cannot be delivered'. HLCs also contribute directly to tackling the 'main problems' outlined in the health strategy, including poverty, poor housing conditions, drug and alcohol misuse, lack of physical activity and poor nutrition, sexual ill-health and unequal access to services and opportunities.

<u>Strategic Structures</u>

The *Healthy Leeds Partnership* is the partnership tasked with delivering the priorities of the Leeds Initiative strategy for health and wellbeing described above.

Each of the five *District Partnerships* are tasked with developing a local plan which will deliver these priorities at local level. However these district partnerships are new, and the relationship between their plans and the overarching strategy for health and wellbeing needs to be pursued further.

Currently access to the appropriate district partnership varies with each HLC, while access to the Healthy Leeds Partnership is dependant on their relationship with the voluntary sector health forum.

It is unclear how the HLCs will influence and help to deliver the developing priorities of the *Local Area Agreement*, currently being negotiated with the Government Office.

4.3 Proposals for Ways Forward

Short Term

1. Promote the delivery achievements of each HLC with their local/district or city wide stakeholders. This should include the PCT, local authority (particularly linking to the Health and Wellbeing workstream within its Corporate Plan) and other key players

2. Promote the delivery achievements of the HLCs as a whole with key city wide structures, including the Healthy Leeds Partnership and Voice

3. Build on these promotions to begin a dialogue with key PCT, local authority and partnership bodies concerning the future role of HLCs

4. Ensure the delivery achievements of the HLCs are included in discussions on developing the LAA

Medium Term

5. Develop a plan with the Healthy Leeds Partnership and District Partnerships which ensures the sustainability of the work of the HLCs in the context of meeting the priorities of Leeds Initiative. This plan should include:

    a. Community capacity building work as well as health and health promotion services
    b. A 'mixed bag' of mainstreaming aspects of the work, commissioning services, developing social enterprises and grant aid.
    c. City wide as well as district functions, which may involve some mergers
    d. A mechanism for strategic coordination of the work across the city

6. Ensure that business planning expertise is available to all HLCs in developing their plans for the future

4.4 Next Steps

A workshop was held at the Hamara Centre on 7th December with HLC representatives and some of the key stakeholders from statutory organisations, to present and discuss the evaluation report. The proposals for ways forward described above were accepted. In addition the following points were made:

- Health inequalities persist within certain population groups as well as within certain neighbourhoods, and so a 'healthy living approach' to tackling health inequalities is appropriate for the whole of Leeds
- The PCTs and local authority can work with individual HLCs to assess the qualitative impact of their work on key targets
- While it is important that the HLCs influence the work and priorities of Leeds Initiative as a whole, via the Healthy Leeds Partnership, it is also important that PCTs and the local authority develop mechanisms (or use existing mechanisms) for the HLCs to link formally and strategically with them
- HLCs can play an important role within a mixed provider approach to the delivery of health and wellbeing services, with their innovatory approaches and focus on delivery of health and wellbeing outcomes
- A dialogue is developing about joint strategic commissioning between the PCTs and the local authority; the HLCs need to be involved in this from the beginning
- Leeds Initiative have appointed a new Health Programme Manager whose brief includes community involvement and linkage between the Initiative and the voluntary and community sector. This post can help provide the strategic coordination for HLCs which had been lost with the demise of the HAZ.

ANNEXE I: MATERIAL STUDIED

The Jigsaw Project
- Armley Prison Visitors' Centre Annual Report 2004 – 5
- The Jigsaw Project Newsletters
- Second Stage Application to NOF
- Annual Monitoring Report to NOF 2003/4 and 2004/5
- Evaluation of Alcohol Awareness Programme 2005
- Draft Version of Strategic Plan 2005-10 for Armley Prison Visitors' Centre

West Leeds Healthy Living Network
- Network News Summer 2005
- Annual Report 2003-2004
- NOF Report 2004
- Annual Monitoring Report 2003-4
- Draft Evaluation Report 2005

Feel Good Factor
- Newsletters
- Annual Monitoring Report 2003-4 & 2004-5
- Business Plan August 2001
- Unity Housing Annual Report 2004
- Menu of Activities 2004-5

Hamara
- Draft Business Plan 2005
- Annual Report 2004
- Needs Analysis Report 2002

Healthy Living
- Annual Newsletter September 2004
- Business Plan September 2001
- Evaluation Report July 2005
- Annual Monitoring Report 2002/3 & 2003/4

Active 4 Life
- Evaluation Report 2004-5, April 2005
- Documents associated with Evaluation Report
- Annual Monitoring Report Healthy Living Centres Programme 2004/5

Policy Reports
- Choosing Health: making healthier choices easier, Department of Health, 2004
- Tackling Health Inequalities: a programme for action, Department of Health, 2003 *and* Status Report, 2005

- Health and Wellbeing: Framework for Action, Leeds Health Partnership, 2005

ANNEXE II: EVALUATION PARTICIPANTS

Project Interviews

Memho
Rachel McCluskey, North West PCT
Anita Chan, MEMHO Coordinator
Alison Lowe, Director Touchstone
Kate Gimlett, East Leeds PCT
Awtar Sagoo, People In Action
Yimin Chen, Leeds Chinese Community Association
Ann Rodriguez, Hamara Centre

West Leeds Healthy Living Network
Bernadette Murphy, Coordinator
Mark Law, Chair and Non-Executive Director of West Leeds PCT
Steve Crocker, West Leeds Area Manager, Leeds City Council

Feel Good Factor
Beverley Weekes, Chair
John Coleman, Social Services Area manager
Andy Taylor, Unity Housing Association
Pia Bruhn, North East Leeds PCT
Rifhat malik, Leeds Health Focus
Ray Duffell, North East Leeds PCT
Corrina Lawrence, Coordinator
Kevin Spencer, New World Steel Orchestra

Healthy Living
Anna Frearson, East Leeds PCT
Michelle Anderson, East Leeds Neighbourhood Team, Leeds City Council
Sue Balcomb, East Leeds Health For All
Mags Shevlin, Coordinator

Hamara Healthy Living Centre
Hanif Malik, Director
Mark Hannigan, South Leeds PCT
John Bracewell, Neighbourhood Renewal Team, Leeds City Council

Jigsaw Project
Susie Griley, Coordinator
Ian Blakeman, Governor HMP Leeds
Carole Clark, West Leeds Area Management Team, Leeds City Council

Howard Mills, Regional Commissioning Manager, Probation Service
Jon Fear, West Leeds PCT

Active 4 Life
Julia Upson, Coordinator
Penny Bainbridge, Cardigan Centre
Ian Cameron, Leeds North West PCT
Nicola Thompson, Leeds North West PCT

City Wide Interviews

Christine Burnett, Policy Director for Health Improvement, Leeds Initiative
Lisa Parkin, Participation Manager, Voice
Adrian Booth, Director Policy and Planning, Leeds PCTs
Greg Fell, Public Health Programme Manager, North West PCT
Liam Murphy, Chief Regeneration Officer, Leeds City Council
Liam Hughes, Chief Executive, East Leeds PCT
John England, Deputy Director of Social Services, Leeds City Council

ANNEXE III: CASE STUDIES

These case studies have been prepared by each Healthy Living Centre

	Sahara Women's Health and Relaxation Project: Active 4 Life
Rationale	Active 4 Life's core principle is to work alongside disadvantaged 'invisible' communities who are on the periphery of mainstream service. This project was designed to meet at least two of Active 4 Life's objectives i.e. • To identify problems related to health and social care concerns, building on broad issues identified so far, which include: food, drug misuse, mental health, poor quality environment and unsupported families. • To set up programmes of health improving activities such as physical activity and stress reducing activities. The project found that women who have experienced domestic violence are more likely to have poor health, chronic pain problems, depression, addictions, difficulties in pregnancy and have attempted suicide than women who have not experienced such violence. They also found that violence debilitates women and girls, physically, psychologically and socially, sometimes with lifelong results. This can be compounded by racism as experiences of racism can have a powerful effect in deterring people from seeking help from services about which they have low expectation. An understanding of the impact of domestic violence on the mental and physical health of women was of the utmost importance.
Process	After an introductory meeting with residents and workers, the Active 4 Life development worker consulted them about complimentary therapies and agreed to provide five sessions as well as a taster on physical exercise.

Content	The five relaxation sessions covered meditation, massage, reflexology, nail manicure, and facials, The exercise class focused on awareness and understanding of basic posture and body alignment using static positions, breathing exercises and creative visualisation. The breathing, with the combination of isometric contractions (non-moving), worked to raise the pulse and warm and maintain the appropriate body temperatures.
Results	The project had a positive impact on all those involved. The women were able to develop social connections, friendships, and explore the possibilities of increased community participation. **Individual outcomes** • Four of the women whom attended the course stated that the course had improved their health • Two people said that they had met new people and made new friends • Participants felt they learnt how to relax and understand their bodies and its needs • All of the women hoped that their physical activity would increase as a result of the taster session **Future activity** • All requested more sessions on physical activities • Some requested sessions on self esteem and confidence building; or mental health and wellbeing; or stress management; or a women's group. **Community involvement** • Since the sessions several of the women have become more involved in the community. • Two women have since been for assessments/ or made enquiries for counselling services • Several women were involved in setting up a women's group. • Two of the women have accessed our recent Eating for Improved Health and well being programme and are set to go on some walks we have planned. • One lady has accessed our swimming programme • One lady said she is looking to get back into work and enquired about volunteering opportunities, she was also involved in making decisions about grant applications, administered by the Cardigan centre, (The healthy living grants).

	Individual support across traditional boundaries: Jigsaw Project
Rationale	The fundamental principle of the Jigsaw Project is to work with all parts of the prison community – prisoners and their families, prison staff and the local community - to address health inequalities. Research shows that up to 80% of prisoners are illiterate, approximately 70% are using drugs before imprisonment, almost half have complex mental health disorders, and half do not have a GP. Financial exclusion affects families of prisoners whilst a parent is imprisoned, along with distress, isolation and the need to make ends meet. An estimated 125,000 children in the UK have a parent in prison. By providing services to local residents and prison staff, who also have particular

	health needs, the Jigsaw Project extends the principle of treating each person accessing its services equally and with decency and respect.
Process	The Visitors' Centre provides information, advice and support to families visiting HMP Leeds. The Jigsaw Project runs a range of services that work inside the prison and from the Visitors' Centre. Complex cases are dealt with through sound partnerships with the prison and in the community.
Content	Jane lives in West Leeds with her 4 year old son. She came into the Visitors' Centre in a state of shock about her husband's sentence for drink driving, which was unexpected. She was frantic about her husband's state of mind and what he might do to himself in prison. She had not had any contact with her husband and this was her first visit. A family support worker spent time listening to Jane and identifying ways in which she could be supported. Jane had just been made redundant and the mortgage and debts were in her husband's name. As she could not have direct contact with her husband, she was at a loss how to progress.
Results	• Jane received support and a listening ear to move her through her initial shock • Jane was referred to the CAB worker, who provided advice about what benefits Jane could claim, and options if she returned to work • With the co-operation of wing officers, the CAB worker met with Jane's husband and arranged for him to take on sole liability for the debts, releasing Jane of any responsibility • A long standing insurance claim that had not progressed in several years was resolved through liaison with Jane and her husband, and a final payout was made. This enabled the debts to be sorted and provided money for childcare, so Jane could consider going back to work. • Jane's husband was seen by the family support worker, who referred him to the Leeds Counselling service run through the Jigsaw Project • He also attended the Alcohol Awareness Programme for prisoners. At the end of the course he stated he was determined to become a better role model for his son. • Following her husband's transfer to another prison, Jane came back to the Visitors' Centre to use some of the healthy living services on offer to the local community.

	Fit and Fab Weight Management Programme: Feel Good Factor
Rationale	Feel Good Factor's (FGF) main aim is to improve the health of people in Chapeltown and Harehills through improved access to opportunities for heath living and promotion of physical and mental well being. The Fit and Fab programme was developed in response to a community needs assessment that identified that people wanted more support and help in both achieving sustainable weight loss and become more physically active. This is an area of high social deprivation, where indicators demonstrate high levels of Coronary Heart Disease, Strokes, Diabetes, Cancers and Obesity. It was felt that a programme such as this would go some way in addressing the rising levels of obesity and related risks of diabetes, high blood pressure and CHD in the local community. It also addresses the area of support that have been often overlooked as a major factor in sustaining long term behaviour change, creating

	self esteem and confidence building.
Process	Having taken on board the needs of the community using an evaluation process, several meetings were arranged with partner organisations who would contribute to developing a programme, which would cover the main elements – Healthy Eating , Mental Well Being and Physical Activity. This partnership consisted of FGF, NHS Community Dietician and NHS Mental Health Practitioner.
Content	The Fit and Fab Club consisted of a 2 hour session over12 weeks which include elements of; **Healthy Eating** • Information and examples of healthy eating • Benefits of a healthy diet and the introduction of food diaries • Triggers that cause bingeing eating and dealing with cravings • Diary Analysis **Physical Activity** • An initial fitness assessment and BMI check for participants • An average of 20 to 30 minutes exercise built into each session • Weighing in sessions • Support in identify a physical programme suitable to the individuals needs. **Mental Well Being** • Thoughts and moods • Body Image • Raising Self Esteem
Results	The project had a positive impact on all those involved. **Individual outcomes** • A total of nearly 3 stone weight loss • Many expressed greater self esteem and confidence, had made new friends and greater motivation. • One expressed that it helped her to think about what she was eating • All of the women stated that their physical activity had increased as a result **Future activity** • Programme reviewed and changes made to ensure a more flexible approach to community involvement and participation. **Community involvement** • Since the sessions, two women have asked to be a part of the next programme as motivators. • New programme design to ensure greater accessibility • New programme will allow for continued participation in terms of support. • Many of the women, have become members of FGF and are attending other healthy living activities provided by FGF.

	South Asian Community Based Cardiac Rehabilitation Service: Hamara

Rationale	Prevalence of Coronary Heart Disease and Diabetes is high amongst the South Asian Population. Recent national and local reports [9] state that there is a great deal of primary preventative as well secondary prevention work required to tackle health inequalities. Current services offered at the LGI and St James's were not catering for the needs of the South Asian Communities who experienced many barriers e.g. • Language • Lack of culturally/religious appropriate environment especially for female Muslims. • Lack of understanding of the benefits of Cardiac Rehabilitation • Lack of bi-lingual culturally/religiously trained staff Good models of practice set up around the country showed that community based facilities with appropriately trained bi-lingual staff and culturally trained professionals could work in parallel to target the 'hard to reach' communities living in inner Leeds.
Process	The Lead Cardiac Nurse Specialist approached Hamara to establish the first South Asian Community Cardiac Rehabilitation Service, with the support Leeds Health Focus, who had considerable experience delivering primary preventative work around CHD and diabetes. A lot of planning took place in order to establish the appropriate personnel, the training/qualifications needed to skill up staff to deliver the service, and the content of the cardiac rehab sessions.
Content	Twice weekly sessions are run at Hamara for six weeks. The patients are referred by the Cardiac Rehab Nurse who visits the patient once they have been discharged from the hospital which is phase 2. The Cardiac Nurse assesses and refers the patient onto the programme which is phase 3. The sessions are delivered by a BACR trained fitness professionals, Cardiac Nurse and our bi-lingual trained, male and female Health Development Workers (HDW) staff. Together they offer the following sessions: 1. B.P health check by the nurse who assesses the patient 2. Pre-shuttle test delivered by fitness instructor to ascertain the patients level of fitness 3. 45 minute low intensity exercise session 4. A 15-30 minutes relaxation session 5. Educational sessions covering topics such as what is heart disease, medication, healthy eating/cooking, welfare rights, and benefits of exercise. The sessions are delivered in the relevant languages where necessary e.g. Mirpuri, Urdu. The content of the sessions are discussed to ensure that the information is culturally appropriate, patient/user friendly.
Results	The programme is a much needed service which takes into account the issues/barriers in accessing mainstream services. The South Asian patients receive support and help in managing their heart disease from culturally/faith sensitive bi-lingual trained staff. This service is a positive step in tackling health inequalities and has been welcomed by patients and their families who strive to deal with family members who suffer from heart disease.

[9] The British Heart Foundation report, Chronic Illness amongst the Pakistani Community by the Nuffield Institute, NSF framework for CHD, the Governments healthy strategy document – 'Choosing Health, the LDP

	Outcomes • Five South Asian Male patients have benefited from this service so far. • Patients are more confident in dealing with their heart disease and have overcome fear that they can exercise safely with trained staff. • The service is currently looking to accept patients from other areas of Leeds until a similar service is set up within their own PCT. • The service has been welcomed by other Cardiac Staff across Leeds and the possibilities of expanding the service are in the pipeline. • This service is unique in meeting the cultural, faith and language needs of South Asian patients affected by heart disease.

	Working with Over 60s: Healthy Living East Leeds
Rationale	Healthy Living aims to improve the health and well-being of local people in a way which brings about lasting change and sustainability. One of its work themes is "Healthy Choices - Over 60s", to work with and extend the impact of existing organisations (Burmantofts Senior Action and Richmond Hill Elderly Action) working with older people in the community. The original workplan specified a gardening group for over 60s, with the health objectives of reduced isolation and improved communication; increased physical activity; reduced hospital admissions; improved mobility and reduced stress.
Process	Conversations with older people identified little interest in the gardening group, but an interest in a number of other activities including dancing, which had the potential to meet the same health objectives. Following a number of taster sessions, a line dancing group was set up in Richmond Hill. Extensive publicity through posters, leaflets, RHEA and visits to sheltered housing schemes generated initial interest.
Content	The classes run weekly at the community centre, using qualified line dancing instructors. Their warmth and humorous style, together with the enthusiasm and popularity of the Healthy Living worker are crucial in encouraging people to participate. Social activities, including line dancing parties, day trips and a weekend away, bring line dancers together from across the area. The sessions provide a friendly and relaxed environment with lots of opportunity to socialise as well as dance.
Results	Word of mouth and continued publicity meant that the class became very popular and two further classes started – one for improvers and one in a different part of the area which is separated by a large main road. Following interest from people under 60, and a review of Healthy Living policy about age restrictions on activities, the classes were opened to all. **Health Outcomes** The line dancing classes are very popular with between 45 and 60 people dancing every week. • 81% of participants say that their health has improved as a result • 92% have made new friends • 98% say they are happier 37% of participants define themselves as having a disability or limiting long-term health condition, including two deaf participants, and a woman with severe ME, who reports that it is the best form of exercise she has tried for regaining fitness. One participant is a walk leader and as a result several of the group now go

	walking together regularly. **Community Involvement** People from the groups now volunteer to make the refreshments, collect the money, help to organise and fundraise for trips. Individuals have gone on to participate in and volunteer at other Healthy Living activities and activities in their local community. Friendships have developed between people across the area.

	Service Users Forum: MEMHO
Rationale	The overall aim of the MEMHO HLC project is to improve the mental health and physical well being of the Minority Ethnic communities in Leeds by offering them and involving them in new health improving activities. We intend to meet our aims by: 1 Increasing the capacity of existing community agencies and buildings to define and deliver healthy living activities. 2 Ensuring that majority of funding if fed directly into activities, chosen by users/ beneficiaries. 3 Safeguarding funding and providing capacity building support for smaller organisations. 4 Improving and supporting access to mainstream services for all partners 5 Supporting partners in managing and delivering projects thus improving and sustaining service to users. The value that underpins the principle of the MEMHO project is inclusion, thus user involvement has become an essential aspect of MEMHO project.
Process	In the partner agent recruitment process, MEMHO requires all partner agents to lead a consultation with their users, making sure the activities are what the users need. Once they have become MEMHO's partner agent, their users are encouraged to get involved on a regular basis.
Content	The partner agents are required to have a consultation process of at least 15 user questionnaires to support their application. This is the initial stage of user involvement. MEMHO has been facilitating a Service User Forum as the next stage of user involvement. We hold a regular monthly Forum for the users at a different venue. The format of the Forum is to invite partner agents to talk about their services, how users can get involved etc. Users are also encouraged to speak about their concerns on a specific issue or their needs. The facilitator of the Forum will try to support the users to look for a way to address it. One user representative is nominated by the users who will attend the monthly Steering Group meeting. The user representative will have first hand experience in how MEMHO is operating. He/She is expected to give input of future planning as a collective body.
Results	The activities of all our partner agents are set out to be user led to meet the requirement of MEMHO. The annual evaluation of the MEMHO project indicated the satisfaction level of users is relatively high. It is because our users feel they own the project in the way they are involved. They have felt less isolated and been included in the process of service provision. Their quality of life has been improved because of the experiences and skills they gained by involvement in the process. The feed back from them is they want to come out more, to join in

	the activities and they have a part to play.

	Community health Educators: West Leeds HLN
Rationale	The Community Health Educator (CHE) model is an empowering health promotion model. The guiding principle is that to fully engage people in making their own choices abut health, (as well as the need to tackle the wider social, political and economic determinants of health) we start from where communities and individual are and build their capacity through community development approaches by training up local people who are trusted by the community members. They take the role of conscious awareness raising through facilitating discussion and critical questioning of issues that concern the community. [10]
Process	The Community Health Educators Project was established in response to the needs of the local communities. While the majority of people have a good understanding of the main health messages e.g. reduce alcohol intake, stop smoking, do more exercise, and eat more fresh fruit and vegetables; the Network found that the ability of people to move from an understanding of the key messages to actually taking action was very limited and on the whole people found changing their behaviours very difficult and even harder within the family context.
Content	The model of Community Health Educators has existed in various formats for a number of years; however much of it was based around the idea of training local people to enable them to be empowered and therefore make a difference by offering training and enhancing their career opportunities. The model West Leeds Healthy Living Network has established is two fold, firstly it offers local people the opportunity to take part in a free 14 week course (we provide child care and travel expenses) after which (if suitable) we employ them as Community Health Educators on a sessional basis.
Results	The first course ran with 12 women from the local community; most of them had not received any training or education since leaving school. One was a recovering Heroin User, a couple had been diagnosed with depression, one woman has a disabled child, and one woman had suffered from domestic violence. We had 4 Asian women and the rest were white women (no men!). All 12 completed the course and 10 signed up to be community health educators, the other 2 securing full time work. The Community Health Educators are paid a sessional rate of £10.40 per hour (this includes holiday pay) plus travel. • 23 sessions have been undertaken. • Community Health Educators are booked up until January 2006. • In total 2471 people from the communities of the West have interacted with, attended sessions, took part in health activities or collected health information from stalls run by the Community Health Educators. • Of those 2471 people that the Community Health Educators have interacted with or received advice and information from, 1722 attended sessions lasting a minimum of one hour. • Session times varied from one hour to half a day. • The Community Health Educators have covered a huge scope of topics such

[10] Lai Fong Chiu (2003) Application and Management of the Community Health Educator Model. Nuffield Institute for Health

	as; Weight management, Coronary Heart Disease, Smoking cessation, Sexual health, Healthy eating and cooking, Gentle exercise, Diabetes and how to use the N.H.S effectively. • There has been a wide range of clients from Men's Health sessions with the prisoners of Armley jail to healthy eating sessions for teenage Mums. • Two of the Community Health Educator's have gone on to take up administrative health related posts. • Two of the Community Health Educator's have now joined West Leeds Healthy Living Network as part time trainee Community Health Development workers. • One Community Health Educator has used the course in conjunction with another qualification to gain access to the second year of a Health Promotion degree at Leeds's Metropolitan University. • All sessions with out exception have received positive feed back. • The new October course is three times over subscribed. • Community Health Educators have been working all over the West of Leeds from Armley to Pudsey at a variety of different venues.

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Effective Community Participation Strategy Community Development Section

1.0 Foreword

As part of the development of the Vision for Leeds a review of community participation revealed that, whilst there are many examples of innovative and effective involvement activities, there is no citywide, collaborative approach to community development and community development projects are often suffering from short-term funding, lack of long-term planning and co-ordination.

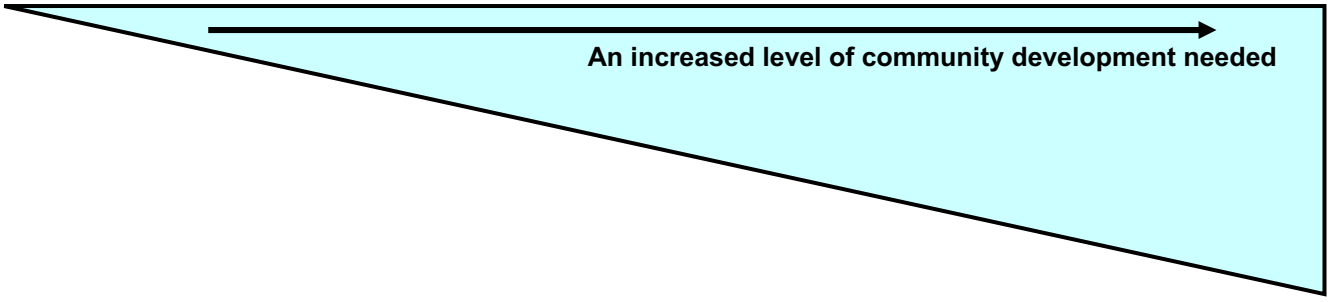
It is difficult for communities to engage with different agencies and systems but increasingly we need to and are required to deliver improved services within a partnership structure. This calls for a concerted effort from all partners to make participation exercises effective and meaningful.

The Vision for Leeds 2004-2020 places the active involvement of communities as central to successful and thriving neighbourhoods. It pledges to **develop** community involvement structures and to carry out a regular resident's satisfaction survey to ensure that progress is being made. Special effort will also be made to involve marginalised groups and individuals in consultation and decision-making.

Community development helps to create environments and cultures that underpin **genuine participation and involvement opportunities**. This section of the Effective Community Participation Strategy lays out the need to develop communities in Leeds, identify the effects that community development can have on issues facing both communities and agencies, the values and methodologies of community development and where to go to find further information and support.

This strategy aims to outline the principles needed to achieve the types of participation to the right hand side of the diagram below. Deciding together, acting together and supporting communities to act for themselves needs investment and support of a community development approach. Without community development these aspirations are unlikely to be reached. It is important to stress that the types of participation to the left hand side of the diagram are also important and have their place in effective community participation.

Type of Participation	Information Sharing	Consultation	Deciding Together	Acting Together	Supporting Communities
Definition	You are telling/informing people about what is planned.	A number of options or questions are posed and you listen to the feedback that is given before making your decision.	You encourage others to provide some additional ideas and options, and join in deciding the best way forward.	You, the community and often other partners decide together what is best. Partnerships may be formed or used to carry it out.	You support communities to do what they want - perhaps within a framework of grants, contracts, advice and support provided by the resource holder.



2.0 'Why include Community Development in the Effective Community Participation Strategy?'

Because:

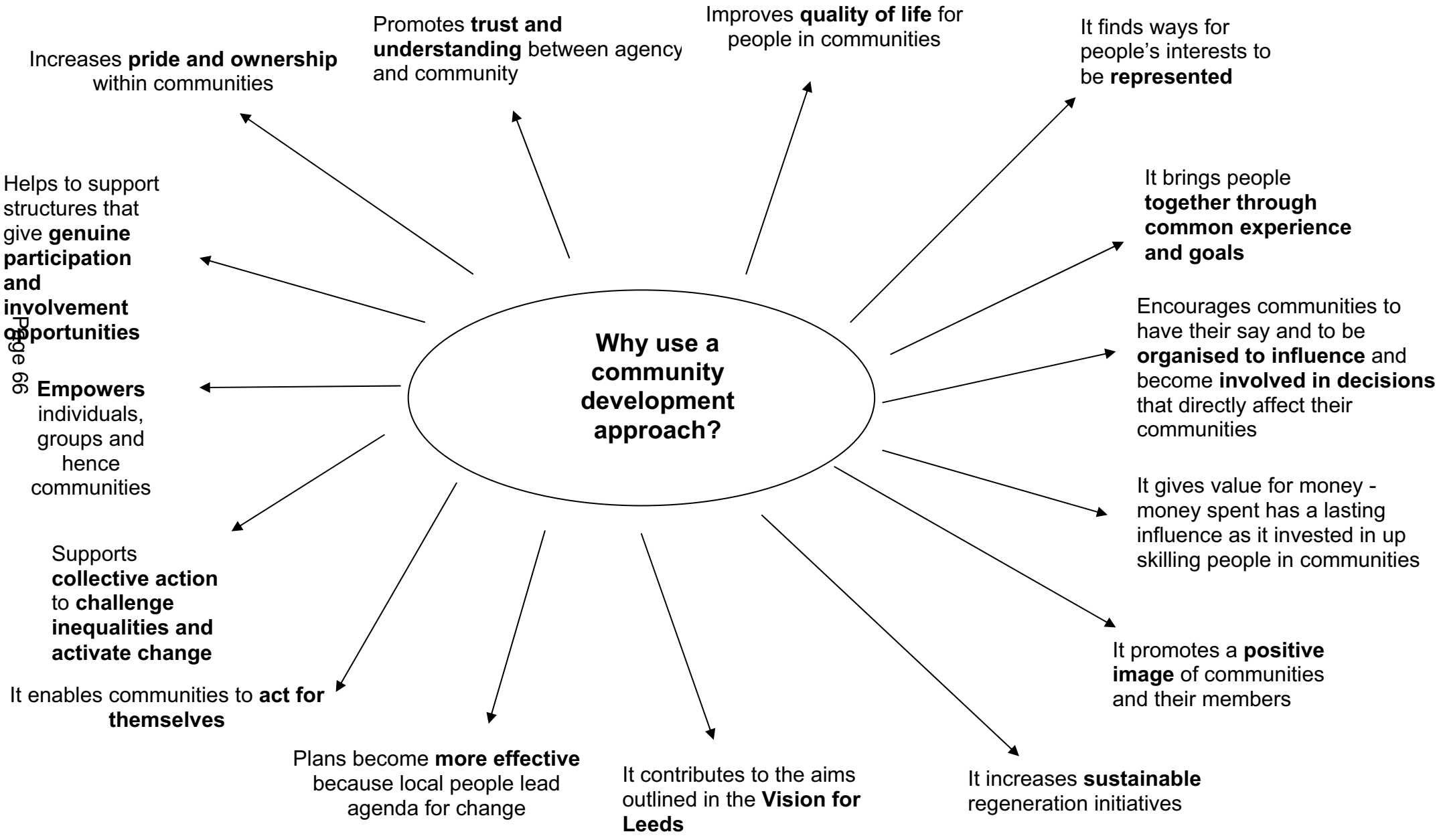
- Community development is about empowering local people to get involved with their community and change the issues that affect their lives.
- Community development is about the sharing of power, experience, skills and knowledge to bring about change and regeneration in communities.
- Community development aims to build active, influential and sustainable communities based on justice, equality and mutual respect.

This part of the Effective Community Participation Strategy highlights the value of community development not just as an approach to achieving effective and meaningful community participation but also as a long-term regeneration initiative which creates sustainable change in communities and will assist practitioners in the achievement of the aims set out in the Vision for Leeds.

The strategy is aimed at Leeds Initiative partners who wish to make better and more successful use of community development processes. It is not intended to replace individual organisations' strategies towards community development or community engagement but to encourage sign up to a set of shared principles and joined up working.

3.0 The objectives of this community development section of the strategy

- To increase the **active involvement** of people in the regeneration of their communities.
- To set and promote **realistic expectations** of what community development can achieve.
- To outline the **values and principles** of community development work.
- To outline realistic **resource requirements**.
- To ensure marginalised and socially excluded groups are **invested in and empowered**.
- To develop **effective partnership** working and **reduce duplication** of resources.
- To support and develop **good practice**.


Why use a community development approach?
Increases **pride and ownership** within communities
Promotes **trust and understanding** between agency and community
Improves **quality of life** for people in communities
It finds ways for people's interests to be **represented**
Helps to support structures that give **genuine participation and involvement opportunities**
It brings people **together through common experience and goals**
Empowers individuals, groups and hence communities
Encourages communities to have their say and to be **organised to influence** and become **involved in decisions** that directly affect their communities
Supports **collective action** to **challenge inequalities and activate change**
It gives value for money - money spent has a lasting influence as it invested in up skilling people in communities
It promotes a **positive image** of communities and their members
It enables communities to **act for themselves**
Plans become **more effective** because local people lead agenda for change
It contributes to the aims outlined in the **Vision for Leeds**
It increases **sustainable** regeneration initiatives

3.0 Definitions of terms

What is community development?

Community development aims to build active and influential communities based on justice, equality and mutual respect.

Community development work involves working with communities to:

- Identify their strengths, needs, rights and responsibilities.
- Plan, organise and take action.
- Assess the effect of any actions taken.

(Community Development Xchange, www.cdx.org.uk/)

What do we mean by community?

In this context community can be where someone lives (geographically) or based around a shared concern, issue or identity (communities of interest). It is important to recognise that individuals have multiple identities and may feel that they belong to more than one community.

4.0 Values of community development

Community development is a way of working that follows these values and commitments:

- Organise and bring people from communities together so that they work **collectively** agreeing and working towards achieving **common goals** or priorities.

- Recognising and optimising the **skills, knowledge, experience and potential** that exist within communities. Where there are gaps **build capacity** through activities that not only build skill but tackle social exclusion, promote community cohesion and nurture relationships.

Community development takes time, starts small, is more than just consulting, might be the first step for people becoming involved in decision making or partnerships in their community and is not the answer to all our problems.

- Bring people who have felt or feel powerless due to discrimination or exclusion together to build their confidence and ability to **challenge and raise awareness of inequalities**.

- Celebrate the **successes** and learn from **challenges** through interactive evaluation.

- Assisting individuals and communities to engage in **decision making** by raising their capacity and improving their **access** to decision making structures.

- Raising a community's **political awareness** of their own community, city, region and country and raising agencies awareness of **real local concerns**.

- **Sustaining change** by investing in people as well as places.

5.0 How is community development undertaken?

The Home Office Firm Foundations Report Sets out the 'basis for change' which will underpin action to expand and improve community development practice within partnerships and agencies. These recommendations have been adapted to be fit for purpose in Leeds.

1. Adopt a community development approach

This means including an element of community development into **planning, policy and resource management.**

Operationally it means working with communities to agree a set of values and goals that are owned by all parties and then taking action together to meet them.

Encouraging communities to be more confident in bringing forward their own agendas for change and being prepared to **listen and negotiate**.

2. Recognise and build on what exists

Spend time getting to know the community. Appreciate and use the skills, experience, interests, knowledge and ideas that already exist. These strengths are sometimes referred to as *social capital*.

Identify and use the **structures and resources** that already exist and where there are gaps acknowledge them and work towards filling them.

In **agencies and organisations** review what is known about community development and what skills are there. Ensure that cross partnership support networks are available.

Consider and use the knowledge of the **voluntary, community and faith sector** as a tool to engage with communities they are often based within communities and have established and strong links.

3. Think long term

Community development can be **self sustaining** because skills and resources are left with the community. Invest in the vibrant community, voluntary and faith sectors, take time to **build strong and equal partnerships.**

4. Ensure that appropriate support is accessible at a neighbourhood level

Access to 'start up' and maintenance funding should not be underestimated. **Small pots** can go a long way.

Somewhere for people to **get together** is often a catalyst for community development.

Skilled workers are available for individuals, groups and organisations to use for support and guidance.

Access to **forums or networks** that create a space where individuals, groups, organisations and partnerships can come together.

5. Embrace Diversity

Organisations may be required to carry out targeted community development work specifically with **communities of interest** rather than concentrating on geographical areas.

Communities and their members are all **different.** It is important to remember that solutions to similar problems may be different in each area. Often the best way to reach solutions is through the community members themselves.

In reality community development comes in many guises. Due to funding, targets, politics and localities the work can sometimes be undertaken in an ad hoc way.

A person does not have to have 'community development' in their job title to be undertaking community development work. It is in fact unlikely that they would have community development in their job title and it may even be that they do not identify the work they are doing as community development.

Similarly a person does not have to be employed to be undertaking community development work they may be a volunteer or a local activist.

This poses a question in terms of staff development, management and sharing of good practice. Community Development Xchange undertook a national survey of people who identified themselves as undertaking community development work.

The survey found that many of the managers of these workers did not understand or were unaware of the values of community development. It also identified that many workers undertook community development in addition to their role.

It is therefore important to identify work as community development and ensure that there is adequate support for it within organisational structures and with the community.

The following are all examples of how a variety of people undertake community development:

Ghulam – Community Education Development Worker

I work in deprived communities with groups and individuals who want to do something about where they live.

At the moment I am working with a group of parents who want to set up an arts study support sessions for the young people on their estate.

We have been meeting regularly talking through the logistics of setting up a group, getting funding, and networking with partners, aligning with national policy and making it sustainable.

I am arranging for them to have some training from the local college around safeguarding children, health and safety and equal opportunities.

Rheta – Unpaid Community Activist

I started off just going to meetings organised at the community house we have down the road and from there have got more and more involved.

I became secretary and then went about setting up a community partnership. There were so many things going on and I just wanted to pull everything together.

We now get so much more done. The young people have designed and helped build a playground that they maintain themselves. It's rarely vandalised because they care about it, they know what went into getting it!

This year we are concentrating on working with the older people on the estate. We want to get the young and older people working together to break down barriers.

Patricia - Public Health Development Worker

My job is so varied. This week I have:

1. Taught a session of community research methods to a group of community members. They will be researching health inequalities and priorities on behalf of the PCT.
2. Visited a new mums group to give support with breast feeding.
3. Helped a new group prepare for their summer launch event. They want to have a 'healthy options' barbeque for the street.
4. Tonight I am going to support the new chair of the local forum.

Stuart – Youth and Community Worker

I am the driver of our young people's van Monday, Wednesday and Friday nights.

It keeps you young that's for sure. This week we are taking out our newly trained condom advisors. They are young people who volunteered for the programme.

I am also going to support the group to present their graffiti work to the local partnership. They are hoping to gain some space to set up a graffiti club. We have some real talents in this village.

Nicola – Community Project Development Worker

At the moment I am working with a group of people from the local mosque. They are setting up a social enterprise at the centre. It's a community café.

Between them there is a book keeper, baker, first aider, PR expert and negotiator. The only thing I have had to sort out for them is a refresher for their food hygiene certificates and health and safety.

We're hoping that they will bring people into the centre. They know everyone and the food is amazing.

Daryl - Neighbourhood Warden

Our aim is to improve quality of life. We provide a authoritative presence in the communities we work in.

I work with the people in communities, getting to know them. Together we promote community safety, help with environmental improvements and housing management.

Policy Drivers

The policy drivers related to community engagement outlined earlier in this strategy are all relevant to community development. In order for communities to become empowered to engage in local strategic decision making and to become active in regeneration initiatives they need to be developed so that they have the capacity to not only *engage* in decision making but to play their part in partnerships and in regeneration generally.

The Home Office Report **Firm Foundations** 'A National Capacity Building Strategy' states that: 'active involvement of citizens and communities with public bodies to improve their quality of life is crucial to the achievement of a wide range of Government objectives'. Community development 'helps achieve civil renewal, with more people exercising their rights and responsibilities and participating actively in the public realm'. The report recognises that a community development approach is vital to the success of both Government and local objectives.

The **Vision for Leeds** aims to answer the question 'How will communities, groups and agencies work together to deliver what is needed?' It is unlikely that this will happen without developing communities so that they can play an active role in all elements of the Vision.

One of the key principles of the **Compact for Leeds** is to recognise and value the diversity that exists in society and in Leeds specifically. It aims to 'include all groups that find themselves under-represented and excluded, for the benefit of people who make up those groups and for communities and individuals as a whole'. It is naïve to think that by diversifying methods of engagement all individuals and groups will be reached. It is important to invest time and resources into developing these individuals and communities so that they can act together and participate in addressing their priorities. Community development creates innovative ways of preparing people for this level of activity.

District Partnerships have been established to deliver services and initiatives. These are dependant on an understanding of local agendas and local people. There is evidence to suggest that areas where a community development approach is used have increased involvement and active participation in influencing and delivering sustainable regeneration initiatives that affect the whole community.

The **Leeds Regeneration Plan 2005 – 2008** outlines the great success Leeds' partnerships have had at addressing national targets around reducing crime, improving educational attainment and housing standards however the gap is far from closed. 1 in 5 people live in neighbourhoods that are amongst the worst 10% in the country. In these areas 1 in 3 children live in families where no-one works. How do we reach these people? How do we ensure that initiatives reach these communities? Community development organises communities, enabling them to identify and address their own challenges alone or in partnerships. When a community's potential is harnessed initiatives are sustainable and value for money added.

Leeds has an innovative and commended **Local Area Agreement** with a welcomed cross cutting theme aimed at '**empowering local people and building the role of the voluntary, community and faith sectors'**. The objectives that accompany this aim include **'**capacity building through activities that build skills create social inclusion and encourage community cohesion and good relationships between diverse groups'. This can not be done without investing in the community development agenda.

7.0 Evaluation and monitoring

Community development produces results. People engaged within community development often feel that their quality of life has improved as that they feel they are an important part of a thriving community.

How do we measure these qualitative outcomes?

Community development can produce personal outcomes that together make a big difference. These outcomes might be:

- An increase in social capital and community cohesion.
- An increase in communities helping themselves; building the capacity of community led service providers to plan and deliver activities and programmes to meet local needs.
- Increased effective community participation.
- Sustainable initiatives and participation through a confident and supported community.

The Local Area Agreement process has enabled the city to negotiate some agreed tangible outcomes and outputs around community development. These are:

- Increase by x% the number of local people who feel they can influence decisions affecting their area.
- Increase in membership of local neighbourhood and residents forums.
- Increase in the number of volunteers.
- Increased awareness of existence of local neighbourhood and residents forums.

Taken from the Leeds Area Agreement 2006 - 2009

These targets will be measured via the performance management arrangements for the Local Area Agreement. Many of the community development or capacity building targets will be measured by qualitative perception analysis surveys conducted throughout the community, voluntary and faith sectors and with their service users and through the Leeds Initiative voluntary, community and faith sector research project. The surveys and research will set a baseline which will then be measured for increase year on year. The qualitative data will be coupled with quantitative measures of individuals, groups and organisations engaging with their community.

There are useful tools specifically designed for assisting with monitoring, measuring and evaluating performance in community development.

A few examples of these are:

The ABCD (achieving better community development) model of Evaluation from www.scdc.org.uk/abcd_model.htm

The Visible Communities Framework from Community Matters www.communitymatters.org.uk or www.cdx.org.uk
Evaluating community projects - A Practical Guide from Joseph Rowntree Foundation www.jrf.org.uk or www.cdx.org.uk

References and Contacts

'Active Citizens, Strong Communities; progressing civil renewal', 2003, Home Office.

'Compact for Leeds', 2002, Leeds Initiative.

'Firm Foundations: The Government's Framework for Community Capacity Building' 2004, Home Office, Civil Renewal Unit.

'Leeds Regeneration Plan 2005 to 2008', 2005, Leeds Initiative.

'Vision for Leeds 2004 to 2020', 2004, Leeds Initiative.

For more information on this strategy contact:

Leeds Initiative on 0113 247 8989
Facilitators of the Community Involvement Network

Leeds Voice 0113 277 2227
Facilitators of the Community Empowerment Network for Leeds and Community Development Strategy Group

Voluntary Action Leeds 0113 297 7920
Facilitators of the Leeds Voluntary, Community and Faith Sector infrastructure Consortium

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Leeds CITY COUNCIL

Originator: A Brogden

Tel: 247 4553

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health and Adult Social Care)

Date: 18th September 2006

Subject: Leeds Mental Health Teaching NHS Trust – Consultation for Foundation Trust Status

Electoral Wards Affected:	**Specific Implications For:**
	Ethnic minorities ☐
	Women ☐
	Disabled people ☐
	Narrowing the Gap ☐

1.0 Introduction

1.1 At its July 2006 meeting, the Board was informed that the Leeds Mental Health Teaching NHS Trust had commenced its 12 week consultation process on its plans to become an NHS Foundation Trust. The consultation period ends 25th September 2006.

1.2 At today's meeting, the Board is asked to provide a response to the consultation. A copy of the Trust's consultation document 'Speak to us….Consultation for Foundation Trust Status. We want to know your views' is attached for Members' consideration.

1.3 Representatives from the Trust will be attending today's meeting to help answer any further questions from Members.

2.0 Recommendation

2.1 The Board is requested to consider and respond to the Leeds Mental Health Teaching NHS Trust's consultation for Foundation Trust Status.

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Leeds Mental Health NHS
Teaching NHS Trust

Speak to us...

Consultation for Foundation Trust Status
We want to know your views

If you have difficulty reading this document you can request it on audio tape or in larger print, please call us on 0113 30 55977

Contents...

We are applying...

to become an NHS Foundation Trust

This document describes what a Foundation Trust (FT) is and why we feel it is a benefit to our service users and to us to become one. It gives key information about the Trust now and how we are planning for the future of our mental health and learning disability services.

The following is a guide to our proposals. We hope you will find it interesting and let us have your thoughts. The consultation process starts on Monday 26th June and ends on 25th September 2006. All feedback must be received by this date.

To respond to the consultation, or to find out more information about Leeds Mental Health Teaching NHS Trust, go to **www.leedsmentalhealth.nhs.uk**

The terms we use...

Service user

This is the most common term used to describe someone who uses our services. We have used it in this document as it is the most commonly used term at present and we want to be consistent and clear, however, we recognise and respect that the term 'service user' is not the definition of choice for everyone. We also recognise that as long as inequalities exist, the terms used to define groups of people will change.

We also recognise that in learning disability services, a service user may also be called a resident.

Carer

A carer is a partner, friend or relative who provides regular care for another person. To be regarded as a carer, a person does not have to live in the same household as the person they support and they can be of any age.

Introduction...

Our plans to become an NHS Foundation Trust

Thank you for taking the time to consider our plans to become an NHS FT. We have produced this document to support our FT application. It will be the backbone to a 12 week formal consultation period starting on Monday 26 June 2006.

We are applying for FT status as it will give us the freedom to run our own affairs while remaining fully within the NHS. We will be accountable to local people and to an independent regulator, Monitor. This will allow us to be more responsive to local needs and to pursue necessary improvements in services.

This is an exciting time for anyone connected to us and will provide our service users, carers, staff and the people of Leeds with an opportunity to have a greater say about how our services develop.

We have a well established history of listening to the views of our service users and carers. By becoming an FT we will be able to develop how we work together in a more formal way and give you real powers to shape the future of the Trust.

As part of your community, our ambition over the coming years is for people to choose us because we always deliver the best mental health and learning disability care and we hope you will join us in this vision.

We welcome your views on the questions we ask throughout this document. These concern our proposals on how local peoples' views about the membership of the new FT will be heard, how we involve service users, carers, staff and other local people and also our future plans for how we develop and deliver our services. We look forward to your feedback on these and any other aspects of our proposals.

Ian Hughes, Chair
Chris Butler, Chief Executive

About us...

and our ambitions

We have an excellent reputation as a provider of specialist mental health and learning disability services. We are also a centre of excellence for teaching, research and development. Our purpose is simple but ambitious and that is to be best at what we do. Our future direction over the next five years is summarised in our 'ambition statement', that;

"In 2011 people choose our FT because we always deliver the best mental health and learning disability care."

We provide a wide range of specialist mental health and learning disability services to over 572,000 adults within the metropolitan boundaries of Leeds. Many of our specialist services, such as eating disorders, also accept service users from across the UK. We;

- Operate from over 70 sites.
- Provide help to over 2,000 people every day.
- Have 16,204 service users currently registered as involved in the Care Programme Approach (CPA).
- Employ over 2,350 staff.
- Operate with an annual budget of £105m.

In recent years, we have established a number of purpose-built acute and community units and closed some old, outdated and very inadequate accommodation. We have done this because we respect our service users' needs and want to provide high standards of care.

We have also continued to invest across a range of community and in-patient facilities to expand and improve existing services and develop new services. These have included;

- Opening a new Eating Disorder Unit, extending in-patient, out-patient and day patient facilities.
- Establishing a Crisis Resolution and Home Treatment Team.
- Redesigning our Acute Community Day Services to ensure facilities are evenly distributed across the city.
- Providing four in-patient beds in our Parent and Child unit (Perinatal).
- Extending memory services across the city for older people.
- Developing many specialist services including prison health, personality disorder, and gender identity.

We have also managed to significantly improve our financial performance. We have achieved this through a combination of increasing efficiency and improving and changing the way we provide services. As an FT we will have a sustainable financial platform from which to further develop and improve.

Would someone tell me...

what is a Foundation Trust?

A Foundation Trust is a completely new kind of NHS organisation known as a Public Benefit Corporation. FTs are still part of the NHS and will still be subject to NHS standards, performance ratings and systems of inspection. They still operate according to NHS principles of free care, based on need and not ability to pay. The difference with an FT is that it is run locally, with local people having a say in how they wish their services to be developed.

FTs are democratic and designed to operate like mutual organisations, for example, some building societies or co-operatives. Everybody will still be able to access our services whether or not they are a member, (local people, service users, carers and staff can become members of the organisation). The members then directly elect representatives to serve on a Membership Council. This Membership Council will work with the Trust's Board of Directors to agree the future plans of the Trust. The Membership Council will also be able to appoint the Trust Chair and Non-Executive Directors. The Board of Directors will retain responsibility for the day to day running of the Trust.

As an FT, we will have the freedom to develop new ways of working that reflect local needs and priorities. We will have greater financial freedom that will be combined with higher levels of influence for members, meaning that we can develop the Trust quicker, more effectively and be more responsive to local needs.

Why do we want...

to become a Foundation Trust?

We believe that becoming an FT would bring about significant benefits for our service users, carers, staff and the local people of Leeds and would help us with our ambition to always deliver the best mental health and learning disability care. Specific benefits include;

Benefits for service users and carers

Service users and carers are our core business and we are proud of the systems we have developed to enable us to work in partnership with them. Working together helps us to improve our services and enhance the experience of people who use them. We endeavour to involve service users and carers with a wide range of perspectives and experiences to ensure their voices reflect the diversity of our city.

As well as striving to become an FT, we are committed to making sure that service users and carers continue to work with us to improve and develop the services we provide. We would not be embarking on the journey towards becoming an FT if we were not confident that it would benefit our service users and carers. Becoming an FT would enable service users and carers to;

- Be directly involved in governing the Trust as members.
- Stand for election to one of the twelve service user and carer Membership Council places.
- Have a say in influencing the day to day operation of services.
- Have a say in influencing the development of new services.
- Receive excellent information about services in a format that suits them.

"As a service user and a member of staff, I think that becoming an FT will allow me to have a much greater say in the running of the Trust and to be better informed about future developments."

Cath Sweeney, FT Project Support Manager

"As a member of clinical staff, I take pride in trying to provide the best service that I can. I think that Foundation Trust status will give service users more say in the running of the Trust, and that's got to be a good thing."

Janet Wilson, Clinical Team Manager, Self Harm Team

Benefits for staff

We believe that our staff are the Trust's biggest asset and they are key to the success of our overall achievement of objectives. We aim to be an organisation where our staff feel valued, supported and listened to. We are proud that we have a dedicated workforce committed to the best interests of our service users. By becoming an FT we will build on these strengths and be an organisation that future staff will see as an employer of choice. Becoming an FT would enable staff to;

- Be part of an organisation with development opportunities and effective leadership.
- Be directly involved in governing the Trust as members.
- Stand for election to one of six staff places on the Membership Council.
- Be part of delivering excellence and be rewarded for doing so.
- Enjoy the best standards of employment practice.

Benefits for local people

By becoming an FT will we will play a much wider role in our local community. We will give local people the opportunity to have a say in the future direction of the Trust and become advocates for mental health services in the city. For the first time, any member of the public from Leeds will have a role to play in the organisation either as a member or by being elected to the Membership Council. Becoming an FT would enable local people to;

- Be directly involved in governing the Trust as members.
- Stand for election to one of eight public Membership Council places.
- Have a say in influencing the day to day operation of services.
- Have a say in influencing the development of new services.
- Enjoy a greater understanding of mental health and learning disability issues.

"If local people are given the opportunity to influence locally provided services, then it must lead to a better understanding of mental health issues, and help to create a service that fits the needs of the local community "

Mrs Susan Cullen, Guiseley

"Moving towards FT status will give commissioners a provider organisation that has greater clarity about its core business and that is able to work more flexibly in a competitive health and social care economy. We hope to continue our strong working relationship with the Trust as it moves to FT status."

Tabitha Arulampulam, Acting Associate Director for Mental Health (Leeds PCT)

Benefits for our partner organisations

We work in partnership with a range of other organisations in and beyond Leeds. These include the West Yorkshire Strategic Health Authority; Leeds Primary Care Trust; Leeds Teaching Hospitals NHS Trust; Leeds City Council, in particular its Social Services Department; the Voluntary Sector; Police; Prisons; and our Private Finance Initiative (PFI) partners Accent and Interserve.

We have an established track record of working in partnership with the local economy across the statutory and non-statutory community. It is a key strength of our organisation and enables us to plan and deliver services that are connected to the community and are based on assessed need.

Becoming an FT would enable our partners to;

- Be directly involved in governing the Trust as members.
- Be a non-elected member of the Membership Council.
- Enjoy a collaborative approach to health improvement.
- Engage in the development of our business plans.

"The achievement of FT status will be an important element of a reformed NHS that provides more responsive, pluralistic, higher quality services. This will be designed to build on much of the excellent practice already in mental health in Leeds."

Jo Franklin, Strategic Health Authority FT Project Lead

How you can help us...

to run the Trust

NHS FTs are influenced and controlled locally. They are accountable to the local community. To achieve this, we need to establish a new way of running the organisation. The term used to describe the way we will be organised, managed and held to account is Governance.

The structure for FTs has been set nationally, however it is for each Trust to individually decide its local arrangements. For instance, we have decided to have specified service user and carer Membership Council places as we want to ensure these groups have a strong voice within our new organisation. The following summarises the different roles within a Foundation Trust and these are explained in more detail in the following pages.

Members

Members are service users, carers, staff and other local people who collectively contribute to the way the Trust is run.

Members elect representatives to sit on the Membership Council.

Members receive information from the Trust and have a direct route to input their ideas and concerns.

Membership Council

Made up of 26 elected members and 10 non-elected members from key local partner organisations. These representatives will become members of the council.

Council members will have ongoing working relations with the membership, representing their views at meetings of the Membership Council.

The Council influences the activities of the Trust and helps shape the future strategy of the Trust.

Board of Directors

Made up of Executive and Non-Executive Directors.

Responsible for the day to day running of the Trust and implementing the Trust's long term plans.

Responsible for meeting national standards and performance targets and reporting this back to the membership through the Membership Council.

Membership...

New ways to contribute to the way the Trust is run

Becoming an FT provides new ways for service users and carers, staff and other local people to contribute to the way the Trust is run. They can become members and then, if they choose, can stand for election to the Membership Council. For members who want to, there will be opportunities for active involvement and participation. Members can become involved as much or as little as suits them. Opportunities will include;

- Elect fellow members to the Membership Council
- Stand for election to the Membership Council themselves
- Receive members' only newsletters
- Have a direct route to present ideas and concerns to the Trust
- Take part in focus groups on strategic issues
- Meet and engage with the Membership Council at Members' Forums
- Attend lectures on health issues
- Attend annual members' meetings

We will work hard to establish a membership base that is inclusive of all minority groups and so ensure everyone has an equal opportunity to contribute and that we hear voices from all of our community.

Membership will be open to anyone over the age of 16. This is because we currently don't provide services to anyone under this age. However, this would be reviewed if the organisation were to undergo any significant changes to its services. There will be no upper age limit.

There will be three elected categories of membership. These will be called constituencies.

Public

This constituency will be open to anyone over the age of 16 living in Leeds. This group will be split into the eight parliamentary constituencies within the Leeds Metropolitan area. These are; Leeds Central; Leeds North East; Leeds North West; Leeds West; Leeds East; Pudsey; Elmet; and Morley and Rothwell. There will be one elected Membership Council place from each of these eight parliamentary constituencies.

Do you have any comments about the proposed formation of the membership?

Do you agree with the lower age limit of 16?

Do you agree with the proposed membership categories?

Do you agree with having a service user and carer category in addition to the public category?

Service users and carers

Some organisations have decided to merge their service users/carers and public constituencies together. However, because we feel that our service users and carers are so important to the organisation we have chosen not to do that and have created a separate constituency.

This constituency will be open to anyone who has ever used Leeds Mental Health Trust services or cared for someone who has used our services, regardless of where they live. Service users and carers can choose whether to be a member of this constituency or of the public constituency. Members can only belong to one constituency at a time. Ten Membership Council places will be available for Leeds based service users and carers and two places for non-Leeds based service users and carers.

Staff

We greatly respect and value our staff and it is important to us that we give all of them the opportunity to be fully involved in the new Foundation Trust. We therefore propose that all staff automatically become members. Staff will still have the right to 'opt out' if they so choose. The staff constituency will also include staff who, although are not employed directly by Leeds Mental Health Trust, work closely with us, eg domestic staff. In addition, our many volunteers who carry out a valuable service for the Trust will also be able to become a member of this constituency.

Six Membership Council places will be elected from the staff constituency, one from each of the following groups;

- Medical - eg Psychiatrists, Doctors etc
- Nursing - eg Nurses
- Clinical support staff - eg Clinical Support Workers
- Other health professionals - eg Psychologists, Occupational Therapists etc
- Non-clinical staff - eg Corporate Staff, Mental Health Act Managers etc
- Volunteers - eg Unpaid voluntary workers

Membership Targets...

Actively involving people

We have set targets to grow membership and involvement over three years. We believe that we should favour a high-engagement policy for members. This means that we will look to attract a higher percentage of members who will be actively involved in creating a vibrant and active membership base.

The overall breakdown for the range of membership numbers during the first three years is;

- Year 1 : 5,000 - 7,500
- Year 2 : 7,500 - 15,000
- Year 3 : 15,000 - 20,000

We have broken down the growth so you can see the proposed numbers from year one to year three for each of the membership constituencies.

	Year 1	Year 2	Year 3
Public	3200	9250	13350
Service Users and Carers	1300	2600	3400
Staff	3000	3150	3250
Total	7,500	15,000	20,000

Although we have set targets for the membership over the first three years, we would not exclude anybody who is eligible to join should we exceed these projected membership numbers.

Do you think the targets for the number of members is appropriate?

Membership Council...

Helping to shape the future

The Membership Council is made up of representatives of the members and also key local partner organisations. They will ensure that the existing Board of Directors, who will maintain responsibility for the day to day running of the trust, is accountable to the community. The members of the council will also oversee the activities of the Trust and help shape the future strategy of the Trust. The Membership Council will be chaired by the Trust Chair.

We are proposing that the Membership Council will be made up of 36 members. This will include;

- 8 Public members
- 12 Service user and carer members
- 6 Staff members.

The Membership Council will be elected by the members. All elections will be by secret ballot and an independent organisation will be used to run and validate the elections. Members of the council will usually be appointed for a term of three years, however some initial appointments will be for less than this. This will mean that there are regular elections to the Membership Council, ensuring the council runs smoothly in its early years of development and providing local people with the opportunity to elect new members to the council or re-elect existing ones.

There will also be 10 stakeholder non-elected members who will be representing the following key partner organisations;

- Accent Care Partnerships
- Health and Wellbeing Scrutiny Committee - Leeds City Council
- Leeds Metropolitan University
- Leeds Primary Care Trust
- Leeds Social Services (Commissioner representative)
- Leeds Social Services (Provider representative)
- Leeds Teaching Hospital NHS Trust
- University of Leeds
- Volition
- West Yorkshire Police

We are restricted by legislation which states that anyone who has been made bankrupt, or received a prison sentence of three months or more in the past five years is not able to become a member of the council. Legislation also states that Council Members will not be paid, but will be entitled to receive expenses in connection with attending meetings.

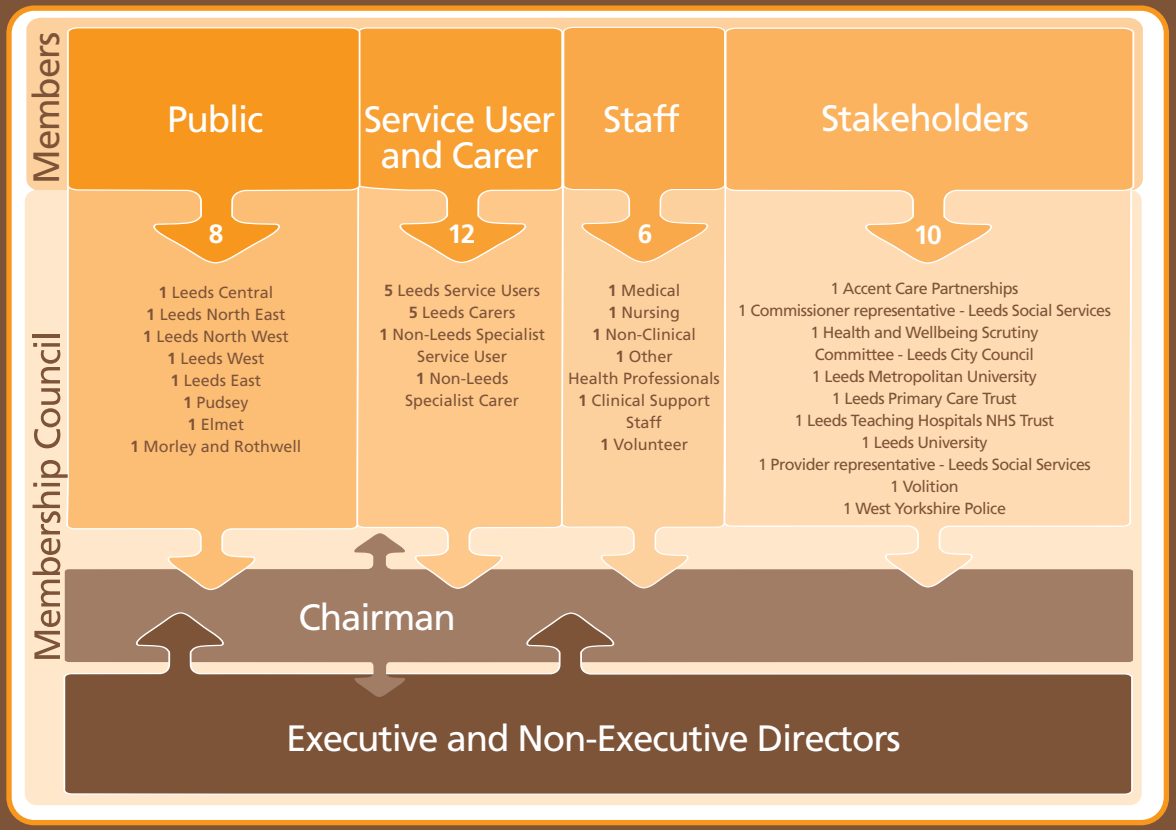
They will have a specified role which will include;

- Meeting several times during the year
- Representing members' views at the Membership Council
- Taking part in informal meetings with members
- Having an ongoing dialogue with the membership constituency that elected them
- Chairing members' focus groups
- Collecting members' views and feeding back to them

Do you agree with the proposed structure of the Membership Council?

Do you agree with the proposed number of public, service user and carer, and staff members on the council?

Do you think there are other key partner organisations who should be represented on the Membership Council?


Members
Public
Service User and Carer
Staff
Stakeholders
Membership Council
8
1 Leeds Central
1 Leeds North East
1 Leeds North West
1 Leeds West
1 Leeds East
1 Pudsey
1 Elmet
1 Morley and Rothwell
12
5 Leeds Service Users
5 Leeds Carers
1 Non-Leeds Specialist Service User
1 Non-Leeds Specialist Carer
6
1 Medical
1 Nursing
1 Non-Clinical
1 Other Health Professionals
1 Clinical Support Staff
1 Volunteer
10
1 Accent Care Partnerships
1 Commissioner representative - Leeds Social Services
1 Health and Wellbeing Scrutiny Committee - Leeds City Council
1 Leeds Metropolitan University
1 Leeds Primary Care Trust
1 Leeds Teaching Hospitals NHS Trust
1 Leeds University
1 Provider representative - Leeds Social Services
1 Volition
1 West Yorkshire Police
Chairman
Executive and Non-Executive Directors

Board of Directors...

Steering the Trust

We are currently led by a team of experienced Non-Executive and Executive Directors. This team is responsible for the day to day running of the Trust, as well as implementing our long term plans. The team of Executive Directors together with the Chair and the Non-Executive Directors make up the current Trust Board. This Board has led us well and we propose that until the expiry of the Non-Executive Directors' current terms of appointment, they continue to lead us, after which they are eligible for re-appointment by the Membership Council.

The Foundation Trust Board of Directors will be made up of;

- Non-Executive Directors, one of whom will be the Chair
- Executive Directors, one of whom will be the Chief Executive

Their responsibilities will include;

- Ensuring the prosperity of the Foundation Trust by collectively directing the Trust's affairs while meeting the appropriate interests of the members and other relevant stakeholders.
- Preparing the Trust's forward plan, taking account of the views of the Membership Council.
- The Chair, Chief Executive and Non-Executive Directors will appoint or remove Executive Directors.
- Non-Executive Directors, subject to the approval of the Membership Council, will appoint the Chief Executive.
- Establishing a committee of Non-Executive Directors to act as an audit committee.
- Establishing a committee of Non-Executive Directors to decide on the remuneration and allowances and other terms and conditions of office, of the Executive Directors.
- Presenting to the Membership Council, at a general meeting, the annual accounts, any report of the auditors and the Annual Report.

Proposed FT Board (Director structure)

Current:

Chief Executive
Director of Finance
Director of HR
Director of Nursing and Clinical Governance
Director of Planning, Performance and Information
Director of Service Delivery
Medical Director

Future:

Chief Executive
Director of Corporate Development
Director of Finance
Director of HR
Director of Nursing and Clinical Governance
Director of Service Delivery
Medical Director

It is proposed that the current board is restructured, this would see the creation of a Director of Corporate Development from within the current team. This role would encompass the Board Secretary which would support the Membership Council and Board of Directors with the legal and statutory responsibilities of the FT.

This role will also be key in establishing and reviewing the procedures for sound governance in the Trust, while advising the Board of Directors and others on the development of governance issues. The Directors will also be complemented by Non-Executive Directors.

Do you have any views on the proposals for the Board of Directors?

Our vision for the future...

Developing our services

We want our services to be the best they can be. We aim to build a culture where people are supported and make a real choice over the type of care available and where and when they receive that care. This means the right expertise available, where and when it is needed and in the safest, most accessible environment. We want the service user experience to be so good that people choose our services over and above others.

To achieve this, we have recently completed a draft five year strategy for the organisation. We have done this by working with people who use our services and in partnership with voluntary organisations and local statutory organisations like Leeds City Council.

We believe that this vision or strategy will help us prepare for changes in healthcare provision and improve care. We work in a complex environment which involves a wide variety of clinical professionals working in many different locations with large numbers of people.

These are supported by corporate teams and support services including;

- Finance
- Human Resources
- Nursing and Clinical Governance
- Planning, Performance and Information
- Marketing and Communications
- Patient and Public Involvement
- Estates and Facilities

Our vision for the future aims to ensure that we provide the 'best care' for the people of Leeds. It is for this reason that we have developed a programme of changes and improvements to the services we provide. We would like you to consider them and tell us what you think about our plans. Our overall vision is to improve the health and well-being of people with mental health problems, learning disabilities and their carers in ways that are determined by them; and to promote mental well-being of the population as a whole.

To achieve this aim we have identified key strategic goals in the following areas which we need to deliver by 2011.

- Clinical care
- Our staff and their dependents
- For service users, carers and the public
- Partners and Commissioners

Clinical care

Appropriate competent assessment, treatment and care - Our service users receive the best treatment and care based on a comprehensive assessment of individual needs, undertaken by relevantly trained, supervised and supported staff.

Effective clinical outcomes - We will use evidenced based practice to deliver effective clinical outcomes through defined care pathways.

Care through fit-for-purpose and therapeutic environments - We will offer services that are matched to individual need through collaboration between service users, carers and staff.

No unavoidable unexpected deaths and Serious Untoward Incidents - We will aim to eliminate deaths and other adverse outcomes that are preventable through the delivery of appropriate care.

No needless delays - We will make sure there are no needless delays in any part of the service.

Care Programme Approach (CPA) fully comprehensive and gateway to Trust services - Every one of our service users has a comprehensive CPA and this will be completed in partnership with the service user and their carer.

Our staff and their dependants

Real diversity - we will ensure that all staff feel valued and have job satisfaction. We will achieve this by;

- successfully recruiting quality staff from the diverse communities we serve
- successfully retaining staff
- making sure that staff surveys show that;
  - our staff feel they have excellent opportunities for personal and professional development
  - our staff feel that they have achieved an appropriate work-life balance

Staff health and safety - we will continue to support staff to improve and maintain well-being

Active involvement - we will make sure that we play an active part in planning, decision-making and improvements as part of every person's role

- We will carry out appraisals and PDPs (Personal Development Plans) ensuring that individual staff development is directly connected to the organisation's objectives

For service users, carers and the public

Communications and information - we will ensure that everyone who needs to know what the Trust and partner organisations do has easy access to the information that they need.

Being part of/closer to our community - we will make sure that our relationship with the community is mutually beneficial by;

- successfully challenging the stigma associated with mental health and learning disabilities
- making the public aware of mental health and learning disability issues
- making sure people who use our services are helped to find and keep jobs and homes, and are more actively involved in their community

Access - we will make sure that people who use our services are helped to make the right choice and are referred to the right service or pathway first time and then seen without delays. We will achieve this by;

- making sure there are no waiting lists and having simpler arrangements for access
- making sure that we have effective early intervention to enable more people to receive prompt support and avoid unnecessary deterioration in their health
- ensuring that people who use our services are regularly contacted after discharge to ensure that their recovery is continuing satisfactorily
- providing better information which enables people to make healthy choices before they reach crisis

Treating and caring for the individual - we will make sure our service is focused on improving the 'whole life' of individuals by;

- providing access to social and other opportunities
- where appropriate, making sure that families and carers are included as equal partners in the provision of care, leading to improved outcomes

Involvement - we will make sure that people who use our services, carers and the public are given the opportunity to participate fully and contribute directly (as equal partners at every stage of development from concept to application) to improving our standards of response and our services.

Do you have comments or views about our vision for the future?

Partners

Responsiveness - we will demonstrate that we provide services that are responsive to changing service user and carer needs as identified by them

Optimised use of resources - We will deploy resources in a cost-effective way to deliver agreed contracted services with our commissioners.

Deliver against agreed service specifications and contractual requirements - we will meet all the requirements of agreed service specifications

Relationship with Primary Care Practices - We will maintain good working relationships with practice based commissioners so that they recognise us as a preferred provider.

We hope that these far reaching and ambitious goals match the kind of organisation that you would like to see providing mental health and learning disability services over the next five years.

We recognise that these changes will take time to implement but we believe with your support as part of an FT, we can truly make this organisation the 'best'. However, for us to do that we really need to understand your views and would like to hear your comments on our service development plans.

The overall aim of the organisation is to make sure that;

- Service users live to their full potential
- We do things that have been shown to work through evidence; we do them right and can demonstrate this.
- We provide cost effective benefits for our services.
- We are recognised as having an excellent reputation in the local population and nationally in the NHS.

We believe that these strategic aims will allow us to fulfill the following aim; "In 2011 people choose our Foundation Trust because we always deliver the best mental health and learning disability care."

Social Development...

Positive benefits

We are a large local employer and a significant contributor to the local economy as a purchaser of goods and services. We therefore have a duty to behave in an ethical and socially responsible way and to think about how our day-to-day activities can be used to bring about positive benefits.

Corporate social responsibility is all about using our corporate powers and resources in ways that benefit rather than damage the social, economic and environmental conditions in which we live. Who we choose to buy our goods from, what sort of transport policies we have, how we manage energy and waste - all of these issues can make a big difference to people's health and to the well-being of society, the economy and the environment.

We would like to hear your views on which areas we should give priority to.

Our name...

Your views

If our application is successful, then we will need to incorporate 'NHS Foundation Trust' in our name.

As part of coming up with a name we decided that any future name should include both Learning Disability and Mental Health. Additionally, we agreed that the Trust needed to retain the 'Teaching' element in its title to help with recruitment as it was a sign of quality.

We would like to have your views on our proposed new name for the organisation. We organised and had an excellent response to a competition for staff, asking them to provide us with some suggested names.

Do you like the new name?

Leeds Mental Health and Learning Disabilities Teaching NHS Foundation Trust

Gathering your views...

An opportunity for you to have your say

This is an opportunity for you to let us have your views. Our application for Foundation Trust status will be shaped by the comments you let us have.

We will be holding meetings, events and roadshows to spread our message and collect your views. At these events you will have the opportunity to have any questions answered directly by Trust managers.

Details of events will be published on our website and publicised in the local media.

If you would like us to come along to speak at a meeting of your organisation or group, please contact us.

Foundation Trust Membership Office,
Trust HQ,
2150 Thorpe Park,
Century Way,
LS15 8ZB

FTmembership@leedsmh.nhs.uk

0113-3055977

Questions for the consultation

In advance of our application to become a Foundation Trust, we will be conducting a 12 week consultation process. This will involve staff, partners, service users, carers and the wider community.

The consultation runs for the following dates;

- Monday June 26th to
- Monday September 25th 2006

Throughout the document, we have asked you questions about the proposals we have made. To help you respond, we have provided you with freepost reply slips. As well as responding to the specific questions outlined in this consultation document we would also welcome any other views you might have.

To help us keep the cost of the consultation down we would ask you to consider responding to this consultation online. You can find the questions and reply online at:

www.leedsmentalhealth.nhs.uk/foundationtrust/

If you would like this information on audio tape, please call Communications on 0113 30 55977

إذا كنت ترغب في الحصول على أي من المعلومات الواردة في هذه الوثيقة بلغتك الأم يرجى الاتصال على الرقم: ٢٨٩٤ ٢٩٥ ٠١١٣ لأجل الحصول على تفاصيل أخرى.

如果您需要這文件內任何資料於你的方言，請緻電 0113 30 55977 查詢細節。

এই দলিলের যে কোন তথ্য আপনার নিজের ভাষায় পেতে চাইলে, দয়া করে আরো বিস্তারিত খবর-বার্তার জন্যে 0113 30 55977 নম্বরে ফোন করুন।

આ દસ્તાવેજમાં આપવામાં આવેલી કોઇ પણ માહિતી તમારી પોતાની ભાષામાં જોઇતી હોય તો, મહેરબાની કરી વધુ વિગતો માટે 0113 30 55977 નંબર પર ટેલિફોન કરો.

ਇਸ ਦਸਤਾਵੇਜ਼ ਵਿਚ ਦਿੱਤੀ ਕੋਈ ਜਾਣਕਾਰੀ ਜੇਕਰ ਤੁਸੀਂ ਆਪਣੀ ਬੋਲੀ ਵਿਚ ਹਾਸਲ ਕਰਨਾ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਹੋਰ ਜਾਣਕਾਰੀ ਲਈ ਕ੍ਰਿਪਾ ਕਰਕੇ 0113 30 55977 ਨੰਬਰ ਤੇ ਟੈਲੀਫ਼ੋਨ ਕਰੋ।

اگر آپکو اِس دستاویز میں سے کسی بھی معلومات کا اپنی زبان میں ترجمہ درکار ہو تو براہِ مہربانی ٹیلی فون نمبر: 0113 30 55977 پر مزید تفصیلات کے لئے رابطہ قائم کریں۔

Nếu quí vị muốn có, bất cứ tin tức nào trong tài liệu này, bằng ngôn ngữ của quí vị, xin vui lòng gọi điện thoại số 0113 30 55977 để biết thêm chi tiết.

Contact us...

Where can I get more information about the plans to become an NHS Foundation Trust?

A number of documents concerning our plans to be an NHS Foundation Trust have been widely circulated around the area. If you would like to obtain any of these documents, please use the contact details below to get in touch with us.

The views of everyone across the local district about our plans to become an NHS Foundation Trust are very welcome, and we invite you to communicate with us via any of the following means:

- For general enquiries or to obtain more information call the Foundation Trust Membership Office on: 0113 305 5977
- Email: FTmembership@leedsmh.nhs.uk
- Website: Visit our website for the latest news, full copies of relevant documents or to find out more about what being an Foundation Trust means.
  www.leedsmentalhealth.nhs.uk
- Write to:
  Membership Office,
  Leeds Mental Health Teaching NHS Trust,
  2150 Century Way, Thorpe Park,
  Leeds, LS15 8ZB.

If you have special communications needs, please ask a carer or friend to contact us so we can discuss individual requirements.

Designed & Produced by Marketing and Communications
LMHT - Trust Headquarters, 2150 Thorpe Park, Leeds, LS15 8ZB
Tel - +44 (0) 113 305 5900

Ref: 0566

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Leeds CITY COUNCIL

Originator: A Brogden

Tel: 247 4553

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health and Adult Social Care)

Date: 18th September 2006

Subject: Dignity in Care for Older People Inquiry - Draft Terms of Reference

Electoral Wards Affected:	**Specific Implications For:**
	Ethnic minorities ☐
	Women ☐
	Disabled people ☐
	Narrowing the Gap ☐

1.0 Introduction

1.1 At the beginning of the municipal year, Members agreed to carry out an Inquiry into Dignity in Care for Older People.

1.2 At today's meeting, Members will be asked to agree terms of reference for its Inquiry. Draft terms of reference for the Board's Inquiry are attached for Members' consideration.

2.0 Recommendation

2.1 The Board is requested to agree terms of reference for its forthcoming Inquiry into Dignity in Care for Older People.

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SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE)

DIGNITY IN CARE FOR OLDER PEOPLE

TERMS OF REFERENCE

1.0 INTRODUCTION

1.1 High quality health and social care services should be delivered in a person-centred way that respects the dignity of the individual receiving them. However, it is recognised nationally that older people in particular are not always treated with the respect they deserve.

1.2 As the main users of hospital and residential services, the concerns around older people led to the introduction of a National Service Framework for Older People in March 2001. In April 2006 the Department of Health published 'A New Ambition for Old Age', which sets out the second stage of implementing the National Service Framework. In particular, this document prioritises the need to ensure older people are treated with dignity when using health and social care services.

1.3 The Department of Health's definition of dignity is based on the moral requirement to respect all human beings, irrespective of any conditions they may suffer from.

1.4 The Board's Inquiry sets out to further promote the dignity agenda in Leeds and the scope of the Inquiry has been based on the aims set out within the Department of Health's document 'A New Ambition for Old Age'. However, the scope of this Inquiry does not extend to the aims and principles surrounding dignity at the end of life. Whilst part of a continuum of care, it is felt that the complexities and sensitivity surrounding end of life care would justify a separate and more detailed Inquiry. However, references to best practice models used nationally, and being piloted locally, for end of life care of older people will be made during the Inquiry.

1.5 It is important to help create a zero tolerance of lack of dignity in the care of older people, in any care setting. There is a need to inspire and equip local people, be they service users, carers, relatives or care staff with the information, advice and support they need to take action to drive up standards of care with respect to dignity for the individual.

2.0 SCOPE OF THE INQUIRY

2.1 The aim of the review is to make an assessment of and, where appropriate, make recommendations on:

- the measures in place, or needed, to help raise awareness of the dignity agenda amongst health and social care providers, staff and other stakeholders;
- whether the needs of older people within local hospitals and care homes are being met, with particular reference to their nutrition, privacy and physical environments;

- the measures in place, or needed, to ensure particular vulnerable groups, such as older people with mental health problems, are treated with respect for their dignity;
- the skills, competence and leadership needs of the workforce to ensure that older people are treated with respect for their dignity;
- the attitudes of staff, particularly when communicating with older people.
- older people with long-term conditions and personal care needs having their specific needs met while receiving care for other reasons in any health or social care setting
- the role of inspectorates and regulators in ensuring the issue of dignity is central to their work, so that breaches of dignity are regarded as serious failures;
- relevant complaints procedures and whistle blowing policies;
- the links to the wider Government work on equalities and human rights.

3.0 COMMENTS OF THE RELEVANT DIRECTOR AND EXECUTIVE MEMBER

3.1 In line with Scrutiny Board Procedure Rule 12.4 the views of the relevant Director and Executive Member have been sought and have been incorporated where appropriate into these Terms of Reference. Full details are available on request to the Scrutiny Support Unit.

4. STRUCTURE FOR THE REVIEW

4.1 It is proposed that a range of approaches to evidence gathering are used in this Inquiry, including the following:

- Full meetings of the Scrutiny Board to consider evidence and question key witnesses

- Discussion with key partners, stakeholders and carers

- Visits to selected establishments to engage with service users and staff

4.2 The Inquiry will conclude with the publication of a report and recommendations by the Scrutiny Board that will be submitted to the appropriate forum.

5. SUBMISSION OF EVIDENCE

5.1 This timetable is subject to change depending upon the outcome of the initial evidence gathering sessions.

5.2 The following formal evidence gathering sessions are scheduled.

5.3 **Site visits – to be carried out during November/December 2006**

5.4 **Session One: Scrutiny Board (Health and Adult Social Care) Meeting – 20th November 2006**

The purpose of this session is to:

- Consider what measures are being used, or needed, to help raise awareness of the dignity agenda amongst health and social care providers, staff and other stakeholders;
- Consider the skills, competence and leadership needs of the workforce to ensure that older people are treated with respect for their dignity;
- Consider the links to the wider Government work on equalities and human rights.

5.5 **Session Two: Scrutiny Board (Health and Wellbeing) Meeting – 22nd January 2007**

The purpose of this session is to:

- share feedback from the site visits carried out;
- explore whether the needs of older people within local hospitals and care homes are being met, with particular reference to communication,, personal assistance, nutrition, privacy and physical environments;
- consider the measures in place, or needed, to ensure particular vulnerable groups, such as older people with mental health problems, are treated with respect for their dignity;
- consider the relevant complaints procedures and whistle blowing policies;
- consider the role of inspectorates and regulators in ensuring the issue of dignity is central to their work, so that breaches of dignity are regarded as serious failures.

5.6 **Session Three: Scrutiny Board (Health and Wellbeing) Meeting – 19th March 2007**

To consider the Board's draft final report

6. WITNESSES

6.1 The following witnesses have been identified as possible contributors to the Inquiry:

- Leeds Primary Care Trust
- Leeds Teaching Hospitals NHS Trust
- Leeds Mental Health Teaching NHS Trust
- Leeds Social Services Department
- Older People's Modernisation Team
- Leeds Carers Association
- Older People's Forum
- Relatives and Residents Association
- Older People's Modernisation Team
- Older People's Champions
- Relevant inspectorates/regulators including the Commission for Social Care Inspection and the Healthcare Commission

7.0 POST INQUIRY REPORT MONITORING ARRANGEMENTS

7.1 Following the completion of the Scrutiny inquiry and the publication of the final inquiry report and recommendations, the implementation of the agreed recommendations will be monitored. The Scrutiny Board will determine those arrangements at the end of the Inquiry.

7.2 The final inquiry report will include information on the detailed arrangements for how the implementation of recommendations will be monitored.

8.0 MEASURES OF SUCCESS

8.1 It is important to consider how the Scrutiny Board will deem if its inquiry has been successful in making a difference to local people. Some measures of success may be obvious at the initial stages of an inquiry and can be included in these terms of reference. Other measures of success may become apparent as the inquiry progresses and discussions take place.

8.2 The Committee will look to publish practical recommendations.

Leeds CITY COUNCIL

Originator: A Brogden

Tel: 247 4553

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health and Adult Social Care)

Date: 18th September 2006

Subject: Work Programme

Electoral Wards Affected:	**Specific Implications For:**
	Ethnic minorities ☐
	Women ☐
	Disabled people ☐
	Narrowing the Gap ☐

1.0 Introduction

1.1 A copy of the Board's current work programme is attached for Members' consideration. The programme reflects changes agreed at the last meeting of the Board.

2.2 Also attached to this report is the current Forward Plan of Key Decisions (appendix 2) and the latest minutes of the Corporate Priority Board for Health and Wellbeing (appendix 3). These will give members an overview of current activity within the Board's portfolio area.

2.0 Recommendations

2.1 The Board is requested to agree the attached work programme subject to any decisions made at today's meeting.

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SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE) – LAST UPDATED 24th JULY 2006

ITEM	DESCRIPTION	NOTES	DATE ENTERED INTO WORK PROGRAMME
Meeting date: 23rd October 2006 - The deadline for reports for this meeting is 10.00am on Friday 6th October 2006			
Making Leeds Better Pre-Consultation Engagement Process	To receive a briefing from the Making Leeds Better Programme Team on the pre-consultation engagement process.		
Challenging Age Discrimination Scrutiny Group	To receive a quarterly update report from the Challenging Age Discrimination Scrutiny Group.		
Partnership for Older People's Projects (POPPs) – progress report	To receive a progress report on the implementation of the Leeds POPPs programme.		
Meeting date: 20th November 2006 - The deadline for reports for this meeting is 10.00am on 3rd November 2006			
Action Learning Project – Community Development in Health and Wellbeing	To receive evidence in line with session three of the Board's action learning project.		
Presentation from the new Leeds Primary Care Trust	To receive a presentation from the Chief Executive of the new Leeds Primary Care Trust.		19.06.06
Dignity in Care for Older People	To receive evidence in line with session one of the Board's Inquiry	Subject to confirmation	

SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE) – LAST UPDATED 24th JULY 2006

Meeting date: 18th December 2006 - The deadline for reports for this meeting is 10.00am on Friday 1st December 2006			
Making Leeds Better Pre-Consultation Engagement Process	To receive a further briefing from the Making Leeds Better Programme Team on the pre-consultation engagement process.		
Leeds Mental Health Teaching NHS Trust – Fire Safety Standards	To receive a further update report from the Trust following its independent fire safety review in April/May 2006.		24.07.06
Meeting date: 22nd January 2007 - The deadline for reports for this meeting is 10.00am on Friday 5th January 2007			
Action Learning Project – Community Development in Health and Wellbeing	To receive evidence in line with session four of the Board's action learning project.		
Challenging Age Discrimination Scrutiny Group	To receive a quarterly update report from the Challenging Age Discrimination Scrutiny Group.		
Dignity in Care for Older People	To receive evidence in line with session two of the Board's Inquiry	Subject to confirmation	

SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE) – LAST UPDATED 24th JULY 2006

Meeting date: 19th February 2007 - The deadline for reports for this meeting is 10.00am on Friday 2nd February 2007			
Food Law Enforcement Service Plan and Food Strategy	To consider the draft Plan in line with the Budget and Policy Framework		
Adult Day Services Review – Update	To receive an update report following the Board's earlier review of Adult Day Services.		
Inquiry into Childhood Obesity – Update from Children Leeds	To receive a report from Children Leeds on the progress made in delivering the new Leeds Childhood Obesity Strategy.		
Meeting date: 19th March 2007 - The deadline for reports for this meeting is 10.00am on Friday 2nd March 2007			
NHS Annual Health Check	To consider reports from each of the local NHS Trusts on the NHS Annual Health Check process.		
Action Learning Project – Community Development in Health and Wellbeing	To consider the Board's draft final report.		
Meeting date: 23rd April 2007 - The deadline for reports for this meeting is 10.00am on Friday 6th April 2007			
Annual Report	To approve the Board's draft annual report		
NHS Annual Health Check – Draft Comments of the Board	To consider and agree the comments of the Board in line with the NHS Annual Health Check process.		

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Appendix 2

LEEDS CITY COUNCIL

FORWARD PLAN OF KEY DECISIONS

EXTRACT RELATING TO THE SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE)

For the period 1 September 2006 to 31 December 2006

Key Decisions	Decision Maker	Expected Date of Decision	Proposed Consultation	Documents to be Considered by Decision Maker	Lead Officer (To whom representations should be made)
Making Leeds Better - Strategic Services Plan To approve the plan outlines and note the intention to proceed to public consultation	Executive Board (Portfolio: Adult Health and Social Care)	20 Sep 2006	Outlining steps to be taken for consultation	The report to be issued to the decision maker with the agenda for the meeting	Chief Social Services Officer
Resource Centres for Disabled People - Commissioning	Executive Board (Portfolio: Adult Health and Social Care)	20 Sep 2006	Follows previous report submitted in February 2006	The report to be issued to the decision maker with the agenda for the meeting	Chief Social Services Officer

Key Decisions	Decision Maker	Expected Date of Decision	Proposed Consultation	Documents to be Considered by Decision Maker	Lead Officer (To whom representations should be made)
Social Services Charging Review To approve the charging policy framework for Social Services and charges for a three year period from April 2006	Executive Board (Portfolio: Adult Health and Social Care)	18 Oct 2006	Service user and carer groups / forum. Voluntary organisations representing service users and carers. Briefing for members and staff	The report to be issued to the decision maker with the agenda for the meeting	Chief Social Services Officer
Day Services for Older People - Commissioning To approve recommendations arising from stakeholder consultation	Executive Board (Portfolio: Adult Health and Social Care)	18 Oct 2006	Follows previous report submitted in February 2006	The report to be issued to the decision maker with the agenda for the meeting	Chief Social Services Officer

NOTES

Key decisions are those executive decisions:

- which result in the authority incurring expenditure or making savings over £500,000 per annum, or
- are likely to have a significant effect on communities living or working in an area comprising two or more wards

Executive Board Portfolios	Executive Member
Central and Corporate	Councillor Mark Harris
Development	Councillor Andrew Carter
City Services	Councillor Steve Smith
Neighbourhoods and Housing	Councillor John Leslie Carter
Leisure	Councillor John Procter
Children's Services (Lead)	Councillor Richard Brett
Children's Services (Support)	Councillor Richard Harker
Adult Health and Social Care	Councillor Peter Harrand
Customer Services	Councillor David Blackburn
Leader of the Labour Group	Councillor Keith Wakefield
Advisory Member	Councillor Judith Blake

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Leeds City Council Corporate Board for Health & Wellbeing

Minutes

From : Mike Simpkin, Social Services, 2474306
Date of Meeting **9th August 2006** **Meeting 22**

Present:

Learning and Leisure	John Davies, Director of Adult Services (Chair)
Social Services	John England, Lead Chief Officer Adult Services
	Mike Simpkin, Public Health Strategy Manager
City Services	Julie Meakin
Neighbourhoods & Housing	Alan Sherwood, Health Development Manager, EHS
Education Leeds	John Freeman, Team Leader (Health Initiatives),
Chief Executive's Unit	Elaine Rey, Senior Project Officer
Corporate Services	Chris Ingham, Human Resources Manager
Directors of Public Health	Dr Ian Cameron NWPCT

Apologies

Learning and Leisure	Mark Allman, Head of Sport and Active Recreation
Development	Dr Tom Knowland, Head of Sustainable Development
Neighbourhoods & Housing	Helen Freeman Chief EHO,
	Christine Addison Area Manager NW
Social Services	Jim Wilson (Interim Chief Social Services Officer)

Item **Action**

1 MINUTES

i) Minutes of the meeting on 7th June were agreed.

ii) Matters Arising

a) **LAA / Ministerial Visit:** MS and IC updated the Board on progress of the Healthier Communities block up to the 6 month Review. The Board noted that the current Block was divided into two workstreams around Older People and Employability, reflecting the priorities agreed last year. However the government is putting increased expectations on the LAA mechanism which is expected to react to the broader range of priorities within Healthy Communities. It was agreed that a reconvening of a broader meeting in October/November (about the time of the Government Review) would help reassess the practicable scope of the Healthier Communities and Older People block of the LAA. **MS IC**

Lord Hunt is still expected on 21st September at the Healthy Leeds Partnership. The agenda is centred around implementation of the national strategy Health Work and Wellbeing, Caring for Our Future and the possible contribution of LAAs. The Board discussed representation and suggested Alan Gay be also invited. Lord Hunt has indicated interest in a regional group and the Board supported this if it adds value. **MS CI HF**

The Board also noted that a Leeds Conference on "Managing Attendance, Promoting Wellbeing" is being arranged for November 15th. **TK**

b) **Strategic Environmental Assessment:** The meeting between TK and colleagues has been delayed because of leave but will be convened shortly. **CA**

c) **Area Management / Health in District Priorities.** A discussion took place at the Area Managers meeting in July but we await the outcome.

d) **Strategy Launches**: Older Better and the Mental Health Strategy were launched in July. The Food Strategy will be launched Sept 7th and the Tobacco Control Strategy on Sept 15th.

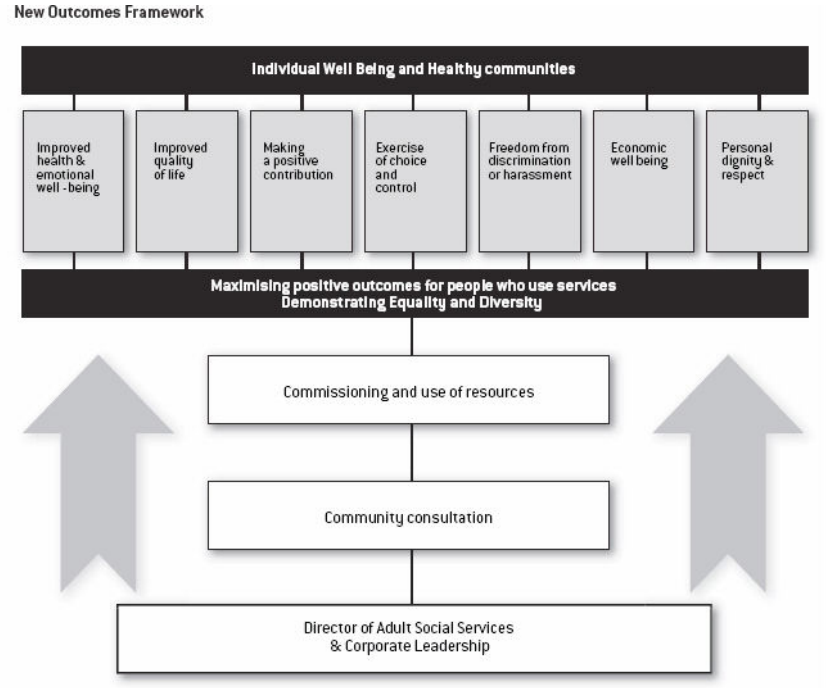
e) **Big Lottery Fund:** A regional bid for £25m including a significant sum for Leeds was submitted to the BLF on 28th July. A regional bid has also been submitted by a grouping of Healthy Living Centres. Only one regional bid is likely to be successful but it is likely that these bids may be amalgamated.

f) **Scrutiny Action Learning Inquiry into Community Development.** Terms of Reference were submitted for comment. It was suggested that North West Homes (ALMO) were included to look at how they were promoting initiatives such as physical activity. It was also noted that there seemed to be no reference to Children and Young People. Facilities such as extended schools, Hunslet Lake, Sure Starts should at least be referenced and Sally Threlfall informed; Youth Forums should also be consulted. MS to send these comments to Scrutiny.

g) **Making Leeds Better timetable:** JE confirmed slippage to this timetable with formal consultation on the Business Case probably not taking place until March. However engagement and Health Impact Assessment event are planned for October and November – including papers to LCC Area Committees. However there is a degree of concern about the possible financial impact on the delivery of health and social care services as expectations expand. **MS**

2 DASS FORMAL GUIDANCE

JD took the meeting through the guidance noting that the differences between the formal framework and the best practice guidance. The new framework with seven outcomes is illustrated below:



A CSCI consultation on performance assessment includes Leadership and Commissioning as part of the Inspection process. It also sets out key lines of inquiry including how authorities may be graded in relation to the health and

wellbeing outcome. A paper will go to the September Executive Board outlining progress.

3 JOINT DPH / PUBLIC HEALTH TRANSITION

JD reported that the LCC Chief Executive had just recently met with Margaret Edwards, the new Chief Executive of the Strategic Health Authority and had subsequently written to her expressing disappointment at the lack of practical involvement of the Council in the PCT transition process. He confirmed the work which is being done to support collaboration at local level following the joint workshop in May and commented that to set up a new Joint Director of Public Health by October was neither feasible nor desirable.

In accordance with the Action Plan agreed after the workshop, a joint group has been convened to make recommendations in relation to a joint public health structure for September. The first meeting will be on 23rd August. **JE**

IC reported that all regional DsPH are having to go through an assessment panel. The appointment process is still not clear but it seems that PCTs are expected to have DsPH in place in October.

The transition work reported at the last meeting is being pulled together. MS asked in particular about the work on partnerships; however this has been delayed owing to the temporary unavailability of the group leader. IC will feed back as soon as he can. **IC**

4 COUNCIL PLAN AND PERFORMANCE MANAGEMENT

ER submitted performance templates previously circulated for Q1 of the new Council Plan. Board Members were asked to check that attributions were accurate and to complete such data as is available. **ALL** ER also submitted the available PAF scores and a draft accountability report which was approved. **ER**

5 CONSULTATIONS

i) LMHT Foundation Trust: Although Health Scrutiny is the formal consultee it is not clear who else within LCC has been involved. Foundation Trusts are significant issues for the Council in many different ways – including Membership – LMHT is aiming for up to 40000 members. MS to contact scrutiny to find out what consultation they may have undertaken within LCC, and especially among elected Members. **MS**

ii) A Stronger Local Voice – Patient and Public Involvement

This major consultation proposes that local authorities are empowered and funded to commission organisations to host local networks to stimulate, facilitate and co-ordinate local networks for patient and public involvement. These will succeed Patient Forums which in turn were preceded by Community Health Councils. Again the lead for the LCC response falls to Scrutiny but there is not another meeting before the consultation ends on 7th September. The Chair of Scrutiny will authorise a response but so far it has elicited little interest. This is a major new role for local authorities and IC pointed out that for the first time, and to reflect joint commissioning, social care is drawn within the remit. It was noted that the commissioning of the LINks will need to be independent of Social Services. There are also implications for the role of scrutiny itself. It was agreed to recommend that LCC should highlight issues of potential concern. MS to discover any LGA view and MS/JE to liaise with scrutiny **MS JE**

Item		Action
iii)	**Health Bill (Smokefree regulations):** The consultation on regulations and exemptions lasts until 9th October. LCC has the opportunity to comment on practical implications. CI explained that after the initial clearing of tobacco use from all main council buildings there is to be further consultation in areas which present special problems – including residential premises and hospitality areas. Central HR take the view that this needs to be taken forward by individual departments with support from the centre. It was felt that this work had possibly fallen into a gap and that relevant DMTs (especially SSD and Leisure Services) needed to consider how to take further steps especially in light of the regulations and exemptions now proposed. SSD also needed to consider the impact on its contracts with the private sector. It would also be possible to feed back comments on the regulations before October. MS to draft a note from the Board to DMTs. Board members to raise the issue.	**MS JE MA CI**
	IC also raised a related consultation on the banning of tobacco sales to young people under 18 (instead of 16 as at present). MS and JF to consider whether LCC should be recommended to support this. Action on Proof of Age has been held up because of inconsistencies between Area Committees.	**MS JF**
iv)	**Regional Spatial Strategy (Examination in Public):** MS reported that he had been involved through GOYH with a small regional group looking at the health impact of the proposed RSS. The significance of the RSS is that is determines the context for Local Development Frameworks and the draft will be subject to public examination by inspectors during the next two months. There are a number of significant issues both in general and in relation to health facilities and the health economy. However there were also differences in emphasis from comments LCC Development Department had made. MS had agreed to take part provided it was as part of a regional public health group and had been in touch with Development in order to maximise consistency.	**MS**
6	**NRF JOINT PUBLIC HEALTH INFORMATION PROJECT**	
	Board Members need to be aware of this NRF funded project whose objective is to work on more sophisticated analysis of health-related data than we are able to produce at present, and to issue a citywide health inequalities report by the end of March 07. The grant from the 06/07 NRF round was to fund a one year Public Health Information Analyst working to the Joint Public Health Information and Intelligence Group (co-chaired by NWPCT and MS) and based in NWPCT. Unfortunately this appointment, though temporary, got caught up in the PCT vacancy freeze and has even now only been partially released as a 6 month secondment. It seems likely that the work may now have to be accomplished through a series of commissions. The first of these, from the Y&H Public Health Observatory on the fitness of our data systems to set targets and assess progress is due in mid September. It is hoped that this report will be helpful across the spectrum of local partnership working for health.	**MS**
7	**CORPORATE PRIORITY BOARD SELF ASSESSMENTS**	
	Item deferred as current expectations for self-assessment have not yet been clarified by the Corporate Centre.	**ER**
8	**FUTURE MEETING SCHEDULE**	
	The next meetings have not yet been scheduled because of difficulties in finding a date. MS to liaise with ER on the reporting cycle. The next meeting will be mid to late October	**MS ER**