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Leeds CITY COUNCIL

# SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE)

**Meeting to be held in Committee Rooms 6 and 7, Civic Hall, Leeds on Monday, 21st January, 2008 at 10.00 am**

## MEMBERSHIP

### Councillors

| | | |
|---|---|---|
| J Bale | - | Guiseley and Rawdon |
| J Chapman (Chair) | - | Weetwood |
| J Dowson | - | Chapel Allerton |
| G Driver | - | Middleton Park |
| P Ewens | - | Hyde Park and Woodhouse |
| J Illingworth | - | Kirkstall |
| M Iqbal | - | City and Hunslet |
| G Kirkland | - | Otley and Yeadon |
| M Rafique | - | Chapel Allerton |
| L Russell | - | Farnley and Wortley |
| P Wadsworth | - | Roundhay |

### Co-opted Members

| | | |
|---|---|---|
| J Fisher | - | Alliance of Service Users and Carers |
| E Mack | - | Leeds Voice Health Forum Co-ordinating Group |
| L Wood | - | Leeds Patient and Public involvement Forums |


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**LEEDS LS1 1UR**

**Principal Scrutiny Adviser:**
**Debbie Chambers**
**247 4792**

# A G E N D A

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| 1 | | | **APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS**<br><br>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**<br><br>To identify items where resolutions may be moved to exclude the public | |
| 3 | | | **LATE ITEMS**<br><br>To identify items which have been admitted to the agenda by the Chair for consideration.<br><br>(The special circumstances shall be specified in the minutes) | |
| 4 | | | **DECLARATIONS OF INTEREST**<br><br>To declare any personal / prejudicial interests for the purpose of Section 81(3) of the Local Government Act 2000 and paragraphs 8 to 12 of the Members Code of Conduct. | |
| 5 | | | **APOLOGIES FOR ABSENCE** | |
| 6 | | | **MINUTES**<br><br>To approve as a correct record the minutes of the meeting held on 17 December 2007. | 1 - 6 |
| 7 | | | **EXECUTIVE BOARD MINUTES**<br><br>To note the minutes of the Executive Board held on 19th December 2007. | 7 - 14 |

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| 8 | | | **OVERVIEW AND SCRUTINY MINUTES**<br><br>To note the minutes of the Overview and Scrutiny Committee held on 6 November 2007 and 11 December 2007. | 15 - 24 |
| 9 | | | **INQUIRY INTO THE LOCALISATION OF HEALTH AND SOCIAL CARE SERVICES - SESSION 2**<br><br>A report from the Head of Scrutiny and Member Development introducing the second session of the Board's Inquiry. | 25 - 82 |
| 10 | | | **LEEDS PARTNERSHIPS FOR OLDER PEOPLE PROJECTS (POPPS) - AN UPDATE**<br><br>A report to provide Scrutiny Board with a review of the POPPs Programme, including the performance, evaluation and governance arrangements and assessment of progress to date. | 83 - 116 |
| 11 | | | **LEEDS STRATEGIC PLAN AND COUNCIL BUSINESS PLAN: OUTCOMES AND PRIORITIES**<br><br>To consider a report from the Assistant Chief Executive (Planning, Policy and Improvement) outlining progress to date with the development of the Leeds Strategic Plan and Council Business Plan. | 117 - 128 |
| 12 | | | **A LOCAL INVOLVEMENT NETWORK (LINK) FOR LEEDS - AN UPDATE**<br><br>A briefing from the Director of Adult Social Services, to provide Members with an update on progress with a LINk for Leeds. | 129 - 138 |
| 13 | | | **WORK PROGRAMME**<br><br>To receive a report from the Head of Scrutiny and Member Development on the Board's Work Programme for the forthcoming Municipal Year. | 139 - 146 |

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| 14 | | | **DATE AND TIME OF NEXT MEETING**<br><br>Monday, 18 February 2008 at 10.00 a.m. (Pre-meeting for all Members at 9.30 a.m.). | |

**SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE)**

**MONDAY, 17TH DECEMBER, 2007**

**PRESENT:** Councillor J Chapman in the Chair

Councillors J Dowson, G Driver, P Ewens, J Illingworth, G Kirkland and P Wadsworth

| | | | |
|---|---|---|---|
| **CO-OPTEES:** | J Fisher | - | Alliance of Service Users and Carers |
| | E Mack | - | Leeds Voice Health Forum Co-ordinating Group |
| | S Morgan | - | Equalities |
| | L Wood | - | Leeds Patient and Public involvement Forums |

## 74 Declarations of interest

Councillor Chapman declared a personal interest in Agenda Item 11, Inquiry into the Localisation of Health and Social Care Services – Area Committee Session, due to her role in the Area Management Review and preparation of the report 'Making a Bigger Difference in Localities – Proposals to Develop Area Management and Area Committees in Leeds'. (Minute no 82 refers).

Councillor Kirkland declared a personal interest in Agenda Item 11, Inquiry into the Localisation of Health and Social Care Services – Area Committee Session, due to his membership of the Wharfedale Hospital Forum. (Minute no. 82 refers).

Councillor Illingworth declared a personal interest in Agenda Item 9, Commissioning Strategy for Adult Social Care due to his wife's position as Chair of the Bethel Day Centre Management Committee. (Minute no.80 refers).

## 75 Apologies for Absence

Apologies for absence were submitted on behalf of Councillors Bale, Iqbal, Rafique and Russell.

## 76 Minutes

**RESOLVED –** That the minutes of the meeting held on 19 November 2007, be confirmed as a correct record subject to the inclusion of Sally Morgan under those in attendance.

## 77 Matters Arising from the Minutes

Minute No.62 – A Local Involvement Network (LINk) for Leeds
It was reported that a funding figure of £300,000 per year for the next 3 years had now been agreed for the LINk.

Minute No.65 – Co-option to the Scrutiny Board (Health and Adult Social Care)
It was reported that there was still a vacancy for another Co-optee to the Board. Members discussed various organisations that may wish to be represented. The Principal Scrutiny Adviser would report back at the January meeting.

**78 Executive Board Minutes**

In response to a question regarding progress updates at Terry Yorath House, it was reported that this would be reported under Agenda Item 10, Recommendation Tracking.

**RESOLVED –** That the minutes of the Executive Board held on 14 November 2007 be noted.

**79 Overview and Scrutiny Minutes**

With regard to Direct Payments, the Board was informed that a decision had not yet been taken as to whether an Inquiry into Direct Payments would be undertaken and whether such an Inquiry would be carried out by this Board or the Overview and Scrutiny Committee.

**RESOLVED –** That the minutes of the Overview and Scrutiny Committee held on 9 October 2007 be noted.

**80 Commissioning Strategy for Adult Social Care**

The Head of Scrutiny and Member Development submitted a report in line with the Board's previous request to receive a quarterly update on the development of a Commissioning Strategy for Adult Social Care.

The Chair welcomed the following to the meeting.

- Dennis Holmes, Chief Officer – Commissioning
- Tim O'Shea, Head of Commissioning
- Wayne Baxter, Chief Procurement Officer

Dennis Holmes gave the Board an update on current commissioning activity in Social Care. He highlighted the following areas:

- Personalisation – how to ensure that support responded to the need of individuals.
- Commissioning locally based activity.

- The resources that Adult Social Services puts into non-statutory activities each year.

Concern was expressed that some voluntary organisations were worried about funding drawing to a close from fixed term funding streams such as the lottery. Adult Social Services had not withdrawn any funding although it was recognised that the Council did not have the resources to replace funding withdrawn from other sources.

In response to comments that Neighbourhood Network services were unevenly distributed across the City and whether gaps could be addressed, it was reported disparities had been recognised by Adult Social Services. Close engagement was needed with all the Neighbourhood Networks to address issues such as distribution of funds and to understand the added value they brought to services. It was noted that Leeds was one of only a few local authority areas that had Neighbourhood Networks.

It was reported that the Commissioning Strategy provided a challenge in terms of procurement and that key stakeholders would be invited to participate in the development. There were ways in which the Council could give support to the Voluntary, Community and Faith Sector through procurement, such as negotiation with suppliers.

Further issues discussed in relation to Members questions and comments included the following:

- The procurement unit's work with the local third sector to help "de-mystify" the procurement process and assist with the paperwork involved.
- Risk Management – it was reported that the next report regarding commissioning could address the issue of risk.
- That quality of care was important as well as value for money.
- Direct Payments and releasing funds to give to individuals to use for their own care.

**RESOLVED –** That the report be noted and that the next report, due in March 2008, specifically address risk factors and risk management.

**81 Recommendation Tracking**

The Head of Scrutiny and Member Development submitted a report which provided Members with a progress update on recommendations of previous Inquiries and issues scrutinised by the Board.

The following issues/inquiries were detailed in the report:

- Childhood Obesity Prevention and Management
- Dignity in Care
- NHS Dental Contract in Leeds
- Terry Yorath House

The Chair welcomed Janice Burberry of Leeds PCT, who was present to discuss the progress following the Board's Inquiry into Childhood Obesity.

It was reported that important progress had been made with the PCT endorsing the Leeds Childhood Obesity Strategy and Education Leeds making it a priority issue. Significant amounts of funding had been made available to tackle childhood obesity issues and key members had been recruited to the Leeds Childhood Obesity Strategy Group.

In response to Members' comments and questions the following issues were discussed in relation to the Childhood Obesity Inquiry:

- How to identify high risk communities and recognise obesity hotspots.
- Engagement of the Development Department and Planners as a long term objective.
- Healthy transport.
- The role of the Healthy Schools Programme and Leeds Play Network/Play Strategy.

Members requested an update on progress with the "State of Play" report, proposed in the Leeds Play Strategy.

With regard to the Inquiry into Dignity in Care, it was reported that all recommendations of the Inquiry had now been achieved or had seen acceptable progress made. Concern was expressed that isolated incidences of treatment without dignity may not be picked up on.

Members discussed the responses to the recommendations into the Inquiry into the NHS Dental Contract in Leeds. Concern was expressed over the following:

- Funding for 2009 not known – Members would wish to see an increase in funding.
- Lack of accessible dental services for disabled people.
- Whether spending on units of dental activity had actually reduced since the five Leeds PCTs were replaced with one PCT.

Regarding Terry Yorath House, Members asked that an update report be provided to the Board once the twin track approach decided upon was fully in place.

**RESOLVED –** That the report be noted and that:

- An update on progress with the "State of Play" report be requested for the March 2008 Board meeting
- the Chair write to the PCT regarding the Board's concerns about dentistry
- an update be provided to the Board regarding developments at Terry Yorath House in six months time.

## 82 Inquiry into the Localisation of Health and Social Care Services - Area Committee Session

The report of the Head of Scrutiny and Member Development highlighted the request of the Board to involve Area Committees in the Localisation of Health and Social Care in Leeds Inquiry and to receive information and their views about the relationships between Area Committees and local NHS Trusts.

The Chair welcomed the following to the meeting:

- Councillor E Minkin, North West Inner Area Committee
- Councillor C Campbell, North West Outer Area Committee
- Councillor B Anderson, North West Outer Area Committee
- Councillor C Fox, North West Outer Area Committee
- Jason Singh, Acting North West Area Manager

In brief summary, the following issues were discussed:

- Importance of the Councillor's role and the need for communication – Examples of a ward closure and sale of NHS trust land were cited as cases where Councillors were not kept informed.
- How Area Committees and Councillors could be involved in the decision making process.
- Localisation of services was not just a geographical issue. It also called for community engagement.
- People would like more involvement in the provision of health services.

The Chair reported that she was due to meet with Maggie Boyle, Chief Executive, Leeds Teaching Hospitals NHS Trust and Christine Outram, Chief Executive, Leeds PCT later in the week and would talk to them about progressing the localisation inquiry at that meeting.

**RESOLVED –** That the report be noted.

## 83 Work Programme

The Head of Scrutiny and Member Development submitted a report which detailed the Board's Work Programme for the 2007/08 Municipal Year.

Members discussed the following issues in relation to the Work Programme:

- The South Area Committees would be scheduled to attend a meeting regarding the Localisation Inquiry.
- Possible Site Visits – Wharfedale Hospital and Otley Clinic, Beeston Hill Medical Centre, Middleton Park Avenue, Yeadon Health Centre

were preferred, with possibly Middlecross Day Centre or Burley Willows if time allowed.

- A further Recommendation Tracking report to be brought in March 2008.
- LINks – The Board was informed of peer support that had been offered by the Centre for Public Scrutiny.
- The NHS Annual Health Check for local NHS Trusts and the Yorkshire Ambulance Service.
- Monitoring progress with the regional Big Lottery Funded "Altogether Better" project.
- Teenage Pregnancy
- Day Services for Sikh Older People in Leeds
- Healthy Learning Centres

**RESOLVED –** That the current Work Programme be agreed and amended to reflect issues raised at the meeting.

## 84 Date and Time of Next Meeting

Monday, 21 January 2008 at 10.00 a.m. (pre-meeting for all Board Members at 09.30 a.m.)

**EXECUTIVE BOARD**

**WEDNESDAY, 19TH DECEMBER, 2007**

**PRESENT:** Councillor A Carter in the Chair

Councillors R Brett, J L Carter, R Finnigan, S Golton, R Harker, P Harrand, J Procter, S Smith, K Wakefield and J Blake

**125 Chair's Opening Remarks**

The Chair welcomed Councillor Golton to his first meeting of the Executive Board.

**126 Exclusion of Public**

**RESOLVED** – That the public be excluded from the meeting during consideration of the following parts of the agenda designated as exempt on the ground that it is likely, in the view of the nature of the business to be transacted or the nature of proceedings, that if members of the public were present there would be a disclosure to them of exempt information so designated as follows:

(a) The appendix to the report referred to in minute 139 under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that the public interest in maintaining the exemption outweighs the public interest in disclosing the information by reason of the fact that it contains commercially sensitive information which, if disclosed, could be prejudicial to contract negotiations.

**127 Declarations of Interest**

Councillor Wakefield declared a personal interest in the item relating to the Children's Services Annual Performance Assessment and half year update on progress and performance (Minute 135) as a member of the Learning and Skills Council and as a Governor of Ashtree School and Brigshaw School.

Councillor Harker declared personal interests in the items relating to North and South Gipton Children's Centres (Minute 133), Leeds Building Schools for the Future (Minute 134) and the Children's Services Annual Performance Assessment and half year update on progress and performance (Minute 135) as a governor of Moortown Primary School and a member of the Children Leeds Partnership. He also declared personal interests in the items relating to the Leeds Local Development Framework Annual Monitoring Report 2007 (Minute 141) and the proposed changes to the Regional Spatial Strategy (Minute 142) as a Trustee of the Thackray Medical Museum which is sited on the edge of the proposed EASEL Area Action Plan.

Councillor Brett declared a personal interest in the item relating to the Annual Performance Report for Adult Social Care (Minute 136) as a member of Burmantofts Senior Action Management Committee.

Councillor Smith declared personal interests in the items relating to the Home Energy Conservation Act (Minute 130) and the Leeds Climate Change Strategy (Minute 145) as a member of Greenpeace.

Councillor Golton declared a personal interest in the item relating to Options for Building Council Houses (Minute 131) as a member of Aire Valley Homes.

Councillor Andrew Carter declared a personal interest in the item relating to Options for Building Council Houses (Minute 131) as a member of the ALMO Outer West Area Panel.

Councillor Harrand declared a personal interest in the item relating to the Annual Performance Report for Adult Social Care (Minute 136) as a governor of the Leeds Mental Health Trust and a member of Moor Allerton Elderly Care.

Councillor Blake declared personal interests in the items relating to Options for Building Council Houses (Minute 131) as a member of the Belle Isle North Estate Management Group; Children's Services Annual Performance Assessment and half year update on progress and performance (Minute 135) as a non executive director of Leeds North West Primary Care Trust. Councillor Blake also declared a personal interest in the item relating to the Annual Performance Report for Adult Social Care (Minute 136) as a member of Middleton Elderly Aid.

**128 Minutes**

**RESOLVED –** That the minutes of the meeting held on 14th November 2007 be approved as a correct record.

**NEIGHBOURHOODS AND HOUSING**

**129 Queenswood Heights Tenant and Residents Association**

The Director of Environment and Neighbourhoods submitted a report responding to the deputation from Queenswood Heights Residents Association to full council on 31st October 2007.

**RESOLVED** – That the report be noted.

**130 Home Energy Conservation Act 11th Report**

The Director of Environment and Neighbourhoods submitted a report presenting the 11th Progress Report as required under Section 2 of the Act.

**RESOLVED –** That the report be noted.

**131 Options for Building Council Houses**

The Director of Environment and Neighbourhoods submitted a report on options available to the Council for the building of homes.

**RESOLVED** –

(a) That the Director of Environment and Neighbourhoods work with other officers as appropriate to bring forward the results of work on the following points to the March 2008 meeting of this Board:

- Explore Housing Corporation grant to two star ALMOs from 2008/9
- Review the availability of land for housing development
- Review Council contributions via the capital programme and capital receipts from Council owned land
- Explore other public sector land in government ownership made available to the Council to support development initiatives
- Lobby government to retain income streams to fund borrowing from rents on existing and new build

(b) That an early report be submitted upon the identification of a suitable site for a small scale scheme

## DEVELOPMENT AND REGENERATION

**132 Deputation to Council - Local Residents concerned about Britannia Quarry**

The Director of City Development submitted a report in response to the deputation made to Council on 29th October 2007 by local residents concerned about Britannia Quarry, Morley.

**RESOLVED** – That it be noted that the site will continue to be monitored on a similar frequency to other minerals and waste sites within Leeds and that where breaches of the planning permission are identified, enforcement action will be taken where it is considered by officers expedient to do so.

## CHILDREN'S SERVICES

**133 North and South Gipton Children's Centres**

The Acting Chief Officer for Early Years and the Youth Service submitted reports on proposed new modular builds to create:

(a) a new North Gipton Children's Centre on a site adjacent to Oakwood Primary School and,

(b) a new South Gipton Children's Centre on a site adjacent to Wykebeck Primary School both schemes to be 100% funded by Children's Centre Capital Grant.

**RESOLVED** –

(a) That approval be given for the transfer of £853,400 from the Phase 2 Children's Centre Parent Scheme and that authority be given to incur total expenditure in the same amount on construction of the North Gipton Children's Centre.

(b) That approval be given for the transfer of £885,000 from the Phase 2 Children's Centre Parent Scheme and that authority be given to incur

total expenditure in the same amount on construction of the South Gipton Children's Centre.

**134 Leeds Building Schools for the Future - Modification to scope of the Outline Business Case for Phases 2 and 3**

The Director of Children's Services and the Chief Executive of Education Leeds submitted a joint report on the proposed removal of Intake High School from Phase 3 of the Leeds BSF project to enable further consideration of the options available for the school, including the possibility of it becoming an academy, and on a proposal that the school form a new Phase 4 to be subject to a separate business case when its status is confirmed

**RESOLVED** – That approval be given for the removal of Intake High school from the Outline Business Case for BSF Phases 2 and 3 and that this school will form part of a new Phase 4 once the status of the school, whether as an academy or a High School in Leeds, has been confirmed.

**135 Children's Services Annual Performance Assessment and Half Year Update on Progress and Performance**

The Director of Children's Services submitted a report providing an overview of half yearly performance against the Every Child Matters outcomes across key themes and areas within children's services, on a number of internal and external audit inspections conducted recently, including the latest Annual Performance Assessment providing a basis to consider progress against the Children and Young People's Plan priorities.

**RESOLVED** – That the report and the Annual Performance Assessment letter attached as appendix A be noted.

(Under the provisions of Council Procedure Rule 16.5 Councillor Wakefield required it to be recorded that he abstained from voting on this decision)

## ADULT HEALTH AND SOCIAL CARE

**136 The Annual Performance Report for Adult Social Care**

The Director of Adult Social Services submitted a report on the annual performance review report of the Commission for Social Care Inspection, providing a brief summary of the key points raised by the Commission, and areas identified by Inspectors where further improvements can be made which will form the basis of the adult social care services improvement plans for the coming year.

**RESOLVED** – That the report and the Performance Review Report from the Commission for Social Care Inspection attached as Appendix 1 be noted.

(Under the provisions of Council Procedure Rule 16.5 Councillor Wakefield required it to be recorded that he abstained from voting on this decision)

## CENTRAL AND CORPORATE

**137 Developing the Financial Plan 2008 - 2013**

The Director of Resources submitted a report on the financial position in the current year, the likely impact of the Comprehensive Spending Review 2007 and their impact on the methodology for the new Financial Plan. The report was intended to form the basis of the initial budget proposals for 2008/09.

**RESOLVED** – That the allocation of resources to services as outlined in the report be approved as the basis for the new Financial Plan and that the report be approved for consideration by the Overview and Scrutiny Committee.

(Under the provisions of Council Procedure Rule 16.5 Councillor Wakefield required it to be recorded that he abstained from voting on this decision )

**138 Provisional Local Government Finance Settlement 2008/09 to 2010/11**

The Director of Resources submitted a report giving details of the provisional Local Government Revenue Support Grant Settlement for 2008/09, 2009/10 and 2010/11 which was announced by the Department of Communities and Local Government on 6th December 2007.

**RESOLVED** – That the report be noted and that representations be made to the Department on a cross party basis, expressing the Council's disappointment and concern.

## DEVELOPMENT AND REGENERATION

**139 Advertising on Lamp Posts**

The Director of City Development submitted a report providing an update on the lamp post advertising city centre trial and its findings, providing an update on the existing lamp post advertising sites and seeking approval to award a contract for lamp post advertising across the city (excluding the defined City Centre area) for the period 2008-2023.

Following consideration of the appendix to the report designated as exempt under Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting, it was:

**RESOLVED** –

(a) That the intention to bring a further report to this Board in relation to City Centre advertising sites be noted.

(b) That the basis of the contract procurement for the rest of the City be noted and approval given for the award of the contract for advertising on street lighting columns 2008-2023.

**140 Development of Delivery Proposals for Leeds/Bradford Corridor**

The Director of Environment and Neighbourhoods submitted a report on the developing collaboration between officers from Leeds and Bradford Councils, overseen by Senior Elected Members from both authorities and on the case for setting this collaboration on a more structured and long term basis.

**RESOLVED** –

(a) That the progress made on the Leeds Bradford joint working to date be noted.

(b) That the principle of joint working between Leeds and Bradford councils and the work programme project plan in Appendix A to the report be approved.

(c) That a budget of £100,000 over two years from Leeds City Council to take forward the work programme be approved.

**141 Leeds Local Development Framework- Annual Monitoring Report 2007**

The Director of City Development submitted a report presenting the Annual Monitoring Report for the Leeds Local Development Framework prior to its submission to the Secretary of State.

**RESOLVED** – That approval be given to the Annual Monitoring Report for submission to the Secretary of State pursuant to Regulation 48 of the Town and Country Planning (Local Development) (England) Regulations 2004.

**142 Proposed Changes to the Regional Spatial Strategy - Leeds City Council representations**

The Director of City Development submitted a report on the proposed City Council's detailed representations and formal response to the Regional Spatial Strategy "Proposed Changes".

**RESOLVED –** That the schedule of representations contained in Appendix 1 to the report be approved as the City Council's formal response to the Proposed Changes, in the preparation of the Yorkshire and Humber Plan (Regional Spatial Strategy).

**143 Re-opening of Sweet Street Bridge.**

The Director of City Development submitted a report on progress to date on re-opening Sweet Street Bridge and describing how this project is a key scheme for Holbeck Urban Village.

**RESOLVED** – That approval be given to the scheme design proposal and brief and to the scheme estimates and cash flows as presented and that scheme expenditure of £636,000 be authorised.

**144 Proposed Chinese Gate of Friendship**

The Head of International Relations submitted a report on a proposal that the Council accept the Gate of Friendship from Hangzhou, on the intention that it be erected on Quarry Hill as detailed in the report and at the associated costs.

**RESOLVED** –

(a) That the Council accepts the Gate of Friendship from Hangzhou and that it be erected on Quarry Hill as detailed in the report.

(b) That expenditure of £200,000 on the erection of the Gate, funded from Section 106 Public Realm Works within the City Centre, be authorised.

## ENVIRONMENTAL SERVICES

**145 Leeds Climate Change Strategy**

The Director of City Development submitted a report outlining the key issues contained within the consultation draft of the Leeds Climate Change Strategy, how it had been developed, the implications and plans for consultation.

**RESOLVED** – That the approach taken be endorsed and that the consultation draft of the Leeds Climate Strategy be published for consultation in January 2008.

DATE OF PUBLICATION: 21ST December 2007
LAST DATE FOR CALL IN: 2nd January 2008 (5.00 pm)

(Scrutiny Support will notify Directors of any items called in by 12 noon on Thursday 3rd January 2008).

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**OVERVIEW AND SCRUTINY COMMITTEE**

**TUESDAY, 6TH NOVEMBER, 2007**

**PRESENT:** Councillor P Grahame in the Chair

Councillors S Bentley, B Gettings, T Hanley, A McKenna, W Hyde, E Minkin and R Pryke

Apologies Councillor B Anderson and S Golton

**49 Councillor Andrea McKenna**

On behalf of the Committee, the Chair congratulated Councillor Andrea McKenna and welcomed her to her first OSC meeting following her recent marriage to Councillor Jim McKenna.

**50 Declaration of Interests**

No declarations of Members' interests were made.

**51 Minutes - 9th October 2007**

(i) Leeds Strategic Plan 2008-2011(Minute No 42 refers)
The Committee agreed to slightly amend this minute, so that the penultimate bullet point referred to the role of Members not only as 'Community Champions' and 'Leaders of Change' but also that the Strategic Plan should make specific reference to the leadership role of Members in planning matters and the design and quality of the built environment.

(ii) Debt Rescheduling (Minute No 40(a) refers)
Further to the Committee's previous discussions on this matter, it was agreed that the Head of Scrutiny and Member Development would arrange a separate meeting with relevant officers of the Resources Department to which all OSC Members would be invited, to receive further detailed explanation of the issues raised by Councillor Hanley.

(iii) Work Programme and Draft Terms of Reference for Proposed Inquiries (Minute No 40(b) refers)
It was reported that the working group would meet on 14th November 2007 at 9.00 am to consider the proposed terms of reference for the ALMO Inquiry.

(iv) Group Offices (Minute No 40 refers)
Further to Minute No 37, 11th September 2007, and Minute No 40, 9th October 2007, it was reported that the information previously supplied by the Chief Democratic Services Officer to Councillor Hanley when he

was Labour Chief Whip, relating to the costs of operating political Group Offices, had now been circulated to OSC Members. Councillor Hanley indicated that if this information was in its original form, it may require to be further refined for the purposes of highlighting the costs per Member of each group.

**RESOLVED –** That subject to (i) above, the minutes of the meeting held on 9th October 2007 be confirmed as a correct record.

(NB: Councillor Gettings joined the meeting at 10.10 am during this item)

**52 Minutes - Executive Board, 17th October 2007**

Several issues were discussed arising from consideration of the minutes of the Executive Board meeting held on 17th October 2007:-

- Holt Park District Centre and Tinshill Recreation Ground (Minute No 87 refers) – following debate at the City Council meeting on 31st October 2007, Councillor Minkin stated that she was pursuing with the Director of City Development issues surrounding the proposal to fence two pitches at Tinshill Recreation Ground in association with the development of the new Ralph Thoresby High School. The Chair indicated that she required a report to OSC regarding which Scrutiny Board had considered this matter, following a referral from the Plans Panel (West) on 12th July 2007, or an explanation regarding why this matter had not been referred to the appropriate Scrutiny Board;
- The Mansion, Roundhay Park (Minute No 88 refers) – It was suggested that the issues surrounding the redevelopment of The Mansion, Roundhay Park and the timescales involved, might be suitable for scrutiny by the Scrutiny Board (Culture and Leisure);
- City Varieties Music Hall – Redevelopment and Refurbishment (Minute No 90 refers) – Similarly, it was suggested that the Scrutiny Board (Culture and Leisure) might wish to investigate the current arrangements whereby this venue was managed as part of the Leeds Grand Theatre Board set-up, and whether separate management arrangements for the City Varieties Music Hall might be appropriate;
- Council Meeting Arrangements – Frustration was expressed regarding a lack of opportunity at Full Council meetings, due to procedural time limitations, to properly discuss and ask questions on minutes of Committee and Board meetings. Rotating the order of the minutes in the book of proceedings was not regarded as a solution. The Chair stated that she had recently written to the Chief Executive, suggesting that Scrutiny Board minutes should be a separate agenda item on the Council agenda, in order to try to address this problem, and the Chair's action was endorsed by the Committee,

  A suggestion was also made that Members indicating a wish to comment or ask questions on submitted minutes should be required to make the nature of their enquiry or comment known prior to the meeting, in order that appropriate responses might be provided, and to avoid officers and

Chairs spending abortive time preparing responses to anticipated comments or questions.

**RESOLVED -** That subject to the above comments, the minutes of the Executive Board meeting held on 17th October 2007 be received and noted.

**53 Performance Report - Quarter 2 2007/08**

The Head of Policy, Performance and Improvement submitted a report updating the Committee on performance against targets across a raft of statutory and local indicators, involving all the Scrutiny Boards' areas of responsibility, and containing predicted CPA scores for 2007/08.

Steve Clough, Head of Policy, Performance and Improvement, attended the meeting and responded to Members' queries and comments. In brief summary, the main issues discussed were:-

- Planning performance and the percentage of appeals allowed against the authority's decision to refuse planning applications – Further to Minute No 32, 11th September 2007, and Minute No 43, 9th October 2007, the predicted improvement in the Council's performance by Quarter 4 in 2007/08 was welcomed. Members expressed frustration at being hidebound to a large degree by Government directives and guidelines on planning matters. The presumption in favour of approval and the restriction of local discretion in planning matters was not widely understood by the public, who often regarded Plans Panels as undemocratic if they did not accede to local objections, and did not appreciate the limited nature of Panels' powers in these matters. The initiatives outlined by the Chief Planning Officer at the last meeting (Minute No 43 refers) were referred to. Greater cognizance of local issues/conditions, and more Ward Member consultation, on the part of planning officers would be helpful;
- Abandoned Vehicles – The use of a contractor based in Doncaster was queried, in view of the time limits imposed for the removal of abandoned vehicles in order to meet this performance indicator. Steve Clough undertook to pursue this issue, in terms of whether there were more local qualified contractors, and whether more than one contractor should perhaps be engaged;
- Graffiti – The information set out in Paragraph 5.3.2 of the report was noted. It was suggested that the work schedule of the so-called 'hot spot' graffiti removal team should be reviewed in order that the frequency of their service matched the requirements of particularly bad areas, although it was accepted that, unfortunately, graffiti seemed to be a never ending problem, and there needed to be an effective response in all parts of Leeds;
- Teenage Pregnancy Rates – The Scrutiny Board (Health and Adult Social Care) had agreed to receive an update report on this issue (OSC Minute No. 31, 11th September 2007 refers;
- Direct Payments – Further to Minute No 44, 9th October 2007, the improving situation in Paragraph 5.6.1 was welcomed

- Steve Clough drew attention to the information on crime and drugs contained in Paragraphs 5.3.1 and 5.3.2 of his report;
- BV174 and 175 – The number of racial incidents recorded by the authority per 100,000 population and the percentage of racial incidents that resulted in further action – Steve Clough confirmed that this was all about ensuring that the information was available at the correct time for monitoring purposes, and this was being addressed;
- The briefing of Scrutiny Board Chairs prior to the commencement of the formal CPA inspection period.

**RESOLVED –** That subject to the above comments the report be received and noted.

**54 Leeds Strategic Plan 2008 - 2011**

Further to Minute No 33, 11th September 2007, and Minute No 42, 9th October 2007, the Committee considered a composite official response proposed to be submitted, which contained the official comments and recommendations of all the Scrutiny Boards following detailed consideration of the draft Leeds Strategic Plan 2008/2011 by all Boards in the October cycle.

Jane Stageman, Chief Executive's Department, was in attendance and responded to Members' queries and comments. In brief summary, the main points discussed were:-

- Jane Stageman thanked the Scrutiny Boards for their contributions to the process. All comments and recommendations would be seriously considered. The proposed final Plan should be ready mid-December, and would be reported to OSC and the other Scrutiny Boards in the January cycle;
- OSC Recommendation 1, relating to the budget making process, was already being acted upon, in terms of preparation of the latest updated Business Plan and service prioritisation;
- It was agreed to add an additional point to the comments of OSC, to incorporate the points made at the last meeting (Minute No 42 refers) regarding the important role of Members in the process, as 'Community Champions', and also as 'Leaders of Change', for instance on planning matters and the design and quality of the built environment;
- The number of recommendations emanating from the Scrutiny Board (Children's Services) reflected that Board's concerns regarding the need to establish links between the Strategic Plan and 'Every Child Matters' and other specific areas of concern.

**RESOLVED –**

(a) That subject to the above comments, the composite response set out at Appendix 1 to the report now submitted be approved as the official statement of OSC on the draft Leeds Strategic Plan 2008-2011

(b) That further reports on this subject be submitted to OSC and the other Scrutiny Boards in the January 2008 cycle.

## 55 Call-In Arrangements

Further to Minute No 35, 11th September 2007, when the Committee had discussed issues surrounding who could sanction a request for a matter to be called-in by OSC, the Committee further considered under what circumstances a matter could or should be called-in.

The Head of Scrutiny and Member Development submitted a report regarding Government advice and good practice, and recommending changes to the existing arrangements as set out in Scrutiny Guidance Note 3. The suggested changes would mitigate against someone seeking to Call-In a decision merely because they did not agree with that decision per se, and would place an obligation on the applicant to justify the request on the grounds that the decision had not been taken in accordance with Article 13 of the Council's Constitution – decision making and principles of decision making. In effect, the onus would be on the applicant to prove that the decision was procedurally flawed, that particular evidence had not been taken into account, that erroneous evidence had been taken into account or that viable options had not been considered. The initial arbiter ('Proper Officer') in the event of a dispute would be the Head of Scrutiny and Member Development and, ultimately, the Assistant Chief Executive (Corporate Governance) in her role as Monitoring Officer.

As a result of a Member's query regarding whether the suggested changes to Guidance Note 3 sufficiently took account of the Government's good practice guidance, in particular where relevant issues did not appear to have been taken into account in reaching a decision, it was agreed that the Head of Scrutiny and Member Development should add some wording to cover this particular aspect.

**RESOLVED –** That subject to the above comment, the proposed amendments to the Call-In procedure, as contained in the revised Scrutiny Board Procedure Rules Guidance Note 3, be approved.

## 56 Work Programme

The Head of Scrutiny and Member Development submitted a copy of the Committee's work programme, updated to reflect decisions taken at previous meetings, together with a relevant extract from the Council's Forward Plan of Key Decisions for the period 1st November 2007 to 29th February 2008. It was reported that consideration of the Council's Business Plan would be added to the agenda for the 8th January 2008 meeting, in order that the Business Plan, the proposed final Leeds Strategic Plan 2008-2011 and the Council's draft Budget Statement could all be considered at the same meeting.

## 57 Dates and Times of Future Meetings

Tuesday 11th December 2007
Tuesday 8th January 2008
Tuesday 5th February 2008

Tuesday 11th March 2008
Tuesday 8th April 2008

All at 10.00 am (pre-meetings at 9.30 am)

# OVERVIEW AND SCRUTINY COMMITTEE

## TUESDAY, 11TH DECEMBER, 2007

**PRESENT:** Councillor P Grahame in the Chair

Councillors S Bentley, B Gettings, T Hanley, A McKenna, E Minkin and R Pryke

## 58 Chair's Welcome

The Chair welcomed everybody to the December meeting of the Overview and Scrutiny Committee and thanked Tonia Bowden and Simon Turner of Primrose High School for allowing the meeting to be held at the school and helping with the arrangements. Primrose High School, as part of the Central Leeds Learning Federation, had been selected as the venue due to its good work with migrant children and their families, which was the focus of today's meeting.

Members of the Committee and Officers introduced themselves. Councillor Chapman was welcomed to the meeting. It was explained that Councillor Chapman would be taking the place of Councillor Golton on the Committee at future meetings and was attending today's meeting as an observer only until her appointment as Chair of Scrutiny Board (Health and Social Care) had been approved by Council.

## 59 Late Items

The Chair indicated that in accordance with her powers under Section 100B(4)(b) of the Local Government Act 1972, she had agreed to accept as a late item of urgent business the report on 'Responding to the Needs of Migrants and their Families', which had not been ready at the time of agenda despatch in order to supply Members with the most up to date information available.

## 60 Declaration of Interests

No declarations of Members' interests were made.

## 61 Apologies for Absence

Apologies for absence were submitted on behalf of Councillors Anderson and W Hyde.

## 62 Minutes - 6th November 2007

(i) Minutes – 9th October 2007 (Minute No 51 refers) - (i) Leeds Strategic Plan 2008-2011 (Minute No 42 refers)

The Committee agreed to amend this minute again, so that the penultimate bullet point referred to the role of Members not only as 'Community Champions' and 'Leaders of Change' but also that the Strategic Plan should make specific reference to the leadership role of Members in planning matters and the design and quality of the built environment.

(ii) Minutes – 9th October 2007 (Minute No 51 refers) - (iv) Group Offices (Minute No 40 refers)
Members were advised that when the information relating to the operating costs of the Group Offices was available, it would be circulated to Members.

(iii) Minutes – Executive Board, 17th October 2007 - The Mansion, Roundhay Park
Members were advised that this issue was in the process of being scrutinised by the Scrutiny Board (Culture and Leisure).

**RESOLVED –** That subject to (i) above, the minutes of the meeting held on 6th November 2007 be confirmed as a correct record.

## 63 Minutes - Executive Board - 14th November 2007

Minutes 107 – Tinshill Recreation Ground
In response to a query by Members, officers confirmed that there had been no call-in request on this issue and that the matter would therefore be considered by Scrutiny Board (City Development).

**RESOLVED –** That the minutes of the Executive Board meeting held on 14th November 2007 be received and noted.

## 64 Scrutiny Inquiry - Terms of Reference - Responding to the need of Migrants and their Families

The Head of Scrutiny and Member Development submitted a report attaching the terms of reference for the Inquiry into 'Responding to the Needs of Migrants and their Families'. The report also explained that a number of interested parties had been invited to this first session of the Inquiry to contribute to the discussion on this topic by way of an 'open forum'. The Committee would also be pleased to hear from any other contributors.

Various people addressed the Committee including Liz Talmadge, Head of the Primrose Federation, Primrose High School, Tonia Bowden, Headteacher, Primrose High School, Julian Gorton, Headteacher, Shakespeare Primary School, Jan Spencer, Inner East Primary Schools and Alison Mander, Assistant Head Teacher, Carr Manor High School.

The Committee was particularly pleased to hear the experiences of a sixth form student from City of Leeds High School.

Liz Talmadge talked to a paper she had prepared which highlighted a number of issues and particular challenges that schools were facing.

A full debate took place between contributors from the floor and the Committee, the substance of which would be fed into future meetings of the Inquiry and be included in the final report.

Various further information was requested of officers and contributors, some of which was statistical data, which would help to inform future sessions of the Inquiry.

The Chair thanked everyone for their contributions.

**65 Scrutiny Inquiry - Responding to the Needs of Migrants and their Families**

The Director of Environment and Neighbourhoods submitted a report providing Members with information and data for today's first session of the Inquiry into 'Responding to the Needs of Migrants and their Families'. The report focused on:

- Contextual information about new migration in the UK
- An overview of the data and intelligence available to the Council and its partners on new migrants in Leeds
- An overview of the current position in Leeds
- A summary of current work to develop an improved understanding of the situation and respond to emerging needs
- An outline of issues to consider when assessing local impacts of migration

Sue Wynne, Head of Policy and Planning, and Martyn Stenton, Partnerships Manager, both from Environment and Neighbourhoods, attended the meeting to present the report and respond to Members' queries and comments. Ken Morton, Locality Enabler (East), Children's Services and Tom Wiltshire, Manager - Housing Needs, were also in attendance.

Various additional pieces of information were requested from officers to feed into the Inquiry.

The Chair thanked officers for their report and for attending the meeting.

**66 Work Programme**

The Head of Scrutiny and Member Development submitted a copy of the Committee's work programme, updated to reflect decisions taken at previous meetings, together with a relevant extract from the Council's Forward Plan of Key Decisions for the period 1st December 2007 to 31st March 2008.

With regard to the ALMO Working Group, it was reported that when the information requested had been received, that another meeting of the Group would be held.

**RESOLVED –**

(a) That the Work Programme be noted.

(b) That the Forward Plan of Key Decisions be received and noted.

## 67 Dates and Times of Future Meetings

Tuesday 8th January 2008
Tuesday 5th February 2008
Tuesday 11th March 2008
Tuesday 8th April 2008

All at 10.00 am (pre-meetings at 9.30 am)

Leeds CITY COUNCIL

Originator: Debbie Chambers
Tel: 247 4792

**Report of the Head of Scrutiny and Member Development**

**Scrutiny Board (Health and Adult Social Care)**

**Date: 21st January 2008**

**Subject: Inquiry into the Localisation of Health and Social Care Services - Session 2**

| **Electoral Wards Affected: All** | **Specific Implications For:** |
|---|---|
| | Equality and Diversity ☐ |
| | Community Cohesion ☐ |
| ☐ Ward Members consulted (referred to in report) | Narrowing the Gap ☐ |

## 1.0 Background

1.1 The Board held the first session of its inquiry into the localisation of health and social care services in November 2007, receiving a joint report from the local NHS Trusts. The Chief Executives of Leeds PCT, the Leeds Teaching Hospitals NHS Trust and the Director of Adult Social Services were in attendance to respond to questions.

1.2 A supplementary session was held at the Board's last meeting, to consider the views of members of the North West Inner and Outer Area Committees.

## 2.0 Session 2

2.1 The purpose of this session is to consider the planning and decision-making process for commissioning health and adult social care in Leeds.

2.2 A report from Leeds PCT is attached as Appendix 1 to provide information on GP practice-based commissioning; Community Needs Assessment; Service Development and Public Consultation and Engagement.

2.3 A report from the Director of Adult Social Services is attached as Appendix 2, providing information in relation to the Leeds Joint Strategic Needs Assessment, which was made a statutory duty under Section 116 of the Local Government and Public Involvement in Health Act 2007.

2.4 The views of any Area Committee Members in attendance from the South Inner and Outer Area Committees will also be considered at this session. Representatives from the Voluntary Sector in Leeds have also been invited to attend.

## 3.0 Recommendation

3.1 The Board is asked to note the attached reports in line with its inquiry into the localisation of Health and Social Care Services.

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Leeds NHS
Primary Care Trust

# SCRUTINY BOARD (HEALTH & SOCIAL CARE)
# INQUIRY INTO LOCALISATION OF HEALTH SERVICES

Content

The attached papers provide information on the planning and decision making process for commissioning health services in Leeds. They should be read in the context of the previous paper circulated to the Scrutiny Board on factors driving localization which gave the high level background.

The papers cover the following:

1. GP Practice Based Commissioning

2. Community Needs Assessment

3. Service Development

4. Public Consultation and Engagement

Members will also have received a report from Dennis Holmes, Chief Officer Social Care Commissioning, on the social care input specifically in relation to commissioning and the community engagement elements of the Joint Strategic Needs Analysis. The commissioning approach and work programme described in the report will be reflected in the new GP commissioning consortia arrangements currently being introduced.

**January 2008**

**Section 1**

# GP Practice Based Commissioning in Leeds

## 1. Background

Practice based Commissioning (PBC) is about engaging practices and other primary care professionals in the commissioning of services. Through PBC, front line clinicians are being provided with the resources and support to become more involved in commissioning decisions. PBC should lead to high quality services for patients in local and convenient settings. GPs, nurses and other primary care professionals are in the prime position to translate patients' needs into redesigned services that best deliver what people want, and achieve better use of resources.

PBC was first mentioned as an aspiration by the incoming Labour government in the NHS Plan. It has been a central part of the government's NHS reforms since April 2005, when interested practices were first entitled to an indicative budget. PCTs were expected to achieve universal coverage of PBC by December 2006. As a minimum PCTS were required to:

- Provide practices with an indicative budget.
- Provide information on use of resources.
- Offer GPs an incentive to engage.
- Put in place governance and accountability arrangements.

PCTs are also expected to provide practices with the tools (e.g. timely, high quality information about activity and finance) and the support they need effectively to discharge their commissioning responsibilities, either directly or through agreed alternative arrangements.

## 2. Current Position in Leeds

Leeds PCT has encouraged practices to group together to implement PBC but has not imposed a specific locality configuration. Practices have therefore come together into groups of like minded practices. All but one practice in the city is signed up to the implementation of PBC through the consortia arrangements outlined in the table below:

| Consortia | No of Practices | Population |
|---|---|---|
| Leodis | 25 | 170,584 |
| H3CG | 13 | 137,741 |
| West Leeds GP Collaborative | 15 | 95,271 |
| NE Consortium | 9 | 85,196 |
| Leeds Virtual Commissioning Collaborative | 15 | 55,953 |
| Wharfe and Aire Consortium | 7 | 54,907 |
| The Morley/Ardsley Consortium | 4 | 48,316 |
| South Leeds Consortium | 8 | 45,342 |

| | | |
|---|---|---|
| The Wetherby & District Group | 5 | 33,038 |
| Church Street Group | 5 | 13,090 |
| **Total in Consortium arrangement** | **106** | **739,438** |
| *Unaligned practices | 9 | 60,029 |

*Note: of the 9 unaligned practices, 8 are implementing PBC as an individual practice; 1 practice is not signed up to PBC.

The attached map shows the configuration of the PBC consortia compared with Local Authority Area Committee boundaries and the super output areas. One of the challenges for the PCT in respect of PBC is how the configuration of PBC consortia relates to the wider partnership agenda in the city.

PBC consortia are supported by the PCT to develop commissioning plans based on assessment of health needs, analysis of current patterns of service provision, identification of gaps and development of proposals for redesign of care pathways in partnership with secondary care clinicians, local authority and voluntary sector stakeholders. Practice based commissioners have a specific responsibility for involving patients and the public in the development of commissioning plans and redesign of care pathways.

The PBC Forum has been established to bring together clinical leaders from the PBC consortia with strategic commissioners from the PCT to enable PBC to take place in the context of the overall vision and strategic priorities for the PCT. The PBC Forum also enables sharing of commissioning plans between consortia and the identification of opportunities for collaborative working.

## 3. Decision making in PBC

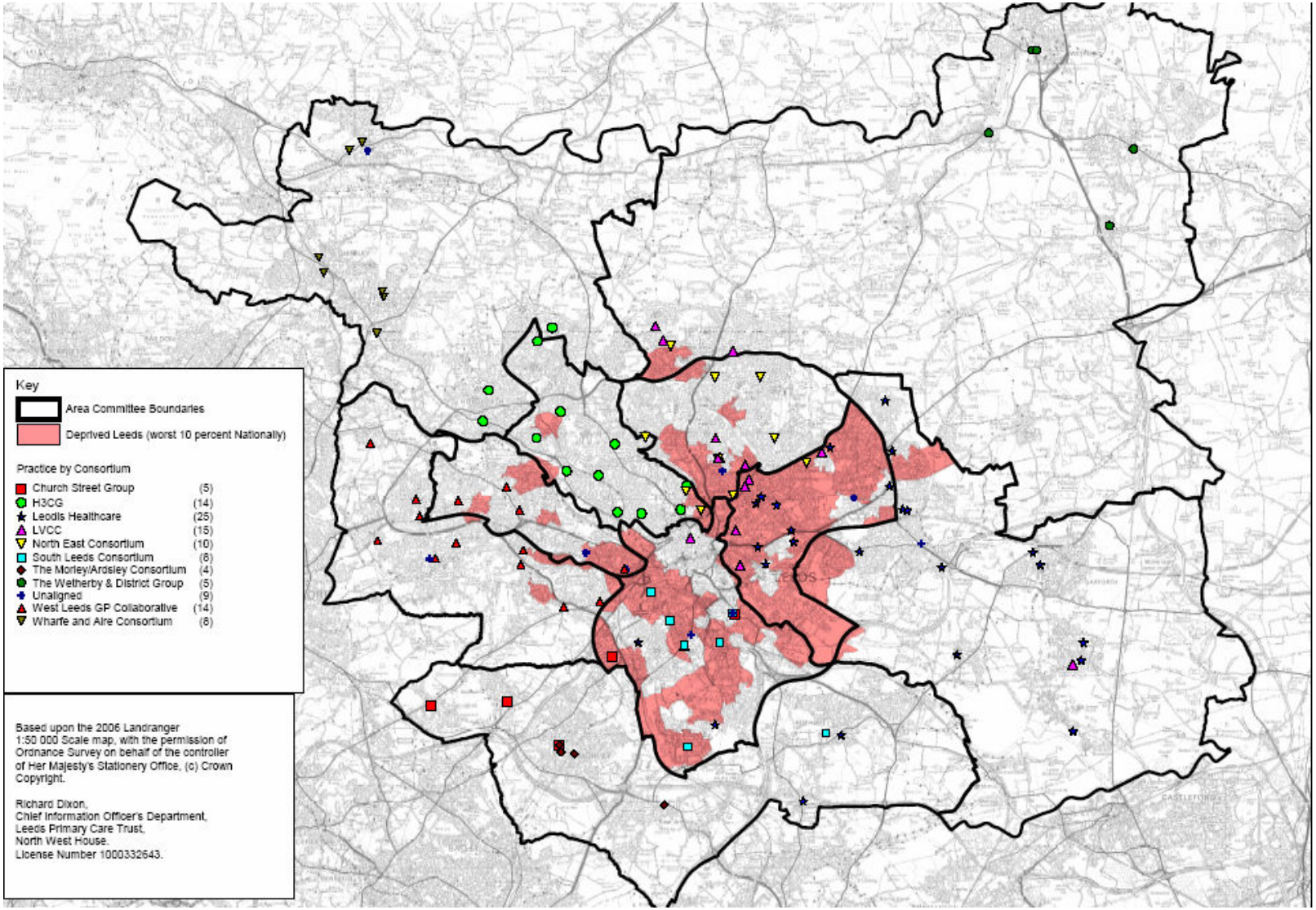
The PCT has established a sub-committee of the Board, the PBC Governance Committee, to approve PBC commissioning plans and business cases, ensuring that potential conflicts of interest in the decision making process are dealt with. The PBC Governance Committee is advised by a Clinical Reference Group, ensuring that proposals reflect evidence based quality services, and a Patient Advisory Group (PAG), ensuring that business cases are reviewed from a patient and public perspective. Questions raised by the group are fully explored by the PBC team to make certain that the proposals reflect the needs of the local population.

The Patient Advisory Group draws its membership from a range of patient groups and community and voluntary organisation in Leeds including a representative from Leeds VOICE – Health Forum, 2 representatives from Leeds Patient and Public Involvement Forum, 1 representative from Leeds Black and Minority Ethnic (BME) Network, 2 representatives from Leeds Involvement Project Locality Development Schemes, 1 representative from the Older People's Modernisation Reference Group, 1 representative from Leeds Carers Strategy Group and 1 representative from Leeds Hospital Alert. The group is chaired by the PCT's Patient and Public Involvement Lead for PBC and Primary Care.

## 4. Mechanisms for local engagement

In addition to the role of the Patient Advisory Group outlined above, all PBC consortia are required to describe processes that they have in place to involve patients and the public in the development of commissioning plans and redesign proposals. One large consortium has appointed a lay member to the Board, and the PCT has supported work to scope the patient/public involvement and partnership agenda in that consortium through the secondment of a member of the Patient and Public Involvement team. The outcome of this piece of work is now informing the development of structures in all consortia to support local engagement. This is likely to include the following approaches:

- Encouraging PBC Consortia to include patient and public representation as part of their governance arrangements.
- Conducting a baseline audit of current arrangements for PPI within PBC Consortia.
- Further development of Patient Participation Groups at practice and consortium level.
- Mapping of and engagement with key local stakeholders (local authority; third sector, etc) in each PBC Consortium area.
- Development of focus groups to inform the redesign of services and to renew new services.
- Development of a database at Consortium level to identify community and voluntary stakeholders in each area.


Key
Area Committee Boundaries
Deprived Leeds (worst 10 percent Nationally)
Practice by Consortium
Church Street Group (5)
H3CG (14)
Leodis Healthcare (25)
LVCC (15)
North East Consortium (10)
South Leeds Consortium (8)
The Morley/Ardsley Consortium (4)
The Wetherby & District Group (5)
Unaligned (9)
West Leeds GP Collaborative (14)
Wharfe and Aire Consortium (8)
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**Section 2**

# Community Needs Assessment

## 1. Introduction

The following report outlines the process to undertake a health needs assessment based on guidance produced by Public Health, Leeds PCT and describes a community health needs assessment recently undertaken for students.

## 2. Health Needs Assessment Process

2.1 Definition

A Community Health Needs assessment is:

- A systematic description of the needs of a community, and the resources that exist for that community
- It is carried out with the active involvement of the community itself

2.2 Purpose

- The Health Needs Assessment (HNA) process has to deliver activities which will improve health and reduce inequalities locally.
- The health concerns and inequalities tackled, must reflect Government and local priorities.

By the end of the process there should have been real steps toward fulfilling the following conditions: is the activity in response to an identified need? Were the local community involved in identifying the need? Does the health need you are responding to affect a lot of people locally? Is it reaching those people with the most to gain?

The population to be targeted needs to be defined i.e. a whole population or a sub-set in response to government/local priorities/greatest need, or a gap in provision, e.g. live in geographic area, share a characteristic e.g. age, ethnicity, gender, disability, health issue, etc.

2.3 Building a Profile of the community

Information on the community needs to be collated which will include population age and distribution, deprivation ratings, mortality and morbidity rates, behaviour related health data, the environment, housing, transport, crime, amenities, statutory and voluntary services. This will involve consultation with local providers and health specialists, as well as local people on whether they think services are adequate.

Carrying out HNA offers the opportunity for team building, partnership building and improving links with the local community, to highlight areas of need that have

previously not been recognized, and to link with other work being done. Partnerships help produce joined up services preferred by the public, and pooling of resources to maximize impact.

Inequalities can be considered across three broad areas:

- Multiple deprivation – what a person experiences in terms of the underlying causes of ill health – this includes housing, poverty, educational attainment, local levels of crime, etc. Evidence suggests that a patient with a chronic disease who experiences high levels of multiple deprivation will have poorer outcomes
- Access – patients need to have similar levels of access to services, particularly those that are known to under use services, and once patients have accessed a service there must be confidence that the provision is appropriate to different need
- Disease burden – in each disease group individuals and communities who are more likely to experience the disease can be identified.

2.4 Feeding back the evidence

The involvement of the community and other key players, should result in identifying the conditions and factors that are impacting on the health of the profiled population. This will be the base-line against which will be measured the outcomes of the actions for change. The main findings should include:

- a baseline profile of the population affected by the proposal
- summary of local circumstances relevant to the proposal
- evidence from the published literature
- information from health impact assessment/s that have been conducted on similar proposals and/or on the same community.

2.5 Health Impact Assessment

The health impact assessment will focus on the programmes, policies or projects, and examines what impact, positive or negative they will have on population health. In identifying which changes would have the most impact on the target population, actions should be examined in respect of the three levels of prevention: 1) primary prevention – preventing the problem occurring at all; 2) secondary prevention – preventing progression or recurrence of the problem; 3) tertiary prevention – preventing the consequences of the problem.

Evidence of effectiveness and pursuing ‘best practice’ has to be incorporated into any programme of action. However it is also important to ensure that the proposed changes are acceptable to the target population, the service providers, the managers, and commissioners.

## 3. Leeds Student Health Needs Assessment

### 3.1 Summary

The following report is drawn from a Health Needs Assessment undertaken during 2006 led by the former Leeds North West PCT (NW PCT). It describes the process undertaken to assess the particular health needs of students and the recommendations. Copies of the full Health Needs Assessment can be requested from the PCT.

### 3.2 Background

The former Leeds North West PCT had a sizeable student population with the three main higher education institutions (HEIs) being located in the NW PCT. The focus on the particular health needs of students in order to identify key priorities was agreed with the HEIs. A multi-agency group with representatives from the HEIs (University of Leeds, Leeds Metropolitan University and Trinity & All Saints College), Students Union, the NW PCT and the voluntary and community sector was brought together to guide the work.

The aim of the Health Needs Assessment is to improve the health and wellbeing of university and college students living in Leeds. The objectives are:

- to identify priority areas to support universities and colleges to be healthy settings
- to identify priority areas to promote positive relationships between students and the local community.

The approach to the collection of data included target (student) population perceptions, stakeholder perceptions and a literature review. The resulting identification of the priority needs of students can be captured in the following themes.

### 3.3 Health Services

Access to health services is a key issue for students. The seasonal nature of the academic calendar creates pressure on a range of services at certain times of the year (particularly the start of term and during exam periods). The fact that students may not be resident in Leeds for 12 months of the year can also impact upon their ability to access services that operate waiting lists. The recommendations included: that all students are registered with a Leeds GP; to promote the Dental Advice Line; and to improve the co-ordination and planning of health related activities at the start of the academic year.

### 3.4 Health Issues

A range of specific health issues were identified including mental health, sexual health, smoking , alcohol and drugs, physical activity and nutrition. Mental health was identified as a key issue for students and a multi-agency group was established to carry out detailed work, the recommendations from which included to prevent and reduce the number of students experiencing mental health

difficulties and to improve the access to timely and appropriate mental health services.
Recommendations for other health issues included: to reduce the incidence and prevalence of Sexually Transmitted Infections in the student population; to expand students access to Leeds Stop Smoking Service; to reduce alcohol and drug related harm in the student population; and to promote healthy eating messages, cooking and budgeting skills within the student population.

3.5 Healthy Community
The universities and their students form part of the fabric and identity of many of the neighbourhoods in the North West and increasingly in other areas of Leeds. There are a number of established initiatives that seek to address the challenges of a high concentration of students, foster positive community relationships and contribute to the development of a Healthy Community. The recommendations for further action included: developing and promoting a Community Guide to provide advice and guidance to students about living in the community; and encouraging all stakeholders to play an active role in sharing, communicating and co-ordinating their approach to students living in the community.

Other themes to emerge included healthy universities and colleges and international students.

# Service Development

## 1. Summary

An overarching aim of Making Leeds Better is to improve primary and community services particularly for patients with long term conditions. This will mean providing more and better services closer to people's homes so that we can diagnose and treat people sooner, help them manage their conditions more effectively, avoid admission to hospital, and provide rehabilitation and other services needed for swifter discharge from hospital. To deliver this we are improving care out of hospital by developing systematic care pathways based on National Service Framework standards. The following report describes a re-design pathway using Chronic Pulmonary Disease (COPD) as an example.

## 2. Introduction/Background

The 'Making Leeds Better' re-design pathway for COPD consists of rolling out the following services across the city based on need:

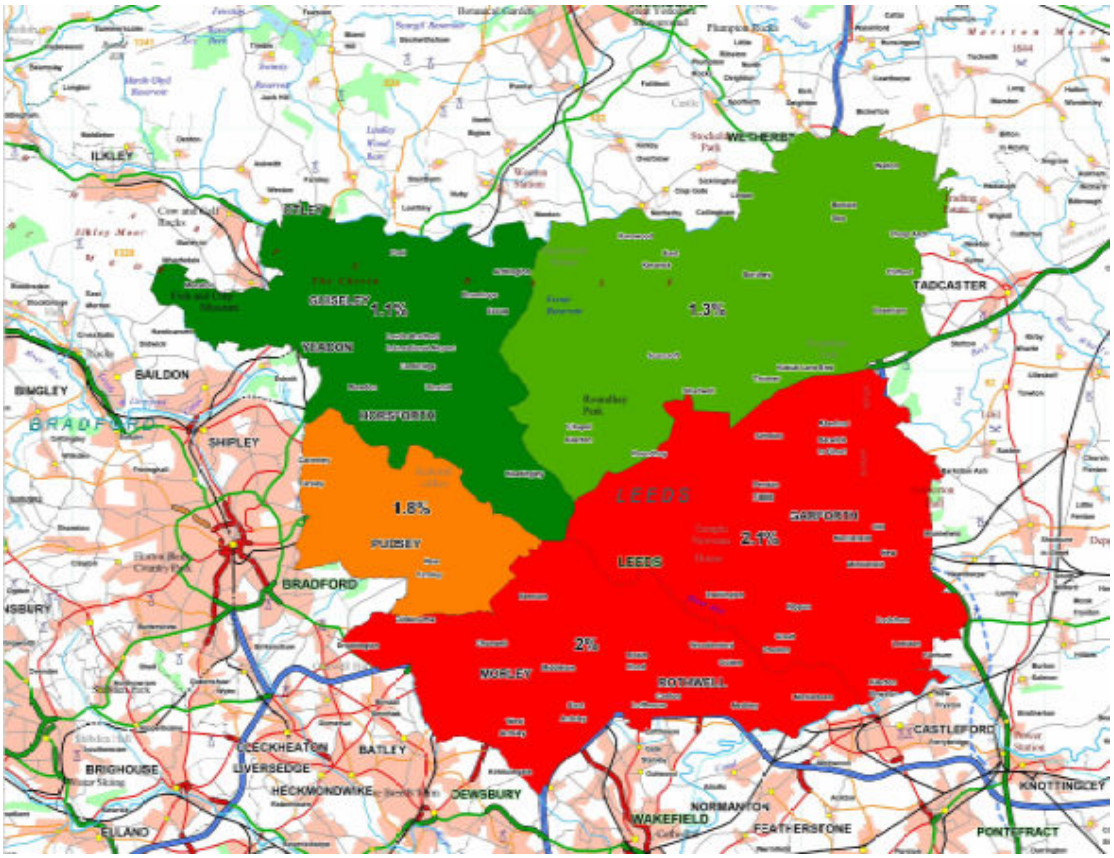
- Diagnosis of COPD using spirometry in primary care
- Early discharge scheme
- Pulmonary rehabilitation
- Chronic disease management

COPD guidelines were developed in 2005 which included patient involvement and identified the GP as the main referrer to the service. The community based service is focused on keeping patients well and delivering care closer to home. The service model comprises of COPD teams of nurses and physiotherapists providing support to GP practices, for all the above elements of the service. The above elements of the service are now provided in the community. Pulmonary rehabilitation capacity has been increased from approximately 60 places in 02/03 delivered in a hospital setting to approximately 650 places in 07/08 delivered in a community setting.

## 3. COPD Needs Assessment for Community Based Services

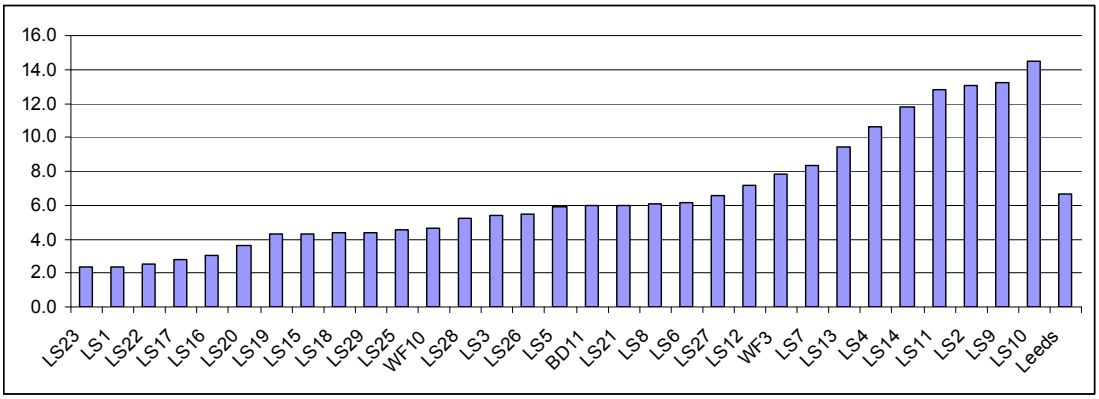
A needs assessment was carried out in 2002/03 for the former East Leeds PCT based on the prevalence and hospital activity data which concluded that there are major health and efficiency gains to be achieved by implementing the above four pathways for COPD patients. More recent data in 2006 on the crude prevalence of COPD by locality (figure 1) and hospital admission rates by postcode based on 2003/06 activity (figure 2), highlights the significant variation in COPD across the city.

**Crude prevalence percentage by PCT: source QMAS 2006**




| Locality | Total number of COPD patients | Crude prevalence in % (95% confidence intervals) |
|---|---|---|
| **Leeds** | 12617 | 1.60 (1.58-1.63) |
| **Headingley / Woodhouse / Burley Total** | 806 | 0.79 (0.73-0.84) |
| **Chapeltown Total** | 521 | 0.99 (0.91-1.08) |
| **Moortown/Roundhay Total** | 1,065 | 1.36 (1.28-1.45) |
| **Cookridge Total** | 662 | 1.42 (1.31-1.53) |
| **Otley / Guiseley Total** | 773 | 1.42 (1.33-1.52) |
| **Rothwell Total** | 414 | 1.48 (1.34-1.62) |
| **Wetherby Total** | 493 | 1.51 (1.38-1.64) |
| **Garforth / Kippax Total** | 668 | 1.62 (1.50-1.74) |
| **Morley Total** | 976 | 1.71 (1.60-1.82) |
| **Wortley / Bramley / Armley Total** | 1116 | 1.84 (1.73-1.94) |
| **Pudsey Total** | 958 | 1.86 (1.74-1.97) |
| **Seacroft Total** | 1147 | 1.97 (1.85-2.08) |
| **Beeston Total** | 822 | 2.11 (1.97-2.25) |
| **Harehills Total** | 1414 | 2.66 (2.53-2.08) |
| **Middleton\Hunslet Total** | 827 | 2.66 (2.48-2.84) |

*Age standardised admission rates for COPD per year per 1000 population 40-99 for each Leeds postcode.*




The assessment clearly highlights that the admission rates and prevalence is at least double in South and East areas of the city compared to other areas and therefore has a greater need for COPD services. Similarly at the locality level, Seacroft and Harehills localities; Middleton/Hunslet and Beeston localities; and Wortley/Bramley/Armley and Pudsey are in the greatest need of COPD services.

There is further local evidence for full implementation of the pathway, with a 29% reduction in admission rates for COPD in the former East Leeds PCT (2003/04) and a downward shift in COPD admissions of 26% (2006/07) in the former Leeds North West PCT.

## 4. Equity of access

Historically the service has been rolled out across the city on a differential basis, whereby the East PCT were the first to achieve full implementation. Immediately prior to the creation of the LEEDS PCT there was full implementation in four out of the five PCTs, with South PCT having only limited implementation. This meant that the provision of community based services for patients with COPD was inequitable as those patients with the greatest need living in the south and to a lesser extent the west of Leeds, did not have the same access to services compared with other areas of the city. To address this inequity the PCT has adjusted the distribution of resources in order that the priority elements of early discharge and pulmonary rehabilitation are provided across the city, and resources are concentrated in the areas of greatest need.

Furthermore an equity audit in East Leeds has identified that the local population is not accessing these services according to the level of their needs. The reasons for this include that the service is still new and that possibly the data system is not being used to collect all activity.

Future work on the strategic development of services for patients with COPD is planned over the next two years which will use prevalence data, admissions data and mortality rates to determine the capacity and geographical location of future services.

**Section 4**

# Public Consultation and Engagement

## 1. Background/Context

The NHS Plan and Our health, Our care, Our say puts patients at the centre of everything the NHS does and plans to do. Section 242 of the NHS Act 2006 which replaces Section 11 of the Health and Social Care Act 2001, requires that services for which the PCT is responsible, involve service users in:

a) the planning of the provision of those services
b) the development and consideration of proposals for changes in the way those services are provided, and
c) decisions to be made by that body affecting the operation of those services.

The changes to commissioning and the introduction of Practice Based Commissioning which will need to reflect the needs, priorities and aspirations of the local population, means that commissioners will engage with the public and actively seek the views of patients, carers and the wider community.

## 2. Mechanisms for consulting with local people

There are a variety of mechanisms we use to consult with local people during the planning and decision-making process. These are a mixture of formal and informal, established groups and approaches, depending on the nature of the change being proposed.

The mechanisms currently being used include:

- The Patient and Public Forum (PPI) which will be replaced with Local Involvement Networks (LINks) from April 2008.
- National patient surveys which are adapted locally on choice and access
- Patient Advice and Liaison Service (PALS) which focuses on improving the service to NHS patients
- Complaints – these are analysed and used to inform service changes. (review services and create opportunities to make improvements)
- Community Groups – the PCT involves community groups as appropriate
- Voluntary sector – the PCT has a Service Level Agreement with Leeds Involvement Project to ensure dialogue with the voluntary sector
- Health Forum – a group of voluntary organizations with a health focus
- Practice Based Commissioning Patient Advisory Group to ensure that proposals reflect the needs of the local population
- Formal public consultation which is held when substantial or significant service change is planned (formerly Section 11)
- Involvement – where discussions take place with a range of stakeholders to look at ways to continually improve and develop services or respond to the need to change

- Information giving – providing people with information on local services
- Focus groups, questionnaires and patient diaries are used as appropriate

## 3. Urgent Care Engagement and Consultation

A recent example of engagement and consultation is the development of the Leeds and West Yorkshire Urgent Care Commissioning Programme. The key points from the work undertaken and the outcome, include:

- responding to a report from the PPI Forum about urgent care and GP Out of Hours Services formed part of the original case for change
- the engagement phase and the feedback from this has been fed into the development of a specification which will be the basis of an invitation to tender from providers
- there have been PPI representatives involved in the short-listing panels and this involvement will continue throughout the procurement process
- patient and public engagement will be on-going throughout the process with a service user reference group being established, which will review consultation methods and materials and commenting on contractor's outline solutions.
- formal 12 week consultation with information available through a website, GP practices, health centres, hospitals, libraries, community groups and centres, media work, events, public meetings, etc.

Leeds CITY COUNCIL

Originator: Dennis Holmes

Tel: 24 74959

**Report of the Director of Adult Social Services**

**Scrutiny Board (Health and Adult Social Care)**

**Date: 21st January 2008**

**Subject: Localisation in Health and Adult Social Care**

| **Electoral Wards Affected:** | **Specific Implications For:** | |
|---|---|---|
| All | Equality and Diversity | |
| | Community Cohesion | |
| Ward Members consulted (referred to in report) | Narrowing the Gap | x |

**Executive Summary**

This report provides information in relation to the development of the Leeds Joint Strategic Needs Assessment (JNSA) which was made a statutory duty under Section 116 of the Local Government and Public Involvement in Health Act 2007. This assessment, jointly lead by the Director of Adult Social Services, the Director of Children's Services and the Director of Public Health for Leeds, will form the evidence base on which a range of health and well-being interventions will be founded.

The duty to complete comes into force on the 1st April 2008.

When completed, the JSNA will be unique to Leeds and represent the unique circumstances of the different localities and communities that make up the City.

The report goes on to discuss potential options for the future co-location of Health and Social Care staff presented by developments in Primary Health, particularly with regard to the role played by General Practitioners as locality commissioners.

## 1.0 Background Information

1.1 The duty to put in place a Joint Strategic Needs Analysis was brought into force by the enactment of Section 116 of the Local Government and Public Involvement in Health Act 2007. In the guidance accompanying the Act*[1], published on the 10th December 2007, the Department of Health defines the JSNA as follows:

"JSNA describes a process that identifies current and future health and well-being needs in the light of existing services and informs future service planning taking into account evidence of effectiveness. The JSNA identifies 'the big picture' in terms of the Health and wellbeing needs and inequalities of a local population."

[1] * Appended as Appendix 1

1.2 In the context of the guidance needs assessment is defined as "*a systematic method for reviewing the health and wellbeing needs of a population leading to agreed commissioning priorities that will improve health and well-being outcomes and reduce inequalities."*

1.3 It is our intention to follow the guidance in relation to the outline methodology which sets out the need to obtain contributions from a wide range of stakeholder interests including the statutory partners in the Local Strategic Partnership, providers form the public, private and third sectors as well as user led organisations. This is in recognition o f the fact that such organisations often have detailed knowledge of the communities in which they operate.

**2.0 Timing and Duration of the JSNA**

2.1 the JSNA is clearly intended to fulfil three purposes, firstly to provide a current picture of the needs of the communities of Leeds and to extrapolate from that the likely needs of those people over a three to five year period. Secondly to be used as a baseline from which more detailed analyses can be conducted in relation to smaller geographic areas, in relation to specific populations or in relation to specific health care conditions and/or concerns. Finally, the JSNA forms the basis of a longer term (10 – 15 years) analysis which will take into account changes in demography and infrastructure developments.

2.2 As might be imagined from an undertaking on this scale, the refinement of the JSNA will be a continuous process commencing with a concise summary of the main health and well-being needs of the communities of Leeds. This in turn will lead to the production of more detailed analyses and further refinements within planning cycles.

2.3 The JSNA is seen as an important support to the Local Area Agreement structure and it's production will be aligned to support the implementation of the Leeds agreement through the early part of 2008. The cycle of its development will then be aligned to that of the LAA (i.e. three yearly).

2.4 Much of the source material in terms of demographic and public health information is already available and is already used to support a range of commissioning initiatives in health and social care. Work is currently being undertaken by Council Officers and their colleagues in Health to identify those elements of the analysis which are already available and those elements which are not available and that will need to be gathered and analysed.

2.5 Community engagement will play a significant role in ensuring that the JSNA accurately reflects the health and well-being aspirations of all the communities of Leeds and gaining the community perspective will therefore become a key work strand in it's development and publication.

2.6 It is proposed that a further update be provided to the Scrutiny Board in six months time, providing greater detail on the progress towards publication and summarising the methodological approach and any emerging findings.

**3.0 Co-Location with Health Partners**

3.1 A companion paper submitted by Health colleagues alerts Members of the Scrutiny Board to the development of Practice based commissioning Consortia which have begun to be formed around the City. Attention is drawn to the close relationship which needs to exist between the JSNA of the health and well-being needs of populations served by the practices.

3.2 The practices own responsibilities for involving and engaging with the public and patients in relation to the development of their commissioning plans is highlighted.

3.3 Importantly, from the Council perspective, the establishment of the practice Based Commissioning Forum has created an opportunity for discussions to be progressed in relation to locality collaboration between and social care professionals.

3.4 The current position in relation to collaboration between primary health and social care professionals is patchy with some areas of the city benefiting from some co-location (Joint Care management Teams for example, which contain intermediate care nurses and therapists alongside their social care colleagues) but in many instances no such arrangements exist.

3.5 Discussions have taken place between Health colleagues and Adult Social Care Officers, to determine the extent to which greater co-location opportunities could be identified and accessed and the ways in which service design could be adjusted to reduce duplication and maximise efficiency and effectiveness of our staff.

3.6 These discussions will be taken forward in the coming months through the PBC forum and informed by the outputs from the JSNA as they become available so as to ensure that the most appropriate blend of staff are located in the most appropriate place to maximise their effectiveness.

**4.0 Recommendations.**

4.1 Members are invited to consider the issues raised in this report in relation to the compilation of the Joint Strategic Needs Analysis for Leeds and the opportunities created for locality engagement and greater co-location within a Practice Based environment.

4.2 Members are invited to consider the content of Appendix A “Guidance on Joint Strategic Needs Assessment” and to receive a further report highlighting progress in its development.

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Department of Health

# Guidance on Joint Strategic Needs Assessment


# Guidance on Joint Strategic Needs Assessment

In partnership with


department for
children, schools and families

## DH INFORMATION READER BOX

| | |
|---|---|
| **Policy**<br>HR/Workforce<br>Management<br>Planning<br>Clinical | Estates<br>Commissioning<br>IM & T<br>Finance<br>Social Care / Partnership Working |
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| **Superseded Docs** | N/A |
| **Action Required** | N/A |
| **Timing** | N/A |
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| **For Recipient's use** | |

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# Foreword

In order to achieve the world class services that people expect, we must have a full understanding of local needs.

The requirement for Joint Strategic Needs Assessment, created earlier this year in the Local Government and Public Involvement in Health Act, will lead to stronger partnerships between communities, local government, and the NHS, providing a firm foundation for commissioning that improves health and social care provision and reduces inequalities. This vision of stronger partnership working is reinforced in the cross-sector concordat *Putting People First: a shared vision and commitment to the transformation of adult social care*.

Earlier this year, as part of the wider consultation on the *Commissioning Framework for Health and Wellbeing*, we asked you about the proposed duty of Joint Strategic Needs Assessment. In response, you told us that you welcomed the duty, but wanted further guidance on certain aspects, including timing and the relationship with other local plans including the Children and Young People's Plan. You also told us that you wanted some flexibility to design approaches that are appropriately tailored to your communities, allowing the unique needs of your areas to drive locally focussed actions. In this guidance, we have built upon the initial approach outlined in the *Commissioning Framework for Health and Wellbeing* and responded to what you have said.

We firmly believe that community engagement is an essential element of Joint Strategic Needs Assessment, and that the process will, in itself, have a positive impact on health and wellbeing. Engaging with communities includes understanding whether services have delivered what was expected, and whether service users have had their needs met.

Joint Strategic Needs Assessment will identify areas for priority action through Local Area Agreements. It will help commissioners, including practice based commissioners, to specify outcomes that encourage local innovation, and help providers shape services to address needs. We will therefore look for evidence that commissioning decisions have been informed by the Joint Strategic Needs Assessment, to achieve improved health and wellbeing and reduced inequalities at best value for all.

We know that carrying out a successful Joint Strategic Needs Assessment will be challenging – joint working arrangements vary around the country, not all identified needs can be met, and there may be technical difficulties, including those around sharing information. However, much of the relevant work is already happening and most areas are already carrying out substantial elements of Joint Strategic Needs Assessment.

We are publishing this guidance alongside the NHS Operating Framework which clarifies the close fit of the NHS and wider public sector performance frameworks for the next three years. The fit between Joint Strategic Needs Assessment, PCT operational plans and the new Local Area Agreements will allow people and communities to drive a sharper focus on their health and social care in partnership with the NHS, local government and other local agencies.

**Rt Hon Dawn Primarolo**
Minister of State for Public Health

**John Healey**
Minister of State for Local Government

**Ivan Lewis**
Parliamentary Under Secretary of State
for Care Services

**Rt Hon Beverley Hughes**
Minister of State for Children,
Young People and Families

**Ben Bradshaw**
Minister of State for Health Services

# Summary

The Local Government and Public Involvement in Health Act (2007) places a duty on upper-tier local authorities and PCTs to undertake Joint Strategic Needs Assessment (JSNA). JSNA is a process that will identify the current and future health and wellbeing needs of a local population, informing the priorities and targets set by Local Area Agreements and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities.

This guidance has been produced following consultation on the *Commissioning Framework for Health and Wellbeing*. The many people and organisations that responded welcomed the duty of JSNA, especially the fact that it will inform Sustainable Communities Strategies and Local Area Agreements. The majority of respondents supported locally designed approaches to JSNA, but requested further guidance, in particular regarding issues around timing and duration, the link with other plans and engaging with communities. Many also commented on the core dataset, welcoming it as a good starting point to build upon and asking for further tools that would support JSNA.

This document complements the draft statutory guidance *Creating Strong, Safe and Prosperous Communities* (currently out for consultation), and sets out the policy context underpinning JSNA, providing guidance and tools for local partners involved in the process. The various stages of JSNA are described, including stakeholder involvement, engaging with communities and recommendations on timing and linking with other strategic plans. This guidance also contains a core dataset, information on using the JSNA to inform local commissioning, and a section on publishing and feedback. Local partnerships will use their own experience and circumstances to develop a more detailed approach to understanding their communities' needs.

# 1. Policy context

**The Local Government and Public Involvement in Health Act (2007)**

The duty to undertake JSNA is set out in Section 116 of the Local Government and Public Involvement in Health Act (2007), and described in the draft statutory guidance *Creating Strong, Safe and Prosperous Communities*, currently out for consultation. The duty will commence on 1st April 2008.

The statutory guidance emphasises that JSNA should be taken into account by the local authority and its partners in preparing the Sustainable Community Strategy, as part of a strengthened commitment to local priorities. The issues identified by JSNA will inform the priorities and targets set by the Local Area Agreement, the delivery agreement for the Sustainable Community Strategy.

In 2006, the Department of Health White Paper *Our health, our care, our say*[1] set out a new direction for improving the health and wellbeing of the population in order to achieve:

- better prevention and early intervention for improved health, independence and wellbeing
- more choice and a stronger voice for individuals and communities
- tackling inequalities and improving access to services
- more support for people with long term needs.

*Our health, our care, our say* identified the need for Directors of Public Health, Adult Social Services and Children's Services to undertake regular strategic needs assessments of the health and wellbeing status of their populations, enabling local services to plan, through Local Area Agreements, both short and medium term objectives. Later that year the Local Government White Paper, *Strong and prosperous communities*[2], outlined a vision of responsive services and empowered communities, including a Community Call for Action across local public services. The Local Government and Public Involvement in Health Act (2007)[3] places a duty on upper-tier local authorities to prepare Local Area Agreements in consultation with others, including district councils in two-tier areas. The Act also places a duty on upper-tier local authorities and PCTs to produce a JSNA. The draft statutory guidance[4] accompanying the Act positions JSNA as underpinning the Sustainable Community Strategy and, in turn, the Local Area Agreements. This *Guidance on Joint Strategic Needs Assessment* aims to support the successful discharge of these new requirements on local authorities and PCTs by providing additional practical advice.

The new performance framework for local authorities working alone or in partnership[5] contains 198 national priorities for local delivery, many of which are relevant to improving adult health and wellbeing. Although performance will be measured against all 198 indicators, each Local Area Agreement will have up to 35 national priority targets that will be subject to performance monitoring, with local partners free to agree additional targets to support improved local delivery and outcomes. A forthcoming Health and Wellbeing narrative sets out how the performance framework will operate to drive improved outcomes in health and social care.

The Department of Health *Commissioning Framework for Health and Wellbeing*[6] builds on these recent reforms, aiming for a:

- shift towards services that are personal, sensitive to individual need and that maintain independence and dignity
- strategic reorientation towards promoting health and wellbeing, investing now to reduce future ill-health costs
- stronger focus on commissioning the services and interventions that will achieve better health, across health services and local government, with everyone working together to promote inclusion and tackle health inequalities.

The *Commissioning Framework for Health and Wellbeing* identified eight steps to effective commissioning, which include understanding the needs of populations and individuals. JSNA will identify the health and wellbeing needs of a local population, and lead to more effective service provision by informing the Sustainable Community Strategy, Local Area Agreement, and other relevant commissioning strategies, driving improvements in the health and wellbeing of a local area and leading to a reduction in health inequalities.*

**Eight steps to effective commissioning**

- Putting people at the centre of commissioning
- Understanding the needs of populations and individuals
- Sharing and using information more effectively
- Assuring high quality providers for all services
- Recognising the interdependence of work, health and wellbeing
- Developing incentives for commissioning for health and wellbeing
- Making it happen: local accountability
- Making it happen: capability and leadership

* The *Commissioning Framework for Health and Wellbeing* is not guidance on how to meet the duty of best value; draft statutory guidance on how to fulfil this duty is currently out for consultation in *Creating Strong, Safe and Prosperous Communities*

In the NHS, the Department of Health's world class commissioning programme will improve commissioning capability. The programme consists of three main areas:

- articulating a vision and purpose for world class commissioning to inspire and motivate the NHS, and setting out the key competencies that commissioning organisations will need in order to become world class
- creating an assurance model to reward PCTs for delivering world class commissioning and to hold them to account
- putting in place a support and development framework to help PCTs attain world class commissioner status.

**World class commissioning competencies for PCTs**

- Locally lead the NHS
- Work collaboratively with community partners
- Engage with the public and patients
- Collaborate with clinicians to inform strategy, service design and resource utilisation
- Manage knowledge and assess current and future needs
- Identify and prioritise investment requirements and opportunities
- Influence provision to meet demand and secure outcomes
- Drive continuous improvement in quality and outcomes through innovation
- Deploy procurement skills that ensure providers have appropriate contracts
- Manage the local health system
- Make sound financial investments

The world class commissioning competencies emphasise the role of JSNA in driving the long term commissioning strategies of PCTs and their collaborative work with community partners, and include an emphasis on public and patient engagement.

# 2. Defining Joint Strategic Needs Assessment

- Joint Strategic Needs Assessment describes a process that identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness
- Joint Strategic Needs Assessment identifies "the big picture" in terms of the health and wellbeing needs and inequalities of a local population

Needs assessment is an essential tool for commissioners to inform service planning and commissioning strategies. For the purpose of JSNA, a clear distinction should be made between individual and population need. JSNA examines aggregated assessment of need and should not be used for identifying need at the individual level. Specifically, JSNA is a tool to identify groups where needs are not being met and that are experiencing poor outcomes.

In the context of this guidance, needs assessment is *a systematic method for reviewing the health and wellbeing needs of a population, leading to agreed commissioning priorities that will improve health and wellbeing outcomes and reduce inequalities.*

Building on the new duty placed upon local authorities and PCTs and commencing 1st April 2008, the key focus of JSNA includes:

- understanding the current and future health and wellbeing needs of the population; over both the short term (three to five years) to inform Local Area Agreements, and the longer term future (five to ten years) to inform strategic planning
- commissioning services and interventions that will achieve better health and wellbeing outcomes and reduce inequalities. In particular, JSNA will address those outcomes described in both the National Indicator Set for local authorities and local authority partnerships, and the "vital signs" referred to in *The NHS in England: The Operating Framework for 2008/09*[7].

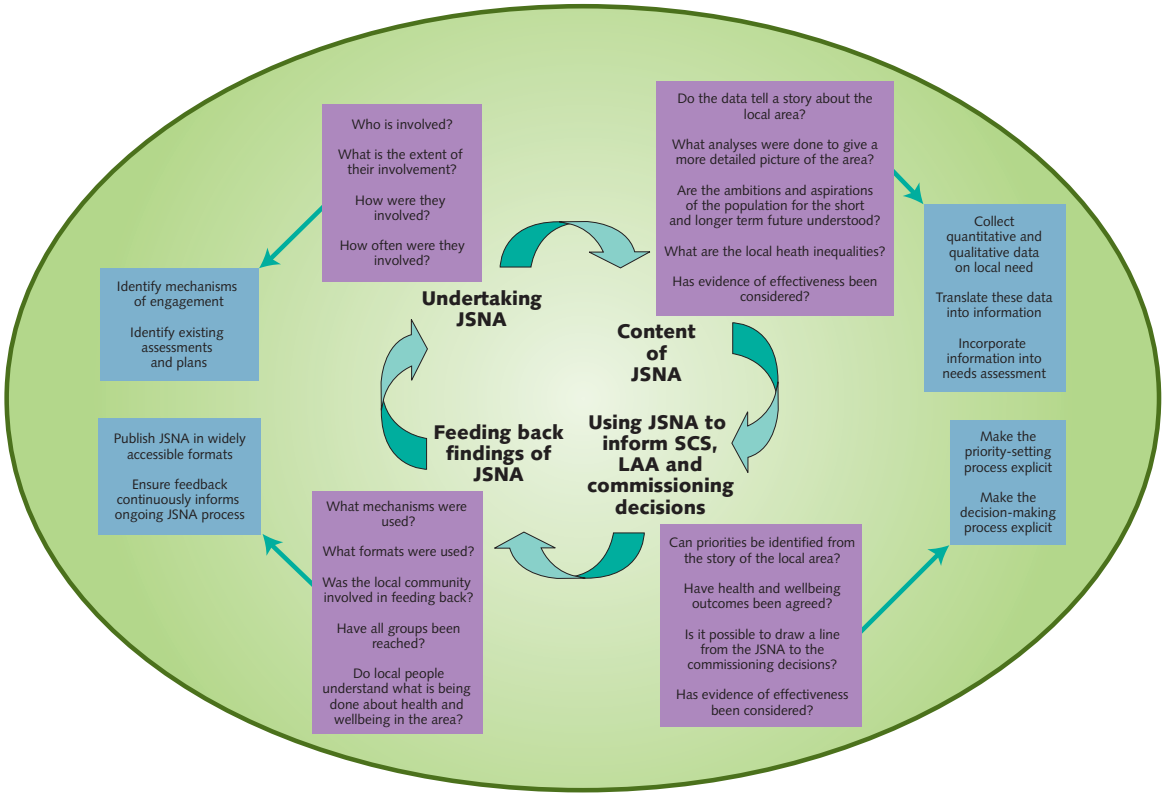
The JSNA process will be underpinned by:

- partnership working: JSNA will be undertaken by Directors of Public Health, Adult Social Services and Children's Services working in collaboration with Directors of Commissioning

- community engagement: actively engaging with communities, patients, service users, carers, and providers including the third and private sectors to develop a full understanding of needs, with a particular focus on the views of vulnerable groups
- evidence of effectiveness: identifying relevant best practice, innovation and research to inform how needs will best be met.

JSNA is a continuous process. All contributing actors should engage with each other throughout and refine their analyses as part of this ongoing process. Figure 1 describes the various stages of JSNA, with accompanying questions and tasks and the anticipated outcomes of these tasks. Each stage of the process is discussed in further detail in later sections of this guidance.

## Figure 1 – The Joint Strategic Needs Assessment process




Each JSNA will be unique and will reflect local circumstances, leading to more detailed analyses of the issues identified. The published findings of the JSNA will be a concise summary of the main health and wellbeing needs of a community as opposed to a large, technical document.

# 3. Undertaking Joint Strategic Needs Assessment

## Who should undertake JSNA?

The Local Government and Public Involvement in Health Act (2007) places the duty of JSNA on upper-tier local authorities and PCTs. In practice, the Director of Public Health, Director of Adult Social Services and the Director of Children's Services will jointly undertake JSNA, working closely with Directors of Commissioning and Finance to help set strategic priorities and make evidence-based investment. Jointly appointed Directors of Public Health can facilitate the process by working across health and local government. For PCTs, the world class commissioning assurance model will ensure that PCT Boards take an active interest in JSNA, and that it is used and understood at a senior governance level.

JSNA will be based on the area of the upper-tier local authority (or unitary council), and should be taken into account by the upper-tier authority in the preparation of the Sustainable Community Strategy. Local arrangements for two-tier areas will therefore need to be agreed in consultation with district councils. PCTs should feed into the JSNA for the local authority area(s) in which the PCT geographical boundary falls.

JSNA will require contributions from a range of stakeholders including statutory partners in the Local Strategic Partnership, providers from the public, private and third sectors and members of the local community. Local practitioners, including those from third sector and user-led organisations, often have detailed knowledge of community needs and are frequently aware of gaps in service provision. They can facilitate exchanges with local communities and groups and identify those who may not have the capacity to make themselves known to services. JSNA will be most effective if communities are involved throughout the process, including design, content, use and feedback. Further guidance on community engagement is given in Section 4.

**Examples of who could contribute to JSNA**

- Neighbourhood services staff including housing leads and community safety officers
- Public health nurses, such as health visitors and school nurses
- District nurses
- Social care staff
- Environmental health officers
- Family planning providers
- Teachers
- Health promotion teams and health trainers
- Community pharmacists
- Youth workers
- GPs and their teams
- Midwives
- Patient Advice and Liaison Services (PALS) and LINks
- Carer centre staff
- Voluntary and third sector providers
- Private providers

## Local Strategic Partnerships

Local Strategic Partnerships (LSPs) are non-statutory bodies responsible for collectively agreeing the Sustainable Community Strategy and Local Area Agreements and overseeing their delivery. The legal duty to produce the Sustainable Community Strategy and the Local Area Agreement rests with the local authority. LSPs and their thematic partnerships will have a key role in encouraging partners to engage with JSNA and use the findings to inform the shared vision and priorities for the place.

## Timing and duration

JSNA will assess current and future needs. In order to have the greatest impact, JSNA will assess needs over the next three to five years, but will include a longer term assessment (five to ten years) to take into account anticipated changes in demography and infrastructure developments and inform strategic planning.

As an absolute minimum, JSNA should align with three-yearly Local Area Agreement planning cycles. Since the findings of JSNA will inform a number of commissioning plans in

addition to the Local Area Agreement, individual areas will use their discretion to update elements of JSNA, responding to local circumstances including the availability of new, strategic, plan-changing, information. Key to updating JSNA is understanding the reliability of available data, including the risks attached to using them. The greater the uncertainty surrounding the data, the more frequently they will need to be re-assessed and a decision made on when to refresh parts, or all, of the JSNA.

## Assessing the needs of children and young people

The Children Act 2004[8] requires local authorities† to prepare and publish an overarching plan setting out their strategy for discharging their functions in relation to children and young people. The Children and Young People's Plan (CYPP) is prepared by local authorities and their partners through the local children's trust cooperation arrangements, feeding into and informed by the Sustainable Communities Strategy. A key element of the CYPP is the requirement to carry out a comprehensive needs assessment, in partnership with all those involved in the planning process, and to review it on a regular basis. The needs assessment is based on the requirement to improve the five Every Child Matters (ECM)[9] outcomes for children, young people and their families: be healthy, stay safe, enjoy and achieve, make a positive contribution, and achieve economic wellbeing. The scope of the CYPP therefore extends to all services affecting children in the locality, not just those provided by the local authority. With its focus on outcomes, partnership working and consultation, the CYPP process is fully consistent with that of JSNA, with JSNA taking the needs of the full age range of the local population into account.

Strategic alignment of the CYPP and JSNA, using consistent and identical datasets, will encourage the planning of services that consider children in the wider context, as part of families, schools and communities. JSNA should take into account the needs of all children, including particularly vulnerable groups such as looked after children, children with disabilities, children in transition and those with caring responsibilities.

The data to inform the health and wellbeing aspects of the five ECM outcomes will eventually be contained within the core dataset for JSNA, together with a wider range of information that can be used to support the CYPP. The Child and Maternal Health Intelligence Unit (CHIMAT, Annex A), is currently developing a specific needs assessment tool for children, based around the requirements of the CYPP and with clear linkage to the JSNA core dataset.

† Four star authorities are exempted from this requirement

# 4. Joint Strategic Needs Assessment: content

## Scope of JSNA

As set out in the draft statutory guidance *Creating Strong, Safe and Prosperous Communities*, the Sustainable Community Strategy must be based on sound evidence. JSNA will identify the health and wellbeing needs of local areas, contributing to this evidence base. JSNA will provide a framework to examine all the factors that impact on health and wellbeing of local communities, including employment, education, housing, and environmental factors. Local authorities and PCTs should therefore build on the core dataset, using clearly defined criteria to select additional, high quality and locally relevant information that provides a clear picture of their area.

## Links to other plans

JSNA will contain a range of information to inform a number of other local authority and PCT strategies and plans. Ensuring linkage of these plans will encourage joined-up commissioning across health and social care, and will have a positive impact on locally provided services.

**Examples of other strategies and plans linking to JSNA**

- PCT and Local Authority commissioning strategies
- PCT Local Delivery Plans
- Children and Young People's Plans
- PBC commissioning plans
- Local development plans
- Community regeneration strategies
- PCT Pharmaceutical Needs Assessments
- Supporting People strategies
- Housing strategies
- Community safety strategies
- Carers strategies
- Workforce planning strategies

## The core dataset

JSNA relies on good quality data. The core dataset (Annex B) is a resource that signposts users to a range of existing data sources that can assist the JSNA process. The dataset is being developed to take into account the set of indicators to support the Department of Health's key outcomes and the Local Government National Indicator Set for local authorities working alone or in partnership. Local areas will be expected to supplement the core dataset with additional, locally relevant information to add depth and insight into the needs of their populations, having locally agreed standards on data quality for inclusion.

Work on the core dataset is ongoing and will be refined as JSNA develops. The latest version of the core dataset can be accessed at http://www.yhpho.org.uk/commissioning_JSNA.aspx; these indicators will be amended as the work evolves.

## Engaging with communities

*Strong and Prosperous Communities* emphasises that citizens and communities know what they want from services and what needs to be done where they live.

Some routinely available data sources on patient and service-user experience are described in the core dataset. These should be supplemented by information gained through active dialogue with local people, service users and their carers. Communities should be involved in all stages of JSNA from planning to delivering and evaluating, rather than being restricted to commenting on final drafts. Careful and relevant community engagement can facilitate and empower people by giving them the chance to voice their needs, whilst local ownership of the process will increase the relevance of services, improving their uptake and sustainability.

Community engagement can be a resource intensive process and PCTs and local authorities should work together, respecting the time and efforts of local people. Many PCTs and local authorities already have wider engagement and consultation strategies in place, and should build on the duties to consult and involve[††] and optimise available listening opportunities such as LINks and Citizens Panels.

†† This guidance only refers to Section 116 of the Local Government and Public Involvement in Health Act (2007)

**Local Involvement Networks (LINks)**

From 1st April 2008, each local authority will establish a LINk in its area. LINks are new bodies designed to involve local people in shaping health and social care services and priorities. They build on the role of patient forums and will enable patients to influence key decisions about all care services.

LINks will be able to investigate issues of concern, demand information, enter and view services, make reports and recommendations, and refer issues to Overview and Scrutiny Committees, providing a one-stop-shop for communities to engage with care professionals and vice versa.

LINks will result in services that are more accountable and make ongoing dialogue with the community easier.

Communities are best engaged through a variety of means and careful consideration should be given in choosing whom to involve, since:

- communities often encompass people with a complex range of interests, many of whom will have different and conflicting priorities
- some may wish to be closely involved in an initiative, others less so
- those who have most need may have less confidence and be least likely to volunteer their involvement.

Ensuring the engagement of particularly vulnerable and hard to reach groups, those with complex medical and social care needs and those experiencing exclusion will be one of the significant challenges of JSNA. Their involvement is important, since they are more likely to suffer from poor health, wellbeing and inequalities, and their engagement with JSNA will best shape services to meet their needs. Third sector and local user-led organisations often have considerable experience in identifying need within these groups.

**Connected Care**

Connected Care is a model for integrating health, housing and social care in the most deprived communities, with the community playing a central role in the design and delivery of those services. The first stage of the model consists of an audit to determine the needs and aspirations of local residents, and their perceptions about the services they currently receive. The audit is carried out by local people trained and supported by the Turning Point Centre of Excellence in Connected Care. The second stage uses the findings from the audit to develop integrated services that better meet the communities' needs.

The box below describes ten standards that are a useful starting point for community engagement. Further resources are described in Annex A.

**Ten steps for effective community engagement**

- **Involve:** Identify and involve the people and organisations who have an interest in the issues which are being explored
- **Support:** Identify and overcome any barriers to people's involvement (transport problems, timing etc)
- **Plan:** Gather evidence of necessary and available resources and use these to plan purpose, scope and timescale of engagement and actions
- **Methods:** Agree to and use methods of engagement that are appropriate and fit for purpose
- **Work together and with others:** Agree to and use clear procedures to enable participants to work with each other effectively and efficiently; work effectively with others who have an interest in the engagement process
- **Share information:** Ensure that necessary information is communicated between participants
- **Improve:** Actively develop skills, knowledge and confidence of all participants
- **Feedback:** Feed back results to all those involved and affected
- **Monitor and evaluate:** Work together to monitor and evaluate whether engagement has achieved its purpose
- **Recognise:** people are different, and processes and services should take meaningful account of those differences

Adapted from *National Standards for Community Engagement*, produced by Communities Scotland

## Evidence of effectiveness

Using evidence of the effectiveness and cost effectiveness of interventions and services is essential in deciding how needs can best be met. Key sources of evidence include NICE, SCIE and IDeA (Annex A). As well as providing guidance to NHS organisations, NICE also provides topical guidance and implementation tools aimed at improving health and wellbeing for use in schools, workplaces, community centres, and leisure, care and community settings. It helps with planning and gives clear standards and recommendations, supported by evidence and costs.

# 5. Using Joint Strategic Needs Assessment

- JSNA is a tool to identify the health and wellbeing needs and inequalities of a local population to inform more effective and targeted service provision
- The Local Strategic Partnership, through the Sustainable Community Strategy and Local Area Agreement, will determine the shared targets to meet these needs
- JSNA will identify priorities for commissioning. Local partnerships should set out explicitly how they are going to prioritise based on the information contained within the JSNA

## Commissioning for outcomes

JSNA will identify the existing and future needs of the community, map services and they way they are used, and include an analysis that will enable the prioritisation of services and therefore commissioning requirements. The Local Area Agreement provides the mechanism through which the wider LSP (which includes the local authority and PCT) can determine the appropriate targets to meet the needs identified.

Historically, most commissioning activity has been expressed through the contractual requirement to provide outputs, such as the number of hours or type of service to be provided. However, measuring the real benefits of services commissioned in this way has proved difficult. In order to translate priorities into commissioning requirements it will therefore be necessary to consider the outcomes that commissioning bodies want to achieve on behalf of communities.

Outcomes are an expression of the results of investing in a service or the provision of the service in a certain manner. They are about improvement, giving control and choice, and the benefits gained. Outcomes can be expressed at four different levels:

- high level outcomes: expressed through developing policy and performance measures, as in the performance framework
- second level outcomes: designed with communities as a way of expressing their involvement and their expectation of changes in service provision or investment in a particular service or treatment

- third level outcomes: designed with groups with common interests and who represent the needs for a proportion of the population that exhibit similarities, for instance some ethnic groups, urban or rural populations or people with needs due to particular disabilities
- there are also individually expressed outcomes for people using services but these would not be the subject of a JSNA priority measure.

Expressed outcomes should be used to assist commissioners. They can be used in discussion with providers to express the results that commissioners want from investment in a service, and open the door to innovative practice and ideas. Commissioners, presenting actual or potential providers with outcomes requirements, may ask providers to write the specification that will lead to the successful results needed.

Expressed outcomes should also be used to measure return on investment - whether the expenditure on one form of provision gives the results required. If not, there should be an understanding of why and whether a different provider could improve results for the same or less investment. This is a key issue in seeking the best ways to gain value for money and improvement, and drives a better understanding of different providers' means of delivering services. In this way, benchmarking of outcomes and subsequent results can be explored between commissioners.

## Publishing and feedback

The findings of the JSNA should be fed back to the local community. Local areas should consider a variety of means of disseminating the findings and ensure that they are available in a range of formats that will be accessible to members of the public. This will include Annual Reports and PCT and local authority websites. PCTs are required to incorporate the findings of the JSNA into the Prospectus, in addition to the outcomes of patient satisfaction and experience surveys and the results of service performance reviews.

### The Director of Public Health Annual Report

There is a long tradition of Directors of Public Health producing independent annual reports. Although PCTs are required to appoint a Director of Public Health to the PCT Board, there is no statutory requirement for them to prepare annual reports.

However, the Priorities and Planning Framework for 2003–06 set out a number of targets which support the Programme for Action for Health Inequalities, including the requirement for PCT service delivery to be informed by an Annual Public Health Report. Directors of Public Health should therefore consider whether they wish to incorporate relevant findings of the JSNA into their annual report, or use their annual report to examine more specific issues and as an expression of their independent, professional view of the state of the health of the local population.

# Annex A: Tools and resources to support Joint Strategic Needs Assessment

This annex provides a list of useful tools and resources that can be used to support JSNA.

## Engaging with communities

### General resources

In 2008 **NICE** will issue guidance for professionals with a role in, and responsibility for, community engagement and development. The guidance will make recommendations about the conditions, infrastructure, approaches and evaluation needed for effective community engagement as a mechanism for health improvement, accompanied by practical tools to support their implementation. The earliest anticipated date of publication is February 2008.

The **Social Care Institute for Excellence** (SCIE) produces knowledge reviews and practical guidance on involving people using social care services.

The **Turning Point: Connected Care Centre of Excellence** champions the delivery of Connected Care in England and Wales. Connected Care is a new vision for community led and fully integrated health, social care and housing services. The Centre will also promote evidence-based best practice for community engagement and community led commissioning.

The Improvement and Development Agency (**IDeA**) provides a number of tools and case studies on effective consultation, including links to the Audit Commission's **Listen Up** pages.

**The NHS Centre for Involvement** supports NHS organisations and staff to create services that are shaped by the views and experiences of patients and the public.

### Children, young people and families

The **Every Child Matters** website links to a number of sources of information on involving children, young people, and their families, and provides guidance on building a culture of participation.

### Older people

The Care Services Efficiency Delivery (CSED) **Anticipating Future Needs Toolkit** provides a methodology for consultation on the future needs of older people in the community, including step-by-step guidelines for conducting questionnaires, focus groups and reporting.

## Identifying current and future need

### Disease prevalence

The Association of Public Health Observatories (APHO) websites provide models for estimating the prevalence of **hypertension**, **diabetes**, **coronary heart disease**, and **chronic obstructive pulmonary disease**, with further models in development.

For diseases lacking local prevalence models, various proxies can be used to estimate need, with variable accuracy. The **National Centre for Health Outcomes Development** website, for example, enables commissioners to compare inputs (expenditure, in the form of Programme Budget Categories) with a range of measures of need and disease outcomes.

### Lifestyle

The **Health Survey for England** (HSfE) provides an overall view of risk factors and disease prevalence. Whilst this does not provide estimates at PCT or local authority levels, local synthetic estimates of some risk factors, based on the HSfE, are available from the **Information Centre**. Local lifestyle surveys and primary care data can be used to support local estimates.

There is currently limited support to help commissioners estimate the impact of local risk factor prevalence on future disease prevalence. The **UKPDS Outcomes Model** is a computer simulation model designed to assess the total burden of disease over an extrapolated lifetime for populations with type 2 diabetes as a risk factor for the diseases. The model uses a wide variety of input data, including knowledge of previous events for individuals, and has the ability to take into account changes in some risk factor levels over time.

### Inequalities

The **Health Poverty Index** gives a high-level overview of each local authority area showing its "health poverty"; a combination of the present state of health, the root causes and intervening factors. It includes some data enabling comparison across ethnic groups.

The **Local Basket of Indicators** for health inequalities, accessed via the London Health Observatory (LHO) website, provides a menu of indicators to examine health inequalities across a range of dimensions.

The interactive **Health Inequalities Intervention Tool**, developed by the Department of Health and the Association of Public Health Observatories (APHO), is designed for use in Spearhead areas. It pulls together key information on disease and life expectancy, allowing areas to establish:

- the size of their local life expectancy gap
- the diseases driving the gap, and by how much and at what ages
- the interventions necessary to ensure rapid impact
- whether plans for key interventions are of sufficient order of magnitude to narrow the life expectancy gap with England.

### Children, young people and families

The Child and Maternal Health Intelligence Unit (**CHIMAT**) is a new national resource providing access to information and knowledge related to child and maternal health.

### Older people

The **Projecting Older People Population Information System** (POPPI), a web-accessed forecasting solution, consists of National Statistics population projections to district level. By February 2008 a number of data enhancements will be available, including population data for 2007–11, and links to ward and SOA area population estimates and poverty and deprivation data.

## Tools to support commissioners

Through funding provided by the Department of Health, the King's Fund has developed the PARR and Combined Model predictive modelling tool, which can assist commissioners in identifying individuals who are most at risk of hospital admissions and in targeting more effective, community based services and interventions. More details at: http://www.kingsfund.org.uk/current_projects/predictive_risk/combined.html. Recent research by the King's Fund has identified the potential to extend the Combined Model approach across both health and social care population data, including the ability to identify individuals most at risk of requiring long term care. The Department of Health is currently discussing how to develop and test the potential of this work with the King's Fund during 2008 (http://www.kingsfund.org.uk/publications/other_work_by_our_staff/predicting_who.html).

Care Service Improvement Partnership (CSIP) provides a range of capacity building tools and networked support for commissioners and providers across local health, housing and social care economies at www.icn.csip.org.uk. Useful tools include:

- The Integrated Care Network (ICN) **Integrated Working: a guide** examines key issues on integrated working and signposts to resources and routes for health and social care communities wishing to progress integration and strategic partnership. An updated version will be published in early 2008.

- ICN: **The role of public health in supporting the development of integrated services** provides an overview of the scope of public health practice, outlines some tools and techniques for designing and evaluating integrated services, and explains how they might be used as a lever for change and service improvement.
- The Better Commissioning Learning and Improvement Network **Commissioning e-book** is a compilation of articles, papers and reports on themes relating to commissioning services across the NHS and local authorities.
- The Housing Learning and Improvement Network (LIN) workbook and CD-ROM **Strategic Moves: thinking, planning and delivering differently** is aimed at those involved in strategic commissioning of older people's services across health, housing and social care. A new edition incorporating JSNA will be published in 2008.

NICE produces a range of bespoke tools for commissioners that can assist those working across a number of complex areas and partnerships and that can inform JSNA. See www.nice.org.uk for more details.

The **Disease Management Intervention Tool** (DMIT) models the effects of possible interventions which may be commissioned at a local level. It supports decision-makers, commissioners and deliverers of care for people with long term conditions. DMIT helps users to analyse and consider the likely impact of possible commissioning decisions.

The Local Health Community (LHC) **Change Capability Appraisal tool** can help PCTs working across the local health community, often with local authorities, to plan and deliver transformational change. It can help assess local change capability and agree a programme of action to address weaknesses that are likely to frustrate the delivery of new models of care.

The **Every Child Matters** website has case studies demonstrating examples of effective practice in commissioning for children, young people and families.

# Annex B: The core dataset

The latest version of the core dataset can be accessed at http://www.yhpho.org.uk/commissioning_JSNA.aspx. Work on the core dataset is ongoing and as the work evolves, indicators may be added, removed or amended.

| Domain | Sub-domain | Sub-sub-domain | Everybody | Children & Young People | Older People | Vulnerable People |
|---|---|---|---|---|---|---|
| Demography | Population numbers | Estimates | 5 year age bands and gender | | | |
| | | Projections | Population 3–5 years ahead | | | |
| | Births | Current | | Current births | | |
| | | Projections | | Projected births | | |
| | Ethnicity | Estimates | Numbers and percentages by ageband | | | |
| | | Projections | 3–5 years ahead | | | |
| | Disability | | Limiting Long-Term Illness | | | |
| | Migration | Misc proxy indicators | *See www.audit-commission.gov.uk/migrantworkers/data for available indicators* | | | |
| Social & Environmental Context | Deprivation | | Index of Multiple Deprivation (IMD) | **Proportion of children in poverty (NI 116)** | | |
| | Living arrangements | Housing | *1. Housing tenure*<br>*2. Overcrowding* | | *1. Living alone*<br>*2. Central heating etc (e.g. from POPPI)* | **1. Adults with learning disabilities in settled accommodation (NI 145)**<br>**2. Adults in contact with secondary mental health services in settled accommodation (NI 149)** |
| | | Transport | *Access to car or van, etc* | | | |
| | Economic | Employment | **1. Overall employment rate (NI 151)**<br>**2. Working age people on out-of-work benefits (NI 152)** | | | **1. Adults with learning disabilities in employment (NI 146)** |

| Domain | Sub-domain | Sub-sub-domain | Everybody | Children & Young People | Older People | Vulnerable People |
|---|---|---|---|---|---|---|
| Social & Environmental Context | Economic | Employment | **3. Working age people claiming out-of-work benefits in worst performing neighbourhoods (NI 153)** | | | **2. Adults in contact with secondary mental health services in employment (NI 150)** |
| | | | *Other Employment Indicators – e.g.: Unemployment rate, Claimant count, etc.* | | | |
| | | Other | Average incomes | | | |
| | Environment | Isolation | Rural or urban location | | | |
| | | | *Access to services (e.g. from Indices of Deprivation)* | | | |
| | Voice | | | | **Satisfaction of people over 65 with home and neighbourhood (NI 138)** | |
| Lifestyle/Risk factors | Behaviours | Smoking | *1. Modelled and/or recorded prevelance 2. Quit rates 3. Deaths due to smoking* | | | |
| | | Eating habits | *Modelled and/or recorded eating behaviour* | **Prevalence of breast-feeding at 6–8 weeks from birth (NI 53)** | | |
| | | Alcohol | **Alcohol-harm related hospital admission rates (NI 39)** *Modelled and/or recorded drinking behaviour* | | | |

| Domain | Sub-domain | Sub-sub-domain | Everybody | Children & Young People | Older People | Vulnerable People |
|---|---|---|---|---|---|---|
| Lifestyle/Risk factors | Behaviours | Physical Activity | *E.g. from Active People Survey* | | | |
| | | Sexual Behaviour | | **Under 18 conceptions (NI 112)** | | |
| | | | | Under 16 conceptions | | |
| | Other | Hyper-tension | *Modelled and/or recorded prevalance* | | | |
| | | Obesity | *Modelled and/or recorded prevalence* | **Obesity among primary school age children in Reception Year (NI 55)** | | |
| | | | | **Obesity among primary school age children in Year 6 (NI 56)** | | |
| Burden of ill-health and disability | Miscellaneous | All causes | All-age All-Cause Mortality (NI 120) | Infant mortality | | |
| | | | Life Expectancy | | | |
| | | | Main causes of death | | | |
| | | | Hospital admissions – top 10 causes | | | |
| | | | **Self-reported measure of overall health and wellbeing (NI 119)** | | | |
| | | | | | **Healthy life expectancy at age 65 (NI 137)** | |
| | | Causes considered amenable to healthcare | Mortality | | | |

| Domain | Sub-domain | Sub-sub-domain | Everybody | Children & Young People | Older People | Vulnerable People |
|---|---|---|---|---|---|---|
| Burden of ill-health and disability | Diabetes | General | Modelled v. recorded prevalence | | | |
| | | | *Implications – e.g. Life Expectancy/ Quality-Adjusted Life Expectancy/Costs from UKPDS* | | | |
| | Circulatory | General | **Mortality rate from all circulatory diseases under 75 (NI 121)** | | | |
| | | CHD | Mortality | | | |
| | | | Modelled v. recorded prevalence | | | |
| | | | *Hospital admission rate for MI (proxy for incidence)* | | | |
| | | | *Admissions for cardiac revascularisation* | | | |
| | | Stroke | Mortality | | | |
| | | | *Hospital admission rate for Stroke (proxy for incidence)* | | | |
| | Cancer | General | **Mortality rate from all cancers under age 75 (NI 122)** | | | |
| | | By site | *Cancer registrations* | | | |
| | Infectious | Respiratory | COPD Mortality | | | |
| | | | COPD modelled v. recorded prevalence | | | |
| | | | *TB notifications* | | | |
| | | STIs | KC60 GUM STI data, particularly gonorrhoea | Chlamydia in under-25s | | Late diagnosis of HIV |
| | | | New diagnoses of HIV/Aids | | | |
| | Dental | Decay | | *% DMFT in 5-year olds* | | |
| | Mental | Dementia | | | e.g. Predictions from POPPI | |

| Domain | Sub-domain | Sub-sub-domain | Everybody | Children & Young People | Older People | Vulnerable People |
|---|---|---|---|---|---|---|
| Burden of ill-health and disability | Trauma | Falls | | | *Hospital admissions for Fractured Neck of Femur (proxy for incidence)* | |
| | | Road accidents | People killed or seriously injured on roads | **Children killed or seriously injured on roads (NI 48)** | | |
| | | Injuries | | **Hospital admissions caused by unintentional and deliberate injuries to children and young people (NI 70)** | | |
| | Musculo-skeletal | Arthritis | | | *Admissions for hip and knee replacement* | |
| | Disability | General | Long-term limiting illness | | | |
| Services | Social Services | Numbers | | | Physical disability, frailty and sensory impairment<br>1. Number of clients<br>2. Number receiving services in community | Physical disability, frailty and sensory impairment<br>1. Number of clients<br>2. Number receiving services in community |
| | | | | | Learning disability,<br>1. Number of clients<br>2. Number receiving services in community | Learning disability,<br>1. Number of clients<br>2. Number receiving services in community |

| Domain | Sub-domain | Sub-sub-domain | Everybody | Children & Young People | Older People | Vulnerable People |
|---|---|---|---|---|---|---|
| Services | Social Services | Numbers | | | Mental health<br>1. Number of clients<br>2. Number receiving services in community | Mental health<br>1. Number of clients<br>2. Number receiving services in community |
| | | | | | Substance misuse<br>1. Number of clients<br>2. Number receiving services in community | Substance misuse<br>1. Number of clients<br>2. Number receiving services in community |
| | | | | | Other vulnerable people<br>1. Number of clients<br>2. Number receiving services in community | Other vulnerable people<br>1. Number of clients<br>2. Number receiving services in community |
| | | Standard of Service | | | | **Timelessness of social care assessment (NI 132)** |
| | | | | | | **People supported to live independently through social services (NI 136)** |

| Domain | Sub-domain | Sub-sub-domain | Everybody | Children & Young People | Older People | Vulnerable People |
|---|---|---|---|---|---|---|
| Services | | Standard of Service | **Carers receiving needs assessment or review and a specific carer's service, or advice and information (NI 135)** | | | |
| | **Preventative** | | Uptake rates for Flu jab, etc | Uptake rates for MMR, etc | | |
| | **Sexual Health Services** | | Offer of an appointment at a GUM service within 48 hours | | | |
| | | | Long acting reversible contraception methods as a percentage of all contraception | | | |
| | | | Access to NHS funded abortions before 10 weeks gestation | Access to NHS funded abortions before 10 weeks gestation | | |
| | **Voice** | User persective on social care | | | **The extent to which older people receive the support they need to live independently at home (NI 139)** | |
| | | | | | | **Self-reported experience of social care users (NI 127)** |
| | | User persective on social care | National Patients Survey Programme findings for local institutions. Available http://www.healthcarecommission.org.uk/healthcareproviders/yourlocalhealthservices.cfm | | | |

**Bold red = National Indicators**

Italic grey = Optional Indicators

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Leeds CITY COUNCIL

Originator: Debbie Chambers
Tel: 247 4792

**Report of the Head of Scrutiny and Member Development**

**Scrutiny Board (Health and Adult Social Care)**

**Date: 21st January 2008**

**Subject: Leeds Partnerships for Older People Projects (POPPs) - an update**

| **Electoral Wards Affected: All** | **Specific Implications For:** |
|---|---|
| | Equality and Diversity ☐ |
| | Community Cohesion ☐ |
| ☐ Ward Members consulted (referred to in report) | Narrowing the Gap ☐ |

## 1.0 Background

1.1 Members will recall that Leeds has received £4.1m over 2 years from the national Partnerships for Older People Programme's (POPP's) ring-fenced budget of £60m.

1.2 The Leeds programme is the largest of the 29 POPP pilot sites across the country and it focuses exclusively on older people's mental health services.

1.3 During 2006/7, the Scrutiny Board received a report about the Leeds POPP at its meeting in October 2006. An update was presented at the meeting in April 2007, which focused on the sustainability of the programme, early headline messages available from the local evaluation and information about the development of an exit strategy. A further update was received at the October 2007 meeting, which focused on the progress being made to prepare and agree a sustainability plan and exit strategy for the Projects. Members asked that a further report be brought to this meeting.

## 2.0 Recommendations

2.1 The Board is asked to

- note the content of the POPPs report and the achievements made through the POPPs programme and
- consider whether it wishes to receive further reports on the whole system re-design of older peoples mental health services.

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Leeds CITY COUNCIL

Originator: J.A.Simpson

Tel: 75936

**Report of the Director of Adult Social Services**

**Scrutiny Board (Health and Adult Social Care)**

**Date: 21st January 2008**

**Subject: Partnerships for Older People Projects (POPPs)**

| **Electoral Wards Affected:** | **Specific Implications For:** |
|---|---|
| | Equality and Diversity ☐ |
| | Community Cohesion ☐ |
| | Narrowing the Gap ☐ |

## Executive Summary

1. Scrutiny Board received a report on Leeds Partnerships for Older Peoples Projects (POPPs) on 15th October and requested a further report in January 08 that gave more detailed information on the management and performance of the Programme.

2. This report gives a summary of the original aims of the programme from a national and local perspective, the governance and performance management arrangements, and the work that has to be done next financial year to secure the sustainability of those projects or services recommended to continue. It summarises the progress achieved so far, and issues still to be addressed.

3. The report concludes that excellent progress has been made thus far, and refers to the positive external feedback that the Leeds Programme has received.

4. The appendices provide an up-dated glossary of abbreviations, a summary of the 12 projects, a copy of the sustainability plan submitted to DH in October 07, and a copy of the National Evaluation interim report.

5. See Appendix 1 for glossary of abbreviations used in this report.

## 1. Purpose of this Report

1.1 To provide Scrutiny Board with a review of the POPPs Programme, including the performance, evaluation and governance arrangements, and assessment of progress to date.

## 2. Background

### 2.1 Aims of the Programme

2.1.1 Nationally the POPPs Programme was set up to test out new ways of working that would promote independence, encourage earlier intervention with the aim of avoiding unnecessary admissions of older people into hospital or long term care. The Programme was also seen as a test bed for developing the principles behind the White Paper "Our Health Our Care Our Say" by encouraging the empowerment of service users and giving more control and choice to older people and their carers, and ensuring their involvement in the planning, development and delivery of services.

2.1.2 The expectation was that real savings could be identified through the new ways of working that would free up financial resources, primarily from the reduction in hospital admissions, care home admissions and length of stay in hospital, which could be redistributed across the health and social care economies. This could then be re- invested into more preventative services and thus sustain those POPPs projects that proved successful.

2.1.3 Locally, in Leeds, the POPPs bid focused on the whole system change and improvement of older people's mental health services aimed at challenging discrimination on the grounds of age, ethnicity or mental health. The bid encouraged more locality and home based services that prevented admission into hospital or long term care, and a reduction in the reliance on institutionalised responses to mental health needs. It supported the broader aims of the larger Making Leeds Better programme, as well as taking forward other national guidance around older peoples mental health services (eg National Service Framework for older people Standard 7; "Everybody's Business" CSIP guidance on older peoples mental services). The 12 projects fall broadly into three themes: earlier intervention, intermediate care and workforce development (*See Appendix 2 for list of the 12 POPP Projects*)

### 2.2 Governance, evaluation and performance monitoring arrangements

2.2.1 At a national level, the Programme is supported by a Department of Health project lead, who in turn is supported by a national lead from Care Services Improvement Partnership (CSIP) and a National Evaluation Team (NET) appointed by the Department of Health.

2.2.2 The Department of Health operates rigorous reporting requirements with quarterly reports to be submitted by each POPP pilot site across the country, and an end of year report which is a more detailed review of the year's activity, progress, achievements and any areas of concern. The traffic light system (red, amber, green) is used to monitor the progress of the pilot sites, and Leeds has been able to consistently report "green/amber" status. The Department of Health has never had any issues with any of the Leeds reports to date, and we have had positive feedback about the quality of our reporting.

2.2.3 The National Evaluation Team (NET) has oversight of all the POPP pilot sites across the country and will ensure the learning and impact of the projects is taken into account in future national policy (*see Appendix 3 for copy of interim report*)

2.2.4 The Local Evaluation Team, (in Leeds this is provided by the University of Leeds) is working with the Leeds POPPs programme to amass evidence of the impact of the Programme and the learning to be captured from the work that has been done. This will report in the spring of 2008.

2.2.5 The POPPs Programme Board provides governance to the Programme on behalf of the partner organisations. It is co-chaired the Chief Officer for Adult Social Care (ASC) and the Director of Service Delivery and Chief Nurse for the Leeds Partnerships Foundation Trust (LPFT). It has on it representatives from all the partner organisations who signed up to POPPs, including the Leeds PCT, Leeds Teaching Hospital Trust (LTHT), Adult Social Care (ASC), Leeds Partnership Foundation Trust (LPFT), Environment and Neighbourhoods, voluntary sector partners as well as members of the Strategic Partnership and Service Development Team. The Board meets monthly and receives highlight reports prepared by the Programme Manager, oversees risks and issues, and provides active support and guidance to keep the Programme on track.

2.2.6 The Programme Manager meets bi-monthly with the Project Leads from the 12 projects, and receives monthly highlight reports from the projects which identifies activities and any slippage against the milestones and indicators. This information feeds into the Board's monthly report.

2.2.7 The POPPs Performance Group is chaired by the commissioning lead for the PCT, the Director of Development and Commissioning (for priority groups) and oversees the performance activity of the Programme. The group is working to show evidence of the impact of the projects across the whole system, evidence that is being used in supporting the business cases for sustainability, and has representation from LPFT, ASC, PCT and the local evaluation team.

2.2.8 The POPPs Programme Office keeps a log of risks, issues and lessons learned which is regularly up-dated by the Programme Manager, and fed into the Board as required. It has also produced documentary evidence and information about the Programme, and learning events undertaken over the two years (eg Intermediate Care event November 06; Resource Centre learning event July 07; Case Studies booklet; Overview document of the 12 projects; lessons learned record)

**2.3. Future requirements**

2.3.1 Although the grand funding of £4.1m was for 2 years, it was acknowledged by the Department of Health that significant slippage was permissible, allowing the Programme to run into a third year. In accordance with this, the national programme which would have formally run from April 06 to March 08 is also extended, and the work of the National Evaluation Team is likely to be extended to October 2009.

2.3.2. The local evaluation report on the Leeds POPP Programme, commissioned from the University of Leeds, should be available by May 2008.

2.3.3 All POPP projects are expected to develop and implement sustainability plans for the projects/services funded through the POPP grant, and to ensure robust exit strategies for the closure of the Programme. This includes arrangements for mainstream funding for those projects/services considered successful in fulfilling the original aims of the Programme, taking into account the evaluation and performance information (*see Appendix 4 Leeds Sustainability Plan).*

**3. Main Issues**

**3.1 Summary of progress to date**

3.1.1 The Leeds Programme has consistently self assessed its RAG (red/ amber/ green traffic light) status as green/amber according to the DH definitions, which is described as *"fair progress, problems manageable, majority of pilot deliverables on schedule*. Overall, we have been able to report that projects are meeting and some are exceeding their activity targets that were set in the Implementation Plans prepared for each project.

3.1.2 All the projects were required to submit their sustainability plan to DH by 12th October this year.(*See Appendix 4 for copy of the plan*) This outlines the process by which agreement will be reached on sustainability of the current POPPs projects/services, with final approval of the recommendations by the respective commissioning bodies being given by February 2008. All the projects recommended for future funding have now had business cases submitted to the respective commissioning bodies, and received support. SP funding has been formally agreed, with Leeds PCT and Adult Social Care funding subject to final approval of their financial plan/budget for next year, which will take place in February 08.

**3.1.3 Recommendations have been agreed on the future for all 12 projects as follows:**

| PROJECT | RECOMMENDATION | FUNDING BODY |
|---|---|---|
| Liaison Psychiatry | Temp extension of funding for 08/09 | PCT |
| Rapid Response | Temp extension of funding for 08/09 | PCT |
| Resource Centres | Temp extension of funding for 08/09 | PCT/ASC |
| Hospital After Care | Transfer of responsibility to SP – extension of contract for 12/18months and thereafter re-tendering exercise. This has now been agreed by the SP Commissioning Body | Supporting People (SP) |
| Community Support (home care) | Roll out of 3 teams to mirror Rapid Response roll-out – funding through re-configuration of in-house service | Adult Social Care (ASC) |
| Carer Support (dementia) | Temp extension of funding for 08/09 pending review of carer support services and their funding across the city | Adult Social Care (ASC) |
| Carer Support (other mental health ) | Service in current form to stop at the end of POPPs funding – alternative approach to be negotiated | |
| Home Support Service for Older People ( HSSOP) | Transfer of responsibility to SP – extension of contract for 12/18 months and thereafter re-tendering exercise. This has now been agreed by SP Commissioning Body | Supporting People (SP) |

| | | |
|---|---|---|
| Community Development Worker (BME) | The older peoples post will not be extended beyond the 2 years POPPs funding – its role will be absorbed into the work of the existing CDW's to provide a none ageist service | PCT |
| SAP/CPA facilitation | This project has now concluded. | |
| Workforce Development | This project will finish at the end March 08 | |
| Website | To absorb into Linkage Plus | |

3.1.4. Representatives from the Leeds Programme met with Department of Health and CSIP in November to present the sustainability plan (*see Appendix 4).* Leeds was commended for its approach to sustainability and was informed that Leeds was in the top group of pilot sites nationally in this respect. The business cases developed by the Leeds Programme were also commended as examples of good practice, and the Department of Health was taking them to use as exemplar templates for the national programme.

3.1.5 The star ratings for ASC were announced nationally in November 07, and in the commentary on the Leeds judgement provided by the Commission for Social Care Inspection (CSCI), the Leeds POPPs programme was mentioned in the achievements section and described as "an exemplar".

**3.2 Key issues for the coming year**

3.2.1 Two projects have now been secured and mainstreamed through Supporting People funding. Five projects have been recommended for extended funded for 08/09 to allow for further evaluation. Four projects will cease at the end of the grant funding, and one will transfer into Linkage Plus.

3.2.2 For those projects with temporary extension of funding, work will continue to ensure the Programme has clear evidence of their performance over the year, and the impact of the services on the whole system improvements that are expected and within the original aims of the POPP Programme. This work continues to be overseen by the Performance Group on behalf of the Programme Board.

3.2.3. For those projects where funding will cease, we have agreed closure plans with the providers.

3.2.4 The emphasis is to establish the impact of POPP projects on the whole system, and commissioners are actively involved in this work, with recommendations and decisions to be made in time for the 09/10 budget setting processes within the PCT and Adult Social Care.

3.2.5 In support of this, further business cases will need to be prepared for consideration next year to enable final decisions to be made on the future long term funding and sustainability of those projects/services.

3.2.6. The POPPs Programme will then conclude, and the Older Peoples Mental Health Strategy Group will oversee the ongoing development and improvement of older people's mental health services.

## 4. Implications for Council Policy and Governance

4.1 The Council is a key partner and provider of some POPP services, and as such must ensure that the Programme complies with Council requirements, and provides positive leadership in the realisation of the Programme.

## 5.Legal and Resource Implications

5.1 The Local Authority will be expected to contribute towards the overall sustainability of the POPPs services, as agreed by the partners, ideally within a joint commissioning and investment context. Initial recommendations have been submitted to the respective commissioning bodies, and further work to secure sustainability will continue as outlined in this report.

## 6. Conclusions

6.1 The Leeds POPPs Programme is the largest and most complex of the 29 national POPPs pilot sites, with the ambitious aim of whole system re-design of older peoples mental health services. It was always expected that the POPPs grant would begin the process of transformation, but that the work would continue beyond POPPs that will take several years to complete.

6.2 The Leeds Programme has made excellent progress against the Application and Implementation Plans it submitted as part of the Stage 2 process for POPPs funding, particularly given that it has only been in operation for 18 months, and some of the projects having been operating for only 12 months.

6.3 There are robust processes in place for managing and monitoring the progress of the Programme at both local and national levels, with clear accountability and governance arrangements in operation.

6.4 The Leeds Programme has received very positive external feedback from the Department of Health, Care Services Improvement Partnership and the Commission for Social Care Inspection

6.5 Positive progress has been made in relation to sustainability, with the outcomes and recommendations as good as could be hoped for at this stage of such a challenging and ambitious Programme.

## 7. Recommendations

That the Board notes the achievements made through the POPP Programme and considers whether it wishes to receive further reports on the whole system re-design of older peoples mental health services.

**Appendix 1 (Scrutiny Board – Health and Adult Social Care- 21st January 2008)**

**Glossary of Abbreviations : POPPs Report**

| | |
|---|---|
| A&E | Accident and Emergency (Department) |
| ASC | Adult Social Care |
| ASS | Adult Social Services |
| CSCI | Commission for Social Care Inspection |
| CSIP | Care Services Improvement Partnership |
| CSSR | Councils with Social Services Responsibilities |
| DASS | Director of Adult Social Services |
| DH | Department of Health |
| EDT | Emergency Duty Team |
| LAA | Local Area Agreement |
| LIT | Local Implementation Team |
| LMHT | Leeds Mental Health Trust |
| LPFT | Leeds Partnerships Foundation Trust (previously known as LMHT) |
| LOS | Length of Stay (in a hospital bed) |
| LTHT | Leeds Teaching Hospitals Trust |
| MLB | Making Leeds Better |
| NET | National Evaluation Team |
| NSF | National Service Framework |
| OPMHSG | Older Peoples' Mental Health Strategy Group |
| PBC | Practice Based Commissioning |
| PbR | Payment By Results |
| PCT | Primary Care Trust |
| PI | Performance Indicators |
| POPP | Partnerships for Older People Projects |
| PSA | Public Service Agreement |
| SP | Supporting People |
| SRO | Senior Responsible Owner |
| SSD | Social Services Department |
| SLA | Service Level Agreement |
| WAA | Working Age Adult (mental health services) |

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# Leeds (Appendix 2- Scrutiny Report 21st January 2008)

## Title
Service redesign for older people with mental health needs

## Client Focus
Older people with mental health problems

## Project Key Elements

Whole system re-design for older people with mental health needs, including delivery of major cultural change.

- liaison psychiatry
- community rapid response service
- three resource centres
- specialist home care service
- hospital aftercare service
- carers support service
- dementia café network
- home support service (practical and emotional support)
- community development focussed on BME communities
- workforce development – SAP/CPA
- website and information service

## Project Outline
Leeds' POPP's project incorporates an ambitious yet considered plan to provide significantly more community-based preventative services and to move resources from acute care where many people are inappropriately placed. The project will bring about a widespread redesign of services for older people with mental health problems by instituting the following service elements:-

### Liaison Psychiatry
The team can be thought of as operating like a community mental health team, but with the population of the general hospital as its sector population. This model will operate on a consultation and liaison basis; referrals will be received as usual as well as being sought proactively through the introduction of staff training and supervision to improve the detection and management of psychiatric co-morbidity. Good channels of communication, with rapid electronic, written and telephone contact, will ensure that community teams and services are kept informed where community follow up is needed, and allow community staff to easily request assessments for people on their caseload who are admitted to the general hospital. As well as extending this service city wide it will also develop a presence in A&E departments. The presence of Liaison Psychiatry in A&E departments, coupled with their presence within hospital wards, would provide the specialist assessment, diagnosis and management advice required to identify those older people who do require acute care and those for whom a community alternative should be sought..

### Community Rapid Response for Older People with Mental health Problems
By providing a rapid response service, crisis situations can be managed without the person going into acute care and rehabilitative and therapeutic services can be provided within the older person's own home. In addition to this, the service will accelerate discharge from hospital by providing the option of

rehabilitative care within the community. Community Mental Health teams (CMHT) will work in partnership with and be physically co-located with the existing Intermediate Care Teams. The two teams will maintain their discreet functions at the same time as jointly managing care, sharing and developing skills and knowledge and developing working protocols.

**Resource centres for older people with mental health problems**
Three resource centres will be created from the remodelling of some residential and day care facilities. The resource centres will enhance the range of enabling support and rehabilitation for people with dementia and provide an equal opportunity for returning home. Each Resource Centre will consist of 5 short-term beds with a focus on rehabilitation and enablement with an adjoining day services base. The short-term beds will be provided to people who experience a crisis or change in circumstances at home and for whom an appropriate level of care cannot be provided within their home but for whom acute care would not be required. They will also be used for people who have been diverted from hospital or for whom a phased return home is more appropriate than a direct move from hospital/A&E to home. Each Resource Centre will develop an outreach aspect to their role whereby they will provide support to older people and their carers living at home in the local communities. A particular focus of the work will be to provide advice and support to carers on managing care within the home.

**Community Support for Older People with Mental Health Problems (Home Care)**
The project will pilot a discrete Community Support team for older people with dementia. It will have a mixed caseload to include people with early onset dementia with a view to maintaining independent living skills from the outset. This team will have enhanced skills to work with older people with mental health problems and will support generic Community Support Assistants in providing support to them. The team will also take a lead role in promoting the use of assistive technology to support older people and their carers at home.

**Hospital aftercare service**
The objective of the Hospital Aftercare Service is to reduce length of stay in mental health beds and to build the confidence and thereby develop the independence skills of people after discharge. It also aims to reduce the likelihood of relapse in symptoms and in particular risk of self-harm and therefore reduce the risk of re-admission to hospital. The service is aimed at older people with mental health problems who have been discharged home from the Leeds Mental Health Trust in-patient services. Age Concern Leeds will provide the individuals with pre- and post-discharge planning, preparation and support as part of the multi-disciplinary team as part of the Care Programme Approach. The Hospital After Care service will be an integrated element within the discharge process and thus support a more positive experience of that pathway for the service user.

**Carers support service**
The project will increase the capacity of the carer support service. The role of the service is to provide support directly to carers as well as specialist advice and information for professionals to increase their skills and confidence when working with carers. The service to carers includes: provision of information; signposting; telephone support; personal contact; benefits advice; advocacy; completing forms; emotional support and reassurance, all by an open referral process. Furthermore, the service will support all five of the city's memory clinics and will also facilitate and hold the budget for the Dementia Café network (see below). In addition, two support workers will work across the city to develop services for carers of older people with mental health problems other than dementia.

**Dementia café network**
The project will open a network of Dementia Cafes across the city. The dementia café model is a new and novel way of bringing people together in a social setting to combat social isolation and loneliness

for people with a dementia and their carers. They offer opportunities to those affected, for the sharing of expertise as well as problems i.e. increase opportunities for self-management/help and prevention of crises. They aim to improve quality of life and well being through being actively involved in developing initiatives that meet their needs and make available advice and information in appropriate ways. They will be staffed by a multi-agency partnership approach, led by the Leeds Alzheimer Society carer development workers with the support of the local voluntary sector, Social Services and Mental Health Trust.

**Home Support Service for Older People (HSSOP)**
The service will provide a wide range of support to clients and carers. This support is emotional and/or practical in nature, focusing on:

- Maintaining/enhancing daily living skills;
- Alleviating isolation and loneliness;
- Building social skills;
- Coping with worries;
- Maximising coping strategies;
- Help in tackling problems;
- Linking with other services;
- Supporting and advising carers.

Support will include organising appointments with doctors, dentists, opticians and chiropodists; accompanying clients to hospital and GP appointments; arranging for them to receive other services such as Home Care; accompanying to resource centres or lunch clubs and providing advice on benefit and other entitlements. Carers will be assisted to visit clients who have been admitted to hospital due to physical health conditions or who have had to move into extra care housing or long-term care because of their deteriorating mental health.

**Community Development Worker (BME)**
The objective of the CDW role is to increase the mental health literacy for older people in local BME communities and to inform service design to remove the barriers to older people from BME communities. The worker will engage with individuals, families, organisations and in communities to:

- raise mental health awareness
- inform communities of available support options and increase uptake
- increase knowledge of the symptom pictures of conditions such as depression and dementia
- inform wider service design

**Workforce Development - SAP/CPA Facilitation**
The project will provide a range of learning opportunities for all professional and voluntary sector staff involved in the provision of care to older people with mental health problems. This would focus initially on the areas of greatest need identified in the Making Leeds Better Dementia Pathway work and could fall under the Older Peoples Mental Health Strategy Group and Dementia Services Collaborative umbrella. Priority will therefore be given to the Primary Care and emergency care parts of the pathway, including groups such as the Police and West Yorkshire Ambulance Service personnel.

**Workforce Development – Trainer for Older People's Mental Health**
The objective of the trainer for Older Peoples Mental Health role is to provide support to non-specialist providers who also work with some older people with mental health problems. The trainer will equip them to work more confidently with older people with mental health problems.

**Older Peoples website & information service**

The project will develop a website for older people and organisations that work with older people in Leeds. It will provide non-stigmatised access to information concerning mental well-being in its broadest sense. As well as providing information about activities, social opportunities and generic services in the community, it will provide links to specialist services.

University of Hertfordshire

# National Evaluation of Partnerships for Older People Projects: Interim Report of Progress

**October 2007**


**The National Evaluation Team who conducted this research comprises:**

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This research is funded by the Department of Health via the Policy Research Programme. More information on the POPP evaluation is available from Kathryn Lord on **k.l.lord@herts.ac.uk**

We are very grateful to the POPP pilot sites for providing key data.


## Introduction

This report provides interim findings and key lessons learnt to date from the Department of Health's POPP programme (Partnerships for Older People Projects). The evaluation is due to present further findings in October 2008. This report will be of interest to localities taking forward strategies to promote independence for older people.

## Key messages

Early findings encompass the following:

- There are early indications that POPP pilot sites are having a significant effect on **reducing hospital emergency bed-day use** when compared with non-POPP sites.
- Pilot sites are reporting **improved access** for excluded groups through proactive case finding, greater publicity and links with the voluntary sector.
- **Partnerships** between statutory organisations and the community and voluntary sectors have improved if compared with the perceived quality of partnerships prior to the initiation of POPP.
- Pilot sites are reporting that **older people's involvement** has increased within steering groups, commissioning, recruitment, provision and evaluation.
- Older people's health (including mental health) and well-being needs are **becoming better integrated within the wider strategic agenda.**

## Background

Within POPP, a total of 29 local authority-led partnerships including health and third sector partners (voluntary, community and independent organisations) have been funded by the Department of Health (DH) to deliver and evaluate locally, innovative schemes for older people. The underlying aim of the 29 pilot projects is to create a sustainable shift in resources and culture away from the focus on institutionalised and hospital-based crisis care towards earlier and better targeted interventions for older people within community settings. The pilots cover a diverse spectrum of activity from low-level to high levels of need.

The POPP projects aim to:

- Provide person centred and integrated responses for older people;
- Encourage investment in approaches that promote health, well-being and independence for older people, and;
- Prevent or delay the need for higher intensity or institutionalised care.

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**October 2007**

## The National Evaluation of the POPP Programme

The Department of Health has commissioned a national evaluation of the POPP programme to assess to what extent these aims are being met and to enable learning to be shared across the country with non-pilot areas. In the longer term the findings from the national evaluation will help to develop the existing evidence base on the effectiveness of initiatives aimed at promoting independence and prevention as highlighted in the Health and Social Care White Paper *'Our Health, Our Care, Our Say: A new direction for community services*'. The national evaluation is being carried out by a partnership of the University of Hertfordshire, Personal Social Services Research Unit, University of Keele, John Moores University and University College London.

A number of methods are being used to explore the impact of the POPP projects including: Analysing activity reports and other key documents from the pilots; assessing the progress of the pilots toward National Public Service Agreement (PSA) targets (reducing emergency bed days and supporting more older people to live at home); analysing cost-effectiveness and measuring, through interviews and focus groups, to what extent POPP interventions are leading to changes in quality of life for older people.

Drawing on the outcomes of some of these methods, seven key areas are now being reported on. The key areas are:

1. The nature of the POPP Projects.
2. The activity of the POPP Projects.
3. The nature of the POPP Partnerships.
4. The involvement of Older People within POPP Projects.
5. Cost-Effectiveness.
6. Approaches to sustainability within the POPP Pilot Sites.
7. Key Learning Points and Achievements to date.

The findings within the report are based on the first six months of data from the POPP projects. These are therefore very early findings and may be subject to change. Final outcomes will be provided in October 2008.

## 1. The nature of the POPP Projects

The POPP programme has two 'waves' of pilot sites. Nineteen pilot sites were established in May 2006 and have developed 193 projects. A further 10 pilot sites came 'on stream' a year later (May 2007) with 52 projects. The pilots are delivering a diverse range of interventions aimed at promoting independence for local older people in line with local needs. The focus of the projects/ interventions includes;

- Community development to promote citizenship and volunteering.
- Providing better access to information, navigation services and peer support for older people.
- Health promotion activities to support healthy living.

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- Low-Level or simple services for older people such as help with shopping, household repairs etc.
- Specialist services for older people with chronic or complex conditions.
- Pro-active case finding of older people at most risk of losing their independence and of hospitalisation.
- Integrated needs assessment and case management to prevent avoidable hospital admissions.
- Better support for older people following discharge from hospital.
- Use of technology such as Telecare.
- Pathway redesign.

Across this range of projects many of the pilot sites are working with their total 'older person' population, including those individuals with mental health needs, those at risk of hospital admission etc. The key areas of 'populations' the projects are working with incorporate:

  - 30% are focused toward all older people in the population.
  - 13% are directed toward older people at risk of hospital admission.
  - 13% target older people with mental health difficulties.
  - 8% are directed toward carers of older people.
  - 5% are taking forward specific projects to develop culturally appropriate services, working closely with their black and minority ethnic populations.

- Of the 245 projects, only 17% are extensions of existing services; either 'rolled-out' county wide or set-up in a new locality. The extent of new services (83%) has, at this early stage, resulted in difficulties around expected service use as it takes time for the wider authority and partner agencies to know what new services may be available and the activities or interventions they may provide.
- Not all the 245 projects are Local Authority led with 32% (n = 79) being provided by voluntary or private organisations.

## 2. The Activity of the POPP Partnerships

In exploring the activity of the 'Round 1' POPP projects, (19), over the first year of operation (May 2006—April 2007), it was reported that:

- 36,069 older people were in contact with, or referred to POPP projects.
- 23,699 individuals had received or were receiving a service within the POPP programme.
- Of those individuals receiving a service, almost two-thirds of users (63%) are aged 75 and over with a quarter of this sample (25%) aged 85 and over.
- Of those staff working in the POPP projects (n=1,068 WTE), 35% (n=378 WTE) are older people as volunteers whilst 20% (n=209 WTE) are drawn from voluntary organisations.

University of Hertfordshire

October 2007

## 3. The nature of the POPP Partnerships

Developing partnerships with other organisations to deliver integrated services is one of the key objectives within the POPP programme.

- At present, 298 organisations are involved across the 29 sites, with the majority of partners being voluntary organisations (54%, n = 162).
- Across the POPP programme, early findings indicate that partnerships between statutory organisations and the community and voluntary sectors have improved if compared with the reported strength of partnerships prior to the initiation of POPP.
- Some of the key challenges that have been reported within the local partnership structures include: Defining and setting roles and responsibilities of partner agencies; negotiating different 'cultures' within the partnerships; the lack of involvement of GPs in some areas; the difficulty of engaging with PCTs in a period of reconfiguration and building the necessary trust and confidence between the different partners.

## 4. Involvement of Older People within POPP Projects

- Across the 29 pilot sites, the involvement of older people has been reported at each stage of the project implementation. This has ensured that the views of older people have been integrated in the design of each local POPP programme.
- Of the 245 projects, the type of older people's involvement includes:
  - 92% of the projects reported they involved older people in the design of the overall POPP programme.
  - 95% of the projects indicate that older people are involved within governance processes (e.g. steering groups, project boards).
  - Within 43% of the projects, older people are reported to be involved in the recruitment process.
  - 77% of projects state that they are involving older people within the local evaluation, either through the design or through direct field work, carrying out interviews and focus groups.

## 5. Cost-Effectiveness

The data exploring the cost-effectiveness of POPP uses emergency bed-day use on a monthly basis between April 2004 and December 2006. A 'difference-in-difference' analysis between POPP pilot sites and non-POPP sites was carried out to enable a measurement of the differences of activity and subsequent costs around emergency bed-days prior to and after, the start of the POPP programme (May 2006). Further information on the analysis and 'difference in difference' model can be found at **www.dh.gov.uk/en/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/DH_4099198**

**There are a number of caveats which should be considered when interpreting these results:**

- Without a full randomised control trial, questions about the attribution of POPP effects must remain. Statistical techniques reduce but do not remove the possibility that some other cause explained the deviation from trend rather than POPP.
- The quality of the Health Episode Statistic Data needs to be considered. The analysis incorporates highly aggregated data so errors should average out, but the risk of errors is real.

With these caveats in mind, the ***early findings*** are:

- When compared with non-POPP sites, there are indications that POPP pilot sites appear to have a significant effect on hospital emergency bed-day use.
- The results show reductions against trend that would produce an average potential cost –saving in the order of; for every £1 spent on POPP, £1 will be saved on hospital bed-days.
- Despite such savings, the challenge for the POPP pilot sites will be in extracting or removing such savings from the secondary care contracts.
- Future cost analysis will explore older people's reported levels of quality of life alongside any data on overarching cost-effectiveness. This will ensure that any benefits to individuals resulting from their involvement in the POPP programme are captured.

## 6. Sustainability

A further key requirement of the POPP programme is that projects that demonstrate effectiveness must be sustained beyond the funding period. Pilot sites have reported a number of ways that sustainability will be promoted.

- The majority of sites identified using National policy mechanisms (e.g. Practice Based Commissioning, Payment by Results and the Health Act flexibilities) to ensure projects are sustainable.
- Local Area Agreements have been identified as a central mechanism to continue project development and sustainability.
- Some pilot sites are concentrating on empowering older people and the wider community to set up and take forward specific projects through Social Enterprise models.

- Of the 245 projects running within the POPP programme in July 2007 it was reported that 161 (66%) will be 'mainstream' funded following the end of the POPP grant. The pilots are currently in the process of updating their sustainability plans.
- All the pilot sites emphasise the importance of negotiating with commissioners and partner organisations at a very early stage in any project evolution if sustainability is to be achieved.

## 7. Key Achievements & Learning Points to Date

Early stage data appear to indicate the following achievements:

### Achievements

**Organisational 'Culture'**

- Improved partnerships between social services and the voluntary sector.
- Older people's health (including mental health) and well-being needs becoming better integrated within the wider strategic agenda.
- Increased and effective representation by older people within steering groups, commissioning, recruitment, provision and evaluation.
- Increase in the capacity of the voluntary sector to bid for and provide services.
- Greater recognition of the necessity of including the voluntary sector within service provision.
- Increased recognition across statutory services of the need for low-level services to sit within the overall health and social care economy.

**Project Process**

It has been reported by the pilot sites that the process of taking forward the POPP projects has led to:

- Improved multi-agency staff working.
- Development of shared procedures and protocols for cross-boundary services.
- Improved access for excluded groups through proactive case finding, greater publicity and links with the voluntary sector.
- Re-branding of services away from 'welfare' to health and well-being.

### Learning Points

- **Time:**
  - The majority of sites have argued the necessity of a longer lead-in time if the projects are to be 'open for business' and demonstrating outcomes within the two year time limit.
  - The time taken to recruit new staff should not be under-estimated.

- Sufficient time needs to be allowed to develop and write contracts, tenders and service level agreements.

- Ensuring appropriate and equal representation of older people requires focused work, training, support and time.

- **Governance**
  - It is necessary to set up and agree rigorous and regular reporting and accountability structures prior to the start of the projects.
  - High quality performance management can ensure early feedback of outputs to help projects refocus the service or intervention where necessary.

- **Outcomes**
  - If projects are to demonstrate effectiveness, datasets must be developed, robust base-line data collected and the focus should be on outcomes rather than outputs.

## Next Steps in the National Evaluation

The National Evaluation will be working within six key areas over the next 12 months:

- On-going performance data will continue to be analysed to explore the activity across and within the POPP programme.

- Progress of the 29 sites toward the Public Service Agreement (PSA) targets will continue to be monitored and analysed.

- Cost-effectiveness data will continue to be collected and analysed at the PSA level, project level and at the level of the individual user through a number of research methods.

- The benefits of the POPP projects to individual users will be assessed through the on-going collection and analysis of quality of life data.

- Six sites will be selected for in-depth analysis. Within these sites, interviews and focus groups will be carried out with key staff to assess the barriers and facilitators to promoting independence with older people.

- Interviews will be carried out with older people within the six sites, both within and outside of the POPP projects, to assess what further value POPP is adding to the health and social care economy.

University of Hertfordshire

October 2007

## POPP Pilot Sites

Further information on the 29 local authority-led pilot partnerships (listed below) and their interventions can be found at: **www.changeagentteam.org.uk/POPP**.

### POPP 'Round 1' Pilot Sites - May 2006

- Bradford City Council
- London Borough of Brent
- London Borough of Camden
- Dorset County Council
- East Sussex County Council
- Knowsley Metropolitan Borough
- Leeds City Council
- Luton Borough Council
- Manchester City Council
- Norfolk County Council
- North Lincolnshire County Council
- Northumberland County Council
- North Yorkshire County Council
- Poole Borough Council
- Sheffield City Council
- Somerset County Council
- London Borough of Southwark
- Worcestershire County Council
- Wigan Metropolitan Council

### POPP 'Round 2' Pilot Sites - May 2007

- Calderdale Metropolitan Council
- London Borough of Croydon
- Devon County Council
- Gloucestershire County Council
- Kent County Council
- Leicestershire County Council
- North Somerset County Council
- Rochdale Metropolitan Council
- Tameside Metropolitan Council
- West Sussex County Council

# LEEDS
# PARTNERSHIPS FOR OLDER PEOPLE PROGRAMME

## SUSTAINABILITY PLAN

## OCTOBER 2007

LEEDS POPPs PROGRAMME

## 1. INTRODUCTION AND BACKGROUND

**The Leeds POPP Programme, with £4.1m over 2 years, is the largest and probably the most complex and ambitious of the 29 pilot sites across the country.**

**It aims to begin the process of change and improvement in older peoples mental health services across the whole health and social care economies. In so doing, it supports and mirrors the larger ambitions of Making Leeds Better (MLB), as well as informing , supporting and benefiting other workstreams and change programmes (for example Carers Strategy; Intermediate Tier review; Intermediate Care services review; Telecare; Linkage Plus; New Type of Worker; Adult Social Care (ASC) Transformation Programme).**

**The 2 year POPP Programme was never seen as the end, but the beginning of the process of change, development and improvement, by testing out different ways of working and approaches to service delivery.**

**The combination of local and national factors and imperatives has led to the current position of the Programme having to show evidence of its impact (across a very large and complex health and social care system) with, in effect, only one full year of activity. Projects came on stream incrementally between April and December 2006.The local evaluation is not due to report until after April 08, after the programme was planned to finish and when it had the full range of evidence available from the 2 years of activity.**

**The Leeds POPP Programme Board had anticipated the need for recommendations by the Autumn of 2007 in order to meet the requirements and timetables of the commissioning partners, and the needs of the provider partners. Key factors to be taken into account include:-**

- **The timing of the financial/budget cycles within PCT, ASC and Supporting People ( SP) processes**
- **The commissioning processes within ASC, PCT and SP- and the development of joint commissioning**
- **The future impact and influence of Practice based Commissioning**
- **The need for provider organisations ( and particularly the voluntary sector organisations) to know where they stand well in advance of the 2 year contract to allow for their financial and HR planning**
- **The time required for any re-commissioning and procurement processes once decisions have been made.**

**Alongside these issues are the very real challenges of providing the necessary evidence acceptable to the commissioners that would give them the confidence to continue to invest in the model of services delivery being tested out by POPPs projects. These include:-**

- **The implications of having evidence from 12 months activity ( which includes the first year when projects were still finding their feet and may not have been working up to full capacity), rather than the two years of activity originally envisaged**
- **The need to develop data collection systems specific to the interests of the POPP Programme, related to older peoples mental health activity – particularly within generic services**
- **The need for good data analysis to interpret the complex data that is available from a POPPs perspective**
- **Apportionality – how to prove it is POPPs that is having any impact, as opposed to other initiatives across the city**
- **The emergence of PbR as the mechanism for funding/the currency for payment across the PCT and Acute Trust. There is a need to understand how older peoples mental health services fit into this, how activity can be demonstrated and how savings delivered through the projects can be clearly identified**
- **Issues concerning the coding of both primary and secondary mental health activity within the Acute Trust**
- **How to show connectivity across projects as part of wider care pathways/networks of care for older people with mental health needs, and to demonstrate the interdependencies between projects**

## 2. OUR APPROACH

**Stage 1 of the process, which this Plan represents, confirms the processes that are in place and that will be used to reach agreement on the future of the projects/services within the Leeds POPPs Programme. The document also includes observations from the POPPs Programme to the commissioners based on the experience and evidence that is available, informed by the learning so far, about which elements of the Leeds programme might be sustained beyond the 2 year POPPs funding. This is presented along with the most appropriate funding streams to consider, together with the current costs of the services and slippage available to support the budget for 08/09. It offers a template providing a summary of this information. Behind this summary is a wealth of information about the projects, learning from the programme , and performance and evaluation information so far available. Supporting information will be made available to commissioners during the Stage 2 process**

**This document states the agreement by the Director of Adult Social Services and the Chief Executive of the Leeds Primary Care Trust to the process and time-frame for decision-making on sustainability for the projects/services.**

**Stage 2 will be the implementation of those processes which will lead to final agreement on the future of each project by the end of December 2007.**

**Those decisions will then inform the exit strategy/plan to bring about the agreed outcomes for the projects/services and to support the projects through the next phase in their POPP lifecycle, which will be either:-**

- **Termination/closure of the project**
- **Mainstreaming**
- **Extended short term funding, up to a maximum of 12 months (covering 08/09)**

**For those projects receiving either mainstream or extended short term funding, there may still be a requirement to :-**

- **Adjust the model of delivery to improve efficiencies/effectiveness**
- **Prepare for a re-commissioning exercise involving re-tendering**
- **Re-negotiate the specification**
- **Provide additional evidence of effectiveness in order for commissioners to make a final decision about the future of the service by the end of 2008/9**

**In all cases, the agreed outcome will be influenced by the lessons learned from the Programme and its individual projects**

**3.THE MATRIX CONTAINING THE POPPs PROGRAMME /BOARD's COMMENTS/OBSERVATIONS ON SUSTAINABILITY AND FUNDING OPTIONS FOR CONSIDERATION BY THE COMMISSIONERS.**

**Colour coding : blue=PCT funded; amber=ASC funded; green- SP funded**

| Project | Sustained Y/N/Temp | Timescale( for decision/ imple mentation) | Funding (rounded up) 08/09 Slipp-age | new | 09/10 | Due Exit Date (when 2 year POPP funding finishes) | Comments(including who will fund and deliver the service; why any delay in decision etc) |
|---|---|---|---|---|---|---|---|
| 1.Liaison Psychiatry | Yes | December 07 – goes into PCT strategic planning process | 164k | 120k (total 284k) | 291k | End September 08 | POPPs funds extension of service city-wide. LPFT is the provider and LTHT the host. Slippage available to fund part year 08/09. Recurrent funding needed for 09/10 During 08/09 further work required to refine optimum model that will achieve maximum efficiency/effectiveness, to identify impact on LTHT activity and potential for negotiation on tariff splits under PbR) PCT responsible for funding |
| 2.Rapid Response | Yes | December 07 – goes into PCT strategic planning processes | 110k | 230k (total 340k) | 347k | End July 08 | POPPs funds 1 team in NW sector LPFT is the provider. Model dependent upon outcomes of Int. Tier and Int. Care Services reviews.( Refer to original LDP). Funding will allow continuation of service in NW wedge to ensure city-wide cover alongside LPFT roll- out. PCT responsible for funding |
| 3.Resource Centres | Temp extension | December 07 for temp extension- Dec 08 for financial year 09/10 | 182k | 59k 59k (total 300k) | 237k 145k (382) | May 08 | POPPs funds 3 sitesx5 beds (15 dementia CIC beds) in 3 LA homes + PCT therapy and LPFT RMN input covering West, East and South Leeds. More time needed to show evidence of diversion from LT care and impact of outreach on carer |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | support. Need to review appropriateness of model for people with dementia, linked to review of I.Tier and I.C Services ;day services review in ASC; partnership group for CU/HOP integration. Slippage to part fund 08/09 costs across ASC and PCT<br>PCT and ASC funding |
| 4.HAC | Yes – subject to SP | November/ Dec 07 | 55k | 55k | End March 08 | POPPs funding city wide service.<br>Age Concern Leeds (ACL) is the provider.<br>SP Commissioning Board to confirm eligibility and compliance with local priorities. If agreed, SP would be required to pick up funding from April 08 |
| 5.Community Support | Temp extension | December 07 for temp extension – Dec 08 for financial year 09/10 | 158k 162k<br><br>(total 320k based on 200 hrs per team) | 705k<br><br>(based on 444hrs per team) | End September 08 | POPPs funds one team in NW – in-house<br>Requires final commissioning decisions – will go to Adult Commissioning Board 1st Nov, for first cut discussions at 15th Nov DMT. Will require interim SLA (for ? 1 year 09/10) pending broader commissioning for CSS and reconfiguration of in-house services<br>ASC funds |
| 6aCarer Support (dementia) | Yes – outcomes not service | December 07 | 8k 98k<br><br>(total 106k) | 109k | End March 08 | POPPs is extending the service city wide- provided by Alzheimers Society.<br>To go to Adult commissioning Board 1st Nov, for first cut discussions at 12th Dec DMT. Both carer support services to be re-commissioned in whole system approach/review of carer support/use of CSG to ensure equity and non-ageist approach (could services be commissioned generically or are there any specialist elements required?) Slippage needed to fund 08/09 if continued investment agreed.(Staff may be TUPE'd into any new |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | service). Otherwise existing services will absorb older peoples services with no additional resources. City wide cover will cease if no funding to continue POPPs |
| 6bCarer Support (OMH) | Yes- outcomes not service | December 07 | -- 54k | 55k | End July 08 | POPPs funding city wide service provided by ACL<br>As CS(D) – note ACL also provide LD carer support service. |
| 7.HSSOP | Yes- subject to SP | December 07 | -- 261k | 266k | End March 08 | POPPs funding extension from LS7 to LS8 & 9. Service provided by Community Links<br>SP to confirm eligibility and compliance with local priorities .If agreed, SP funding required to pick it up from April 08. Need to address equity of provision across the city. |
| 8CDW(BME) | No | April 08 | 16k -- | -- | End August 08 | To absorb older peoples issues into work of existing CDWs after 2 years POPPs funding ceases. . |
| 9a SAP/CPA | No | Close project by end March 08 | 60k -- | -- | End March 08 | Currently no post-holder in place. Short term work up to end March may be commissioned |
| 9b Workforce Development | No | Close project by August 08 | -- -- | -- | End August 08 for full 2 years, but contract is up to end March 08 | The project will produce/recommend a workforce development strategy for health and social care (including 3rd tier) for older peoples mental health |
| 10Website | No | Close by end March 08 | -- -- | -- | End March 08 | Subsumed within Linkage Plus and maintenance requirements will be managed as part of that exit strategy. |
| | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Evaluation** | **No** | **To complete 2 year evaluation as commissioned** | **4.5k** **--** | **--** | **End March 08 ( report will be later when analysis completed)** | **To consider re-tendering for additional evaluation for those projects on temporary extended time-scales, if required** |
| **Programme Management** | **Temp extension** | **To maintain co-ordination to end Sept 08** | **5k** **51k** **(total 56k)** | **--** | **End March 08** | **Costs of Programme Manager and Office Support to extend the co-ordination of the Programme a further 6 months. If PM costs are absorbed within existing role/s of whoever takes over, then POPPs costs reduced.** |

## 4.THE FINANCIAL ENVELOPE for 08/09 and 09/10: how it would look if commissioning decisions sustained services as above

| Code | Project | Forecast | | Funded By | | | Forecast | | Funded By | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 08/09 | Slippage | LCC | PCT | Supp People | 09/10 | Slippage | LCC | PCT | Supp People |
| 776 | Liaison Psychiatry | 284,151 | 163,900 | | 120,251 | | 291,214 | | | 291,214 | |
| 777 | Rapid Response | 339,546 | 109,818 | | 229,728 | | 347,547 | | | 347,547 | |
| 778 | Resource Centres | 298,716 | 181,773 | 58,472 | 58,472 | | 381,691 | | 236,900 | 144,791 | |
| 779 | Hospital After Care | 55,214 | 40 | | | 55,174 | 56,172 | | | | 56,172 |
| 780 | Community Support | 320,178 | 158,261 | 161,917 | | | 704,696 | | 704,696 | | |
| 701 | Carers Support - Dementia | 106,448 | 8,352 | 98,096 | | | 109,053 | | 109,053 | | |
| 702 | Carers Support - OMH | 54,253 | 96 | 54,157 | | | 55,229 | | 55,229 | | |
| 784 | HSSOP | 260,890 | 0 | | | 260,890 | 266,084 | | | | 266,084 |
| 785 | Community Development | 16,070 | 16,070 | | | | 0 | | | | |
| 786 | SAP / CPA | 0 | 0 | | | | 0 | | | | |
| 787 | Staff Training | 0 | | | | | 0 | | | | |
| 789 | Website | 0 | | | | | 0 | | | | |
| 790 | Evaluation | 4,500 | 4,484 | 16 | | | 0 | | | | |
| 781 | Programme Co-ordination | 55,963 | 5,395 | 50,568 | | | | | | | |
| | TOTAL | 1,795,929 | 648,189 | 423,225 | 408,451 | 316,064 | 2,211,685 | 0 | 1,105,877 | 783,552 | 322,256 |
| | Uncommitted slippage | | 60,340 | | | | | | | | |
| | | | 708,529 | | | | | | | | |

n.b. Maximum permissible slippage into 08/09 = £741,018

**It is commissioning decisions that ultimately decide the future of the POPPs services and if finance is not found to sustain the projects either on a temporary or permanent basis from next year, then services will stop incrementally over 2008/9 as the slippage runs out. Future funding may depend on revised specifications and models of service delivery which could bring greater efficiencies, which are not factored into the above costs. 2.5% annual increases have been factored into forecasts. Figures are based on projected spend for 07/08**

## 5.THE PROCESSES OF DECISION-MAKING

**Lead-up to commissioning decisions re sustainability**

**The POPPs Performance Group was established, chaired by the PCT, with a view to supporting the Programme to pull together all available evidence on activity/impact across the whole system/health and social care economies. The plan is to revise the economic appraisal using local PbR principles, based on monitoring activity of the PCT for Acute Trust activity/ SLA which informs the payment to LTHT.**

**January 07 : POPPs sustainability has been identified on the PCT risk register with regards to risks of lack of robust evidence of impact and financial constraints. The forecast impact of POPPs has been included in MLB activity forecasts and associated PbR financial savings**

**March 07: The original economic appraisal submitted as part of the Stage 2 application was refreshed in March 07 at the request of DH for the End of Year 1 report, using the original assumptions and methodology**

**1st March and 5th April 07: POPPs has been to the Adult Social Care Commissioning Board**

**March 07: A first draft Options Appraisal for sustainability was prepared and has been to the POPPs Board, Scrutiny Board and ASC Commissioning Board. It was also submitted as part of End of Year 1 Report to DH as sustainability plan work in progress.**

**24th July 07 POPPs Board time out reviewed the Options Appraisal in light of evidence from performance data and the local evaluation, to inform the case for sustainability. Board members re-assessed the projects against a series of questions put together on a template similar to that presented at the national Project Leads Network**

**26th July 07 The Executive Director for Commissioning and Development for the PCT was briefed about POPPs**

**July 07 The PCT Director of Commissioning and PCT rep on the POPPs Board briefed the PCT Director of Finance .**

**August 07: requirements associated with POPPs have been included in the new SLA for LPFT from the commencement of Foundation trust status on 1 August 2007.**

**6th September 07 POPPs was on agenda of Adult Transformation Board to discuss sustainability plans.**

**22nd September :user and carer focus group met**

**12th October submission to DH of Sustainability Plan for Leeds POPP Programme, signed by DASS and CE of PCT**

**5th November – meeting with DH to discuss Sustainability Plans**

**Commissioning partners' processes and time-scales up to December 07**

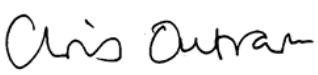
**PCT:- Carol Cochrane will sponsor the sustainability proposals that will go to the Executive Management Team of Leeds PCT on 24th/31st October and be included in the draft PCT financial plan to be considered by the PCT Board in November. Preparation of report/s by JS/CC**

**ASC:- Business case will go to ASC commissioning Board 1st November and into DMT on 15th November for first cut decisions on budget proposals. Preparation of reports by JS, HP**

**SP:- Proposals will go to 4th Oct/31st October SP Commissioning Board for decision on eligibility and priority for HAS and HSSOP schemes. Preparation of reports by SP Team**

**I agree to the time-table and processes above within which agreement will be reached on the sustainability of the projects or services or outcomes of the Leeds POPPs Programme.**

**Chris Outram, Chief Executive, Leeds Primary Care Trust**



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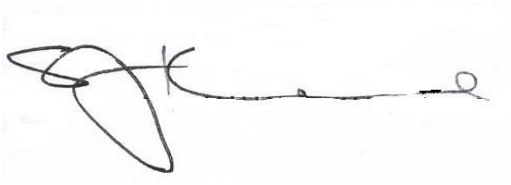
**Sandie Keene, Director of Adult Social Services**



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Leeds CITY COUNCIL

Originator: J Stageman/ H Pinches
Tel: 2474352

**Report of the Assistant Chief Executive (Planning, Policy and Improvement)**

**Scrutiny Board (Health and Adult Social Care)**

**Date: 21st January 2008**

**Subject: Leeds Strategic Plan and Council Business Plan: Outcomes and Priorities**

| **Electoral Wards Affected:** | **Specific Implications For:** | |
|---|---|---|
| | Equality and Diversity | x |
| | Community Cohesion | x |
| | Narrowing the Gap | x |
| ☐ Ward Members consulted (referred to in report) | | |

## Executive Summary

1. The Leeds Strategic Plan and Council Business Plan outcomes and Improvement priorities together with the financial strategy set out the strategic approach of the Council that will underpin service delivery for the period 2008-11. The Budget and Policy Framework requires the initial proposals for such plans to be reviewed by Scrutiny so that they have the opportunity to shape policy and make recommendations for change.

2. This report sets out the initial proposals for the Local Strategic Partnership, alongside the processes already undertaken for the development of these significant plans. It also clarifies the next stages for the full development of both plans in line with statutory and constitutional requirements.

## 1.0 Purpose Of This Report

1.1 The Leeds Strategic Plan and Council Business Plan outcomes and improvement priorities together with the five year financial strategy set out the strategic approach of the Council that will underpin delivery of services in the period 2008-11. This report outlines the progress to date in the development of the Leeds Strategic Plan and Council Business Plan.

1.2 The report updates the Board on the findings of the stakeholder consultation undertaken between September and November 2007 to determine the strategic outcomes and improvement priorities for the Leeds Strategic Plan 2008-11. The Board is asked to receive and comment upon changes made based on feedback received.

1.3 The draft business outcomes and improvement priorities are presented to Scrutiny for the first time and feedback is sought on these to help shape and develop the Council's business transformation and development agenda which will support the delivery of the Leeds Strategic Plan.

## 2.0 Background Information

2.1 Members of Executive Board approved a revised corporate planning framework for the city in July 2007. The strategic element of this framework includes two high level plans which set the strategic level outcomes and priorities for both the city and the organisation for a three year period. These are:

- **Leeds Strategic Plan 2008-11** - sets out the strategic outcomes and improvement priorities that will guide delivery of what the Council needs to focus on across the city either on its own, or in partnership with others, during the period 2008-11. This plan includes the statutory requirements regarding Leeds' Local Area Agreement as detailed in the Local Government and Public Involvement in Health Act 2007.

- **Council Business Plan 2008-11** - sets out what the council needs to do organisationally to achieve the outcomes and priorities in the Leeds Strategic Plan. This includes outlining the business development, organisational change, business transformation and financial planning activities that we plan to undertake over the next three years. The five year financial strategy was considered by members of Executive Board in December and will be integrated into the Council Business Plan.

2.2 The agreed framework specified that these strategic level plans not only set out the overarching priorities but also include the mechanisms for measuring success in achieving these priorities. The Budget and Policy framework specifies that the initial proposals contained in both of these plans are to be published at least two months in advance of adoption and that Scrutiny is allowed at least six weeks to respond to these initial proposals.

2.3 A three year planning timeframe has been adopted for both the Leeds Strategic Plan and Council Business Plan based on the fact that the Local Area Agreement, required by statute, spans three years and the Comprehensive Spending Review 2007 provides a three year funding settlement. However, we recognise that for some aspects of our work there is a need for a longer term view. The Vision for

Leeds 2004-20 provides the longer term ambitions of the city for the three year Leeds Strategic Plan. We have also developed longer term visions for some of our Business Plan priorities and therefore it is our intention to reflect these within the Council Business Plan where appropriate eg inclusion of our five year financial strategy.

## 3.0 Leeds Strategic Plan

### Feedback on Stakeholder Consultation

3.1 During July and August 2007 a draft set of strategic outcomes and improvement priorities were compiled that described what the Council and, where relevant its partners, aim to focus attention on during the period 2008-11. The draft outcomes and priorities are organised around the eight themes of the long term vision for the city – the Vision for Leeds 2004-2020. Evidence of where we need to focus our efforts was drawn from:

- The Annual Citizens Survey;
- The council's and partners' performance management systems;
- Current demographic and economic trends of the city; and
- Local knowledge of Members, council officers and partners.

3.2 During September to November 2007 a wide range of stakeholders were consulted across the city to provide the opportunity to 'check' whether the right improvement priorities had been identified, highlight any gaps and explore views on how delivery can best be achieved over the next three years. The following stakeholders were consulted:

- All Elected Members (Executive Members, Scrutiny Boards, Area Committees, Members' Seminar)
- Statutory partners
- Voluntary, Community and Faith Sector
- Representatives of the business community
- Representatives of the Trade Unions
- Council Staff
- Equality Groups
- Citizen Focus Groups

3.3 The general messages to emerge from the consultation were as follows:

- General support for the strategic outcomes and improvement priorities as drafted. It was commonly felt that the appropriate themes had been identified, and the balance in terms of 'Going up a League' and 'Narrowing the Gap' was judged to be about right.
- Some concern that the priorities in the areas of 'Environment' and 'Transport' should be strengthened and a stronger emphasis be placed on Children and Young People and Older People.
- Generally felt that the themes and priorities were strongly interdependent and that this should be both strengthened in places and communicated throughout the planning framework.

- Whilst the priorities were judged to have generally targeted the right areas, respondents often noted that their wording would benefit from the use of more positive, simple and clear language.

A full report summarising comments from the consultation is available for more detailed information.

**Changes to Strategic Outcomes and Improvement Priorities**

3.4 The feedback from the consultation has resulted in a series of changes and improvements to the draft strategic outcomes and improvement priorities.

3.5 It is intended that the context to the Leeds Strategic Plan provides an explanation of the importance placed on:

- Children and Young People
- Older People (with the recognition that we wish to rise to the challenges and opportunities presented by an ageing society)
- Interconnectivity between our strategic themes and priorities

Further proposed changes are:

| | |
|---|---|
| **Our Ambition** | Our Mission is to bring the benefits of a prosperous, vibrant and attractive city to **all** the people* of Leeds. We want:<br>• people to be happy, healthy, safe, successful and free from the effects of poverty;<br>• our young people to be equipped to contribute to their own and the city's future well being and prosperity;<br>• local people to be engaged in decisions about their neighbourhood and community and help shape local services;<br>• neighbourhoods to be inclusive, varied and vibrant offering housing options and quality facilities and free from harassment and crime, and;<br>• a city-region that is prosperous, innovative, attractive and distinctive enabling people, business and the economy to realise their full potential. |

| Strategic Outcomes | Improvement Priorities |
|---|---|
| **Culture**<br>Increased participation in cultural opportunities through engaging with all our communities.<br>Enhanced cultural opportunities through encouraging investment and development of high quality facilities of national and international significance. | Enable more people to become involved in sport and culture by providing better quality and wider ranging activities and facilities<br>Facilitate the delivery of major cultural schemes of international significance. |
| **Skills and Economy**<br>Increased entrepreneurship and innovation through effective support to achieve the full potential of people, business and the economy.<br>Increased international competitiveness through marketing and investment in high quality infrastructure and physical assets, particularly in the city centre. | Increase innovation and entrepreneurial activity across the city<br>Facilitate the delivery of major developments in the city centre to enhance the economy and support local employment<br>Enhance the skills of the workforce to fulfil individual and economic potential.<br>Increase international communications, marketing and business support activities to promote the city and attract investment. |
| **Learning**<br>Enhance the current and future workforce through fulfilling individual and economic potential and investing in learning facilities. | Enhance the skill level of the workforce to fulfil individual and economic potential<br>Improve learning outcomes for all 16 year olds, with a focus on narrowing the achievement gap.<br>Improve learning outcomes and skill levels for 19 year olds.<br>Increase the proportion of vulnerable groups engaged in education, training or employment.<br>Improve participation and early learning outcomes for all children, with a focus on families in deprived areas. |
| **Transport**<br>Increased accessibility and connectivity through investment in a high quality transport system and through influencing others and changing behaviours | Deliver and facilitate a range of transport proposals for an enhanced transport system.<br>Improve the quality, use and accessibility of public transport services in Leeds.<br>Improve the condition of the streets and transport infrastructure by carrying out a major programme of maintenance and improvements.<br>Improve road safety for all our users, especially motor cyclists and pedal cyclists. |

| | |
|---|---|
| **Environment**<br><br>Reduced ecological footprint through responding to environmental and climate change and influencing others.<br><br>Cleaner, greener and more attractive city through effective environmental management and changed behaviours. | Reduce the amount of waste going to landfill.<br><br>Reduce emissions from public sector buildings, operations and service delivery, and encourage others to do so.<br><br>Undertake actions to improve our resilience to current and future climate change.<br><br>Address neighbourhood problem sites; improve cleanliness and access to and quality of green spaces. |
| **Health and Wellbeing**<br><br>Reduced health inequalities through the promotion of healthy life choices and improved access to services.<br><br>Improved quality of life through maximising the potential of vulnerable people by promoting independence, dignity and respect.<br><br>Enhanced safety and support for vulnerable people through preventative and protective action to minimise risks and wellbeing. | Reduce premature deaths from circulatory diseases.<br><br>Reduce the number of people who smoke.<br><br>Reduce rate of increase in obesity and raise physical activity for all.<br><br>Reduce teenage conception and improve sexual health.<br><br>Improve the assessment and care management of children, families and vulnerable adults.<br><br>Improve psychological and mental health services for children, young people and families.<br><br>Increase the number of vulnerable people helped to live at home.<br><br>Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives.<br><br>Embed a safeguarding culture for all. |

| | |
|---|---|
| **Thriving Places**<br>Improved quality of life through mixed neighbourhoods offering good housing options and better access to services and activities.<br>Reduced crime and fear of crime through prevention, detection, offender management and changed behaviours.<br>Increased economic activity through targeted support to reduce worklessness and poverty. | Increase the number of "decent homes".<br>Increase the number of affordable homes.<br>Reduce the number of homeless people.<br>Reduce the number of people who are not able to adequately heat their homes.<br>Increase financial inclusion in deprived areas.<br>Reduce crime and fear of crime.<br>Reduce offending.<br>Reduce the harm from drugs and alcohol to individuals and society.<br>Reduce anti-social behaviour.<br>Reduce bullying and harassment.<br>Reduce worklessness across the city with a focus on deprived areas.<br>Reduce the number of children in poverty.<br>Develop extended services, using sites across the city, to improve support to children, families and communities. |
| **Stronger Communities**<br>More inclusive, varied and vibrant communities through empowering people to contribute to decision making and delivering local services.<br>Improved community cohesion and integration through meaningful involvement and valuing equality and diversity. | An increased number of local people engaged in activities to meet community needs and improve the quality of life for local residents.<br>An increase in the number of local people that are empowered to have a greater voice and influence over local decision making and a greater role in public service delivery.<br>Enable a robust and vibrant voluntary, community and faith sector to facilitate community activity and directly deliver services.<br>An increased sense of belonging and pride in local neighbourhoods that help to build cohesive communities. |

## 4.0 Measuring success in achieving Strategic Outcomes and Improvement Priorities

4.1 As part of the Government's intention to reduce the performance management burden for local government, it has recently reduced the estimated 1,200 indicators for assessing performance to 198. This national indicator set of 198 measures will be the only measures on which central government will performance manage outcomes delivered by local government working alone, or in partnership with others, from April 2008.

4.2 These measures will, where appropriate, be included in the final version of the Leeds Strategic Plan, matched against the relevant strategic outcomes and improvement priorities. In addition a number of local measures will also be required to adequately measure progress in areas not captured by the national indicator set.

## 5.0 Local Area Agreement requirements

5.1 The Local Government and Public Involvement in Health Act 2007 formalised the Local Area Agreement (LAA) as a key statutory tool in exercising the place shaping responsibility of the local authority. The LAA will be the only place from April 2008 onwards where central government will agree targets with local authorities and their partners against the set of national indicators. Each LAA will include 'up to 35' targets developed from the national indicators, supplemented by 17 statutory targets on educational attainment and early years.

5.2 Our LAA proposals for negotiation with Government are being drawn from the improvement priorities that are agreed as part of the Leeds Strategic Plan. 'Up to 35' improvement priorities will be selected and aligned with the 'best fit' national indicators. Targets will then need to be developed for each improvement priority/indicator and negotiated and agreed with Government. The final sign off of the LAA requirements with Government will take place in June 2008.

5.3 The local authority has a statutory duty to consult with partners named in the Local Government and Public Involvement in Health Act 2007 in identifying improvement priorities and targets and partners have a statutory duty to co-operate in the delivery of the agreed targets.

## 6.0 Council Business Plan 2008-11

### Development of the Plan

6.1 The purpose of the Council Business Plan 2008-11 is to set out the business outcomes and improvement priorities for the next three years. This is to ensure that the council is 'fit for purpose' and to support the delivery of the Leeds Strategic Plan. Therefore the process for the development of both plans has been closely linked.

6.2 The first phase of work to develop the Council Business Plan 2008-11 involved a series of meetings with senior officers to seek their views, with reference to the first draft of the strategic outcomes and improvement priorities, on what issues the business plan needed to address. From these meetings a wide range of potential improvement priority areas were identified and from these CLT identified four key outcome areas:

- Business intelligence
- One council – cultural change
- Service prioritisation
- Democratic and community engagement

6.3 From these inputs, and with reference to projects already underway through the Smarter Working: Better Results change programme, an initial set of outcomes and improvement priorities were developed. These were then tested and challenged alongside the strategic outcomes and improvement priorities. This process ensured that the developing business outcomes were fully aligned to, and supported the

delivery of, the Leeds Strategic Plan. The final element of this initial consultation process was two staff focus groups in December.

**Business Plan Outcomes and Improvement Priorities**

6.4 The resultant draft business plan outcomes and improvement priorities are shown below.

| **Business Outcome 1 - We are an intelligent organisation, using good quality information to commission better outcomes** | |
|---|---|
| Delivered through | Business Improvement Priorities |
| Information and knowledge management | • Improve our systems and processes to enable us to use our information effectively and efficiently<br>• Use our information to shape service provision, provide constructive challenge and improve our decision making at all levels<br>• Ensure we have the right intelligence to inform our strategic planning<br>• Develop arrangements to protect and share information in line with legislative and regulatory requirements |
| Customer involvement, choice and satisfaction | • Improve our understanding of our customers<br>• Increase the provision of choice<br>• Improve our services based on customer feedback<br>• Manage customer expectation and deliver on our promises |
| **Business Outcome 2 - We are a values led organisation and our staff are motivated and empowered** | |
| Delivered through | Business Improvement Priorities |
| Looking after Leeds | • Reduce the carbon emissions arising from our buildings, vehicles and operations<br>• Increase the proportion of socially responsible goods and services that we procure<br>• Promote our narrowing the gap agenda through our Corporate Social Responsibility programme |
| Putting Customers First | • Develop joined up and person centred services designed around the needs of our customers<br>• Enhance the links between front and back office services to deliver excellent end-to-end services |
| Treating People Fairly | • Ensure colleagues reflect the diversity of our communities<br>• Ensure fair access to all our services |
| Valuing colleagues | • Empower, support and develop our staff<br>• Improve understanding and transparency of our decision-making and accountability processes<br>• Ensure we have the right staff, in the right place with the right skills at the right time |

| | |
|---|---|
| Leadership | • Improve leadership at all levels including officers and elected members<br>• Strengthen communication at all levels<br>• Enhance our leadership of the city |
| **Business Outcome 3 - Our resources are clearly prioritised to provide excellent services and value for money.** | |
| Delivered through | Business Improvement Priorities |
| Resource Prioritisation | • Increase the proportion of resources used to support our priorities by redirecting resources away from our non-priorities<br>• Embed sustainability in our resource management processes |
| Efficiency/Value for Money | • Improve the efficiency of our services<br>• Embed value for money at all levels |
| Service Improvement | • Enhance service improvement capacity to deliver excellent and sustainable services |
| Partnerships | • Develop sustainable and effective partnership governance framework |
| Income generation | • Maximise our income |
| Commissioning | • Improve service provision through an effective commissioning process |
| Support services | • Improve quality and efficiency of support services |
| **Business Outcome 4 - Our citizens, businesses and communities are empowered and involved in decision making** | |
| Delivered through | Business Improvement Priorities |
| Democratic engagement | • Strengthen our democratic processes to improve governance and policy making<br>• Increase member involvement in policy development decision making and accountability |
| Stakeholder Engagement | • Increase involvement, engagement and participation of all communities<br>• Build trust with local communities to encourage greater engagement |

## 7.0 Next Steps

7.1 **Leeds Strategic Plan** – the next step is to align the national indicator set and develop relevant local indicators to ensure robust measures are in place for all our agreed strategic outcomes and improvement priorities. A series of negotiations, commencing in January 2008, will be undertaken with partners and with the Government Office of Yorkshire and Humber to agree the Local Area Agreement requirements outlined in 4.2.

7.2 **Council Business Plan** - the next step is for the draft business outcomes and improvement priorities to be revised based on Scrutiny feedback. At the same time work will also continue to develop performance indicators and targets to monitor our

progress in delivering this plan. The new national indicator set contains very few relevant measures so these will need to be locally determined. The five year financial plan will also be incorporated into the Council Business Plan.

7.3 A format for both the Leeds Strategic Plan and Business Plan is being developed that will clearly link both these key strategy documents. An appropriate accountability framework will be outlined in both documents highlighting responsibilities of senior council officers, partners and Elected Members.

## 8.0 Implications for Council Policy and Governance

8.1 The Leeds Strategic Plan and Council Business Plan form part of the Council's Policy and Budget Framework as set out in the Constitution. This requires Scrutiny to have the opportunity to provide input on the initial proposals in order to shape the development of these key plans prior to endorsement to by Executive Board and approval by Full Council. It is proposed that this is undertaken in a staged approach as outlined below:

| Task | Date |
|---|---|
| OSC and Scrutiny Boards commented on draft Strategic Outcomes and Improvement Priorities of the Leeds Strategic Plan | October 2007 |
| OSC and Scrutiny Boards receive feedback on the revised Strategic Outcomes and Improvement Priorities of the Leeds Strategic Plan and comment on the draft Business Plan Outcomes and Improvement Priorities.<br>OSC considers the overview of 5 year Financial Plan | January 2008 |
| Executive Board considers annual budget 2008/9 and 5 year Financial Plan | 8th February 2008 |
| Full Council considers annual budget 2008/9 and 5 year Financial Plan | 20th February 2008 |
| Executive Board considers full draft Leeds Strategic Plan and Council Business Plan 2008-11 | 12th March 2008 |
| Full Council considers full draft Leeds Strategic Plan and Council Business Plan 2008-11 | 9th April 2008 |

8.2 The targets linked to the LAA requirements of the Leeds Strategic Plan will continue to be negotiated with Government beyond the formal approval date identified above. It is proposed that authority is delegated to the Chief Executive to agree the final formulation of these targets and that the final agreed targets be reported retrospectively to members.

## 9.0 Legal And Resource Implications

9.1 A key element of the Council Business Plan is the five year financial plan which underpins the delivery of the Strategic and Business Plans. In order to comply with the legislative requirements for the annual budget it is proposed that an overview of the financial elements of the Business Plan will be approved alongside the budget for 2008-9 at Full Council on 11th March 2008 as outlined in the timetable above.

## 10.0 Recommendations

10.1 The Scrutiny Board is recommended to:

i. comment on the revised strategic outcomes and improvement priorities for the Leeds Strategic Plan to enable negotiations on the LAA to commence;

ii. comment on the draft business outcomes and improvement priorities.

Originator: Mike Simpkin

Tel: 24 74306

**Report of the Director of Adult Social Services**

**Scrutiny Board Health and Adult Social Care**

**Date: 21st January 2008**

**Subject: A Local Involvement Network (LINk) for Leeds – Update**

| **Electoral Wards Affected:** | **Specific Implications For:** |
|---|---|
| All | Equality and Diversity ☐ |
| | Community Cohesion ☐ |
| ☐ Ward Members consulted (referred to in report) | Narrowing the Gap ☐ |

**Executive Summary**

1. The Board received a first briefing on developments in Leeds to establish a Local Involvement Network (LINk) for health and social care at its October meeting. Legislation enabling the LINk to be set up received Royal Assent on October 30th 2007.

2. Since then a consultation and procurement process has been set in train in order to contract with an organisation to host the Leeds LINk. A stakeholder event was held on 4th December and there have been other consultative meetings. The closing date for Expressions of Interest under the restricted procurement process was 31st December.

3. This report provides the Board with an update (to date of writing 2nd January) on the procurement . The report also shows how the procurement process is expected to unroll and lists a number of challenges.

4. The development of the LINk will have implications for the work of this Scrutiny Board in that part of the LINk's role is to promote and support public and patient involvement in the commissioning, provision and scrutiny of local care services.

5. The overview and scrutiny function within the local authority also has a role in scrutinising how the contracting process was undertaken, and ensuring that best value is achieved and Members are asked for their observations.

## 1.0 Purpose Of This Report

1.1 This report is formally to update the Board about progress in securing a LINk for Leeds.

## 2.0 Background Information

2.1 The background to LINks was contained in a report to the October meeting of the Board.

2.2 Following Royal Assent to the Local Government and Public Involvement in Health Act in on 30th October 2007, the Commission for Patient and Public Involvement will be wound up on 31st March 2008, signifying the end of Patient and Public Involvement Forums. Local Authorities are required to commission an organisation to act as Host for the Local Involvement Network (LINk) in their area. The LINk will replace local Forums and also extend to social care. Brief details of the Act are contained in Appendix 1 and Appendix 2 has website reference for further information.

2.3 Leeds City Council was among bodies which made representation to the government that the timetable for commissioning would be unlikely to produce a Host organisation, let alone a LINk by the time that PPI Forums were wound up. A late government amendment to the Bill gave Local Authorities responsibility for setting up transitional arrangements but there are not expected to last longer than six months maximum.

2.4 For several months there was uncertainty about the resources which would be made available and in November the Department of Health announced that in addition to the £10,000 set up costs already allocated to local authorities for this year, each local authority would receive a flat sum of £60,000 per year plus a weighted percentage. The allocation would be annual and for three years from April 2008. This announcement created anxiety since it seemed to lead to much less than had previously been talked about. The final allocations from the Department of Health were eventually announced in mid December and it emerged that Leeds is to get more than originally expected at slightly over £300,000 per annum for the next three years. This is a much more realistic sum but has led to further uncertainties since, as forecast, the allocation is not ring-fenced and forms part of the Area Based Grant. In many authorities this format for the allocation is leading to further delay because of local decision making procedures, generally involving partners, around the use of the Area Based Grant. The Healthy Leeds Partnership has recommended to the Council that the full allocation is used to support the LINk, and despite pressure on resources following the settlement for 2008/9, there has been no indication that the City Council will not wish to support this new statutory duty with the full resource.

## 3.0 Procurement Process for the Leeds LINk

### 3.1 Structure

3.1.1 The commissioning process was begun by an advisory team with officers from the City Council (including Corporate Procurement and Scrutiny Support), the involvement lead officers from Leeds PCT, Leeds Teaching Hospitals Trust and Leeds Partnerships Foundation Trust, Leeds Voluntary Community and Faith Sector and the Patient and Public Involvement Forums. Potential bidders were excluded from formal development of procurement by a Project Team but as much as possible has been discussed in the wider group. The Project Team will continue to undertake the procurement process and make recommendations to a formal Procurement Board.

3.1.2 A formal Procurement Board is being established which will be chaired by a senior officer from the Council's Corporate Services and will include the Deputy Director of Adult Social Services, the Council's Chief Equality Officer and probably one other LCC officer. The NHS will be represented by a PCT Executive Director, the VCF sector by a representative of the Leeds Voice Health Forum not connected to any potential bidders and there will be two service user / patient representatives.

3.2 **Timetable**

3.2.1 A formal invitation to submit Expressions of Interest to be Host for the LINk was issued and advertised on 22nd November with a closing date of 31st December. An information meeting for potential bidders was hosted on 6th November and other support has been given by the Council's Procurement Team. A verbal update on the result of this process will be given at the Board meeting.

3.2.2 The Expressions of Interest will be evaluated by the Project Team which will make recommendations on a short list to the Procurement Board which is scheduled to meet around the 25th January. This meeting will also approve draft specifications for the Host. There will then be a meeting with organisations shortlisted to be invited to tender to explain, discuss and comment on the proposed specifications. The prospective tenderers will then be asked to develop their formal proposals on how best to meet the specifications. Final tenders are expected to be requested by Easter leading to the award of contract for the Host during April. The contract will be subject to the City Council's normal ratification procedures.

3.3 **Consultation and Engagement**

3.3.1 The Project Team has sought to distribute information about the LINk widely within Leeds and updated information has been available on the Council's website as well as on the Procurement website. Information has been made available on audio tape and Braille where requested. NHS involvement networks for patient groups have been contacted by the NHS Trusts.

3.3.2 A city-wide event for patient, service user and carer groups was hosted in the Civic Hall on 4th December. The purpose was both to provide further information and to seek views on how the Host and LINk should be constituted. The former Chair of the Health and Adult Care Scrutiny Board attended the whole event and the current Chair was available to attend in the morning. Although the timing of the event limited attendance to around 60 people, the meeting was extremely helpful and was generally very well received. Further consultation is taking place with groups whose voices are not often heard. The evaluation is attached at Appendix 3 and the results are available separately.

3.3.3 A Service User, Carer and Patient Reference Group has been established and met for the first time on 19th December. This group will provide representatives onto the Project Team and Procurement Board, to be drawn equally from NHS patient representatives and users of Social Care services.

3.3.4 The engagement process has so far been predominantly about seeking views a vision for the LINk and consequent implications for the Host organisation specifications. However as the formal procurement process continues it will be important separately to develop a basis of involvement contacts for the new Host to engage with on appointment. There have also been discussions with Children Leeds to ensure that the interests of Children and Young People are included and represented as appropriate.

3.4 **Transitional Arrangements**

3.4.1 The Act instructs Local Authorities to make transitional arrangements where there will not be a Host or LINk operative by the time the current PPI Forums are wound up at the end of March. Information from around the country suggests that only a minority of areas will have a Host organisation, let alone a LINk functioning at this time and, as reported in 2.3 above, the Council joined in representations to the Secretary of State for Health to make appropriate provision.

3.4.2 Although, if the projected timetable goes to plan the transitional period in Leeds will be fairly short, further discussions will take place with all stakeholders around what is required, and especially around continuity for NHS patient interests where there is formal representation via the PPI Forums., both within the NHS Trusts and for bodies such as this Scrutiny Board. The Director of Adult Social Services has written to all PPI Forum members in Leeds recognising the contribution they currently make and offering discussions around how their commitment can best be maintained. The letter also recognises that this is a particularly difficult time for all those connected with the Forums, not least the Support Organisation staff.

3.5 **TUPE**

3.5.1 The October report to this Board drew attention to the potential issue of TUPE provision for staff employed locally in supporting Forums. In Leeds, most recently, these staff have been employed by the Commission for Patient and Public Involvement in Health which is being wound up. The Act makes it clear that all CPPIH assets will revert to the Secretary of State for Health though it is not clear whether further guidance will enable assets to be made locally available to Host organisations. CPPIH staff had argued strongly that TUPE should apply but the Department of Health was leaving this decision to local authorities which were taking different views particularly as it was unclear to what extent the resource allocation could both be attractive to bidders and support TUPE provision. In early December, following representations from many quarters, the Department of Health and CPPIH issued Counsel's opinion which took the view that overall TUPE probably did not apply although it still might in local circumstances. Further advice has been sought over the period from the Council's own legal officers and the Procurement Board will state how this advice will affect formal tenders.

3.6 **Regulations for the LINk**

3.6.1 The Department of Health formally consulted on proposed regulations for the LINk and a response was formulated on behalf of the Council's Project Team. It was suggested that rather than rely on the Freedom of Information Act, relationships between the LINk and local agencies should be primarily through a locally negotiated set of protocols which built on the existing legislation. Further guidance was also sought about the inspection by LINk members of health and social care services commissioned by the NHS and the Local Authority.

3.7 **Regional and National Support**

3.7.1 The Project Team has kept in touch with development in the region and elsewhere. An offer of support from the Centre for Public Scrutiny has been taken up and will probably focus on the implications of the LINk for scrutiny and for elected Members.

3.7.2 There have also been discussions with the Commission for Social Care Improvement about a regional event to share progress and problems.

## 4.0 Implications for Council Policy And Governance

4.1.1 The government's proposal for LINks is extremely ambitious. Although initially the LINk will not replace existing involvement mechanisms, it has the potential to recast the whole way in which statutory agencies engage with the public and users of their services. Although NHS organisations have for some time been accustomed to service inspections on behalf of patients, this formal dimension is new to social care and there will need to be further planning around how social care services will engage with the LINk

4.1.2 The Local Authority will have responsibility for assigning the contract for the Host and performance managing it over its three year period. Although the Host will eventually be primarily accountable to the LINk itself, a mechanism will be needed for formally reporting on contract performance mainly around technical issues and probity issues. However there could also be a troubleshooting role and it may also be that an offer of support and liaison from the statutory agencies would be welcomed by the LINk and the Host.

4.1.3 However the independence of the LINk is protected in the legislation. The local authority is not permitted to influence the LINk through management of the contract.

## 5.0 Legal And Resource Implications

5.1 The initial sum of £10,000 is currently being spent on supporting consultation and engagement and on administrative matters such as legal advice. Guidance will be sought as to whether any residue can be carried over into the next financial year as the commissioning and transitional processes continue.

5.2 By the time of this Scrutiny Board meeting, there may be formal confirmation of how the LINk allocation will be treated within the Area Based Grant. The allowance from the Department of Health is £308,000 for next year, with approximately similar sums for the following two years. Additional costs to the local authority and NHS of any transitional arrangements will need to be met from the first year's allocation.

## 6.0 Conclusions

6.1 The Council remains on track to commission the Host organisation for the Leeds LINk within the recommended timescale. Although, at the time of writing, there are still hurdles to surmount such as the establishment of a credible shortlist of bidders, the finalisation of specifications and the creation of transitional arrangements, the Council appears to be reasonably placed in terms of progress in comparison with other local authorities apart from those formally classed as Early Adopter Pilots.

6.2 The work so far could not have been successfully carried out without the active support of partners from the NHS, the VCF sector, and from patient, service user and carer groups. Their support and goodwill will continue to be needed as we negotiate the still tricky path towards establishment of the Leeds LINk.

## 7.0 Recommendations

7.1 The Board is requested to note the information in this report and to make such comment as it deems appropriate.

## APPENDIX 1 LOCAL GOVERNMENT AND PUBLIC INVOLVEMENT IN HEALTH ACT
**Part 14: Patient and Public Involvement in Health and Social Care**

**Procurement of "hosts"** - Section 221 requires each social services authority to procure an organisation or "host" to establish and support a Local Involvement Network (LINks) in each local authority area. The "host" will support LINks to:

- promote and support the involvement of people in commissioning, provision and scrutiny of local care services ( "care services" refers to both health and social care)
- enable local people to monitor and review the standard of local care services and report on how they could be improved
- obtain the views of local people about their experience of local care services and their care needs.

The responsibilities of LINks can be amended by regulation by the Secretary of State but that they can only be added to not taken away, as was possible in the original Bill. The Act outlines the bodies that are not permitted to provide such support or become a LINk: they are local authorities; NHS trusts; NHS foundation trusts; primary care trusts or strategic health authorities.

**Local Involvement Networks (LINks)** – LINks will be required to have a clear governance structure including: the process for decision-making; how LINks members are authorised to act on behalf of the LINks; financial arrangements; and how breaches of authority are dealt with.

Health and social care providers will be required to: respond to LINks requests for information; consider and respond to reports and recommendations made by LINks; allow authorised representatives of LINks to enter and view premises on which care is delivered (but representatives will not be permitted to enter and view private rooms of individuals).

LINks must produce an annual report giving details of their activities, their membership and their financial arrangements.

**Relationship between LINks and overview and scrutiny committees** – LINks are able to refer "social care matters" to the appropriate overview. There is no obligation for the committee to act on every referral but they must acknowledge the receipt of the referral and "keep the referrer informed of the committee's actions in relation to the matter".

**Transitional arrangements** – Local authorities will be expected to procure host arrangements by 31 March 2008 but in those areas where this has not been possible, local authorities will be subject to "temporary duty" lasting until 31 September 2008 to ensure that there are means to support LINks activities. Temporary arrangements could include the local authority providing support to LINks or agreeing an interim contract with another organisation to provide support to LINks. The Act does not specify the consequences for local authorities if they have not procured host support by 31 September 2007.

**Abolition of the Commission for Patient and Public Involvement in Health and Patients' Forums** – The Act abolishes the CPPIH and all Patients' Forums with effect from 1 April 2008. All property, rights and liabilities of Patients' Forum will transfer to the Secretary of State for Health. Furthermore, any legal proceedings may be continued by the Secretary of State. Before they are abolished, they will be required to prepare a report of "anything being done by the Patients' Forum".

**Duty to involve service users (Section 233)** – All NHS bodies, including strategic health authorities, must make arrangements to involve service users and/or their representatives in the planning, delivery, development and decision-making in relation to health services. Furthermore, all health bodies must publish a report (believed to be annual although this is not specified in the Act) giving details of the consultation it has carried out or proposes to carry out before making commissioning decisions. It must also report on "the influence the results of any relevant consultation had had on such matters".

**APPENDIX 2**

**Website links**

***A Stronger Local Voice*** July 2006 – the original consultation document setting out intentions.
http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=20130&Rendition=Web

**Government Response** to comments on A Stronger Local Voice December 2006
http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=SS_GET_PAGE&siteId=en&ssTargetNodeId=566&ssDocName=DH_062839

**House of Commons Select Committee on Health** report and the government response can be downloaded via:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075501

The NHS national centre for involvement has a section on LINks and Department of Health **LINks bulletins** so far can be downloaded from
http://www.nhscentreforinvolvement.nhs.uk/index.cfm?Content=142

***Getting Ready for Links Guidance Documents*** **August 2007**

Planning your Local Involvement Network

Contracting a Host for your Local Involvement Network

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_077266

## APPENDIX 3 - Stakeholder Event 4th December 2007 Evaluation

### Results of Evaluation

| | Strongly Agree | Agree | Neither Agree or Disagree | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| **I felt able to have my say!** | **16** | **20** | **2** | | |

Group work listened to and being able to contribute
Yes our leader very good at including everyone and interpreting our unprepared words
The group was very active and well facilitated. I felt that it was run in a very inclusive way
Good facilitation
We were given time & space listen to
Opportunity for all to input
All able to listen to & respect each others ideas
Biased views from platform
Everybody listened to each point of view
I felt comfortable to state my views
The groups were small enough for everybody to have their views say
I and all others on our table had an input and good point to make
Frank and open disagreement
In the first session after lunch
Good discussions sessions
I felt we did – I just hope all the evidence taken today will be positively looked at and implemented
Need to get the Link and Host basics sorted out, LCC & other organisations need strong foundation to build up
Found some of the means of harnessing information limited discussion
Small group discussion everybody had there say
Well facilitated, but concerned more clarity needed on disabled access needs prior to the event
Very effective workshops with excellent facilitation
Points of views were listened to an recorded

| | | | | | |
|---|---|---|---|---|---|
| **I enjoyed myself!** | **18** | **19** | **4** | | |

Please give details:
The food was good
Very good environment and food
Friendly groups with genuine concerns and the food was great
Taking part, meeting people good food
Good food, would have liked to see more service user & care involvement
I had a good time, nice to work with such a range of people, loads of different of opinions
It's the delivery well found out whether or not you listened
Conductive and positive around my table
Met many people from different groups
v. useful to hear a number of views different to those of my own
Networking format, diversity of views
Found much useful information and enjoyed talking with new folk and old hands!
Good to meet with other groups and people ( making links)
Interesting company and enlightening discussions
Good opportunity for meeting a variety of people & for discussion
Concern about lack of definition of Links and delay in budget/set up
Meeting new people and listening to them
I thought the event was well organised. i.e. seating , programme, catering , venue
The discussions were lively and I leant a lot from them, the presentations were the right length and paced out well. The day was the right length
All the people on table 3 were good and hard working good food that was a real choice – not just bread and cakes
I await the outcome, then I will be happy or not

| | | | | | |
|---|---|---|---|---|---|
| **I found the day useful!** | **17** | **16** | **3** | | |

Please give details:
Lots of talk, interesting different views
I appreciate the information in different formats
Best of luck in the future
Feel I understand Link better
All info given today was useful but the proof of its usefulness is to be decided i.e. in your hands
Networking awareness raised of forthcoming changes
Listening to this points raised in the open discussion which often reflect the specific views of the people on the tables
As above useful information and encouragement to get involved.
Better microphones would have improved hearing but I did feel I began to understand the complexities around the issues
I have learned a lot – reason to come to Leeds
Well organised locally – but still waiting for some clarification nationally!
More informed about Link now
Networking achieved by all attendees at my table
Clarified a lot of issues
Opportunity to contribute ideas
Disagree with selecting 3 comments from meeting to support platform – this was biased and not a good start for Links
Don't; know until the outcome
Learnt some ideas about Links but am still not clear about eventual outcome
I was pleased to attend & found the event informative and encouraging
Exchanging views with different people was very interesting and informative
There is very mixed and unclear information around the functions and governance of Links and how they will impact on existing funding streams and involvement
If you don't take part and say what you think no one will know your views
The day was useful and informative. Presentations provided me with information requested
Microphones still not as good and people need to know how to use them
The networking was very good, I met a good number of people with whom I can work with, in a project I am involved with – because of my experience of working with support from PPI Forum
Now I know what the Link is!

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Leeds CITY COUNCIL

Originator: Debbie Chambers
Tel: 247 4792

**Report of the Head of Scrutiny and Member Development**

**Scrutiny Board (Health and Adult Social Care)**

**Date: 21st January 2008**

**Subject: Work Programme**

| **Electoral Wards Affected:** | **Specific Implications For:** |
|---|---|
| | Equality and Diversity ☐ |
| | Community Cohesion ☐ |
| ☐ Ward Members consulted (referred to in report) | Narrowing the Gap ☐ |

## 1.0 Introduction

1.1 A copy of the Board's current work programme is attached for Members' consideration (Appendix 1).

1.2 Also attached to this report is the current Forward Plan of Key Decisions (Appendix 2), which 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) – WORK PROGRAMME 2007/8 – LAST UPDATED DECEMBER 2007

| ITEM | DESCRIPTION | NOTES | DATE ENTERED INTO WORK PROGRAMME |
|---|---|---|---|
| **Meeting date: 18 February 2008 - The deadline for reports for this meeting is 10.00am on Friday 1 February 2008** | | | |
| **Performance Management** | Quarter 3 information for 2007/08 (Oct-Dec) | All Scrutiny Boards receive performance information on a quarterly basis | |
| **Strategic Plan - update on priorities, draft indicators and targets** | A further opportunity for the Board to comment on the Strategic Plan and agreed priorities, draft indicators and targets. | Following on from the presentation of the Consultation on Strategic Outcomes and Improvement Priorities for the Leeds Strategic Plan at the October Board meeting and update on priorities, received at the last meeting. | 15th October |
| **Delivering Healthcare Closer to Home – an overview** | Presentation from LTHT and Leeds PCT | Linked to the Localisation Inquiry. | 19th December |
| **Performance of Homecare Providers** | To consider an update on the performance of homecare providers June to December 2007. | Regular, quarterly, performance update for homecare providers (both independent sector, and in-house). | |
| **Meeting date: 17 March 2008 - The deadline for reports for this meeting is 10.00am on Friday 29 February 2008** | | | |
| **Renal Services** | To receive an update report on the long term plans for renal services in Leeds addressing some of the concerns of the KPA which have been raised with the Scrutiny Board. | Last year the Scrutiny Board received regular reports regarding the long term plans for renal services in Leeds following concerns raised by the LGI Kidney Patients Association. The Board recommended that the provision of renal services continued to be monitored by Scrutiny in the new municipal year. | 17th December 07 |

**SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE) – WORK PROGRAMME 2007/8 – LAST UPDATED DECEMBER 2007**

| ITEM | DESCRIPTION | NOTES | DATE ENTERED INTO WORK PROGRAMME |
|---|---|---|---|
| **NHS Annual Health Check** | To consider reports from each of the local NHS Trusts on the NHS Annual Health Check process. | | |
| **Recommendation Tracking** | Progress with recommendations from previous scrutiny reports, including the Social Services Transport Arrangements report and the NHS Dental Contract: One Year On statement. | All Scrutiny Boards receive information on progress with previous Scrutiny recommendations. | |
| **Altogether Better** | To consider an update report on progress with Altogether Better, a Big Lottery Funded regional project. To address how the project will be performance managed. | Requested as a result of a delegated decision to enter into a contract with the SHA to deliver this project, taken on 12 -12- 07. | 17 December 07 |
| **Commissioning Strategy** | To consider a report on risk assessment and risk management factors related to Adult Social Care Commissioning | Regular quarterly updates requested at the meeting on 10th September – risk factor report requested at the meeting in December 2007. | |
| **Meeting date: 21 April 2008 - The deadline for reports for this meeting is 10.00am on Friday 4 April 2008** | | | |
| **Inquiry Session 3** | To consider the Board's draft final report. | | |
| **Annual Report** | To approve the Board's draft annual report | | |
| **State of Play report** | To consider a progress report with this piece of work from the Leeds Playwork Network. | Linked to recommendation 4 in the Board's Childhood Obesity report about physical recreation. | 17th December 07 |

**SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE) – WORK PROGRAMME 2007/8 – LAST UPDATED DECEMBER 2007**

| ITEM | DESCRIPTION | NOTES | DATE ENTERED INTO WORK PROGRAMME |
|---|---|---|---|
| **Urgent Care Services** | To contribute to the public consultation on proposals for the re-design and re-commissioning of Leeds and West Yorkshire urgent care services. | The Health Proposals Working Group received a briefing about this issue at its December meeting. It was determined that this would be a substantial change to services and should therefore be considered by the full Board.<br><br>**NB:** Some elements of the proposal are West Yorkshire wide, so there may need to be consultation between members in our neighbouring West Yorkshire Authorities on those aspects. | 18 June 07 |
| **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. | | |



Other issues to be scheduled into the work programme as special working group meetings:-

| | | | |
|---|---|---|---|
| **Teenage Pregnancy** | One-off special working group meeting to discuss the issues and produce a statement.<br><br>Date tba in January. | Arising from recommendation from Childrens Services Scrutiny Board and previous work done on sexual health | 15th October |
| **Obesity** | One-off special working group meeting to discuss the issues and produce a statement.<br><br>Date tba in February or March. | Arising from the Board's concerns at the increasing problem and following on from previous work on Childhood Obesity. | 15th October |

**To carry forward to the next municipal year:** Update on Terry Yorath House in June or July.

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# LEEDS CITY COUNCIL

## FORWARD PLAN OF KEY DECISIONS

For the period 1 January 2008 to 30 April 2008

| 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 Care Mental Health Services<br>Request to waive Contract Procedure Rules and continue the Voluntary Sector Mental Health Services for 1 year from 1st April 2008 to 31st March2009 with the option to extend for a further 6 months if required | Director of Adult Social Services | 24/1/08 | | Report of the Chief Officer Commissioning - Adult Social Care | Director of Adult Social Services |
| Social Care - Older People's Neighbourhood Networks<br>Request to waive Contracts Procedure Rules and extend the Adult Social Care Older People's Neighbourhood Network Contracts for 1 year from 1st April 2008 to 31st March 2009 with the option to extend for a further 6 months if required. | Director of Adult Social Services | 24/1/08 | | Report of the Chief Officer Commissioning - Adult Social Care | Director of Adult Social Services |

**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 Richard Brett |
| Development and Regeneration | Councillor Andrew Carter |
| Environmental Services | Councillor Steve Smith |
| Neighbourhoods and Housing | Councillor John Leslie Carter |
| Leisure | Councillor John Procter |
| Children's Services | Councillor Stewart Golton |
| Learning | Councillor Richard Harker |
| Adult Health and Social Care | Councillor Peter Harrand |
| Leader of the Labour Group | Councillor Keith Wakefield |
| Leader of the Morley Borough Independent Group | Councillor Robert Finnigan |
| Advisory Member | Councillor Judith Blake |

In cases where Key Decisions to be taken by the Executive Board are not included in the Plan, 5 days notice of the intention to take such decisions will be given by way of the agenda for the Executive Board meeting.