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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE)

Meeting to be held in Committee Rooms 6 and 7 on
Monday, 17th March, 2008 at 10.00 am (Pre-meeting for all Members at 09.30 a.m.)

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
C Fox	-	Adel and Wharfedale
J Illingworth	-	Kirkstall
M Iqbal	-	City and Hunslet
G Kirkland	-	Otley and Yeadon
M Rafique	-	Chapel Allerton
L Russell	-	Farnley and Wortley

Co-opted Members

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

Agenda compiled by: **Andy Booth**
Telephone: **247 4325**
Governance Services Unit
Civic Hall
LEEDS LS1 1UR

Principal Scrutiny Adviser:
Debbie Chambers
247 4792

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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25 of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded)	
2			**EXCLUSION OF THE PUBLIC** To identify items where resolutions may be moved to exclude the public	
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes)	
4			**DECLARATIONS OF INTEREST** To declare any personal / prejudicial interests for the purpose of Section 81(3) of the Local Government Act 2000 and paragraphs 8 to 12 of the Members Code of Conduct.	
5			**APOLOGIES FOR ABSENCE**	
6			**MINUTES** To approve as a correct record the minutes of the meeting held on 18 February 2008	1 - 8
7			**EXECUTIVE BOARD MINUTES** To note the minutes of the Executive Board held on 18 February 2008.	9 - 24

Item No	Ward/Equal Opportunities	Item Not Open		Page No
8			**RENAL SERVICES IN LEEDS** A report from the Head of Scrutiny and Member Development presenting an update on the long term plans for renal services in Leeds from the Department of Renal Medicine, Leeds Teaching Hospitals NHS Trust.	25 - 30
9			**NHS ANNUAL HEALTH CHECK** To consider information from local NHS trusts on their self assessment declaration to the Healthcare Commission this year.	31 - 70
10			**RISK AND COMMISSIONING IN ADULT SOCIAL CARE** To consider information from local NHS trusts on their self assessment declaration to the Healthcare Commission this year.	71 - 74
11			**LEEDS STRATEGIC PLAN 2008-11** To consider an update report on the text of the Leeds Strategic Plan from the Assistant Chief Executive (Policy, Planning and Improvement).	75 - 112
12			**RECOMMENDATION TRACKING** To consider a report from the Head of Scrutiny and Member Development assessing progress with the Board's recommendations.	113 - 126
13			**WORK PROGRAMME** To receive a report from the Head of Scrutiny and Member Development on the Board's Work Programme fir the remainder of the municipal year.	127 - 134

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SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE)

MONDAY, 18TH FEBRUARY, 2008

PRESENT: Councillor J Chapman in the Chair

Councillors J Bale, J Dowson, G Driver, P Ewens, J Illingworth, M Iqbal, G Kirkland and M Rafique

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

96 Declarations of interest

Councillors Dowson and Rafique declared personal interests in Item 13, Neighbourhood Network Service for Sikh Older People, due to their respective positions as Ex-officio Members of the Sikh Welfare Trust. Minute No. 105 refers.

Joy Fisher declared a personal interest in Item 12, Performance of Homecare Providers (Independent and Directly Provided) as she was a service user. Minute No. 104 refers.

Further declarations of interest were made during the meeting. Minute Nos 103 and 104 refer.

97 Apologies for Absence

Apologies for absence were submitted on behalf of Councillors Russell and Wadsworth.

98 Minutes

RESOLVED – That the minutes of the meeting held on 21 January, be confirmed as a correct record.

99 Executive Board Minutes

RESOLVED – That the minutes of the Executive Board held on 23 January 2008 be noted.

100 Overview and Scrutiny Committee Minutes

RESOLVED – That the minutes of the Overview and Scrutiny Committee held on 8 January 2008 be noted.

101 Co-option to Scrutiny Board (Health and Adult Social Care)

The Head of Scrutiny and Member Development submitted a report requesting the co-option of a Member to the Board.

The Chair welcomed Somoud Saqfelhait to the meeting. Somoud had been nominated for co-option to the Board and she gave the Board an overview of her involvement with Touchstone Mental Health Services.

RESOLVED – That Somoud Saqfelhait be co-opted to the Scrutiny Board (Health and Adult Social Care) for the remainder of the 2007/08 Municipal Year.

102 Performance Report Quarter 3 2007/08

The Head of Policy, Performance and Improvement submitted a report which highlighted key performance issues considered to be of corporate significance for the Scrutiny Board (Health and Adult Social Care). Appended to the report was information on a range of performance indicators relating to Health and Adult Social care along with the Council's progress on these indicators.

The Chair welcomed the following to the meeting:

- Sandie Keene – Director of Adult Social Services
- Dennis Holmes – Chief Officer, Commissioning
- Stuart Cameron Strickland, Commissioning Manager – Performance & Quality Assurance

It was reported that a number of the performance indicators had shown positive progress although the performance of comparator authorities demonstrated the need for continued improvement. It was felt that there had been a significant overall improvement across Social Care services in Leeds over the past year.

In response to Members questions and comments, the following issues were discussed:

- Direct Payments – It was noted that there had been an improvement in the number of service users taking up Direct Payments for services. It was reported that there were still significant challenges facing the Council regarding Direct Payments. Members were reminded of the recent report to Executive Board and the need to develop a strategy for the use of Direct Payments. Concerns expressed included the bureaucratic process of using Direct Payments, screening of employees, quality of service delivery and health and safety issues. It

was reported that national guidance was still awaited on many of these areas of concern.

- Intensive home care – concern was expressed about Leeds' position at the bottom of Core City performance for indicator BV53, which related to intensive home care. Members were informed that day centre provision was not eligible for recording within this indicator. Leeds provided more intensive day centre care than other authorities and should this be included it would give a more favourable position.
- Demographics which made Leeds very different to other core cities
- Provision of respite care for those living alone.
- Individualised budgets.
- How to meet next years targets.

The Chair thanked those present for this item.

RESOLVED – That the report be noted.

103 Care Closer to Home

The Head of Scrutiny and Member Development submitted a report which presented information from Leeds PCT, Leeds Teaching Hospital Trust (LTHT) and Adult Social Services regarding the provision of care closer to home.

The Chair welcomed the following who were present for this item:

- Maggie Boyle, Chief Executive, LTHT
- Jill Copeland, Chief Executive, Leeds PCT
- Sandie Keene, Director Adult Social Services
- Dennis Holmes, Chief Officer – Commissioning

Jill Copeland reported that the PCT had engaged local people in developing a strategy to provide care closer to home. Priority areas identified had been for patients with Diabetes, Chronic Obstructive Pulmonary Disease (COPD) and Stroke rehabilitation and treatment. Different methods of providing this care closer to home had involved the use of Community Nurses and providing services at GPs surgeries. Benefits realised from this had included increased independence and easier access to specialist care. There had been a 10% reduction in COPD admissions and 15% overall reduction in hospital admissions. There was ongoing investment in new facilities and reference was made to the use of the LIFT centres. It was also reported that local community engagement would be increased with links between the PCT and Area Committees.

Leeds Teaching Hospital Trust had been developing care pathways on chronic disease conditions with the involvement of patient and user groups. Joint working by the PCT and Social Services was also due to start in April, to develop a combined Health and Social Services Strategy. In terms of making services more accessible to the population it was reported that the use of

peripheral hospital sites and how to maximise their capacity was under consideration.

Social Services had an emphasis on enabling people to stay in their own home as long as possible. There were joint teams of social workers, physiotherapists and others who provided care in the community for users. Reference was also made to joint funded posts between Social Services and the PCT which had provided improved and streamlined services.

In response to Members questions and comments, the following issues were discussed:

- Dental provision at Yeadon Lift Centre – It was reported that 2 of the 3 dental chairs had now been filled.
- Diabetic care at Wharfedale Hospital – work had taken place with GPs in the Otley area regarding diabetic care. The PCT and LTHT were working closely together to develop the most appropriate care which would meet the needs of local people.
- Lift Centres – it was reported that a full range of services could not be provided at each centre. The availability of services could be affected by patient choice or how easy access to alternative services could be.
- Referral management had been part of a major work programme and it was hoped that this would now make referrals quicker.
- Recruitment of District Nurses – there had been staffing shortages in these positions.
- More flexible opening times to allow easier access to services and the walk-in centre at the Light Shopping Centre.
- There was a PCT board looking at how to implement the national service framework on long term neurological conditions
- There were no plans to close any of the City's peripheral hospitals.
- End of life care.

The Chair thanked those present for this item.

RESOLVED – That the report be noted.

(Councillor Kirkland declared a personal interest in this item due to his position on the Wharfedale Hospital Forum).

104 Neighbourhood Network Service for Sikh Older People

The report of the Head of Scrutiny and Member Development reminded the Board of dissatisfaction amongst some of the Sikh Community in Leeds regarding the consultation and procurement exercise undertaken to secure the Neighbourhood Network Service for Sikh Older People. Appended to the report was a report of the Director of Adult Social Care that outlined the procurement and consultation process along with correspondence between the Sikh Welfare Trust and the Council.

The Chair welcomed the following to the meeting for this item:

- Dennis Holmes, Chief Officer – Commissioning
- Alison Lowe, Chief Executive, Touchstone
- Parminder Singh Syan, Sikh Welfare Trust
- Ujjal Singh Ryatt, Sikh Welfare Trust

Several concerns had been raised by the Sikh Community regarding the tendering of the Neighbourhood Network Service for Sikh Older People. It was felt that the consultation had not been appropriate or that it had involved the right people. It was also felt that the tender specifications had not been suitable and that this had led to dissatisfaction with the services provided as they did not meet the needs of the Sikh Community. The Community felt there had been a significant reduction in the level of service provided since the new Neighbourhood Network Service began.

Dennis Holmes reported that the consultation carried out had been as wide as possible and the decision to appoint Touchstone had reflected the outcome of the consultation and tender process. Social Services were eager to work with the Sikh community to see how service delivery could be improved and how to develop the best service model.

In response to Members questions and comments, the following issues were discussed:

- Terms of the contract could be amended in consultation with the contractor. There would be issues such as employee rights to consider and these would have to form part of any negotiations.
- The Council could extend Touchstone's contract if contractual obligations had been met.
- Involvement of female members of the Sikh Community during the consultation process.
- The composition of the steering group.

RESOLVED – That the issue be referred to the Executive Member for Adult Health and Social Care.

(Somoud Saqfelhait declared a personal interest in this item due to her involvement with Touchstone).
(Councillors Bale, Kirkland, Iqbal and Rafique left the meeting at 12.30 p.m. following the conclusion of this item).

105 Performance of Homecare Service Providers (Independent and Directly Provided)

The report of the Chief Officer, Commissioning, presented performance information on Homecare Service Providers (Independent and Directly Provided).

Further to Members comments and questions, the following issues were discussed:

- Dignity – indicators for dignity were being developed in conjunction with the PCT and would be included in contracts. Service users would also be involved in the development of any indicators.
- In response to a question of why some providers had higher ratios of staff to users, it was reported that this may be due to the complexities of care packages required for an individual user and how teams were organised from provider to provider.
- The role of the Voluntary, Community and Faith Sector and Neighbourhood Networks.
- Although many of the providers had been rated as adequate, it was expected that they should be achieving good or excellent ratings. Those who were rated adequate by the Commission for Social Care Inspection could ask for an early review and likewise a review of their services could be requested.
- The requirement for providers to employ a minimum of 50% of staff with NVQ Level 2 in Health and Social Care.
- Individualised budgets and Direct Payments.
- Concern regarding the frequent changes of Managers and Senior Managers in the independent sector and the fact that assessments were based under previous management. It was reported that management was one of the national inspection standards to be met.
- There were no plans to privatise any Local Authority Homecare services.

RESOLVED – That the report and performance information be noted.

106 Formal response to the Scrutiny Board Statement - the NHS Dental Contract in Leeds: One Year On

The Head of Scrutiny and Member Development submitted a report regarding the Formal Response to the Scrutiny Board Statement - The NHS Dental Contract in Leeds: One Year On. Responses from Leeds PCT, the Leeds Local Dental Committee and Department of Health were appended to the report.

With regards to the Board's recommendation regarding the re-opening of the debate on the fluoridation of water, Members discussed the possibility of submitting a white paper to full Council or a deputation.

RESOLVED – That the report be noted.

107 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 Work Programme and the following issues:

- NHS Annual Health Check

- Review of the National Blood Service – information was also requested on the Bone Marrow Register
- Localisation Inquiry – draft final report

RESOLVED – That the current Work Programme be agreed

108 Date and Time of Next Meeting

Monday, 17 March 2008 at 10.00 a.m. (Pre-meeting for all Members at 9.30 a.m.).

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EXECUTIVE BOARD

FRIDAY, 8TH FEBRUARY, 2008

PRESENT: Councillor A Carter in the Chair

Councillors R Brett, S Golton, R Harker, P Harrand, J Procter, S Smith and K Wakefield

Councillor Blake – Non Voting Advisory Member

161 Chair's Announcements

The Chair announced that the funeral of Mr John Gunnell, a former West Yorkshire County Councillor, Leeds City Councillor and MP for Morley was being held today. On behalf of Executive Board, the Chair paid tribute to Mr Gunnell and requested that the Board's condolences be conveyed to Mr Gunnell's family.

162 Exclusion of Public

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

(a) Appendix F to the report referred to in minute 168(C) 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 because the appendix contains details of sites scheduled for future disposal by the Council, which if disclosed would, or would be likely to prejudice the Council's commercial interests in relation to the level of capital receipts generated from the future disposal of such sites.

(b) Appendix D to the report referred to in minute 171 under the terms of Access to Information Procedure Rule 10.4(4) and (5) and on the grounds that the public interest in maintaining the exemption outweighs the public interest in disclosing the information because the Council is currently defending a large number of equal pay cases before the Employment Tribunal and release of the information at this time could prejudice the outcome of such tribunal claims, proving costly to the Council, and thereby having an adverse impact on the public.

(c) Appendix 1 to the report referred to in minute 177 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 as disclosure would, or would be

likely to prejudice the commercial interests of the Council by virtue of the fact that sensitive negotiations are currently ongoing with private sector investors and Yorkshire Forward to secure a contribution to the Albion Place improvement works.

(d) Appendices 5, 7 and 8 to the report referred to in Minute 179 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 as disclosure of information relating to the remaining leasehold properties to be acquired in both Beeston Hill and Holbeck and Little London, as detailed within the appendices would be likely to prejudice the Council's commercial interests when undertaking negotiations in respect of such properties.

Appendix 9 to the report referred to in minute 179 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 as disclosure would, or would be likely to prejudice the Council's commercial interests by virtue of the fact that it includes information relating to the Council's financial position in the Outline Business Case for Beeston Hill and Holbeck, the details of which are yet to be fully agreed. In addition the Council has also commenced competitive dialogue with PFI bidders, and the disclosure of such information could prejudice the ongoing procurement process.

(e) Annex 2 to the report referred to in minute 181 under the terms of Access to Information Procedure Rule 10.4(1) and (2) and on the grounds that the public interest in maintaining the exemption outweighs the public interest in disclosing the information as Education Leeds has a duty to secure improvement and increased confidence in the schools concerned and this would be adversely affected by disclosure of the information.

(f) Annex 3 to the report referred to in minute 182 under the terms of Access to Information Procedure Rule 10.4(1) and (2) and on the grounds that the public interest in maintaining the exemption outweighs the public interest in disclosing the information as Education Leeds has a duty to secure improvement and increased confidence in the schools concerned and this would be adversely affected by disclosure of the information.

(g) Appendix 1 to the report referred to in minute 185 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 as disclosure would prejudice the Council's commercial interests as the appendix details matters where negotiations of a confidential nature will ensue. In these circumstances

it is considered that the public interest in not disclosing the commercial information outweighs the public interest in disclosure.

163 Declaration of Interests

Councillor Brett declared a personal interest in the items relating to 'Health and Wellbeing Partnership Arrangements' and 'Consultation Paper – Valuing People Now: From Progress to Transformation' (minutes 186 and 187 refer respectively) as a member of the Burmantofts Senior Action Management Committee.

Councillor Smith declared a personal and prejudicial interest in the item relating to 'Pay and Grading Review' (minute 171) due to his wife being an employee of Education Leeds.

Councillor Blake declared a personal interest in the item relating to 'Health and Wellbeing Partnership Arrangements' (minute 186) due to her position as Non-Execuitve Director of Leeds North West Primary Care Trust and a member of Middleton Elderly Aid.

A further declaration made during the meeting (Councillor Wakefield) is referred to at minute 176.

164 Minutes

RESOLVED – That the minutes of the meeting held on 23rd January 2008 be approved.

LEISURE

165 Inquiry into River Safety Management at Wharfemeadows Park, Otley - Final Report and Recommendations

The Chief Democratic Services Officer submitted a report presenting the final report and recommendations of the Scrutiny Board (Culture and Leisure) following its inquiry into 'River Safety Management at Wharfemeadows Park, Otley'.

A minority report submitted by a member of the Scrutiny Board (Culture and Leisure) was appended to the report.

The Chair of the Scrutiny Board attended the meeting and presented the Scrutiny report.

RESOLVED – That the contents of the Scrutiny inquiry report be received.

166 Inquiry into River Safety Management at Wharfemeadows Park, Otley - Officer Observations

The Assistant Chief Executive (Corporate Governance) submitted a report in order to assist Members when considering the recommendations of Scrutiny Board (Culture and Leisure) in regard to their inquiry into the decision by Executive Board to erect fencing at Wharfemeadows Park Otley.

The final report of the Scrutiny Board was considered as a separate item on the agenda (minute 165 refers).

RESOLVED – That recommendations 1, 3 an 4 of the report by Scrutiny Board (Culture and Leisure) be accepted and that the Assistant Chief Executive (Corporate Governance) report back on recommendation 2 of the Scrutiny Board's report, in relation to the availability of Counsel's advice to the public.

CENTRAL AND CORPORATE

167 Budget Arrangements 2009/2010

The Chair circulated to Board members a copy of a letter from John Healey MP, Minister for Local Government confirming that the Council's failure to qualify for monies under the Working Neighbourhoods Fund would not be subject to further consideration.

RESOLVED – That, in view of the reductions in funding in 2009/2010 which can be anticipated as a result of this confirmation, the Director of Resources be requested to report back to the Board on potential savings which may be realised in that year in relation to Council publications, engagement of consultants and procurements.

168 Council Budget 2008/2009 and Capital Programme

(A) Revenue Budget and Council Tax 2008/09

The Director of Resources submitted a report on the Council's budget for 2008/09 following detailed consideration of service requirements and taking account of the Local Government Finance Settlement. The report indicated that the budget would result in a Band D Council Tax of £1,064.37 for consideration by Council.

RESOLVED –

(i) That Council be recommended to approve the Revenue Estimates for 2008/09 totalling £540,509,000 as detailed and explained in the submitted report and accompanying papers, including a 4.7% increase in the Leeds' element of the Council Tax.

(ii) That as the Police Authority budget meeting is currently scheduled for 22nd February 2008, Council be recommended to establish a committee of the Council specifically to set the final Council Tax.

(iii) That the fees and charges policy as detailed in appendix 5 of the report be approved.

(iv) That the proposal to change the childcare fee structure as detailed in the Children's Services budget briefing report be approved.

(v) That the proposed local performance indicators as detailed within paragraph 13 of the report be approved.

(B) Housing Revenue Account Budget 2008/09

The Directors of Resources and Environment and Neighbourhoods submitted a joint report on the Housing Revenue Account budget and ALMO management fee distribution for 2008/09.

RESOLVED –

(i) That the Council be recommended to approve the budget at the average rent increase figure of 5.8%.

(ii) That the Council be recommended to approve that service charges be increased in line with average rent rises.

(iii) That the Council be recommended to approve that the charges for garage rents be increased to £5.55 per week.

(C) Capital Programme 2007-2012

The Director of Resources submitted a report setting out the updated capital programme for 2007-2012.

Following consideration of appendix F 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 –

(i) That the Council be recommended to approve the capital programme as attached to the submitted report.

(ii) That the Director of Resources be authorised to manage, monitor and control scheme progress and commitments to ensure that the programme is affordable.

(iii) That the disposal of land and property sites as detailed within exempt appendix F to the report be agreed in order to generate capital receipts to support the capital programme.

(iv) That the Council be recommended to approve the proposed Minimum Revenue Provision policies for 2008/09 as set out in paragraph 5.3.2 and appendix G to the report.

(D) Treasury Management Strategy 2008/09

The Director of Resources submitted a report on the proposed Treasury Management Strategy for 2008/09 and the revised affordable borrowing limits under the prudential framework. The report also provided members with a review of strategy and operations in 2007/08.

RESOLVED –

(i) That the initial Treasury Strategy for 2008/09 as set out in section 3.3 of the report be approved and that the review of the 2007/08 strategy and operations, as set out in sections 3.1 and 3.2 of the report be noted.

(ii) That the Council be recommended to set the borrowing limits for 2007/08, 2008/09, 2009/10 and 2010/11, as set out in section 3.4 of the report.

(iii) That the Council be recommended to set the treasury management indicators for 2007/08, 2008/09, 2009/10 and 2010/11, as set out in section 3.5 of the report.

(iv) That the Council be recommended to set the investment limits for 2007/08, 2008/09, 2009/10 and 2010/11, as set out in section 3.6 of the report.

(The matters referred to in parts A(i) and (ii), B(i), (ii) and (iii), C(i) and (iv) and D (ii), (iii) and (iv) of this minute being matters reserved to Council were not eligible for Call In)

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

169 Financial Health Monitoring 2007/08 - Third Quarter Report

The Director of Resources submitted a report setting out the Council's financial health position for 2007/08 after nine months of the financial year, in respect of the revenue expenditure and income to date compared to the approved budget, the projected year end position and proposed actions to ensure a balanced budget by the year end. The report also highlighted the position regarding other key financial indicators, including Council Tax collection and the payment of creditors.

RESOLVED –

(i) That the projected financial position of the authority after nine months of the new financial year be noted.

(ii) That the transfer of the projected surplus to general reserves be approved.

170 Final Local Government Finance Settlement 2008/09 and Revised Provisional Settlements for 2009/10 and 2010/2011

The Director of Resources submitted a report providing details of the final Local Government Revenue Support Grant Settlement for 2008/09 and the revised provisional settlements for 2009/10 and 2010/11 which were announced on 24th January 2008.

RESOLVED – That the contents of the report be noted.

171 Pay and Grading Review

The Director of Resources submitted a report which sought approval of an amended version of the pay structure and confirmed the position on pay protection for the purpose of the Pay and Grading Review. The report also updated members on negotiations with the trade unions.

Following consideration of appendix D to the report designated as exempt under Access to Information Procedure Rule 10.4(4) and (5) which was considered in private at the conclusion of the meeting it was

RESOLVED –

(i) That the amended pay structure, as detailed within appendix A to the report be approved.

(ii) That the pay protection arrangements for Phase 1 and Phase 2 employees be confirmed as previously agreed by the Executive Board in March 2007, which is for those staff whose grade changes adversely as a result of the job evaluation exercise:-

- A period of no longer than 3 years protection – attracting annual pay award and increments in line with the NJC for Local Government service pay agreements effective from 1st February 2008;
- Year 4 – go directly to the maximum point of the new substantive grade/pay range.

(iii) That the Board notes that the Director of Resources will continue negotiations with the Trade Unions and will continue to work with the Trade Unions to identify means of avoiding individual loss wherever possible and appropriate.

(iv) That the Director of Resources be authorised to take steps to implement the new pay structure, by agreement or otherwise, in the light of the negotiations with Trade Unions.

(Having declared a personal and prejudicial interest, Councillor Smith left the meeting during consideration of this matter)

172 Comprehensive Performance Assessment - 2007 Result

The Assistant Chief Executive (Policy, Planning and Improvement) submitted a report updating members on the arrangements for reporting Leeds City Council's Comprehensive Performance Assessment (CPA) judgement for 2007, namely a 4 star authority which is improving well.

RESOLVED –

(i) That the contents of the report be noted.

(ii) That all staff of the authority be offered the thanks of the Board for their contribution to this result.

173 225 York Road Taxi and Private Hire Licensing Section Extension

The Assistant Chief Executive (Corporate Governance) submitted a report on a proposed extension to the existing purpose built accommodation for the Taxi and Private Hire Licensing Section at 225 York Road.

RESOLVED –

(i) That the further injection into the 2007/08 capital programme of £84,000 be approved.

(ii) That authority be given to incur expenditure of £610,000 on construction costs, £17,600 on equipment and £78,500 on fees.

DEVELOPMENT AND REGENERATION

174 West End Partnership - Proposed Memorandum of Understanding

The Director of City Development submitted a report on a proposed Memorandum of Understanding which would facilitate collaboration between Leeds City Council and six private developers to promote the West End vision.

RESOLVED –

(i) That the Council be authorised to enter into the Memorandum of Understanding with the six companies comprising the West End Partnership.

(ii) That the general terms of the Memorandum of Understanding as outlined in paragraph 2.6 of the report, be agreed, with the specific details being agreed by the Director of City Development and the Assistant Chief Executive (Corporate Governance) as appropriate.

(iii) That the Director of City Development be requested to examine processes whereby elected Members can be briefed as to progress of the proposals.

175 Roundhay Road Proposed High Occupancy Vehicle Lane

The Director of City Development submitted a report on the proposed implementation of a scheme to improve the existing bus lane on Roundhay Road, which would facilitate its use by High Occupancy Vehicles, in addition to ensuring a more reliable passage for buses at an overall cost of £540,000.

RESOLVED –

(i) That the Roundhay Road Bus and High Occupancy Vehicle Corridor Scheme, as illustrated on drawing numbers 760217/002, at an estimated cost of £538,717 be approved.

(ii) That £511,717 expenditure, comprising £336,354 works costs, statutory undertakers costs of £103,619 and a further £71,744 staff costs for supervision, monitoring and enforcement be approved. These costs to be met from the Integrated Transport Scheme 99609 within the approved Capital Programme which is eligible for 100% Government funding and may be reimbursed at a later date via Section 106 contributions.

(iii) That the previous approval of staff costs of £27,000 which were met from the Integrated Transport Scheme 99609 within the approved Capital Programme be noted.

176 Private Streets Programme

The Director of City Development submitted a report which provided an update on the progress of the Private Streets Programme, sought approval to extend the programme for a further 3 years from April 2008 and to incur expenditure of a further £3,600,000, which was the remaining balance of the overall capital programme provision for the initiative.

RESOLVED –

(i) That the updated position report on the current Private Streets Programme be noted.
(ii) That the continuation of the Private Streets Programme for a further 3 years up to and including 2010/11 be approved.
(iii) That authority be given to the further expenditure of £3,600,000 on the continuing implementation of the Private Streets Programme, funded from Scheme Number 28967 in the approved Capital Programme, £4,200,000 expenditure having been previously approved.

(Councillor Wakefield declared a personal interest in this matter as the owner of a property adjoining a street which had benefited under this programme)

177 Albion Place Refurbishment

The Director of City Development submitted a report which sought approval of the project's scheme design, and sought authority to spend monies from Leeds City Council's capital budget for the refurbishment scheme.

Following consideration of appendix 1 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 –
(i) That the scheme design, as outlined within the report be approved.
(ii) That the release of scheme expenditure as detailed in table (vi) at lines CPRH (3) and CPRH (6) of exempt appendix 1 be authorised.

178 Yeadon Town and District Centre Regeneration Scheme

The Directors of City Development and Environment and Neighbourhoods submitted a joint report on a proposal to spend £941,218 to aid the regeneration of Yeadon High Street by making significant improvements to the public realm and pedestrian use of the area.

RESOLVED –
(i) That the project brief and scheme design as presented within the report be noted.
(ii) That the Design and Cost Report for scheme 12154/YEA/000 be approved, and that the scheme expenditure, totalling £941,218 be authorised.

NEIGHBOURHOODS AND HOUSING

179 Little London and Beeston Hill and Holbeck PFI Projects - Land Assembly Issues and Update on the Lovells Multi-Storey Flats

The Directors of Environment and Neighbourhoods and City Development submitted a joint report providing an update on the Beeston Hill and Holbeck and Little London PFI schemes, commenting on the Outline Business Case for Beeston Hill and Holbeck which had been made available to Members of the Board and proposing a number of key recommendations to enable the projects to progress.

Following consideration of appendices 5,7, 8 and 9 to the report designated as exempt under Access to Information Procedure Rule 10.4(3) which were considered in private at the conclusion of the meeting, it was

RESOLVED –

(i) In respect of the properties at **Little London**:

a) That the Director of Environment and Neighbourhoods be authorised to make a Compulsory Purchase Order in respect of such properties and interests as may be required subject to the Director being satisfied that the requirements of Section 226(1)(a) of the Town and Country Planning Act 1990 (as amended) and the provisions of Circular 06/2004 are complied with.

b) That officers be authorised to take all necessary steps to secure the making, confirmation and implementation of the Compulsory Purchase Order including:

(i) the publication and service of all notices and the presentation of the Councils case at any Public Inquiry

(ii) approving the acquisition of interest in land within the Compulsory Purchase Order either by agreement or by way of compulsory powers

(iii) approving agreements with landowners setting out the terms for the withdrawal of objections to the Order including, where appropriate, seeking exclusion of land from the Order and/or making arrangements for the relocation of occupiers

(iv) such other agreements including Indemnity and Development Agreements as may be necessary to promote the Scheme.

(ii) In respect of the properties at **Beeston Hill and Holbeck**:

a) That the development sites included in the PFI scheme be noted and the Director of City Development be authorised to enter into such negotiations as are required to acquire properties and interests within the area on such terms as she thinks appropriate in order to facilitate the Scheme, subject to the approval by government of the PFI Outline Business Case for Beeston Hill and Holbeck.

b) That the Director of Environment and Neighbourhoods be authorised to make a Compulsory Purchase Order in respect of such properties as may be required subject to the Director being satisfied that the requirements of Section 229(1)(a) of the Town and Country Planning Act 1990 (as amended) and Circular 06/2004 are complied with.

c) That officers be authorised to take all necessary steps to secure the making, confirmation and implementation of the Compulsory Purchase Order including:-

(i) the publication and service of all notices and the presentation of the Council's case at any Public Inquiry

(ii) approving the acquisition of interest in land within the Compulsory Purchase Order either by agreement or by way of compulsory powers

(iii) approving agreements with landowners setting out terms for the withdrawal of objections to the Order including, where appropriate, seeking exclusion of land from the Order and/or making arrangements for the relocation of occupiers

(iv) such other agreements including Indemnity and Development Agreements as may be necessary to promote the Scheme

(iii) That the Director of Environment and Neighbourhoods, in consultation with the Assistant Chief Executive (Corporate Governance), be authorised to make minor changes to the development site boundaries in both Beeston Hill & Holbeck and Little London where required as a result of further due diligence.

(iv) That the Director of Environment and Neighbourhoods be authorised to make an application to Government for Decent Homes funding for refurbishment of the Lovells multi-storey flats.

(v) That the financial issues detailed in exempt appendix 9 to the report be agreed and that approval be given to the affordability of both the Beeston and Holbeck and Little London schemes and to the capital contribution for the Beeston Hill and Holbeck PFI scheme.

180 Disposal of Land for Affordable Housing

The Director of Environment and Neighbourhoods submitted a report on a proposal to dispose of the first six sites from the 77 acres within the Affordable Housing Strategic Partnership at less than best consideration calculated at £5,000 per plot. The report also sought approval for the Director of City Development to undertake further disposals of sites within the Affordable Housing Strategic Partnership at less than best consideration of £5,000 per plot.

RESOLVED –

(i) That the disposal of the first six sites within the Affordable Housing Strategic Partnership at less than best consideration, calculated at £5,000 per plot be approved.

(ii) That the Director of City Development be authorised to dispose of other sites within the 77 acres allocated to the Affordable Housing Strategic

Partnership where the disposal is at less than best consideration calculated at £5,000 per plot.

(iii) That the Director of Environment and Neighbourhoods be requested to prioritise progress on the Highfield Gardens site within the context of the Board's decision of 19th December 2007 on options for Building Council Housing with appropriate adjustments to this programme.

CHILDREN'S SERVICES

181 Annual Standards Report - Primary

The Chief Executive of Education Leeds submitted a report providing an overview of the performance of primary schools at the end of 2006/07, as demonstrated through statutory national testing, Ofsted inspections and the Education Leeds emerging concerns protocols. It also outlined the action taken by Education Leeds to fulfil its responsibilities to this Board and schools.

Following consideration of annex 2 to the report designated as exempt under Access to Information Procedure Rule 10.4(1) and (2), which was considered in private at the conclusion of the meeting, it was

RESOLVED –That the progress which has been made in recent years, in addition to the key issues and challenges which are currently being addressed be noted.

182 Annual Standards Report - Secondary

The Chief Executive of Education Leeds submitted a report providing an overview of the performance of secondary schools at the end of 2006/07 which analysed the results of the tests at the end of Key Stage 3, GCSE and vocational examinations at Key Stage 4. The report also reviewed the progress of schools receiving additional support through the extended or focused partnerships.

Following consideration of annex 3 to the report designated as exempt under Access to Information Procedure Rule 10.4(1) and (2) which was considered in private at the conclusion of the meeting it was

RESOLVED –

(a) That the contents of the report be noted, together with the good progress made in recent years, the improvements achieved in value added indicators particularly for progress between Key Stages 2-3 and Key Stages 3-4, the new floor targets which have been established at Key Stages 3 and 4 which focus upon achievement in English and mathematics and require new strategies from schools to ensure that pupils achieve, in addition to the co-ordination and combination of efforts from across the service areas of Education Leeds and Children Leeds that will be necessary to improve outcomes for underachieving groups and to close the gap between the most and the least successful.

(b) That the Chief Executive of Education Leeds be requested to bring a further report to the Board on the strategies being used to address identified areas of comparative under achievement.

183 The 'Children's Plan - Building Brighter Futures'

The Director of Children's Services submitted a report summarising the content of the recently published 'Children's Plan – Building Brighter Futures' and highlighting the key implications within the plan for children's services in Leeds.

RESOLVED – That the proposal for the authority to lead the development to renew the city's strategy for children's services through a revised Children and Young People's Plan be approved.

184 Integrated Capital Strategy for Youth Centres

The Director of Children's Services submitted a report on a proposal to develop an integrated capital strategy designed to enable quality integrated youth centres to be established in Leeds.

RESOLVED –

(i) That the establishment of an integrated capital strategy for youth centres, as described within the report be approved.

(ii) That proposals be progressed for the establishment of quality youth hub centres in pursuance of the ambitions detailed within the report.

(iii) That approval be given for the strategy to be progressed by the emerging Integrated Youth Support Service and as part of the wider Children's Services Asset Management Plan.

185 Leeds Independent Living PFI Project

The Deputy Chief Executive submitted a report providing an update on the affordability position of the Children's Services element of the Independent Living Project. The report also outlined the sites to be used within the Independent Living Project and sought approval to lease the relevant sites to the PFI contractor for use during the 25 year life of the contract.

Following consideration of appendix 1 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 –

(i) That the financial implications for the Council entering into the Children's Services element of the Independent Living Project be approved, and the maximum affordability ceiling for that element of £360,000 for the first full financial year (2010/11) as set out in exempt appendix 1 to the report be agreed.

(ii) That, subject to consent being obtained as required under Section 25 of the Local Government Act 1988, authority be given to the Chief Asset Management Officer to determine the disposal of those sites detailed at appendix 2 to the report under Section 123 of the Local Government Act 1972, to the housing management contractor under

the Independent Living Project, on a leasehold basis and at less than best consideration where indicated.

ADULT HEALTH AND SOCIAL CARE

186 Health and Wellbeing Partnership Arrangements

The Director of Adult Social Services submitted a report outlining the proposed changes to the functions and partnership structure under the Healthy Leeds Partnership, the consultation process which had been undertaken, and the response to the key points which had emerged from such consultation. As one of the key partners, the Executive Board was asked to give its approval to the proposed changes to the Healthy Leeds Partnership.

RESOLVED –

(i) That the summary of comments received through the consultation on revised partnership arrangements for health and well being be noted.

(ii) That the proposals detailed within the consultation document on health and wellbeing partnership arrangements be supported.

(iii) That Leeds City Council's support for the partnership proposals be reported to the Healthy Leeds Partnership at its next scheduled meeting on 10th March 2008.

187 Consultation Paper - Valuing People Now: From Progress to Transformation

The Director of Adult Social Services submitted a report providing information on the publication of a recent document from the Department of Health entitled 'Valuing People Now – From Progress to Transformation', which followed on from earlier Valuing People documents seeking to promote equal citizenship for people with learning disabilities.

RESOLVED –

(i) That the publication of the Valuing People Now document and the wide ranging proposals it makes in relation to improving the lives of people with learning disabilities be noted.

(ii) That the implications for the Council as detailed in section 4 of the report, particularly in relation to the transfer of commissioning responsibilities from the PCT and in relation to the provision of more individualised and community based service provision for people with learning disabilities be noted.

(iii) That the preparation of a consultation response by the Leeds Learning Disability Partnership Board be noted.

(iv) That the proposal for the final report to be issued by the Department of Health in the summer be noted.

DATE OF PUBLICATION: 12TH FEBRUARY 2008

LAST DATE FOR CALL IN: 19TH FEBRUARY 2008 (5.00 PM)

(Scrutiny Support will notify Directors of any items called in by 12 noon on Wednesday 20th February 2008)

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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: 17th March 2008

Subject: Renal Services in Leeds

Electoral Wards Affected:

☐ Ward Members consulted (referred to in report)

Specific Implications For:

Equality and Diversity ☐

Community Cohesion ☐

Narrowing the Gap ☐

1.0 Introduction

1.1 During the municipal year 2006/7, Scrutiny Board (Health and Adult Social Care) received regular reports regarding the long term plans for renal services in Leeds following concerns raised by the LGI Kidney Patients Association. In April 2007, the Scrutiny Board recommended that the Leeds Teaching Hospitals NHS Trust continue its ongoing dialogue with the Kidney Patients Association and Leeds PCT on this matter. The Board also recommended that the provision of renal services continue to be monitored by Scrutiny in the new municipal year.

1.2 In November 2007, the Chair received communication from the LGI Kidney Patients Association about problems service users were experiencing at Seacroft hospital, including poor access, insufficient wheelchairs, low staff levels, loss of skilled staff, regular water treatment plant failures, transport issues and long waits for patients to get onto dialysis once they arrive at the hospital.

1.3 In view of the past Scrutiny involvement and the problems raised by the LGI Kidney Patients Association, the Board decided to request a further update from the Leeds Teaching Hospitals NHS Trust for this meeting, to consider the long-term plans for renal services in Leeds. Members agreed to invite both the Trust and the LGI Kidney Patients Association together for a discussion of the issues raised by the Association.

2.0 Recommendations

2.1 The Board is requested to consider

- the information provided from Leeds Teaching Hospitals NHS Trust in the report attached
- the discussion at the meeting today

and determine whether this matter requires any further scrutiny.

DEPARTMENT OF RENAL MEDICINE

Ms D Chambers
Principal Scrutiny Adviser
Scrutiny Support Unit
1st Floor West
The Civic Hall
Leeds
LS1 1UR

Secretary: Mrs S Hidle
Direct Line: 0113 2064583
Fax: 0113 2066216

Reference: CGN/SEH
Typed: 29 February 2008

Dear Ms Chambers

I am responding to your email dated 4 February asking for an update report for the March meeting of the Scrutiny Board regarding long-term plans for renal services in Leeds.

I would like to start by reminding colleagues that renal services are broad. There are a number of treatments for end stage renal failure, all of which are provided by the Leeds renal service:

- haemodialysis in main renal units at SJUH (Ward 55) and Seacroft (Parsons Unit)
- haemodialysis in satellite renal units (six in total) across West Yorkshire - five in NHS hospitals and one in a GP surgery. Two of these are in Leeds, at Seacroft (B Ward) and Beeston
- home haemodialysis - patients self care at home and can dialyse up to six times per week
- peritoneal dialysis (PD) - patients self care at home. There are three modalities: continuous ambulatory peritoneal dialysis (CAPD); automated PD (APD) and, recently, Assisted APD (AAPD), where the patient is provided with help in the home to start or sustain APD.
- transplantation - by far the most clinically effective, cost efficient and quality of life enhancing treatment.

In addition approximately 300 patients a year are treated for acute renal failure. This is kidney failure which almost always recovers but these are patients who are seriously unwell and need intensive inpatient care. Finally, largely outpatient review occurs for approximately 5,000 individuals with much less severe kidney disease. A proportion of these patients, however, do have kidney failure which is steadily progressing and these would be considered a "pre-dialysis/low clearance" cohort.

To update you on long-term plans for renal services in Leeds.

Leeds General Infirmary Haemodialysis Unit
This is planned to be sited in Ward 46 which is the area preferred by both staff and patient representatives. The works will go out to tender on 25 April. It is expected the Trust Board would agree the approved contractor at its meeting on 26 June with a start on site date of 14 July. Completion is anticipated on 12 December with commissioning between December 2008 and January 2009.

Main Seacroft Dialysis Unit
This is planned to be sited on Wards R and S, next door to the current temporary unit on Wards T and U. The schedule for this went out to tender today, 29 February. It is expected the Trust Board will agree the approved contractor at its meeting on 24 April with a start on site date of 13 May. Completion is expected 24 November with commissioning in the months of November/December 2008.

Inpatient Ward Reconfiguration
With the forced closure of Wellcome Wing the inpatient ward at the Leeds Infirmary (ex Ward 32) was relocated in a ward in Gledhow Wing (Ward 4) at St James's. The plan had been to move this ward into newer accommodation in the same wing as the whole of the rest of the inpatient renal beds and main haemodialysis unit at St James's and this move is happening today, with Ward 4 moving to Ward 62 in Lincoln Wing close to the rest of the renal clinical facilities.

Dialysis at Wharfedale General Hospital
I remember that the creation of a dialysis unit at Wharfedale General Hospital was broached at the Scrutiny Board. This we have said previously would have to be in addition to the LGI unit, not as a substitute – because of the far greater access issues for people in west Leeds getting to WGH than people in north Leeds getting to LGI – it would be a far smaller facility but would have a similar capital cost because of the critical mass costs of the plant. Staffing costs would also be disproportionate, again because of the critical mass required.

The Trust is therefore not considering putting any haemodialysis facility at WGH at the present time. Of course if the PCT wishes to prioritise satellite haemodialysis further and wanted to invest in a small facility at WGH, then we would be happy to discuss this.

Expansion of "Pre-Dialysis/Low Clearance" Care
There is an increasing volume of referrals from primary care colleagues for management of the patients in this position. Treating patients' anaemia, which involves injections of iron and a hormone, is the most important and difficult part of this treatment. We have been in negotiation with primary care colleagues with the intention of setting up a community renal clinic. In addition as part of the renal business case for the forthcoming financial year is the ambition to increase this service. However at the time of writing this depends on decisions about business planning priorities.

Transport for Patients Treated with Haemodialysis
Board members will almost certainly remember that this has been a significant problem with a poorer quality of service for patients requiring transport to and from haemodialysis treatment than we would wish. This is a problem throughout the whole country. A formal tendering process was embarked upon which attracted one bidder and Yorkshire Ambulance Service were awarded the contract. There are monthly meetings between Trust representatives and Yorkshire Ambulance Service senior management staff and there is no doubt the commitment of those colleagues to

deliver a good service. There have been a variety of initiatives including a central telephone hub to co-ordinate services.

At the present time this performance of this service falls below the agreed contract standard.

It may be that involvement of the Health and Wellbeing Scrutiny Board directly with Yorkshire Ambulance Service would be the most appropriate way to explore this further.

Live Donor Renal Transplantation
I am pleased to report that a Super-Regional Services bid to increase the volume of live donor transplantation activity in Leeds from 40 to 70 per year over the next three years was supported by the Specialist Commissioners. This is a highly significant investment which over time should make a real difference to the number of patients who receive a transplant.

Colleagues may be aware of the recent governmental report of the Organ Donor Task Force and the government commitment of significant financial resource with the intention of increasing the number of heart beating cadaveric organ donors, most likely by decreasing the current approximately 60% "relative refusal rate". If this plan is successful it would be expected to lead to considerable benefits for the patient population with end stage renal failure.

Unfortunately I am obliged to be in London on the day of the Scrutiny Board Meeting, it may be possible for Dr Mooney, who kindly substituted for me at a previous meeting, to attend.

Yours sincerely

Dr C G Newstead
Consultant Renal Physician
Clinical Director Renal Services

cc via email: Maggie Boyle, Chief Executive, Trust Headquarters, SJUH
Sylvia Craven, Director of Planning, Trust Headquarters, SJUH
Paula Dearing, Leeds PCT
Nigel Gray, Leeds PCT
Judith Lund, Directorate Manager, Specialty Medicine, 2nd Floor Stables Block, LGI
Dr A F Mooney, Consultant Renal Physician, SJUH

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Leeds CITY COUNCIL

Originator: Debbie Chambers
Tel: 247 792

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health and Adult Social Care)

Date: 17th March 2008

Subject: NHS Annual Health Check

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

1.0 Introduction

1.1 In 2005/6, the Healthcare Commission introduced the new NHS performance assessment process 'Annual Health Check'. As part of the health check, NHS trusts must submit a self assessment declaration to the Commission by midday on 30th April 2008. These declarations are supplemented with comments from representatives of patients and other partners in the community, such as Patient and Public Involvement (PPI) Forums, Local Authorities' Overview and Scrutiny Committees, Foundation Trusts' boards of governors and Strategic Health Authorities.

2.0 The role of Scrutiny in the Annual Health Check

2.1 The Healthcare Commission invites Overview and Scrutiny Committees, and other bodies, to comment on how they think local Trusts are performing against the 24 "core standards" set by Government. Core standards represent the minimum standards for services that must be met, for all patients, by all NHS bodies. The 24 standards were agreed by the Department of Health in July 2004 and published in the document 'Standards for Better Health', attached at Appendix 1. They are divided into 7 domains: Safety, Clinical and Cost Effectiveness, Governance, Patient Focus, Accessible and Responsive Care, Care Environment and Amenities, and Public Health.

2.2 Local NHS Trusts are required to ask this Board and PPI Forums to comment on the Trust's performance against the core standards. However, the Board and PPI Forums are not compelled to provide comments.

2.3 In accordance with Healthcare Commission guidance, where Scrutiny Board (Health and Adult Social Care) does provide comments to Trusts, such comments will need to be supported by evidence of work carried out by the Board and must also be relevant to the assessment period (this year that assessment period is April 2007 to March 2008). In view of this, the Commission acknowledges that the Board may wish to, but is not obliged to, limit comments to those areas where it has undertaken reviews or monitored services.

2.4 The Board is therefore invited to make comments on the information received from each of the NHS Trusts in Leeds, at Appendices 2, 3 and 4. Some members may recall that the Board was also asked to comment on developmental standards last year, however this was a pilot assessment for Trusts and is not applicable this year.

3.0 Briefings from Local NHS Trusts

3.1 Representatives from the Leeds Teaching Hospitals NHS Trust, Leeds Mental Health Teaching NHS Trust, and Leeds Primary Care Trust will be attending today's meeting to brief the Board on the progress made by the Trusts in complying with the core standards. Briefing papers have been provided by all three Trusts and are attached.

3.2 Should the Board decide to formulate comments for submission to the Trusts as part of the Annual Health Check process, comments will need to be formally agreed and conveyed to the Trusts in time to meet their deadlines for submission to the Healthcare Commission.

4.0 Recommendation

4.1 The Board is are asked to:

(a) consider and comment on the progress made by the Trusts in complying with the core standards
(b) identify and discuss any areas relevant to the core standards, which it might like to provide comments on, based on the work of the Board over the last 12 months
(c) determine, in discussion with Trust representatives, the timescales for providing any comments to comply with their deadlines for submission to the Healthcare Commission.

STANDARDS FOR BETTER HEALTH

Core and Developmental Standards

The outcome for these standards is specified for each domain. The core standards set out below are not optional. They should be met from the date of publication. Progress is expected to be made against the developmental standards across much of the NHS as a result of the NHS Improvement Plan and the extra investment in the period to 2008. Demonstrating improvements against the developmental standards will be essential to achieve an overall high performance rating.

First Domain - Safety

Domain Outcome

Patient safety is enhanced by the use of health care processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

Core standard

Core standard	*Related Developmental Standard:*
C1 Health care organisations protect patients through systems that a) identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents; and b) ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales.	D1
C2 Health care organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.	
C3 Health care organisations protect patients by following NICE Interventional Procedures guidance.	
C4 Health care organisations keep patients, staff and visitors safe by having systems to ensure that a) the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA; b) all risks associated with the acquisition and use of medical devices are minimised; c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed; d) medicines are handled safely and securely; and e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to	

the health and safety of staff, patients, the public and the safety of the environment.

Developmental standard

D1 Health care organisations continuously and systematically review and improve all aspects of their activities that directly affect patient safety and apply best practice in assessing and managing risks to patients, staff and others, particularly when patients move from the care of one organisation to another.

Second Domain – Clinical and Cost Effectiveness

Domain Outcome

Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes

Core standards

C5 Health care organisations ensure that
a) they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care;
b) clinical care and treatment are carried out under supervision and leadership;
c) clinicians continuously update skills and techniques relevant to their clinical work; and
d) clinicians participate in regular clinical audit and reviews of clinical services.

Related Developmental Standard: D2

C6 Health care organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.

Developmental standard

D2 Patients receive effective treatment and care that:

a) conform to nationally agreed best practice, particularly as defined in National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery;

b) take into account their individual requirements and meet their physical, cultural, spiritual and psychological needs and preferences;

c) are well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations; and

d) is delivered by health care professionals who make clinical decisions based on evidence-based practice.

Third Domain – Governance

Domain Outcome

Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the health care organisation.

Core standards

C7 Health care organisations
- a) apply the principles of sound clinical and corporate governance;
- b) actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources;
- c) undertake systematic risk assessment and risk management;
- d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources;
- e) challenge discrimination, promote equality and respect human rights; and
- f) meet the existing performance requirements set out in the annex.

Related Developmental Standard: D3

C8 Health care organisations support their staff through
- a) having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services; and
- b) organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.

Related Developmental Standard: D7

C9 Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

Related Developmental Standard: D6

C10 Health care organisations
a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies; and
b) require that all employed professionals abide by relevant published codes of professional practice.

Related Developmental Standard: D7

C11 Health care organisations ensure that staff concerned with all aspects of the provision of health care
a) are appropriately recruited, trained and qualified for the work they undertake;
b) participate in mandatory training programmes; and
c) participate in further professional and occupational development commensurate with their work throughout their working lives.

C12 Health care organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.

Related Developmental Standard: D3

Developmental standards

D3 Integrated governance arrangements representing best practice are in place in all health care organisations and across all health communities and clinical networks.

D4 Health care organisations work together to
a) ensure that the principles of clinical governance are underpinning the work of every clinical team and every clinical service;
b) implement a cycle of continuous quality improvement; and
c) ensure effective clinical and managerial leadership and accountability.

D5 Health care organisations work together and with social care organisations to meet the changing health needs of their population by
a) having an appropriately constituted workforce with appropriate skill mix across the community; and
b) ensuring the continuous improvement of services through better ways of working.

D6 Health care organisations use effective and integrated information technology and information systems which support and enhance the quality and safety of patient care, choice and service planning.

D7 Health care organisations work to enhance patient care by adopting best practice in human resources management and continuously improving staff satisfaction.

Fourth Domain - Patient Focus

Domain Outcome

Health care is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.

Core standards

C13 Health care organisations have systems in place to ensure that
a) staff treat patients, their relatives and carers with dignity and respect;
b) appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information; and
c) staff treat patient information confidentially, except where authorised by legislation to the contrary.

C14 Health care organisations have systems in place to ensure that patients, their relatives and carers
a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services;
b) are not discriminated against when complaints are made; and
c) are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

Related Developmental Standard: D8

C15 Where food is provided, health care organisations have systems in place to ensure that
a) patients are provided with a choice and that it is prepared safely and provides a balanced diet; and
b) patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.

C16 Health care organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.

Related Developmental Standard: D9

Developmental standards

D8 Health care organisations continuously improve the patient experience, based on the feedback of patients, carers and relatives.

D9 Patients, service users and, where appropriate, carers receive timely and suitable information, when they need and want it, on treatment, care, services, prevention and health promotion and are
a) encouraged to express their preferences; and

b) supported to make choices and shared decisions about their own health care.

D10 Patients and service users, particularly those with long-term conditions, are helped to contribute to planning of their care and are provided with opportunities and resources to develop competence in self-care.

Fifth Domain - Accessible and Responsive Care

Domain Outcome

Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway.

Core standards

C17 The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.

C18 Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

C19 Health care organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.

Related Developmental Standard: D11

Developmental standard

D11 Health care organisations plan and deliver health care which
a) reflects the views and health needs of the population served and which is based on nationally agreed evidence or best practice;
b) maximises patient choice;
c) ensures access (including equality of access) to services through a range of providers and routes of access; and
d) uses locally agreed guidance, guidelines or protocols for admission, referral and discharge that accord with the latest national expectations on access to services.

Sixth Domain - Care Environment and Amenities

Domain Outcome

Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective

and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.

Core Standards

C20 Health care services are provided in environments which promote effective care and optimise health outcomes by being
a) a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation; and
b) supportive of patient privacy and confidentiality.

C21 Health care services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

Related Developmental Standard: D12

Developmental standard

D12 Health care is provided in well-designed environments that
a) promote patient and staff well-being, and meet patients' needs and preferences, and staff concerns; and
b) are appropriate for the effective and safe delivery of treatment, care or a specific function, including the effective control of health care associated infections.

Seventh Domain - Public Health

Domain Outcome

Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

Core standards

C22 Health care organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by

a) co-operating with each other and with local authorities and other organisations;
b) ensuring that the local Director of Public Health's Annual Report informs their policies and practices; and
c) making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.

Related Developmental Standard: D13

C23 Health care organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

Related Developmental Standard: D13

C24 Health care organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.

Developmental standard

D13 Health care organisations

a) identify and act upon significant public health problems and health inequality issues, with primary care trusts taking the leading role;
b) implement effective programmes to improve health and reduce health inequalities, conforming to nationally agreed best practice, particularly as defined in NICE guidance and agreed national guidance on public health;
c) protect their populations from identified current and new hazards to health; and
d) take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health promotion and prevention services for the public, and the commissioning and provision of services.

Appendix 1: GLOSSARY

Access: the extent to which people are able to receive the information, services or care they need.

CHI: The Commission for Health Improvement was, until April 2004, the independent, inspection body for the NHS. Its functions were transferred to the Healthcare Commission

CHAI: The Commission for Health, Audit and Inspection was established by the Health and Social Care (Community Health and Standards) Act 2003 and is now known as the Healthcare Commission.

Clinical audit: a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against specific criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in health care delivery.

Clinical governance: a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

Clinical network: connections across disciplines which provide integrated care across institutional and professional boundaries, raising clinical quality and improving the patient experience.

Clinician: professionally qualified staff providing clinical care to patients.

Crime and disorder reduction partnerships: partnerships between the police, local authorities, probation service, health authorities, the voluntary sector, and local residents and businesses which work to reduce crime and disorder in their area.

Criteria: criteria devised and published by the Healthcare Commission, and approved by the Secretary of State, with reference to which the Healthcare Commission must each financial year conduct a review of the provision of health care by and for each English NHS body, and each cross-border SHA.

Cross-border SHA: a special health authority performing functions in respect of both England and Wales.

English NHS body: a primary care trust, strategic health authority or NHS trust, all or most of whose hospitals, establishments and facilities are situated in England, or an NHS foundation trust or special health authority performing functions only or mainly in respect of England.

Foundation trust: a public benefit corporation established by the Health and Social Care (Community Health and Standards) Act 2003 which is authorised to provide goods and services for the purpose of the health service.

Governance: a mechanism to provide accountability for the way an organisation manages itself.

Healthcare Commission: established in April 2004 as the independent body encompassing the work of the Commission for Health Improvement (CHI). The Healthcare Commission also took on functions transferred from the national NHS value for money work of the Audit Commission and the independent health care work of the National Care Standards Commission (NCSC).. It inspects health care provision in accordance with national standards and other service priorities and reports directly to Parliament on the state of health care in England and Wales.

Health care organisation: English NHS bodies, cross-border SHAs and other organisations and individuals, including the independent and voluntary sectors, which provide or commission health care for individual patients and the public.

Health care professional: a person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Health care: services provided for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.

Health care associated infection: all infections acquired as a direct or indirect result of health care.

Health inequalities: differences in people's health between geographical areas and between different groups of people.

Health promotion: includes the provision of information on healthier lifestyles for patients, and how to make the best use of health services, with the intention of enabling people to make rational health choices and of ensuring awareness of the factors determining the health of the community.

Local strategic partnerships: non-statutory bodies intended to bring together the public, private, voluntary and community sectors at a local level. Their purpose is to improve the delivery of services and quality of life locally.

Medical devices: all products, except medicines, used in health care for diagnosis, prevention, monitoring or treatment. The range of products is very wide: it includes contact lenses and condoms; heart valves and hospital beds; resuscitators and radiotherapy machines; surgical instruments and syringes; wheelchairs and walking frames.

National Service Frameworks:
NSFs

- set national standards and identify key interventions for a defined service or care group;
- put in place strategies to support implementation; and
- establish ways to ensure progress within an agreed time-scale.

The NSFs published to date cover:
- mental health
- coronary heart disease
- older people
- diabetes

NSFs on children, renal services and long term conditions (focusing on neurological conditions) are in preparation.

NICE: a special health authority for England and Wales. Its role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current "best practice". The guidance covers both individual health technologies (including medicines, medical devices, diagnostic techniques, and procedures) and the clinical management of specific conditions.

NICE guidance: guidance includes:
- **Clinical guidelines** cover the appropriate treatment and care of patients with specific diseases and conditions within the NHS in England and Wales.
- **Technology appraisals** cover the use of new and existing medicines and treatments within the NHS in England and Wales.
- **Interventional procedures** cover the safety and efficacy of interventional procedures used for diagnosis or treatment.
- **Public health guidance.**

Patient: those in receipt of health care provided by or for an English NHS body or cross-border SHA.

Primary care: first-contact health services directly accessible to the public.

Primary care trust: a local health organisation responsible for managing local health services. PCTs work with local authorities and other agencies that provide health and social care locally to make sure the community's needs are being met.

Public health: Public health is concerned with improving the health of the population, rather than treating the diseases of individual patients. Public health functions include:
- Health surveillance, monitoring and analysis
- Investigation of disease outbreaks, epidemics and risk to health
- Establishing, designing and managing health promotion and disease prevention programmes
- Enabling and empowering communities to promote health and reduce inequalities
- Creating and sustaining cross-Government and intersectoral partnerships to improve health and reduce inequalities

- Ensuring compliance with regulations and laws to protect and promote health
- Developing and maintaining a well-educated and trained, multi-disciplinary public health workforce
- Ensuring the effective performance of NHS services to meet goals in improving health, preventing disease and reducing inequalities
- Research, development, evaluation and innovation
- Quality assuring the public health function

Public Service Agreement: The PSA for the Department of Health sets out the priorities for the Department's spending programme and, for each priority, the target it is expected to achieve.

Quality assurance: a systematic process of verifying that a product or service being developed is meeting specified requirements.

Research governance framework: defines the broad principles of good research governance and is key to ensuring that health and social care research is conducted to high scientific and ethical standards and applies to all research undertaken within the remit of the Secretary of State for Health.

Risk management: covers all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.

Service user: an individual who uses a health care service, including those who are not in need of treatment, such as blood donors, carers or those using screening services.

Strategic health authority: responsible for:
- developing plans for improving health services in its local area;
- making sure local health services are of a high quality and are performing well;
- increasing the capacity of local health services so they can provide more services; and
- making sure national priorities are integrated into local health service plans.

Systematic risk assessment: a systematic approach to the identification and assessment of risks using explicit risk management techniques.

Appendix 2: Extracts from the Health and Social Care (Community Health and Standards) Act 2003

The "Duty of Quality":

45 Quality in health care

(1) It is the duty of each NHS body to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care provided by and for that body.

(2) In this Part "health care" means-

(a) services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

(b) the promotion and protection of public health.

(3) In subsection (2)(a), "illness" has the meaning given by section 128(1) of the 1977 Act.

The Power for the Secretary of State to prepare and publish standards, and the duty of upon every English NHS body and cross-border SHA to take account of the standards:

46 Standards set by Secretary of State

(1) The Secretary of State may prepare and publish statements of standards in relation to the provision of health care by and for English NHS bodies and cross-border SHAs.

(2) The Secretary of State must keep the standards under review and may publish amended statements whenever he considers it appropriate.

(3) The Secretary of State must consult such persons as he considers appropriate-

(a) before publishing a statement under this section;

(b) before publishing an amended statement under this section which in the opinion of the Secretary of State effects a substantial change in the standards.

(4) The standards set out in statements under this section are to be taken into account by every English NHS body and cross-border SHA in discharging its duty under section 45.

CHAI's annual reviews, reviews and investigations, their use of set criteria and the requirement upon CHAI to take into account the standards:

50 Annual reviews

(1) In each financial year the CHAI must conduct a review of the provision of health care by and for-

(a) each English NHS body, and

(b) each cross-border SHA,

and must award a performance rating to each such body.

(2) The CHAI is to exercise its function under subsection (1) by reference to criteria from time to time devised by it and approved by the Secretary of State.

(3) The CHAI must publish the criteria devised and approved from time to time under subsection (2).
(4) In exercising its functions under this section in relation to any health care the CHAI must take into account the standards set out in statements published under section 46.

51 Reviews: England and Wales

(1) The CHAI has the function of conducting reviews of-
(a) the overall provision of health care by and for NHS bodies;
(b) the overall provision of particular kinds of health care by and for NHS bodies;
(c) the provision of health care, or a particular kind of health care, by and for NHS bodies of a particular description.
(2) If the Secretary of State so requests, the CHAI must conduct-
(a) a review under subsection (1)(a);
(b) a review under subsection (1)(b) of the overall provision of a kind of health care specified in the request; or
(c) a review under subsection (1)(c) of the provision of health care, or health care of a kind specified in the request, by or for NHS bodies of a description so specified.
(3) The Secretary of State must consult the Assembly before making a request under subsection (2).
(4) In conducting a review under this section in relation to any health care the CHAI must take into account-
(a) the standards set out in statements published under section 46, where the health care is provided by or for an English NHS body or cross-border SHA;
(b) the standards set out in statements published under section 47, where the health care is provided by or for a Welsh NHS body.

52 Reviews and investigations: England

(1) The CHAI has the function of conducting other reviews of, and investigations into, the provision of health care by and for English NHS bodies and cross-border SHAs.
(2) The CHAI may in particular under this section conduct-
(a) a review of the overall provision of health care by and for English NHS bodies and cross-border SHAs;
(b) a review of the overall provision of a particular kind of health care by and for English NHS bodies and cross-border SHAs;
(c) a review of, or investigation into, the provision of any health care by or for a particular English NHS body or cross-border SHA.
(3) The CHAI has the function of conducting reviews of the arrangements made by English NHS bodies and cross-border SHAs for the purpose of discharging their duty under section 45.
(4) If the Secretary of State so requests, the CHAI must conduct-
(a) a review under subsection (2)(a);
(b) a review under subsection (2)(b) of the overall provision of a kind of health care specified in the request;

(c) a review or investigation under subsection (2)(c), or a review under subsection (3), in relation to the provision of such health care by or for such body as may be specified in the request.

(5) In exercising its functions under this section in relation to any health care the CHAI must take into account the standards set out in statements published under section 46.

LEEDS PRIMARY CARE TRUST

Report for the Leeds Health and Adult Social Care Scrutiny Board on the Leeds PCT Standards for Better Health declaration, March 2008

1. Introduction

The Healthcare Commission (HCC) is responsible for assessing how well healthcare organisations such as Leeds Primary Care Trust (LPCT) are performing nationally against defined standards known as the standards for better health. The standards are in areas which the HCC considers important for all healthcare organisations to meet. This assessment is undertaken by all National Health Service organisations.

This report provides an overview of the PCT's current position against the standards for better health. Its aim is to provide the local Overview and Scrutiny Committee (OSC), with the information they require in order to provide comment on the areas where they have worked closely with the PCT throughout the year. The comment provided by the OSC forms part of the PCT's declaration to the Healthcare Commission.

2. Current Position

At present the PCT intends to declare compliance with all but one of the core standards by the end of March 2008. There are several standards where it is still to decide how the PCT will declare; these areas have been highlighted in this report and the PCT Executive Team and Board continue to monitor those core standards against agreed action plans as a priority.

The Leeds PCT Board will assess its position against the standards and review progress against the action plans, to determine the current position for the full year declaration (1st April 2007 – 31st March 2008). This will take place at the Board meeting on 20th March 2008 and be submitted to the Healthcare Commission prior to the 30th April deadline.

An overview of the PCT's current position against the standard can be seen in Appendix 1.

3. Background to the Process

3.1 LPCT is a new organisation which was formed on 1st October 2007. During the formation of the new PCT and the subsequent restructuring of the organisation, there was a period of consolidation. This caused some delay in the preparation for measurement and comparison against the standards.

3.2 In 2006/2007 Leeds PCT declared "fully met" on all but one core standard.

4. Background to the Standards

4.1 The standards are grouped into 7 areas known as domains which describe what the standards relate to. The standards are also separated into core and developmental. The core standards are considered to be the fundamental

building blocks required, whilst the developmental standards look at making improvements.

4.2 Primary care and commissioning make up a part of the assessment on each standard. To date, the primary care self assessment is in the final stages of completion. There has been no notification of significant risk.

4.3 This year the developmental standard D13 will continue to be reviewed in shadow form only; that is the outcome will not be counted towards the PCT's rating.

5 Summary of PCT Current Position against the Standards for Better Health Core Standards.

A full overview of the standards and the PCT's position against them is illustrated in Appendix 1. This section highlights a selection of both good practice and development required against the standards.

5.1 Domain 1: Safety

This domain concentrates on all aspects of Safety within the organisation.

C1 - Relates to patient safety issues and incident reporting. This year has seen the PCT develop new Incident and Serious Incident Management Policies.

C2 – Relates to safeguarding children. The PCT will be declaring compliant in relation to this standard. Leeds is making good progress in relation to safeguarding children and works closely with local partners. New statutory requirements for the Child Death Processes are currently being implemented. A new e-learning package for staff was introduced in September 2007. The course has evaluated well and work is ongoing to increase uptake.

C4c - Decontamination of reusable medical devices. Leeds PCT have to declare not compliant with this standard as the European Union Directive requirements (EEC93/42MDD) for the PCT managed Dental and Podiatry Services are currently insufficient. The level of risk to patients from infections caused by these procedures remains low; however work is underway to meet the EEC Directive by later this year. Leeds PCT have taken steps in 2007/08 to ensure minor surgery undertaken by GP's meets the Directive.

Leeds PCT is currently in the same situation on decontamination as other PCTs in West Yorkshire and the work to meet the European Union Directive is being undertaken on a county wide partnership basis.

C4d - Medicines are safely and securely handled. The PCT will declare compliant against this standard. The evidence submitted for compliance is robust. The PCT has formed strong working relationships and processes for the supervision of controlled drugs.

5.2 Domain 2: Clinical and Cost Effectiveness

This domain looks at care & treatment given to the people receiving care in Leeds. It covers standards for ensuring that individual healthcare professional and service planners take into account national guidelines and standards when they practice and as they work to improve and update services.

The PCT will be declaring compliant in relation to the standards within this domain.

5.3 Domain 3: Governance

In the governance domain the standards are concerned with ensuring that the organisation is well-run. This includes ensuring that senior staff in healthcare organisations have clearly defined responsibilities and that the organisation is accountable to the public for both the service they provide and for financial management.

The PCT continues to monitor the following areas closely and has yet to confirm how it will be declaring against these standards.

C 8b, looks at how personal development programmes recognise the contribution of staff addressing under representation in minority groups.

C11a,b &C: These standards relate to the recruitment and selection of staff, the training and professional development of staff.

5.4 Domain 4: Patient Focus

The Patient Focus domain focuses on the patient receiving an equality of care regardless of their background, age, race or sexuality. It looks at respect & dignity at every stage of treatment. The PCT will be declaring compliance against the standards in this domain.

5.5 Domain 5: Accessible & Responsive Care

Accessible & Responsive Care highlights the importance of taking local views into account when planning, developing and improving the healthcare services provided to the people of Leeds.

The PCT is yet to decide how standard **C18** in this domain will be declared.

5.6 Domain 6: Care Environment & Amenities

The PCT has revised its Health, Safety and Security Manual, undertaken a programme of site inspections and revised the Corporate Induction training programme during the year.

5.7 Domain 7: Public Health

This domain looks at the local & national partnerships the organisation has. It highlights the importance of reducing health inequalities.

Work in 2007-8 has focussed on the priority areas of: tackling health inequalities experienced by our residents living in the lowest 10% Super Output Areas; building and supporting effective partnerships with city wide and local partnerships within the statutory, non statutory, voluntary and private sector; focussing on reducing the gap in life expectancy by addressing vascular disease and smoking related illness and the high impact changes to reduce infant mortality; reducing the number of people who smoke; tackling obesity; improving sexual health; improving mental health and well being; reducing harm and encouraging sensible drinking; helping children and young people to lead healthy lives and promoting healthy and active life amongst older people.

The Director of Public Health has produced an annual report which details the work undertaken in each of these areas.

6 Summary of PCT Current Position against the Standards for Better Health Developmental Standards.

Standard D13 looks at how health equalities are addressed, and how nationally agreed best practice such as NICE guidance is implemented. Developmental standards are assessed on a four point scale ranging from limited, fair, good and excellent. LPCT will be declaring a rating of 'good' in relation to this standard.

7. Conclusions

The PCT will continue to develop and closely monitor action plans against the core standards to ensure that we achieve and maintain compliance.

Kathryn Stewart - Risk Manager (Patient Safety)
Leeds PCT

Appendix 1

Core Standards: Position at 27/2/08

No	Dir lead	Compliant	Standard Description	El No	Risk	Element Description
First Domain: Safety						
C 1a	JGM	Yes	Healthcare organisations protect patients through systems that: identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents	1	G	The healthcare organisation has a defined reporting process and incidents are reported, both within the local reporting process and to the National Patient Safety Agency (NPSA) via the National Reporting and Learning System, taking into account Building a safer NHS for patients: implementing an organisation with a memory (Department of Health 2001).
				2	G	Reported incidents are analysed to seek to identify root causes and likelihood of repetition, taking into account Building a safer NHS for patients: implementing an organisation with a memory (Department of Health 2001).

Core Standards: Position at 27/2/08

No	Dir lead	Compliant	Standard Description	El No	Risk	Element Description
				3	A	Improvements in practice are made as a result of analysis of local incidents taking into account Building a safer NHS for patients: implementing an organisation with a memory (Department of Health 2001), and also as a result of information arising from the National Patient Safety Agency's (NPSA) national analysis of incidents via the National Reporting and Learning System.
C 1b	JGM	Yes	Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety, which require action, are acted on within required timescales.	1	G	Patient safety notices, alerts and other communications issued by the Safety Alert Broadcast System (SABS) and Medicines and Healthcare products Regulatory Agency (MHRA) are implemented within the required timescale, in accordance with chief executive's bulletin article (Gateway 2326) and the drug alerts system administered by the Defective Medicines Support Centre (part of the MHRA).
C 2	SC	Yes	Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations	1	G	The healthcare organisation has defined and implemented effective processes for identifying, reporting and taking action on child protection issues, in accordance with the Protection Of Children Act 1999, the Children Act 2004, Working together to safeguard children (Department of Health 1999) and Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities (Department of Health July 2001).
	SC			2	G	The healthcare organisation works with all relevant partners and communities to protect children in accordance with Working together to safeguard children (HM Government, 2006)).
	JGM			3	G	Criminal Records Bureau (CRB) checks are conducted for all staff and students with access to patients and relatives in the normal course of their duties. In carrying out CRB checks the healthcare organisation should be meeting the requirements of CRB disclosures in the NHS (NHS Employers 2004).
C 3	MW	Yes	Healthcare organisations protect patients by following National Institute for Health and Clinical Excellence (NICE) interventional procedures guidance	1	G	The healthcare organisation follows NICE interventional procedures guidance in accordance with the Interventional Procedures Programme (Health Service Circular 2003/011).
C4a	IC	Yes	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving a year on year reduction in Methicillin-Resistant Staphylococcus Aureus (MRSA).	4	G	The PCT has taken steps to minimise the risk of healthcare acquired infection to patients, in accordance with The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections (Department of Health 2006) and taking account of Winning ways (Department of Health 2003), A matron's charter: an action plan for cleaner hospital (Department of Health 2004), Revised guidance on contracting for cleaning (Department of Health 2004), Audit Tools for Monitoring Infection Control Standards (Infection Control Nurses Association 2004), Prevention of healthcare-associated Infection in Primary and Community Care (NICE 2003) and Essential steps to safe, clean care: introduction and guidance (Department of Health, 2006)
				5	G	The healthcare organisation has systems in place to ensure it contributes to year on year reductions in MRSA in inpatient wards
C 4b	PC	Yes	All risks associated with the acquisition and use of medical devices are minimised	1	G	The healthcare organisation has systems in place to minimise the risks associated with the acquisition and use of medical devices in accordance with guidance issued by the MHRA.

Core Standards: Position at 27/2/08

No	Dir lead	Compliant	Standard Description	El No	Risk	Element Description
C 4c	IC	No	All reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.	1	R	Reusable medical devices are properly decontaminated in appropriate facilities, in accordance with guidance issued by the MHRA and Medical Devices Directive (MDD) 93/42 EEC and with the relevant requirements of the Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections (Department of Health 2006)
C 4d	PC	Yes	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely	1	G	The healthcare organisation has systems in place to ensure that medicines are handled safely and securely, taking into account Building a safer NHS: Improving Medication Safety (Department of Health 2004), and in accordance with the statutory requirements of the Medicines Act 1968.
				2	G	The healthcare organisation has systems in place to ensure that controlled drugs are managed in accordance with the Misuse of Drugs Act 1971, the Misuse of Drugs Act 1971 (Modification) Order 2001 and Safer management of controlled drugs: Guidance on strengthened governance arrangements (Department of Health, 2006)
C 4e	LB	Yes	The prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.	1	G	Waste is properly managed to minimise the risks to patients, staff, the public and the environment, in accordance with the Environmental Protection Act 1990, the Controlled Waste Regulations 1992, and the Hazardous Waste Regulations 2005.
Second Domain – Clinical and Cost Effectiveness						
C 5a	MW PC	Yes	Healthcare organisations ensure that they conform to National Institute for Health and Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care	1	G	The healthcare organisation conforms to NICE technology appraisals taking account of How to put NICE guidance into practice (NICE, December 2005).
				2	G	The healthcare organisation takes into account, when planning and delivering care, nationally agreed best practice as defined in national service frameworks (NSFs), NICE clinical guidelines, national plans and nationally agreed guidance.
C 5b	PC	Yes	Healthcare organisations ensure that clinical care and treatment are carried out under supervision and leadership	1	G	All staff involved in delivering clinical care and treatment receive appropriate supervision, taking into account national guidance from the relevant professional bodies.
				2	G	Clinical leadership is supported and developed within all disciplines.
C 5c	PC	Yes	Healthcare organisations ensure that clinicians continuously update skills and techniques relevant to their clinical work.	1	G	Clinicians from all disciplines have access to and participate in activities to update the skills and techniques relevant to their clinical work.
C 5d	PC	Yes	Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services	1	G	Clinicians are involved in prioritising, conducting, reporting and acting on clinical audits.
				2	G	Clinicians participate in reviewing the effectiveness of clinical services through evaluation, audit or research.
C 6	JC	Yes	Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.	1	G	The healthcare organisation works with relevant partner agencies to ensure that patients' individual needs are properly met and managed across organisational boundaries in accordance with Guidance on the Health Act Section 31 partnership arrangements (Department Of Health 1999).
Third Domain - Governance						
C 7 a,c	JGM	Yes	Healthcare organisations: a) Apply the principles of sound clinical and corporate governance	2	G	The healthcare organisation has arrangements in place for corporate governance, that accord with Governing the NHS: A guide for NHS

Core Standards: Position at 27/2/08

No	Dir lead	Compliant	Standard Description	El No	Risk	Element Description
			c) Undertake systematic risk assessment and risk management			boards (Department of Health and NHS Appointments Commission 2003), Corporate governance framework manual for NHS trusts (Department of Health April 2003), Assurance: the board agenda (Department of Health 2002) and Building the assurance framework: a practical guide for NHS boards (Department of Health 2003).
	MW			3	G	The healthcare organisation has effective arrangements in place for clinical governance which take account of Clinical governance in the new NHS (HSC 1999/065).
C 7 b	KH	Yes	Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.	1	G	The healthcare organisation actively supports staff to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources in accordance with the Code of Conduct for NHS Managers (DoH 2002) and Directions to NHS Bodies on Counter Fraud Measures (DoH 2004)
C 7 e	JGM	Yes	Healthcare organisations challenge discrimination, promote equality and respect human rights	1	A	The healthcare organisation challenges discrimination, promotes equality and respects human rights, in accordance with current legislation and guidance, with particular regard to the Human Rights Act 1998, the Race Relations Act 1976 (as amended), the Equal Pay Act 1970 (as amended), the Sex Discrimination Act 1975, the Disability Discrimination Act 1995, the Sex Discrimination (Gender Reassignment) Regulations 1999, the Employment Equality (Religion or Belief) Regulations 2003 and the Employment Equality (Sexual Orientation) Regulations 2003, and takes into account the supporting codes of practice produced by the Commission for Racial Equality, the Equal Opportunities Commission and the Disability Rights Commission.
				2	G	The healthcare organisation promotes equality in accordance with the Race Relations Act 1976 (as amended), the Code of Practice on the Duty to Promote Race Equality (Commission for Racial Equality 2002), Delivering Race Equality in Mental Health Care (Department of Health, 2005) and the Disability Discrimination Act
C 8a	JGM	G	Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services	1	G	The healthcare organisation has arrangements in place to ensure that staff know how to raise concerns, and are supported in doing so, in accordance with The Public Disclosure Act 1998: Whistle-blowing in the NHS (HSC 1999/198).
C 8b	JGM	To be Decided	Healthcare organisations support their staff through organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under representation of minority groups	1	A	The healthcare organisation supports and involves staff in organisational and personal development programmes as defined by the relevant areas of the Improving Working Lives standard at Practice Plus level
				2	G	Staff from minority ethnic groups have opportunities for personal development in accordance with Leadership and race equality in the NHS Action Plan (Department of Health 2004)
C 9	LT	Yes	Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the	1	G	The healthcare organisation has systems in place to ensure that records are managed in accordance with the Records management: NHS code of practice (Department of Health, April 2006).

Core Standards: Position at 27/2/08

No	Dir lead	Compliant	Standard Description	El No	Risk	Element Description
			organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required			
C 10a	JGM	Yes	Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies.	1	G	The necessary employment checks are undertaken for all staff in accordance with Safer recruitment - A guide for NHS employers (NHS Employers 2006) and CRB disclosures in the NHS (NHS Employers 2004).
C 10b	JGM PC MW	Yes	Healthcare organisations require that all employed professionals abide by their relevant published codes of professional practice.	1	G	The healthcare organisation requires staff to abide by relevant codes of professional practice, including through employment contracts and job descriptions
				2	G	The healthcare organisation has systems in place to identify and manage staff who are not abiding by relevant codes of professional practice.
C 11a	JGM	To be Decided	Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake	1	A	The healthcare organisation recruits staff in accordance with relevant legislation and with particular regard to the Employment Relations Act 1996, the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976 (as amended), the Disability Discrimination Act 1995, the Disability Discrimination Act 2005, the Sex Discrimination (Gender Reassignment) Regulations 1999, the Employment Equality (Religion or Belief) Regulations 2003, the Employment Equality (Sexual Orientation) Regulations 2003, the Employment Equality (Age) Regulations 2006 and the Code of practice for the international recruitment of healthcare professionals (Department of Health 2004).
				2	A	The healthcare organisation undertakes workforce planning which aligns workforce requirements to its service needs.
				3	G	The healthcare organisation ensures that staff participate in work-based training programmes necessary to the work they undertake as defined by the relevant areas of the Improving Working Lives standard at Practice Plus Level
C 11b	JGM	To be Decided	Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes.	1	A	All staff participate in relevant mandatory training in accordance with the Management of Health and Safety at Work Regulations 1999.
				2	A	Staff and students participate in relevant induction programmes.
C 11c	JGM	To be Decided	Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in further professional and occupational development commensurate with their work throughout their working lives.	1	A	Staff have opportunities to participate in professional and occupational development in accordance with Working together - learning together: a framework for lifelong learning for the NHS (Department of Health 2001) and Continuing professional development: quality in the new NHS (HSC 1999/154)
C 12	IC	Yes	Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied	1	G	The healthcare organisation complies with the requirements of the Research governance framework for health and social care, second edition (Department of Health 2005).
Fourth Domain – Patient Focus						
C 13a	PC	Yes	Healthcare organisations have systems in place to ensure that staff, treat patients, their relatives and carers with dignity and respect.	1	G	The healthcare organisation has taken steps to ensure that all staff treat patients, carers and relatives with dignity and respect at every stage of their care and treatment, taking into account,

Core Standards: Position at 27/2/08						
No	Dir lead	Compliant	Standard Description	El No	Risk	Element Description
						where appropriate, the relevant benchmarks from the Essence of Care toolkit.
	IC			3	G	The healthcare organisation has systems in place to meet the needs and rights of different patient groups with regard to dignity and respect including in accordance with the Disability Discrimination Act 1995 and Disability Discrimination Act 2005, the Race Relations Act 1976 (as amended) and the Human Rights Act 1998 and taking into account NHS Chaplaincy Meeting the religious and spiritual needs of patients and staff (Department of Health, 2003).
	PC			4	G	The healthcare organisation has systems in place to identify areas where dignity and respect may have been compromised and takes action in response
C 13b	MW PC	Yes	Healthcare organisations have systems in place to ensure that appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information	1	G	The healthcare organisation has processes in place to ensure that valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all treatments, procedures (including post-mortem) and investigations in accordance with the Good practice in consent: achieving the NHS plan commitment to patient centred consent practice (HSC 2001/023), Reference guide to consent for examination or treatment (Department of Health 2001), Families and post mortems: a code of practice (Department of Health 2003) and Seeking Consent: working with children (Department of Health 2001)
	Linked E1			2	G	The healthcare organisation has processes in place to ensure that valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all treatments, procedures (including post-mortem) and investigations in accordance with the Good practice in consent: achieving the NHS plan commitment to patient centred consent practice (HSC 2001/023), Reference guide to consent for examination or treatment (Department of Health 2001), Families and post mortems: a code of practice (Department of Health 2003), Seeking Consent: working with children (Department of Health 2001) and Code of Practice to the Mental Health Act 1983 (Department of Health 1999).
	LT			4	G	Patients, including those with language and/or communication support needs, are provided with information on the use and disclosure of confidential information held about them, in accordance with Confidentiality: NHS code of practice (Department of Health 2003)
C 13c	LT	Yes	Staff, treat patient information confidentially, except where authorised by legislation to the contrary	1	G	Staff act in accordance with Confidentiality: NHS code of practice (Department of Health 2003), the Data Protection Act 1998, Protecting and using patient information: a manual for Caldicott guardians (Department of Health 1999), the Human Rights Act 1998 and the Freedom of Information Act 2000 when using and disclosing patients' personal information.
C 14a	JGM	Yes	Healthcare organisations have systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints	1	G	Patients, relatives and carers are provided with accessible information about, and have clear access to, formal complaints systems in accordance with the NHS (Complaints) Regulations 2004 and associated guidance.

Core Standards: Position at 27/2/08

No	Dir lead	Compliant	Standard Description	El No	Risk	Element Description
			and feedback on the quality of services Preface By patient we mean any user of health services of any age, including children and young people.	2	G	The healthcare organisation provides opportunities for patients, relatives and carers to give feedback on the quality of their services.
C 14b	JGM	Yes	Healthcare organisations have systems in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made	1	G	The healthcare organisation has systems in place to ensure that patients, carers and relatives are not discriminated against as a result of having complained.
C 14c	JGM	Yes	Healthcare organisations have systems in place to ensure that patients, their relatives and carers are assured that the organisation acts appropriately on any concerns and where appropriate, makes changes to ensure improvements in service delivery	1	G	The healthcare organisation responds to complaints from patients, relatives and carers in accordance with NHS (Complaints) Regulations 2004 and associated guidance.
				2	G	The healthcare organisation uses concerns and complaints from patients, relatives and carers to improve service delivery, where appropriate.
C 15a	SC	Yes	Where food is provided healthcare organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet	1	G	The healthcare organisation offers patients a choice of food in line with the requirements of a balanced diet and in accordance with the relevant requirements of the Better hospital food programme (NHS Estates 2001), reflecting the needs and preferences and rights (including faith and cultural needs) of its service user population.
				2	G	The preparation, distribution, handling and serving of food is carried out in accordance with food safety legislation and national guidance (including the Food Safety Act 1990, the Food Safety (General Food Hygiene) Regulations 1995 and EC regulation 852/2004).
C 15b	SC	Yes	Where food is provided healthcare organisations have systems in place to ensure that patients' individual nutritional, personal and clinical dietary requirements are met, including where necessary help with feeding and access to food 24 hours a day.	1	G	Patients have access to food and drink 24 hours a day in accordance with the requirements of the Better hospital food programme (NHS Estates 2001).
				2	G	The nutritional, personal and clinical dietary requirements of individual patients are assessed and met, including the right to have religious dietary requirements met.
				3	G	Patients requiring assistance with eating and drinking are provided with appropriate support.
C16	JGM	Yes	Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care.	1	G	The healthcare organisation provides suitable and accessible information on the services it provides and in languages and formats relevant to its service population, and which accords with the Disability Discrimination Act 1995 and the Disability Discrimination Act 2005 and the Race Relations Act 1976 (as amended).
	JGM			2	G	The healthcare organisation provides patients and where appropriate, carers (including those with communication or language support needs) with sufficient and accessible information on the patient's individual care, treatment and after care, taking into account the Toolkit for producing patient information (Department of Health 2003), Information for patients (NICE), Guidance On Developing Local Communication Support Services And Strategies (Department of Health 2004) and other nationally agreed guidance where available.
	SC			3	A	MENTAL HEALTH SERVICES & LEARNING DISABILITY SERVICES The healthcare organisation provides information to mental health service users, and where appropriate their carers, about their care plan (including after care) under the care

Core Standards: Position at 27/2/08

No	Dir lead	Compliant	Standard Description	El No	Risk	Element Description
						programme approach, in accordance with the National Service Framework for Mental Health (Department of Health 1999) and, if detained, about their rights under the Mental Health Act 1983
Fifth Domain – Accessible and Responsive Care						
C17	JGM	Yes	The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services	1	G	The healthcare organisation seeks the views of patients, carers and the local community, including those facing barriers to participation, in accordance with Strengthening Accountability, patient and public involvement policy guidance Section 11 of the Health and Social Care Act 2001 (Department of Health 2003) and, as appropriate, the associated practice guidance, and the Race Relations Act 1976 (as amended).
				2	G	The healthcare organisation takes into account the views of patients, carers and the local community when designing, planning, delivering and improving healthcare, in accordance with Strengthening accountability, policy guidance - Section 11 of the Health and Social Care Act 2001 (Department of Health 2003) and, as appropriate, the associated practice guidance.
C18	JGM	To be Decided	Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.	1	A	The healthcare organisation has taken steps to ensure that all members of the population it serves are able to access its services on an equitable basis, including acting in accordance with the Sex Discrimination Act 1975, the Disability Discrimination Act 1995 and 2005 and the Race Relations Act 1976 (as amended 2000)
	MW			2	A	The healthcare organisation has taken steps to offer patients choice in access to services and treatment, where appropriate, and ensures that this is offered equitably, taking into account Building on the best: choice, responsiveness and equity in the NHS (Department of Health 2003).
Sixth Domain – Care Environment and Ameneities						
C 20a	LB	Yes	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation	1	G	The healthcare organisation minimises the health, safety and environmental risks to patients, staff and visitors, in accordance with health and safety at work and fire legislation, the Disability Discrimination Act 1995 and The Management of Health, Safety and Welfare Issues for NHS Staff (NHS Employers 2005).
				2	G	The healthcare organisation protects patients, staff and visitors by providing a secure environment, in accordance with NHS Estates building notes and health technical memoranda and taking account of A professional approach to managing security in the NHS (Counter Fraud and Security Management Service 2003) and other relevant national guidance.
				4	G	The healthcare organisation effectively protects its physical assets and those of patients, staff and visitors taking into account A professional approach to managing security in the NHS (Counter Fraud and Security Management Service 2003).
C 20b	LB	Yes	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality.	1	G	The healthcare organisation has taken steps to provide services in environments that are supportive of patient privacy and confidentiality, including the provision of single sex facilities and accommodation

Core Standards: Position at 27/2/08

No	Dir lead	Compliant	Standard Description	El No	Risk	Element Description
C21	LB	Yes	Healthcare services are provided in environments, which promote effective care and optimise health outcomes by being well designed and well maintained, with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.	1	G	The healthcare organisation has taken steps to provide care in well designed and well maintained environment taking into account Developing an estates strategy (1999) and Estatecode: essential guidance on estates and facilities management (NHS estates 2003) A risk based methodology for establishing and managing backlog (NHS estates 2004) NHS Environmental assessment tool (NHS estates 2002) and in accordance with the Disability Discrimination Act 1995 and the Disability Discrimination Act 2005 and associated code of practice.
				3	G	The healthcare organisation provides care in an environment that meets the national specification for clean NHS premises in accordance with The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections (Department of Health, 2006) Revised guidance on contract cleaning (Department of Health 2004) and A matron's charter: an action plan for cleaner hospitals (Department of Health 2004)
Seventh Domain – Public Health						
C 22 a,c	IC Link MW	Yes	Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by: a) Cooperating with each other and with local authorities and other organisations c) Making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships	2	G	Improve health and narrow health inequalities, including by contributing appropriately and effectively to nationally recognised partnerships, such as the local strategic partnership, and to statutory partnerships including the Crime and Disorder Reduction Partnership (CDRP) and youth offending teams, in accordance with Choosing health: making healthier choices easier (Department of Health 2004) and associated implementation guidance, Tackling health inequalities: a programme for action (Department of Health 2003), Making partnerships work for patients, carers and service users (Department of Health 2004).
				3	G	The PCT agrees a set of priorities in relation to health improvement and narrowing health inequalities with local authorities and other organisations, which is informed by health needs, health equity audit and public service agreement targets in accordance with Choosing health: making healthier choices easier (Department of Health 2004) and associated implementation guidance; Tackling health inequalities: a programme for action (Department of Health 2003), National Standards, Local Action (Department of Health 2004).
				4	G	The PCT makes information on health and healthcare needs available to local authorities and other organisations, including community groups taking account of Choosing health: making healthier choices easier (Department of Health 2004) and associated implementation guidance, Making partnership work for patients, carers and service users (Department of Health 2004).
C 22b	IC	Yes	Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by ensuring that the local director of public health's annual report informs their policies and practices	1	G	The healthcare organisation's policies and practice to improve health and reduce health inequalities are informed by the local Director of Public Health's annual public health report (APHR).
				2	G	The PCT's commissioning is informed by the local Director of Public Health's APHR.

Core Standards: Position at 27/2/08

No	Dir lead	Compliant	Standard Description	El No	Risk	Element Description
C23	IC	Yes	Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections	1	G	The healthcare organisation collects, analyses and makes available information on the current and future health and healthcare needs of the local population with particular regard to the priorities of Choosing health: making healthy choices easier (Department of Health 2004) and Delivering Choosing health: making healthier choices easier (Department of Health 2005).
				2	G	The PCT sets planning priorities for disease prevention, health promotion and narrowing health inequalities using information on local population health, including ethnic monitoring, and evidence of effectiveness with particular regard to the priorities of Choosing health: making healthy choices easier (Department of Health 2004) and in accordance with Tackling Health Inequalities: A programme for action (Department of Health 2003).
				4	G	The PCT commissions or provides disease prevention and health promotion services and programmes to improve health and narrow health inequalities based on population needs and using evidence of effectiveness with particular regard to the priorities in Choosing health: making healthier choices easier (Department of Health 2004) and in accordance with Tackling health inequalities: A programme for action (Department of Health 2003)
				6	G	The healthcare organisation monitors and evaluates its disease prevention and health promotion services and programmes and uses the findings to inform the planning process
				7	G	The healthcare organisation implements policies and practice to support healthy lifestyles among the workforce in accordance with Choosing Health: making healthier choices easier (Department of Health 2004) and Delivering Choosing Health: making healthier choices easier (Department of Health 2005)
				8	G	The healthcare organisation has an identified lead for public health or access to public health expertise to meet its strategic and operational roles
C24	IC	Yes	Healthcare organisations protect the public by having planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services.	1	G	The healthcare organisation has up-to-date and tested plans to deal with incidents, emergency situations and major incidents, which includes arrangements for business continuity management, in accordance with The Civil Contingencies Act 2004, The NHS Emergency Planning Guidance 2005 (Department of Health, 2005), Beyond a major incident (Department of Health, 2004) Getting Ahead of the Curve (Department of Health 2002) and UK influenza pandemic contingency plan (Department of Health 2005)
				2	G	The healthcare organisation works with key partner organisations, including through Local Resilience Forums, in the preparation of, training for and annual testing of emergency preparedness plans, in accordance with The Civil Contingencies Act 2004, The NHS Emergency Planning Guidance 2005, (Department of Health, 2005), and UK influenza pandemic contingency plan (Department of Health, 2005)

Developmental Standards						
No	Dir Lead	Declaration	Standard Description	El No	Risk	Element Description
D13 a&b	IC	Good	Healthcare organisations: a) identify and act upon significant pubic health problems and health inequality issues, with primary care trusts taking the leading role; b) implement effective programmes to improve health and reduce health inequalities, conforming to nationally agreed best practice, particularly as defined in NICE guidance and agreed national guidance on public health	1	G	Criterion 1: The primary care trust (PCT) gathers, generates and shares high quality local intelligence about the health, health inequalities and well-being of its local population.
				2	G	Criterion 2: The PCT uses local intelligence to commission effective services and programmes to improve the health and well-being of its local population and to narrow health inequalities.
				3	G	Criterion 3: The PCT improves health and well-being, and tackles health inequalities through the delivery of high quality, evidence-based services and programmes.

THE LEEDS TEACHING HOSPITALS NHS TRUST

BRIEFING NOTE FOR OVERVIEW AND SCRUTINY COMMITTEE 17 MARCH 2008

The Leeds Teaching Hospitals NHS Trust's declaration for 2006/7 indicated that all of the core standards were met with the exception of just 4 elements (see attached schedule) and had no significant lapses. Action plans are in place for achieving compliance with these elements.

In addition to these 4 non-compliant elements, the Trust has been focusing attention in 2007/08 on a further 2 elements which we feel need particular attention, as can be seen on the attached schedule. This is due to changes in the guidance for achieving these particular standards, requiring additional actions in order to be compliant.

The Chief Executive, Chief Nurse and Director of Quality met with representatives from the Healthcare Commission on 4 February 2008 to review progress and agree the position in terms of compliance against the standards for 2007/08 and confirm the actions in those areas that will be declared non-compliant. Standard Domain Leads (Executive Directors) met on 26 February 2008 to review risk areas and agree the current position in relation to compliance with each of the standards, including specific actions required for 2008/09. The Trust Board will reassess the position against all the core standards on 11 March 2008 and review progress against the action plans to determine the current position for the full year declaration in 2007/08 and projections for 2008/09.

The Trust continues to develop detailed planning guidance each year for each of the standards to ensure the current position is maintained and improvements are made in relation to compliance with each of the standards and this remains core to our business planning processes.

We believe we have developed a robust process enabling our Trust Board to be assured of the standards we are achieving, which has the added value of external validation by the HCC.

Hugo Mascie-Taylor
Medical Director

Craig Brigg
Director of Quality

Domain	Core Standard	2006/7 Compliant Y/N	Specific focus in 2007/8
Safety	**Generic**		
C1: Healthcare organisations protect patients through systems that:	**a) identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents**	Y	
	b) ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales.	Y	
C2: Healthcare organisations:	**protect children by following national child protection guidelines within their own activities and in their dealings with other organisations.**	Y	
C3: Healthcare organisations:	**protect patients by following National Institute for Clinical Excellence (NICE) interventional procedures guidance.**	Y	
C4: Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that:	**a) the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in MRSA**	N	*
	b) all risks associated with the acquisition and use of medical devices are minimised	Y	*
	c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed	N	*
	d) medicines are handled safely and securely	Y	
	e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.	Y	*
Clinical and Cost Effectiveness	**Generic**		
C5: Healthcare organisations ensure that:	**a) they conform to National Institute for Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care**	Y	
	b) clinical care and treatment are carried out under supervision and leadership	Y	
	c) clinicians continuously update skills and techniques relevant to their clinical work	Y	
	d) clinicians participate in regular clinical audit and reviews of clinical services	Y	
C6: Healthcare organisations:	**cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met**	Y	
Governance			
C7: Healthcare organisations:	**a) apply the principles of sound clinical and corporate governance**	Y	
	b) actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources	Y	
	c) undertake systematic risk assessment and risk management (including compliance with the controls assurance standards)	Y	
to be assessed outside declaration process	**d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources**	Not assessed	
	e) challenge discrimination, promote equality and respect human rights	Y	
to be assessed outside declaration process	**f) meet the existing performance requirements (list of targets)**	Not assessed	
C8: Healthcare organisations support their staff through:	**a) having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services**	Y	
	b) organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups	Y	
C9: Healthcare organisations:	**have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required**	N	*
C10: Healthcare organisations:	**a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies**	Y	
	b) require that all employed professionals abide by relevant published codes of professional practice	Y	
C11: Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare:	**a) are appropriately recruited, trained and qualified for the work they undertake**	Y	
	b) participate in mandatory training programmes	N	*
	c) participate in further professional and occupational development commensurate with their work throughout their working lives	Y	
C12: Healthcare organisations:	**which either lead or participate in research have systems in place to ensure that the principles and requirements of the research**	Y	

	governance framework are consistently applied		
Patient Focus	**Generic**		
C13: Healthcare organisations have systems in place to ensure that:	**a) staff treat patients, their relatives and carers with dignity and respect**	Y	
	b) appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information	Y	
	c) staff treat patient information confidentially, except where authorised by legislation to the contrary	Y	
C14: Healthcare organisations have systems in place to ensure that patients, their relatives and carers:	**a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services**	Y	
	b) are not discriminated against when complaints are made	Y	
	c) are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery	Y	
C15: Where food is provided healthcare organisations have systems in place to ensure that:	**a) patients are provided with a choice and that it is prepared safely and provides a balanced diet**	Y	
	b) patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day	Y	
C16: Healthcare organisations:	**make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care**	Y	
Accessible and responsive care			
C17:	**The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services**	Y	
C18: Healthcare organisations:	**enable all members of the population to access services equally and offer choice in access to services and treatment equitably**	Y	
C19: Healthcare organisations: to be assessed outside declaration process	**ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services**	Not assessed	
Care environment and amenities	**Generic**		
C20: Healthcare services are provided in environments which promote effective care and optimise health outcomes by being:	**a) a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation**	Y	
	b) supportive of patient privacy and confidentiality	Y	
C21: Healthcare services are provided in environments which promote effective care and optimise health outcomes by being:	**well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises**	Y	*
Public health			
C22: Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:	**a) cooperating with each other and with local authorities and other organisations**	Y	
	b) ensuring that the local Director of Public Health's annual report informs their policies and practices	Y	
	c) making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships	Y	
C23: Healthcare organisations:	**have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections**	Y	
C24: Healthcare organisations:	**protect the public by having a planned, prepared and, where possible, practiced response to incidents and emergency situations which could affect the provision of normal services**	Y	

Note: C7d, e and C19 are not assessed by the Healthcare Commission as part of the Declaration process

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Briefing Note for Overview and Scrutiny Committee – 17 March 2008

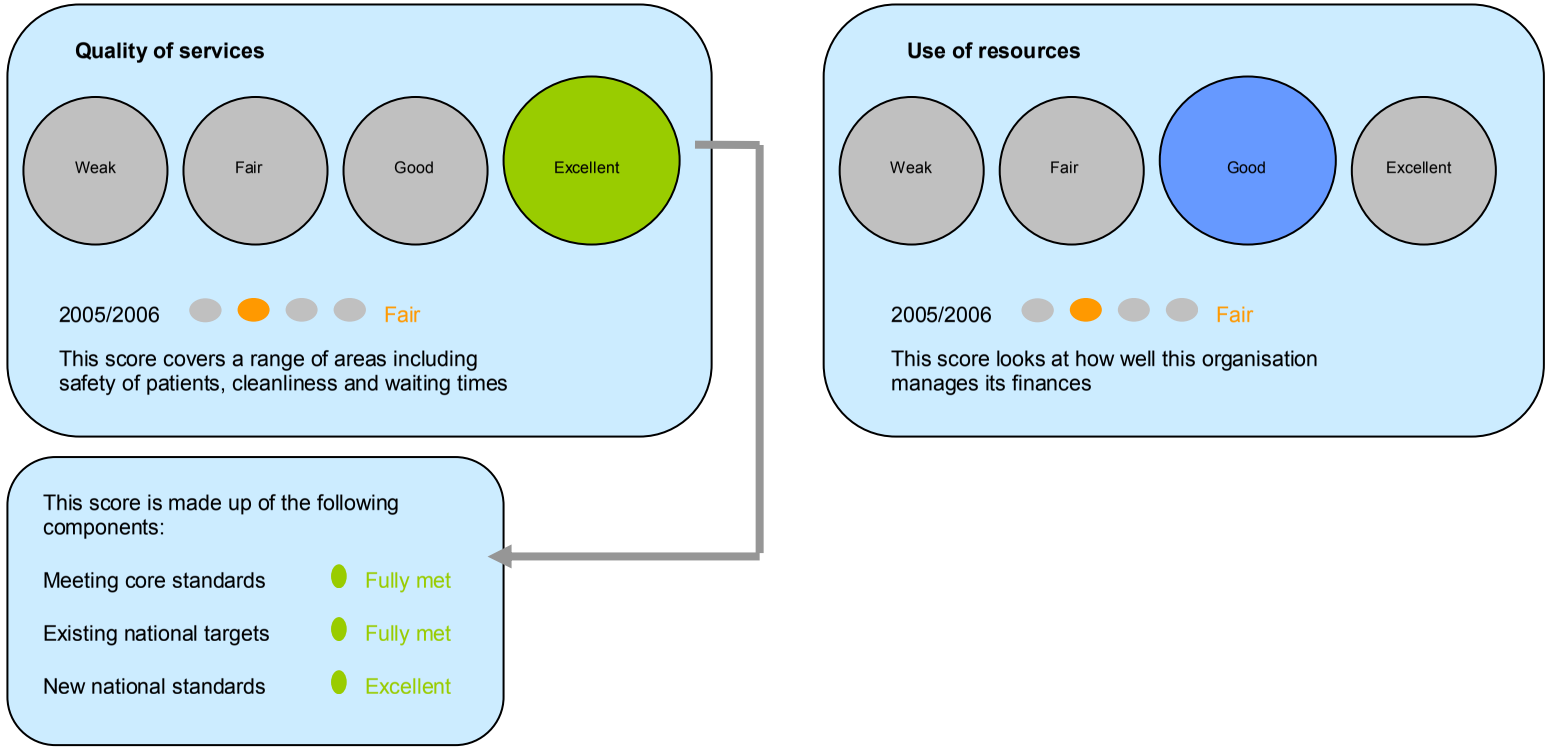
Leeds Partnerships NHS Foundation Trust's declaration for 2006/7 indicated that we met all the core standards.

During the period 1 April 2006 to 31 March 2007 the Trust Board believe that there were no significant lapses in meeting the core standards other than in C1a and C11b where compliance was achieved from 1 September 2006 and 1 March 2007 respectively.

The Trust Board will re-assess our position against all core standards on 24 April 2008 to determine our current position for the full year 2007/2008.

We continue to work towards maintaining and improving the core standards and ensure that this remains an important element of our business planning process. The Healthcare Commission confirmed our internal assessment when they published the 2006/2007 Annual Health check ratings and where we were rated as excellent for our "Quality Services" and good for our "Use of Resources".

We believe we have developed a robust process enabling our Trust Board to be assured of the standards we are achieving, which has the added value of external validation by the HCC.



Chris Butler
Trust Chief Executive

Guy Musson
Trust Director of Finance and Performance

Core Standards

The Annual Health Check is the Healthcare Commission's system for assessing healthcare organisations. One element of the Annual Health Check is the assessment of core standards, which describe a service which is acceptable and which must be universal. The chart below shows the core standards and LPFT's assessment of overall compliance in 2006/07. The Board will be asked to ratify the Trust's Annual Health Check declaration for 2007/08 at its April meeting and the declaration will be submitted to the Health Care Commission by 30th April 2008. No significant breach has been identified in any core standard in year.

Domain	Core Standard	2006/7 declaration
Safety	**Patient safety is enhanced by the use of healthcare processes, working practices and systematic activities that prevent or reduce the risk of harm to patients**	
C1: Healthcare organisations protect patients through systems that:	a) identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents. b) ensure that patient safety notices, alerts and other communications concerning patient safety, which require action, are acted upon within required timescales	C1a compliant from Sept 2006
C2: Healthcare organisations:	protect children by following national child protection guidelines within their own activities and in their dealings with other organisations.	
C3: Healthcare organisations:	protect patients by following National Institute for Health and Clinical Excellence (NICE) interventional procedures guidance	
C4: Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that:	a) the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA) b) all risks associated with the acquisition and use of medical devices are minimised c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed d) all medicines are handled safely and securely e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment	
Clinical and Cost Effectiveness	**Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services, based on what assessed research evidence has shown provides effective clinical outcomes.**	
C5: Healthcare organisations ensure that:	a) they conform to National Institute for Health and Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care b) clinical care and treatment are carried out under supervision and leadership c) clinicians1 continuously update skills and techniques relevant to their clinical work d) clinicians participate in regular clinical audit and reviews of clinical services	
C6: Healthcare organisations	Co-operate with each other and social care organisations to ensure that patients' individual needs are properly managed and met	
Governance	**Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation.**	
C7: Healthcare organisations	a) apply the principles of sound clinical and corporate governance b) actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources c) undertake systematic risk assessment and risk management d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources e) challenge discrimination, promote equality and respect human rights f) meet the existing performance requirements	
C8: Healthcare organisations support their staff through:	a) having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services b) organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, underrepresentation of minority groups	
C9: Healthcare organisations have:	a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required	
C10: Healthcare organisations:	a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies b) require that all employed professionals abide by relevant published codes of professional practice	
C11: Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare:	a) are appropriately recruited, trained and qualified for the work they undertake b) participate in mandatory training programmes c) participate in further professional and occupational development commensurate with their work throughout their working lives	C11b compliant from March 2007
C12: Healthcare organisations:	which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are	

	consistently applied	
Patient Focus	**Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient wellbeing.**	
C13: Healthcare organisations have systems in place to ensure that:	a) staff treat patients, their relatives and carers with dignity and respect b) appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information c) staff treat patient information confidentially, except where authorised by legislation to the contrary	
C14: Healthcare organisations have systems in place to ensure that patients, their relatives and carers:	a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services b) are not discriminated against when complaints are made c) are assured that the organisation acts appropriately on any concerns and where appropriate, make changes to ensure improvements in service delivery	
C15: Where food is provided healthcare organisations have systems in place to ensure that:	a) patients are provided with a choice and that it is prepared safely and provides a balanced diet b) patients' individual nutritional, personal and clinical dietary requirements are met, including where necessary help with feeding and access to food 24 hours a day	
C16: Healthcare organisations:	make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care	
Accessible and Responsive Care	**Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or the care pathway.**	
C17:	the views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services	
C18: Healthcare organisations:	organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably	
C19: Healthcare organisations:	ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services	
Care Environment and Amenities	**Care is provided in environments that promote patient and staff wellbeing and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.**	
C20: Healthcare services are provided in environments which promote effective care and optimise health outcomes by being:	a) a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation b) supportive of patient privacy and confidentiality	
C21: Healthcare services are provided in environments, which promote effective care and optimise health outcomes by being:	well designed and well maintained, with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises	
Public Health	**Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.**	
C22: Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:	a) cooperating with each other and with local authorities and other organisations b) ensuring that the local Director of Public Health's annual report informs their policies and practices c) making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships	
C23: Healthcare organisations:	have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections The elements are driven by the health improvement and health promotion requirements set out in NSFs and national plans with a particular focus on the following priority areas: • encouraging sensible drinking of alcohol • encouraging people to stop smoking and providing a smokefree environment • promoting opportunities for healthy eating • increasing physical activity • reducing drug misuse • improving mental health and well-being • promoting sexual health • preventing unintentional injuries	
C24: Healthcare organisations	protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services	

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Originator: Dennis Holmes

Tel: 24 74959

Report of the Director of Adult Social Services

Scrutiny Board Health and Adult Social Care

Date: 17th March 2008

Subject: Risk & Commissioning in Adult Social Care Update

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

Executive Summary

This report provides information requested by members of the Scrutiny board following discussion of the Commissioning context for adults in Leeds. In particular, the question of risk in commissioning. This report sets out the background to risk analysis in Health and Social Care Commissioning, from its traditional emphasis centred on financial and reputational risk, to its more modern and broader interpretation which is founded in principles of choice, control and improved outcomes.

The report goes on to provide further information in relation to the most recent guidance on risk analysis in relation to the Commissioning Framework for Health and Well-being and highlights further guidance in relation to the role and responsibilities for the Local Authority in relation to the range of risks which might be anticipated through the increasing preference of many people to utilise direct payments to fund their own care arrangements.

1.0 Background Information

1.1 A report was submitted to the December meeting of the Health and Adult Social Care Scrutiny Board updating the Board in relation to commissioning activity in relation to a range of current and prospective contractual arrangements with voluntary sector providers in the City.

1.2 The report set out the context in which commissioning takes place within Adult Social Care. It also referred to the commissioning responsibilities of Local Authorities and the processes developed to enable the discharge of those responsibilities, these features having been the subject of detailed reporting to the September meeting of the Board. One element of that national context is presented in more detail in this report in relation to the risk framework in which Health and Social care commissioning is based.

1.3 The December report also highlighted the emerging challenge for Health and Social Care commissioners focusing on commissioning for individuals (personalisation) shaping responses to meet their needs within their local community. Again, the risk framework which will need to be developed for this new type of commissioning responsibility is highlighted. The issue of direct payments and associated risks for and to individual recipients was raised; this report seeks to address those issues in greater detail.

1.4 Finally, a more integrated approach to commissioning within the Council is being developed in relation to this increasingly diverse range of activities and considerations, these considerations are to be included in the overall Council Commissioning Framework currently under development under the accountability of the Chief Procurement Officer.

2.0 Risk analysis, management and sharing in Health and Social Care Commissioning

2.1 Traditionally, risk in Commissioning has been chiefly concerned with financial or reputational risks arising out of a contracted activity which either fails to deliver its intended value or benefit or is discharged negligently by the contractor.

2.2 To mitigate the potential negative impact of such occurrences, great care is taken in developing service specifications which identify the potential sources of risk that may arise within the contracted area of activity and to set out the means by which those risks should be addressed and the remedies available to both commissioner and contractor if they are not.

2.3 Within social care, guidance produced throughout the last decade by the Department of Health has concentrated on these traditional perceptions of risk in commissioning. In particular, great efforts have been made to ensure that commissioners understand the need to more equitably share risks in the contracts that they let, particularly in relation to residential and nursing care provision and for home care.

2.4 This guidance came in response to suggestions that Commissioners were seeking to transfer risk away from their responsible organisation to the providers of service, requiring compliance with contract conditions which proved extremely difficult to meet.

2.5 To redress the balance, the Department produced best practice guidance in 2004 in relation to the specific contracting element of social care commissioning. This guidance reinforced the need for commissioners to engage with service providers at an early stage in any commissioning process to agree a risk sharing framework and a collegiate approach to the development of service specifications.

2.6 Also in 2004 the Department released guidance for Social Care Commissioners in relation to the need for much closer engagement with the end recipients of care services and their carers in the development of both contracts and specifications for care services. This guidance began to emphasise the importance of improving outcomes as a consequence of the commissioned activity and began to broaden the framework in which the issue of risk should be considered.

2.7 Contracts entered into by adult social care since 2004 in relation to both domiciliary and residential care have been designed to reflect this best practice approach of risk sharing in relation to being more based in improving outcomes for recipients of care and in terms of sharing the financial risk of the contract. Although this is clearly an area which is subject to regular review and refinement as new issues arise in relation to such arrangements.

2.8 Moving away from the traditional financial and reputational confines of risk analysis in commissioning, the more recent guidance began to offer a broader definition of the risks inherent in recipients of care more closely defining how they wished that care to be provided.

2.9 Clearly, placing greater emphasis on individuals exercising greater choice and control over their care arrangements moves into sharper focus the need for all the participants in such an arrangement, commissioners, providers, recipients and carers, to participate in the individual specification of how care is to be undertaken.

2.10 Recognising the increasing complexity of these emerging arrangements the Department of Health published further guidance in May 2007 (a web link is provided at the footnote below)[1]

2.11 That guidance makes explicit some of the key considerations for all the parties to commissioning activity set out above, in particular the guidance anticipates the fear that supporting people to take risks as a consequence of exercising choice and control will expose health and social care providers and commissioners to compensation claims if things go wrong.

2.12 In addressing the possibility of negligence it is recognised that Local authorities, health bodies, private care providers and individual care staff do all owe a duty of care to individuals for whom they provide services. A duty of care is an obligation placed on an individual requiring that they exercise a reasonable standard of care while doing something (or possibly omitting to do something) that could foreseeably harm others. This means that organisations and individuals must maintain an appropriate standard of care in all the circumstances of their work and not be negligent, the risk of negligence in clearly minimised if the duty of care is observed.

2.13 In the context of recipients of direct payments, there is clearly a delicate balance to be achieved between empowerment and safeguarding, choice and risk. The guidance makes clear that It is important for practitioners (care managers) to consider when the need for protection would override the decision to promote choice and empowerment and that a clear distinction is drawn between putting a person at risk and having the necessary practical supportive arrangements in place to enable them to manage risks appropriately.

2.14 In Leeds that approach has lead to the commissioning of the direct payments support service which is operated by the ASSIST organisation working out of the Leeds Centre for Integrated Living. For the past 5 years the organisation has supported increasing numbers of people to put into place and safely manage a variety of care arrangements, providing practical support, advice and advocacy. It is the intention of commissioners to extend and enlarge this type of service in anticipation of substantial increases in the number of recipients of this type of care. Officers are currently working with the ASSIST organisation to amend it's current service specification to reflect these anticipated changes.

2.15 The guidance highlights the role of Central Government in regulating this new system of care, it acknowledges that registration of groups in the health and social care workforce and employers' use of CRB checks do go a considerable way to ensuring that appropriate staff are employed. The guidance anticipates that in late 2008, direct payment recipients and others buying their own support will be able to check those who will be working with them.

2.16 Within this new system, individuals will retain the choice about whether or not to make a check, but it is suggested a new duty will be placed on local authorities to inform direct payments recipients of their right to engage with the new scheme. It is

[1] Independence, choice and risk: a guide to best practice in supported decision making. DoH 2007
http://www.dh.gov.uk/en/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance

suggested that this will allow direct payment recipients the opportunity to decide how they vet the people that they employ, but ensure they are making an informed choice.

2.17 Finally the guidance suggests that local commissioners, providers and recipients of care (and their carers) work together to develop and create outcome based commissioning opportunities which encourage individuals to exercise choice and control over their own care needs within a risk framework agreed with them.

2.18 Health and Adult Social Care Commissioning work with providers and users of a range of mental health services in the City has already been reported to the Board. This work has paid close attention to the DoH guidance in relation to choice and risk and the outcome of that work will be incorporated into the specification of the future service models.

Next Steps

3.1 Three further initiatives are relevant to the overall consideration of risk in a context of increasingly personalised health and social care commissioned and directly purchased services. The Commissioning Framework for Health and Well-being[2] sets out a vision and practical proposals for the commissioning of health, care and well-being from 2008/09 that looks to strengthen local skills, capability, partnerships and to address local priorities. A large part of how this will be done is by offering people more choice over the services they want to access. Previous reports have highlighted how Adult Social Care commissioning officers are closely engaged with PCT colleagues in developing shared approaches to these issues.

3.2 In connection with that, in January the Government enacted legislation that will, commencing in 2009, change the inspection and regulation regime of Health and social care, combining the current Commission for Social Care Inspection (CSCI) with the current Healthcare Commission and the Mental Health Commission. The principles of these changes are contained in a consultation paper first published in 2006[3]. In the consultation, the intention is emphasised to focus the work of the new independent regulator to support all the changes highlighted in this report.

3.3 Finally, the publication in the coming months of the overall Council Commissioning framework will provide an opportunity for all the Council commissioning functions which have an key interest in the implications of personalisation, to set out a common approach to the shared analysis and management of risk not only in relation to the content of specifications but also in relation to the ways in which the Authority and it's partners can help to support recipients of care services mange risk in their own care arrangements.

4.0 Recommendations.

4.1 Members of the Scrutiny Board are invited to note the content of this report.

[2] http://www.dh.gov.uk/en/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/DH_072604 Published on 6 March 2007;

[3] The future regulation of health and adult social care in England, Department of Health, 2006 http://www.dh.gov.uk/en/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance

Leeds CITY COUNCIL

Agenda Item 11

Originator:	Jane Stageman/ Dylan Griffiths
Tel:	74352

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

Scrutiny Board (Health and Adult Social Care)

Date: 17 March 2008

Subject: Leeds Strategic Plan 2008 – 11

Electoral Wards Affected: ALL	**Specific Implications For:**
	Equality and Diversity [X]
	Community Cohesion [X]
[ ] Ward Members consulted (referred to in report)	Narrowing the Gap [X]

Eligible for Call In [ ] Not Eligible for Call In (Details contained in the report) [ ]

EXECUTIVE SUMMARY

This report introduces the text of the Leeds Strategic Plan 2008-11. This Plan, when complete in June 2008, will mark several milestones for Leeds City Council. First, it will demonstrate how the Council is exercising its community leadership and place shaping role by outlining a single set of strategic outcomes, improvement priorities and targets for the city to be delivered by the Council on its own, or in partnership with others, over the next three years. Secondly, it will constitute the key delivery plan for the Leeds Sustainable Community Strategy ('Vision for Leeds 2004 – 2020') for the period 2008-11. Finally, it fulfils the Council's statutory obligations to provide a Local Area Agreement for Leeds as required by the Local Government and Public Involvement in Health Act 2007.

The report asks Members of the Health and Adult Social Care Scrutiny Board to comment on the text of the Plan that is attached at Appendix 1, to support our negotiations with Government on agreeing up to 35 LAA improvement targets.

1.0. Purpose of This Report

This report explains the development, approach and broad content of the Leeds Strategic Plan 2008-11. It seeks Health and Adult Social Care Scrutiny Board comments on the text of the plan prior to negotiations with central government concerning priorities for improvement in Leeds.

2.0. Background Information

2.1. In July 2007 Executive Board agreed a new corporate planning framework for the Council. At the heart of this framework is the Leeds Strategic Plan which sets out a single set of strategic outcomes and improvement priorities for the city for the next three years, shared with the Council and its partners.

2.2. During the autumn of 2007 there was extensive consultation on the strategic outcomes and improvement priorities for this plan among Elected Members, public, private and voluntary community and faith sector partners and focus groups of local residents and Leeds City Council employees. The latest evidence on local circumstances and prospects and public opinion were also examined to draw up the priorities to capture the most important issues for the city for the next three years.

2.3. The Leeds Strategic Plan, when complete, will fulfil the requirements of the new Local Area Agreement as required by the Local Government and Public Involvement in Health Act 2007.

3.0. Main Issues

3.1. Partnership Approach

The Leeds Strategic Plan represents a new approach in that it will cover what is being delivered by the Local Authority on its own or in partnership with others in the city over the period 2008-11. It therefore has a broader coverage than the former Corporate Plan because these priorities are also shared by the Council's public, private and voluntary, community and faith sector partners. A number of public bodies, designated as statutory partners in the Local Government and Public Involvement in Health Act 2007, have a duty to cooperate in the delivery of the targets and to have regard to the targets in this plan when drawing up their own budgets and action plans.

3.2. Accessible Format

The Leeds Strategic Plan sets out to communicate the agreed strategic outcomes, improvement priorities and targets for 2008-11 to all relevant persons and partners as defined by the Local Government and Health Information Act 2007 as well as all statutory partners. It has therefore been designed to be as accessible as possible in terms of language and format.

3.3. Broad Content

The content of the Leeds Strategic Plan sets out in section 1: making a difference, an overview of the progress and challenges facing Leeds and the general ambitions of the Council and its partners in this context. Section 2: priorities by theme, follows the eight themes in the Leeds Sustainable Community Strategy ('Vision for Leeds 2004 – 2020'). Each provides the contextual explanation for the selected strategic outcomes, the real changes the Council and its partners want to see in the lives of people in Leeds, and the improvement priorities, the key areas where we want to focus our efforts to ensure these changes really take place.

3.4. Framework for Implementation

Supporting the Leeds Strategic Plan will be a number of thematic plans covering important policy areas in greater detail. Some such as the Children and Young People's Plan already exist and others such as the Climate Change Strategy and Health and Well Being Strategy are under development. The Leeds Strategic Plan refers to the most significant plans and strategies supporting each theme.

3.5 The third and final section of the plan sets out an agreed set of partnership principles on which joint delivery will be based. It also outlines how and by whom performance will be measured, monitored and relevant reporting arrangements. Finally it explains how the plan will be reviewed and revised.

3.5. An appendix will be attached to the Plan that will outline the targets to be set against each improvement priority and the indicators that will measure progress. This is not presented at this stage due to a number of the targets being subject to further negotiation during March and April with central government. These are the 'up to 35' designated targets that, as a package, will be eligible for a small performance reward grant. In a number of other improvement priority areas it will not be possible to establish targets in the first year of the Plan. This is due to the fact that the National Indicator Set has introduced new measures in these areas and the first year will be used to establish a baseline position against which to set targets for further years. It is anticipated that all targets that are possible to set at this stage will be presented for approval to the Executive Board meeting on May 14th 08 before formal submission to central government to agree the 'up to 35' designated targets. Full Council approval of the text and appendix of the Leeds Strategic Plan will be sought on July 2nd 08.

4.0. Implications For Council Policy And Governance

4.1. The Leeds Strategic Plan is part of the Council's Budget and Policy Framework. The Overview and Scrutiny Committee have been consulted three times in the preparation of the text of the plan and will also have an opportunity to comment on the content of the appendix.

4.2. The Council is preparing a separate Business Plan which will set out how the Council will align its activities and resources to deliver its contribution to the Leeds Strategic Plan.

5.0. Legal and Resource Implications

5.1. The Leeds Strategic Plan will fulfil our statutory obligations for a Local Area Agreement (LAA) for the Leeds area. In drawing up the contents of this plan the Council has consulted and negotiated with a number of partners including public sector partners designated as statutory partners in the Local Government and Public Involvement in Health Act 2007. These partners have a duty to have regard to the targets in the Leeds Strategic Plan when setting out their own plans and budgets.

5.2. The Leeds Strategic Plan will fulfil the duty of the Council to publish information about its LAA containing the specified information of a 'memorandum relating to the LAA'. It will be publicly available, accessible in its format and used as a basis for active communication to citizens. In this respect it will form an active role in the Council's duty to involve local communities in shaping their own future.

5.3. The Local Government and Public Involvement in Health Act 2007 extends the scope of the Council's Scrutiny Boards to include the work of the public sector partners designated as statutory partners to deliver targets agreed in the Leeds Strategic Plan. Overview and Scrutiny Committee has agreed a protocol with partners on how to exercise this extended role for scrutiny.

5.4. Resources to deliver the targets in this plan will be identified from the budgets of the Council and its partners including the new Area Based Grant. Resources will have to be used as efficiently as possible to deliver all the targets in the Leeds Strategic Plan and the scope to increase impact through innovative delivery methods including strategic commissioning, pooled budgets and joint service delivery will be explored as part of delivering the Leeds Strategic Plan.

5.5. The Leeds Strategic Plan 2008-2011 will require the formal approval of Members of full Council at their meeting on July 2nd 2008. Members of the Executive Board will receive a full copy of the plan at its meeting on May 14th 08, including the appendix of the Leeds Strategic Plan that is currently in development.

6.0. Conclusions

6.1. The Leeds Strategic Plan will mark several significant milestones for Leeds City Council. The Leeds Strategic Plan 2008-11 will when complete set out the strategic outcomes, improvement priorities and targets for the city, shared by our key partners and stakeholders. It will be a key delivery plan for this three year period for the longer term Vision for Leeds 2004-20. It will also demonstrate how the Council is rising to the challenge of its community leadership and place shaping role as defined in the Local Government and Public Involvement in Health Act 2007.

7.0. Recommendations

7.1 Members of Health and Adult Social Care Scrutiny Board are asked to comment on the text of the Leeds Strategic Plan 2008-2011, attached at Appendix 1.

Leeds
CITY COUNCIL

Leeds Strategic Plan 2008

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Working in partnership through the Leeds Initiative

LIST OF PARTNERS HERE

DRAFT

Front Cover

Inside cover – logos of partner organisations

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Foreword – (Leaders, Chief Executive) Background to plan, Our Values

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DRAFT

Foreword - to include:

- Delighted to present the Leeds Strategic Plan for 2008-11;
- The Plan is a significant milestone in working together as partners across the city to agree the real changes we want to see in the lives of the people in Leeds and in the city by 2011 and how we will deliver these in partnership;
- Builds on a strong history of partnership working, co-ordinated through Leeds Initiative. This has brought together the Council, business, voluntary, community and faith groups and public bodies and produced a longer term strategy for the Leeds Community, the Vision for Leeds 2004-20;
- The Leeds Strategic Plan shows how these long term goals will be translated into practical action over the next three years - both in terms of what will be achieved and how it will be delivered;
- Key areas for improvement by 2011 have been informed by consultation both from citizen representatives in different areas in the city and representatives of city wide networks who represent different 'interests' in the city. Also, analysis of the most up-to-date information about current conditions and prospects for Leeds and anticipated social and population changes;
- Leeds City Council has a key leadership role, with its partners, in both 'shaping' Leeds for now and future generations and in making sure that promises made are delivered.
- Recent government legislation reinforces this role, particularly enhancing the role of Councillors as leaders of change at city-wide and community levels.
- The Council has recently been awarded the highest possible '4 star' grading in terms of its performance placing it in an excellent position to undertake this role in Leeds.

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SECTION 1

MAKING A DIFFERENCE

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PROGRESS and CHALLENGES

Leeds is recognised as one of Britain's most successful cities. It has transformed itself over the last 20 years from a mainly industrial city into a broad based commercial centre, the most important financial and legal and business service centre outside London. Leeds is the largest city in the Yorkshire region and is the biggest retail and employment centre.

Leeds is a quality place to live, work and raise families and has attracted the largest absolute increase in population in the country, 4.8% since 2001. This current population of over 750,000 embraces a rich diversity of 130 different nationalities.

Economic, cultural and environmental factors have made major contributions to Leeds being a successful place. Over the past decade Leeds has benefited from continued and significant economic growth. Between 1996 and 2006 the City has seen Gross Value Added, a measure of wealth creation, increase by 36% and 59,000 new jobs created with a forecast of a further 48,000 by 2010. Recent investment in the city has been impressive with £3.2bn invested in commercial property development and a further £7.2bn under construction or planned. The public sector has also invested significantly in new schools, health facilities and creating new spaces like Millennium Square.

Culturally, Leeds continues to invest in its magnificent and growing collection of concert halls, theatres, galleries, museums, parks and sporting venues. There is lively participation in community festivals across the city and Leeds offers the widest range of free events in the country.

Environmentally, Leeds is a green city with two-thirds of its area green belt land. Improving local neighbourhoods is also a strong priority and real improvements have been made. Cleanliness has been improved in 28 of the 31 most deprived neighbourhoods as a result of partner agencies working together with local residents. There has also been considerable investment to bring all our homes in Leeds up to the national 'Decent Homes' standard and by 2010 this will be met.

People in Leeds are generally living longer and more safely. Life expectancy for both men and women has grown by over a year over the last 10 years. Crime has fallen by approximately 30% since 2003/4, the second highest fall in crime in the country.

More children are doing well at school than ever before with results at GCSE showing strong and sustained improvement. These changes are being achieved by an approach that engages children and young people and puts schools and childcare centres at the heart of the community. It is being supported by large scale investment in new and refurbished schools and childcare centres. Leeds is also a major centre of learning for further and higher education, with two leading universities and a student population of over 124,000.

However, despite these positive trends, many problems still remain to be solved and recent developments present fresh challenges.

Too many children and young people still leave school with few or no qualifications, particularly from low income families, those with special educational needs, some black and minority ethnic groups and looked after children and young people.

Health inequalities continue to exist. Children born into the most deprived neighbourhoods can expect to live almost 12 years less than those in areas that enjoy the best health. The percentage of people over 60, currently 20% of the population, is forecast to grow raising issues of how older people's health, independence and contribution to the life of the community will be supported.

Some neighbourhoods and communities have not shared in the economic success enjoyed by much of the city. The numbers of people unable to work due to illness or injury remains a key issue for the city. Many local people are excluded from job opportunities or developing their careers due to a mismatch between their skills and aspirations and the skills now required. Only 50% of the Leeds workforce has level 2 skills (equivalent to five A* to C GCSEs) against a national skills target of 90% by 2020.

A growing population and greater prosperity puts pressure on the housing market in Leeds The impact of climate change can be clearly seen in Leeds and will be an increasingly important issue for the city. Parts of the city were flooded in the summer and winter of 2007 and there is an urgent need to reduce CO_2 and other green house gas emissions to contribute to national and global targets. More people living and travelling to work in Leeds places greater strain on the transport system. Road traffic grew by 4.9% between 1996 and 2006 and further growth is predicted. Migration enriches our diversity but raises challenges for creating and sustaining a sense of belonging amongst all communities.

These are some of the key challenges facing the city and city region over the next three years and beyond. They are explained in fuller detail in section 2 of this Plan accompanied by an explanation of where we need to focus our efforts to overcome these challenges.

OUR AMBITION

Leeds has an ambitious vision for Leeds and for the people who live, work and visit the city. This vision is captured in the Leeds' sustainable community strategy, the Vision for Leeds 2004 to 2020. This sets out the twin goals of 'going up a league' both economically and in terms of quality of life and 'narrowing the gap' between the richer and poorer parts of the city.

The Council and its partners all share the desire 'to bring the benefits of a prosperous, vibrant and attractive city to all the people of Leeds'. Our ambitions for the next three years are to see:

- people happy, healthy, safe, successful and free from the effects of poverty;
- our young people equipped to contribute to their own and the city's future well being and prosperity;
- local people engaged in decisions about their neighbourhood and community and help shape local services;
- neighbourhoods that are inclusive, varied and vibrant offering housing options and quality facilities and free from harassment and crime;
- an environment that is clean, green, attractive and above all, sustainable; and
- a city-region that is prosperous, innovative and distinctive enabling individuals and businesses to achieve their economic potential.

REAL CHANGE

The Vision for Leeds 2004 to 2020 sets out eight themes that provide a broad framework for our actions. These are Culture, Enterprise and Economy, Learning, Transport, Environment, Health and Wellbeing, Thriving Neighbourhoods and Harmonious Communities.

This plan sets out the outcomes - the real changes we want to see in the lives of people in Leeds and the city by 2011 in each of the Vision themes. It is based on a robust analysis of the strengths and weaknesses of the city and identifies the key areas where we want to

focus our efforts to ensure we achieve results. These areas we describe as improvement priorities. Finally, it sets targets for what will be achieved and how we will measure progress over the three year journey.

VIEWS AND COMMITMENT

The experiences and views of a wide range of people in the city have been taken into account in identifying the outcomes and improvement priorities in this plan. 71% of the population of Leeds was involved in establishing the themes of the Vision for Leeds in 2004. As well as the consultation findings from that exercise we have updated our understanding of what the people of Leeds want by gathering fresh evidence. We consulted Councillors representing people of all communities in the City; we drew on the latest results of the Annual Citizen's Survey and we organized a series of focus groups representative of the gender, age, ethnic origin, disability and sexuality of the Leeds population.

We also consulted a wide range of city wide networks and key partners who represent different interests in the city. These included black and ethnic minority communities, local businesses and voluntary sector networks and representatives and partners from education, health, community safety, culture, transport, economic and environmental sectors.

Our discussions have been informed by the latest information available on the changing context of Leeds in terms of social, economic, demographic and environmental data and progress in reaching established targets in areas such as education, crime, health and employment and the overall prosperity of the city. We have also considered the implications of national policies where relevant, such as the 'Every Child Matters' agenda, promoting the health and wellbeing of adults and economic, transport and housing policy developments.

We now have a shared and inclusive vision of the changes we want to see and with our partners are committed to turning the vision into a reality in Leeds. We know too that there is a great commitment from those living, working, investing, volunteering and participating in organisations and communities that will also make a huge contribution to more positive changes in the city.

APPROACH

Many people have raised the importance of **how** we approach what we need to do over the next three years. Below, are key areas that have been highlighted and will inform the 'spirit' of implementation.

- **Interconnectivity and partnership working**

Getting to the 'root' of many challenges in the city will require an awareness of the 'interconnection' between our different outcomes and improvement priorities. For example, consistently raising achievement levels of young people in some of the most deprived areas of Leeds involves raising the quality of life for families living in those communities, finding solutions to, and engaging people in, employment opportunities, housing security and environmental and health issues.

Listening, sharing and learning from each other will help us identify where our efforts are best concentrated to achieve the best results. Such a 'partnership approach' is something we are already proud of in the city and in many areas is mature and embedded as an approach to delivering services. It has contributed to some impressive results. For example, neighbourhoods in the city that are the most deprived according to recent results of a national measure of multiple deprivation have reduced from 31 to 22 neighbourhoods.

However, it is important that we build on this strong basis and engage in more innovative thinking about how needs can be met and services improved, effectively and efficiently, through partnership working. A series of principles underpinning our approach to partnership working is outlined on page….

- **Equality, cohesion and integration**

We are committed to increasing equality for, and valuing the diversity of all communities in the city. We recognise that priorities and actions can affect some communities or groups of people who participate in the city differently. The plan has been reviewed in this respect and careful and thorough assessments of more detailed targets and actions in all areas will need to continue over its duration.

We also need to work more intensively to make sure that the implementation of our 'improvement priorities' supports and encourages a shared sense of belonging in all communities in the city and widely shared sense of the contribution of different individuals and groups to a future local vision. We recognise that people with different backgrounds should experience similar life opportunities and access to services and work to develop a strong sense of an individual's local rights and responsibilities.

- **Sustainability**

Finally, we need to ensure that any developments that meet the needs of the present do not compromise the ability of future generation to meet their own needs. The plan has been reviewed in terms of its impact on the environment and sustainable development. Sustainability also means ensuring we have the right resources and can use them effectively to implement the plan. The Council is producing its own separate business plan to outline its contribution; other key partners are also including their contribution to meeting agreed targets in their own corporate and business plans.

MAKING IT WORK

The Council's lead role in helping to shape the future of Leeds has been strengthened by recent legislation - the Local Government and Public Involvement in Health Act 2007. The government has asked Council's to work with partners to ensure that they jointly agree the ambitions for their area over the next three years. Partners have also been asked to co-operate with Council's and other partners to agree and deliver targets that ensure the ambitions result in real change. These legal responsibilities are carried out in drawing up and implementing this Plan as it fulfills the requirements of a local area agreement for Leeds.

Leeds Initiative, the overarching partnership body in Leeds, provides the forum for collectively reviewing and steering resources to support the delivery of the priorities in the Leeds Strategic Plan. However, all target-setting and consequent financial, commissioning or contractual commitments agreed are put in place through the Leeds City Council and other partners arrangements for making decisions. These will be subject to the normal scrutiny by Councillors and openness to the public. Leeds City Council will have overall accountability for the delivery of the Leeds Strategic Plan.

Leeds Initiative thematic partnerships contribute to the development of the supporting strategies and plans for the Vision for Leeds and for the Leeds Strategic Plan. Some of these strategies provide an in-depth and longer term expression of the objectives or aspects of a Vision theme, for example, Culture and Climate Change. Others are more specific, time limited thematic plans that contain more detail of what will be delivered and by whom during

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the lifespan of the Leeds Strategic Plan. Key strategies and plans are signposted in each theme in Section 2.

Section 3 outlines how the plan will be delivered in greater detail. It shows how the Leeds Strategic Plan fits in the overall framework of city-wide planning. It also sets out the partnership principles that will guide how partners will work together over the duration of the plan. Accountability is further clarified with an explanation of how performance will be reviewed and managed. Finally, it explains the arrangements for reviewing and revising the Plan as a whole.

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Section 2

Priorities by Theme

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Culture

Strategic Outcomes

What we want to see by 2011:

- Increased participation in cultural opportunities through engaging with all our communities.
- Enhanced cultural opportunities through encouraging investment and development of high quality facilities of national and international significance.

Context

Through culture in all its different forms, people can find enjoyment, enrich their lives and fulfil their potential. The benefits of culture are linked to improved health, wellbeing and educational attainment. A broad-based and diverse approach to culture can both help to regenerate communities and contribute to the standing and profile of a city. We seek to provide the widest range of opportunities for local people and visitors to experience and participate in.

Consultation on the priorities for this plan showed that Leeds' people prioritise the participation by all groups and communities, in cultural events. In the 2007 resident's survey, over a quarter of residents said that activities specifically for teenagers should be a priority for the council. Excellence, diversity and wider participation are also emphasised nationally and the run up to the 2012 London Olympics will focus attention particularly on participation in sport.

Leeds has a large and growing range of cultural events and facilities, including, theatres, galleries and museums, sporting venues, parks and open spaces, an International Concert Season of more than 200 concerts per year, young people's and adult International Film Festivals, 53 Libraries and renowned opera and ballet companies. Leeds City Council also has a longstanding commitment to free events for local people such as Party and Opera in the Park and the German Christmas market.

Over the last three years, substantial investment in cultural facilities has resulted in the first phase of restoration of the Art Gallery and Central Library (85% increase in visitor figures), opening of the Kirkstall Abbey visitor centre, refurbishment of the Grand Theatre, and opening of an Aquatics Centre at the John Charles Stadium. Further opportunities will be created by the opening of Leeds' new museum in 2008, restoration of the City Varieties Music Hall, a major redevelopment of Garforth Library and two new leisure centres in Armley and Morley funded by a £30m PFI project. Extensive consultation about parks and open spaces has resulted in an additional £4.5m of investment to improve community parks.

However, there is still a great deal of progress to be made in ensuring that Leeds has the highest quality cultural facilities and activity that are accessible and inclusive of all its citizens. Some of Leeds' cultural facilities still do not match the quality of its events or fulfil their potential to help put Leeds on an international stage. A sustainable future also needs to be found for some of Leeds' most exciting cultural events, for them to thrive and grow.

We need to do more to increase people's access to cultural opportunities. We are working towards doubling visitor figures for Leeds' museums and galleries; creating initiatives to

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bring more people to cultural buildings in the city centre and finding ways to better represent all sections of the community and consult people about what they want.

Leeds is working particularly hard to ensure that young people can enjoy cultural opportunities on offer. The Breeze Card is an increasingly useful channel for children and young people to access cultural activities and facilities. Over 167,000 Breeze card holders participated in 100 holiday sports programmes while a further 15,500 attended Breeze on Tour activities across Leeds. We need to further develop ways of better coordinating opportunities for young people to engage in creative activity outside school, to ensure that no young people are left behind.

Our priorities listed below will enhance the cultural life of Leeds to reflect its status as a vibrant cosmopolitan city and enable everyone to participate in and enjoy what the city has to offer.

Improvement Priorities

What we want to deliver by 2011:

- Enable more people to become involved in sport and culture by providing better quality and wider ranging activities and facilities.
- Facilitate the delivery of major cultural schemes of international significance.

Supporting Strategies:

Cultural Strategy – (in development)

Informed by:

- Library Plan and associated strategies
- Renaissance in the Regions (Museums Strategy)
- Parks & Greenspace strategy *(in development)*
- Taking the Lead: A strategy for sport and active recreation in Leeds 2006 to 2012
- Physical Activity Strategy *(in development)*
- Children and Young People's Plan 2006-09

Enterprise and the Economy

Strategic Outcomes

What we want to see by 2011:

- Increased entrepreneurship and innovation through effective support to achieve the full potential of people, business and the economy.
- Increased international competitiveness through marketing and investment in high quality infrastructure and physical assets, particularly in the city centre.

Context

The story of Leeds is undeniable a success and the renaissance of the Leeds economy underpins the city's success.

Between 1996 and 2006 the city has seen Gross Value Added increase by 36% and 59,000 new jobs, more than any city outside London. Recent investment in the city has been phenomenal with £3.2bn invested in commercial property development and a further £7.2bn under construction or in the pipeline. Major new developments such as the £300m Trinity Quarter retail scheme, the regeneration of the Aire Valley and the completion of the East Leeds Link road (which will unlock 400 hectares of prime development land and a potential 30,000 jobs over the next 10-15 years) will build on the recent history of success.

However, we are not complacent about Leeds' future economic performance and significant challenges remain. Leeds has produced fewer new businesses than other cities and far fewer new businesses are set up in the poorest parts of the city. Similarly, consultation for this plan showed that spreading enterprise to the more deprived parts of the city and equipping the workforce with the skills to participate in the economy were key priorities. The business community also emphasised the need to make the most of private sector investment and enhance the city's reputation as a centre for knowledge and innovation.

The city council fulfils a pivotal role in guiding the city's renaissance and providing a supportive framework for investment and development including investing in the public realm – such as creating new public spaces like Millennium Square The council and its partners are supporting economic development and regeneration in neighbourhoods and local communities across the city in programmes such as the 'Town and District Centre' and Local Enterprise Growth Initiative which is specifically aimed at developing enterprise, creating new jobs and boosting prosperity in the city's most disadvantaged communities.

Leeds is also an engine of growth for West Yorkshire and the region as a whole. In 2006 a Leeds City Region Development Plan was launched to accelerate the creation of new jobs in the area, particularly by enhancing transport links and the skills of the local workforce. A multi area agreement with Leeds and its neighbouring local authorities and government will help deliver the ambitious goals set out in the City Region Development Plan.

However, if Leeds is to achieve all it can for its residents and the wider region it must establish itself on the international stage and attract businesses and investment from further afield. We are now developing a new Economic Development Strategy which will build on the current core aims and incorporate many recent changes. This includes the recognition of increasing globalisation and the consensus on climate change; the establishment of

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Yorkshire Forward and the city region perspective and the potential statutory duty for local authority economic development including an economic assessment.

Our priorities listed below seek to support our aspiration to ensure Leeds' continued success and establish it as a leading European city which provides better outcomes for local people and narrows the gap between the most disadvantaged people and communities and the rest of the city.

Improvement Priorities

What we want to deliver by 2011:

- Increase innovation and entrepreneurial activity across the city.
- Facilitate the delivery of major developments in the city centre to enhance the economy and support local employment.
- Increase international communications, marketing and business support activities to promote the city and attract investment.

Supporting Strategies:

Leeds Economic Development Strategy – *(in development)*

Informed by:

- City Region Development Plan
- Regional Economic Strategy 2006-2015
- Leeds Renaissance Framework
- Regional Spatial Strategy to 2016 (Published December 2004)
- Local Development Framework, core strategy and other policies

Transport

Strategic Outcomes

What we want to see by 2011:

- Increased accessibility and connectivity through investment in a high quality transport system and through influencing others and changing behaviours.

Context

Whether a journey is in a car, on a bus or train, on two wheels, or on foot and whether it is to get to work school or to the shops, quality of life is undoubtedly enhanced by being able to move around more easily. Similarly, moving people and goods within Leeds and beyond is key to the city being a good place to do business. Accessible, affordable, and convenient transport will make a big contribution to the city being a place where people want to live and work. Our aspirations are to deliver this goal and ensure that future growth is not constrained by transport difficulties.

Leeds has good transport links - the M1, M621 and A1(M) provide good road links to other parts of the country; Leeds' railway station has the highest number of passengers of any station outside London with 90,000 passengers using the station every day and it has recently undergone refurbishment to meet this growing demand. Leeds also has an extensive bus network with about 90 million passenger journeys every year. Innovations like guided bus routes along converted central reservations have improved journey reliability and punctuality.

Transport is however, a major concern for local people. Consultation during the autumn of 2007 to identify priorities for this plan found that improving the quality, accessibility and use of public transport was a priority for all groups and improving access to job opportunities was a key issue for many. Similarly, the business community emphasised the need to improve international links and connectivity for the benefit of both local businesses and people. In 2007 residents said that road and pavement repairs were the most important issue in their local area and should also be a top priority for the council.

However, as more people live in and travel to work in Leeds greater strain will be imposed on the transport system. Road traffic grew by 4.9% between 1996 and 2006 and further growth is predicted. In 2001 around 108,000 people commuted into Leeds daily for work and that number is estimated to have grown significantly in recent years; and in 2006 the total number of trips into the city averaged about 122,500 a day; consequently, further investment to boost the capacity of the transport system, particularly for buses and trains in Leeds will be needed to meet rising demand within the city and the surrounding area.

A proposal to upgrade the city's buses and develop a high grade transit system is under development and this could deliver a fast and convenient alternative to the car for many journeys, as well as reducing congestion and pollution. With our neighbouring local authorities and Metro we are working together to improve rail and bus links within and around Leeds and have established an ambitious 25 year Transport Vision which will ensure that these improvements are City Region based rather than just within Leeds. We are also investing heavily in highways maintenance to significantly improve the network. Supplementing Central Government funding, we have made an extra £82m available to

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complete hundreds of schemes across the city by 2012 which will significantly improve the condition of our streets.

The priorities below address these issues and also indicate how improving our streets and roads and public transport can contribute to reducing the number of people killed or seriously injured in traffic accidents as well as help to improve the city's environment.

Improvement Priorities

What we want to deliver by 2011:

- Deliver and facilitate a range of transport proposals for an enhanced transport system.
- Improve the quality, use and accessibility of public transport services in Leeds.
- Improve the condition of the streets and transport infrastructure by carrying out a major programme of maintenance and improvements.
- Improve road safety for all our users, especially motor cyclists pedal cyclists and pedestrians.

Supporting Strategies:

West Yorkshire Local Transport Plan 2006-2011

Informed by:

- 25 year Leeds city-region Transport Vision
- Highways Asset Management Plan
- Traffic Management Action Plans (in development)
- Regional Transport Strategy as part of Regional Spatial Strategy

Environment

Strategic Outcomes

What we want to see by 2011:

- Reduced ecological footprint through responding to environmental and climate change and influencing others.
- Cleaner, greener and more attractive city through effective environmental management and changed behaviours.

Context

We are fully committed to being at the leading edge of responding to the challenge of climate change and so managing and adapting to this challenge is a key priority for Leeds. Fortunately, Leeds is well placed to meet this challenge. The council monitors its impact on the environment through the rigorous EMAS standard including issues relating to air quality and environmental noise, and with local partners working together to develop a Climate Change Strategy to mitigate the impact of climate change on the city.

Local residents also feel the environmental challenge is important. In 2007, 14% of local residents surveyed said that a clean neighbourhood (without litter or graffiti) was one of the five things most in need of improvement in their area. A third of residents said that rubbish and litter lying around was a local problem and over a quarter said that vandalism and graffiti were also local problems. Linked issues like the state of pavements and roads and access to parks and green space were also cited as issues of concern. A well maintained environment contributes to other important aspects of well being like accessibility and opportunities for leisure and relaxation, and we are proud that two-thirds of Leeds' area is green space and six of our parks have achieved Green Flag status.

Waste and recycling is also important locally. Doorstep recycling collection and local recycling facilities have been used by virtually all local residents and there are generally high levels of satisfaction with the facilities provided in Leeds. However, Leeds' performance in terms of recycling and particularly waste going to landfill, is mediocre in comparison with other authorities and further progress will be needed to meet the Government's targets for recycling (40% by 2010 rising to 50% by 2020).

The environment is a key priority nationally and globally too. The UK Government is on track to reduce its CO_2 and other greenhouse gas emissions by 12.5 per cent (using 1990 levels as a baseline) as part of its commitment under the Kyoto Protocol. This has been achieved through greater energy efficiency, promoting less polluting and encouraging the use of renewable sources of energy and also reducing the amount of pollution emitted from all energy sources. The current Climate Change Bill (due for enactment in 2008) proposes a statutory framework for reducing greenhouse gas emissions and will set 'carbon budgets' to drive forward reductions in CO_2 emissions by households, businesses, local authorities and other public bodies.

We will all have an obligation to change our behaviour to mitigate the effects of climate change. The council, for example, is already reducing its impact on the environment by switching the majority of its electricity to 'green electricity', establishing schemes within its buildings to involve staff in managing environmental impacts, and delivering and advising on

energy efficiency in both privately owned and Housing Association homes. Through planning regulations, developers and partners are being encouraged to improve design quality and sustainability to reduce the environmental impact of their activities. For example, developers working in Holbeck Urban Village have produced a sustainability report to support planning applications which covers energy efficiency, waste management and the reduction of CO_2 emissions.

The impact of climate change can be clearly seen in Leeds and will be an increasingly critical issue for the city. Parts of the city were flooded, both in the summer and winter of 2007, and consequently we are working with our partners and actively participating in the delivery of an effective flood defence system.

The priorities below set out where we are concentrating our efforts over the next three years to take on the challenge to improve the city's environment.

Improvement Priorities

What we want to deliver by 2011:

- Increase the amount of waste reused and recycled and reduce the amount of waste going to landfill.
- Reduce emissions from public sector buildings, operations and service delivery, and encourage others to do so.
- Undertake actions to improve our resilience to current and future climate change.
- Address neighbourhood problem sites; improve cleanliness and access to and quality of green spaces.
- Improve the quality and sustainability of the built and natural environment.

Supporting Strategies:

- Local Development Framework
- Regional Spatial Strategy to 2016 (Published December 2004)
- Climate Change Strategy – *(in development)*
- Integrated Waste Strategy 2006 - 2025
- Leeds Strategic Flood risk assessment
- West Yorkshire Local Transport Plan
- Energy and Water Management Plan
- Parks and Greenspace Strategy

Learning

Strategic Outcomes

What we want to see by 2011:

- Enhance the current and future workforce through fulfilling individual and economic potential and investing in learning facilities.

Context

Learning is central to achieving our aspirations for the city. A skilled and well-trained workforce is vital for the future prosperity of Leeds and for everyone to share in that success. In addition, learning and educational success helps to promote better wellbeing and health for individuals and communities and supports a culturally vibrant city. The foundations for this are laid in our schools but, increasingly, training to update and acquire new skills will be a lifelong activity for us all.

Leeds' schools and early years providers have made great progress in recent years, strengthened by massive investment in award-winning new buildings and IT systems for schools and children's centres. Early years provision is a strength of the city and the most recent results show strong improvements. Primary schools are good and results are in line with national averages and performance in similar areas. Secondary schools have improved strongly in recent years, particularly in those schools in the most challenging circumstances. Results for 14 year olds are now in line with national averages and similar authorities. Outcomes at GCSE have seen strong and sustained improvement so that results are now in line with similar areas, and are close to the national average. However, despite this progress significant challenges remain. Particular priorities include: increasing the progress made by learners throughout secondary school; raising attendance in secondary schools and reducing the number of students who are persistently absent; and lastly narrowing the gap in achievement for vulnerable groups of children and young people, especially those from low income families, those with special educational needs, some Black and Minority Ethnic groups and lastly, but importantly, Looked After Children and Young People.

Increasing participation and educational success for young people is a key priority. At present fewer young people continue in learning or employment after the age of 16 in Leeds than in similar areas or nationally. Vulnerable groups of young people are more likely to not be in learning and work. As such it is important that schools, colleges and partners continue to work together to develop better choice and better routes and pathways to learning so that all young people are engaged, successful and ready for adult life.

Around a fifth of the Leeds workforce were recorded as having no skills in 2005, and although a survey showed in 2005 that 63 per cent of respondents had undertaken some form of training in the previous year, more will have to be done if the workforce in Leeds is to meet the national targets set out in the government's review of skills needs published in 2006. This review set a target of 90% of the workforce having level 2 skills (equivalent to five good GCSEs) by 2020. The current figure for Leeds is around 50%.

Consultation on the priorities for this plan showed strong support among all groups for improving the results achieved by children and young people and raising the participation levels among our children and young people in education and training. The business community also emphasised the importance of the city's universities and colleges.

The priorities below address these issues and will measure the improvement achieved by our young people and across the workforce over the coming three years.

Improvement Priorities

What we want to deliver by 2011:

- Enhance the skill level of the workforce to fulfil individual and economic potential.
- Improve learning outcomes for all 16 year olds, with a focus on narrowing the achievement gap.
- Improve learning outcomes and skill levels for 19 year olds.
- Increase the proportion of vulnerable groups engaged in education, training or employment.
- Improve participation and early learning outcomes for all children, with a focus on families in deprived areas.

Supporting Strategies:

Children and Young People's Plan 2006-2009

People Centred Places *(In development)*

Informed by:

- Leeds 14-19 Strategy 2006-2010
- Education Leeds Strategic Plan 2004 – 2007
- HE/FE Plans

Health and Wellbeing

Strategic Outcomes

What we want to see by 2011:

- Reduced health inequalities through the promotion of healthy life choices and improved access to services.
- Improved quality of life through maximising the potential of vulnerable people by promoting independence, dignity and respect.
- Enhanced safety and support for vulnerable people through preventative and protective action to minimise risks and maximise wellbeing.

Context

People in Leeds are growing healthier and living longer. At birth men can expect to live for 76.2 years compared to 74.6 years in 1997. Life expectancy at birth for women has increased from 80.1 years to 81.2 in the same period.

A challenge for Leeds is that this increase is not evenly spread across the city. The gap between richer and poorer areas of Leeds can be counted in extra years of life and it is not narrowing. Despite the death rate falling in Leeds during the last ten years, the fall has been faster in the wealthier parts of the city. Children born in the city's most disadvantaged neighbourhood can expect to live almost twelve years less than those in areas of Leeds which enjoy the best health.

As people live longer they should also enjoy more years of good health. Again this is more likely in wealthier parts but across the city it is inevitable that longer life and the increasing number of older people will increase the need for additional services or support to maximise the capacity of elderly or vulnerable people to continue living independently.

Health is influenced by many different factors. Some of these will be improved by action undertaken within other themes, particularly culture through sport and physical activity and the environment through cleaner air and noise reduction. Our lifestyles and choices around issues like smoking, drinking or exercise have an impact not just on our health as individuals but also on the health needs of Leeds as a whole. People with poor diets or who do not take enough exercise are much more likely to become overweight or obese which brings with it a higher risk of diabetes, stroke or heart disease. Excessive drinking also contributes to ill health and increases the risk of injury or accidents. The rate of sexually transmitted diseases is rising among young people in Leeds.

Leeds is rising to the challenge to have active lifestyles that encourage improved health and well-being. In 2007, there were over four million visits to Leeds City council leisure centres and 36,470 visits to 'Active Life' classes, for people aged over 50, across the city.
Through schemes such as the Keeping House project, which provides domestic services for over 2,000 older and disabled people in Leeds, the council and its partners are working hard to help adults and particularly older adults to live happy and independent lives. Adult care services in Leeds have recently been commended for achieving quality of life improvements for vulnerable adults and helping them to get better access to services. We are working to build up the opportunity for people to have direct payments so that they can choose the services they want and there has been a X% increase in take-up since ?.

Despite recent progress, we are facing significant challenges over the next few years, the most important of which will be to reduce the health inequalities gap. With our key partners in the health service we will work to help people quit smoking, and increase their rate of physical activity. Whilst the general health of the population has improved, new threats to health are emerging, including increasing levels of obesity and teenage pregnancies. We want to give greater independence to vulnerable people by supporting them to choose the services to improve their opportunity and quality of life. Direct payments and individual budgets will help to achieve this alongside improved access to mainstream services, such as training for a job or enjoying local community and recreational facilities.

There remains much more to do to reduce health inequalities for local people and improve their physical, mental and social wellbeing. Our new priorities set out below how we will meet these challenges in the coming years.

Improvement Priorities

By 2011:

- Reduce premature mortality in the most deprived areas.
- Reduce the number of people who smoke.
- Reduce rate of increase in obesity and raise physical activity for all.
- Reduce teenage conception and improve sexual health.
- Improved assessment and care management for children, families and vulnerable adults.
- Improved psychological mental health and learning disabilities services for all.
- Increase the number of vulnerable people helped to live at home.
- Increased proportion of people in receipt of community services enjoying choice and control over their daily lives.
- Embed a safeguarding culture for all.

Supporting Strategies:

Health and Wellbeing Plan (In development)

Children and Young People's Plan 2006-9

Informed by:

- Leeds Tobacco Control Strategy 2006-2010
- Food Matters: a food strategy for Leeds 2006-2010
- Leeds Childhood Obesity Strategy 2006-2016
- Leeds Alcohol Strategy 2007-2010
- Older Better Strategy 2006-2011
- Leeds Emotional Health Strategy 2008/11
- Leeds Mental Health Strategy 2006-2011
- Supporting People Strategy 2005-2010
- Physical Activity Strategy
- West Yorkshire Local Transport Plan

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Thriving Neighbourhoods

Strategic Outcomes

What we want to see by 2011:

- Improved quality of life through mixed neighbourhoods offering good housing options and better access to services and activities.
- Reduced crime and fear of crime through prevention, detection, offender management and changed behaviours.
- Increased economic activity through targeted support to reduce worklessness and poverty.

Context

The priorities in this theme are the key concerns of local people. Low crime, low levels of anti-social behaviour and affordable, decent housing are the three most important things for making somewhere a good place to live according to Leeds residents in 2007. Tackling crime and anti-social behaviour were also cited as two of the top five priorities for the Council in 2008.

Stakeholders consulted on priorities for this plan echoed the views of residents; crime, housing and reducing worklessness were chosen as the top priorities in that exercise. Councillors in particular saw this theme as vital for 'narrowing the gap' in the city between areas with low crime, good housing and high employment and more deprived parts of Leeds.

Partnership work with West Yorkshire Police to reduce crime, anti-social behaviour and the fear of crime in those neighbourhoods with the highest crime levels has proved successful with crime falling by more than a quarter over the last three years, the second highest fall in crime in the country. However, there is more to do to reduce crime further by targeting persistent offenders and addressing anti-social behaviour and the problems that arise from alcohol and drug misuse.

The council has made significant progress in improving council housing to ensure that by 2010 it will meet the national 'Decent Homes' standard. Work with private sector landlords has resulted in over 2,300 empty homes being brought back into use in the last year and we have provided grants and advice to enable lower income households to heat their homes as cheaply and efficiently as possible. However, many households are finding it increasingly difficult to buy or rent a home in the city and higher fuel bills mean that an increasing number of residents find it difficult to heat their homes.

The Council will work with its partners to deliver more new housing at a level that is affordable to buy and rent to ensure that we can meet the housing needs for all residents and not just those on high incomes. Work is underway to improve existing homes and build new homes through our existing PFI scheme in Swarcliffe with further work planned for Little London and Beeston Hill. The East and South East Leeds Project (EASEL), will deliver over 5,000 new homes, along with community facilities and businesses over the next 15-20 years, helping to create strong, sustainable communities in those areas.

There are neighbourhoods where too many people do not have a job, households are dependent on benefits and children grow up in poverty. Many residents do not have a bank account or can not borrow or save money at reasonable rates. The Council will work with its partners to support residents to obtain the right skills to secure work and progress in existing and new jobs. We will extend our award winning programmes to give households greater control over their money and access to trustworthy and reliable savings and credit so that families can be financially secure.

The priorities below build on these successful programmes to create the conditions for thriving neighbourhoods over the next three years.

Improvement Priorities

By 2011:

- Increase the number of "decent homes".
- Increase the number of affordable homes.
- Reduction in the number of homeless people.
- Reduce the number of people who are not able to adequately heat their homes.
- Increased financial inclusion in deprived areas.
- Reduce crime and fear of crime.
- Reduce offending.
- Reduce the harm from drugs and alcohol to individuals and society.
- Reduce anti-social behaviour.
- Reduced bullying and harassment.
- Reduce worklessness across the city with a focus on deprived areas.
- Reduce the number of children in poverty.
- Develop extended services, using sites across the city, to improve support to children, families and communities

Supporting Strategies:

Leeds Housing Strategy 2005/06 – 2009/10

Regional Spatial Strategy

Local Development Framework

Children and Young People's Plan 2006-9

Safer Leeds Strategy 2005 -2008

Regional Spatial Strategy - 2016

Local Development Framework

Informed by:

- Leeds Affordable Warmth Strategy 2007-2016
- Leeds Domestic Violence Strategy 2004-2007
- Leeds Alcohol Strategy 2007-2010

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Harmonious Communities

Strategic Outcomes

What we want to see by 2011:

- More inclusive, varied and vibrant communities through empowering people to contribute to decision making and delivering local services.
- Improved community cohesion and integration through meaningful involvement and valuing equality and diversity.

Context

Local pride, a sense of belonging and neighbourliness are key ingredients for the sorts of places people want to live in. Leeds residents report high levels of belonging and satisfaction with where they live. In the 2007 Residents Survey three quarters of respondents said they feel they belong to their neighbourhood and nearly half (46%) said they feel that local people work together to improve their neighbourhood. Two thirds of residents said that people of different backgrounds got on well together and three fifths of residents said that people respected ethnic difference where they lived. Overall 81% were satisfied with their neighbourhood as a place to live.

However, not all parts of the city share this sense of belonging and neighbourliness in equal measures. Residents in the south of the city were less likely to say they belonged to their neighbourhood or that people worked together to improve their neighbourhood. Young people were less likely than older people to say that people of different backgrounds got on well together where they lived or that people respected ethnic differences where they lived. Although a third of residents said they were satisfied with the way they could influence public services in their area, over a third said they would like more say in making decisions that affected their local area.

A growing and increasingly diverse population creates new challenges as well as opportunities for creating strong cohesive communities. Integrating new migrants from eastern Europe as well as long established communities will enrich the city over time but perceptions of disadvantage or unfairness need to be addressed immediately. Fostering more ways for people to engage in and shape the life of their communities will be a vital part of the process of creating strong, sustainable and harmonious communities.

In parts of the city the Council has put in place Neighbourhood Managers to encourage local people to speak out and work with those delivering services to make the changes needed in their neighbourhood. Results show that people in these areas feel that they can make themselves heard and that they are listened to. Satisfaction with the way that problems like litter, graffiti or anti-social behaviour are dealt with has risen. Other services like the Police have also put in place neighbourhood teams so that they are closer to the local community they serve.

There are numerous groups and organisations in the city, known collectively as the Voluntary, Community and Faith sector, that support a wide range of activity and services needed in local communities. These organisations provide opportunities for local people to volunteer their time and skills to help others in their community and foster good relationships. Groups such as these are often community led and supported by grant funding and are

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vulnerable to changes in the way public services are delivered and grant funding is provided. The council is committed to working in partnership with this sector to ensure that it can continue to offer locally based services and opportunities for local citizens to take an active part in community life.

The priorities and targets below will measure progress towards these goals over the next three years.

Improvement Priorities

What we want to deliver by 2011:

- An increased number of local people engaged in activities to meet community needs and improve the quality of life for local residents.
- 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.
- Enable a robust and vibrant voluntary, community and faith sector to facilitate community activity and directly deliver services.
- An increased sense of belonging and pride in local neighbourhoods that help to build cohesive communities.

Supporting Strategies:

Community Engagement Framework 2006

Community Cohesion action Plan

Children and Young People's Plan 2006-9

SECTION 3

MAKING IT HAPPEN

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STREAMLINING THE CITY'S PLANNING FRAMEWORK

The Leeds Strategic Plan sets out the goals that Leeds City Council and its partners have agreed to achieve over the next three years to help achieve the longer term objectives contained in the Vision for Leeds 2004 to 2020. The Leeds Strategic Plan is effectively the delivery plan for the long term Vision for Leeds.

We have used the legal requirement to develop a new Local Area Agreement (LAA) for Leeds as an opportunity to make the planning process in the city simpler. The Leeds Strategic Plan replaces two plans, the Council's Corporate Plan, which contained the Council's priorities for the City (and itself as an organisation) and the Leeds Regeneration Plan which focused on 'narrowing the gap' between the poorest and wealthiest parts of Leeds.

Leeds Initiative has also revised its structures to ensure that they include all the key partners and stakeholders and can monitor and manage performance and shape the delivery of targets in the Leeds Strategic plan effectively.

The council has produced its own Business Plan which will describe how the council will organise itself to deliver what it has agreed to do in the Leeds Strategic Plan. Other partners will also have their own business and action plans to deliver what is agreed in this plan and integrate their other goals.

City wide plans will be translated into action at an area level and for particular services. Area delivery plans (ADPs) will provide the local interpretation of the Leeds Strategic Plan reflecting and shaping the partnership activities for each area. The ADPs are developed by each of the ten area committees. These committees are led by councillors representing local citizens embedding democratic accountability into partnership activities at an area level.

On a different scale, it is increasingly an accepted fact that the Leeds economy works on a wider scale than the administrative boundaries of the city, and the success of Leeds also brings greater prosperity to neighbouring towns and cities. Therefore, to complement the targets in the Leeds Strategic Plan we have also agreed a Multi Area Agreement (MAA) for Leeds and its neighbouring authorities.

We have also taken into account other local and regional plans, including the Local Development Framework and the Regional Spatial Strategy and the Regional Economic Strategy.

DIAGRAM OF PLANNING FRAMEWORK HERE

EFFECTIVE DELIVERY THROUGH PARTNERSHIP WORKING

Leeds has a good record of partnership working. Since 1990 Leeds Initiative has brought together public agencies, private businesses and voluntary, community and faith groups to develop a shared vision of a successful, prosperous and inclusive Leeds. Leeds Initiative has also developed a 'Compact for Leeds' to support the work of the city's voluntary, community and faith groups. This recognises the role of value and community activity. It encourages the effective use of resources and promotes equal partnerships through good communication, consultation and sharing of information.

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Building on these foundations Leeds City Council and its partners have adopted a set of partnership principles to make sure that our joint efforts really do achieve our common ambition:

to bring the benefits of a prosperous, vibrant and attractive city to all the people of Leeds

through:

- focusing on the partners' common purpose and community needs;
- having clear responsibilities and arrangements for accountability;
- good conduct and behaviour, treating all partners and stakeholders equally, fairly and respectfully;
- informed, transparent decision-making and managing risk;
- developing skills and capacity individually and as a partnership to deliver the outcomes and priorities in this plan; and
- engaging stakeholders in drawing up our outcomes, priorities and targets and keeping people informed on how well we are delivering.

The challenge for the Leeds Strategic Plan is to apply these principles to deliver real improvements for local people. This requires new ways of working in Leeds, sharing information and pooling resources among partners where this brings benefits through greater effectiveness and efficiency. The Local Government and Public Involvement in Health Act creates a new duty for partners to cooperate in the delivery of targets in this Plan and this sets a context for us to deepen partnership working. Closer partnerships may be the right solution in many cases and the Council and its partners will explore the potential of extending joint service delivery and joint commissioning to deliver services more efficiently and effectively.

MEASURING AND MANAGING PERFORMANCE

Delivering on our targets is essential if the Leeds Strategic Plan is to achieve our ambitions for Leeds and its residents. This will be a collective endeavour for all the partners to this agreement. Senior council officers will have lead accountability for each of themes, improvement priorities and targets in the Leeds Strategic Plan and will work with similar senior officers in partner organisations. Every partner will have regard to all the targets in the Plan when drawing up their own budgets and business plans. Partners will commit to leading or contributing to the achievement of specific targets in the Plan and will then be held to account for doing the things needed to meet those targets. In the appendix, lead and contributory partners are identified to each target.

We have developed reliable measures for each target and have put in place robust processes for regularly reporting performance. These processes will measure progress against each targets as well as the plan's impact on wider objectives for Leeds like equality, community cohesion and sustainability. For some targets, measures will be broken down by their impact on particular areas of the city and on the basis of gender, ethnic origin, age, disability, religion or belief and sexual orientation.

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The Council is ultimately accountable for drawing up and delivering the Plan. The Plan will be approved by whole Council involving all 99 Councillors. The Executive Board (of senior councillors) will receive regular reports on performance and recommend actions and changes to plans where performance is not on target. The council's Scrutiny Boards will also receive regular performance reports and have an opportunity to discuss issues of concern, call in council officers and partners to account for their work to deliver targets in the plan and make recommendations to the council and its partners to improve performance.

The Leeds Strategic Plan is a partnership plan and the Council will, through the Leeds Initiative, agree its contents with and engage partners to monitor and manage the performance of the plan. The Leeds Strategy Group will bring together the Council and its partners to monitor performance against the targets in the plan, allocate resources, develop new ways of delivering more effectively for Leeds and regularly review the contents of the plan.

Other thematic groups in the Leeds Initiative will also be kept informed of progress in relevant areas and contribute to the delivery of the Leeds Strategic Plan through developing more in depth strategies and action plans. Local business representatives and representatives from voluntary, community and faith groups are involved alongside public sector partners in the work of these groups.

The ten area committees across the city will also be reviewing progress towards achieving targets identified at an area level. They will be particularly vigilant in assessing improvements at a neighbourhood as well as an area level. The achievement of these targets will make a fundamental contribution to achieving the overall city wide targets and outcomes

Local people will receive regular updates on performance through stories in About Leeds, the Council newspaper, on the Council and Leeds Initiative websites and elsewhere. For example, progress will be reported to the Leeds Youth Council. Everyone will have opportunities to give their views on how well the Leeds Strategic Plan is being delivered.

Up to 35 targets in this plan have been negotiated and agreed with Government Office and reflect shared priorities with national government. Progress against these targets must be reported annually to the government who must agree to any changes to these targets. The government will reward Leeds with additional funding if these targets are met.

REVIEWING AND REVISING THE LEEDS STRATEGIC PLAN

Leeds' priorities will inevitably change over time and the priorities and targets in the Leeds Strategic plan will be regularly reviewed and updated to ensure this plan is still relevant and addresses the city's real needs.

The council and its partners will collect and use information on social, economic and environmental conditions and trends, including performance data against the targets in this plan, to change priorities and set new targets as necessary. Already, the council and the PCT are working jointly to assess current and future health needs in Leeds through a Joint Strategic Needs Assessment (JSNA). The findings from this assessment will inform future health priorities in this plan.

Public opinion, gained through regular resident surveys will also feed into the setting of priorities and targets in future versions of this plan. The views of council Scrutiny Boards, Area Committees and other partners and stakeholders will also be taken into account before the council and its partners agree any changes to the contents of the Plan.

The Government will regularly assess conditions and prospects for every part of England through a new Comprehensive Area Assessment process. Achievement of the targets in the Leeds strategic plan will form part of the Government's annual assessment of how well Leeds is improving. The Government will look at the full range of performance indicators on local conditions and prospects. Further, more specific reviews on particular issues can be required where the Comprehensive Area Assessment suggests there is a risk of underperformance. Where the Government feels that performance in Leeds is unsatisfactory it will recommend new priorities for the Leeds Strategic Plan and the council and its partners will negotiate with the Government whether a target should be set to address that issue. Government Office will monitor performance and initiate discussions where performance is not on track and can intervene where performance is significantly below what is expected.

At every stage the Council will inform, consult and involve local people, representatives of geographical communities and communities of interest, partners and stakeholders in the city and beyond where relevant, and draw on expert analysis to ensure that the priorities and targets in the plan have been rigorously challenged, are truly robust and are relevant to the achievement of our ambitions for Leeds.

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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: 17th March 20008

Subject: Recommendation tracking

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 Last year Overview and Scrutiny Committee agreed to adopt a new, more formal system of recommendation tracking, to ensure that scrutiny recommendations were more rigorously followed through.

1.2 As a result, each Board now receives a quarterly report, allowing the Board to monitor progress and identify completed recommendations; those progressing to plan; and those where there is either an obstacle or progress is not adequate. The Board is then be able to take further action as appropriate.

1.3 A standard set of criteria has been produced, to enable the Board to assess progress. These are presented in the form of a flow chart at Appendix 1. The questions should help to decide whether a recommendation has been completed, and if not whether further action is required.

1.4 To assist Members with this task, the Principal Scrutiny Adviser has given a draft status for each recommendation in the tables in Appendix 2 and 3. The Board is asked to confirm whether these assessments are appropriate, and to change them where they are not.

1.5 In deciding whether to undertake any further work, members will need to consider the balance of the Board's work programme.

2.0 Previous recommendation tracking reports

2.1 The Board's last quarterly report was received at the December meeting, rescheduled from November, in the interests of maintaining a balanced work programme. At this meeting, the Board's tracking report will cover recommendations in the Dignity in Care

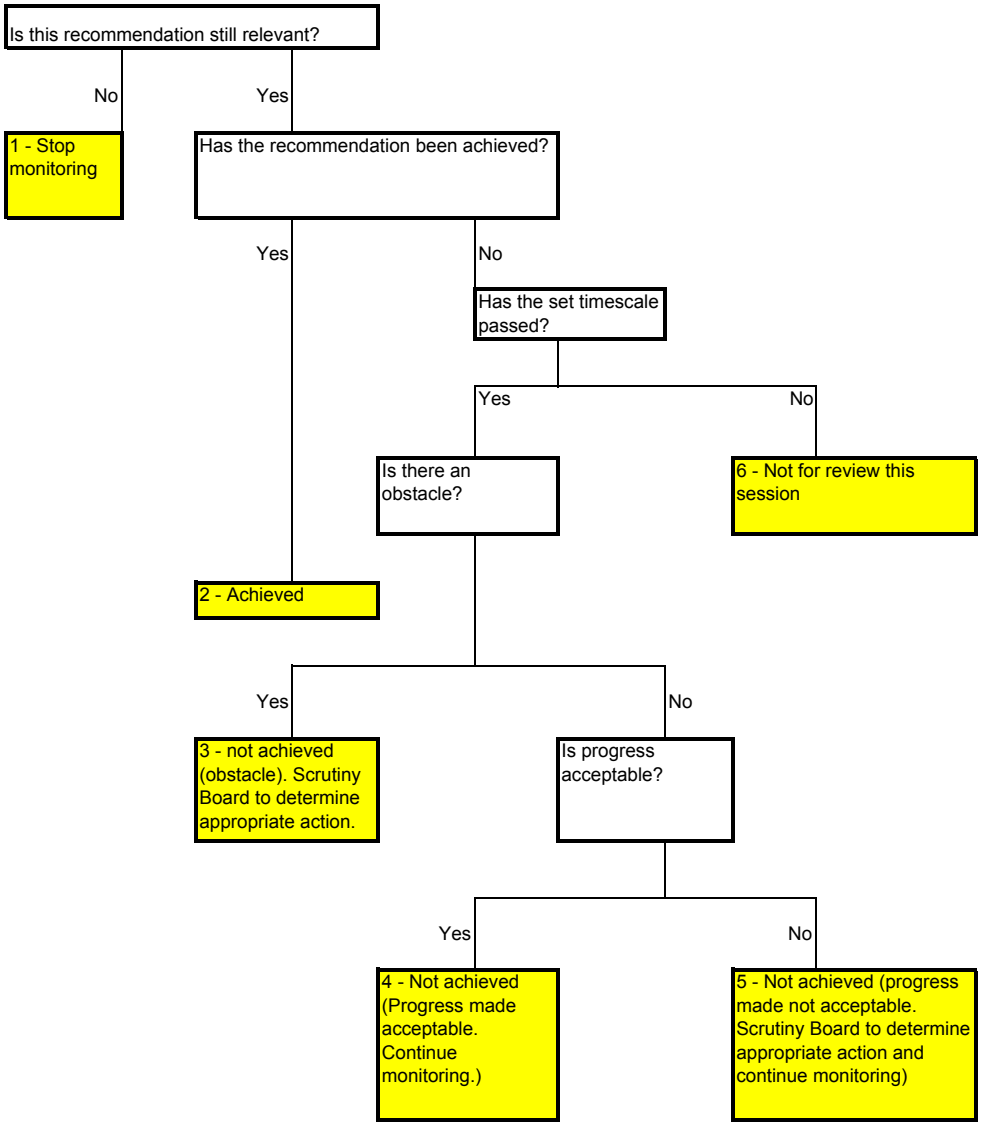
And Community Development in Health and Well Being reports. A joint response has been provided for the Community Development report from Leeds PCT, Adult Social Services and the Healthy Leeds Partnership.

4.0 Recommendation

4.1 Members are asked to:

- Agree those recommendations which no longer require monitoring;
- Identify any recommendations where progress in unsatisfactory and determine the action the Board wishes to take as a result.

Recommendation tracking flowchart and classifications:
Questions to be Considered by Scrutiny Boards



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Dignity in Care Report (Published April 2007)
Formal Response received July 2007: update received September 2007

Recommendation 4
We recommend that relevant local professional bodies support policy and practice development in their sectors in order to promote a culture of dignity.
The formal response in July detailed existing and planned activity in this area. At the update in September 2007, work on the Dignity Audit Tool was still outstanding.
Where we are up to now:
The Dignity Audit Tool has now been launched and a press release issued (attached).
The findings from the project will be used to develop better practice and to help plan better services for older people in Leeds.
Stage: 2 (achieved)

Recommendation 7
We recommend that the relevant local professional bodies consider the development of more consistent and patient focussed complaints procedures and develop common standards across health and social care services in Leeds.
Where we are up to now:
Since the last update, events have moved forward nationally. Plans for a new streamlined health and social care complaints system were announced in Feb 2008. Early adopter sites will be trialling it before national rollout in April 2009.
The Board might wish to monitor progress with the early adopters and national rollout.
Stage:1 (recommendation no longer relevant – stop monitoring)

Scrutiny of Community Development in Health and Wellbeing (Published July 2007) Formal Response received October 2007

For Recommendations 1-6 please see the joint response at Appendix 3

Recommendation 7
That the Leeds City Council Member Development Working Group includes community development training within the Member training programme.
The Working Group responded in October 2007 requesting more information in order to consider the recommendation more fully. More information was supplied to the Group.
Where we are up to now: Verbal update to be provided at the meeting.
Stage: 4 (not achieved – progress made acceptable)

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News Release

Date: 20 February 2008

LEEDS RECRUITS OLDER PEOPLE AS RESIDENTIAL HOME INSPECTORS

Older people's residential homes in Leeds are in future to be inspected by the people who know most about their care – older people themselves!

In a pioneering move, older people in Leeds are to be recruited to visit residential care homes and nursing homes throughout Leeds, to carry out an audit of how well people's dignity is promoted and protected by care and nursing staff.

The 'Dignity Watchdogs' will be knocking on doors to interview residents and staff and make an assessment of how well people are treated with respect and courtesy, how their rights as an individual are upheld, how their privacy is protected and how people are able to complain without fear of reprisal.

'Dignity in Care' is a national campaign being led by the government to promote high quality care services that respect people's right to courtesy, offer a personalised service, reduce loneliness and isolation and have a zero tolerance of all forms of abuse.

As part of the campaign, Leeds City Council, Leeds Primary Care Trust and independent care home owners from the Leeds Care Association have come together to work with Age Concern Leeds.

Corporate Communications, Civic Hall, Leeds LS1 1UR
Tel. 0113 247 4328 Fax. 0113 247 4736
For more news and information from Leeds City Council visit www.leeds.gov.uk

INVESTOR IN PEOPLE

Age Concern will recruit, train and support a group of older people to visit care and nursing homes to conduct the 'Dignity Checks'.

The recruits will be assisted by staff from Leeds City Council's Adult Social Care Service and Leeds PCT. They will jointly develop a questionnaire that will get to the heart of whether residents are being treated well.

Carol Wardman, Chief Executive of Age Concern Leeds, welcomed plans being made for the audit and said:

> "We are delighted to be involved in this important project. Dignity in the care of older people is at the heart of all that Age Concern does. Respecting dignity, choice and individuality, often in the smallest of ways, can make all the difference to the quality of life of someone in residential care. I hope that this project will raise this issue to all those involved in choosing and providing care."

The Dignity watchdogs will be trained to observe and record instances such as where staff may be patronising towards residents, using first names without permission, or delivering personal care, such as changing dressings, in a lounge rather than the privacy of the resident's own room. The findings from the project will be used to develop better practice and to help plan better services for older people in Leeds.

Councillor Peter Harrand, Leeds City Council's Executive Board member with responsibility for Adult health and Social Care and Older People's Champion said:

> "Dignity and respect should lie at the heart of all services for older people. An audit of this kind has never before been done in care and nursing homes in Leeds and its findings will be carefully analysed so that, where changes in behaviour are needed, we will make them.

"The people who will be carrying out this audit will all be volunteers and who could do this job better than older people themselves? They will be making an important contribution to making sure people who are in care in Leeds are valued and treated with all the politeness and good manners they deserve."

Notes for editors

The Dignity in Care campaign has laid down 10 'Dignity Challenges' to all who work in health and social care. They are:

- Have a zero tolerance of all forms of abuse;
- Support people with the same respect you would want for yourself or a member of your family;
- Treat each person as an individual by offering a personalised service;
- Enable people to maintain the maximum level of independence, choice and control;
- Listen and support people to express their needs and wants;
- Respect people's right to privacy;
- Ensure people feel able to complain without fear of retribution;
- Engage with family members and carers as care partners;
- Assist people to maintain confidence and self-esteem;
- Act to alleviate people's loneliness and isolation.

For media enquiries please contact:

John Donegan, Leeds City Council Press Office (0113) 247 4450

email John.Donegan@leeds.gov.uk

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Update on Scrutiny Report Community Development: Recommendation Tracking

General

The PCT and Adult Social Services, as well as other Healthy Leeds Partners, welcomed the recommendations of the Scrutiny Report. Although the restructure of the PCT and the Local Authority has had an impact on progressing the recommendations, community health development will be a key component of the new Health and Well Being Plan which will be developed later this year. Both the Leeds PCT and Leeds City Council already make a significant investment in community health development work. However we would like to emphasise the importance of community development for the wider Leeds Strategic Plan and not just for the health and well being theme. The recently published National Institute for Health and Clinical Excellence Guidance on community engagement also needs to be taken into account.

Recommendation 1

That Leeds Primary Care Trust, jointly with Adult Social Services, progresses immediately the development of a cohesive Community Development Strategy for Health and Wellbeing.

As both the Leeds PCT Strategy and the Leeds Strategic Plan are near completion, we are now in a better position to develop our strategic approach to community development and to ensure it links strongly to the strategic outcomes we have agreed. All the partners at the HLP in December 2007 agreed the importance of the community development approach and committed staff time to work together to develop a coordinated approach. The Executive, to whom progress planning was remitted, accepted that a strategic approach needed to inform future joint commissioning should be an early issue for the new joint commissioning group for promoting health. Also the PCT and Adult Social Services are currently completing a review of the Healthy Living Centres whose Big Lottery funding has expired together with related community health development projects. Bridge funding has been provided by the PCT until June 2008 and proposals will be brought to the joint commissioning group to provide a basis during the remainder of 2008-9 on which a firmer commissioning approach can be taken over the following two years. However it should be noted that this is in the context of a resource framework which is less than the overall funding previously provided by the Big Lottery.

This recommendation is now included in the objectives of the PCT Health Inequalities Manager (Neighbourhoods) who will work with the Local Authority to take this work forward. The Neighbourhoods Manager has met with the CD lead for Wakefield PCT, and the same post for Bradford PCT and has been offered guidance and access to their CD strategies, which will help inform the work in Leeds. The PCT also joined the Community Development Exchange, as a mechanism to ensure our work is based on best practice regionally and nationally.

We will also draw on earlier work carried out by Leeds Voice on a community development strategy for Leeds.

Stage: 2 (achieved)

Recommendation 2
We recommend that the Local Strategic Partnership proactively challenges the level of commitment and investment made from all partners towards community development and develops an action plan aimed at further embedding community development values and principles across the partnership.

The Leeds Initiative Programme Manager for Harmonious Communities started in post in January 2008 and is discussing with organisations and different departments about her future work programme. This will include addressing the embedding of community development values and principles across the partnership.

Stage: 4 (not achieved – progress made acceptable))

Recommendation 3
That all health and social care service commissioners in Leeds commit to 3 year minimum contracts for community development programmes and that the full cost of delivering these programmes, including contributions to core costs, is recognised with these contracts.

Commitment was given at the last meeting to take this recommendation forward. Partners are exploring how they will implement this in line with the new commissioning approach.

Stage: 2 (achieved)

Recommendation 4
That the Health Leeds Partnership champions the Leeds Community Health Development Network (CHDN) and ensures that it provides opportunities for community development projects to share best practice, celebrate achievements and actively encourage joint working initiatives across the city.

The Network should also develop a themed training programme based on the needs of community development workers and encourage broader education and understanding of community development across the city.

The Healthy Leeds Partnership values the Community Development Network and, in relation to the new partnership arrangements, is examining where it would need to be placed to have the most influence.

The Community Health Development Network has identified the need to develop training as part of its future work programme. The future of the CHDN is integral to the development of accredited training for current CD workers as well as the development of induction plans for new workers. The majority of CD work is delivered by CVFS partners, and the aim is to improve the skills and competence of those workers. This development work needs to be supported through the CHDN, which would ensure local staff became competent using the National Competency Standards for CD.

Stage: 4 (not achieved – progress made acceptable)

Recommendation 5
That the Healthy Leeds Partnership carries out an evaluation of the Community Health Development Network during its first year and explores joint funding opportunities to maintain the sustainability of the Network in the long term. The results of this evaluation will be reported back to the Scrutiny Board in April 2008.

The current and potential contribution of the network is recognised at senior level by the Chief Executive of the PCT and the Director of Adult Social Services. In the previous response we agreed that evaluation the Community Health Development Network was important but that it would be too early to do this after its first year. We can give the Scrutiny Board an update on its first year's activity and we are exploring mechanisms to do an independent evaluation at a later date.

A meeting of key officers and Community Health Development Network representatives was convened in January to address the sustainability of the Network. From this a small task group, involving the PCT, voluntary sector and the Leeds Initiative was set up to develop a proposal to secure resources to continue to develop and maintain the Network. The PCT has secured £25K funding for a part time post to support the CHDN and work on the delivery of the recommendations. In the meantime Leeds VOICE is providing interim support for the network.

Stage: 4 (not achieved – progress made acceptable)

Recommendation 6
That Community Development is seen as an integral part of any continuing professional development across all partners and particularly within the health and social care sector.

The PCT recognises that all Public Health staff complete elements of CD training within their PH Masters or Postgraduate Diploma. The new part time post will contribute to training for staff and elected members as well as induction planning for CD staff.

The commissioning approach will take into account the need for capacity building referred to in Recommendation 6. The new direction being taken by Adult Social Care emphasises the need for an understanding of the community development approach which relates strongly to Leeds Strategic Plan objectives (for example promoting independent living). The Council's newly established Strategic Leadership Team for health and wellbeing, together with a joint commissioning structure for wellbeing, which will include other Council services, will enable both service and workforce issues to be taken up more widely. Commissioning will also be informed by the Joint Strategic Needs Assessment being prepared during 2008 and the new Local Involvement Network for which the Council, as local commissioner, has included a community development in the specification.

Stage: 2 (achieved)

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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: 17th March 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 March 2008

ITEM	DESCRIPTION	NOTES	DATE ENTERED INTO WORK PROGRAMME
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.		
Statements	To approve two statements drafted by Working Groups:- • Teenage Pregnancy Obesity		
National Blood Service	To receive a presentation from the NHS Blood and Transplant service about the outcome of a recently completed review of the National Blood Service Strategy.	To provide members with an opportunity to assess how the plans will impact on Leeds.	18th February 08
LINks	To receive an update on the establishment of a Local Involvement Network (LINk) for Leeds.		
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
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. **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

SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE) – WORK PROGRAMME 2007/8 – LAST UPDATED March 2008

To carry forward to the next municipal year:

- Update on Terry Yorath House in June or July
- Update on Joint Strategic Needs Assessment in July
- Update on POPPs in July
- Update on Performance of Homecare Providers in June
- Monitoring of actions regarding Putting People First: A shared vision and commitment to the transformation of Adult Social Care

LEEDS CITY COUNCIL

FORWARD PLAN OF KEY DECISIONS

For the period 1 March 2008 to 30 June 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)
Roundhay Road Relocation Project Use of the capital receipt from the sale of site to support relocation of the 25 teams into more suitable accommodation plus approval to identified relocation proposals with cost estimates.	Executive Board (Portfolio:Adult Health and Social Care)	12/3/08	Executive Members, Asset Management Group , Staff, Managers and Service Users of affected services.	The report to be issued to the decision maker with the agenda for the meeting	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.

LEEDS CITY COUNCIL

BUDGET AND POLICY FRAMEWORK DECISIONS

Decisions	Decision Maker	Expected Date of Decision	Proposed Consultation	Documents to be considered by Decision Maker	Lead Officer

NOTES:
The Council's Constitution, in Article 4, defines those plans and strategies which make up the Budget and Policy Framework. Details of the consultation process are published in the Council's Forward Plan as required under the Budget and Policy Framework.

Full Council (a meeting of all Members of Council) are responsible for the adoption of the Budget and Policy Framework.

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