Public Document Pack

Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH)

Meeting to be held in Civic Hall, Leeds on
Tuesday, 21st September, 2010 at 10.00 am

(A pre-meeting will be held for ALL Members of the Board at 9.30 am)

MEMBERSHIP

Councillors

S Armitage	-	Cross Gates and Whinmoor;
M Dobson (Chair)	-	Garforth and Swillington;
P Ewens	-	Hyde Park and Woodhouse;
P Harrand	-	Alwoodley;
J Illingworth	-	Kirkstall;
G Kirkland	-	Otley and Yeadon;
M Lobley	-	Roundhay;
J Matthews	-	Headingley;
A McKenna	-	Garforth and Swillington;
E Taylor	-	Chapel Allerton;

Co-opted Members (Non-Voting)

Arthur Giles - Leeds LINk
Nominee to be confirmed - Leeds LINk

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

Agenda compiled by:
Stuart Robinson
Governance Services
Tel: 24 74360

Principal Scrutiny Advisor:
Steven Courtney
Tel: 24 74707

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Chief Democratic Services Officer at least 24 hours before the meeting.)	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:- **No exempt information or items have been identified on this agenda**	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**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 AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES OF THE PREVIOUS MEETING** To confirm as a correct record the minutes of the meeting held on 27th July 2010.	1 - 10
7			**JOINT PERFORMANCE REPORT QUARTER 1 2010/11** To consider a joint report of Leeds City Council and the NHS Leeds presenting performance information which summarised the progress against the joint council and NHS Leeds priorities as set out in the Leeds Strategic Plan, as well as key NHS Leeds priorities for first quarter of 2010/11.	11 - 30
8			**VISION FOR LEEDS 20111 TO 2030 - PROGRESS WITH DEVELOPMENT AND NEXT STEPS** To consider a report of the Director of Leeds Initiative on progress with regards to the development and next steps in relation to the Vision for Leeds 2010 to 2030.	31 - 60

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**EQUITY AND EXCELLENCE: LIBERATING THE NHS - WHITE PAPER** To consider a report of the Head of Scrutiny Support and Member Development on Liberating the NHS White Paper and supporting consultations.	61 - 118
10			**UPDATED WORK PROGRAMME 2010/11** To receive and consider a report from the Head of Scrutiny and Member Development outlining the Scrutiny Board's work programme for the remainder of the current municipal year.	119 - 176
11			**DATE AND TIME OF NEXT MEETING** To note that the next meeting of the Scrutiny Board will be held on Tuesday 26th October 2010 at 10.00am (Pre meeting for Board Members at 9.30am)	

SCRUTINY BOARD (HEALTH)

TUESDAY, 27TH JULY, 2010

PRESENT: Councillor S Armitage in the Chair

Councillors P Ewens, P Harrand,
J Illingworth, G Kirkland and M Lobley

CO-OPTEES: Mr A Giles (Leeds Local Involvement Network)

11 Election of Chair

It was announced at the beginning of the meeting that Councillor M Dobson, Chair of Scrutiny Board (Health) had conveyed his apologies due to illness. Therefore the Board were asked to appoint a Chair for this meeting.

Following a formal vote of those Members present, Councillor S Armitage was elected as Chair in the absence of Councillor Dobson.

12 Chair's Opening Remarks

The Chair welcomed everyone to the July meeting of the Scrutiny Board (Health).

13 Late Items

The Chair informed the meeting that she had agreed to admit the following document to the agenda as supplementary information:

Liberating the NHS: Local Democratic legitimacy in health – A consultation on proposals (Agenda Item 9). As the consultation document had not been published until 22 July 2010, it had not been possible to provide this with the agenda papers previously distributed. (Minute 20 refers).

14 Declarations of Interest

There were no declarations made at the meeting.

15 Apologies for Absence

Apologies for absence were received on behalf of Councillors M Dobson, J Matthews, A McKenna and E Taylor.

16 Minutes - 25th June 2010

RESOLVED – That the minutes of the meeting held on 25th June 2010 be confirmed as a correct record.

17 Joint Performance Report Year End 2009/10

The Head of Scrutiny and Member Development submitted a report presenting the joint performance report from NHS Leeds and Leeds City Council which provided an overview of progress against key improvement priorities and performance indicators relevant to the Board at Quarter 4, 2009/10.

The principle of a joint report had been established to align performance reporting, with the aims of:

- Reducing duplication
- Eliminating potential confusion
- Streamlining documentation
- Bringing closer together the performance teams / functions from both organisations.

Appended to the report were copies of the following documents for information / comment of the meeting:

- Appendix 1 – summary sheet showing the overall progress rating against the LSP *improvement priorities* relevant to the Health Scrutiny Board
- Appendix 2 – selected amber and red rated action trackers from the Leeds Strategic Plan priorities relevant to the Health Scrutiny Board. These trackers included a contextual update as well as key performance indicator results
- Appendix 3 – Performance Indicator report containing year end results for all performance indicators from the National Indicator set and any key local indicator which were relevant.

The following officers from NHS Leeds and Leeds City Council were in attendance to present the key issues highlighted in the report and to address any specific questions identified by the Scrutiny Board:

- John England, Deputy Director – Adult Social Services, Leeds City Council
- Graham Brown, Performance Manager, NHS Leeds.

In introducing the report, the Deputy Director (Adult Social Services) highlighted some issues associated with mortality rates across the City, including:

- The data provided represented a rolling 3-year average and should be considered in this context.
- Discussions with Leeds Director of Public Health had identified some specific actions and activities.
- A review of the Council's contribution to improving health and reducing health inequalities was scheduled to take place in September 2010.
- The continuing need to raise awareness of the impact of health determinants (such as Housing, Employment and Education) across the Council and NHS Leeds.

There was a full discussion around the report and associated appendices. In summary, the main issues highlighted were as follows:

Obesity and physical activity

- Recognition that obesity and levels of physical activity (particularly in children) posed a significant challenge across the City – as highlighted in the Scrutiny Board's previous report around Promoting Good Public Health – specifically in terms of incorporating the guidance produced by the National Institute for Clinical Excellence (NICE) around providing a sustainable built environment.
- A member of the Board outlined some considerable concern in this regard, citing the potential full consideration of the Leeds Girls High School planning application by the Plans Panel (West) meeting on 12th August 2010. It was unclear whether due consideration of the Board's recommendations around Promoting Good Public Health would be highlighted as part of this process.
- It was also highlighted that the Government had undertaken some recent consultation around an additional / revised Planning Policy Statement: *Planning for a Natural and Healthy Environment.* It was understood that the outcome of this work would be expected in September 2010.
- There was agreement that both the highlighted issues may impact on the material considerations associated with the Leeds Girls High School planning application and that the Acting Chair should write to the Chair of Plans Panel (West) to highlight the concerns of the Scrutiny Board.

Mortality rates

- While mortality rates had generally improved, a significant challenge remained around narrowing the gap between those in the most deprived areas of the city and those in the least deprived areas.
- The need for additional statistical analysis / presentation of the information reported – such as breakdowns by electoral ward and ethnicity, alongside comparative information from other Core Cities.

Teenage conception rates

- Levels of teenage conceptions remain a significant challenge for the City.
- Request for additional information around the:
    - Relevance of strategies used elsewhere to successfully target teenage conception rates
    - Profile of teenage conceptions in Leeds and the associated level of targeted resources, when compared to other areas
    - Available support for young fathers
    - Level of teenage conceptions resulting in terminations.

RESOLVED –

(a) That the contents of the report and appendices be noted.

(b) That on behalf of the Board, the Acting Chair writes to the Chair of Plans Panel (West), highlighting the Board's concerns with regard

to the potential full consideration of the Leeds Girls High School planning application on 12th August 2010.

(c) That the relevant officers be requested to provide the additional information highlighted at the meeting.

18 Leeds Local Involvement Network (LINk) - Annual Report (2009/10)

The Head of Scrutiny and Member Development submitted a report introducing the 2009/10 Annual Report of Leeds Local Involvement Network (LINk).

In presenting the LINk's Annual Report (2009/10), it was intended that this would:

- Continue to raise awareness of the role and work of Leeds' LINk (both publicly and among members of the Scrutiny Board).
- Provide Members with more detail of Leeds' LINk activity during its second year, alongside any future plans.
- Provide an opportunity for a discussion between the Scrutiny Board (Health) and representative members of Leeds' LINk, regarding the general relationship between the two bodies, and any issues associated with coordinating respective work programmes.

Appended to the report was a copy of a document entitled 'Leeds LINk – Leeds Local Involvement Network Annual Report 2009/10' for the information / comment of the meeting.

The following representatives from Leeds LINk were in attendance to present the key issues highlighted in the report and to address any specific questions identified by the Scrutiny Board:

- Arthur Giles (Co-Chair) – Leeds Local Involvement Network
- Emily Wragg (Co-ordinator) – Leeds Local Involvement Network.

In introducing the report, the Co-Chair highlighted that continuing to raise the profile of the LINk and increase membership remained key priorities. A general discussion took place, with specific reference being made / clarification sought around the following issues:

- Arrangements for making the annual report available within the local community and the importance of disseminating information efficiently and effectively.
- Views of the future role of LINk following the proposed changes outlined by the Government's recent White Paper 'Equality and excellence; Liberating the NHS'.
- The main issues / concerns highlighted by service users when contacting the LINk.

In response, the LINk Co-ordinator highlighted that the LINk held a number of events around the City to promote its work, disseminate information and encourage membership.

In relation to the proposed changes outlined in the White Paper, the Co-Chair expressed a willingness and desire to continue to develop arrangements that recognise, value and promote public and patient involvement in the development and delivery of local health care services.

In terms of the main issues / concerns highlighted by service users, the following issues were outlined:

- Waiting times
- Access to services (particularly mental health services) – i.e. how to access services
- Carers – access to information and support
- Hospital food.

Members of the Board also enquired about any information about the LINk that may assist with their day-to-day ward duties. The LINk Co-ordinator, agreed to supply such details via the Board's Principal Scrutiny Adviser.

The Chair thanked the representatives for attending the meeting and presenting the report.

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

19 Kirkstall Joint Service Centre - Scrutiny Board Statement and response

The Head of Scrutiny and Member Development submitted a report providing the Scrutiny Board (Health) with details of the recommendations from the recent City and Regional Partnerships Scrutiny Board inquiry into the proposal for a new Joint Service Centre at Kirkstall and the associated response.

Appended to the report were copies of the following documents for the information / comment of the meeting:

- Scrutiny Board (City and Regional Partnerships) – Statement on Kirkstall Joint Service Centre – April 2010 (Appendix 1 refers)
- Final Statement and Recommendations of the City and Regional Partnerships Scrutiny Board's Statement on the Kirkstall Joint Service Centre – Report of the Assistant Chief Executive (Planning, Policy and Improvement) – Executive Board – 22nd June 2010 (Appendix 2 refers)

The Board's Principal Scrutiny Adviser presented the key issues highlighted in the report and addressed specific points of clarification identified by the Scrutiny Board.

RESOLVED –

a) That the contents of the report and appendices be noted.

b) That approval be given to assume the formal monitoring role of the former Scrutiny Board (City and Regional Partnerships) as it relates to the statement and recommendations around Kirkstall Joint Service Centre.

20 Input to the Work Programme 2010/11 - Sources of Work and Establishing the Board's Priorities

Referring to Minute 7 of the meeting held on 25th June 2010, the Head of Scrutiny and Member Development submitted a report providing information and guidance to assist the Scrutiny Board develop its work programme for 2010/11.

Appended to the report were copies of the following documents for the information / comment of the meeting:

- The Operating Framework for the NHS in England for 2010/11 (Appendix 1 refers)
- Revision to the Operating Framework for the NHS in England for 2010/11 (Appendix 2 refers)
- The NHS Constitution (2010) (Appendix 3 refers).

In addition to the above appendices, a copy of a document entitled 'Liberating the NHS: Local Democratic legitimacy – A consultation proposals' was circulated as supplementary information (Item 13 refers).

The following representatives were in attendance to address any specific questions identified by the Scrutiny Board:

- Linda Pollard, Chair, NHS Leeds
- John Lawlor, Chief Executive, NHS Leeds
- Ian Cameron, Director of Public Health, NHS Leeds
- Mike Collier, Chair, Leeds Teaching Hospitals NHS Trust (LTHT)
- Maggie Boyle, Chief Executive, Leeds Teaching Hospitals NHS Trust (LTHT).

The Chair welcomed the representatives to the meeting and invited them to provide a brief introduction / overview, outlining key issues and priorities relevant to the work of the Scrutiny Board (Health).

An overview of the current context associated with the management and provision of health care services was provided – with significant reference being made to various aspects outlined in the Government's recent White Paper *'Equity and Excellence: Liberating the NHS'*.

The main issues highlighted were:

- Recent improvements to working relationships within the local health system.
- Significant financial challenge over the next few years.

- Significant (proposed) structural change across the NHS – as outlined in the White Paper, with the abolition of Primary Care Trusts and an increasing role for GP consortia.
- Resultant changes to service commissioning – with 75% of commissioning being undertaken by GP consortia.
- Major changes around the provision of public health services – both nationally and locally: A White Paper outlining proposals in more detail being expected in December 2010.
- LTHT achieving Foundation Trust status by April 2012.
- Continued emphasis on patient choice and patient and public involvement.
- Changes in commissioning arrangements leading to potential funding source issues for service providers.

It was also highlighted that currently 3 GP consortia groups (representing approximately 70% – 75% of GP practices) were operating well across Leeds – each with different strengths and areas for improvement. NHS Leeds had a significant role in working with local GPs to prepare for the shift in commissioning responsibility.

The following LTHT specific matters were also highlighted:

- £40M cost base reduction over the next 3 years.
- Potential changes to out patient follow-up care – with a greater role for primary care providers.
- Changes to systems and processes to improve efficiency and effectiveness, including:
    - Reduction in the number of excess bed days and subsequent rationalisation of wards and removal of excess capacity
    - Capital estate rationalisation.

Detailed discussion ensued and the Board sought clarification on the following areas:

- The future role in relation to preventive medicine arising from the new proposals contained in the White Paper the Board.
- Capacity and resource implications arising from the proposals set out in the White Paper the Board.
- The potential loss of focus on service provision (as a result of the proposed major structural changes).

The Board recognised the importance and significance of the White Paper (and supporting consultation documents), highlighting the potential significant resource implications and additional responsibilities for the Council as a particular area of interest. The Board expressed a desire to establish a working group to explore the proposals and likely implications in more detail

In conclusion, the Chair thanked the representatives in attendance for providing a comprehensive overview to assist the Board with the development of its work programme for 2010/11.

RESOLVED – That the contents of the report and appendices, alongside the issues raised through discussion, be noted.

21 Determining the Work Programme 2010/11

The Head of Scrutiny and Member Development submitted a report on the Board's formal conclusions and recommendations arising from consideration of Agenda Item 9 'Input to the Work Programme 2010/11 – Sources of Work and Establishing the Board's Priorities'.

Appended to the report were copies of the following documents for the information / comment of the meeting:

- Scrutiny Board (Health) – Protocol between the Scrutiny Board (Health) and NHS Bodies in Leeds (Appendix 1 refers)
- Scrutiny Board (Health) – Health Service Developments Working Group – Terms of Reference (Appendix 2 refers)
- Scrutiny Board (Health) – Work Programme 2010/11 (Appendix 3 refers)
- Scrutiny Board Procedure Rules Guidance Note 7 – Inquiry Selection Criteria (Appendix 4 refers)

The Board's Principal Scrutiny Adviser presented the report and responded to Board Member's queries and comments.

RESOLVED –

(a) That the contents of the report and appendices be noted.

(b) That, with an open membership arrangement, approval be given to establishing a Health Service Developments Working Group in line with the draft terms of reference.

(c) That approval be given to establishing a Working Group to consider the proposals contained in the White Paper 'Equality and excellence: Liberating the NHS', alongside the subsequent and supporting consultation documents.

(d) That, while participation in the working group referred to in (c) above be open to all members of the Board, the following members be appointed as core members of the working group: Councillor M Dobson, Councillor P Harrand and Mr A Giles.

(e) That, while a 'flexible' and 'open' approach is to be adopted with regard to the work programme for 2010/11, approval be given the Board's draft work programme for 2010/11, as now outlined, subject to the inclusion of the following items:

- Equality and excellence; Liberating the NHS – Initial Findings of the Working Group(September 2010)
- Dermatology
- Narrowing the Gap
- Public Health consultation document (December 2010).

22 Date and Time of Next Meeting

Tuesday 21st September 2010 at 10.00am (Pre-meeting for Board Members at 9.30am)

(The meeting concluded at 12.05pm.)

This page is intentionally left blank

Leeds CITY COUNCIL

Originator:
Heather Pinches/ Graham Brown
Tel: 22 43347/305 7540

LCC and NHS Leeds Joint Performance Report

Meeting: Health Scrutiny Board

Date: 21st September 2010

Subject: Joint Performance Report Quarter 1 2010/11

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

1 Executive Summary

1.1 This report presents the performance information summarising our progress against the joint council and NHS Leeds priorities as set out in the Leeds Strategic Plan, as well as key NHS Leeds priorities, for first quarter of 2010/11. The report includes two action trackers from the Leeds Strategic Plan which are from the small number (10 in total) of key performance areas as identified by CLT in Dec 2009. The purpose of these extra trackers is to enable officers and members the opportunity to more closely performance manage these high risk areas and ensure that as necessary appropriate remedial action is taken. In addition a Performance Indicator (PI) report is provided and it should be noted that the range of indicators reported through to the board has been substantially revised and reduced in light of the changes to the national performance regime. Of the indicators which can be reported at quarter 1 relevant to the Health Scrutiny Board 86% are currently predicted to hit target. However, the board should note that only half of the indicators are available quarterly with the rest provided annually.

2 Purpose of the Report

2.1 The purpose of this report is to present an overview of performance against our priority outcomes so that the Board may understand our current performance and, as necessary, take appropriate action. This joint report also enables the Board to fufill their role to scrutinise the performance of NHS Leeds.

3 Background Information

3.1 The agreed performance reporting process for the joint priorities in the Leeds Strategic Plan provides PI reports only at Quarters 1 and 3 with Action Trackers and PI reports at Quarters 2 and 4. The action trackers report progress against our LSP priorities and bring together qualitative and quantitative information including progress against targets for aligned performance indicators, the delivery of key actions/activities and relevant challenges and risks. An overall traffic light rating is assigned by the Accountable Officer and agreed with the Accountable Director. This is supplemented by a direction of travel arrow that indicates whether progress is improving, static or deteriorating. In December 2009 CLT identified a small number of high risk performance areas where they wanted to

receive a more regular update and for these 10 areas actions trackers are produced on a quarterly basis. Some changes to these processes are proposed below.

3.2 Accountable Officers were asked to provide a high level summary only within the action trackers and were requested to limit their action trackers to one A4 page (ie 2 sides). However, many accountable officers were unable to do this without missing essential information and therefore the limit was not rigidly applied so that the trackers provided a complete picture of performance.

3.3 A number of appendices of information are provided with this report and these are summarised below:

- **Appendix 1** – action trackers for the high risk performance area from the Leeds Strategic Plan which are relevant to the Health Scrutiny Board. This tracker includes a contextual update as well as key performance indicator results.
- **Appendix 2** – performance indicator report showing the Q1 result and predicted year end traffic lights for all key performance indicators aligned to the LSP which are relevant to the Health Scrutiny Board as well as indicators relating to the key priorities for NHS Leeds.
- **Appendix 3** – provides an update on the outstanding PIs from the Q4 2009/10 which were not available at the time of the Q4 report or were not confirmed as validated results.

This information is supported by a guidance document to aid the reader in interpreting the actions trackers.

4 Main Issues

4.1 Over recent months the new coalition government have been making changes to the national performance regime including removing the Comprehensive Area Assessment and deleting a range of national performance indicators. These changes mean that local services have more freedom in how they manage their own performance. The Department of Health (DH) has published its new Outcomes Framework for consultation and for use from April 2011 onwards. The performance framework for the current year is based on the DH Operating Framework, as revised in June, which contains a range of Existing Commitments and Vital Signs. In light of this a review has been undertaken on the performance indicators which are reported through the corporate accountability in order to streamline the process and enable more focus to be placed on the joint priorities agreed in the LSP and the Priorities for NHS Leeds. In terms of the Health Scrutiny Board there has been a reduction of 25% (from 36 to 27) with 14 of these available quarterly. This review has also enabled more of the PIs to be clearly aligned to the improvement priorities in the LSP so that this more focused reporting will enable us to dispense with the separate LSP PI report at Quarters 2 and 4 and just report progress through Action Trackers. In this way it ensures the Board's time and effort is clearly focused on examining the performance issues which are of most importance to the Council and its partners. However, the Health Scrutiny Board will still receive a performance indicator report relating to the NHS Leeds only priorities.

Analysis of Performance
Improvement Priorities

4.2 The table below sets out the overall progress rating of the one high risk improvement priority from the Leeds Strategic Plan which is relevant to the Board and how this has progressed over the past year or so.

Improvement Priority	**2009/10 Q2**	**2009/10 Q3**	**2009/10 Q4**	**2010/11 Q1**
HW-1d/CYPP 7 Reduce teenage conception and improve sexual health	↓	↓	↓	↔
HW-1a Reduce premature mortality in most deprived areas	↑	↑	↓	↓

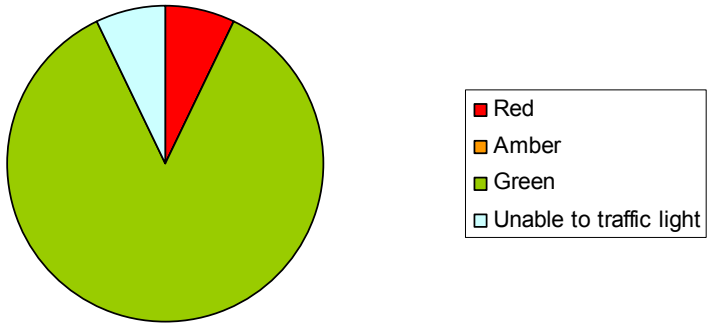
4.3 Teenage conception has an improved direction of travel arrow as a result of some encouraging local performance data although it does acknowledge that the next set of official figures will not be available until February 2011. Health Inequalities remains red and deteriorating but work is underway on a peer review and to plan an innovation day to develop new approaches to tackling the issue.

Performance Indicators

4.4 An analysis of the new cohort of Performance Indicators for the Board is shown below with 86% of these performance indicators currently predicted to hit their 2010/11 targets. However, the board should note that only half of the indicators are available quarterly with the rest provided annually.

	Number	%
Red	1	7%
Amber	0	0%
Green	12	86%
Unable to traffic light	1	7%

RAG rating for Health Performance Indicators



4.5 It is not possible to provide a like-for-like comparison with this time last year as the indicator set has been substantially revised.

Data Quality

4.6 The data quality traffic lights reported this quarter are based on a new data quality audit process which brings a more robust, consistent and wider based data quality judgement for our key performance indicators. The revised approach, developed in conjunction with Internal Audit, produces an overall score for each indicator which is then translated into the traffic light that appears on the report. These judgements were also taken into account during the PI review and as a result a number of PIs where the data was not reliable were dropped.

5 Implications for Council Policy and Governance

5.1 The Leeds Strategic Plan is part of the council's Budget and Policy Framework. Effective performance management enables senior officers and Elected Members to be assured that the Council is making adequate progress and provides a mechanism for them to challenge performance where appropriate.

6 Legal and Resource Implications

6.1 The Leeds Strategic Plan fulfils the local partners statutory requirement to prepare a Local Area Agreement. These government agreed targets are subject to performance reward grant - however this is currently under review by Government.

7 Conclusions

7.1 This report provides the Health Scrutiny Board with a Q1 update of the performance against the joint LCC/NHS Leeds improvement priorities in the Leeds Strategic Plan and the key priorities for NHS Leeds. This report highlights areas where progress is not on track and Members need to satisfy themselves that these areas are being addressed appropriately and where necessary involving partners in any improvement activity.

8 Recommendation

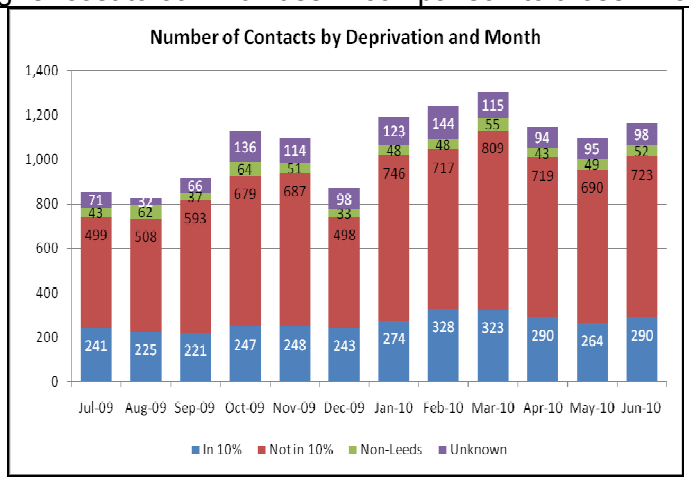
8.1 Members are asked to consider the overall performance information provided against the strategic priorities and where appropriate, recommend action to address the specific performance concerns raised

HW-1d/CYPP 7 - Reducing teenage conception

Lead Officer – Sarah Sinclair

Overall Progress
⟷

Why is this a priority	Evidence shows that having children at a young age can damage young women's health and wellbeing and severely limit their education and career prospects. Long term studies show that children born to teenagers are more likely to experience a range of negative outcomes in later life and are up to 3 times more likely to become teenage parents themselves. Teenage parents are shown to be high users of services compared to other parents and are therefore a significantly higher cost to communities in comparison to those who become parents in later life.



Overall progress to date and outcomes achieved – Quarter 1 2010-11

Overall Summary

Our progress against our 2009-10 action plan was positive with a majority of actions completed in line with national best practice recommendations. Conception rates are particularly high in the Inner East and Inner South hotspot localities. As a result our assessment of progress at this stage must be red due to a full year rate for 2007-8 being higher than the rate for 2006-7. However, evidence such as that of service take up (detailed below) suggests that actions over the previous 18 months will show a positive impact on teenage conception rates for 2009. Q1 2009 shows a very modest reduction in rates from 50.8 to 50.5 (rate per 1000 15-17 year old young women).

Our performance is measured against Office of National Statistics (ONS) conception rates for 15 -17 year old young women. New data on under 18 conceptions rates from ONS will be available for Q2 2009 on 24 August 2010 and for the whole of 2009 in February 2011. Local analysis of Leeds births and terminations is not yet sufficiently robust to report at this time, we expect to report this in the next quarterly reporting cycle.

A positive impact is already being seen in Citywise, our primary city-centre based sexual health service for young people. The graph above shows the number of Citywise contacts by month in the twelve month period to June 2010. The data shows total contacts split by user place of residence/deprivation levels. Some key points to take from the chart are:

- The number of people using the service from the most deprived areas of the city is rising. During Q1 an average of 27% of the people using Citywise came from the areas of Leeds with the highest 10% of deprivation. This suggests that the emphasis on locality working and targeted campaigns are being effective in promoting access to services in these areas.

- Generally, the number of people using the Citywise services is steadily rising which we hope will have the impact of reducing future conception rates.

Activity Achievements since the last quarter

Boys' and young men's work

It is an action within the Prevention Action Plan to audit and improve the number and quality of young father targeted and young father friendly services in the city. Our achievement this quarter was to create wide understanding and ownership of the need for young father friendly services through two locality events in Inner

East and Inner South. The events had high attendance and feedback from attendees was that they were highly valued. Action plans created within workshops will be taken forward as part of the locality work programme. An example is a multi-agency task and finish group to create a resource pack for work with boys and young men for practitioners in East and South Leeds.

Reducing repeat conceptions

We have noted high rates of repeat pregnancy after the removal of a baby by Social Care and following miscarriage, neonatal death and abortions. Our achievement has been to commission an audit of the types, rates and outcomes of early loss of a child. Recommendations for action will be presented to the Teenage Pregnancy and Parenthood Partnership Board (TPPPB) Sept 2010.

Sexual health services

- Integrated sexual health services with better coherence between IYSS, Health and other partners are effective in reducing teenage pregnancy in low rate authorities. A Sexual Health Modernisation Team has been formed to take forward an integrated sexual health service model for Leeds. A completed service specification is due for September.
- 'You're Welcome' is a nationally recognised set of criteria that services in health settings need to meet in order to become 'young people friendly'. CaSH is the first service in Leeds to achieve the 'You're Welcome' accreditation.
- Consultation with young people has been undertaken to improve of local CaSH outreach clinics in priority areas. Action to relocate existing resources will follow the recommendations of the consultation.
- In order to ensure that young people have swift and easy access to high quality sexual health services, a multi-agency mystery shopping project has been commissioned and is currently underway in the inner east. It is already yielding some interesting results which will in future help us to improve service accessibility.

Looked After Children (LAC)

- Looked After Children are over-represented in the teenage conception rates and in response to this an updated LAC Action Plan is now in place with common targets/actions linked into the teenage pregnancy prevention work plan.
- Two commissioned services who work with LAC have agreed to a discrete extension of service to 25 years of age for LAC. This will be reviewed in October.

Work in school settings

The Healthy Young People's Service (HYPS) model practised in a number Leeds schools offers support and information on health issues such as: bullying, sexual health, pregnancy. A paper has been drafted summarising a number of findings around HYPS and school nursing in order to enable discussion and decision-making on what NHS Leeds is commissioning school nursing to deliver for the HYPS based on the most effective interventions.

Youth Justice Provision

To help support some of our most vulnerable young people within East Moor Secure Unit we are providing 1-1 support and group based support work. This work will be commissioned using Youth Justice money which is sustainable over the next 2 Years.

Work with parents and carers

Leeds has adopted the Speakeasy approach which is a non-threatening group-based opportunity for parents and carers to acquire the confidence and skills they need to talk to their children about sex and sexuality. Following the successful uptake of Speakeasy courses across the city and the positive feedback received from parents, carers and facilitators, two more Speakeasy courses have been planned for September and October in the Inner East and Inner South to meet demand in the localities.

HW-1d/CYPP 7 - Reducing teenage conception

Lead Officer – Sarah Sinclair

Challenges/Risks

Senior strategic leadership
Effective cities have leadership and challenge at the very highest level agreeing to be accountable for reducing teenage conceptions. Leeds continues to be at a disadvantage if its senior leaders do not systematically approach joint working to address teenage pregnancy.

Sexual health services
Leeds has a lower investment in community based health services which young people can access for their sexual health needs than other leading cities and the challenge will be whether we can meet the demand for service use with the likely reduced investment levels in this area.

Work in School settings
A review of the HYPS approach has been completed in order to ensure existing services are of sufficient quality and deliver the required outcomes. This will be considered when looking at the further roll out of HYPS.

Embedding the teenage pregnancy strategy in other services and strategies
There is a risk that services do not consider teenage pregnancy and parenthood as a priority and therefore there is insufficient progress in addressing the wide range of causative factors.

Young people friendly
The challenge is to ensure that services must become 'young people friendly' in order to ensure that young people will access them, particularly those who would not otherwise access mainstream services.

Work with boys and young men
The risk is that a lack of services for post-school age young fathers will result in them being ill-prepared for parenthood and increasingly likely of becoming NEET.

New hotspots
There is a risk that newly identified hotspots are not understood across council and partner services as a priority for action.

Budget Pressure
A 25% in-year reduction of the Area Based Grant which supports teenage pregnancy has resulted in the risk of a reduction in the overall progress of the work programme. Impacts will be felt through reducing the strategic change resources available and/or the support given to service users.

All the challenges and risks identified above are being considered by the Teenage Pregnancy Board with mitigating actions included in the action plan.

Council / Partnership Groups			
Approved by *(Accountable Officer)*	Paul Bollom/ Sarah Sinclair	**Date**	30.07.10
Approved by *(Accountable Director)*	Sarah Sinclair in Eleanor Brazil's absence	**Date**	30.07.10

HW-1d/CYPP 7 - Reducing teenage conception

Lead Officer – Sarah Sinclair

Key actions for the next 6 months					
	Action	**Lead Officer**	**Milestone**	**Timescale**	**Date Action Last Reviewed**
1	A leadership review of teenage conception to be undertaken through a summit of senior leaders of the authority, health services, elected members and parliamentary representation.	Paul Bollom	Date originally arranged for summit was August 2010 however this is likely to be put back until we get the confirmed start date of the new Director for Children's Services (DCS)	September 2010	9 August 2010
2	A benchmarking report to be completed to review the service investment made in sexual health services targeting young people in Leeds against high performing cities.	Vicky Womack	Benchmark information reported to TPPPB (June 2010)	September 2010 (Revised from July 2010)	July 2010
3	A review of the HYPS program to be undertaken to provide recommendations on swift and easy access to sexual health services in all priority schools.	Vicky Womack	• Report writing group formed (April 2010) • Report presented to TPPPB (June 2010)	September 2010 (report completed but will be presented to later TPPPB meeting)	9 August 2010
4	Youth work commissioning and family support commissioning outlined in the children's services improvement plan will include TP actions and outcomes in their specification	Paul Bollom	• Youth work commissioner employed – completed. • Family support and youth work commissioning specifications are agreed by universal commissioning group (September 2010)	October 2010	9 August 2010
5	Plan for all CaSH, Genitourinary Medicine (GUM) and the Termination of Pregnancy (TOP) providers will be 'You're Welcome' accredited – the scheme to accredit health services as young people friendly. Target set for GP practices in high rate localities	Vicky Womack	• Report plan for all sexual health service providers to be accredited by end of year. (July 2010) – completed. • Report on number of new accreditation submissions and success to be provided to TPPPB. (July 2010) – completed. • A target set for GP practices in high rate areas to complete 'You're Welcome' accreditation. (July 2010) – milestone revised Sept 2010. Expressions of interest received from four GP practices in You're Welcome accreditation by July 2010.	November 2011	9 August 2010

HW-1d/CYPP 7 - Reducing teenage conception

Lead Officer – Sarah Sinclair

Key actions for the next 6 months					
	Action	**Lead Officer**	**Milestone**	**Timescale**	**Date Action Last Reviewed**
6	To report on the availability and effectiveness of services for young fathers and use to inform the family support and parenting commissioning activity for March 2011	Jenny Midwinter	• Report commissioned from external provider by March 2010 - completed • Interim findings to be provided to TPPPB, June 2010. Milestone revised final report to be presented to TPPPB October 2010 • Family Support and Parenting Commissioning Plan to reflect outcomes of report in addressing needs of young fathers. (September 2010) – revised to October 2010	October 2010	9 August 2010
7	Develop action plan for identified hot pockets in West Leeds (noted in previous action tracker – locality work already underway to address hotspots in Inner East and Inner South Leeds)	Paul Bollom	• To place paper before Inner West area committee on local hotspot rates and suggested actions.	March 2010 (Revised to September 2010)	9 August 2010
	To review all expenditure across partners of TP related services and make recommendations to improve efficiency and effectiveness and look for opportunities to combine program with other appropriate expenditure.	Paul Bollom	• Recommendations to make savings to be shared with deputy director of commissioning and TPPPB	September 2010	New Action

Performance Indicators										
Performance indicators aligned to the Improvement Priority										
Reference	**Title**	**Owner**	**Frequency & Measure**	**Rise or Fall**	**Baseline**	**2009/10 Result**	**2010/11 Target**	**Q1 2010/11 result**	**Predicted Year End Result**	**Data Quality**
NI 112	Under 18 conception rate per 1000 girls ages 15-17	PCT	Annual	Fall	50.4	50.6 conceptions per 1000 (691) (2008)	TBD	The 2009 figures are released in February 2011		No Concerns

This page is intentionally left blank

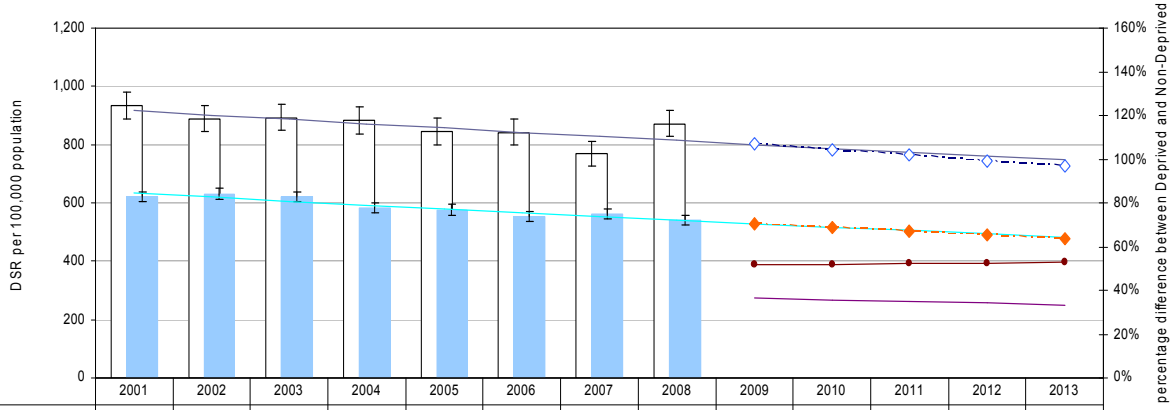
Improvement Priority – Reduce Premature Mortality in the Most Deprived Areas

Lead Officers – John England, Brenda Fullard

Overall Progress

Why is this a priority	In Leeds 20 % of the population live in the 10% most deprived Super Output Areas (SOAs) in England. There are health inequalities within Leeds for men and women by areas of deprivation: •There is a 10.1 year gap in life expectancy for men between City & Hunslet and Harewood (71.6 years:81.7years) • There is a 9.6 year gap in life expectancy for women between City & Hunslet and Adel/Wharfedale (76.1year:85.7years

Leeds Deprived and Non-deprived Gap in Mortality Rates - All Persons



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Deprived Leeds actual	934	889	893	881	844	842	768	871					
Non-Deprived Leeds actual	621	631	621	583	577	553	563	541					
Deprived Leeds trend line	917	902	886	871	857	842	828	814	800	786	773	760	747
Non-Deprived Leeds trend line	634	619	605	592	579	566	553	541	529	517	505	494	483
Deprived Leeds -0.50% yr on yr improvement on trend									801	782	764	745	728
Non-Deprived Leeds -0.25% yr on yr improvement on trend									527	514	501	489	477
gap									274	268	263	256	251
gap as percentage difference									52%	52%	52%	52%	53%

year

sources: YHPHO, NHS Leeds and LAA trajectory submissions

Overall progress to date and outcomes achieved April 2010 – June 2010

Summary

All age all cause mortality is still a significant issue in deprived areas of Leeds however this rate has decreased each year from 2001 to 2007 but there was increase in 2008. Based on the actual figures from the five year average periods 2001-2005 to 2004-2008 a forecast continuing at the same rate shows that difference in female and male life expectancy between the 10% most deprived and 10% least deprived LSOAs will continue to increase.

Achievements since the last report

- **Leeds Strategy** - A challenge event was attended by over 80 people with 21 partnership organisations and agencies represented alongside chief officers from all directorates in Leeds City Council. Five priority areas emerged from an exercise and workshop discussion at the event. A health and wellbeing task and finish group has been formed to clarify and frame the priority areas.
- **NHS Commissioning for health Inequalities plan** - under completion for approval by NHS Leeds Executive management team in August 2010
- **Obesity and Alcohol treatment services:** Health commissioning Priorities Plans developed for agreement by NHS Leeds in October 2010
- Joint workforce development programme development progressing - to increase in the number of Health Champions and LCC/ NHS staff skilled to address the reduction of health inequalities through their individual work objectives.
- **NHS Health Checks** - 60 GP practices have now signed up to the Local Enhanced Service (LES) for the delivery of the NHS Health Check, 6577 vascular risk assessments were under taken in the last quarter 09/10 and first quarter 2010-2011 and over 30% of those seen were at over 20% risk of developing CVD in the next 10 years, and are now within a management pathway.
- **Healthy Living Services** - A programme approach has commenced to develop and sustain behaviour change interventions across a large audience, on an 'industrial' scale and initially targeting the Cardiology Department at Leeds Teaching Hospital Trust and 6 practices within the 10% most deprived areas. Projects within the programme include: rapid appraisal of the effectiveness of stop smoking and weight management services; increase capacity and skills of front line workers to deliver brief advice and interventions; and develop, manage and promote a comprehensive Leeds data base of services and facilities.

Improvement Priority – Reduce Premature Mortality in the Most Deprived Areas

Lead Officers – John England, Brenda Fullard

- **Under age sales of alcohol and tobacco-** West Yorkshire Trading Standards in partnership with NHS Leeds one year project to reduce illegal sales of substances to those under age in Armley and Middleton commenced June 2010
- **Reducing Excess Winter deaths** – A project is in progress to identify high risk populations from the Adult Social Care register and GP practice profiles to enable all vulnerable people on the register to be pro-actively and systematically offered, and supported to take up, a suite of interventions prior to the onset of Winter 2010.
- **Infant Mortality** – The 2 Demonstration Sites (Chapeltown and Beeston Hill) continue to implement an intensive programme of interventions. Evaluation of their impact is being undertaken. Initiatives to improve the accessibility of maternity services to women continue, including an assessment of factors which influence late booking among certain ethnic groups, and the development of an asylum seeker maternity pathway. Monitoring data indicate that the proportion of women booking before 12 weeks continues to improve. Data concerning smoking levels in pregnancy continues to improve in quality. An incentive scheme to support women in challenging circumstances to remain smoke free, through intensive visiting, is showing early success. NICE guidance concerning obesity among pregnant women has just been published, and work will commence shortly to consider implementation in Leeds.

- **Increasing Community Capacity -** NHS Leeds are reviewing Voluntary, Community and Faith Sector (VCFS) contracts and are committed to protecting the VCSF sector and re-commissioned to deliver work on advocacy , participation of the voluntary sector in commissioning strategic development, Health improvement and actively targeting interventions for people in specific disease groups to prevent deterioration of the condition and maintain their independence. Annual data from VCFS showed:
  - 14,071 people accessed VCFS community health provision (6,427 were new contacts);
  - 6,662 (not including children) were supported to access services/other support to address physical health issues, including registering with a GP/dentist, taking up cervical and breast screening, quit smoking support, flu and immunisation uptake.
  - In the 12 months to April 10, an additional £427,000 was secured by VCFS, supported by NHS, to deliver health improvement work in deprived areas of Leeds.
- **Locality based Commissioning -**. Three Locality action plans are being implemented on four key challenges and shared priorities of: Communication and community engagement; Commissioned services and local initiatives meeting the needs of deprived communities; translation of citywide priorities into actions at local level; reducing the Health Inequalities gap between deprived communities and the rest of Leeds through strengthening partnerships, building health capacity and maximizing resources.

- **Health Promoting Hospital:** Leeds Teaching Hospital Board approved their Public health strategy and an action plan is now in pace to with agreement to introduce the first phase of this work in the Cardiac unit.

- **Promoting health, wellbeing and health inequalities** Workshop held with heads of service in City Development on their role in promoting health and wellbeing and health inequalities.

Challenges and Risks

- **NHS Health Check and Healthy Living Services -** Given the financial climate a 'no increase' or a reduction in investment could lead to lower levels of clinical engagement, lower uptake in key communities and inability to produce local and national monitoring requirements
- The change process resulting from the White paper 'Liberating the NHS' and the forthcoming white paper on public health is likely to affect both the content and future timescales of commissioning and health improvement plans
- Increasing the integration of health improvement and reducing health inequalities across plans and objectives across all Directorates of LCC.
- **Infant Mortality -** The rising birth rate in Leeds, together with the changing ethnic profile of the child bearing population and the impact of recession on economic wellbeing (32% of Leeds births take place within SOAs which fall into the 10% most deprived nationally), are all likely to impact on infant mortality rates.

Approved by	John England	**Date**	09/08/10
Delivery Board			

Improvement Priority – Reduce Premature Mortality in the Most Deprived Areas

Lead Officers – John England, Brenda Fullard

Key actions for the next 6 months					
	Action	**Lead Officer**	**Milestone**	**Timescale**	**Date Action Last Reviewed**
	The Leeds Strategic plan**:** will be revised during 2010-11 and this is likely to include many of the recommendations set out in the 2010 national strategic review of health inequalities: Fair Society, healthy Lives (Marmot review) plus the actions from the NHS commissioning for reducing health inequalities plan	John England/Brenda Fullard	Secure joint ownership of a revised Health and Wellbeing Partnership action plan with short to medium term objectives agreed	October 2010	
	Joint workforce development programme	Brenda Fullard/John England	Agreed and project plan in place to increase in the number of LCC and NHS Leeds staff skilled to address the reduction of health inequalities through their individual work	December 2010	
	Infant mortality: Combined antenatal Down's Syndrome screening to commence. Implementation of the breastfeeding strategy, "Food for Life" is ongoing. A social marketing campaign promoting breastfeeding is being taken forward in South Leeds. A social marketing campaign concerning co-sleeping is being planned. A training programme, commissioned from the University of Bradford, for front line staff aiming to enhance their understanding of cousin marriage, is being rolled out in October and November.	Sharon Yellin	Further reduction of infant mortality in demonstration sites	November 2010	
	Health and Wellbeing Locality Partnership Action Plans	John England/Brenda Fullard	Action plans implemented and monitored	January 2011	
	To inform the new **Housing Strategy for Leeds,** a piece of work was commissioned by Leeds City Council from Sheffield Hallam University to understand the impact of poor housing on health in Leeds and estimate the future cost of housing related ill health. The final document is expected late August and recommendations will for discussion at the Leeds Health Improvement Board.		Recommendations of this work included in the Leeds Strategy subject to consultation and investment	October 2010	
	Building on the outcomes of the regional workshop held in February 2010, develop and agree a joint approach to improve health and **reduce health inequalities through spatial planning**	Christine Farrar	Joint approach to improve health and reduce health inequalities through spatial planning agreed	October 2010	

Improvement Priority – Reduce Premature Mortality in the Most Deprived Areas

Lead Officers – John England, Brenda Fullard

	Increase in number of people reducing lifestyle risk through NHS Health Check and Healthy Living Services.	Lucy Jackson/Ruth Middleton/ Brenda Fullard	Rapid appraisal of healthy living services completed, brief intervention capacity building programme commenced and healthy living database completed.	December 2010	
	Reduce under age sales of alcohol and tobacco in Armley and Middleton	Tony Downham/Heather Thomson	Initial results to be reported	January 2011	
	Implement NHS Leeds and LCC joint programme of work to reduce excess winter deaths, including reducing fuel poverty,	Dawn Bailey/ John England	Increase in the number of at risk people identified and offered intervention programme	January 2011	
	Agree the LTHT health promoting hospital plan and recruit a programme manger with the aim of implementing and measuring action to reduce lifestyle risk in patients, visitors and staff	Phil Ayers/Dawn Bailey	1. Health promotion Hospital project manager recruited 2. Working example in cardiology commenced 3. Benchmarked against HPH standards in best hospitals with a view to proposal to join network to Board	January 2011	
	Priorities to be identified with City Development of key areas of joint work with health	Gary Bartlett/ Janette Munton/ Christine Farrar		Sept 2010	
	A health innovation event has been arranged with LCC and key Health staff to explore new/different ways of working on health inequalities	John England		November 2010	

Health Performance Indicators Quarter 1 2010-11

	PI Type	Ref	Title	Service	Frequency & Measure	Rise or Fall	Baseline	Last Year Result	Target	Quarter 1	Predicted Year End Result	Direction of Travel	Data Quality
1	Leeds Strategic Plan - Partnership Agreed	NI 123A	16+ current smoking rate prevalence (City Wide)	PCT	Quarterly %	Fall	Not set	22.00%	21.00%	22.60%	21.00%	↑	No Concerns with data
		NI 123B	16+ current smoking rate prevalence (10% SOA)	PCT	Quarterly %	Fall	31.00%	30.00%	27.10%	29.67%	27.10%	↑	No Concerns with data
		The Q1 data is used here, but it is set against an end of year target, so whilst the rate in derived areas is above the target, there is time for further work to impact, toward the annual target level.											
2	Leeds Strategic Plan - Government Agreed	NI 40	Number of drug users recorded as being in effective treatment	Community Safety	Quarterly Number	rise	2,939	3,325	3,149	3,325	3,550	↑	No Concerns with data
		Target achieved (variation = +10%) A 13.1% improvement on the baseline year and 5.8% above the national trajectory (Q4 2009/10 figures).											
3	National Indicator	NI 51	Effectiveness of child and adolescent mental health (CAMHS) services	NHS Leeds	Quarterly Number	Rise	16	13	15	14	15	↑	No Concerns with data
		This measure is assessed by answering a series of four questions each worth 4 points enabling a maximum score of 16. The assessment focuses on the following areas: 1. range of CAMH services - assessed at 3 2. access to services and accommodation appropriate to their age and level of maturity - assessed at 3 3. availability of 24 hour cover to meet urgent mental health needs - assessed at 4 4. range of early intervention support services delivered in universal settings - assessed at 3. The quarter 1 result has seen a slight improvement from the 2009/10 year end position. This performance is a result of one of the questions relating to the provision of a full range of CAMHs services for Children and Young People with learning disabilities, increasing to a score of 4.											
4	National Indicator	NI 53A	Coverage of breast-feeding at 6-8 wks from birth (Breastfeeding coverage)	NHS Leeds	Quarterly %	Rise	89.0%	90.9%	95.0%	93.3% (2340/2509)	95.0%	↑	No Concerns with data
		The coverage rate continues to rise with just over 93% of babies at 6-8 weeks having the breastfeeding status recorded. This is an improvement on the 2009/10 year end position and a significant improvement when compared to the same period last year which achieved 88.78%.											
5	National Indicator	NI 53B	Prevalence of breast-feeding at 6-8 wks from birth (Breastfeeding	NHS Leeds	Quarterly %	Rise	41.0%	40.8%	44.0%	44.9% (1126/2509)	44.0%	↑	No Concerns with data
		The prevalence rate continues to rise and has already exceeded the year end target for 2010/11. Work is ongoing to ensure this level of performance is maintained through continued improvement in data recording, the launching of the breastfeeding strategy 'Food for Life' and by targeted work in particular localities within Leeds.											

Health Performance Indicators Quarter 1 2010-11

	PI Type	Ref	Title	Service	Frequency & Measure	Rise or Fall	Baseline	Last Year Result	Target	Quarter 1	Predicted Year End Result	Direction of Travel	Data Quality
6	National Indicator	NI 125	Achieving independence for older people through rehabilitation/intermediate care	Access & Inclusion	Quarterly %	Rise	91.9%	78.8%	85.0%	85.7%	85.7%	↑	No Concerns with data
		During the first quarter of 2010/11 there were 49 occasions where people were discharged from a hospital setting for intermediate care. Of these, on 42 occasions the person was living in their own home.											
7	National Indicator	NI 131	Delayed transfers of care	PCT	Quarterly Number	Fall	5.24	4.44	Not Set	6.45	6.45	↓	Some Concerns with data
		The figures represent an average of 39.9 delayed discharges per week during the year. Delayed discharges that were the responsibility of the local authority (rather than the Health Authority) were around 17 per week - compared to 23 for those for which the Health Authority was responsible. Performance has deteriorated since February 2010 following a 20% increase in referrals from the Leeds Teaching Hospital Trust and the closure of 12 CIC (Community Intermediate Care) beds reducing the capacity to deal with people due to be discharged from hospital.											
8	National Indicator	NI 113	Prevalence of Chlamydia in under 25 year olds measured through % percentage of the resident population aged 15 -24 accepting a test/screen for chlamydia	PCT	Quarterly %	Rise	n/a	32025	49106	7736	No year end prediction is available		No Concerns with data
		This target is not likely to be achieved. A revised prevalence approach to those most at risk is being taken. Screening within CaSH and prisons will continue alongside selected GP practices and online testing. All outreach screening has been suspended. Screening activity is being reviewed monthly against expenditure.											
9	PCT Vital Signs	VSA01	Incidence of MRSA - number of cases	PCT	Quarterly Number	Fall	n/a	n/a	34	9	34		No Concerns with data
		This is a new indicator for the PCT. Previous indicators have related only to acute hospital providers. The overall establishment of the target has taken down the maximum number of cases by around 100%, compared to the levels seen previously. The overall position is at or near the tightened trajectory, month on month.											

Health Performance Indicators Quarter 1 2010-11

	PI Type	Ref	Title	Service	Frequency & Measure	Rise or Fall	Baseline	Last Year Result	Target	Quarter 1	Predicted Year End Result	Direction of Travel	Data Quality
10	PCT Vital Signs	VSA03	Incidence of C difficile - number of cases	PCT	Quarterly Number	Fall	870	425	579	81	400	↑	No Concerns with data
	This target continues to be met, with a decline in the number of cases well within the maximum allowed number.												
11	PCT Vital Signs	VSA13	% patients waiting no more than 62 days from referral to treatment for cancer	PCT	Quarterly %	Rise	n/a	84.78%	85.00%	83.56%	85.00%	↑	No Concerns with data
	Presently, the target is not being delivered, achievement placed in the amber category, although performance is expected to improve through the year.												
12	PCT Vital Signs	VSA12	Cancer: 31 day wait standard - diagnosis to treatment and subsequent surgery	PCT	Quarterly %	Rise	n/a	96.99%/ 89.93%	96.00%/ 94.00%	96.21%/ 96.04%	96.00%/ 94.00%		No Concerns with data
	This target is being delivered, although there are risks to performance, which are being addressed.												
13	PCT Vital Signs	VSA12	Cancer; 31 day wait standard - subsequent drug and radiotherapy	PCT	Quarterly %	Rise	n/a	99.53%/ 90.40%	98.00%/ 94.00%	99.04%/ 92.45%	98.00%/ 94.00%		No Concerns with data
	The target for drug therapy is being achieved. The performance target for the radiotherapy element does not take effect until Dec 2010.												
14	PCT Vital Signs	VSB 10	% Children who completed immunisation by recommended ages	PCT	Quarterly %	Rise	n/a	n/a	95.0%	90.9% to 96.4%, across the range	95.0%		No Concerns with data
	Performance continues to improve, albeit more slowly than ideal. A wide range of initiatives is under way, covering both improved delivery and more efficient and accurate data gathering and recording.												

This page is intentionally left blank

	PI Type	Ref	Title	Service	Frequency & Measure	Rise or Fall	Baseline	Last Year Result	Target	Full Year Result	Direction of Travel	Data Quality
1	Leeds Strategic Plan - Government Agreed	NI 120A	All age all cause mortality rate - Females city wide	PCT	Annually Number	Fall	605.00	500.49 (2008)	481.00 (2009/10)	483.00	⬆	No Concerns with data
		NI 120B	All-age all cause mortality rate - Females 10% worst SOA	PCT	Annually Number	Fall	682.00	640.00 (2006-08)	639.00 (2009/10)	Not Available - See comments		
		NI 120C	All-age all cause mortality rate - Males city wide	PCT	Annually Number	Fall	942.00	751.91 (2008)	697.00 (2009/10)	683.83	⬆	
		NI 120D	All-age all cause mortality rate - Males 10% worst SOA	PCT	Annually Number	Fall	1,098.00	1042.00 (2006-08)	1002.00 (2009/10)	Not Available - See comments		
		Note that 2009/10 mortality data at the small area level is not yet available, though the whole city level data is. The small area data will be available in November and an update will be provided at that time. The "Team Neighbourhood" approach is now being progressed in three areas of the city. A Neighbourhood Management process based on best practice is to be progressed. Financial inclusion is being promoted through the running of training courses, Healthy Start programmes in two areas, and welfare advice in conjunction with partners.										
2	Leeds Strategic Plan - Partnership Agreed	NI 121	Mortality rate from circulatory diseases at ages under 75 (per 100,000 population)	PCT	Annually Number	Fall	145 (1995-97)	77.84 (2008)	72.70	74.37 (2009)	⬆	No Concerns with data
		The national indicator defintion specifies using a single year rate to enable timely reporting and the 2009 rate is shown above for the 2009/10 performance year However, there will be fluctuations in reporting through individual years and a rolling 3 year average often used to monitor trends as it smoothes out the peaks and troughs in the data and this is 78.69 for the 2007-09 period.										
3	National Indicator	NI 122	Mortality from all cancers at ages under 75	PCT	Annually Number	Fall	158.96 (1995-97)	123.83 (2008)	118.56	111.07 (2009)	⬆	No Concerns with data
		The national indicator defintion specifies using a single year rate to enable timely reporting and the 2009 rate is shown above for the 2009/10 performance year However, there will be fluctuations in reporting through individual years and a rolling 3 year average often used to monitor trends as it smoothes out the peaks and troughs in the data and this is 119.10 for the 2007-09 period. It can be seen that the rate for 2009 is well below the rates for the other years quoted so needs to be interpreted with caution.										
4	National Indicator	NI 124	People with a long term condition supported to be independent and in control of their condition	PCT	Annually %	Rise	Not Set	68% (2007/08)	Not Set	82% (2009/10)	⬆	No Concerns with data
5	National Indicator	NI 39 VSC 26 WCC 6	Reduce the rate of increase of alcohol related hospital admissions	PCT	Annual rate per 100,000 population	Fall	1277	1356	1421	1561 (2008/09)	⬇	No Concerns with data

		The latest data, showing the position for 2008/09 has been provided. This is the data used for the performance year 2009/10. Actions include - A revised target to reduce the rate of increase of alcohol related admissions by 2% year on year. The alcohol hospital liaison scheme will expand, helping move patients into community services. ADS (the alcohol treatment service) is making service delivery changes to ensure those most in need get the quickest access to alcohol treatment. Police intelligence is being used to identify frequent intoxicated offenders, through to the arrest referral scheme. A new alcohol board has been established to ensure maximum efficiency and effectiveness of commissioning budgets. Liverpool John Moore's University are to provide an economic evaluation of the costs and benefits of alcohol to Leeds.										
6	Vital Signs Indicator	VSA13	% patients waiting no more than 62 days from referral to treatment for cancer	PCT	Quarterly %	Rise	N/A	N/A	85%	84.78%	N/A	No Concerns with data
		The target for 2009/10 was revised, following the rebasing exercise.										
7	Vital Signs Indicator	VSA12	Cancer: 31 day wait standard - diagnosis to treatment and subsequent surgery	PCT	Quarterly %	Rise	N/A	N/A	96%/ 94%	96.99%/ 89.93%	N/A	No Concerns with data
		The targets for 2009/10 were revised, following the rebasing exercise.										
8	Vital Signs Indicator	VSA12	Cancer; 31 day wait standard - subsequent drug and radiotherapy	PCT	Quarterly %	Rise	N/A	N/A	98%/ 94%	99.527%/ 90.4%	N/A	No Concerns with data
		The targets for 2009/10 were revised, following the rebasing exercise. The performance target for the radiotherapy element does not take effect until Dec 2010.										

Leeds CITY COUNCIL

Originator: Sally Corcoran

Tel: 78944

Report of Leeds Initiative

Scrutiny Board Health

Date: 21 September 2010

Subject: Vision for Leeds 2011 to 2030 – progress with development and next steps

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

1.0 Introduction

1.1 Members will be aware that this will be the third Vision for Leeds. The Leeds Initiative Executive agreed that a new Vision should be commissioned at their meeting of 25 March 2009. It was agreed a new Vision would look ahead to Leeds in 2030, and that the Leeds Strategic Plan from 2011 to 2014 would be the first three-year delivery plan for the Vision.

2.0 Progress to date

2.1 The 'Where are we now?' report developed at the end of 2009 formed the basis of discussions held during the stakeholder engagement phase with almost 40 different groups of people, third sector events, business events, Leeds Initiative strategy and development groups, specific interest groups, all the Leeds City Council political groups, and scrutiny boards.

2.2 A joint meeting of the Narrowing the Gap and Going up a League Boards took place on 8 February to consider and discuss the conclusions drawn from the discussions around the 'Where are we now?' report to firm up a proposition which formed the basis of the consultation draft.

2.3 The project team, comprising officers from across the full Leeds Initiative and Partnerships team, meets on a monthly basis, to drive the project forward and ensure the process is fully coordinated with other strategies and plans.

2.4 The team has:

- developed the consultation document (Appendix 1);

- identified the impact assessments that need to be undertaken on risk, sustainability and equality;

- drawn up communications and consultation plans (Appendix 2); and

- commissioned an agency to develop a campaign brand and consultation website – 'What if Leeds …? Talk today. Shape tomorrow'.

2.5 The Vision Steering group, comprising senior members of the Leeds Initiative's partners, has met three times since January to give their views on progress and inform the consultation process and the thinking behind the consultation document.

3.0 Next steps

3.1 The **public consultation phase** on the new Vision for Leeds runs from September to December 2010. The consultation approach will allow the public to respond on both shorter term priorities and the long term. The exercise will therefore create evidence for the Vision and the Leeds Strategic Plan. A full list of consultation activity both planned and already undertaken is attached at Appendix 3, and includes:

- a printed consultation document available across the city in public buildings, including libraries, community centres and one stop centres;

- a double-page spread and survey in the council's 'About Leeds' September edition;

- a week-long series of articles and features in the Yorkshire Evening Post;

- joint activities and blogs with www.guardian.co.uk/leeds ;

- a bespoke, time-limited website – www.whatifleeds.org - inviting people to get involved in a debate about the kind of city they want Leeds to be and their ideas for how to make it happen;

- 'Whatifleeds' Facebook, LinkedIn and Twitter accounts; and

- consultation with specific interest groups at events across the city;

3.2 The consultation timetable is constantly being added to as we continue to look for more community groups to engage with.

Timetable:

- Close consultation 31 December 2010

- Drafting of final Vision for Leeds document from December 2010 to February 2011

- CLT- LMT- Executive Board approval process

- Partnership approval processes

- Full Council – April 2011

- Formal public launch July 2011

4.0 Recommendations

4.1 That members of the Scrutiny Board are invited to:

4.1.1 note and comment on the work carried out to date to develop a new Vision for Leeds 2011 to 2030

4.1.2 note and comment on the consultation document, 'What if Leeds …'; and

4.1.3 give support to the process of consultation

5.0 Background papers

None

Appendix II

Consultation and communications plans for the Vision for Leeds 2011 to 2030

The sustainable community strategy, the Vision for Leeds 2011 to 2030, is the overarching plan for other local and regional plans and will take into account how they inform one another.

The Government says that it should be:

- based on local needs;
- underpinned by a shared evidence base;
- informed by community aspirations; and
- lead to improvements in the social, environmental and economic wellbeing of the area.
- the starting point for producing a sustainable community strategy is consultation.

Aims of the consultation and communications for the Vision for Leeds 2011 to 2030

The consultation and communications plans will aim to:

- increase public awareness of the Vision and engage meaningfully with local people;
- make sure the links between the Vision and other relevant strategies and plans are clear; and
- enable a wide and diverse range of people to take part and thereby influence the Vision.

Objectives

The consultation and communications plans will enable us to:

- work with partners to avoid duplication, maximise resources and participation and increase opportunities for joint consultation;
- understand the views of members of the public and other stakeholders about the future of Leeds;
- develop an understanding of alternative, innovative methods of consultation as a basis for service improvement;
- develop accessible consultation materials that will appeal to and engage with more Leeds' citizens;
- involve under-represented groups and groups at risk of exclusion;
- share intelligence and information with respect to the consultation outcomes for all partners and key consultees;

- work with partners to make sure that other key strategies are consistent with the Vision document; and

- provide staged feedback to all consultees.

Challenges

Challenges in putting into practice the consultation and communications plans to achieve effective results include:

- persuading a broader range of people to actively engage in the consultation process; and

- working with reduced capacity and limited budget to form a large-scale consultation.

Rationale for the consultation and communications approach

In order to address the issues outlined above an invitation to tender exercise was carried out to appoint an agency to develop a public-facing look and feel to the Vision for Leeds consultation and communications. Evidence has shown that successful consultation exercises that seek to engage with the general public have adopted a campaign approach creating a separate identity rather than using the brand of the commissioning organisation.

A Leeds-based agency, Home, has been appointed to develop a public-facing campaign identity and website for the 'Vision for Leeds' consultation project – 'What if Leeds …? Talk today. Shape tomorrow'.

The aim is to:

- create an inclusive approach to the consultation;

- create an identity which is used on all communications media (website, consultation document, questionnaire) associated with the consultation,

- be instantly recognisable to the public, and

- build up momentum throughout the campaign.

Home has had previous success with this approach for several other public-sector organisations, including 'the Great Drink Debate' campaign for the COI from an original working title of 'Attitudes and behaviour towards alcohol in the Yorkshire & Humber region – a public consultation'. For this they developed a colour palette, imagery, a typography style and a strapline of "Views on booze. What's yours?". The campaign elicited 13,000 responses in three months.

The design proposition – What if Leeds …? Talk today. Shape tomorrow.

The invitation to engage is at the heart of the proposition - the main objective being to get a response and to get people to join in to tell us where they see Leeds by 2030.

In replacement of the working title 'Vision for Leeds', the agency has developed the concept 'What if Leeds…'. And the website www.whatifleeds.org

‘What if Leeds…’ aims to:

- inspire people who live and work in Leeds to think to the long term;
- provoke interest by suggesting there’s more to come;
- pose a question, thus opening up the subject to debate;
- use everyday language that will appeal to a broad demographic; and
- immediately make the campaign ownable to Leeds;

The concept name of ‘What if Leeds…’ is then substantiated with the strapline ‘Talk today. Shape tomorrow’.

‘What if Leeds…’ acts as a stage in the development of the new Vision for Leeds by suggesting points of view that will spark debate, for example:

- what if Leeds has the best quality of life in the UK?
- what if Leeds is the UK’s most family friendly city?
- what if Leeds has the strongest and most sustainable economy in the country?
- what if Leeds …? You tell us!

The owl design device serves as a visual representation of the campaign and gives an alternative to using images of people, which is difficult when representing a broad demographic.

A stand-alone website – whatifleeds.org – has been developed to support our consultation. The website will use social media (Facebook, Twitter, YouTube, Linkedin, Flickr, blogs, etc) to engage a wide demographic. Since the last Vision for Leeds was published, social media has become the most natural and conventional means of communication for a large majority of the population, and, in particular, young people. Recent research carried out by Nielsen showed that more people now communicate using social media than through email and 24 million people actively use Facebook in the UK (50% of these log on to Facebook in any given day) . Three million people are members of social networks associated with Leeds.

Online consultation has a number of other benefits:

- quick and easy responses;
- effective for large-scale consultation – able to reach a wider audience cost-effectively;
- information can be quickly updated;
- environmentally-friendly;
- ‘viral marketing’ can drive traffic to the site (using existing website databases, such as Breeze);
- participants can ask for more information, seek clarification and receive more immediate feedback than from traditional consultation methods;
- it encourages a two-way, more active process – people can pose their own questions rather than being the passive recipients of questions provided by ourselves;

- it gives people the opportunity to debate – something which has found a new voice in popular culture following the televised political debates for the general election;
- online tools allow for effective analysis and evaluation; and
- the website could provide a sustainable consultation platform subsequently.

Other groups e.g. Silver Surfers, and learning groups in libraries, have been approached in order to broaden participation. Guardian.co.uk/leeds is also engaged with the project.

A variety of other methods will be used in order to engage a broad range of audiences and yield both quantitative and qualitative results.

They will include:

- face-to-face (focus groups), particularly targeted at under-represented groups;
- print (newspaper, newsletters etc.) including one week of articles in the Yorkshire Evening Post with real-life case studies, and articles in a range of local newspapers;
- the communications networks of partner organisations;
- online newsletters;
- hard copies of the consultation document to be distributed to a wide range of organisations with public receptions;
- questionnaires;
- attendance at existing local community events and festivals;
- workshops for special interest groups;
- joint consultation with key strategic partners to avoid duplication;
- in-house consultation for schools, FE and HE sectors (young people and adults);
- employee engagement through staff networks (e.g. LCC, NHS); and
- presentations to a range of audiences.

Feedback will be provided to all consultees at staged intervals during the consultation process.

Key consultees will be approached to provide evaluation at the end of the consultation exercise.

Appendix III

Consultation timetable

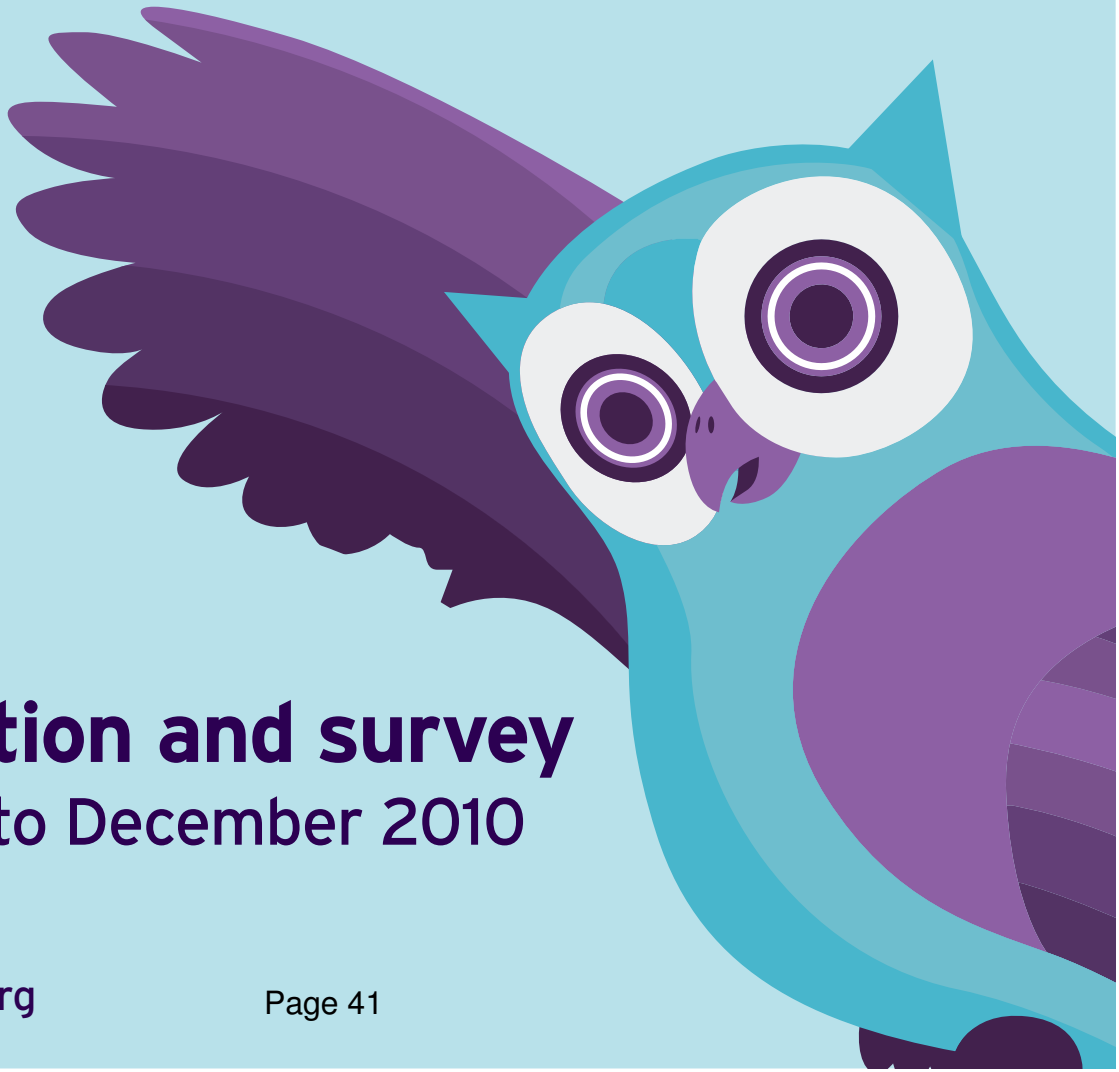
Month	Activity
May 2010	21 May - Open Space (cross-sector event with 20 workshops) 22 May - TINWOLF (Transition Inner North West Of Leeds Forum) event – Reinventing our City – creating community solutions for a sustainable Leeds
June 2010	18 June - LSP challenge event Four-week project in Holy Rosary and St Anne's, Chapeltown for all key stage 2 students Robin Hood Primary pupils and parents event
July 2010	1 July - physical and sensory impairment event – Headingley 6 July - LGB young people 22 July - Hamwattan Elderly Group 22 July - Jewish Older People 26 July - Armley Helping Hands – older people 27 July - Seacroft Older people Launch of e-consultation – email to Breezecard database Breeze on Tour events
August 2010	3 August - Leeds Black Elders 4 August - PACTS (Police and Communities Together) meeting Hunslet 6 August - Leeds Irish older people, Harehills 8 August – Community Interfaith Event - Beeston 10 August – Meeting with disabled adults (Leeds Involving People) 11 August - Together for Peace – DIY Vision event for businesses 18 August - Morley Elderly Action

September 2010	2 September – Otley community groups (Otley Town Council) 3 September – Culture Vultures 'Tales of the City' 21 September - BettaKultcha (social media networking) Business event with Leeds Ahead Scrutiny Board meetings Schools - Whitecote Primary, Bramley - Garforth Comprehensive - New Bewerley Primary, Beeston - Cookridge Primary - Rodillian School(disabled young people) Institute of Directors - email to contact list 1500+ plus events Youth Council Women's Group (Hamara Centre) Area management events
October 2010	Leeds Metropolitan University University of Leeds Leeds City College October 21 LINk Focus group GATE (Leeds Gypsy and Traveller Exchange) Focus group ROMA community Disabled young people Leeds Chinese Community including businesses Leeds Chamber Business Forum event LINk event
November 2010	Focus group MESMAC (LGB) PACTS meeting Wetherby 18 November – Equalities Assembly Conference

This page is intentionally left blank

What if **Leeds...**

Talk today. ***Shape tomorrow***



Consultation and survey

September to December 2010

Want to have your say?
Visit whatifleeds.org

If you want to have your say on the future of your city then our website offers you the chance to do so, right now.

Visit whatifleeds.org to submit your answers to the survey quickly and easily. You can also search for and join the debates that are of interest to you. And, if you have something you want to talk about, you can bring up a topic that has yet to be discussed.

Join in the debate at whatifleeds.org

What if Leeds... is your chance to shape the long-term future of the city through our public consultation to develop a Vision for Leeds 2011 to 2030.

The Leeds Initiative is the city's local strategic partnership. Founded in 1990, we bring together a wide range of people and organisations from the public, private, community, voluntary and faith sectors to work together to improve the city and overcome problems for the benefit for everyone. We work with over 500 organisations throughout the city. Our formal partners include:

Leeds City Council
Leeds, York and North Yorkshire Chamber of Commerce and Industry
Third Sector Leeds
Arts Council
Education Leeds
English Heritage
Environment Agency
Government Office Yorkshire and The Humber
Highways Agency
Jobcentre Plus
Leeds City College
Leeds Civic Trust
Leeds Faiths Forum
Leeds Metropolitan University
Leeds Partnership Foundation Trust
Leeds Teaching Hospitals Trust
Leeds Voice
Museums Libraries & Archives Yorkshire
NHS Leeds
Natural England
Skills Funding Agency
Sport England
University of Leeds
West Yorkshire Fire and Rescue Service
West Yorkshire Metro
West Yorkshire Police
West Yorkshire Police Authority
West Yorkshire Probation Service
Yorkshire Forward
Youth Offending Service

All our documents, and the notes of all our meetings, are on our website at www.leedsinitiative.org

We can make this document available in Braille, large print and audio format on request.

A new Vision for Leeds

The Leeds Initiative, the partnership organisation for the city led by Leeds City Council, is developing a new, long-term plan for the future of the city. It is called Vision for Leeds 2011 to 2030, which is also the sustainable community strategy for the Leeds area. This Vision will also help to decide the shorter term priorities that need to be delivered for the city over the next three years.

This document is a consultation and sets out principles and broad aims. It provides an opportunity to debate, raise issues and challenges as we seek to gain agreement. The Leeds Initiative will engage with the people of Leeds to develop this Vision. Each place and community can and will benefit from thinking through how the Vision will be made real for them, for example, in individual neighbourhoods or places of business, in the city centre or our market towns.

A Vision for all of Leeds

This Vision is for everyone who lives and works in the Leeds Metropolitan District, an area covering 217 square miles. Leeds is the second largest metropolitan authority in the country and the largest in the north of England. It is a rich and varied place, including a vibrant city centre - well known for its shopping and nightlife – with built-up areas surrounding it, some more rural areas, and several towns and villages. These stretch from Otley in the north-west, Wetherby in the north-east, the rural areas of Bramham and Aberford to the east, Rothwell, Allerton Bywater and Methley to the south and south-east, and Pudsey and Morley to the west and south-west. A unique and distinctive place, two-thirds of the district is green belt and is in easy reach of two national parks.

Leeds is a city of 750,200 people[1]. In general, people are living longer and Leeds has as many people over 60 as under 16. There is a higher proportion of young people than the national average, including a large student population. Leeds is also a city with many cultures, languages, races and faiths. 11% of our population is made up of people from black and ethnic-minority communities[2].

Leeds is the regional capital and the main economic driver for Yorkshire with major road, rail and air connections to neighbouring towns and cities and to national and international networks. The city is home to some of the largest financial institutions in the country and is known as the leading financial and legal centre in the UK outside London. It has a varied economy, excellent universities and world-class culture and sport. Despite becoming wealthier as a city over the last 20 years, Leeds still has too many deprived areas, where there is a poor quality of life, low educational performance, too much crime and anti-social behaviour, poor housing, and families where no-one has worked for generations. We need to continue to tackle the multiple problems of poverty and to improve all parts of Leeds.

1 Office of National Statistics, 2006

2 Census of Population 2001

A changing environment

We last published a long-term plan for the city in 2004. This set out a plan to 2020, much of which has been achieved or is underway. But since then much has changed both globally and locally, which is why we are now revising this plan. We are facing a series of major challenges following the global recession, which has led to a significant fall in the public money available to spend. Nevertheless, we still have to think ahead and plan for future success. We have set out some of the other main changes below.

Tackling climate change

In 2004 there was little public information on how climate change would affect our city. Regardless of the reasons for our changing weather patterns, it is generally accepted that climate change is a fact. In Leeds we have already seen how small changes can have a dramatic impact on our daily lives – such as the flooding which caused havoc to our communities and businesses. We are also using up the planet's natural resources at an alarming speed – as early as 2020 our demand for oil could exceed supply. We need to plan for this and look at alternatives.

Responding to the global recession

Over the last ten years, Leeds has gained a national reputation as a city of economic growth, creating jobs in a range of industries and sectors. But the recession has posed a number of serious questions about the future of our local economy. There has been a real impact on some of Leeds' key sectors, including construction, and business and financial services. Combined with the challenge of tackling climate change, we will also need to find new ways to remain competitive.

Anticipating changes to our population

Leeds' population is forecast to grow.
This growth will include:

- greater numbers of children and young people;
- more people aged 75 years and over; and
- more people from black, ethnic-minority and mixed race backgrounds.

Like other successful big cities, it is also likely we will attract a larger number of people from elsewhere in the UK and EU. We need to start planning now to make sure that the city can manage these predicted changes to our population.

We are facing a series of major challenges following the global recession, nevertheless we still have to think ahead and plan for future success.

What we have achieved since 2004

In 2004 we set the direction for the future of Leeds.

"Our Vision for Leeds is an internationally competitive European city at the heart of a prosperous region where everyone can enjoy a high quality of life."

The three aims of the current Vision are:

1 "Going up a league as a city – making Leeds an internationally competitive city – the best place in the country to live, work and learn, with a high quality of life for everyone."

This aimed to capture the magical mixture of economic development, quality of life and competitiveness that makes cities great, and makes them recognised in the world. We are now firmly established as an international city and are named as one of the top 30 European cities in which to do business[1]. But there is still more to do, and the current economic situation has given us new challenges.

2 "Narrowing the gap between the most disadvantaged people and communities and the rest of the city."

We have 'narrowed the gap' – but not enough and not always with lasting results. We have made good progress in achieving some targets – our young people are getting better exam results, the number of people smoking has fallen, and fewer of our neighbourhoods are in the 3% most deprived in the country.

But progress remains slow in other areas such as the health gap between our richer and poorer areas. Despite all our efforts, one in five people in Leeds still lives in poverty. Many people are unable to afford to heat their homes adequately, live in poor quality housing, and lose out further because they cannot access basic financial services that many of us take for granted.

3 "Developing Leeds' role as the regional capital, contributing to the national economy as a competitive European city, supporting and supported by a region that is becoming increasingly prosperous."

Leeds is now firmly established as the regional capital. We are working closely together with ten other local authorities to develop a regional approach, which recognises the impact of Leeds' economic strength on the wider Leeds area, and have created ways of planning more effectively at that level.

The Vision for Leeds 2004 to 2020 also set out twelve priority projects, based on what the people of Leeds told us was important, to improve the quality of life in the city and the region. You can read more about our progress on these projects on our website - www.leedsinitiative.org

Our challenge for the future

Our challenge now in 2010 is to look to the future beyond the plans we have set to think through the big issues affecting Leeds and how we tackle them.
We need to look again at where the city is going and ask ourselves where we want to be in 2030.
For example:

- **What if Leeds has the best quality of life in the UK?**
- **What if Leeds is the UK's most family friendly city?**
- **What if Leeds has the strongest and most sustainable economy in the country?**
- **What if Leeds ...? You tell us!**

1 Cushman & Wakefield's European Cities Monitor

Developing our new Vision

The Leeds Initiative's partners regularly listen to people's views on how we can improve. We have used these day-to-day insights to help us make a start on developing some new aims for the city. In addition, over the last year, we have held events and workshops with many of Leeds' organisations and people, who have also told us how they think Leeds should develop in the future. All of this has resulted in the following proposals about where we should aim to be as a city by 2030. We now want your views on these.

Our Vision

By 2030, Leeds will be internationally recognised as the best city in Britain - a city that is fair, open and welcoming with a prosperous and sustainable economy, a place where everyone can lead safe, healthy and successful lives.

Our aims

By 2030, Leeds will be fair, open and welcoming.

Leeds will be a place where everyone has an equal chance to live their life successfully and realise their potential. Leeds will embrace new ideas, involve local people, and welcome visitors and those who come here to live, work and learn.

To do this Leeds will be a city where:

- people from different backgrounds and ages feel comfortable living together in communities;
- people are treated with dignity and respect at all stages of their lives;
- we all behave responsibly;
- people have a shared sense of belonging;
- there are good relations within and between communities;
- the causes of unfairness are understood and addressed;
- people feel confident about doing things for themselves and others;
- our services meet the diverse needs of our changing population;
- people can access support where and when it is needed;
- local people have the power to make decisions that affect us;
- people are active and involved in their local communities; and
- everyone is proud to live and work.

Developing our new Vision (Continued)

By 2030, Leeds' economy will be prosperous and sustainable.

We will create a prosperous and sustainable economy, using our resources effectively. Leeds will be successful and well-connected offering a good standard of living. Our culture of being excellent at everything we do will create a great quality of life for all.

Leeds will be a city that has:

- a strong local economy driving sustainable economic growth;
- a skilled workforce to meet the needs of the local economy;
- a world-class cultural offer;
- built on its strengths in financial and business services, and manufacturing, and continued to grow its strong retail, leisure and tourism sectors;
- world-class, cultural, digital and creative industries;
- developed new opportunities for green manufacturing and for growing other new industries;
- improved levels of enterprise through creativity and innovation;
- work for everyone with secure, flexible employment and good wages;
- high-quality, accessible, affordable and reliable public transport;
- successfully achieved a 40% reduction in carbon emissions (by 2020);
- adapted to changing weather patterns;
- increased use of alternative energy supplies and locally produced food; and
- buildings that meet high sustainability standards in the way they are built and run.

By 2030, Leeds' communities will be safe, healthy and successful.

Everyone has the opportunity to be safe, successful and secure, and lead happy, healthy and fulfilling lives. Leeds' communities will thrive and people will be confident, skilled, enterprising, active and involved.

To do this Leeds will be a city where:

- people have the opportunity to get out of poverty;
- education and training helps more people to achieve their potential;
- communities are safe and people feel safe;
- all Leeds' homes are of a decent standard and everyone can afford to stay warm;
- healthy life choices are easier to make;
- community-led businesses meet local needs;
- local services, including shops and healthcare, are easy to access and meet our needs;
- local cultural and sporting activities are available to all;
- there are high quality buildings, places and green spaces, and
- happiness forms the basis of a good quality of life.

How will our Vision affect different places?

Our Vision needs to be relevant to all our local communities and neighbourhoods, as well as the city centre, Yorkshire region, nationally and internationally.

We have outlined below a few examples of how some of the ideas in this Vision will affect these different places.

Leeds neighbourhoods

Each community will be unique, but they can all be safe and inclusive, well planned, built and run, offering prosperity, good services and opportunities for all. We will work hard to release the potential of everyone in Leeds to make sure the Vision aims are achieved in every neighbourhood. To do this we will work with residents as equal partners who can determine their own and their communities' future. Services will be developed and delivered with local people, including older and younger people, and people of all abilities to be active and involved citizens.

Leeds city centre

Our city centre will be a key economic driver not just for the Yorkshire region, but for the country as a whole. It will remain one of the UK's leading retail destinations and a major draw for businesses and visitors alike, welcoming and well connected. It will be a place that is sustainable with a high quality environment and cultural offer, and a city that is safe, family-friendly and attractive to people of all ages and backgrounds.

Leeds Metropolitan District

Leeds is already committed to a 40% reduction in the carbon put into the atmosphere by 2020. This is a stretching target for the whole district, which requires Leeds' residents and organisations to work together to make it happen. The Leeds Climate Change Strategy has set the direction for the city. Now the partners are planning the actions in transport, and managing buildings, including homes, and business operations. We will need to challenge and support each other to develop the new ideas needed to achieve such a challenging target. We will also need to engage with the imagination and creativity of the people of Leeds so that they can contribute.

Leeds City Region

By working with the Leeds City Region[1], we will create a sustainable and prosperous economy by engaging with business and our partners across the wider Leeds area. Working together we will achieve better results for our local economy, skills, housing, transport and innovation.

Leeds' role nationally and internationally

Leeds will punch its weight as a leading city nationally, making sure that decision makers and opinion formers understand the city and what it offers and the needs of its communities. We will make sure that Leeds gets its fair share of investment and funding. We will work to improve the reputation of the city nationally and internationally as the natural alternative to London, for investment, employment and a great quality of life.

1 The Leeds City Region brings together the eleven local authorities of Barnsley, Bradford, Calderdale, Craven, Harrogate, Kirklees, Leeds, Selby, Wakefield, York and North Yorkshire County Council to work together on areas such as transport, skills, housing, planning and innovation.

What if Leeds works together?

The success of our city depends on all of us working together to make sure that our Vision and all our plans and strategies are robust and have been tested and challenged. We will make sure that we continue to work in partnership and with local communities to achieve the best for the people of Leeds.

We will listen to different points of view, we will be honest, open and straightforward – saying what we mean, and meaning what we say. We will use evaluation and evidence to make sure we make progress with our priorities.

You can join the debate by:

Visiting whatifleeds.org

Sending us a tweet @whatifleeds

Visiting us at facebook.com/whatifleeds

Visiting us at whatifleeds.org/linkedin

What if you had your say?

Before we finalise the Vision for Leeds 2011 to 2030, we would like the views of as many people as possible that live or work in all parts of Leeds. We would also like your thoughts on the priorities for the next three years.

This survey is one way of telling us your views. Please take a few minutes to answer the questions on the following pages and return this survey (together with any extra comments) to the address shown (you do not need a stamp).

Why not have a conversation about the ideas in this draft Vision with friends, at work, or in your clubs and associations and tell us what you think?

Survey

What if Leeds … becomes the best city in the UK?

What does this mean to you? How would you make this happen?

What if Leeds … becomes fair, open and welcoming?

What does this mean to you? How would you make this happen?

What if Leeds … has a prosperous and sustainable economy?

What does this mean to you? How would you make this happen?

What if Leeds' communities are safe, healthy and successful?

What does this mean to you? How would you make this happen?

Thinking about the next three years, what if you could choose …?

What would the top priorities for the city be in the next few years? What are the big issues you think we need to tackle as a city?

We want to make sure that the final version of the Vision for Leeds 2011 to 2030 is accessible to people. Please tell us your favourite options.

☐ A printed document ☐ An online document ☐ An online film or podcast ☐ A DVD
☐ Other (please specify)

About you

To help us make sure that we reach as wide a range of people as possible, it would help us if you could answer the questions below. The information you provide will be kept confidential.

☐ Male ☐ Female Year of birth First part of postcode (e.g. LS10)

Ethnic origin: Please choose one section from A to E and then tick the appropriate box to indicate your ethnic background.

A. White	B. Mixed Race	C. Asian or Asian British	D. Black or Black British	E. Other ethnic groups
☐ British ☐ Irish ☐ Any other White background please write below	☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Any other Mixed background please write below	☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Kashmiri ☐ Any other Asian background please write below	☐ Caribbean ☐ African ☐ Any other Black background please write below	☐ Chinese ☐ Gypsy/Traveller ☐ Any other background please write below

Do you consider yourself to be disabled? ☐ Yes ☐ No

Type of disability:

☐ Physical – such as using a wheelchair to get around or difficulty using your arms
☐ Sight or hearing problems – such as being blind or partially blind, or deaf or partially deaf
☐ Mental health condition – such as depression or schizophrenia
☐ Learning disability – such as Down's syndrome or dyslexia – or difficulties in thinking, planning, and memory – such as autism or brain injury
☐ Long-standing illness or health condition – such as cancer, HIV, diabetes, chronic heart disease, or epilepsy

Sexual orientation: ☐ Heterosexual/straight ☐ Lesbian/gay woman ☐ Gay man ☐ Bisexual

Religion or belief: Please tick the appropriate box to describe your religion or belief

☐ Buddhist ☐ Christian ☐ Hindu ☐ Jewish
☐ Muslim ☐ Sikh ☐ No religion ☐ Other (please specify)

MOISTEN HERE

FREEPOST PLUS RSCS-ZTJU-CLXH
Leeds City Council
Merrion House
110 Merrion Centre
Merrion Way
Leeds
LS2 8ET

For Leeds Initiative, Fisrt Floor West, Civic Hall

What if Leeds...
Talk today. Shape tomorrow

Mixed Sources
Product group from well-managed forests and other controlled source
www.fsc.org Cert no. SGS COC 3059
© 1996 Forest Stewardship Council

the Leeds Initiative

HA/TP/SC/08.10/8K

Published by The Leeds Initiative, August 2010

Appendix 2

Consultation and communications plans for the Vision for Leeds 2011 to 2030

The sustainable community strategy, the Vision for Leeds 2011 to 2030, is the overarching plan for other local and regional plans and will take into account how they inform one another.

The Government says that it should be:

- based on local needs;
- underpinned by a shared evidence base;
- informed by community aspirations; and
- lead to improvements in the social, environmental and economic wellbeing of the area.
- the starting point for producing a sustainable community strategy is consultation.

Aims of the consultation and communications for the Vision for Leeds 2011 to 2030

The consultation and communications plans will aim to:

- increase public awareness of the Vision and engage meaningfully with local people;
- make sure the links between the Vision and other relevant strategies and plans are clear; and
- enable a wide and diverse range of people to take part and thereby influence the Vision.

Objectives

The consultation and communications plans will enable us to:

- work with partners to avoid duplication, maximise resources and participation and increase opportunities for joint consultation;
- understand the views of members of the public and other stakeholders about the future of Leeds;
- develop an understanding of alternative, innovative methods of consultation as a basis for service improvement;
- develop accessible consultation materials that will appeal to and engage with more Leeds' citizens;
- involve under-represented groups and groups at risk of exclusion;
- share intelligence and information with respect to the consultation outcomes for all partners and key consultees;

- work with partners to make sure that other key strategies are consistent with the Vision document; and

- provide staged feedback to all consultees.

Challenges

Challenges in putting into practice the consultation and communications plans to achieve effective results include:

- persuading a broader range of people to actively engage in the consultation process; and

- working with reduced capacity and limited budget to form a large-scale consultation.

Rationale for the consultation and communications approach

In order to address the issues outlined above an invitation to tender exercise was carried out to appoint an agency to develop a public-facing look and feel to the Vision for Leeds consultation and communications. Evidence has shown that successful consultation exercises that seek to engage with the general public have adopted a campaign approach creating a separate identity rather than using the brand of the commissioning organisation.

A Leeds-based agency, Home, has been appointed to develop a public-facing campaign identity and website for the 'Vision for Leeds' consultation project – 'What if Leeds …? Talk today. Shape tomorrow'.

The aim is to:

- create an inclusive approach to the consultation;

- create an identity which is used on all communications media (website, consultation document, questionnaire) associated with the consultation,

- be instantly recognisable to the public, and

- build up momentum throughout the campaign.

Home has had previous success with this approach for several other public-sector organisations, including 'the Great Drink Debate' campaign for the COI from an original working title of 'Attitudes and behaviour towards alcohol in the Yorkshire & Humber region – a public consultation'. For this they developed a colour palette, imagery, a typography style and a strapline of "Views on booze. What's yours?". The campaign elicited 13,000 responses in three months.

The design proposition – What if Leeds …? Talk today. Shape tomorrow.

The invitation to engage is at the heart of the proposition - the main objective being to get a response and to get people to join in to tell us where they see Leeds by 2030.

In replacement of the working title 'Vision for Leeds', the agency has developed the concept 'What if Leeds…'. And the website www.whatifleeds.org

‘What if Leeds…’ aims to:

- inspire people who live and work in Leeds to think to the long term;
- provoke interest by suggesting there’s more to come;
- pose a question, thus opening up the subject to debate;
- use everyday language that will appeal to a broad demographic; and
- immediately make the campaign ownable to Leeds;

The concept name of ‘What if Leeds…’ is then substantiated with the strapline ‘Talk today. Shape tomorrow’.

‘What if Leeds…’ acts as a stage in the development of the new Vision for Leeds by suggesting points of view that will spark debate, for example:

- what if Leeds has the best quality of life in the UK?
- what if Leeds is the UK’s most family friendly city?
- what if Leeds has the strongest and most sustainable economy in the country?
- what if Leeds …? You tell us!

The owl design device serves as a visual representation of the campaign and gives an alternative to using images of people, which is difficult when representing a broad demographic.

A stand-alone website – whatifleeds.org – has been developed to support our consultation. The website will use social media (Facebook, Twitter, YouTube, Linkedin, Flickr, blogs, etc) to engage a wide demographic. Since the last Vision for Leeds was published, social media has become the most natural and conventional means of communication for a large majority of the population, and, in particular, young people. Recent research carried out by Nielsen showed that more people now communicate using social media than through email and 24 million people actively use Facebook in the UK (50% of these log on to Facebook in any given day) . Three million people are members of social networks associated with Leeds.

Online consultation has a number of other benefits:

- quick and easy responses;
- effective for large-scale consultation – able to reach a wider audience cost-effectively;
- information can be quickly updated;
- environmentally-friendly;
- ‘viral marketing’ can drive traffic to the site (using existing website databases, such as Breeze);
- participants can ask for more information, seek clarification and receive more immediate feedback than from traditional consultation methods;

- it encourages a two-way, more active process – people can pose their own questions rather than being the passive recipients of questions provided by ourselves;
- it gives people the opportunity to debate – something which has found a new voice in popular culture following the televised political debates for the general election;
- online tools allow for effective analysis and evaluation; and
- the website could provide a sustainable consultation platform subsequently.

Other groups e.g. Silver Surfers, and learning groups in libraries, have been approached in order to broaden participation. Guardian.co.uk/leeds is also engaged with the project.

A variety of other methods will be used in order to engage a broad range of audiences and yield both quantitative and qualitative results.

They will include:

- face-to-face (focus groups), particularly targeted at under-represented groups;
- print (newspaper, newsletters etc.) including one week of articles in the Yorkshire Evening Post with real-life case studies, and articles in a range of local newspapers;
- the communications networks of partner organisations;
- online newsletters;
- hard copies of the consultation document to be distributed to a wide range of organisations with public receptions;
- questionnaires;
- attendance at existing local community events and festivals;
- workshops for special interest groups;
- joint consultation with key strategic partners to avoid duplication;
- in-house consultation for schools, FE and HE sectors (young people and adults);
- employee engagement through staff networks (e.g. LCC, NHS); and
- presentations to a range of audiences.

Feedback will be provided to all consultees at staged intervals during the consultation process.

Key consultees will be approached to provide evaluation at the end of the consultation exercise.

Appendix 3

Consultation timetable

Month	Activity
May 2010	21 May - Open Space (cross-sector event with 20 workshops) 22 May - TINWOLF (Transition Inner North West Of Leeds Forum) event – Reinventing our City – creating community solutions for a sustainable Leeds
June 2010	18 June - LSP challenge event Four-week project in Holy Rosary and St Anne's, Chapeltown for all key stage 2 students Robin Hood Primary pupils and parents event
July 2010	1 July - physical and sensory impairment event – Headingley 6 July - LGB young people 22 July - Hamwattan Elderly Group 22 July - Jewish Older People 26 July - Armley Helping Hands – older people 27 July - Seacroft Older people Launch of e-consultation – email to Breezecard database Breeze on Tour events
August 2010	3 August - Leeds Black Elders 4 August - PACTS (Police and Communities Together) meeting Hunslet 6 August - Leeds Irish older people, Harehills 8 August – Community Interfaith Event - Beeston 10 August – Meeting with disabled adults (Leeds Involving People) 11 August - Together for Peace – DIY Vision event for businesses 18 August - Morley Elderly Action

September 2010	2 September – Otley community groups (Otley Town Council) 3 September – Culture Vultures 'Tales of the City' 21 September - BettaKultcha (social media networking) Business event with Leeds Ahead Scrutiny Board meetings Schools - Whitecote Primary, Bramley - Garforth Comprehensive - New Bewerley Primary, Beeston - Cookridge Primary - Rodillian School(disabled young people) Institute of Directors - email to contact list 1500+ plus events Youth Council Women's Group (Hamara Centre) Area management events
October 2010	Leeds Metropolitan University University of Leeds Leeds City College October 21 LINk Focus group GATE (Leeds Gypsy and Traveller Exchange) Focus group ROMA community Disabled young people Leeds Chinese Community including businesses Leeds Chamber Business Forum event LINk event
November 2010	Focus group MESMAC (LGB) PACTS meeting Wetherby 18 November – Equalities Assembly Conference

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 21 September 2010

Subject: Equity and Excellence: Liberating the NHS – White Paper

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

1.0 Purpose

1.1 The purpose of this report is to provide details of the new Government's overall vision for the future of the NHS via its White Paper, '*Equity and excellence: Liberating the NHS'* – which sets out key proposals for change and reform. This paper also seeks to introduce a range of inputs from local stakeholders around the proposals and likely implications.

2.0 Background

2.1 In early July 2010, the new Government published its overall vision for the future of the NHS via its White Paper, '*Equity and excellence: Liberating the NHS'* – which set out key proposals for change and reform. In mid-July 2010, under the umbrella of the White Paper the Government also published a suite of consultation papers setting out more specific and detailed proposals. The current consultation documents are:

- Equity and Excellence: Liberating the NHS – White Paper (executive summary attached at Appendix 1);
- Transparency in outcomes – a framework for the NHS (executive summary attached at Appendix 2);
- Local democratic legitimacy in health (full consultation document attached at Appendix 3);
- Commissioning for patients (executive summary attached at Appendix 4);
- Regulating healthcare providers (executive summary attached at Appendix 5).

2.2 Full copies of each consultation document are available on request, or can be accessed via the Department of Health (DH) at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

2.3 In addition, the Government's vision for the NHS and the associated actions have been set out in a draft Structural Reform Plan (SRP). This document (attached at Appendix 6) provides a useful summary of priorities, associated actions and key milestones.

3.0 Liberating the NHS – proposals and implications.

3.1 The Board was first made aware of the NHS change and reform proposals at its previous meeting on 27 July 2010. At that stage, the Board agreed to establish a working group to consider the proposals in more detail (in particular those concerned with for local democratic legitimacy in health) and consider drafting a consultation response. To date, that working group has not met.

3.2 Nonetheless, this report and its appendices provide a range of information for members of the Scrutiny Board (Health) to consider in detail. Furthermore, a range of local stakeholder organisations have been invited to attend the meeting to outline their views on the proposals and the associated implications.

3.3 In the short-term, the information provided in this report may assist the Board in drafting a consultation response. In the longer-term, it may also help the Board identify and maintain an overview of any specific matters associated with local implementation of the proposals.

4.0 Recommendations

4.1 Members are asked to consider the details presented in this report and:

4.1.1 Confirm the Board's intention regarding the submission of a consultation response on the proposals set out in this report, and identify any specific matters to be included (if appropriate);

4.2 Consider and identify any specific matters associated with local implementation of the proposals to be included in the Board's future work programme.

5.0 Background Documents

None

Equity and excellence: Liberating the NHS

White Paper executive summary

1. The Government upholds the values and principles of the NHS: of a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay.
2. We will increase health spending in real terms in each year of this Parliament.
3. Our goal is an NHS which achieves results that are amongst the best in the world.

Putting patients and public first

4 We will put patients at the heart of the NHS, through an information revolution and greater choice and control:

a) Shared decision-making will become the norm: no decision about me without me.

b) Patients will have access to the information they want, to make choices about their care. They will have increased control over their own care records.

c) Patients will have choice of any provider, choice of consultant-led team, choice of GP practice and choice of treatment. We will extend choice in maternity through new maternity networks.

d) The Government will enable patients to rate hospitals and clinical departments according to the quality of care they receive, and we will require hospitals to be open about mistakes and always tell patients if something has gone wrong.

e) The system will focus on personalised care that reflects individuals' health and care needs, supports carers and encourages strong joint arrangements and local partnerships.

f) We will strengthen the collective voice of patients and the public through arrangements led by local authorities, and at national level, through a powerful Commission.

g) We will seek to ensure that everyone, whatever their need or background, benefits from these arrangements.

Improving healthcare outcomes

5 To achieve our ambition for world-class healthcare outcomes, the service must be focused on outcomes and the quality standards that deliver them. The Government's objectives are to reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all:

h) The NHS will be held to account against clinically credible and evidence-based outcome measures, not process targets. We will remove targets with no clinical justification.

i) A culture of open information, active responsibility and challenge will ensure that patient safety is put above all else, and that failings such as those in Mid-Staffordshire cannot go undetected.

j) Quality standards, developed by NICE, will inform the commissioning of all NHS care and payment systems. Inspection will be against essential quality standards.
k) We will pay drug companies according to the value of new medicines, to promote innovation, ensure better access for patients to effective drugs and improve value for money. As an interim measure, we are creating a new Cancer Drug Fund, which will operate from April 2011; this fund will support patients to get the drugs their doctors recommend.
l) Money will follow the patient through transparent, comprehensive and stable payment systems across the NHS to promote high quality care, drive efficiency, and support patient choice.
m) Providers will be paid according to their performance. Payment should reflect outcomes, not just activity, and provide an incentive for better quality.

Autonomy, accountability and democratic legitimacy

6 The Government's reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level:
n) The forthcoming Health Bill will give the NHS greater freedoms and help prevent political micromanagement.
o) The Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia.
p) To strengthen democratic legitimacy at local level, local authorities will promote the joining up of local NHS services, social care and health improvement.
q) We will establish an independent and accountable NHS Commissioning Board. The Board will lead on the achievement of health outcomes, allocate and account for NHS resources, lead on quality improvement and promoting patient involvement and choice. The Board will have an explicit duty to promote equality and tackle inequalities in access to healthcare. We will limit the powers of Ministers over day-to-day NHS decisions.
r) We aim to create the largest social enterprise sector in the world by increasing the freedoms of foundation trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises. All NHS trusts will become or be part of a foundation trust.
s) Monitor will become an economic regulator, to promote effective and efficient providers of health and care, to promote competition, regulate prices and safeguard the continuity of services.
t) We will strengthen the role of the Care Quality Commission as an effective quality inspectorate across both health and social care.
u) We will ring-fence the public health budget, allocated to reflect relative population health outcomes, with a new health premium to promote action to reduce health inequalities.

Cutting bureaucracy and improving efficiency

7 The NHS will need to achieve unprecedented efficiency gains, with savings reinvested in front-line services, to meet the current financial challenge and the future costs of demographic and technological change:

v) The NHS will release up to £20 billion of efficiency savings by 2014, which will be reinvested to support improvements in quality and outcomes.

w) The Government will reduce NHS management costs by more than 45% over the next four years, freeing up further resources for front-line care.

x) We will radically delayer and simplify the number of NHS bodies, and radically reduce the Department of Health's own NHS functions. We will abolish quangos that do not need to exist and streamline the functions of those that do.

Conclusion: making it happen

8 We will maintain constancy of purpose. This White Paper[1] is the long-term plan for the NHS in this Parliamentary term and beyond. We will give the NHS a coherent, stable, enduring framework for quality and service improvement. The debate on health should no longer be about structures and processes, but about priorities and progress in health improvement for all.

9 This is a challenging and far-reaching set of reforms, which will drive cultural changes in the NHS. We are setting out plans for managing change, including the transitional roles of strategic health authorities and primary care trusts. Implementation will happen bottom-up.

10 Many of the commitments made in the White Paper of which this is an executive summary require primary legislation and are subject to Parliamentary approval.

Responding to the White Paper

We are consulting on how best to implement these changes and draw your attention to the full version of the White Paper and to related consultation documents, available on the Department of Health website at www.dh.gov.uk/liberatingthenhs. In particular, the Department would welcome comments on the implementation of the proposals requiring primary legislation, and will publish a response to the views raised on the White Paper and the associated papers, prior to the introduction of the Bill. Comments should be sent to: nhswhitepaper@dh.gsi.gov.uk or the White Paper Team, Room 601, Department of Health, 79 Whitehall, London SW1A 2NS.

This page is intentionally left blank

Liberating the NHS:

Transparency in outcomes - a framework for the NHS

A consultation on proposals

For the last 10 years, our doctors and nurses have been forced to meet government targets that often did little to improve patients' health. We want to free the NHS to work towards what really matters to patients and clinicians – what actually happens to the patient's health as a result of the treatment and care they receive. We want to create an NHS that is transparent about the outcomes it is achieving for patients.

What will the NHS Outcomes Framework do?

- It will help patients, the public and Parliament understand how well the NHS overall is doing in terms of improving the health outcomes of the patients it treats and cares for.
- It will allow the Secretary of State for Health to hold a new NHS Commissioning Board to account for the outcomes it is securing for patients. This new Board will be independent of the Government and responsible for allocating a budget of approximately £80bn to groups of GPs who will then purchase healthcare services to meet the needs of their local populations
- Through greater transparency, it will help drive improvements in what actually happens to patients' health as a result of the treatment and care they receive – patients' health outcomes.

What will be included in the NHS Outcomes Framework?

The proposed NHS Outcomes Framework is structured around five high level outcome domains. These are intended to cover everything the NHS is there to do. These five outcome domains are

- Preventing people from dying prematurely
- Enhancing the quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury

EFFECTIVENESS

- Ensuring people have a positive experience of care

PATIENT EXPERIENCE

- Treating and caring for people in a safe environment and protecting them from avoidable harm

SAFETY

Each of these five areas would have:

- An **overarching outcome indicator** (or set of indicators) to measure the overall progress of the NHS across the breadth of activity covered by the domain
- A small number of **specific improvement areas** where the evidence suggests better outcomes are possible or areas that are identified as being particularly important to patients
- **Supporting Quality Standards** developed by the National Institute for Health and Clinical Excellence (NICE) to help patients, clinicians and commissioners understand how to deliver better care.

The NHS Outcomes Framework will be based on the following principles:

- **Accountability and transparency**
- **Balanced** – Outcomes will be chosen to look across the whole NHS
- **Internationally Comparable** – So that the NHS can be compared against other countries
- **Focussed on what matters to patients and clinicians**
- **Promoting excellence and equality**
- **Focussed on outcomes that the NHS can influence but working in partnership with other public services where required** – The NHS Outcomes Framework should explain where public health interventions and or social care services are also responsible for an outcome
- **Evolving over time** – The NHS Outcomes Framework will be based on what we can measure now, but will be updated in coming years

Why are we consulting on this?

We need your help in developing this national Outcomes Framework for the NHS. We need to know about what matters to you to ensure the NHS Outcomes Framework is as good as it can be. The consultation document can be viewed and downloaded at www.dh.gov.uk/liberatingtheNHS

How to get involved?

You can respond to this consultation by:

- coming along to one of our regional events for NHS staff and patients which will be held across the country, details of which will be posted on the DH website shortly; or
- responding to the questions in this document by completing a template which can be downloaded from our website at www.dh.gov.uk/liberatingtheNHS and returning it to us by 11 October 2010 via
    - *email:* nhswhitepaper@dh.gsi.gov.uk
    - *post:* Consultation Responses
      Quality and Outcomes Policy Team
      Room 602A, Skipton House
      80 London Road
      London
      SE1 6LH

NHS

Liberating the NHS:

Local democratic legitimacy in health

A consultation on proposals

Communities and Local Government

DH Department of Health

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Consultation/Discussion
Gateway Reference	14531
Title	Local Democratic Legitimacy in Health
Author	Department of Health & Communities and Local Government
Publication Date	22 Jul 2010
Target Audience	PCT CEs, Care Trust CEs, Directors of PH, Local Authority CEs, Directors of Adult SSs, PCT Chairs, GPs, Directors of Children's SSs
Circulation List	PCT CEs, Care Trust CEs, Directors of PH, Local Authority CEs, Directors of Adult SSs, PCT Chairs, GPs, Directors of Children's SSs, Voluntary Organisations/NDPBs
Description	The document sets out proposals to strengthen the role of local government in health by: i) local authorities taking on local public health improvement functions; ii) local authorities having a new role in promoting integration; and iii) Local HealthWatch organisations acting as independent consumer champions, accountable to local authorities.
Cross Ref	Equity and Excellence: Liberating the NHS (July 2010)
Superseded Docs	
Action Required	Interested parties should respond to the consultation
Timing	**Respond by 11 October 2010**
Contact Details	The White Paper Team - Consultation responses 6th Floor Richmond House 79 Whitehall London SW1A 2NS nhswhitepaper@dh.gsi.gov.uk www.dh.gov.uk/liberatingtheNHS
For Recipient's Use	

Foreword

A decade of centralising, controlling government has left our public services strangled with red tape, focused on processes not outcomes, and weakened by the need to account to bureaucrats instead of the public. Too many decisions have been made nationally, rather than locally, without enough public involvement. The NHS, like other public services, has suffered as a result. The creativity and innovation of health professionals has been stifled while the public are frustrated at the lack of opportunities to speak up and make a difference to their local health services.

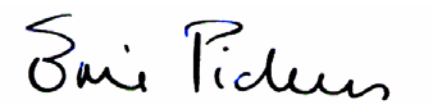
Localism is one of the defining principles of this Government: pushing power away from Whitehall out to those who know best what will work in their communities. Our plans to make this happen in health are set out in the recent white paper: *Equity and Excellence: Liberating the NHS*. It will restore real decision-making powers to patients and GPs.

The NHS is one of Britain's greatest achievements, and a service of which we can all be proud. It will continue to be a national service, held to account by Parliament. But for the first time in forty years, there will be real local democratic accountability and legitimacy in the NHS. Elected councillors and councils will have a new role in ensuring the NHS is responsible and answerable to local communities. By commissioning HealthWatch - the new way for patients and the public to shape health services - councils will be responsible for ensuring local voices are heard and patients are able to exercise genuine choice. Councils will also take the lead in improving local public health.

In this new role, councils will be assessing local needs, promoting more joined up services, and supporting joint commissioning. This builds on the excellent work that is already being done by some councils in joining up services to improve local health and social care and will help ensure a closer working relationship between health and other council responsibilities, such as housing and environmental health. This means that patients who need the help of both health and social care services can expect to get much more coherent, effective support in future.

This short paper seeks your views on these important changes to establish local democratic accountability in the NHS. We look forward to hearing from you.

Rt. Hon. Andrew Lansley CBE MP
Secretary of State for Health



Rt. Hon. Eric Pickles MP
Secretary of State for Communities and Local Government

Contents

1.	**Introduction**	**1**
2.	**Strengthening public and patient involvement**	**4**
3.	**Improving integrated working**	**6**
4.	**Local authority leadership for health improvement**	**14**
5.	**Conclusion and summary of consultation questions**	**16**

Introduction

1. The White Paper *Equity and Excellence: Liberating the NHS* set out the Government's strategy for the NHS. Our intention is to create an NHS which is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

2. *Liberating the NHS* makes clear the Government's policy intentions, and provides a coherent framework. Further work lies ahead to develop and implement detailed proposals. In progressing this work the Department will be engaging with external organisations, seeking their help and wishing to benefit from their expertise.

3. This short document, *Local democratic legitimacy in health,* provides further information on proposals for increasing local democratic legitimacy in health, through a clear and enhanced role for local government. Through elected members, local authorities will bring greater local democratic legitimacy to health. They will bring the perspective of local place - of neighbourhoods and communities - into commissioning plans. Local authorities can take a broader, more effective view of health improvement. They are uniquely placed to promote integration of local services across the boundaries between the NHS, social care and public health.

4. This consultation has been produced jointly by the Department of Health and the Department for Communities and Local Government.

5. It is part of a public consultation on specific aspects of the White Paper. The initial suite of supporting papers also includes:

    - *Commissioning for patients*
    - *Regulating healthcare providers*
    - *The review of arm's-length bodies*
    - *Transparency in outcomes: a framework for the NHS*

    The Government will publish a response prior to the introduction of a Health Bill later this year.

6. National accountability for the health service is critical. It currently receives about £100 billion of taxpayers' funding, and it is right that it is held to account for the stewardship of these finances and outcomes through Parliament. The reforms the Government set out in *Liberating the NHS* will remove ongoing political interference from the health service, through the creation of an independent NHS

Commissioning Board, but national accountability will remain. In the future, there will be a more transparent relationship between national government and the NHS, with less scope for day-to-day political interference.

7. One of the central features of the proposals in the White Paper is to devolve commissioning responsibilities and budgets as far as possible to those who are best placed to act as patients' advocates and support them in their healthcare choices. Through our world-renowned system of general practice, GPs and other primary care professionals are already supporting patients in managing their health, promoting continuity and coordination of care, and making referrals to more specialist services. In empowering GP practices to come together in wider groupings, or 'consortia', to commission care on their patients' behalf and manage NHS resources, we are building on these foundations. We are also empowering them to work more effectively alongside the full range of other health and care professionals.

8. Most commissioning decisions will now be made by consortia of GP practices, free from top-down managerial control and supported and held to account for the outcomes they achieve by the NHS Commissioning Board. This will push decision-making much closer to patients and local communities and ensure that commissioners are accountable to them. It will ensure that commissioning decisions are underpinned by clinical insight and knowledge of local healthcare needs. It will enable consortia to work closely with secondary care, other health and care professionals and with community partners to design joined-up services that make sense to patients and the public. It will not be appropriate for all commissioning decisions to be made at a local level and some specialist services, such as paediatrics, will need to be commissioned at a higher geographical unit, by the NHS Commissioning Board. *Commissioning for patients* - published alongside this document - gives further detail of how GP commissioning consortia and the NHS Commissioning Board will work.

9. Within this strong national system, the Government wants to strengthen local democracy. Giving people the opportunity to exercise their voices as individuals is an important part of this. The proposals build on the existing mechanisms, such as patients using information about a provider to exercise choice, or participating as an active member of a local foundation trust. We will strengthen the collective voice of patients and the public through arrangements led by local authorities, and at national level, through a powerful new consumer champion, HealthWatch England, located in the Care Quality Commission.

10. Within this new system, local authorities will have an enhanced role in health. The Government intends that they will have greater responsibility in four areas:

- leading joint strategic needs assessments (JSNA)[1] to ensure coherent and co-ordinated commissioning strategies;
- supporting local voice, and the exercise of patient choice;
- promoting joined up commissioning of local NHS services, social care and health improvement; and
- leading on local health improvement and prevention activity.

11. With the local authority taking a convening role, it will provide the opportunity for local areas to further integrate health with adult social care, children's services (including education) and wider services, including disability services, housing, and tackling crime and disorder. This has the potential to meet people's needs more effectively and promote the best use of public resources. The local authority will lead the process of undertaking joint strategic needs assessments across health and local government services and promote joint commissioning between GP consortia and local authorities. GP consortia and the NHS Commissioning Board will be responsible for making health care commissioning decisions, informed by the JSNA. We would encourage local authorities to take the NHS Constitution into account when influencing local commissioning decisions about NHS services.

12. The Government will work with the Local Government Association to understand the potential benefits of place-based budgets through the Spending Review period. We will look at the potential application of these approaches to cross-cutting areas of health spending that require effective partnerships with local authorities and other frontline organisations, for example older people's services, and substance misuse.

13. The Government is committed to ensuring that there is a strong local voice for patients through democratic representation in healthcare. The Coalition Programme proposed directly elected individuals on the primary care trusts (PCT) board as a mechanism for doing this. However, because of the proposed transfer of commissioning functions to the NHS Commissioning Board and GP consortia, the Government has concluded that PCTs should be abolished. Instead, we propose an enhanced role for elected local councillors and local authorities, as a more effective way to boost local democratic engagement. In this document, the Government is bringing forward practical plans that give stronger effect to its intentions for local democratisation in health.

[1] A joint strategic needs assessment is an assessment of the health and wellbeing needs of the population in a local area and since 2007 it has been a statutory duty for primary care trusts and local authorities to undertake one. They aim to establish a shared, evidence based consensus on key local priorities to support commissioning to improve health and wellbeing outcomes and reduce inequalities. In practice the JSNA falls to the Directors of Public Health, Directors of Adult Social Services and Directors of Children's Services to carry out, as set out in the JSNA guidance.

Strengthening public and patient involvement

14. *Liberating the NHS* set out plans to create a much more responsive NHS that is genuinely centred on the needs and wishes of patients, through increased choice, an information revolution, stronger voice, and commissioning by GP consortia. These changes will radically shift the power of the health service away from Whitehall and closer to the individual and the professionals that serve them.

15. Choice, control and better information are at the heart of these plans, but these need to be backed up by support for individuals and local voice. We want local people to have a greater say in decisions that affect their health and care and have a clear route to influence the services they receive. Since the *NHS Plan*, structures for leading local involvement have been subject to numerous changes. The Government intends to build on the current statutory arrangements, to develop a more powerful and stable local infrastructure in the form of local HealthWatch, which will act as local consumer champions across health and care. Local Involvement Networks (LINks) will become the local HealthWatch.

16. We propose that local HealthWatch be given additional functions and funding. Like LINks, they will continue to promote patient and public involvement, and seek views on local health and social care services which can be fed back into local commissioning. Also like LINks, they are likely to continue to take an interest in the NHS Constitution.

Q1 Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?

17. We also propose that HealthWatch perform a wider role, so that they become more like a "citizen's advice bureau" for health and social care - the local consumer champion - providing a signposting function to the range of organisations that exist. We therefore propose that they are granted additional specific responsibilities, matched by additional funding, for:

- NHS complaints advocacy services. Currently, this is a national function for the NHS, exercised through a Department of Health contract for the Independent Complaints Advocacy Service. We propose that this responsibility is devolved to local authorities to commission through local or national HealthWatch, so that they can support people who want to make a complaint.

- Supporting individuals to exercise choice, for example helping them choose a GP practice. Giving patients and users the right to choice, and greater information, is essential, but it is not always sufficient to enable everyone to exercise it. Local HealthWatch will have a key role in offering support to those that need it.

Q2 Should local HealthWatch take on the wider role outlined in paragraph 17 with responsibility for complaints advocacy and supporting individuals to exercise choice and control?

18. Local authorities have a vital role in commissioning HealthWatch arrangements that serve their local populations well. They will continue to fund HealthWatch, and contract for their services. Local authorities have an important responsibility, set out in statute, for discharging these duties, and holding local HealthWatch to account for delivering services that are effective and value for money. They will also ensure that the focus of local HealthWatch activities is representative of the local community. In the event of under-performance, a local authority should intervene; and ultimately re-tender the contract where that is in the best interests of its local population.

Q3 What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?

19. Local HealthWatch would still be able to report concerns about the quality of the provision of local NHS or social care services to HealthWatch England, in order to inform the need for potential regulatory action, independently of its host local authority. HealthWatch England will form a statutory part of the Care Quality Commission (CQC), the quality regulator for health and social care. This key role for local HealthWatch will be underpinned by continued rights to visit provider services.

Improving integrated working

20. People want services that feel joined up, and it can be a source of great frustration when that does not happen. Integration means different things to different people but at its heart is building services around individuals, not institutions. The Government is clear that joint, integrated working is vital to developing a personalised health and care system that reflects people's health and care needs. Services also need to be developed in ways that fit around the people who use them, and their families, and that they can understand and shape. We have an opportunity to strengthen integrated working across the health and social care agenda, from the point of providing services, to people understanding how services need to be commissioned to best meet the health and wellbeing needs of local populations. We can also improve integrated working right along the care pathway - from prevention, treatment and care, to recovery, rehabilitation and re-ablement.

21. *Liberating the NHS* has been designed to strengthen integration in many ways, for example:

- by giving people using services more choice and control about what matters most to them. Critically this includes choice of treatment and care not just choice of provider. People will have more power in the system to decide what matters most to them;
- by extending the availability of personal budgets in the NHS and social care, with joint assessment and care planning;
- quality standards will be developed systematically across patient pathways, for example the recently published NICE dementia standard;
- through the CQC as an effective inspectorate of essential quality standards, that span health and social care;
- through payment systems being used to support joint working, for example the proposals around payment by results and hospital readmissions, which should create opportunities for the full engagement of the wider health and care economy before discharging people from hospital; and
- through freeing up providers to innovate and focus on the needs of people using services rather than the needs of a top-down central bureaucracy. For example, the Government is proposing to remove the

constraints that currently exist for foundation trusts to enable them to augment their NHS role, by, for example, expanding into social care.

22. The existing framework provided in legislation[2] sets out optional partnership arrangements for service-level collaboration between local authorities and health-related bodies. The arrangements include:

- lead commissioning (with PCTs or local authorities leading commissioning services for a client group on behalf of both organisations);
- integrated provision (for example care trusts); and
- pooled budgets.

23. Take up of the current flexibilities to enable joint commissioning and pooled budgets has been relatively limited. It has tended to focus on specific service areas, such as mental health and learning disabilities. The full potential of joint commissioning, for example to secure services that are joined up around the needs of older people or children and families, remains untapped. The new commissioning arrangements will support this. GP commissioning consortia will have a duty to work with colleagues in the wider NHS and in social care to deliver higher quality care, a better patient experience and more efficient use of NHS resources.

Q4 What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?

Q5 What further freedoms and flexibilities would support and incentivise integrated working?

24. The Government believes that there is scope for stronger institutional arrangements, within local authorities, led by elected members, to support partnership working across health and social care, and public health. Local authorities' skills, experience and existing relationships present them with an opportunity to bring together the new players in the health system, as well as to provide greater local democratic legitimacy in health.

25. One option is to leave it up to NHS commissioners and local authorities as to whether they want to work together, and should they so wish, to devise their own local arrangements. An alternative approach, which the Government prefers, is to specify the establishment of a statutory role, within each upper tier local authority, to support joint working on health and wellbeing.

[2] Section 75 of the NHS Act 2006

26. The advantages of having a statutory arrangement are that it would provide duties on relevant NHS commissioners to take part, and provide a high-level framework of functions. In this way it would offer clarity of expectation about partnership working.

Q6 Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?

27. One way in which respective roles and responsibilities could be enhanced further, is through a statutory partnership board - a health and wellbeing board - within the local authority. This would provide a vehicle and focal point through which joint working could happen. Alternatively, local partners may prefer to design their own arrangements. We would like your views on how best to achieve partnership working and integrated commissioning.

28. If health and wellbeing boards were created, requirements for such a board would be minimal, with Local Authorities enjoying freedom and flexibility as to how it would work in practice.

Q7 Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

Functions of health and wellbeing boards

29. The primary aim of the health and wellbeing boards would be to promote integration and partnership working between the NHS, social care, public health and other local services and improve democratic accountability. The local authority would bring partners together to agree priorities for the benefit of patients and taxpayers, informed by local people and neighbourhood needs.

30. The Government proposes that statutory health and wellbeing boards would have four main functions:

- to assess the needs of the local population and lead the statutory joint strategic needs assessment;
- to promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health;
- to support joint commissioning and pooled budget arrangements, where all parties agree this makes sense; and

- to undertake a scrutiny role in relation to major service redesign (as set out in paragraph 42 - 50).

Q8 Do you agree that the proposed health and wellbeing boards should have the main functions described in paragraph 30?

Q9 Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking JSNAs?

31. The health and wellbeing board would allow more effective engagement between local government and NHS commissioners. There would be a statutory obligation for the local authority and commissioners to participate as members of the board and act in partnership on these functions. Whilst responsibility and accountability for NHS commissioning would rest with the NHS Commissioning Board and GP consortia, the health and wellbeing board would give local authorities influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to health improvement, reducing health inequalities, and social care.

32. The aim is to ensure coherent and coordinated local commissioning plans across the NHS, social care and public health, for example in relation to mental health, older people's or children's care, with intelligence and insight about people's wants and needs systematically shaping and commissioning decisions. These arrangements would also enable local authorities to engage more effectively via GP consortia, who would be making health care commissioning decisions. A significant benefit of the health reforms will be the removal of political interference in the day-to-day running of the health service. The local authority and its partners will only be able to ensure that the needs of their population are adequately assessed if they work together to ensure that national politics are not replaced by unconstructive local politics.

33. The health and wellbeing board could also be a vehicle for taking forward joint commissioning and pooled budgets, where parties agree this makes most sense and it is in line with the financial controls set by the NHS Commissioning Board.

Q10 If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?

Operation of health and wellbeing boards

34. We anticipate that the statutory health and wellbeing boards would sit at the upper tier local authority level. However, the boards would want to put in place

arrangements to discharge their functions at the right level to ensure that the needs of diverse areas and neighbourhoods are at the core of their work, and that democratic representatives of areas below the upper tier can contribute. This would be particularly important in two-tier areas, where boards may want to delegate the lead for some functions to districts or neighbourhoods. Neighbouring boroughs may also choose to establish a single board covering their combined area, should that make most sense locally.

35. We anticipate that the health and wellbeing boards would have a lead role in determining the strategy and allocation of any local application of place-based budgets for health. The health and wellbeing boards would have an important role in relation to other local partnerships, including those relating to vulnerable adults and children's safeguarding. If the Local Children's Safeguarding Board became concerned that the local safeguarding arrangements were not working as they should, and in particular if there were concerns about the NHS partners, they could raise this with the health and wellbeing board, who would escalate it to the NHS Commissioning Board if they were unable to achieve local resolution.

36. To reduce bureaucracy, we anticipate that local authorities may want to use the proposed health and wellbeing boards to replace current health partnerships where they exist, and work with the local strategic partnership (at the upper tier) to promote links and connections between the wider needs and aspirations of local neighbourhoods and health and wellbeing.

37. If these proposals are taken forward, we will need to ensure that appropriate arrangements are made to support the full package of reforms in London with links between the borough boards and the Mayor. The Government would particularly welcome views on this point.

Q11 How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

Membership of health and wellbeing boards

38. If taken forward, the boards would bring together local elected representatives including the Leader or the Directly Elected Mayor, social care, NHS commissioners, local government and patient champions around one table. The Directors of Public Health, within the local authority, would also play a critical role. The elected members of the local authority would decide who chaired the board.

39. The board would include both the relevant GP consortia and representation from the NHS Commissioning Board (where relevant issues are being discussed). It may be relevant for the NHS Commissioning Board to attend when issues relating to the services that they commission are being discussed, for example family health services, specialised services and maternity services. We would specify both parties' duty to take part in the partnership in legislation.

40. In addition to the strategic role, at a practical level, health and wellbeing boards could agree joint NHS and social care commissioning of specific services, for example mental health services, including prevention, or agree the allocation and strategy for place-based budgets on cross-cutting health issues. The precise role of place-based budgets should be a decision for the health and wellbeing board in light of local priorities. For the board to function well, it will undoubtedly require input from the relevant local authority directors, on social care, public health and children's services. We also propose a local representative from HealthWatch will have a seat on the board, so that it has influence and responsibility in the local decision-making process. We recognise the novelty of arrangements bringing together elected members and officials in this way and would welcome views as to how local authorities can make this work most effectively.

41. To ensure that the board is able to engage effectively with local people and neighbourhoods, local authorities may also choose to invite local representatives of the voluntary sector and other relevant public service officials to participate in the board. They may also want to invite providers into discussions, taking care to adhere to the principles of fairness, engaging providers in an equal and transparent manner.

Q12 Do you agree with our proposals for membership requirements set out in paragraph 38 - 41?

Overview and scrutiny function

42. In the current system, overview and scrutiny committees (OSCs) have the power to scrutinise major health service changes and the ongoing planning, development and operation of services. They are set up in local authorities and set their own priorities for scrutiny, reflecting the interests and concerns of the communities they serve. They are able to hold the NHS to account by:

- calling NHS managers to give information, answer questions and provide explanation about services and decisions and making recommendations locally;

- requiring consultation by the NHS where major changes to health services are proposed; and

- referring contested service changes to the Secretary of State for Health.

43. If a health and wellbeing board was created within a local authority, it would have a key new role in promoting joint working, with the aim of making commissioning plans across the NHS, public health and social care coherent, responsive and integrated. It would be able to exercise strategic oversight of health and care services. It would be better equipped to scrutinise these services locally. To avoid duplication, we propose that the statutory functions of the OSC would transfer to the health and wellbeing board.

44. This transfer would strengthen the overview that local authorities have on health decisions and bring in the voice of the local HealthWatch. Having a seat on the health and wellbeing board gives HealthWatch a stronger formal role in commissioning discussions than currently exists for LINks. This would provide additional opportunity for patients and the public to hold decision makers to account and offer scrutiny and patient voice.

45. Members of the health and wellbeing board, including elected councillors, would have the opportunity to identify shared goals and priorities and to identify early on in their respective commissioning processes how best to address these. This emphasis on proactive local partnership would minimise the potential for disputes. We will work with local authorities and the NHS to develop guidance on how best to resolve these issues locally, so that they are only referred on in the most exceptional circumstances.

Q13 What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?

46. Within the scope of NHS services, as defined by the Secretary of State, GP consortia will be free to decide commissioning priorities to reflect local needs, consistent with the public sector equality duties and supported by the national framework of quality standards, tariffs and national model contracts established by the NHS Commissioning Board. GP consortia will also have a duty to engage and involve the public in planning services and considering any proposed changes in how those services are provided. In addition, the health and wellbeing board would have an important role in enabling the NHS Commissioning Board to assure itself that GP consortia are fulfilling their duties in ways that are responsive to patients and the public.

47. If health and wellbeing boards had significant concerns about substantial service changes, an attempt should first be made to resolve this locally, for example with local commissioners, through the health and wellbeing board itself. The boards

would be expected to take account of the need to deliver services more efficiently, and of the wider quality, innovation, productivity and prevention (QIPP) agenda. The board may choose to engage external expertise to help resolve the issue, for example a clinical expert, the Centre for Public Scrutiny or the Independent Reconfiguration Panel.

48. For a minority of cases, there will still need to be a system of dispute resolution beyond the local level. This should happen only in exceptional cases as local resolution should be the preferred course of action. Where the dispute is unable to be resolved, the health and wellbeing board would have a power to refer the commissioning decision to the NHS Commissioning Board. If the issue relates to a decision made by the NHS Commissioning Board (e.g. in relation to maternity services) the health and wellbeing board may choose to refer it directly to the Secretary of State.

49. If the NHS Commissioning Board is satisfied that the correct procedure has been followed and that the decisions are based on clinical evidence, but the health and wellbeing board still has significant concerns about the issue, the health and wellbeing board would have a statutory power to refer cases to the Secretary of State. The Secretary of State would then consider the NHS Commissioning Board's report alongside the reasons for referral, seeking advice from the Independent Reconfiguration Panel. In the context of the new regulatory framework, the Secretary of State for Health's involvement will be subject to independent decisions made by regulators - the economic regulator, and the Care Quality Commission - for example on the basis of patient safety.

Q14 Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

Q15 How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

50. Public scrutiny is an essential part of ensuring that Government and public services remain effective and accountable. It helps to achieve a genuine accountability for the use of public resources. A formal health scrutiny function will continue to be important within the local authority, and the local authority will need to assure itself that it has a process in place to adequately scrutinise the functioning of the health and wellbeing board and health improvement policy decisions.

Q16 What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?

Local authority leadership for health improvement

51. In future, local authorities will have a stronger influence on the health outcomes of their local area. When PCTs cease to exist we intend to transfer responsibility and funding for local health improvement activity to local authorities. Embedding leadership for local health improvement activity within local authorities builds upon the existing success of the many joint Director of Public Health appointments between local authorities and PCTs. It is intended to unlock synergies with the wider role of local authorities in tackling the determinants of ill health and health inequalities.

52. Funding for health improvement includes that spent on the prevention of ill-health by addressing lifestyle factors such as smoking, alcohol, diet and physical exercise. So, for example, we envisage that smoking cessation services would be funded from the resources transferred to the local authority, but treatment for individuals with impaired lung function through smoking would be funded from resources allocated to GP consortia by the NHS Commissioning Board.

53. Local authority leadership for local health improvement will be complemented by the creation of a National Public Health Service (PHS). The PHS will integrate and streamline health improvement and protection bodies and functions, and will include an increased emphasis on research, analysis and evaluation. It will secure the delivery of public health services that need to be undertaken at a national level.

54. In order to manage public health emergencies, the PHS will have powers in relation to the NHS, matched by corresponding duties for NHS resilience. The NHS Commissioning Board will have a role in supporting the Secretary of State for Health and the PHS to ensure that the NHS in England is resilient and able to be mobilised during any emergency it faces, or as part of a national response to threats external to the NHS.

55. The local authority will also play an important role in PHS campaigns of national importance, which aim to protect public health or provide population screening; and it will have a role in national health improvement campaigns, tailoring programmes to meet the needs of its local population.

56. Local Directors of Public Health will be jointly appointed by local authorities and the PHS. They will have a ring-fenced health improvement budget, allocated by the PHS; and they will be able to deploy these resources to deliver national and local priorities. There will be direct accountability to both the local authority, and, through the PHS, to the Secretary of State. Through being employees of the local authority, local Directors of Public Health will have direct influence over the

wider determinants of health, advising elected members and as part of the senior management team of the local authority.

57. The Secretary of State, through the PHS, will agree with local authorities the local application of national health improvement outcomes. It will be for local authorities to determine how best to secure the outcomes and this may include commissioning services, for example, from providers of NHS care. Local neighbourhoods will have freedom and flexibility to set local priorities, working within a national framework.

58. In the Government's work to develop a public health White Paper, we will engage stakeholders on arrangements for the abolition of PCTs and the establishment of the public health ring-fenced health improvement budget. Arrangements for health improvement will also be aligned with future arrangements for outcomes in local government, and in particular with the approach to social care outcomes.

Conclusion and summary of consultation questions

59. This document has set out the Government's plans for increasing local democratic legitimacy in health, by giving local authorities a stronger role in supporting patient choice and ensuring effective local voice; promoting more effective NHS, social care and public health commissioning arrangements, through the proposed new health and wellbeing boards; and local leadership for health improvement. We will need to ensure, through this consultation exercise and broader policy work, that the health system is financially sustainable through the transition to the new structures that we lay out here, as well as in the longer term.

60. Implementation will be consistent with the new burdens doctrine. Subject to legislation, health improvement functions will transfer to local authorities from 2012. We propose that statutory partnership functions would also be established formally from 2012. However, if the idea receives positive support, the Departments of Health and Communities and Local Government will support local authorities to establish shadow arrangements with the PCT, emerging GP consortia and LINks in 2011. The Government proposes to make the changes through its forthcoming Health Bill, planned for introduction this autumn, subject to the responses received to this consultation.

61. The Government would welcome views on the following questions:

Q1 ***Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?***

Q2 ***Should local HealthWatch take on the wider role outlined in paragraph 17, with responsibility for complaints advocacy and supporting individuals to exercise choice and control?***

Q3 ***What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?***

Q4 ***What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?***

Q5 ***What further freedoms and flexibilities would support and incentivise integrated working?***

Q6 ***Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?***

Q7 ***Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?***

Q8 ***Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 30?***

Q9 ***Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?***

Q10 ***If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?***

Q11 ***How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?***

Q12 ***Do you agree with our proposals for membership requirements set out in paragraph 38 - 41?***

Q13 ***What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?***

Q14 ***Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?***

Q15 ***How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?***

Q16 ***What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?***

Q17 ***What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public and, where appropriate, staff?***

Q18 ***Do you have any other comments on this document?***

62. Responses to the questions in this consultation document should be sent to nhswhitepaper@dh.gsi.gov.uk or to the White Paper Team, Room 601, Department of Health, 79 Whitehall, London SW1A 2NS by 11 October 2010.

Annex 1: The consultation process

Criteria for consultation

This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks - the policies in this document were included in the NHS White Paper, *Liberating the NHS*, which was launched on 12 July for a 12 week consultation period closing on 5 October;
- be clear about the consultations process in the consultation documents: what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the Code of Practice and related guidance is on the Better Regulation

website at www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator
Department of Health
3E48, Quarry House

Leeds
LS2 7UE
e-mail: consultations.co-ordinator@dh.gsi.gov.uk
Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter (available at www.dh.gov.uk).

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A response to this consultation will be made available at www.dh.gov.uk by the end of this year.

LIBERATING THE NHS: COMMISSIONING FOR PATIENTS
A consultation on proposals

Executive summary

Introduction

1. The White Paper *Equity and Excellence: Liberating the NHS* sets out the Government's strategy for the NHS. Our intention is to create an NHS which is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

2. This document, *Commissioning for patients,* sets out the intended arrangements for GP commissioning and the NHS Commissioning Board's role in supporting consortia and holding them to account, and invites views on the implementation of these proposals.

3. It is part of a suite of documents supporting the White Paper and should be read alongside the parallel document *Local democratic legitimacy in health*, which sets out plans to increase local democratic accountability. These documents can be found on the Department of Health website at www.dh.gov.uk/liberatingthenhs .

Proposed commissioning arrangements

4. Our proposals for GP commissioning and the NHS Commissioning Board mark a fundamental break with the past. Most commissioning decisions will now be made by consortia of GP practices, free from top-down managerial control and supported and held to account for the outcomes they achieve by the NHS Commissioning Board. This will push decision-making much closer to patients and local communities and ensure that commissioners are accountable to them. It will ensure that commissioning decisions are underpinned by clinical insight and knowledge of local healthcare needs. It will enable consortia to work closely with secondary care, other health and care professionals and with community partners to design joined-up services that make sense to patients and the public.

5. Our proposed model will not mean all GPs, practice nurses and other practice staff having to be actively involved in every aspect of commissioning. Their predominant focus will continue to be on providing high-quality primary care to their patients. It is likely to be a smaller group of primary care practitioners who will lead the consortium and play an active role in the clinical design of local services, working with a range of other health and care professionals. All GP practices, however, will be able to ensure that commissioning decisions reflect their views of their patients' needs and their own referral intentions. It will be a requirement for every GP practice to be part of a consortium and to contribute to its goals, not least in ensuring that as a practice they provide services in ways that support high-quality outcomes and efficient use of NHS resources.

6. Nor will the practitioners who lead the consortia need to carry out all commissioning activities themselves. Whilst it is likely that they will coordinate most of the clinical aspects of commissioning themselves, consortia will be able to employ staff or buy in support from external organisations, including local authorities, voluntary organisations and independent sector providers, for instance to analyse population health needs, manage contracts with providers and monitor expenditure and outcomes. Consortia will have the freedom to decide which aspects of commissioning activity they undertake fully themselves and which aspects require collaboration across several consortia, for instance through a lead commissioner managing the contract with a large hospital or commissioning low-volume services not covered by national and regional specialised services.

7. GP consortia will also be supported by the role of the NHS Commissioning Board in developing commissioning guidelines, model contracts and tariffs.

8. Transferring commissioning functions to consortia and, in some cases, the NHS Commissioning Board, alongside the potential role for local health and wellbeing boards set out in *Local democratic legitimacy in health*, means that PCTs will no longer have a role. We expect that PCTs will cease to exist from April 2013, in light of the successful establishment of GP consortia. A number of PCTs have made important progress in developing commissioning experience. We will be looking to capitalise on that existing expertise and capability in the transitional period, where this is the wish of GP consortia.

9. PCTs will have an important task in the next two years in supporting practices to prepare for these new arrangements. We want implementation to be bottom-up, with GP consortia taking on their new responsibilities as rapidly as possible and early adopters promoting best practice.

Responsibilities of GP consortia

10. In order to shift decision-making as close as possible to individual patients, the Department will devolve power and responsibility for commissioning most healthcare services to groups of GP practices.

11. Consortia of GP practices will commission the great majority of NHS services on behalf of patients, including elective hospital care and rehabilitative care, urgent and emergency care (including out-of-hours services), most community health services, and mental health and learning disability services.

12. Consortia will not be responsible for commissioning primary medical services, which will be the responsibility of the NHS Commissioning Board, but consortia will become increasingly influential in driving up the quality of general practice. The NHS Commissioning Board will also commission the other family health services of dentistry, community pharmacy and primary ophthalmic services, as well as national and regional specialised services, maternity services and prison health services, but with the influence and involvement of consortia.

13. The NHS Commissioning Board will calculate practice-level budgets and allocate these resources directly to consortia. Consortia will be responsible for managing these combined budgets, which will be kept separate from GP practice income, and deciding how best to use resources to meet the healthcare needs of their patients. They will have a duty to ensure that expenditure does not exceed their allocated resources. They will enter into contracts with providers and hold providers to account for meeting their contractual duties, including required quality standards and patient outcomes.

14. Consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services and public health.

15. Consortia will need to engage patients and the public on an ongoing basis as they undertake their commissioning responsibilities, and will have a duty of public and patient involvement.

Relationship between consortia and individual practices

16. The Government will discuss with the BMA and the profession how primary medical care contracts can best reflect new complementary responsibilities for individual GP practices, including a duty to be a member of a consortium and to support it in ensuring efficient and effective use of NHS resources.

The role of the NHS Commissioning Board

17. To support consortia in their commissioning decisions we will create a statutory NHS Commissioning Board, which will:
    - provide national leadership on commissioning for quality improvement, for instance by developing commissioning guidelines based on quality standards and by designing tariffs and model NHS contracts
    - promote and extend public and patient involvement and choice
    - ensure the development of consortia and hold them to account for outcomes and financial performance
    - commission certain services that are not commissioned by consortia, such as the national and regional specialised services
    - allocate and account for NHS resources.

18. The NHS Commissioning Board will be accountable to the Secretary of State for managing the overall commissioning revenue limit and for delivering improvements against a number of measures of health outcomes. The Board will in turn hold consortia to account for their performance.

Establishment of GP consortia

19. The intention is to put GP commissioning on a statutory basis, with powers and responsibilities set out through primary and secondary legislation.

20. Every GP practice will be a member of a consortium, as a corollary of holding a list of registered patients. Within the new legislative framework, practices will have flexibility to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. The NHS Commissioning Board will have a duty to ensure comprehensive coverage of GP consortia, and we envisage a reserve power for the Board to assign practices to consortia if necessary.

21. Consortia will be formed on a bottom-up basis, but will need to have sufficient geographic focus to be able to agree and monitor contracts for locality-based services (such as urgent and emergency care), to have responsibility for commissioning services for people who are not registered with a GP practice, to commission services jointly with local authorities, and to fulfil effectively their duties in areas such as safeguarding of children. The consortia will also need to be of sufficient size to manage financial risk effectively, notwithstanding their ability to work with other consortia to manage financial risk.

Freedoms and accountabilities

22. We envisage that consortia will receive a maximum management allowance to reflect the costs associated with commissioning. Consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities they choose to buy in support from external organisations, including local authorities, private and voluntary sector bodies.

23. Consortia will have the freedom to use resources in ways that achieve the best and most cost-efficient outcomes for patients. At the same time, the economic regulator and the NHS Commissioning Board will ensure transparency and fairness in spending decisions and promote competition, for instance by ensuring wherever possible that any willing provider has an equal opportunity to provide services. The Department will discuss with the NHS the safeguards that will be needed to ensure these objectives, particularly with regard to consortia commissioning services from general practice (over and above the primary care services that they already have a duty to provide).

24. The NHS Commissioning Board will be responsible for holding consortia to account for the outcomes they achieve, for stewardship of NHS resources and for fulfilling duties such as public and patient involvement and partnership with local authorities. In turn, each consortium will develop its own arrangements to hold its constituent practices to account.

25. We propose that the NHS Commissioning Board, supported by NICE, will develop a commissioning outcomes framework so that there is clear, publicly available information on the quality of healthcare services commissioned by consortia, including patient-reported outcome measures and patient experience, and their management of NHS resources. The framework would also seek to capture progress in reducing health inequalities.

26. We propose, subject to discussion with the BMA and the profession, that a proportion of GP practice income should be linked to the outcomes that practices achieve collaboratively through commissioning consortia and the effectiveness with which they manage NHS resources. The NHS Commissioning Board will need powers to intervene in the event that a consortium is unable to fulfil its duties effectively or where there is a significant risk of failure. We propose working with the NHS to develop criteria or triggers for intervention.

Partnership

27. Consortia will need to work closely with the patients and local communities they serve, including through Local Involvement Networks (which will become local HealthWatch bodies) and patient participation groups, and with community partners.

28. The proposed new local authority health and wellbeing boards would enable consortia, alongside other partners, to contribute to effective joint action to promote the health and wellbeing of local communities, including combined action on health improvement, more integrated delivery of adult health and social care, early years' services and safeguarding of children and vulnerable adults.

29. We will work with the NHS and the health and care professions to promote multi-professional involvement in commissioning.

Implementation

30. Our proposed implementation timetable is:

In 2010/11

- GP consortia to begin to come together in shadow form (building on practice-based commissioning consortia, where they wish)

In 2011/12

- a comprehensive system of shadow GP consortia in place and the NHS Commissioning Board to be established in shadow form

In 2012/13

- formal establishment of GP consortia, together with indicative allocations and responsibility to prepare commissioning plans, and the NHS Commissioning Board to be established as an independent statutory body

In 2013/14

- GP consortia to be fully operational, with real budgets and holding contracts with providers.

Conclusion and responding to the consultation

31. We are consulting on how best to implement the changes outlined in this summary and draw your attention to the full version of this consultation document which contains specific consultation questions, the White Paper, and other related consultation documents, available on the Department of Health website at www.dh.gov.uk/liberatingthenhs . Responses to the questions in the full consultation document should be sent to nhswhitepaper@dh.gsi.gov.uk or to the White Paper team, Room 601, Department of Health, 79 Whitehall, London SW1A 2NS by 11 October 2010.

LIBERATING THE NHS: REGULATING HEALTHCARE PROVIDERS

A consultation on proposals
Executive summary

Introduction

1. The White Paper, *Equity and excellence: Liberating the NHS*, set out the Government's strategy for the NHS. Our intention is to create an NHS which is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

2. The consultation document, *Regulating Healthcare Providers,* invites views on our proposals to free foundation trusts from central Government control and to develop their current regulator, Monitor, into an independent economic regulator for health and adult social care.

Increasing freedoms for foundation trusts

3. The Government's intention is to free providers so that they can focus on improving outcomes, be more responsive to patients, and innovate. In doing this, we will build on the overall success of the foundation trust model. All NHS trusts will be supported to become, or be part of, a Foundation Trust within three years.

4. Foundation trusts will continue to have as their principal purpose the provision of goods and services to the health service in England. The broad statutory framework will ensure that any surplus are reinvested in the organisation, not distributed externally.

5. Ahead of bringing forward legislation, we are seeking views on the options for increasing Foundation Trusts' freedoms, in particular on proposals to:

    - repeal the arbitrary cap on the amount of income foundation trusts may earn from private patients to reinvest in their services; allowing trusts to expand the services they can offer for the benefit of patients, whilst maintaining their primary purpose of providing goods and services to the health service, and allowing the NHS to take proper advantage, for the benefit of this country, of the power of its brand abroad;

    - remove statutory controls over foundations trusts' borrowing limits. The Government is consulting over whether these controls will remain relevant, within a new system of economic regulation with strong incentives for financial discipline;

    - allow foundation trusts to change their own constitutions to meet their local needs, replacing the current requirement to obtain the consent of the regulator with more robust internal checks. In making changes foundation trusts would need to ensure that their constitution is consistent with the legal form prescribed in legislation;

- make it easier for foundation trusts, with their focus on providing services to the NHS, to choose how best to evolve and organise themselves and cooperate to make themselves more effective. We propose to remove unnecessary barrier to allow trusts to more easily merge with or acquire another foundation trust or NHS trust, or demerge; and

- allow flexibility for some foundation trusts to adapt their governance arrangements to suit their particular circumstances. The Government has no intention of requiring or encouraging any existing foundation trust to change its governance model. However, we are interested in allowing some additional flexibility, for example to increase staff influence. For example, there may be a case for some foundation trusts to be led only be employees, for example smaller organisations such as those providing community services or those who have few capital assts that were paid for by the taxpayer, below a specified threshold.

6. The consultation document also considers the arrangements for the management of the taxpayers' investment in foundation. Currently, Monitor has a role in managing this investment and minimising the risk and cost of it being written off in the event of a foundation trust's financial failure. In the future it will be important for Monitor, acting as economic regulator, to avoid having a special interest in foundation trusts as a group of providers. We proposed that the role could be undertaken by the Department of Health or a third party working on behalf of the Department – this could include Monitor if the independence of the regulator role is maintained.

Economic Regulation

7. As we move away from a system of top-down performance management, Monitor will be developed into the economic regulator for all of health and adult social care in England. The Government's approach is that where specific control mechanisms are needed for providers, these should in general take effect through regulatory licensing and clinically-led contracting, rather than hierarchical management by regions or the centre.

8. Monitor will be responsible for regulating all providers to promote efficient, financially sustainable service provision. It will operate independently of Government so that providers have confidence in a stable, rules-based system – without the risk of political interference – to make long-term investments in services. All providers of NHS care should be able to compete on a level playing field with patients able to choose care from the provider they think the best.

9. Monitor will continue to have the status of a non-departmental public body and will be required to account to central government for the use of its resources.

Monitor's functions

10. Monitor's principal duty will be to protect the interests of patients and the public in relation to health and adult social care services. Monitor will have powers to license providers of NHS services and core functions to regulate prices for NHS services, where needed, promote competition, and support service continuity. Monitor will be required to exercise its functions in a manner consistent with the Secretary of State's duty to promote a comprehensive health service in England.

Licensing

11. In the new system Monitor and the Care Quality Commission with be jointly responsible for administering and integrated and streamlined registration and licensing regime. Our aim is for a streamlined process that helps to minimise bureaucracy and ensures that regulation is proportionate.

12. Monitor will be responsible for developing a general licence setting out conditions for all relevant providers of NHS services. The general licence conditions are likely to include a requirement that an organisation is a fit and proper body to provide NHS services - for example that it is a recognised legal body, with a properly constituted board, clear governance arrangements and a business plan. We envisage this replacing Monitor's current role in authorising foundation trusts.

13. Monitor will have a range of powers, including fines, to ensure that providers comply with their licence conditions. We propose that Monitor should fund its regulatory activities for licensed providers by charging fees and receiving grant-in-aid if needed to support other activities.

Price regulation and setting

14. Monitor will be responsible for setting efficient prices, or maximum prices, for NHS-funded services in order to promote fair competition and drive productivity. Monitor and the NHS Commissioning Board will work closely in deciding which service should be subject to national tariffs.

15. The tariff setting methodology should be made transparent and fully open to scrutiny. Providers will have right of appeal to the Competition Commission if they oppose Monitor's methodology.

16. On rare occasions we propose Monitor should have powers to modify tariffs for individual providers where it is in the interest of patients and the public.

Promoting Competition

17. We propose that in carrying out its functions Monitor would have a duty to promote competition, where appropriate including:

    - setting licence conditions to prevent anti-competitive behaviour
    - investigating anti –competitive conduct under the Competition Act 1998

- Carrying out studies and referring malfunctioning markets to the Competition Commission
- Investigating complaints about commissioning after referral to the NHS Commissioning Board
- Providing advice to Government and NHS Board on barriers to competition / level playing field

Supporting Continuity of services

18. Although commissioners will have the lead responsibility for ensuring continuity of services, Monitor may also need to intervene to ensure continued access to key services in some limited circumstances. Monitor will be able to classify services which require additional regulation as additionally regulated services and set conditions in providers' licences to protect the continuity of those services. Special licence conditions could include controls on the disposal of the assets needed to provide key services or requirements to give notice of planned changes to services.

19. We will also build protections to ensure the continued safe provision of additionally regulated services in the event that a provider becomes insolvent. A special administration regime will work as in other sectors, providing an alternative to ordinary insolvency procedures. Monitor will be responsible for establishing funding arrangements to finance the continued provision of services in the event of special administration. It is likely that it will initially do this by establishing a funding risk pool raised from levies on the providers of regulated services.

Conclusion and summary of consultation questions

20. The consultation invites comments on proposals for freeing foundation trusts and establishing independent economic regulation of providers by 11 October 2011. The Government proposes to make the changes through its forthcoming Health Bill, planned for introduction this autumn.

Responding to the Consultation

21. We are consulting on how best to implement the changes outlined in this summary and draw your attention to the full version of this consultation document and to the White Paper and other related consultation documents, available on the Department of Health website at www.dh.gov.uk/liberatingthenhs. Responses to the questions in the full consultation document should be sent to nhswhitepaper@dh.gsi.gov.uk or to the White Paper Team, Room 601, Department of Health, 79 Whitehall, London SW1A 2NS.

Department of Health
Draft Structural Reform Plan

12 July 2010

Structural Reform Plans

Structural Reform Plans are the key tool of the Coalition Government for making departments accountable for the implementation of the reforms set out in the Coalition Agreement. They replace the old, top-down systems of targets and central micromanagement.

The reforms set out in each department's SRP are designed to turn government on its head, taking power away from Whitehall and putting it into the hands of people and communities. Once these reforms are in place, people themselves will have the power to improve our country and our public services, through the mechanisms of local democratic accountability, competition, choice, and social action.

The reform plans set out in this document are consistent with and form part of the Department's contribution to the Spending Review. All departmental spending is subject to the Spending Review.

We have adopted a cautious view of the timescales for delivering all legislative measures due to the unpredictability of pressures on Parliamentary time.

Departmental Priorities

1. A patient-led NHS

- Strengthen the patient's ability to exercise extended choice, to manage their care and to have their voice heard within the NHS

2. Shift resources to promote better healthcare outcomes

- Shift focus and resources towards better healthcare outcomes, including national healthcare outcome measures, patient-reported outcomes and patient experience measures

3. Revolutionise NHS accountability

- Create a long-term sustainable framework of institutions with greater autonomy for doctors and nurses, and greater accountability to patients and the public, focused on outcomes

4. Promote better public health

- Promote better public health for the nation by centring the Department's focus on public health, developing a clear strategy and partnering with the voluntary and private sectors

5. Reform social care

- Enable people needing care to be treated with dignity and respect; reform the system of social care to provide much more control to individuals and their carers, easing the cost burden that they and their families face

1. A patient-led NHS (1/2)

Strengthen the patient's ability to exercise extended choice, to manage their care and to have their voice heard within the NHS

ACTIONS	Start	End
1.1 Extend patient choice - including how, and by whom, care is delivered		
i. Amend the NHS operating framework to allow patients to choose any healthcare provider (from all sectors) to deliver care within the NHS, at NHS standards and within the NHS tariff	Jun 2010	
ii. Publish proposals for extending choice in White Paper	Jul 2010	
iii. Begin preparatory work to give every patient the right to register with the GP practice they want, without being restricted by where they live	Jul 2010	
iv. Give patients the right to register with GP practice of their choice	2012	
v. Begin preparations for a 24/7 urgent care service (new 111 access number)	Jul 2010	
vi. Begin implementation of comprehensive urgent care services, joining together services such as the ambulance service, GP out-of-hours services, and NHS Direct	Apr 2011	
vii. 24/7 urgent care service operational in every area of England	Apr 2012	
1.2 Put patients in charge of decisions about their care, giving control of health records		
i. Outline "information revolution" proposals in White Paper	Jul 2010	
ii. Publish information strategy	Sep 2010	
iii. Consult on information needs and the best methods for structure, collection and distribution, encouraging more organisations to provide information to patients	Sep 2010	Jan 2011
iv. Begin implementation of patient-held records	Apr 2011	

MILESTONES		
A. Publication of more detailed information, in an open and standardised format, to help patients choose where to be treated	Jun 2010	
B. Right to register with a GP practice without being restricted by where a patient lives	2012	
C. 24/7 urgent care service in place	Apr 2012	

1. A patient-led NHS (2/2)

Strengthen the patient's ability to exercise extended choice, to manage their care and to have their voice heard within the NHS

ACTIONS	Start	End
1.3 Begin regular publication of detailed performance data, in an open and standardised format, on all healthcare providers	Jun 2010	
1.4 Introduce personal health budgets for people with chronic/long-term conditions		
i. Continue piloting of personal health budgets	Jun 2010	Oct 2012
ii. Publish final evaluation report of pilot sites	Oct 2012	
iii. Initiate national roll-out, informed by the results of the evaluation	Oct 2012	
1.5 Create HealthWatch, a new body to act as the voice for patients and the public		
i. Publish proposals for HealthWatch in White Paper	Jul 2010	
ii. Begin transformation of patient Local Involvement Networks into local HealthWatch	Apr 2011	
iii. Launch HealthWatch nationally	Apr 2012	
1.6 Strengthen the role of the Care Quality Commission		
i. Publish White Paper including proposals for the strengthening of the Care Quality Commission and include provisions in Health Bill	Jul 2010	
ii. Implement proposals set out in White Paper, so that the Commission will inspect on the basis of essential standards	Aug 2010	Apr 2012

MILESTONES	
D. HealthWatch launched	Apr 2012
E. Personal health budgets evaluation published	Oct 2012

2. Promote better health outcomes (1/2)

Shift focus and resources towards better health outcomes, including national health outcome measures, patient reported outcomes and patient experience measures

ACTIONS	Start	End
2.1 Scrap process targets and introduce national health outcome measures to prioritise the health results that really matter, and promote best practice through greater transparency		
i. Remove process targets with no clinical justification		Jun 2010
ii. Instruct NICE to begin publication of quality standards		Jul 2010
iii. Develop incentives to improve access to primary care in disadvantaged areas		Apr 2011
iv. Fully implement new outcomes framework		Apr 2012
2.2 Reform Payment by Results to provide incentives for health care services to deliver high quality care		
i. Publish revised Operating Framework and pay for performance plan		Jun 2010
ii. Start to implement reformed Payment by Results in hospitals		Apr 2011
iii. Extend Payment by Results to community services, mental health and end-of-life care		Apr 2012

MILESTONES		
A. Consultation on outcomes measures framework published		Jul 2010
B. Pilot of reformed hospital Payment by Results begins		Apr 2011
C. Outcomes framework published		Apr 2011

2. Promote better health outcomes (2/2)

Shift focus and resources towards better health outcomes, including national health outcome measures, patient reported outcomes and patient experience measures

ACTIONS	Start	End
2.3 Improve support to hospices		
i. Review funding model for hospices	Jul 2010	Summer 2011
ii. Funding model on preferred option(s) developed	Summer 2011	Oct 2011
iii. Decision on final option	Dec 2011	
2.4 Introduce a value-based pricing system to align treatments with outcomes		
i. Publish proposals in White Paper to reform NICE and place it on a firmer statutory footing	Jul 2010	
ii. Create a Cancer Drugs Fund to enable patients to access an increased range of cancer drugs to operate until full transition to new pricing process	Apr 2011	
iii. Begin work to develop new pricing process with drug companies	Apr 2011	
iv. New pricing process operational	Jan 2014	
2.5 Introduce new dentistry contract, with particular focus on oral health of children		
i. Publish proposals for pilots to inform development of contract	Dec 2010	

MILESTONES	
D. Cancer Drugs Fund established	Apr 2011
E. NICE established on a firmer statutory basis	Apr 2012
F. Transition to new pricing process complete	Jan 2014

3. Revolutionise NHS accountability (1/3)

Create a long-term sustainable framework of institutions with greater autonomy for doctors and nurses, and greater accountability to patients and the public, focused on outcomes

ACTIONS	Start	End
3.1 Improve the effectiveness of commissioning and resource allocation		
i. Publish commissioning proposals in White Paper	Jul 2010	
ii. Establish NHS Commissioning Board in shadow form	Apr 2011	
iii. Complete abolition of Strategic Health Authorities	Apr 2013	
iv. NHS Commissioning Board fully established	Apr 2012	
v. NHS Commissioning Board makes allocations to GP consortia for 2013/14	Autumn 2012	
3.2 Enhance commissioning to give GPs greater autonomy		
i. Launch engagement on proposals for GP commissioning consortia	Jul 2010	
ii. Begin to establish GP commissioning consortia in shadow form	Apr 2011	
iii. Formally establish GP commissioning consortia	Apr 2012	
iv. GP consortia take full responsibility for commissioning	Apr 2013	

MILESTONES	
A. Announce principles to guide new financial allocation process	Apr 2011
B. NHS Commissioning Board operational in shadow form	Apr 2011
C. Full GP commissioning in place	Apr 2013

3. Revolutionise NHS accountability (2/3)

Create a long-term sustainable framework of institutions with greater autonomy for doctors and nurses, and greater accountability to patients and the public, focused on outcomes

ACTIONS	Start	End
3.3 Reduce bureaucracy		
i. Publish review of Arm's Length Bodies	Summer 2010	
ii. Legislate to abolish unnecessary Arm's Length Bodies	Oct 2010	Nov 2011
iii. Incorporate health protection functions into the Public Health Service	Apr 2012	
iv. Abolition of Primary Care Trusts once NHS Commissioning Board and GP commissioning are in place	From Apr 2013	
3.4 Set providers free and reduce political interference		
i. Publish proposals in White Paper to reform Foundation Trust governance	Jul 2010	
ii. Establish "turn-around team" for NHS Trust transition to Foundation Trust status	Sep 2010	
iii. Complete transition to Foundation Trust status	2013/14	

MILESTONES	
D. Complete transition of all NHS trusts to Foundation Trust status	2013/14
E. PCTs abolished	From Apr 2013

3. Revolutionise NHS accountability (3/3)

Create a long-term sustainable framework of institutions with greater autonomy for doctors and nurses, and greater accountability to patients and the public, focused on outcomes

ACTIONS	Start	End
3.5 Strengthen local democratic legitimacy by creating a greater role for local government in health and well-being		
i. Publish proposals in White Paper for consultation		Jul 2010
ii. Begin implementation of proposals		Apr 2011
iii. Full implementation of proposals		Apr 2013
3.6 Increase local say over reconfigurations		
i. Local authorities have the right to challenge health organisations over the closure of local services, and refer cases for national arbitration		Jun 2010
ii. Stop the centrally-dictated closure of A&E and maternity wards, so that people have better access to local services		Jun 2010
3.7 Develop Monitor into an economic regulator that will oversee regulation to ensure access, choice, competition and price-setting for health and social care		
i. Publish proposals for developing Monitor into an economic regulator		Jul 2010
ii. Include provisions in Health Bill for Monitor to become an economic regulator		Nov 2010
iii. Launch Monitor as an economic regulator		Apr 2012
iv. Monitor regulates all providers		2013/14

MILESTONES		
F. Set criteria for local decisions in major service changes		Jul 2010
G. Monitor fully operational as an economic regulator		2013/14

4. Promote public health (1/3)

Promote better public health for the nation by centring the Department's focus on public health, developing a clear strategy and partnering with the voluntary and private sectors

ACTIONS	Start	End
4.1 Establish Public Health Service, including relevant health protection functions, and incorporate into DH the nutrition functions of Food Standards Agency		
i. Incorporate FSA nutrition functions into DH		Oct 2010
ii. Publish White Paper on public health		2010
iii. Begin implementation of Public Health Service		Apr 2011
iv. Public Health Service fully established		Apr 2012
4.2 Give local communities greater control over public health budgets, with payment by the outcomes they achieve in improving the health of local residents		
i. Publish proposals in White Paper		Dec 2010
ii. Publish subsequent consultation document, including guidance on the most effective behaviour change techniques		Dec 2010
iii. Ring-fence public health allocations and establish "health premium" rewarding local authorities for tackling health improvement challenges among disadvantaged communities, and targeting public health resources on those with poorest health		Apr 2012
4.3 Begin to implement Public Health Responsibility Deal recommendations		Oct 2010

MILESTONES		
A. White Paper on public health published		2010
B. Ring-fenced public health budgets allocated in shadow form with new performance-based regime and "health premium" in place		Apr 2012

4. Promote public health (2/3)

Promote better public health for the nation by centring the Department's focus on public health, developing a clear strategy and partnering with the voluntary and private sectors

ACTIONS	Start	End
4.4 Improve the quality of occupational health services and promote healthy workplaces with a focus on small businesses		
i. Begin improvement of standards for occupational health by working with business, NHS+, Faculty of Occupational Medicine and the NHS Review	Jun 2010	
ii. Work with business to implement the Responsibility Deal on health and employment	Jun 2010	
iii. Introduce accreditation system for the new occupational health standard	Early 2011	
4.5 Revise public health marketing strategy	Early 2011	
i. Ensure all activity demonstrates a clear return on investment	Jul 2010	Dec 2010
ii. Include new requirements for private sector participants to demonstrate significant changes in business practices	Jul 2010	Dec 2010
4.6 Ensure greater access to talking therapies to reduce long-term costs for the NHS	Jun 2010	
4.7 Work with Home Office to ensure that hospitals share non-confidential information with the police so they know where gun and knife crime is happening	Jun 2010	Apr 2011
4.8 Prioritise dementia research within the health research and development budget	Jun 2011	

MILESTONES	
C. Revised public health marketing strategy published	Early 2011

4. Promote public health (3/3)

Promote better public health for the nation by centring the Department's focus on public health, developing a clear strategy and partnering with the voluntary and private sectors

ACTIONS	Start	End
4.9 Recruit 4,200 extra Sure Start health visitors, subject to the Spending Review		
i. Develop goals and scope of implementation programme	Jun 2010	Aug 2010
ii. Develop initiatives and incentives to drive return to practice	Aug 2010	Nov 2010
iii. Develop plans to increase health visitor training places	Aug 2010	Nov 2010
iv. Identify appropriate commissioning structure to deliver specified number of visits	Aug 2010	Nov 2010
v. Develop new curriculum reflecting enlarged scope of health visitor role	Aug 2010	Nov 2010
vi. Communicate our priorities for enlarged scope of health visitor role to the Nursing and Midwifery Council	Jan 2011	
vii. Begin implementation, subject to the Spending Review	Jan 2011	

MILESTONES	
A. Return to practice offer in place	Feb 2011
B. Extra health visitors studying under revised curriculum	Sep 2011
C. 4,200 extra Sure Start health visitors in place	2015

5. Reform social care (1/2)

Enable people needing care to be treated with dignity and respect; reform the system of social care to provide much more control to individuals and their carers, easing the cost burden that they and their families face

ACTIONS	**Start**	**End**
5.1 Reform funding of the social care system		
i. Establish a commission on the funding of long-term care to consider a range of ideas, including both (a) a voluntary insurance scheme to protect the assets of those who go into residential care, and (b) a partnership scheme	Jul 2010	Jul 2011
ii. Publish vision for social care reform setting out ambitions for greater independence and choice for users of social care	Nov 2010	
iii. Publish White Paper on social care	Oct 2011	
iv. Introduce legislation	Nov 2011	
5.2 Extend the greater roll-out of health and social care personal budgets to give people and their carers more control and purchasing power		
i. Agree new milestone for roll-out of social care personal budgets with ADASS/LGA	Apr 2011	
ii. Set up additional personal health budget pilot sites, and investigate how personal health budgets and personal budgets for social care can be joined together	Jul 2010	Oct 2012
iii. Evaluate results from pilots and develop proposals for national implementation	Oct 2012	

MILESTONES	
A. Establish a commission on funding long-term care	Jul 2010
B. Publish strategy for social care reform (including personalisation, prevention and re-ablement)	Nov 2010
C. White Paper on sustainable funding and legislative framework for social care	Oct 2011

5. Reform social care (2/2)

Enable people needing care to be treated with dignity and respect; reform the system of social care to provide much more control to individuals and their carers, easing the cost burden that they and their families face

.

ACTIONS	Start	End
5.3 Improve access to respite care by using direct payments to carers and better community-based provision		
i. Publish a re-focused carers' strategy	Apr 2011	
5.4 Remove barriers between health and social care funding to incentivise preventative action		
i. Introduce new post-discharge tariff requiring NHS and social care joint working to manage 30-day hospital discharge and reduce re-admissions, including provision of re-ablement services	Apr 2011	
ii. Begin evaluation of dementia strategy's progress	Oct 2010	
5.5 Support the work of local authorities and provider organisations to deliver gains in efficiency and effectiveness through best practice		
i. Work with the sector to disseminate best practice in terms of efficiency and effectiveness	Jan 2011	
ii. Create the necessary support tools to achieve best practice at a local level	Jan 2011	Dec 2011

MILESTONES	
A. Re-focused carers' strategy published	Apr 2011

This page is intentionally left blank

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 21 September 2010

Subject: Updated Work Programme 2010/11

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

1.0 Purpose

1.1 The purpose of this report is to present and update members on the current activity across a number of work areas and present an outline work programme. The Board is asked to consider, amend and agree its work programme, as appropriate.

2.0 Background

2.1 At its meetings on 25 June 2010 and 27 July 2010, the Board received a number of inputs to help members consider the Board's priorities during the current municipal year. This included specific inputs from:

- Executive Board Member for Adult Health and Social Care
- Deputy Director (Adult Social Services)
- NHS Leeds – Chair and Chief Executive
- Leeds Teaching Hospitals NHS Trust (LTHT) – Chair and Chief Executive
- Leeds Partnerships Foundation Trust (LPFT) – Chair and Chief Executive
- Leeds Director of Pubic Health

2.2 At those meetings a number of potential work areas were identified by members of the Board and are confirmed in the outline work programme attached at Appendix 1.

2.3 As in previous years, the outline work programme, including any emerging issues, will continue to be routinely presented to the Scrutiny Board for consideration, amendment and/or agreement: The work programme was previously presented and agreed at the Scrutiny Board meeting held on 27 July 2010.

3.0 Update on specific work areas and associated activity

3.1 This section of the report seeks to provide a more detailed update on specific activities and elements of the Board's work programme.

Health Service Developments Working Group

3.2 At the Board meeting on 27 July 2010, to help the Scrutiny Board maintain a focus on changes and/or developments of local health services, while maintaining the Board's capacity to undertaken other work, the Scrutiny Board established a Health Service Developments Working Group to:

- Consider, at an early stage, proposals for service changes and/or developments of local health services, including:
  - Whether or not the relevant Trust's plans for patient and public engagement and involvement seem satisfactory[1]; and,
  - Whether the proposal is in the interests of the local health service.
- Consider the significance of any proposed service changes and/or developments, alongside the associated levels of patient and public engagement and involvement.
- Maintain on overview and on-going involvement in current service change proposals and associated patient and public engagement and involvement activity, including details of any stakeholder feedback and how this is being used to shape the proposals.
- Refer any matters of significant concern to the Scrutiny Board (Health) for detailed and specific consideration.

3.3 This working group is scheduled to hold its first meeting on 14 September 2010. As such, there is no information currently available for distribution with this report: However, a summary of the outcome and proposed recommendations will be presented at the meeting for consideration.

Children's cardiac surgery services – national review

3.4 In September 2009, members of the Scrutiny Board were made aware of a national review of Children's Cardiac Surgery Services currently being undertaken and in October 2009 the Board was advised of the proposed timescales.

3.5 The Scrutiny Board (Health) received a further update on progress at its meeting in January 2010, with the review being identified and maintained as an unscheduled item since that time.

3.6 More recently, in August 2010 the National Specialised Commissioning Team (NSCT) – responsible for leading the national review – issued a further briefing note, attached at Appendix 2. This briefing note summarises current progress and outlines the next stages of the review, which currently allows for a 3-month consultation period – once the recommendations for change are published in October 2010.

[1] This early engagement with Scrutiny will help the Working Group to discuss and agree the proposed degree of variation, prior to the commencement of any patient and public engagement and involvement activity.

3.7 Members of the Board are reminded that Children's Cardiac Surgery Services are currently provided by Leeds Teaching Hospitals NHS Trust (LTHT). Currently, LTHT is the only Trust to provide such services across the Yorkshire and Humber region; therefore any recommendations for change and/or reconfiguration of services are likely to have an impact both in Leeds and across the region.

3.8 Once the recommendations are published in October 2010, in common with other Overview and Scrutiny Committees across the region, the Board will be asked to consider whether or not it considers the proposals to be 'substantial'. As such, this may result in some joint scrutiny arrangements being established to consider the proposals in more detail.

4.0 Work programme (2009/10)

4.1 For information, the minutes from the Executive Board meeting held on 25 August 2010 are attached at Appendix 3. In addition, in recognition of the complementary role that Leeds Local Involvement Network (LINk) can play in reviewing the planning and delivery of local health (and social care) services, the current LINk work programme is attached at Appendix 4.

4.2 The Scrutiny Board is asked to consider the content of both Appendix 3 and 4, within the context of making any adjustments to its work programme.

4.3 Members will be aware that the outline work programme should be regarded as a 'live' document, which may evolve and change over time to reflect any in-year change in priorities and/or emerging issues. As such, the Scrutiny Board is asked to consider the attached outline work programme (presented at Appendix 1) and agree / amend as appropriate.

5.0 Recommendations

5.1 Members are asked to consider the details presented in this report and:

5.1.1 Note the information presented at the meeting from the Health Service Developments Working Group and consider/ agree the proposed level of engagement activity in relation to the identified service areas.

5.1.2 Note the updated information presented in terms of the Children's Cardiac Surgery Services review and determine any further activity at this stage;

5.1.3 Consider the outline work programme attached at Appendix 1 and agree / amend as appropriate,

6.0 Background Documents

- Scrutiny Board (Health) – Work programme (25 June 2010)
- Scrutiny Board (Health) – Work programme (27 July 2010)

This page is intentionally left blank

APPENDIX 1

Scrutiny Board (Health)

Outline Work Programme 2010 /11 – September 2010

Item	Description	Notes	Type of item
Meeting date – September 2010			
Liberating the NHS: White Paper	To consider the proposals of the recent NHS White Paper and the associated implications .		B /SC
Promoting Good Public Health: The Role of the Council and its Partners	To consider the response to the Boards inquiry report published in May 2010.		RP
Quarterly Accountability Reports	To receive quarter 1 performance reports		PM
Leeds Strategic Plan and Vision	To receive a formal consultation report. This will provide details of proposed Vision aims, Local Strategic Plan and Business Plan priorities.		DP

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 1

Scrutiny Board (Health)

Outline Work Programme 2010 /11 – September 2010

Item	Description	Notes	Type of item
Meeting date – October 2010			
Children's Cardiac Surgery Services – National Review	To consider the recommendations arising from the national review and determine the significance of the proposals.	Precise publication date of the recommendations is to be confirmed.	SC
Meeting date – November 2010			
Leeds Strategic Plan and Vision	Scrutiny Board involvement in target setting process, linked to the Leeds Strategic Plan and Business Plan priorities		DP

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 1

Scrutiny Board (Health)

Outline Work Programme 2010 /11 – September 2010

Item	Description	Notes	Type of item
Meeting date – December 2010			
Quarterly Accountability Reports	To receive quarter 2 performance reports		PM
Recommendation Tracking	To monitor progress against the recommendations agreed following previous Scrutiny Board inquiries.		MSR
Public Heath consultation / proposals	To consider government proposals regarding the delivery of Public Health services.	Publication date to be confirmed	B / SC
Meeting date – January 2011			
Leeds Strategic Plan and Vision	Composite report to be submitted to Scrutiny Board for agreement prior to submission to Executive Board as part of the Budget and Policy Framework		DP

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 1

Scrutiny Board (Health)

Outline Work Programme 2010 /11 – September 2010

Item	Description	Notes	Type of item
Meeting date – February 2011			
Meeting date – March 2011			
Quality Accounts	To consider draft quality account submissions for 2010/11		PM
Quarterly Accountability Reports	To receive quarter 3 performance reports		PM
Recommendation Tracking	To monitor progress against the recommendations agreed following previous Scrutiny Board inquiries.		MSR

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 1

Scrutiny Board (Health)

Outline Work Programme 2010 /11 – September 2010

Item	Description	Notes	Type of item
Meeting date – April 2011			
Annual Report	To agree the Board's contribution to the annual scrutiny report		

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 1

Scrutiny Board (Health)

Outline Work Programme 2010 /11 – September 2010

Working Groups			
Working group	**Membership**	**Progress update**	**Dates**
Health Service Developments Working Group	All Board members (subject to availability)	• Working Group established in July 2010 • Working group meeting to be held on 14 September 2010	14 Sept. 2010
Liberating the NHS Working Group	Open to all members of the Board, but with core membership of: • Cllr. Dobson • Cllr. Harrand • A. Giles	• Established in July 2010 to consider the proposals contained in the White Paper 'Equality and excellence: Liberating the NHS', alongside the subsequent and supporting consultation documents.	*TBC*

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Narrowing the Gap	To consider the impact of the 'Narrowing the Gap' initiative, in terms of improving healthy outcomes.	Added to the work programme: December 2009, but no formal consideration of issue in 2009/10. Highlighted as an area to consider in July 2010.
Children's Cardiac Surgery Services	To contribute to the national review and consider any local implications.	First newsletter published (August 2009) National stakeholder event held 22 October 2009. Local (regional) involvement event to be held on 17 June 2010. Briefing note produced by National Specialised Commissioning Team (NSCT) published in August 2010. Discussions around forming a series of joint health scrutiny committee to consider the proposals are on-going.

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Children's Neurosurgery Services	To contribute to the national review and consider any local implications.	**Carried over from 2009/10.** First bulletin published (September 2009) National stakeholder event held 30 November 2009. Newsletter issued in April 2010. Local involvement likely to be towards the end of 2010.
Foundation Trust Status	To consider LTHT's progress against its aspiration of attaining Foundation Trust status.	**Carried over from 2009/10.** Initial and subsequently revised proposals considered in 2009/10. Details regarding anticipated changes in costs to support proposed new governance arrangements requested in May 2010
Primary Care Service Development and use of the Capital Estate	To consider the NHS Leeds' longer-term strategy for developing/ delivering services through its capital estate.	**Added to the work programme in December 2009**, but no formal consideration of issue in 2009/10. It may be more appropriate to consider this matter across the whole local health economy.

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Health Scrutiny – Department of Health Guidance	To receive and consider revised guidance associated with health scrutiny and any implications for local practice.	**Carried over from 2009/10.** Revised guidance was due to be published in November 2009, but was subsequently delayed until after the general election. No firm publication date is yet available and may be superseded by the details and any subsequent legislation and regulations arising from the White Paper – Equity and Excellence: Liberating the NHS
Specialised commissioning arrangements	To consider the current arrangements for specialised commissioning within the region and the role of scrutiny.	**Carried over from 2009/10.** No formal consideration of issue in 2009/10. Regional work with other local authorities is on-going. The next regional member network meeting is to be confirmed.
Openness in the NHS	To consider how the Department of Health guidance is interpreted and implemented locally.	**Carried over from 2009/10.** No formal consideration of the issue in 2009/10 and may be better linked with any detailed consideration of the White Paper – Equity and Excellence: Liberating the NHS

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Dermatology Services	To consider proposals for the delivery of dermatology services.	Follow up to the issues considered in 2009/10. **Added to work programme in July 2010.**
Hospital Discharges	To consider a follow up report on progress against the recommendations (i.e. 15, 16 and 17) detailed in the Independence, Wellbeing and Choice inspection report	Identified as potential issue for 2009/10 but insufficient capacity to consider the issue. **Highlighted as a potential area for scrutiny by the Executive Board member in June 2010.**
Out of Area Treatments (Mental Health)	To consider the report prepared by Leeds Hospital Alert and the response from LPFT.	Leeds Hospital Alert report received 1 July 2009. Responses received from LPFT in July 2009. No formal consideration of issue in 2009/10. **Carried over from 2009/10.**

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Use of 0844 Numbers at GP Surgeries	To consider the impact of the recent Government guidance on local GP practices and any implications for patients.	**Carried over from 2009/10.** Various correspondence exchanged and clarification sought. The Board to maintain a watching brief and kept up-to-date with any developments. No formal consideration of issue in 2009/10.

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

This page is intentionally left blank

Safe and Sustainable
Children's Heart Surgery: A Briefing

Our aim

This briefing aims to provide Health Overview and Scrutiny Committees with further information on the NHS review of children's heart surgery services in England. It is possible that when the NHS delivers proposals for change in these services some HOSCs may consider them to be a 'substantial variation', requiring us to formally consult with those HOSCs.

What we would like from HOSCs

We would like HOSCs to let us know of their proposed scrutiny arrangements in time for formal public consultation in the autumn of 2010. This will help us to start to plan how best to work with HOSCs during the consultation and it will help HOSCs to begin to plan for how they might be consulted. We realise that HOSCs cannot be certain about the exact arrangements until they have seen the review's proposals and decided whether the proposed changes constitute a substantial variation but we would like to plan with you now so that HOSCs can make best use of the consultation period.

When does public consultation take place?

The NHS will hold consultation from **October 2010 to January 2011.** Please see back page for further dates.

Who will consult?

The NHS is establishing a national joint committee of Primary Care Trusts (PCTs) that will have legal powers for consultation and decision making. The committee will include the Chair of each of the 10 Specialised Commissioning Groups in England (each SCG Chair is a PCT Chief Executive).

What is the likely outcome of the review and what are we likely to be consulting about?

Children's heart surgery is a complex and relatively rare treatment. On average a PCT is likely to have only 20 children each year requiring heart surgery. It is likely that the review will recommend a reduction in the number of NHS hospitals that provide children's heart surgery. Although surgery may cease in some hospitals, they would continue to provide a specialist cardiology service for children in their region.

There are currently 11 surgical centres across England – the map on page three shows their locations.

Why is there a need for the review?

- Children's heart surgery is becoming increasingly complex
- Services have developed on an ad hoc basis; there is a need for a planned approach for England and Wales
- Surgical expertise (31 surgeons) is spread too thinly over 11 surgical centres
- Some centres are reliant on one or two surgeons and cannot deliver a safe 24 hour emergency service
- Smaller centres are vulnerable to sudden and unplanned closure
- Current arrangements are inequitable as there is too much variation in the expertise available from centres
- Fewer surgical centres are needed to ensure that surgical and medical teams are seeing a sufficient number of children to maintain and develop their specialist skills
- Available research evidence identifies a relationship between higher-volume surgical centres and better clinical outcomes
- Having a larger and varied caseload means larger centres are best placed to recruit and retain new surgeons and plan for the future
- The delivery of non-surgical cardiology care for children in local hospitals is inconsistent; strong leadership is required from surgical centres to develop expertise through regional and local networks
- Increasing the national pool of surgeons is not the answer, as this would result in surgeons performing fewer surgical procedures and increase the risk of occasional surgical practice

What does the review aim to achieve?

- Better results in the surgical centres with fewer deaths and complications following surgery
- Better, more accessible diagnostic services and follow up treatment delivered within regional and local networks
- Reduced waiting times and fewer cancelled operations
- Improved communication between parents and all of the services in the network that see their child
- Better training for surgeons and their teams to ensure the sustainability of the service
- A trained workforce expert in the care and treatment of children and young people with congenital heart disease
- Centres at the forefront of modern working practices and innovative technologies that are leaders in research and development
- A network of specialist centres collaborating in research and clinical development, encouraging the sharing of knowledge across the network

Is there support for the review?

There is strong support for the review, which was instigated at the request of national parent groups, NHS clinicians and their professional associations. However, some local parent groups and clinicians working in the centres are understandably concerned about the future of their own centres.

How will the NHS consult the public?

- Face to face events across England and Wales
- Online communications, including video and accessible information
- Printed communications, such as the consultation document itself and newsletters
- Through the media

How will the NHS consult with HOSCs?

We want you to help us plan for consultation by telling us how you think we can best engage with HOSCs.

The 2003 Direction from the Secretary of State requires scrutiny committees to convene a joint HOSC when two or more HOSCs consider proposals affecting a population larger than a single HOSC to be 'substantial'.

There are 10 Strategic Health Authority regions in England, so it may make sense to align scrutiny arrangements with these regions. We are aware that HOSCs in several regions already have protocols for joint scrutiny of health issues.

Current Surgical Centres

1 Freeman Hospital, Newcastle

2 Leeds Teaching Hospital

3 Alder Hey Childrens Hospital, Liverpool

4 Glenfield Hospital, Leicester

5 Birmingham Children's Hospital

6 John Radcliffe Hospital, Oxford

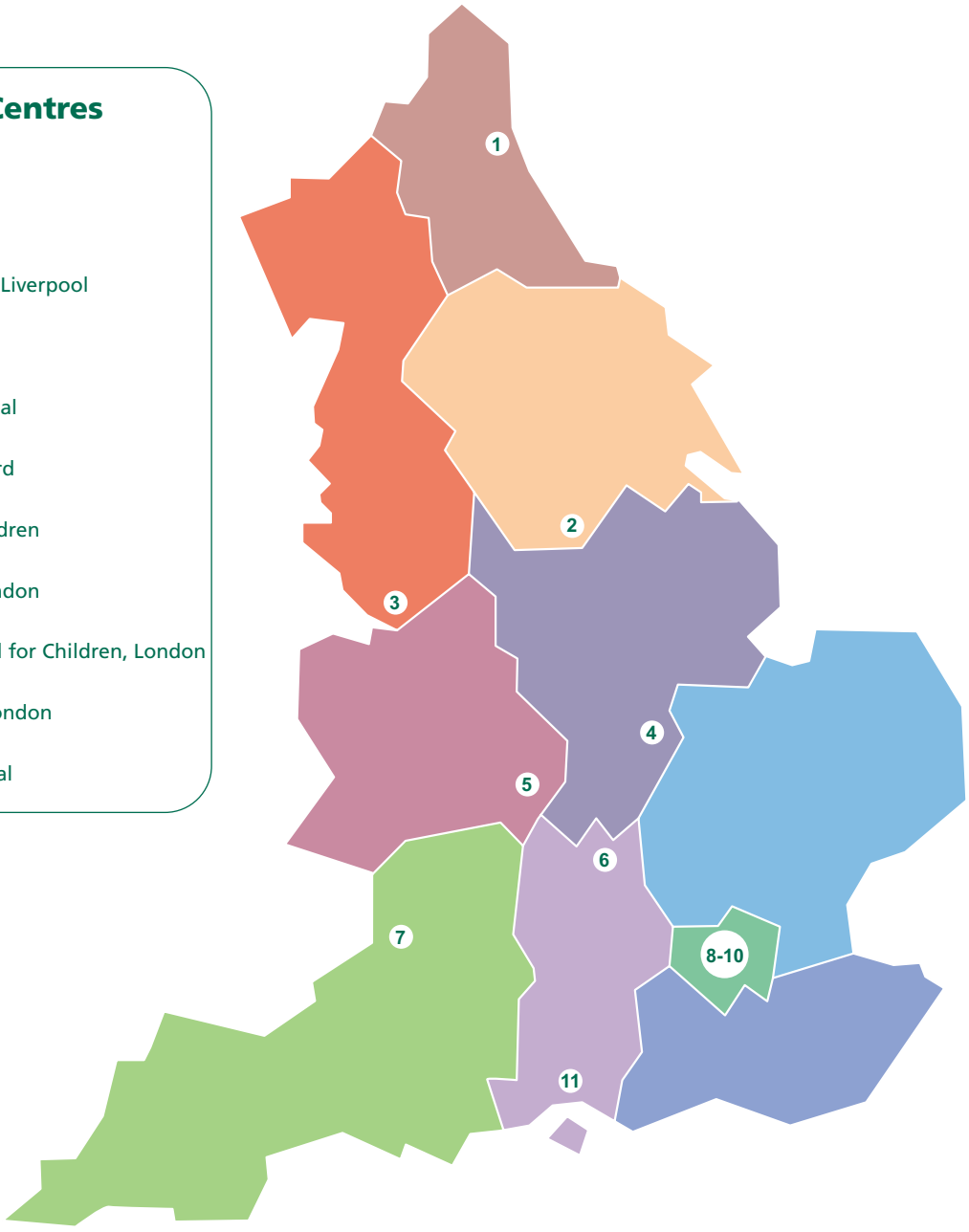
7 Bristol Royal Hospital for Children

8 Royal Brompton Hospital, London

9 Great Ormond Street Hospital for Children, London

10 Evelina Children's Hospital, London

11 Southampton General Hospital



What is the timeline?

October 2010	NHS publishes recommendations and starts a national consultation
October 2010	HOSCs decide whether the recommendations constitute a 'substantial variation' and the NHS consults those HOSCs that decide proposals are 'substantial'.
31 January 2011	National consultation ends
1 February 2011	NHS starts to consider the outcome of consultation
Early February 2011	NHS reports to relevant HOSCs on the outcome of consultation and asks that HOSCs provide their responses to the proposals by early March 2011
April 2011	NHS makes final decision and communicates the decision to relevant HOSCs. These HOSCs decide whether to contest the proposals to the Secretary of State
2013	Changes are expected to be implemented (this may be subject to Secretary of State approval if the Secretary of State asks the Independent Reconfiguration Panel to provide advice)

Please let us know:

1. **Your proposed arrangements for scrutiny (for example, whether or not you think that existing arrangements for regional joint scrutiny can be used)**
2. **Contact details so that we can start to confirm dates and venues for presentations to HOSCs (we suggest that we set dates now so that we can start to work with you in developing a consultation that meets your needs)**
3. **Any other questions that you may have**

Contact details

The NHS review is led by the National Specialised Commissioning Team on behalf of the 10 Specialised Commissioning Groups in England.

Please contact: Zuzana Bates, Project Liaison Manager **e:** Zuzana.Bates@nsscg.nhs.uk

National Specialised Commissioning Team 2nd floor, Southside, 105 Victoria Street, London SW1E 6QT
Direct Line: 020 7932 3771

Further information

Other documents that you may wish to read include:

- 'The Need for Change' (April 2010) which sets out the reasons why change is considered necessary
- Clinical standards that hospitals providing children's heart surgery must meet in the future (March 2010)
- Newsletters

These, and other documents, are available from our website: **http://www.specialisedcommissioning.nhs.uk/index.php/safe-and-sustainable-programmes/childrens-heart-surgery-services-programme/**

We would like to thank the Centre for Public Scrutiny for their assistance.

EXECUTIVE BOARD

WEDNESDAY, 25TH AUGUST, 2010

PRESENT: Councillor K Wakefield in the Chair

Councillors A Blackburn, J Blake, A Carter, S Golton, P Gruen, R Lewis, T Murray and L Yeadon

Councillor J Dowson – Non-Voting Advisory Member

57 Substitute Member

Under the terms of Executive Procedure Rule 2.3, Councillor Mulherin was invited to attend the meeting on behalf of Councillor Ogilvie.

58 Exempt Information - Possible Exclusion of the Press and Public

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

(a) Appendix 1 to the report referred to in Minute No. 62, under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that the information contained therein relates to the commercial position of the City Council in respect of the proposed procurement. Therefore, the public interest in maintaining the confidentiality outweighs the public interest in disclosing such information.

Appendix 4 to the report referred to in Minute No. 62, which has been placed in the Members' Library for inspection, under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that it contains information about the commercial position of the City Council. Therefore the public interest in maintaining confidentiality outweighs the public interest in disclosing such information.

(b) Appendix 2 to the report referred to in Minute No. 71(b), under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that it contains information relating to the financial or business affairs of third parties and also contains information which is subject to ongoing negotiations. As such, the release of this information would be likely to prejudice the interest of all the parties concerned. Whilst there may be a public interest in disclosure, in all the circumstances of the case maintaining the exemption is considered to outweigh the public interest in disclosing this information at this time.

(c) Appendix 2 to the report referred to in Minute No. 74, under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that the public interest in maintaining the exemption in relation to this information outweighs the public interest in disclosure, by reason of the fact that it contains information and financial details which, if disclosed, would adversely affect the business of the Council and may also adversely affect the business affairs of the other parties concerned.

59 Late Items

There were no late items as such, however it was noted that supplementary information had been circulated to Board Members prior to the meeting which provided details of the equality impact assessment undertaken in respect of the proposals within the report on grant reductions (Minute No. 71(b) refers).

60 Declaration of Interests

Councillor Yeadon declared a personal interest in the item relating to grant reductions (Minute No. 71(b) refers), due to being a former employee of an organisation referred to in exempt appendix 2 of the submitted report and having close personal connections with employees of that organisation.

Councillor Murray declared a personal interest in the item relating to the lease of the St. Aidan's Trust Land to the RSPB (Minute No. 76 refers), as a Council representative on the St. Aidan's Trust Fund and Trust Land Advisory Committee. Councillor Murray also declared a personal interest in the item relating to grant reductions (Minute No. 71(b) refers), due to being a Director of an organisation referred to in exempt appendix 2 of the submitted report and a personal and prejudicial interest in this item as the Chief Executive of a separate organisation detailed within the same appendix.

Councillor Blake declared a personal interest in the item relating to grant reductions (Minute No. 71(b) refers), due to being vice chair of the trustees of an organisation referred to in exempt appendix 2 of the submitted report.

Councillor Wakefield declared a personal and prejudicial interest in the item relating to grant reductions (Minute No. 71(b) refers), due to being a member of and having close personal connections with an organisation referred to in exempt appendix 2 of the submitted report.

Councillor Golton declared a personal interest in the item relating to the Primary Capital Programme (Minute No. 66 refers), due to his position of governor of Oulton Primary School.

A further declaration of interest was made at a later point in the meeting. (Minute No. 66 refers).

61 Minutes

Having taken in to consideration comments made in respect of Minute No. 34, entitled, 'Neighbourhood Network Services', it was

RESOLVED – That the minutes of the meeting held on 21st July 2010 be approved as a correct record, subject to the addition of the following words at the end of resolution (c) to Minute No. 34 for the purposes of clarification: "failing which, a further report be brought back to this Board."

62 Introduction of the New Chief Executive

On behalf of the Board, the Chair introduced Tom Riordan, as this marked the first ordinary meeting of Executive Board since he began his tenure as Chief Executive.

NEIGHBOURHOODS AND HOUSING

63 Round 6 PFI Outline Business Case: Lifetime Neighbourhoods for Leeds

Further to Minute No. 188, 12th February 2010, the Director of Environment and Neighbourhoods submitted a report proposing the submission of the Lifetime Neighbourhoods for Leeds Outline Business Case (OBC) to the Homes and Communities Agency under the national Round 6 PFI Housing programme. In addition, the report also sought approval of the proposed revisions to the project's scope, sites and affordability position.

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, and appendix 4 to the report, which was also designated as exempt under Access to Information Procedure Rule 10.4(3) and made available for Board Members' inspection via the Members' Library, it was

RESOLVED –

(a) That the submission of the Lifetime Neighbourhoods for Leeds Outline Business Case under the national Round 6 PFI Housing programme, as detailed at exempt Appendix 4 to the submitted report, which had been placed within the Members' Library for Board Members' inspection, be approved.

(b) That the revised scope of the project, as set out in paragraph 4.3 of the submitted report, be approved.

(c) That the inclusion of seven of the sites in the project, as approved by Executive Board on 12th February 2010 be confirmed as follows:

(1) Brooklands Avenue, Central Seacroft, (part of) Killingbeck & Seacroft Ward
(2) Primrose High School, Burmantofts, (part of) Burmantofts & Richmond Hill Ward
(3) Beckhill Approach/Garth, Meanwood, Chapel Allerton Ward
(4) Farrar Lane, Holt Park – sheltered housing, Adel & Wharfedale Ward
(5) Haworth Court, Yeadon, Otley & Yeadon Ward
(6) Mistress Lane, Armley, Armley Ward
(7) Acre Mount, Middleton, Middleton Park Ward

(d) That the inclusion of the four additional sites in the OBC, as set out below and as detailed in appendix 2 to the submitted report be approved subject to consultation:

(1) Cranmer Gardens, Moor Allerton, Alwoodley Ward
(2) Rocheford Court, Hunslet, City & Hunslet Ward
(3) Parkway Close, South Parkway, Seacroft, Killingbeck & Seacroft Ward
(4) Wykebeck Mount, Osmondthorpe, Temple Newsam Ward

(e) That the affordability position, as set out in the financial appraisal in exempt Appendix 1 to the submitted report, be approved.

(f) That the service charge assumptions for the extra care accommodation, as included in paragraph 9.2 of the submitted report, be approved.

(g) That the City Council's anticipated financial contribution to the project, as agreed by Executive Board on 12th February 2010, be noted.

64 Regional Housing Board Programme 2008-2011: Acquisition and Demolition Schemes Update

The Regional Housing Programme Board submitted a report outlining proposals to rescind approvals previously approved in respect of the Holbeck Phase 4 acquisition and demolition scheme for the purposes of transferring funding to other acquisition and demolition schemes as detailed within the submitted report, in order to enable the remaining demolitions to take place before March 2011.

RESOLVED -

(a) That £580,000 be rescinded from the Holbeck Phase 4 acquisition and demolition scheme and that the revised cash flow position be agreed.

(b) That scheme expenditure, as set out in appendix B to the submitted report be authorised in order to complete the demolitions and clearance of the 5 sites in the Beverleys, Holbeck Phases 1, 2 and 3 and Cross Green Phase 2.

CHILDREN'S SERVICES

65 Children's Services Improvement Update Report

The Interim Director of Children's Services submitted a report providing an update on the implementation of Leeds' Improvement Plan for Children's Services and the work of the Improvement Board, the transformation programme aimed at providing an integrated delivery model for children's services and the development of a new Children and Young People's Plan for the city.

On behalf of the Board, the Chair paid tribute to and thanked the Interim Director of Children's Services, Eleanor Brazil, as this was potentially the final Board meeting in which she would be in attendance.

Following the high levels of attainment achieved in the recent GCSE and Alevel results, in addition to the positive fostering inspection report which had been received, the Board paid tribute to and thanked all of those involved.

RESOLVED -

(a) That the progress made against the Improvement Plan for Children's Services in Leeds and the work of the Improvement Board undertaken to support this be noted.

(b) That the intention to consult on, and then develop a new Children and Young People's Plan for Leeds, intended to be ready by spring 2011, be noted.

(c) That the progress made to date on the transformation programme and the next steps designed to develop and propose a revised leadership structure and model for integrated service delivery and integrated business support functions, which will be brought back to Executive Board in autumn 2010, be noted and endorsed.

66 Primary Capital Programme: Works at Richmond Hill, Swillington, Saints Peter and Paul, Gildersome, Greenhill and Oulton Primary Schools

The Chief Executive of Education Leeds submitted a report on the proposed building of three new school buildings for Richmond Hill Primary School, Swillington Primary School and Saints Peter and Paul Catholic Primary School, Yeadon, and on the extension and refurbishment of buildings at Gildersome Primary School, Greenhill Primary School and Oulton Primary School.

RESOLVED –

(a) That the design proposals in respect of the schemes to new build schools at Richmond Hill, Swillington and Saints Peter and Paul, and extension and refurbishment works at Gildersome, Greenhill and Oulton be approved.

(b) That the injection of Governors' contribution to scheme number 15178/PET of £393,700 be approved.

(c) That authority be given to incur expenditure of £33,125,500 from capital scheme numbers 15178/RIC, SWI, PET, GIL, GRE and OUL.

(Councillor Golton declared a personal interest in this item, having attended Richmond Hill Primary School)

67 Design and Cost Report and Final Business Case: Building Schools for the Future Phase 3: Corpus Christi Catholic College

The Chief Executive of Education Leeds submitted a report which sought approval of the Final Business Case in respect of the Corpus Christi Catholic College project for submission to the Partnerships for Schools organisation. The Final Business Case had been placed within the Members' Library for inspection.

RESOLVED – That the Final Business Case for the Corpus Christi Catholic College project be approved, and the submission of the Final Business Case to Partnerships for Schools be authorised.

LEISURE

68 Crematoria Mercury Abatement

The Acting Director of City Development submitted a report outlining proposals on how the Council intended to meet Government legislation targets in respect of mercury emissions abatement during the cremation process and providing details of how the Council proposed to renew its cremation facilities on a phased basis.

Members received assurances that cremations would be undertaken at a specified crematorium, that bodies would not be transferred between crematoria for the purposes of cremation and that such matters would be dealt with as sensitively as possible when accommodating service users' preferences.

RESOLVED –

(a) That the legislative requirements relating to mercury abatement and the need to implement a solution by 2012 be noted.

(b) That the preferred approach to replace cremators and abate mercury at Rawdon by December 2012, as detailed within the submitted report, be approved.

(c) That the longer-term strategy to replace cremators at Cottingley in 2016 and to replace cremators and consider future abatement for mercury at Lawnswood in 2018 be agreed, subject to further detailed business cases and funding plans being brought forward.

(d) That in order to ensure this strategy meets the target of 50% mercury abatement by the end of 2012, the Board notes that it will be necessary to increase the proportion of cremations at Rawdon until abatement is fitted at Lawnswood.

(e) That the initiation of the design and development of the specification for Rawdon, which will be funded from Prudential Borrowing and a continuing surcharge on cremations, be approved.

(f) That a fully funded injection of £2,900,000 into the Capital Programme be agreed in order to finance Mercury Abatement works, financed through the Council exercising its prudential borrowing powers using the fees generated by the environmental surcharge introduced for this purpose in 2008.

(g) That a Design and Cost Report be submitted to Executive Board once a more detailed cost estimate for the Rawdon works has been developed, and that further information on the proposals relating to the future provision of the service be submitted to the Board for consideration at that time.

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

69 Design and Cost Report: The Development of Middleton Park through a Heritage Lottery Fund Parks for People Grant

Further to Minute No. 132, 9th December 2009, the Acting Director of City Development submitted a report detailing proposals to spend the £1,797,929 which had previously been injected into the capital programme, outlining the proposed capital development works and cost profile of the scheme, and regarding the processes for the acceptance of the £1,465,000 Heritage Lottery Fund grant and the delegation of relevant approvals.

RESOLVED -

(a) That expenditure against the injection of £1,797,929 made into the 2010/11 Capital Programme by Executive Board in December 2009 be approved.

(b) That the proposed capital development works and the cost profile of the scheme be noted.

(c) That acceptance of the £1,465,000 grant be authorised and related approvals be delegated to the Chief Recreation Officer.

ADULT HEALTH AND SOCIAL CARE

70 Response to the Deputation to Council - The Access Committee for Leeds Regarding "Please Help us to Save Woodlands Respite Care Centre, York"

The Director of Adult Social Services submitted a report in response to the deputation to Council, entitled, 'Please help us to save Woodlands Respite Care Centre, York', from members of the Access Committee for Leeds on 14th July 2010.

It was suggested that further work was undertaken with other local authorities in a bid to identify an alternative service provider.

RESOLVED –

(a) That the response to the deputation and the proposed actions of Adult Social Services officers, as outlined within the submitted report, be noted.

(b) That should an alternative service provider not be found, a report be submitted to a future meeting of the Board providing an update on the work undertaken to support the affected service users.

RESOURCES AND CORPORATE FUNCTIONS

71 Financial Health Monitoring 2010/2011

(a) Financial Health Monitoring 2010/2011: First Quarter Report

The Director of Resources submitted a report providing an update on the financial health of the authority for 2010/2011 after three months of the financial year. The report provided details of the revenue budget, the housing revenue account and Council Tax collection rates. The report also identified a number of pressures, particularly in relation to income and demand led budgets and the actions being taken by directorates to address such pressures.

RESOLVED –

(a) That the projected financial position of the authority after three months of the new financial year be noted, and that directorates be requested to continue to develop and implement action plans which are robust and which will deliver a balanced budget by the year end.

(b) That a virement of £500,000 from the training budget into the domiciliary care budget, as detailed within the submitted Adult Social Care report, be approved.

(c) That the reallocation of budgets within Adult Social Care to reflect revised management arrangements, as detailed within the submitted Adult Social Care report, be noted.

(b) Reductions In Grants: Implications for Services

Further to Minute No. 16, 22nd June 2010, the Director of Resources submitted a report providing details of the implications for Leeds arising from the grant reductions to Local Authorities announced by Government as part of its accelerated deficit reduction plan and outlining proposals to deal with such reductions.

Supplementary information had been circulated to Board Members prior to the meeting which provided details of the equality impact assessment undertaken in respect of the proposals detailed within this report.

Officers undertook to provide the relevant Board Members with information in response to issues raised during the consideration of this item in respect of specific organisations detailed in exempt appendix 2.

The Chief Executive invited Members to submit any views they had in respect of how potential impacts could be effectively assessed as part of the overall budgetary process.

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

RESOLVED –

(a) That the following virements in respect of the in year reductions in grants, as detailed at paragraph 2.1 of the submitted report be approved:

- a virement from the Strategic budget to services to reflect the reductions in Area Based Grant and the LPSA2 Reward grant which are held centrally;
- a virement within City Development directorate to reflect the loss of Housing and Planning Delivery Grant and Free Swimming grant;
- a virement within Children's Services in respect of Nursery Education Pathfinder Grant, Buddying, Playbuilder, Training and Development Agency, Contact Point, Harnessing technology and Local Delivery Support grants.

(b) That the reductions in expenditure/additional income, as detailed in Appendix 1 to the submitted report, be approved.

(c) That the proposed reductions in payments to external providers, as detailed at exempt appendix 2 to the submitted report be noted, with the relevant decisions being taken by officers under delegated powers in consultation with the appropriate Executive Members when negotiations have been concluded.

(Having declared a personal and prejudicial interest in relation to the matter considered at Minute No. 71(b), due to being a member of and having close personal connections with an organisation referred to in exempt appendix 2 of the submitted report, Councillor Wakefield vacated the Chair in favour of Councillor R Lewis and withdrew from the meeting room for the duration of this item)

(Having declared a personal and prejudicial interest in relation to the matter considered at Minute No. 71(b), as the Chief Executive of an organisation referred to in exempt appendix 2 of the submitted report, Councillor Murray withdrew from the meeting room for the duration of this item)

(Under the provisions of Council Procedure Rule 16.5, Councillors A Carter and Golton required it to be recorded that they had abstained

from voting on the matters referred to within Minute Nos. 71(a) and 71(b))

72 Capital Programme Update 2010-2014

The Director of Resources submitted a report providing an updated financial position on the 2010-2014 Capital Programme, detailing the implications of the recent reductions in capital grants announced by Government, reporting on a review of uncommitted schemes which had taken place and detailing a small number of capital projects for which specific approvals were sought.

RESOLVED –

(a) That approval to spend of £3,051,000 on the vehicle replacement programme be confirmed.

(b) That authority be given to spend £3,138,000 on the equipment replacement programme.

(c) That the capital review process currently underway, which will be reported back to Executive Board at a later date, be noted.

(d) That an injection of £300,000 to the capital programme, funded through unsupported borrowing be approved, and authority to spend be given in respect of the relocation of services from Blenheim and Elmete to Adams Court.

(e) That the removal of the remaining funding of £1,300,000 for the City Card scheme be approved.

(f) That an injection into the capital programme of £1,300,000 be approved in order to implement the first phase of the Home Insulation scheme, with all relevant details being presented to a future meeting of Executive Board for approval.

(g) That approval be given to the use of the balance of Adult Social Care fire safety funding to address identified fire safety risks across all operational buildings within the Corporate Property Management portfolio.

(Under the provisions of Council Procedure Rule 16.5, Councillors A Carter and Golton required it to be recorded that they had abstained from voting on this matter)

73 Shared Business Rates Service

The Director of Resources submitted a report on the proposed establishment of a shared service for the billing and collection of Business Rates for Leeds and Calderdale businesses which would be delivered by Leeds City Council. The report provided information on the work undertaken to date and detailed the timescales in which a shared service could be delivered.

RESOLVED –

(a) That authority be delegated to the Director of Resources to enable him to make the necessary decisions and approvals to allow the scheme to proceed.

(b) That the Board be provided with updates regarding the development of further partnership arrangements being established with other local authorities as and when appropriate.

74 Transforming Leeds: Phase 1 Changing the Workplace

The Director of Resources submitted a report which provided an update on the Changing the Workplace programme, particularly focussing upon proposals to rationalise and modernise the Council's city centre office portfolio, in order to support the delivery of further long term efficiencies. The report sought approval to move forward with negotiations and related work on a preferred accommodation option in the city centre and highlighted areas where the programme could deliver short term benefits within the context of the wider business transformation programme.

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

RESOLVED –

(a) That the overarching business transformation context, as outlined within the submitted report, be noted.

(b) That the recommendations for progressing phase 1 of the Changing the Workplace programme, as detailed at paragraph 7 of exempt appendix 2 to the submitted report, be approved.

75 Regulation of Investigatory Powers Act 2000 - Adoption of a New Council Policy

The Chief Officer (Legal, Licensing and Registration Services) and the Director of Environment and Neighbourhoods submitted a joint report outlining the Council's proposed policy on covert surveillance conducted under the Regulation of Investigatory Powers Act (RIPA) 2000.

RESOLVED – That the proposed policy in respect of the Regulation of Investigatory Powers Act 2000, as set out in Appendix 1 to the submitted report, be approved.

DEVELOPMENT AND REGENERATION

76 Lease of the St. Aidan's Trust Land to the Royal Society for the protection of Birds

Further to Minute No. 38, 6th July 2005, the Acting Director of City Development submitted a report regarding the proposed completion of a lease to the Royal Society for the Protection of Birds (RSPB) in respect of former opencast coal and coal mining land between Methley and Swillington.

Officers undertook to provide the relevant Board Members with briefings on matters which were raised during the consideration of this item, specifically in relation to visitor numbers and access issues.

The Board gave particular thanks to Max Rathmell for his efforts throughout the development of this long running project.

RESOLVED –

(a) That the completion of the lease to the RSPB, based on the Heads of Terms outlined within Appendix 1 to the submitted report, be agreed as soon as practically possible after the transfer of the Trust Land to the St. Aidan's Trust, and that this matter be delegated to the Acting Director of City Development on completion of any outstanding documentation.

(b) That officers continue to explore the opportunities for the wider involvement of the RSPB in the development of the Lower Aire Valley as a major recreational and wildlife resource.

DATE OF PUBLICATION: 27th August 2010
LAST DATE FOR CALL IN: 6th September 2010 (5.00 p.m.)

(Scrutiny Support will notify Directors of any items called in by 12.00noon on 7th September 2010)

APPENDIX 2

Leeds LINk Work Plan 2010/2011

	Work Stream	Service	Action Plan	Lead Member	LINk Members Involved	Timescales
1	Mental Health work group	Leeds Partnerships NHS Foundation Trust	See attached action plan	Gill Crawshaw	Mental Health work group	See attached Action Plan for specific Timescales
2	SHED work group (Seldom Heard and Equality and Diversity)	Health and Social Care – Various	See attached action plan	Beatrice Rogers	SHED work group members	See attached Action Plan for specific timescales
3	Maternity Services	Leeds Teaching Hospitals NHS Trust	To review the findings of the report from CHANGE and identify any issues which need resolution. Analyse the results of the	Betty Smithson	Maternity Services work group members (This group is currently on hold until the information highlighted is	It is anticipated that the information will be received in August 2010

	Work Stream	Service	Action Plan	Lead Member	LINk Members Involved	Timescales
			National maternity services questionnaire at a local level been carried out by the Care Quality Commission and analyse the findings for issues and best practice.		available) Analysis of the surveys carried out by the LINk has been received from the freelance researcher	LINk to consider the analysis by end of September 2010
4	Hospital Food Group	Leeds Teaching Hospitals NHS Trust	a) To support the LTHT during the period leading up to the renewal of their outside catering contract in June 2012. b) To consider the following elements in	Bob Mason	Hospital Food Group members	There is a commitment to support the LTHT during the period leading to the renewal of their outside catering contract in June 2012 it is envisaged that the Project will

	Work Stream	Service	Action Plan	Lead Member	LINk Members Involved	Timescales
			connection with the provision of food at the LTHT; *Patient Choice* *Food Quality* *Food Delivery* *Special Dietary Requirements* *Food Safety* *Customer Satisfaction and Complaints* *Wastage* *Staff/Meals and Restaurants*			continue after this date in order to monitor the success of that change.
5	Carers – Personalisation Agenda	Adult Social Care	Carers Leeds will carry out research on self directed support and the impact it is having on carers in Leeds	Val Hewison	Val Hewison	Event for information and Q&A session for carers re self directed support to be

	Work Stream	Service	Action Plan	Lead Member	LINk Members Involved	Timescales
			on behalf of the LINk. Carers Leeds will feed the findings back to the LINk in report format for the Steering Group to action.			held September 8th 2010 Carers Leeds will submit the report to the LINk Steering Group 25th November 2010
6	Feedback from the public / Monitoring of PALS / Complaints feedback via the Patient Opinion Website and comments received through the LINk office.	Health and Adult Social Care	To identify and prioritise issues for the LINk's future work plan by gathering feedback from the public using the following methods; a) From the results of the LINk feedback questionnaire. b) From the PALS	a Steering Group b, c, d Bob Mason	All LINk members	Ongoing – Analysis and results of first batch of feedback questionnaires to be received at the Steering Group meeting on 29th July 2010 Full report to be received by Steering Group

	Work Stream	Service	Action Plan	Lead Member	LINk Members Involved	Timescales
			and Complaints information received from each Health Trust and Adult Social Care. c) From feedback on the Patient Opinion Website. d) From issues raised via the LINk office.			on 26th August 2010-Decision to be taken regarding use of the report Monthly reports for b,c and d to be sent to Bob Mason on a monthly basis for analysis and feedback to the LINk at Steering Group meetings.
7	To raise awareness of the LINk and increase membership	N/A	See Marketing and Communications Sub Group Action Plan.	Arthur Giles	Opportunity for all LINk members to be involved.	See attached Action Plan for specific timescales
8	Care Quality Commission Sub Group – Enter and View	Adult Social Care	Following a report received	Care Quality Commission	Joy Fisher Bob Mason	-Enter and View Plan

	Work Stream	Service	Action Plan	Lead Member	LINk Members Involved	Timescales
	activity		from the Care Quality Commission rating a Care Home as zero, the Care Quality Commission Sub Group will carry out an Enter and View visit to the Care Home in Question.	Sub Group members		Sheet approved by the Steering Group on 24th June 2010. -Enter and View Plan sheet to Adult Social Care on 5th July 2010. -Enter and View Activity to take place on 2nd August 2010. -Report to be submitted to the service provider by 3rd September 2010.
	CQC Learning Set Project	N/A	The LINk has been invited to take part in a	Care Quality Commission Sub Group	Jim Kerr	

	Work Stream	Service	Action Plan	Lead Member	LINk Members Involved	Timescales
			learning set with the CQC. The aim of this project is to understand what kinds of relationships LINks have already developed with the CQC and to develop protocols for working together.			Action plan – Aug 2010 Project to be completed by March 2011

Mental Health Work Group Action Plan

ISSUES	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
Cleanliness: Leeds LINk Feedback form – Becklin Centre Wing 32 The Feedback form highlights issues of cleanliness and understaffing.	Leeds Partnerships Foundation Trust (LPFT) Patient Safety	Contact LPFT to enquire about whether it is aware of these problems. Enter and View visit to the Becklin Centre to look at the cleanliness.	Gill Crawshaw and Emma Hanusch	Enter and View visit to be completed by end of Oct'10. Report to the Trust to be submitted by end of Nov '10.	Two more comments received on lack of cleanliness at the Becklin Centre from LINk Week. Contact made with LPFT – happy to support Enter and View Necessary forms for the visit are being compiled.	Improve cleanliness

ISSUES	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
Temperature at the Mother and Baby Unit at the Mount: Following an unresolved issue investigated by the Mental Health Patient and Public Involvement Forum - Investigate whether the temperature is still too high on the mother and baby unit.	LPFT Patient Safety	Make initial contact with LPFT to see if this issue has been resolved. If the issue has not been resolved, follow up with LPFT.		Confirmation that the units have been installed and conditions improved by end of Sept '10.	LPFT has informed the Group that air conditioning units are being sourced and will be fitted in the near future. The Group will monitor this situation.	Ensure safe and comfortable temperature for staff patients and babies at the mother and baby unit

ISSUES	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
Service Provision for prisoners and ex offenders: Following an initial discussion between LINk staff and ICAS, one of the themes raised was the lack of mental health service provision for prisoners and ex offenders (This initial evidence is anecdotal) services and with Jigsaw. (Following initial	LPFT / Adult Social Care	Establish what support is currently provided and establish a link with the prison Contact the Jigsaw Project at Armley Prison Monitor 'Crime Reduction Forum' at Leeds Voice for useful	Sharanjit Boughan Emma Hanusch Emma Hanusch	Carry out meeting by end of Oct '10 To follow up after their first meeting on 20th Sept '10	Contact made with Armley prison - report on mental health provision is positive.	Increase mental health service provision for prisoners and ex offenders

ISSUES	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
concerns raised through ICAS).		contacts and issues		Evaluate progress of issue in November ’10 and decide how to move forward		
Crisis and Emergency Services: Concerns have been raised by members of the public re access to crisis services for people with mental ill health	Adult Social Care – short term counselling for people. Crisis centre Health Trusts/Adult Social Care	Investigate with Adult Social Services what short term counselling is available and where / how this service is publicised		Evaluate the progress of this issue in Sept ’10 meeting		Increase publicity about how to access crisis services and ensure the information is accessible to all communities. Ensure LINk involvement of

ISSUES	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
National crisis resolution campaign – MIND Link (Service user campaigning department of MIND)		Investigate what information is currently available from Adult Social Care and LPFT, where this is publicised and in what formats. Keep up to date with developments	Gill Crawshaw			any new materials are created to advertise these services

ISSUES	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
Ongoing gathering of evidence from the public about Mental Health Services in Leeds: Continue to gather evidence from Service Users about Mental Health Services in Leeds. The evidence gathered will then form future work topics for the Mental Health Work	LPFT / Social Services	Contact Groups and visit Day Centres to gather feedback from Service Users, including: Potterdale Vale Day Centre Stocks Hill Lovell Park	Emma Hanusch and members	Potterdale Day Centre – visit to be carried out by end of Oct '10.	Leeds Mind visit – complete.	Improve patient experience by taking forward issues which directly affect service users.

ISSUES	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
Group.		Mental Health Service User and Reference Group De Lacy House	Janet Somers to contact other day centres about LINk Aug ’10. Gill Crawshaw and Paola Vietri	Visits to be scheduled by end of November ‘10 Visit to be carried out by September ‘10 work group meeting		

ISSUES	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
		Use the LINk e-bulletins and Facebook page to request ask questions relating to the work plan to gather feedback			Questions about crisis services have been inserted into the LINk e-bulletin and several comments have been received	
Encourage and support the development of a network of Mental Health Service User Groups	Voluntary Sector / LPTF / Adult Social Care	Liaise with LPFT to drive forward the development of a mental health service user group network	Gill Crawshaw and Emma Hanusch	Plan of action to be established by end of Sept '10	Contact made with John Thorpe – a group has met to discuss this (June '10)	Create a stronger voice for people using mental health services to positively influence change to services

ISSUES	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
					Emma to follow up with John about next steps by end of Sept '10	
Access to Mental Health Services for Deaf and hard of hearing people	LPFT	Liaise with the Becklin Centre and Community Health Teams to increase basic Deaf awareness amongst staff	Sign Health, Sue Gill / Emma Hanusch	Work to be complete by March '11	Sue Gill to attend work group meeting Sept '10 Emma to contact Caroline Bamford (LPFT) about current staff training and future needs by Sept '10	Increase deaf awareness amongst frontline staff to improve services

ISSUES	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
Interface between the emergency services and NHS for mental health service users – sub group of the regional YAS group	Yorkshire Ambulance Service	Emma Stewart to attend the first meeting (yet to be scheduled)	Emma Stewart			

SHED Work Group Action Plan

Issues	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
Equality and Diversity checklist	Health and Social Care	Design a checklist for people to use in order to evaluate the inclusivity of meetings/events they attend. The checklist will also inform people hosting the meetings/events.	Joy Fisher and Linda Boadle to make first draft.	To be completed by Sept '10	Draft has been done building on the existing Physical and Sensory Impairment Network leaflet. Some further ideas for development have been agreed in May. Linda to	To improve the inclusivity and accessibility of meetings.

Issues	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
					confirm final sign off at VAL by Aug '10	
The Gender Identity Clinic, Seacroft Hospital. Trans Yorkshire approached the LINk with concerns about the location of the Leeds Gender Clinic (Newsam centre).They feel it is	Leeds Partnership Foundation Trust	- Build relationship with the Leeds Partnership Foundation Trust to establish history around the relocation of the clinic to the Newsam. - Possible visit to the clinic to look first hand at the suitability of the surroundings and speak to Clinical Manager.	Facilitated by Host staff. LINk Members And staff		**Visit carried out for 21st July 2010. Report produced and sent to the work group with recommendation on how to take**	To make a recommend ation to the Trust that the clinic is relocated.

Issues	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
undignified for users of the service and that they are being stigmatised as having a mental illness.		- Define how to gather some more views from trans individuals about the clinic.	LINk work group.	Review views that have been gathered by Oct '10 and decide how to take forward the issue	**forward**	
Access for Seldom Heard groups **(1)** Barriers for trans individuals when accessing	Health and Social Care	**(1)** Joint working with NHS Leeds to find out specifically what trans individuals in Leeds think about access to Primary	LINk work group and a member of the Vulnerable	Update from Paul by Sept '10	Paul Sandom is liaising with his team to see how this	To add findings to the NHS Leeds

Issues	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
services. **(2)** Language Line and Interpreters. It has been highlighted by LINk member organisations that some groups cannot access services due to language barriers.		Care services. **(2)** Research how Language Line and Interpreters are made available to people who require them. Receive statistics from NHS Leeds on the use of Language Line across primary care services in Leeds.	groups team at NHS Leeds LINk members/staff Paul Sandom/Sharon Moore	 Present in report for Oct '10 meeting End of June '10 Review of the issue at the October '10 meeting to	can be approached. Statistics received June '10. Group to decide how to proceed in October meeting.	'Single Equality Scheme' To improve access for people who don't speak English.

Issues	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
				determine how to progress.		
'A Need for a space in Leeds for lesbian and bisexual women' – report from Amy Rebane at Leeds Involving	Health and Social Care	Amy Rebane (LIP) shared this report with the group and they agreed that they would like to support the work and help move it forward.	Work group members	Group to decide in the October meeting how to take this forward.		To submit the report to relevant statutory body and gain a recognition of the needs of lesbian and bisexual women in Leeds.

Issues	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress	Desired Outcomes
People						
Equality and Diversity training	Health and Social Care	Training to be organised for the LINk membership to raise awareness of equality and diversity across the seven strands of diversity.	Emma to source and organise with guidance from the work group	First training course scheduled for 20th September ’10. Further courses to be rolled out in early ’11.		Training will help members to ensure that principles are embedded into the LINk and it’s membership .

Marketing and Communications Subgroup Action Plan

Item	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress
Newsletter (quarterly)	Ensure balance of Health and Social Care issues and articles	Staff and members to collect information over each quarter i.e. events, consultations, issues. Staff and members to produce articles and write-ups. - Staff to pull together into an edition. - Staff and members meet to edit and prepare for print.	. **ALL** – subgroup members and supporting member of staff.	Quarterly	
Media Representative		- Ask the Steering Group for a volunteer with the right skills, experience. - If no one volunteers, then the Co-Chairs should carry out this role. - Chosen representatives to undergo training. - Katie Baldwin (YEP) to be informed when representatives in place and trained.	Joy Fisher Arthur Giles Ken Ward	Training organised for 7th September '10	**Joy Fisher, Arthur Giles and Ken Ward chosen as media representatives.**
Easy Read Leaflet		- Easy Read version of LINk leaflet to be designed externally.	- Emma to source organisation. - Members to agree design.		**Work completed March '10**
The LINk Annual Report 2009-10		- This group will take the lead on the report. - To decide on design and sections. - LINk work/sub group members to submit content.		Final Draft to be complete by 1st June	**Work complete June '10**

Item	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress
		- Emma to pull the draft together. - To be checked by Steering Group.		2010	
Development of Posters and Flyers		- Current LINk poster design to be printed professionally. - Basic A6 flyer to be designed.	Emma		**Work complete Nov '09**
'LINk Week' (A series of information/outreach drops across the city	Health and Social Care	- Group decided on 'LINk Week' – promotional week to raise awareness and also gather views from the public to develop the work groups. - To have a presence in hospitals, Health centres. Leeds Market stall. - To take place in May/June - Radio advertising to take place in conjunction. Emma to research. Report produced for the week so that the Steering Group could analyse the effectiveness.	Host staff and members Host		**Work complete June '10** Complete – commercial aired June '10 Submitted to the July '10 Steering group
Promotional Video	Health and Social Care	To produce a DVD that tells people what the LINk is, what it can do and how to become involved in making changes to	Members facilitated by hosts staff	Early-Mid 2011	

Item	Service	Step by Step Action Plan	Person Responsible	Timescales	Progress
		services in Leeds. Meet with media/production company to begin discussions.			Carried out in Aug '10
<u>White Paper Consultation</u> - Briggate	Health	To organise an event on Briggate to consult on the Health White Paper. Also to consult with the public on the current LINk work plan and ask their ideas for future development and work priorities.	LINk staff and members	Information gathered on the White Paper from the public to be submitted to the Department of Health by 5th October '10	Event date set for 14th September.
		Advertise the event widely in Leeds through e-bulletin and other channels i.e. radio, tv and newspapers.	Host staff	To complete by end of August '10	