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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

Meeting to be held in Civic Hall, Leeds on
Friday, 22nd July, 2011 at 10.00 am

(A pre-meeting will take place for ALL Members of the Board at 9.30 a.m.)

MEMBERSHIP

Councillors

S Armitage	-	Cross Gates and Whinmoor;
K Bruce	-	Rothwell;
J Chapman	-	Weetwood;
A Hussain	-	Gipton and Harehills;
W Hyde	-	Temple Newsam;
J Illingworth	-	Kirkstall;
G Kirkland	-	Otley and Yeadon;
G Latty	-	Guiseley and Rawdon;
A McKenna	-	Garforth and Swillington;
L Mulherin (Chair)	-	Ardsley and Robin Hood;
S Varley	-	Morley South;

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

Agenda compiled by:
Angela Bloor
Governance Services
Civic Hall
LEEDS LS1 1UR
Tel: 24 74754

Principal Scrutiny Adviser:
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 THE 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 items on this agenda.**	

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** To approve the minutes of the Scrutiny Board (Adult Social Care) held on 13th April 2011 and the Scrutiny Board (Health) held on 26th April 2011 (minutes attached)	1 - 14
7			**CHANGES TO THE COUNCIL'S CONSTITUTION IN RELATION TO SCRUTINY** To consider a report of the Head of Scrutiny and Member Development providing information on recent amendments to the Council's Constitution which relate to or impact on the work of Scrutiny Boards (report attached)	15 - 16

8			**CO-OPTED MEMBERS** To consider a report of the Head of Scrutiny and Member Development seeking the Board's consideration for the appointment of co-opted members to Scrutiny Board (Health and Well-being and Adult Social Care) (report attached)	17 - 20
9			**SOURCES OF WORK AND AREAS OF PRIORITY FOR THE SCRUTINY BOARD** To consider a report of the Head of Scrutiny and Member Development providing information and guidance on potential sources of work and areas of priority within the Board's terms of reference (report attached)	21 - 96
10			**FUTURE OPTIONS FOR LONG TERM RESIDENTIAL AND DAY CARE SERVICES FOR OLDER PEOPLE** To consider a report of the Director of Adult Social Services updating Members on the programme of work development by Adult Social Care to progress and implement the recommendations of Executive Board on the future requirements of older people's residential and day care services, agreed on 15th September 2010 (report attached)	97 - 110
11			**WORK SCHEDULE** To consider a report of the Head of Scrutiny and Member Development on the Board's work schedule for the forthcoming municipal year (report attached)	111 - 126

12			**DATE AND TIME OF THE NEXT MEETING** Wednesday 21st September 2011 at 10.00am (pre-meeting for Board Members at 9.30am)

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SCRUTINY BOARD (ADULT SOCIAL CARE)

WEDNESDAY, 13TH APRIL, 2011

PRESENT: Councillor T Hanley in the Chair

Councillors B Cleasby, P Grahame, S Hamilton, A Hussain, V Kendall, M Lyons, R Pryke, K Renshaw, D Schofield and S Varley

CO-OPTEES J Fisher and S Morgan

90 Declarations of Interest

Joy Fisher and Sally Morgan declared personal interests as Service Users.

91 Apologies for Absence and Notification of Substitutes

Apologies for absence were submitted on behalf of Councillor P Davey and Co-opted Member, Mrs B Smithson. Councillor P Grahame was in attendance as substitute.

92 Minutes - 4 and 16 March 2011

RESOLVED – That the minutes of the meetings held on 4 and 16 March 2011 be confirmed as a correct record.

93 Response to the Tri-Centre Group submissions in relation to the recommendation to the reconfiguration of Leeds City Council Mental Health Day Services Response to UNISON Concerns in relation to Crisis Centre and Day Services Reconfiguration Equality Impact Assessments

The report of the Head of Scrutiny and Member Development referred to the meeting of 16 March 2011 when the Board heard representations from the Tri-Centre Group in relation to the reconfiguration of Leeds City Council Mental Health Services and from UNISON in relation to reconfiguration Equality Impact Assessments.

Appended to the report were detailed responses of the Director of Adult Social Services to the representations from the Tri-Centre Group and UNISON. Sandie Keene, Director of Adult Social Services attended the meeting and gave the Board an overview of the responses. The Board was also asked to endorse the recommendation that the matter regarding the reconfiguration of services be returned to Executive Board, advising that the recommendation should not be implemented pending the formalisation of the existing consultation.

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

- The need to consult on future reconfiguration of services and how pathways to Mental Health support should be supported. There was a need to look as all services provided across the City including those within the voluntary sector and any areas of overlap or gaps need to be identified.
- The challenge to provide improved quality of services and deliver change with diminished budgets.
- Provision of support within the community and helping people to achieve independence.
- Members welcomed the approach to take the recommendation back to the Executive Board.

RESOLVED –

(1) That the content of the report and its conclusion (Response to Tri-Centre Group submission) be noted and endorsed.
(2) That the content of the report (Response to UNISON concerns) be noted.

94 Recommendation Tracking - Supporting Working Age Adults with Severe and Enduring Mental Health Problems

The report of the Head of Scrutiny and Member Development gave a progress report on the recommendation tracking following the Board's Inquiry into Supporting Working Age Adults with Severe and Enduring Mental Health Problems.

Members attention was brought to the appendix of the report which highlighted that of the six recommendations detailed in the report, four of these were considered to have been achieved and the remaining two had seen acceptable progress.

RESOLVED – That the progress status on the achieved recommendations be accepted and that no further monitoring be required.

95 Scrutiny Inquiry - Terms of Reference - Leeds Crisis Centre

The report of the Head of Scrutiny and Member Development referred to the request for scrutiny from the Leeds Local Involvement Network (LINk) concerning the proposal to decommission the Crisis Centre. Draft terms of reference had been drawn up and were appended to the report for the Board's approval.

John Lennon, Chief Officer – Access and Inclusion, Adult Social Care was in attendance for this item.

Members' attention was brought to the scope of the Inquiry which would focus on future provision and exit strategies. It was reported that implementation of the decision to decommission the Crisis Centre had commenced following the outcome of the call-in meeting on 4 April and further issues highlighted included the following:

- Opening hours of the centre had now reduced and there would be no new referrals.
- Ongoing consultation was going on with staff; some staff had already found alternative employment.
- Ongoing discussion with the NHS regarding service provision.
- Future arrangements for Service Users and staff – it was suggested that the Terms of Reference be extended to include exit strategies for staff and some concern was expressed regarding the loss of professionally qualified staff.

RESOLVED – That the draft Terms of Reference be approved

(Councillor S Hamilton declared a personal interest in this item due to her employment with the NHS).

96 Inquiry into the Future of Residential and Day Care Provision for Older People in Leeds

The report of the Director of Adult Social Services updated the Board on the programme of work developed to progress and implement the recommendations of Executive Board agreed in December 2010. It explained the circumstances and reasons for the delays in progressing to the next phase of the review and presented revised plans for the next phase. It also presented interim feedback from the consultation so far and provided opportunity for Members to consider this feedback before embarking on stage two of the more detailed consultation on the specific options for each individual home and day care centre affected.

Dennis Holmes, Chief Officer – Commissioning and John Lennon, Chief Officer – Access and Inclusion were in attendance for this item.

Members attention was drawn to the following:

- Consultation carried out so far – including public, residents, carers and staff.
- Details to be included and those to be consulted in stage two of the process.
- Negotiations with NHS Leeds.
- Timescales for the consultation

RESOLVED – That the report be noted.

(Councillor Cleasby declared a personal interest in this item due to his position with the Horsforth Living at Home Scheme)

97 Domicilliary Care and Reablement Update

The report of the Director of Adult Social Services provided the Board with a progress update on the development and improvement work relating to Domiciliary Care and Reablement Services.

Emma Lewis, Programme Manager, Services Transformation joined Dennis Holmes and John Lennon for this item.

Members were reminded of the paper considered by Executive Board in November 2010 and given an overview of issues detailed in the report including the impact of staff departures under the Early Leaver's Initiative, commissioning of independent/voluntary sector services and the future of in house services which would eventually be reported back to Executive Board.

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

- Choice for service users – it was reported that service change was partially driven by staff changes due to the Early Leavers Initiative. The option for service users to remain with the in house services would be kept wherever possible. Direct payments could also be used as an option when choosing service provision.
- Differences in cost between public and independent sector costs, particularly in relation to staffing costs. Measures to reduce in house staffing costs had included restructuring of services and progress made in reducing sickness absence through managing attendance.
- The role of Neighbourhood Networks in the reablement process.

RESOLVED – That the report and discussion be noted.

98 Summary of Progress in Response to Self Directed Support Inquiry Recommendations

The report of the Director of Adult Social Services provided a summary of progress of Adult Social Services in response to recommendations contained within the Self Directed Support: Scrutiny Inquiry Report. John Lennon and Dennis Holmes were in attendance for this item.

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

- Safeguarding risk for individuals – it was reported that best practice guidance had been developed and training for staff had been undertaken. Emergency contact cards had been issued to service users as part of risk management arrangements.

- All facilities that provided personal care were monitored and regulated by the Care Quality Commission. Where individuals lived independently or in supported accommodation, the responsibility for regulation was with the funding authority.
- Potential impact of the Localism Bill.
- There was a strong trend of voluntary sector involvement in Leeds and it was hoped to build on this support.
- Personalised budgets and cash payments.

RESOLVED – That the report be noted.

99 Annual Report 2010/11

The report of the Head of Scrutiny and Member Development presented the Board's contribution to the Scrutiny Boards Annual report.

The contribution included an introduction and summary from the Chair and also summarised the work and Inquiries carried out by the Board over the previous year.

The Chair thanked Members and Co-optees for their contribution over the past year and also extended his thanks to officers and all other organisations involved in contributing to the work of the Board.

RESOLVED – That the Board's contribution to the composite Annual Report for 2010/11 be approved.

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SCRUTINY BOARD (HEALTH)

TUESDAY, 26TH APRIL, 2011

PRESENT: Councillor S Armitage in the Chair

Councillors P Ewens, P Harrand, J Illingworth, G Latty, J Matthews and E Taylor

CO-OPTED MEMBERS	Arthur Giles	Leeds LINk
	Emma Stewart	Leeds LINk

99 Election of the 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.

100 Chair's Opening Remarks

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

101 Late Items

The Chair agreed to accept the following documents as supplementary information:-

- Dermatology Services in Leeds – Report of the Head of Scrutiny and Member Development, together with a submission document received from the Leeds Teaching Hospitals NHS Trust (LTHT)(Agenda Item 7)(Minute 105 refers)
- Leeds Alcohol Harm Reduction Plan (2011 – 2015) – Consultation - Report of the Head of Scrutiny and Member Development (Agenda Item 8)(Minute 106 refers)
- National Review of Children's Congenital Cardiac Services – Progress report - Report of the Head of Scrutiny and Member Development (Agenda Item 9)(Minute 107 refers)
- Recommendation Tracking - Report of the Head of Scrutiny and Member Development (Agenda Item 10)(Minute 108 refers)
- Scrutiny Board (Health) – Annual Report 2010/11 - Report of the Head of Scrutiny and Member Development (Agenda Item 11)(Minute 109 refers)
- Updated Work Programme 2010/11- Report of the Head of Scrutiny and Member Development (Agenda Item 12)(Minute 110 refers)

The documents were not available at the time of the agenda despatch, but made available on the Council's Internet site prior to and immediately after the meeting.

102 Declarations of Interest

Councillor E Taylor made a general declaration of personal interest in respect of today's agenda, in her capacity as an NHS employee.

Councillor J Illingworth in his a capacity as an attendee at the Public Inquiry for the Leeds Girl's High School (Agenda Item 12) (Minute 110 refers).

103 Apologies for Absence and Notification of Substitutes

Apologies for absence were received on behalf of Councillors M Dobson and G Kirkland.

104 Minutes of the Previous Meeting

RESOLVED – That the minutes of the meeting held on 22nd March 2011 be confirmed as a correct record.

105 Dermatology Services in Leeds

The Head of Scrutiny and Member Development submitted a report presenting the Scrutiny Board (Health) with an updated position regarding the proposed development of dermatology services within Leeds.

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

- An outline of some areas of progress provided by the Leeds Dermatology Patients Panel (Appendix 1 refers)
- A list of main issues/concerns that remain in relation to both in-patient and out-patient services (Appendix 2 refers)
- Letter from the Skin Care Campaign addressed to the Chair of the Scrutiny Board (Health) dated 12th April 2011 regarding treatment, care and support of patients with skin diseases in Leeds (Appendix 3 refers)

In addition to the above documents, a copy of a submission from Leeds Teaching Hospitals NHS Trust (LTHT) on Dermatology Services in Leeds was circulated to assist Board Members with their deliberations. The information provided consisted of:

- A briefing paper on the Trust's plans for the Dermatology Outpatient Service, including the associated timescales, and in response to concerns highlighted by the Leeds Dermatology Patient Panel (LDPP)
- Details of patient and public involvement
- Response to the inpatient concerns raised by Leeds Dermatology Patients Panel

- Response to the outpatient concerns raised by Leeds Dermatology Patients Panel

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

- Victor Boughton, Chair, Leeds Dermatology Patients Panel
- Professor Bill Cunliffe, Secretary, Leeds Dermatology Patients Panel
- Dr. Graham Johnson, Divisional Medical Manager, Medicine Division, LTHT
- Judith Lund, Directorate Manager, Specialty Medicine (LTHT)
- Philip Norman, Divisional General Manager (LTHT)
- Alan Sheward, Divisional Nurse Manager, Medicine Division (LTHT)

The Chair invited Victor Boughton and Professor Bill Cunliffe, Leeds Dermatology Patients Panel to briefly outline the specific concerns as at 13th April 2011 as referred to in Appendix 2 of the report.

Following this process, the Chair then invited Dr. Graham Johnson; Judith Lund; Philip Norman and Alan Sheward from the Leeds Teaching Hospitals NHS Trust (LTHT) to briefly respond to the concerns raised by Leeds Dermatology Patients Panel.

Arising from detailed discussions, Board Members raised their concerns about the lack of progress in the following specific areas:

- Infection control
- Ward signage (e.g. male and female toilets and bays)
- Ward lighting
- Cleaning regimes
- Staff morale
- Patient safety

In concluding, the Board requested representatives from the Leeds Teaching Hospitals NHS Trust (LTHT) to produce a report, in consultation with the Leeds Dermatology Patients Panel, detailing the outstanding issues with completion dates, together with a list of resolved issues, for circulation to Members.

RESOLVED-

a) That the contents of the report and appendices be noted.
b) That a further report, detailing any outstanding issues with expected completion dates, together with a list of resolved issues, be prepared and circulated to members of the Board as soon as practicable.
c) That the Principal Scrutiny Adviser be requested to arrange a visit of the Board to the Dermatology ward in the new Municipal year (June/July).

106 Leeds Alcohol Harm Reduction Plan: 2011-15 - Consultation

Referring to Minute 75 of the meeting held on 25th January 2011, the Head of Scrutiny and Member Development submitted a report providing the Scrutiny Board (Health) with the opportunity to comment on the draft Alcohol Harm Reduction Plan (2011-2015).

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

- A copy of the Leeds draft Alcohol Harm Reduction Plan (2011-2015) (Appendix 1 refers)
- Leeds Alcohol Harm Reduction Action Plan – A consultation response form (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.

Arising from discussions, in brief summary Board Members raised the following points:

- A clearer focus on heavy drinkers drinking less alcohol
- The role of education in raising awareness of the dangers of excessive alcohol consumption
- Conveying a positive message around sensible and responsible consumption of alcohol.
- The national position regarding minimum pricing for alcohol
- The role and work of specific groups/ organisations, such as Universities and Colleges, around preventative measures

As part of the discussion, members of the Board suggested that consideration should be given to the effectiveness of the PubWatch scheme. As part of this, the Board's Principal Scrutiny Adviser agreed to gather and circulate details associated with the scheme to members of the Board.

RESOLVED-

a) That the contents of the report and appendices be noted.
b) That the Principal Scrutiny Adviser be requested to draft a consultation response, summarising comments from the Board, for circulation prior to formal submission.
c) That, with reference to the ongoing national consideration of minimum pricing levels for alcohol, a copy of the Boards previous inquiry report (Promoting Good Public Health) be sent to all local Members of Parliament and relevant Government Departments, including the Department of Health.

(Councillor G Latty left the meeting at 11.20am at the conclusion of this item)

107 National Review of Children's Congenital Heart Services - Progress Report

The Head of Scrutiny and Member Development submitted a report providing the Scrutiny Board (Health) with an update around the national review of children's congenital heart services and the associated work of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) – the regional scrutiny body specifically formed to consider the proposals.

Appended to the report was copy of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) – Reconfiguration of Children's Congenital Heart Services in England – Proposed Action Plan and Timetable document for the information/comment of the meeting (Appendix 1 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 the Board be kept informed of progress and developments associated with the work of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber).

108 Recommendation Tracking

The Head of Scrutiny and Member Development submitted a report providing a progress update on the Board's previous scrutiny inquiries and recommendations.

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

- Recommendations tracking flowchart and classifications: Questions to be considered by Scrutiny Boards (Appendix 1 refers)
- Promoting Good Health: The role of the Council and its partners – Progress Report (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 the draft assessment of the status recommendations as detailed in Appendix 2 of the report.

109 Scrutiny Board (Health) - Outline Annual Report 2010/11

The Head of Scrutiny and Member Development submitted a report Seeking comment from Members of the Scrutiny Board (Health) regarding the content of the Board's Annual Report for 2010/11.

Appended to the report was a copy of the Board's full work programme 2010/11 for the information/comment of the meeting.

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.

There was a general discussion around the main areas of the Board's work during the current municipal year.

RESOLVED-

a) That the contents of the report and appendices be noted.
b) That, in consultation with the Chair, approval be given for the detailed content of the Board's Annual Report to be finalised by the Principal Scrutiny Adviser and circulated to Members of the Board for comment/approval.

110 Work Programme - Update

The Head of Scrutiny and Member Development submitted a report outlining the Scrutiny Board's work programme for the remainder of the current municipal year.

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

- A copy of the Board's work programme for 2010/11 (Appendix 1 refers)
- Equity and Excellence; Liberating the NHS – Managing the transition – Letter from the Department of health dated 13th April 2011 (Appendix 2 refers)
- Leeds Local Medical Committee Limited – Minutes of a LMC meeting with Members of the Scrutiny Board (Health) held on 25th March 2011 (Appendix 3 refers)
- Statement of Common Ground – Leeds Girl's High School Inquiry - 14th June 2011 (Appendix 4 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.

The Board briefly discussed issues raised by Councillor Illingworth around the forthcoming Leeds Girls High School Public Inquiry, but concluded not to take any action in this regard.

On behalf of members not present at the meeting, the Board's Principal Scrutiny Adviser also raised the issue of a potential ward closure at Wharfedale Hospital. The Board's Principal Scrutiny Adviser outlined that this matter formed part of Leeds Teaching Hospitals NHS Trust's 'Managing for Success' programme, and that any further consideration of issues associated with Wharfedale Hospital might usefully be considered in the context of the overall programme.

The Board concluded not to consider issues associated with Wharfedale Hospital at the current time.

RESOLVED - That the contents of the report and appendices be noted.

111 Arthur Giles - Co-optee

The Chair informed the meeting that Mr Giles, Co-optee, had recently tendered his resignation as a Leeds Local Involvement Network (LINk) representative on the Board. Therefore this would be his last Board meeting in that capacity.

The Chair and Board Members thanked Mr Giles for his support and contributions to the Board over recent years and wished him much success for the future.

In addition, as the last scheduled meeting for the current municipal year, this was also likely to be Ms Stewart's last meeting during the current year.

The Chair and Board Members also thanked Ms Stewart for her work and contributions throughout the year.

(The meeting finished at 11.35am)

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health and Well-being and Adult Social Care)

Date: 22 July 2011

Subject: Changes to the Council's Constitution in relation to Scrutiny

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

1 Purpose of this report

1.1 This report provides the Board with information on recent amendments to the Council's Constitution, as agreed by Council on 26 May 2011, which directly relate to and/or impact on the work of Scrutiny Boards.

2 Background information

2.1 The annual review of Scrutiny more often than not identifies a number of areas for amendment within Article 6 of the Constitution, the Scrutiny Boards' Terms of Reference and the Scrutiny Board Procedure Rules. These are either to ensure consistency in wording, to reflect legislative changes or to provide procedural clarity.

3 Main issues

3.1 The more significant amendments made to the Council's Constitution in relation to the Overview and Scrutiny function are summarised below.

Article 6

3.2 The inclusion of specific reference to the appointment of Scrutiny Chairs. To demonstrate and reinforce the importance of a non-political group approach to Scrutiny, Group spokespersons shall not be appointed to Chair a Scrutiny Board which corresponds to the same portfolio.

Scrutiny Board Terms of Reference

3.3 Five themed Scrutiny Boards have been established to mirror the current Strategic Partnership Boards. This approach promotes a more strategic and outward looking

Scrutiny function and focuses on the City Priorities. The terms of reference for the five Scrutiny Boards now determine a number of areas of review to be undertaken by the Boards as part of their workload during a municipal year.

3.4 A sixth Scrutiny Board has also been established and called Scrutiny Board (Resources and Council Services). Decisions made, or actions taken, in connection with the discharge of any functions which are the responsibility of the executive, which do not fall within the terms of reference of the five themed Scrutiny Boards, will be considered by the Scrutiny Board (Resources and Council Services).

Scrutiny Board Procedure Rules

3.5 Procedures in relation to Call In, which previously resided in the Scrutiny Board Guidance Notes, are now incorporated into the Scrutiny Board Procedure Rules to provide clarity.

3.6 Call-Ins will continue to be considered by the relevant Scrutiny Board. However, those requesting a Call In are now required to consider the financial consequences of Calling In the decision. The financial implications will be detailed to those Calling In the decision as part of the required pre Call In discussion with the relevant Director or Executive Board Member.

3.7 Previously, a Scrutiny Board Member could not be a signatory to a Call In if they were a member of the Scrutiny Board considering the Call In. This restriction has now been removed. A decision can be Called In by two non executive elected Members (who are not from the same political group) or any five non executive elected Members. Those Scrutiny Board Members not in a political group would be eligible but not co-opted Board members.

3.8 Added to the list of decisions exempt from Call In are decisions made during the development and approval of documents forming part of the Budget and Policy Framework. This amendment is in accordance with existing practice and procedure as the decision rests with full Council and not the Executive.

3.9 With regard to petitions, where a Scrutiny Board Chair receives in their capacity as a Scrutiny Chair a petition, the Chair will respond to the petition organiser only. Thereafter the Scrutiny Officer will be responsible for notifying the petition organiser of the date on which the petition will be considered and of the outcome of that meeting. The Scrutiny Officer will ensure the appropriate Executive Board Member receives a copy of the petition.

3.10 A minor amendment is made in relation to education co-optees on the relevant Scrutiny Board. This amendment clarifies the process of nomination and confirmation of education representatives to the Scrutiny Board.

4 Recommendations

4.1 In fulfilling the role and function of the Scrutiny Board, Members are requested to note the amendments to the Council's Constitution outlined in this report.

Background Papers

- Report of the Head of Scrutiny and Member Development on Overview and Scrutiny – Proposed Changes and Amendments to the Constitution. General Purposes Committee, 17th May 2011.
- Council's Constitution - Scrutiny Board Procedure Rules.

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health and Well-being and Adult Social Care)

Date: 22 July 2011

Subject: Co-opted Members

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

1 Purpose of this report

1.1 The purpose of this report is to seek the Scrutiny Board's formal consideration for the appointment of co-opted members to the Board.

2 Background information

2.1 For a number of years the Council's Constitution has made provision for the appointment of co-opted members to individual Scrutiny Boards. For those Scrutiny Boards where co-opted members have previously been appointed, such arrangements have tended to be reviewed on an annual basis, usually at the beginning of a new municipal year. However, the appointment of co-opted members has not been considered consistently across all Scrutiny Boards.

3 Main issues

<u>General arrangements for appointing co-opted members</u>

3.1 It is widely recognised that in some circumstances, co-opted members can significantly aid the work of Scrutiny Boards. This is currently reflected in Article 6 (Scrutiny Boards) of the Council's Constitution, which outlines the options available to Scrutiny Boards in relation to appointing co-opted members.

3.2 In general terms, Scrutiny Boards can appoint:

- Up to five non-voting co-opted members for a term of office that does not go beyond the next Annual Meeting of Council ; and/or,

- Up to two non-voting co-opted members for a term of office that relates to the duration of a particular and specific scrutiny inquiry.

3.3 In the majority of cases the appointment of co-opted members is optional and is determined by the relevant Scrutiny Board. However, Article 6 makes it clear that co-option would normally only be appropriate where the co-opted member has some specialist skill or knowledge, which would be of assistance to the Scrutiny Board. Particular issues to consider when seeking to appoint a co-opted member are set out later in the report.

3.4 There are also some legislative arrangements in place for the appointment of specific co-opted members. Such cases are also set out in Article 6 (Scrutiny Boards) of the Council's Constitution and are summarised below.

Arrangements for appointing specific co-opted members

Education Representatives

3.5 In addition to elected Members appointed by Council, the Local Government Act 2000 states that the relevant Scrutiny Board dealing with education matters shall include in its membership the following voting representatives in accordance with statutory requirements:

- One Church of England diocese representative[1]
- One Roman Catholic diocese representative[1]
- Three parent governor representatives[2]

3.6 The number and term of office of education representatives is fixed by full Council and set out in Article 6. Representatives of the Church of England and Roman Catholic dioceses are nominated by their diocese and parent governor representatives are elected. Such representatives are then notified to the Scrutiny Board and their appointment confirmed.

3.7 Where the Scrutiny Board deals with other non-educational matters the co-opted members may participate in any discussion but shall not be entitled to vote on those matters.

Crime and Disorder Committee

3.8 In accordance with the requirements of the Police and Justice Act 2006, the Council has designated the Scrutiny Board (Safer and Stronger Communities) to act as the Council's crime and disorder committee.

3.9 In its capacity as a crime and disorder committee, the Scrutiny Board (Safer and Stronger Communities) may co-opt additional members to serve on the Board, providing they are not an Executive Member.

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[1] Article 6 states this appointment shall be for a term of office that does not go beyond the next Annual Meeting of Council

[2] Article 6 states these appointments shall be for a four-year term of office

3.10 The Scrutiny Board (Safer and Stronger Communities) may limit the co-opted member's participation to those matters where the Scrutiny Board is acting as the Council's crime and disorder committee.

3.11 Unless the Scrutiny Board (Safer and Stronger Communities) decides otherwise, any co-opted member shall not be entitled to vote and the Board may withdraw the co-opted membership at any time.

Issues to consider when seeking to appoint co-opted members

3.12 Currently, there is no overarching national guidance or criteria that should be considered when seeking to appoint co-opted members. As a result, there is a plethora of methods employed within Councils for the appointment of co-optees to Overview and Scrutiny Committees (Scrutiny Boards). For example, some Council's use "job descriptions", some carry out formal interviews and some advertise for co-optees in the local press, with individuals completing a simple application form which is then considered by Members.

3.13 The Constitution makes it clear that 'co-option would normally only be appropriate where the co-opted member has some specialist skill or knowledge, which would be of assistance to the Scrutiny Board'. In considering the appointment of co-opted members, Scrutiny Boards should be satisfied that a co-opted member can use their specialist skill or knowledge to add value to the work of the Scrutiny Board. However, co-opted members should not be seen as a replacement to professional advice from officers.

3.14 Co-opted members should be considered as representatives of wider groups of people. However, when seeking external input into the Scrutiny Board's work, consideration should always be given to other alternative approaches, such as the role of expert witnesses or use of external research studies, to help achieve a balanced evidence base.

3.15 When considering the appointment of a standing co-opted member for a term of office, Scrutiny Boards should be mindful of any potential conflicts of interest that may arise during the course of the year in view of the Scrutiny Boards' wide ranging terms of reference. To help overcome this, Scrutiny Boards may wish to focus on the provision available to appoint up to two non-voting co-opted members for a term of office that relates to the duration of a particular and specific scrutiny inquiry.

3.16 Despite the lack of any national guidance, what is clear is that any process for appointing co-opted members should be open, effective and carried out in a manner which seeks to strengthen the work of Scrutiny Boards.

Previously appointed co-opted members

3.17 In 2010/11, the Scrutiny Board (Adult Social Care) and the Scrutiny Board (Health) formally appointed non-voting co-opted members to their membership. Without predetermining the Board's decision whether or not to appoint any co-opted members for the current year (2011/12), such previously appointed co-opted members have been asked to express their interest in being considered to be formally appointed.

3.18 All expressions of interest received will be reported at the meeting for consideration.

4 Recommendations

4.1 In line with the options available outlined in this report, Members are asked to consider the appointment of co-opted members to the Scrutiny Board.

Background Papers

- The Council's Constitution
- Police and Justice Act 2006
- KPMG Scrutiny Review May 2009

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health and Well-being and Adult Social Care)

Date: 22 July 2011

Subject: Sources of work and areas of priority for the Scrutiny Board

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

1.0 Purpose of this report

1.1 To assist the Scrutiny Board in effectively managing its workload for the forthcoming municipal year, this report provides information and guidance on potential sources of work and areas of priority within the Board's terms of reference.

2.0 Background information

2.1 Scrutiny Boards are responsible for ensuring that items of scrutiny work come from a strategic approach as well as a need to challenge service performance and respond to issues of high public interest.

2.2 The amendments made to the Overview and Scrutiny function this year encourage Scrutiny to be more strategic and outward looking in its operation and focus on the City Priorities.

2.3 City Priority Plans have recently been established to replace the Leeds Strategic Plan. These new city-wide partnership plans identify the key outcomes and priorities to be delivered by the Council, and its partners, over the next 4 years. The City Priority Plans are aligned to the new Strategic Partnerships who will own the plans and be responsible for ensuring the delivery of the agreed priorities.

2.4 The City Priority Plans are structured around a small set of short term (4 years) priorities each of which is measured through a headline indicator. As such they are the "must-do" priorities or "obsessions" for each partnership and may be supported by more detailed plans as the partnership sees fit.

3.0 Main issues

3.1 Five of the Scrutiny Boards are now themed to mirror the Strategic Partnership Boards. In doing so, the terms of reference for these Scrutiny Boards now determine a number of areas of review to be undertaken during a municipal year on behalf of the Council.

Scrutiny Board Terms of Reference

3.2 For this Scrutiny Board the focus of review is;

a) Reducing smoking in the over 18s
b) Service Change and Commissioning in Adult Social Care
c) Reducing avoidable admissions to hospital and care homes
d) The transformation of health and Social Care Services

3.3 These areas of review are focused around the City Priorities and therefore come from a strategic approach. However, all Scrutiny Boards remain autonomous in determining the scope of their reviews.

3.4 A copy of the terms of reference for the Board (Health and Well-being and Adult Social Care) is attached for reference purposes (Appendix 1).

Other sources of Scrutiny work

3.5 In addition to the areas of review outlined with the Scrutiny Board's terms of reference, other sources of work will continue to be 'requests for scrutiny' and corporate referrals. The Scrutiny Board may also undertake further pieces of scrutiny work as considered appropriate.

3.6 However, over the last few years of Scrutiny Board work, experience has shown that the process is more effective and adds greater value if the Board seeks to minimise the number of substantial inquiries running at one time and focus its resources on one key issue at a time. This view was echoed within the findings of the KPMG external audit report 2009 on the Scrutiny function in Leeds.

3.7 The Scrutiny Board Procedure Rules require Scrutiny Boards, before deciding to undertake an inquiry, to consider the current workload of the Scrutiny Board and the available resources to carry out the work.

4.0 Consultation

4.1 It is recognised that in order to enable Scrutiny to focus on strategic areas of priority, each Scrutiny Board needs to establish an early dialogue with key stakeholders, including the most relevant Director, the Executive Board Member holding the relevant portfolio and representatives from the NHS.

4.2 The Director of Adult Social Services and the Executive Board Member with responsibility for Adult Health and Social Care have therefore been invited to attend the meeting to discuss the City Priorities in relation to the Board's terms of reference.

4.3 It should be noted that both the Director of Adult Social Services and the Executive Board Member with responsibility for Adult Health and Social Care have previous commitments and will be unable to attend the meeting. However, the Executive Board Member has provided the following points in relation to the Adult Social Care portfolio and the Board's work programme:

- **Older people's residential care** – the previous scrutiny board undertook some very useful work in relation to older people's residential care provision and the Board may wish to monitor the ongoing implementation of changes to our older people's residential care provision *(NB a separate report around this issue is presented elsewhere on the agenda for consideration)*;

- **Homecare** – the Council's in-house homecare service is currently undergoing significant change and the Board may wish to monitor this.

- **Mental Heath day services** – a consultation exercise is underway and the Board may wish to have some input.

- **Consultation by Adult Social Care in general** – What do we do well and how could we improve?

It should be noted that Adult Social Service's Deputy Director Strategic Commissioning will be representing the Director at the meeting. The Chief Executive from NHS Leeds and the Joint Director of Public Heath have also been invited to attend the meeting to assist the Board in considering its work programme for the year.

4.4 An extract of the draft City Priority Plan 2011 – 2015 relevant to the Board's terms of reference is attached at Appendix 2 for information.

4.5 Attached as Appendix 3 and 4 respectively are the latest Executive Board minutes and the Council's current Forward Plan relating to this Board's portfolio.

5.0 Other considerations and useful information

5.1 In considering the draft City Priority Plan 2011 – 2015 and the Board's specific terms of reference, the following information is also attached for the Board's information:

- Appendix 5 – Fair Society, Healthy Lives – The Marmot Review Executive Summary (February 2010);
- Appendix 6 – Leeds Health Profile (2011);
- Appendix 7 – Leeds Smoking Profile;
- Appendix 8 – Overview of Leeds Health and Social Care Transformation Programmme.

6.0 Recommendations

6.1 Members are requested to use the attached information and the discussion with those present at the meeting to confirm the areas of priority for the Scrutiny Board over the forthcoming municipal year.

Background papers

None used

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Scrutiny Board (Health and Well-being and Adult Social Care)

The Scrutiny Board (Health and Well-being including Adult Social Care) is authorised to discharge the following overview and scrutiny functions[1].

1. to review or scrutinise the exercise of any council or executive function or any other related matter including :-

    a) Reducing smoking in the over 18s
    b) Service Change and Commissioning in Adult Social Care
    c) Reducing avoidable admissions to hospital and care homes
    d) The transformation of health and Social Care Services

2. to carry out such other reviews or policy development tasks as it may be requested to do by either the Executive Board or the Council.

3. to act as the appropriate Scrutiny Board in relation to the Executive's initial proposals for a relevant plan or strategy[2] within the Budget and Policy Framework[3]

4. to review or scrutinise executive decisions made that have been Called In[4]

5. To consider such proposals as are referred to it by local NHS bodies and the authority and to report back the result of its considerations to the referring body and others as appropriate.

6. In relation to matters in respect of which a local NHS body consults more than one scrutiny committee within its area, or in relation to matters which a number of Yorkshire and Humber Councils elect to jointly scrutinise a function or service provided by the NHS body[5], to:

    a) nominate Members to a joint committee, such nominations to reflect the political balance of the Board;

    b) delegate its scrutiny functions to another local authority.

7. to receive and monitor formal responses to any reports or recommendations made by the Board

[1] In relation to functions delegated to the Director of Adult Social Services under the Officer Delegation Scheme whether or not those functions are concurrently delegated to any other committee or officer.
[2] Namely the Health and Wellbeing City Priority Plan
[3] In accordance with Budget and Policy Framework Procedure Rules.
[4] In accordance with the Scrutiny Board Procedure Rules.
[5] Or in relation to matters which a number of councils are required to carry out joint scrutiny by virtue of a direction of the Secretary of State.

8. to review outcomes, targets and priorities within the Council Business Plan and City Priority Plans and to make such reports and recommendations as it considers appropriate;

9. to receive requests for scrutiny and councillor calls for action[6] and undertake any subsequent work

[6] Including requests made in relation to health and social care matters in accordance with the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 but not including requests in relation to crime and disorder matters.

Health and Wellbeing City Priority Plan 2011 to 2015

Vision for Leeds 2030

The Leeds Initiative, our city partnership, has developed the Vision for Leeds 2011 to 2030 – a long-term plan for the future development of the city. The purpose of this plan is to improve life for the people of Leeds and make our city a better place. After listening carefully to what local people, businesses and organisations have said, our vision is that:

By 2030, Leeds will be locally and internationally recognised as the best city in the UK.

This long-term Vision is supported by three aims.

- Leeds will be fair, open and welcoming.
- Leeds' economy will be prosperous and sustainable.
- All Leeds' communities will be successful.

The Vision will be the driver for the city's other strategies and action plans and for our continued partnership working over the next 20 years. However, we know that it is difficult to anticipate all the changes that will take place between now and 2030 and we also recognise that there are urgent issues that we need to address now. This is why, alongside the long-term Vision for Leeds, we are publishing the City Priority Plans, which sets out the key outcomes and priorities to be delivered by the council, and its partners, over the next four years.

What do we want to achieve by 2015?

In the current environment of reduced public funding, we have to make difficult choices about where we can make progress by 2015. We have developed a set of priorities that we must do over the next four years - urgent issues that we need to address to deliver our long term ambition to be the best city in the UK.

Five separate action plans have been drawn up to deliver these priorities. These are:

- Children and Young People's City Priority Plan;
- Health and Wellbeing City Priority Plan;
- Housing and Regeneration City Priority Plan;
- Safer and Stronger Communities City Priority Plan;
- Sustainable Economy and Culture City Priority Plan.

Measuring our progress

Along with the four-year priorities, the partnership has identified a series of headline indicators. These have been chosen as the best overall measure of our progress towards the priority. In addition, we will track other indicators and measures of our progress, which will make sure we have a more detailed understanding of the factors that impact on achieving our priorities.

The vision for Leeds to be the best city… for health and wellbeing

The long term vision is:

Leeds will be a healthy and caring city for all ages where:

- people live longer and have healthier lives;
- people are supported by high quality services to live full, active and independent lives; and
- inequalities in health are reduced, for example, people will not have poorer health because of where they live, what group they belong to or how much money they have.

The four-year priorities are given on the attached chart along with the main areas for action and the headline indicators. The main areas include the following:

Helping people choose healthier lifestyle covers a range of activities including: increasing the role of frontline staff and voluntary sector in improving community health; developing local people as health champions; the 'Leeds Lets Change' programme focussing on healthy eating and physical activity; and supporting work on smoking, alcohol and illegal drug use.

The Health and Social Care transformation programme focuses on how health and social care services will work together better to help people stay active and independent for as long as possible. If care is needed, this will be provided in their own homes or communities if possible so reducing the risk of being admitted to hospitals or care homes.

There are a range of wider social, economic and environmental factors that affect people's health and these are particularly responsible for some people having poorer health than others. Reducing health inequalities work will focus in the first instance on children under five. However, there will be work to support the other four strategic partnerships to address how housing, education, transport, green space, work and poverty can affect health and what we can do to help everyone have the best chance to be healthy.

The more detailed action plans for the priorities are being developed and we are using the 'outcomes based accountability' approach to ensure that the partnership agrees what difference we are aiming to make for the population of Leeds. It is important that the plan gives equal importance to the actions to improve public health as to the ones on transforming health and social care services. The development of the shadow Health and Wellbeing Board later this year and a full Joint Health and Wellbeing Strategy next year as a result of the *Equity and Excellence: Liberating the NHS* will build on the work to develop this city priority plan.

Health and Wellbeing City Priority Plan 2011 to 2015

Vision

Leeds will be a healthy and caring city for all ages where:

- people live longer and have healthier lives;
- people are supported by high quality services to live full, active and independent lives; and
- inequalities in health are reduced, for example, people will not have poorer health because of where they live, what group they belong to or how much money they have.

4 Priorities	13 Actions	Headline Indicator
People will make healthy lifestyle choices	• Helping people not to smoke or be exposed to second-hand tobacco smoke • Making sure people are free from harm caused by alcohol • Helping people to eat a healthy diet and be more active	Life expectancy in all areas of Leeds (Healthy Life Expectancy subject to Office National Statistics development work)
People live safely in their own homes	• Develop intermediate care services • Reduce avoidable admissions to hospitals and care homes • Enhance re-ablement and prevention services	Rate of emergency admissions to hospital and admissions to care homes
People will have choice and control over their health and social care services	• Increase uptake of personal health and social care budgets • Enhance the quality of life for people with long term conditions	Proportion of people with long-term conditions feeling supported to be independent and manage their condition
People who are poorest improve their health fastest	• Minimise the impact of poverty on the health of 0 – 5 year olds • Support action on housing, transport and open spaces to improve health • Support people back into work • Increase advice and support to minimise debt and maximise income of individuals and families • Ensure equitable access to services that improve health	Children achieving a good level of development at age 5 ensuring the most deprived 20% of areas do better faster

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EXECUTIVE BOARD

WEDNESDAY, 22ND JUNE, 2011

PRESENT: Councillor K Wakefield in the Chair

Councillors J Blake, A Carter, M Dobson, R Finnigan, S Golton, P Gruen, R Lewis, A Ogilvie and L Yeadon

1 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 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) Appendices 1 – 5 to the report referred to in Minute No. 5, under the terms of Access to Information Procedure Rule 10.4(5) and on the grounds that the appendices detail legal advice and related correspondence. As there is potential for legal action to be initiated by any of the interested parties, in that context, the public interest in allowing access to the specific legal advice to and analysis of the present position by Council officers, is outweighed by the need for the Council to be able to respond appropriately to any potential future legal challenge. Therefore, the public interest in maintaining the exemption outweighs the public interest in disclosing this information at this point in time.

(b) The appendix to the report referred to in Minute No. 24, under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that the public interest in maintaining the exemption outweighs the public interest in disclosing the information by reason of the fact that it contains 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.

2 Late Items

The Chair admitted to the agenda the following late items of business:

(a) Proposed Aire Valley Leeds Enterprise Zones (Minute No. 26 refers)
Whilst the decision of the Local Enterprise Partnership on the 15th June 2011 to submit the Aire Valley Leeds proposal to Government as the Leeds City Region Enterprise Zone had been taken after the publication of the Executive Board agenda, it was determined essential that this matter was considered by the Board at the earliest opportunity in order to keep the Board informed of the progress made on this issue,

whilst also seeking the Board's endorsement to the approach taken and obtaining support for the further work required to deliver an Enterprise Zone in Aire Valley Leeds.

(b) Closure of East Leeds Leisure Centre and Middleton Pool and Reduced Opening Hours of Garforth Squash and Leisure Centre (Minute No. 16 refers)

The report was not available for inclusion within the agenda papers, as the formal responses from the relevant directorate to the Scrutiny Board's proposals were being compiled at that time. However, it was determined necessary that Executive Board consider the responses to the Scrutiny Board's recommendations at the earliest opportunity, following the conclusion of the scrutiny inquiry.

(c) Grants to Culture and Sport Related Organisations (Minute No. 18 refers)

The report was not available for inclusion within the agenda papers, as the formal responses from the relevant directorate to the Scrutiny Board's proposals were being compiled at that time. However, it was determined necessary that Executive Board consider the responses to the Scrutiny Board's recommendations at the earliest opportunity, following the conclusion of the scrutiny inquiry.

(d) Response to the Review of Home Farm, Temple Newsam – Scrutiny Inquiry Report (Minute No. 17 refers)

The report was not available for inclusion within the agenda papers, as the formal responses from the relevant directorate to the Scrutiny Board's proposals were being compiled at that time. However, it was determined necessary that Executive Board consider the responses to the Scrutiny Board's recommendations at the earliest opportunity, following the conclusion of the scrutiny inquiry.

(e) Little London and Beeston Hill and Holbeck PFI Housing Project – Value for Money (VFM) Review and Final Business Case Update (Minute No. 29 refers)

The report was not available for inclusion within the agenda papers, as the correspondence from the Homes and Communities Agency confirming that the project had passed the Value for Money test, subject to some amendments, was not received until the 20th June 2011, and it was deemed necessary that Executive Board be formally provided with the latest position at the earliest opportunity.

3 Declaration of Interests

Councillor A Carter declared a personal interest in the item entitled, 'Local Sustainable Transport Fund Bid for West Yorkshire', due to being a member of the West Yorkshire Integrated Transport Authority (Minute No. 23 refers).

Further declarations of interest were made at a later point in the meeting (Minute Nos. 12 and 17 refer).

4 Minutes

RESOLVED – That the minutes of the meeting held on 18th May 2011 be approved as a correct record.

ADULT HEALTH AND SOCIAL CARE

5 Neighbourhood Network Update

Further to Minute No. 34, 21st July 2010, the Director of Adult Social Services submitted a report providing an account of the negotiations held to date in line with the resolutions of the Executive Board in July 2010 in respect of Neighbourhood Networks, detailing the outcome of those negotiations, whilst also providing a recommendation on a potential way forward based upon legal advice obtained by the Council.

Correspondence received from the solicitors acting on behalf of Leeds Irish Health and Homes had been circulated to Board Members for their consideration prior to the meeting, with separate correspondence from the Chief Executive of the same company being tabled at the meeting.

The report provided details of the equality impact assessment which had been undertaken in respect of the original tendering exercise.

Following consideration of Appendices 1,2,3,4 and 5 to the submitted report, designated as exempt under Access to Information Procedure Rule 10.4(5), which was considered in private at the conclusion of the meeting, it was

RESOLVED -

(a) That no contract (advertised under the overall tendering of Neighbourhood Network services in 2009/10) be awarded for the provision of Neighbourhood Network services in relation to those 5 areas of East Leeds specified in this report, namely Burmantofts, South Seacroft, Swarcliffe, Richmond Hill and Crossgates and District.

(b) That the commencement of a renewed tendering exercise for the provision of Neighbourhood Network services in relation to those areas of East Leeds specified in the submitted report be approved.

(c) That the tendering exercise be constructed in such a way as to take account of the lessons learnt in the original tender process, the analysis of the current position as set out in confidential Appendix 4 and arising from the specialist legal advice contained within exempt Appendix 3 to the submitted report.

(d) That it be noted that the services currently being delivered will continue through an extension of existing contracts to 31st March 2012, pending the outcome of resolutions (b) and (c) above.

RESOURCES AND CORPORATE FUNCTIONS

6 Financial Performance - Outturn 2010/2011

The Director of Resources submitted a report setting out the Council's financial outturn position for 2010/11, including both revenue and capital elements, in addition to the Housing Revenue Account. In addition, the report covered revenue expenditure and income compared to the budget, reported on the outturn for Education Leeds and the ALMOs, highlighted the position regarding other key financial health indicators and invited the Board to consider the approval, creation and usage of the Council's reserves.

The Board thanked all of those officers who had been involved in managing the financial performance of the Council throughout the 2010/11 financial year and into 2011/12.

In response to Members' enquiries regarding the issue of car parking charges, the Board noted that a further report regarding car parking policy was scheduled to be submitted to the September Board meeting.

RESOLVED -

(a) That the contents of the submitted report be noted.

(b) That the creation of an earmarked reserve for an early leavers scheme in 2011/12 be approved.

(c) That the earmarked reserves, as detailed within Appendix 2 of the submitted report, be approved.

(d) That the immediate release of £12,400,000 earmarked reserves as detailed in paragraph 6.9 of the submitted report be approved.

7 Financial Health Reporting 2011/2012

The Director of Resources submitted a report providing information as to both the context and arrangements for the reporting of the Council's financial health during 2011/2012.

In response to Members' enquiries regarding the timescales for reporting the Council's financial health to the Board, the Director of Resources undertook to ensure that each update report would contain the most up to date information possible.

RESOLVED – That the proposals for financial health reporting in 2011/2012, as detailed within the submitted report, be approved.

8 New Vision and Strategic Plans

The Assistant Chief Executive (Planning, Policy and Improvement) submitted a report outlining the key stages of the development of several of the Council's important plans, including consultation undertaken with the public and with partners, detailing how due regard needed to be given to equality and diversity in preparing them, whilst presenting the plans

themselves for consideration and endorsement prior to formal approval by Full Council.

The Chief Executive provided details of the changes which had been made to the city and council planning and partnership framework and highlighted the introduction of an outcomes based accountability approach which had been incorporated into the strategic planning and performance management arrangements.

The Board thanked all of those officers and partners who had been involved in the compilation of the Vision for Leeds 2011-30, the City Priority Plan 2011-15 and the Council Business Plan 2011-15.

The report provided details of the Equality, Diversity, Cohesion and Integration Impact Assessment which had been undertaken in respect of the New Vision and Strategic Plans.

RESOLVED -

(a) That the Vision for Leeds 2011 to 2030, City Priority Plan 2011 to 2015 and the Council Business Plan 2011 to 2015, as attached at appendix 1 to the submitted report, be endorsed.

(b) That Members of Full Council be recommended to approve the Vision for Leeds 2011 to 2030, City Priority Plan 2011 to 2015 and the Council Business Plan 2011 to 2015 at their meeting on 13th July 2011.

(c) That Members of Full Council be recommended to authorise Executive Board to make “in-year” amendments to these plans as may be necessary.

(d) That the Assistant Chief Executive (Planning, Policy and Improvement) be authorised to complete the plans with any outstanding information prior to their submission for approval to Full Council on 13th July 2011.

(e) That a report be submitted to a future meeting of the Board in respect of the outcome based accountability approach being incorporated into the strategic planning and performance management arrangements.

(The matters referred to in this minute being matters reserved to Council were not eligible for Call In)

CHILDREN'S SERVICES

9 Children's Services Improvement Update Report

The Director of Children’s Services submitted a report providing the Board with an update on the improvement activity that was continuing across children’s services in Leeds. The report particularly focussed upon the wider context, in view of a number of significant policy developments which had taken place, improvement and inspection activity and the Children’s Services Transformation Programme.

Members were provided with responses to enquiries raised regarding the replacement of the Electronic Social Care Recording system for Children's Services.

In response to enquiries, the Director of Children's Services undertook to provide Members with a timetable detailing the proposed schedule for the roll out to a locality level of the outcomes based accountability methodology.

RESOLVED - That the contents of the submitted report be noted and that the continuing direction of travel across children's services in Leeds along with the preparations being undertaken for a possible announced inspection during summer 2011 be supported.

10 Children & Young People's Plan 2011-2015

The Director of Children's Services submitted a report presenting the final version of the Children & Young People's Plan (CYPP) and seeking endorsement and support for the important statement of outcomes, priorities and indicators which had been agreed by all the Children Leeds partners as the framework for improving outcomes.

The report provided details of the Equality, Diversity, Cohesion and Integration Impact Assessment which had been undertaken in respect of the strategic planning approach and City Priority Plans.

RESOLVED –

(a) That the Children and Young People's Plan 2011-15, as attached at appendix 1 to the submitted report, be endorsed and supported, subject to formal approval by full Council on 13 July 2011.

(b) That Executive Board Members contribute towards the delivery of the CYPP by using the CYPP 2011-15 as a key criterion in their scrutiny and evaluation of all issues relating to children and young people.

(The matters referred to in this minute being matters reserved to Council were not eligible for Call In)

11 Annual Review of the Fostering and Adoption Statements of Purpose

The Director of Children's Services submitted a report presenting for approval the revised statements of purpose for Leeds City Council's Fostering and Adoption Services.

RESOLVED - That the Statements of Purpose for both the Fostering and Adoption Services for Leeds City Council be approved.

12 Design and Cost Report for E-ACT Leeds East Academy, Submission of Stage 0 Proposal to Partnerships for Schools and Disposal of Parklands Leasehold at Nil Consideration

The Director of Children's Services submitted a report which sought approval to submit the Confirmation of Procurement Approval (Stage 0) Document to

the Partnerships for Schools (PfS), for the injection of funding and 'Authority to Spend' for E-ACT Leeds East Academy (BSF Wave 1, Phase 5). In addition, the report also sought the relevant approvals in respect of the disposal of the leasehold interest of Parklands Girls' High School at nil consideration.

Copies of the document entitled, 'Confirmation of Procurement Approval for Subsequent Phases in a BSF Wave (Stage 0)' had been provided to Board Members as part of their agenda packs.

The report advised that an Equality, Diversity, Cohesion and Integration Screening form had been completed for the project, which determined that it was not necessary to carry out a formal impact assessment.

RESOLVED –

(a) That the submission of the Stage 0 proposal to Partnerships for Schools be approved.

(b) That the injection of £5,253,100 into scheme 16155 - E-ACT East Leeds Academy into the Council's capital programme be approved, and that the Authority to Spend this additional funding also be approved.

(c) That the disposal of the leasehold interest of Parklands Girls' High School at nil consideration be approved.

(Councillors Gruen and Finnigan both declared personal interests in this item due to being members of Plans Panel (East))

LEISURE

13 Response to Deputation to Council: Friends of Bramley Baths

The Acting Director of City Development submitted a report in response to the deputation to Council on 6th April 2011 regarding the reduction of hours a Bramley Baths.

The report provided details of the outline Equality, Diversity, Cohesion and Integration Impact Assessment had been conducted.

RESOLVED -

a) That the response to the deputation from the Friends of Bramley Baths be noted.

b) That the process of advertising for expressions of interest in the Community Asset Transfer of this site, on the terms as described within the submitted report, be approved.

14 Response to Deputation to Council: West Riding Track League

The Acting Director of City Development submitted a report in response to the deputation to Council on 6th April 2011 from the West Riding Track League

highlighting the League's success over the last 65 years, whilst also seeking Council support for the future of league and grass track racing on the historic track at Roundhay Park.

The report provided details of the Equality Impact Assessment Screening Form which had been completed in respect of this matter.

RESOLVED - That the response detailed within the submitted report to the West Riding Track League's deputation to Council of 6th April 2011 be noted and endorsed.

15 Mercury Abatement Works - Rawdon Crematoria: Capital Scheme No. 16194

Further to Minute No. 68, 25th August 2011, the Acting Director of City Development submitted a report advising Members of the current position with regard to facilitating the installation of cremators with mercury filtration equipment at Rawdon crematorium and requesting that Members authorise the letting of the works contract and the incurring of expenditure of £1,645,050, including fees from existing budget provision.

RESOLVED -

a) That the works planned for Rawdon Crematorium be noted.

b) That the award of the design and build contract in the sum of £1,445,050 be authorised.

c) That authority to spend up to £1,645,050 on the scheme, including fees, be authorised.

16 Closure of East Leeds Leisure Centre and Middleton Pool and Reduced Opening Hours of Garforth Squash and Leisure Centre

The Head of Scrutiny and Member Development submitted a report inviting the Board to consider the recommendations of the former Scrutiny Board (City Development) following the Scrutiny Board's consideration of issues relating to proposals regarding the closure of East Leeds Leisure Centre, Middleton Pool and the reduction in operating hours at Garforth Squash and Leisure Centre.

Councillor J Procter, the Chair of the former Scrutiny Board (City Development) attended the meeting to present the Board's findings.

Copies of the report had been circulated to Board Members prior to the meeting for their consideration.

RESOLVED –

(a) That it be noted that the former Scrutiny Board (City Development) recommends that any proposals to reduce services should be fully consulted upon before the matter is referred to Executive Board for determination.

(b) That it be noted that the former Scrutiny Board (City Development) opposes the reduction in operating hours at Garforth Squash and Leisure Centre and the proposed Community Asset Transfer to the School Partnership Trust and the closure of East Leeds Leisure Centre and Middleton Pool.

17 Response to the review of Home Farm Temple Newsam Scrutiny Board Inquiry

The Head of Scrutiny and Member Development submitted a report inviting the Board to consider the recommendations of the former Scrutiny Board (City Development) following the conclusion of the Scrutiny Board's inquiry entitled, 'Review of Home Farm, Temple Newsam'.

Councillor J Procter, the Chair of the former Scrutiny Board (City Development) attended the meeting to present the Board's findings.

Copies of the report and accompanying documents had been circulated to Board Members prior to the meeting for their consideration.

RESOLVED – That the recommendations of the former Scrutiny Board (City Development) and the directorate responses be noted, with a further report being submitted to a future meeting of the Board in order to further consider ways in which the operation of Home Farm can be developed in the future.

(Councillor Wakefield declared a personal interest in this item, as a member of Meanwood Valley Urban Farm)

18 Grants to Culture and Sport Related Organisations

The Head of Scrutiny and Member Development submitted a report inviting the Board to consider the recommendations of the former Scrutiny Board (City Development) following the Scrutiny Board's consideration of issues relating to proposals regarding changes by the Arts Council and West Yorkshire Grants to their approach towards grant making.

Councillor J Procter, the Chair of the former Scrutiny Board (City Development) attended the meeting to present the Board's findings.

Copies of the report and accompanying documents had been circulated to Board Members prior to the meeting for their consideration.

RESOLVED – That the recommendations of the former Scrutiny Board (City Development) and the directorate responses be noted.

DEVELOPMENT AND THE ECONOMY

19 Response to Deputation to Council: West Park Residents Association

The Acting Director of City Development submitted a report in response to the deputation to Council on 6th April 2011 from the West Park Residents' Association regarding the future use of the centre.

The report provided details of the An Equality, Diversity, Cohesion and Integration impact assessment scheduled to be carried out as part of the options appraisal.

RESOLVED -

(a) That the response to the deputation from the West Park Residents' Association be noted.

(b) That officers be authorised to undertake an options appraisal in order to determine the future of the building and the future location of services currently provided on site, with the outcomes from the options appraisal being reported back to Executive Board with recommendations later in the year.

20 Response to Deputation to Council: Danoptra Ltd.

The Acting Director of City Development submitted a report in response to the deputation to Council on 6th April 2011 from Danoptra Ltd. regarding the draft Horsforth and Cragg Hill Conservation Area Appraisal and Management Plan.

RESOLVED - That the contents of the submitted report be noted.

21 Response to Deputation to Council: Leeds Students' Unions

The Acting Director of City Development submitted a report in response to the deputation to Council on 6th April 2011 from Leeds Student Unions regarding the proposed Article 4 Direction affecting Houses of Multiple Occupation (HMOs).

RESOLVED –

(a) That the content of the submitted report which responds to issues raised by the Leeds Student Unions in relation to the proposed Article 4 Direction be noted.

(b) That a report be submitted to a future meeting outlining the response to the Article 4 Direction consultation.

22 Housing Appeals - Implications of the Secretary of State's Decision relating to Land at Grimes Dyke, East Leeds

The Acting Director of City Development submitted a report providing an update on the outcome of an appeal relating to a substantial greenfield housing site at Grimes Dyke, East Leeds. The report noted that the decision taken by the Secretary of State followed a series of similar cases determined by individual inspectors and invited consideration of the consequences arising from the decision in terms of the Council's approach towards similar greenfield developments in the future.

Members highlighted the need for an all party lobbying exercise to be undertaken in order to relay the Council's concerns in respect of this matter to the Minister for Housing and Local Government, with enquiries being made as to the possibility of involving other Local Authorities who were in a similar position.

Having highlighted the importance of maintaining the current balance between greenfield sites and urban settlements across the city, the Chief Executive highlighted the need for officers and Members to engage further with developers in order to move forward on this matter.

RESOLVED -

(a) That the outcome of the appeal at Grimes Dyke and the consequences for Council policy, as set out within the submitted report, be noted.

(b) That the release of all the Phase 2 and 3 housing allocations in the UDP be agreed, subject to proposals coming forward being otherwise acceptable in planning terms.

(c) That the withdrawal from the appeal on land at Whitehall Road, Drighlington, be agreed.

(d) That approval be given to the Regional Spatial Strategy providing the basis for assessing the 5 year land supply pending the Core Strategy.

(e) That the Prospectus, attached as Appendix A to the submitted report, be endorsed as the basis for informal consultation on the Core Strategy housing issues.

(f) That Scrutiny Board (Regeneration) be invited to review and report on the population and household projection information that will underpin the Core Strategy, in addition to the land banking practices of developers, with such a review being undertaken as a matter of urgency in order to enable progress to be maintained according to the Core Strategy timetable, with the outcomes from the review being submitted to the Executive Board in due course.

(g) That an all party lobbying exercise be undertaken in order to relay the Council's concerns in respect of this matter to the Minister for Housing and Local Government.

(The matters referred to in this minute were not eligible for Call In as there was a further, similar appeal case for which evidence was due, and it was important that the Council's approach towards that case was established and confirmed at the earliest opportunity).

23 Local Sustainable Transport Fund Bid for West Yorkshire

The Acting Director of City Development submitted a report providing details of the bid which had been prepared and submitted to the Department for Transport regarding the Local Sustainable Transport Fund project for West Yorkshire.

RESOLVED -

(a) That the preparation of funding bids for the Local Sustainable Transport Fund and the submission of a Large Project bid made to the Government on 6th June 2011 be noted.

(b) That the decision made by the West Yorkshire Integrated Transport Authority Executive (Appointed Members) taken on 3rd June 2011 to approve the bid be noted.

(c) That it be noted that the Council is a partner in a separate Thematic bid for travel to school, led and submitted by Sustrans in partnership with a consortium of local authorities.

24 Elland Road Masterplan

The Acting Director of City Development submitted a report providing an update on the progress made in respect of the Elland Road Masterplan since its inclusion within the Informal Planning Statement for Elland Road, the acquisition of the Castle Family Trust land, developments regarding a potential park and ride facility and the sale of the former Greyhound Stadium. The report also sought approval of the revised Heads of Terms with the operator of the proposed ice rink on Elland Road, whilst also seeking an injection from the Capital Programme into the proposed realignment of Lowfields Road.

Following consideration of the Appendix 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 continuing development of the Informal Planning Statement through the acquisition of the Castle Family land and the sale of the Greyhound Stadium to the West Yorkshire Police Authority for their new divisional headquarters be noted.

(b) That the revised Heads of Terms and additional 6 month exclusivity period to the ice rink operator, as identified within the exempt appendix to the submitted report, be approved.

(c) That approval be given to the injection of £500,000 from the Capital Programme as a contribution towards the implementation of the masterplan, allowing for the realignment of Lowfields Road on the terms identified within the exempt appendix to the submitted report.

25 Rugby League World Cup 2013

The Acting Director of City Development submitted a report providing details of the 2013 Rugby League World Cup (RLWC) and the bidding process for potential Host Cities. In addition, the report sought approval for the submission of a final bid and provided details on the role of a consortium who would lead on RLWC activity.

Members thanked officers for the work which had been undertaken on this matter to date, given the restricted timescales involved.

The report provided details of the Equality, Diversity and Cohesion and Integration Impact Assessment (EDCI) which had been undertaken in respect of the bid process and of Leeds hosting the event.

RESOLVED –

(a) That the contents of the submitted report be noted.

(b) That approval be given for Leeds to submit a bid to be a Host City for the Rugby League World Cup 2013 on July 15th 2011.

(c) That the requirement for the consortium to take responsibility for the Rugby League World Cup bid and subsequent World Cup related activity be noted.

(d) That approval be given for the consortium to progress contractual and commercial discussions with the Rugby Football League and for officers to report back to Executive Board with requirements once contractual and commercial details are known.

(The matters referred to in this minute were not eligible for Call In due to the imminent deadline for the submission of the final bid to become a Host City for the 2013 Rugby League World Cup)

26 Proposed Aire Valley Leeds Enterprise Zone

The Acting Director of City Development submitted a report advising of the submission to the Local Enterprise Partnership Board of the proposal for an Enterprise Zone in Leeds, welcoming the subsequent decision of the Local Enterprise Partnership Board and seeking endorsement to the approach taken and support for the further work required to deliver an Enterprise Zone in Aire Valley Leeds.

Copies of the report and accompanying documents had been circulated to Board Members prior to the meeting for their consideration.

The Board emphasised the significance of the Enterprise Zone as a catalyst for growth throughout the whole of the Leeds City Region (LCR). In addition, Members highlighted the need to support each partner Local Authority within the LCR to help them deliver their strategic priorities, as this would be to the benefit of the whole of the region and underlined the important role that the Local Enterprise Partnership would play in this process.

RESOLVED –

(a) That the recommendation of the Local Enterprise Partnership Board be welcomed and that the further development of the Aire Valley Leeds Enterprise Zone proposal for submission to Government be agreed.

(b) That the preparation of a Local Development Order be agreed, with the details of which being reported to Executive Board for approval.

NEIGHBOURHOODS, HOUSING AND REGENERATION

27 Assistance to Vulnerable Households: the business case for unsupported borrowing to fund equity release loans to vulnerable households

The Director of Environment and Neighbourhoods submitted a report outlining proposals regarding a financial model which would enable Leeds City Council to deliver unsupported borrowing for the provision of equity loans to vulnerable households.

The report provided details of the Equality, Diversity and Community Cohesion Impact (EDCI) screening form which had been completed in respect of this matter.

RESOLVED - That approval be given to the proposal to introduce an equity release loans scheme for vulnerable home owners, funded through unsupported borrowing, with the redeemed Leeds Loans used to subsidise costs, up to a limit of £500,000 per annum based upon the model set out within the submitted report for up to the next 4 years, subject to annual review of the scheme, in order to minimise the risk to the Council.

28 Reducing Reported Burglary in Leeds

The Director of Environment and Neighbourhoods submitted a report providing an overview of the burglary problem in Leeds and outlining the key drivers in relation to this offence. In addition, the report sought agreement to the Leeds Burglary Reduction Strategy and approval to the allocation of £1,326,000 made available through the Community Safety Fund to support the delivery of the Leeds Burglary Reduction Programme.

In response to Members' enquiries, officers undertook to provide Board Members with the burglary statistics broken down by Ward.

RESOLVED –

(a) That the Leeds Burglary Reduction Strategy be agreed.

(b) That the allocation of £1,326,000 of resources made available through the Community Safety Fund to support the delivery of the Leeds Burglary Reduction Programme be approved.

(c) That the annual funding allocations currently assigned to the Community Safety Fund for 2011/12 and 2012/13 be amended to make this more evenly split across the two financial years and aligned to the Burglary Reduction Programme, as outlined within section 5 of the submitted report.

(d) That a further report on the progress made to reduce domestic burglary be submitted to the Board in one year (June 2012).

29 Little London and Beeston Hill & Holbeck PFI Housing Project - Value For Money Review and Final Business Case

The Director of Environment and Neighbourhoods submitted a report informing the Board of the progress made to date on the Little London and Beeston Hill and Holbeck PFI Housing Project, whilst focussing upon the status of the project in relation to the Department for Communities and Local Government's Value for Money assessment of the programme and the remaining approval processes and likely timetable.

Copies of the report and accompanying documents had been circulated to Board Members prior to the meeting for their consideration.

RESOLVED -

(a) That the contents of the submitted report be noted.

(b) That the positive outcome for the project with regard to the Department for Communities and Local Government's Value for Money review be noted.

(c) That the impact of delays on the project and the likely programme to the financial close be noted.

(d) That a further, more detailed report be submitted to the Board on 27th July 2011 in order to confirm the final proposed scope and affordability of the project for further approval by the Government.

DATE OF PUBLICATION: 24TH JUNE 2011

LAST DATE FOR CALL IN OF ELIGIBLE DECISIONS: 1ST JULY 2011 (5.00 P.M.)

(Scrutiny Support will notify Directors of any items called in by 12.00noon on 4th July 2011)

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FORWARD PLAN OF KEY DECISIONS (relevant to Health and Wellbeing and Adult Social Care Scrutiny Board)

1 July 2011 – 31 October 2011

Key Decisions	Decision Maker	Expected Date of Decision	Proposed Consultation	Documents to be Considered by Decision Maker	Lead Officer (To whom representations should be made and email address to send representations to)
Charges for Non-Residential Adult Social Care Services To report on the outcome of the consultation on charges for non-residential services (home care, supported living, day care, transport, and direct payments) and request Executive Board to approve a changes to the charges for these services.	Executive Board (Portfolio: Adult Health and Social Care)	27/7/11	Service users and carers Voluntary organisations representing service users and carers Members of the public Briefings for members, staff and service providers	The report to be issued to the decision maker with the agenda for the meeting	anne.hill@leeds.gov.uk

Key Decisions	Decision Maker	Expected Date of Decision	Proposed Consultation	Documents to be Considered by Decision Maker	Lead Officer (To whom representations should be made and email address to send representations to)
Transforming day opportunities for adults with learning disabilities Agreement to re-provide day services to adults with a learning disability	Executive Board (Portfolio: Adult Health and Social Care)	7/9/11	Service users carers and staff have been consulted and the results of this are contained in the report	The report to be issued to the decision maker with the agenda for the meeting	Michele Tynan michele.tynan@leeds.gov.uk

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Fair Society, Healthy Lives

The Marmot Review
Executive Summary

Strategic Review of Health Inequalities in England post-2010

Fair Society, Healthy Lives

The Marmot Review
Executive Summary

Strategic Review of Health Inequalities
in England post-2010

Rise up with me against
the organisation of misery
Pablo Neruda

Note from the Chair

People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours – it should become the main focus. Consider one measure of social position: education. People with university degrees have better health and longer lives than those without. For people aged 30 and above, if everyone without a degree had their death rate reduced to that of people with degrees, there would be 202,000 fewer premature deaths each year. Surely this is a goal worth striving for.

It is the view of all of us associated with this Review that we could go a long way to achieving that remarkable improvement by giving more people the life chances currently enjoyed by the few. The benefits of such efforts would be wider than lives saved. People in society would be better off in many ways: in the circumstances in which they are born, grow, live, work, and age. People would see improved well-being, better mental health and less disability, their children would flourish, and they would live in sustainable, cohesive communities.

I chaired the World Heath Organisation's Commission on Social Determinants of Health. One critic labelled the Commission's report 'ideology with evidence'. The same charge could be levelled at the present Review and we accept it gladly. We do have an ideological position: health inequalities that could be avoided by reasonable means are unfair. Putting them right is a matter of social justice. But the evidence matters. Good intentions are not enough.

The major task of this Review was to assemble the evidence and advise on the development of a health inequalities strategy in England. We were helped by nine task groups who worked quickly and thoroughly to bring together the evidence on what was likely to work. Their reports are available at www.ucl.ac.uk/gheg/marmotreview/Documents. These reports provided the basis for the evidence summarised in Chapter 2 of this report and the policy recommendations laid out in Chapter 4.

Of course, inequalities in health are not a new concern. We stand on the shoulders of giants from the 19th and 20th centuries in seeking solutions to the problem. Learning from more recent experience forms the basis for Chapter 3.

While we relied heavily on the scientific literature, this was not the only type of evidence we considered. We engaged widely with stakeholders and attempted to learn from their insights and experience. Indeed, an exciting feature of the Review process was the level of commitment and interest we appear to have engaged in central government, political parties across the spectrum, local government, the health services, the third sector and the private sector. The necessity of engaging these partners in making change happen is the subject of Chapter 5.

Knowing the nature and size of the problem and understanding what works to make a difference must be at the heart of taking action to achieve a fairer distribution of health. We therefore propose a monitoring framework on the social determinants of health and health inequalities in Chapter 5 and Annex 2.

From the outset it was feared that we were likely to make financially costly recommendations. It was put to us that economic calculations would be crucial. Our approach to this was to look at the costs of doing nothing. The numbers, reproduced in Chapter 2, are staggering. Doing nothing is not an economic option. The human cost is also enormous – 2.5 million years of life potentially lost to health inequalities by those dying prematurely each year in England.

We are extremely grateful to two Secretaries of State for Health: Alan Johnson for having the vision to set up this Review and Andy Burnham for continuing to support it enthusiastically. When the report of the Commission on Social Determinants of Health was published in August 2008, Alan Johnson asked if we could apply the results to England. This report is our response to his challenge.

The Review was steered by wise Commissioners who gave of their knowledge, experience and commitment. It was served by a secretariat whose knowledge and selfless devotion to this task were simply inspiring. I am enormously grateful to both groups. One way and another, through excellent colleagues at the Department of Health, working committees, task groups, consultations and discussions, we involved scores of people. I hope they will see their influence reflected all through this Review.

I quoted Pablo Neruda when we began the Global Commission, and it seems appropriate to quote him still:

'Rise up with me against the organisation of misery'

Michael Marmot (Chair)

Terms of Reference

In November 2008, Professor Sir Michael Marmot was asked by the Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The strategy will include policies and interventions that address the social determinants of health inequalities.

The Review had four tasks

1 **Identify, for the health inequalities challenge facing England, the evidence most relevant to underpinning future policy and action**

2 **Show how this evidence could be translated into practice**

3 **Advise on possible objectives and measures, building on the experience of the current PSA target on infant mortality and life expectancy**

4 **Publish a report of the Review's work that will contribute to the development of a post-2010 health inequalities strategy**

Disclaimer

Acknowledgements

The work of the Review was championed, informed, and guided by the Chair of the Commission and the Commissioners.

Report writing team: Michael Marmot, Jessica Allen, Peter Goldblatt, Tammy Boyce, Di McNeish, Mike Grady, Ilaria Geddes.

The Marmot Review team was led by Jessica Allen. Team members included Peter Goldblatt, Tammy Boyce, Di McNeish, Mike Grady, Jason Strelitz, Ilaria Geddes, Sharon Friel, Felicity Porritt, Elaine Reinertsen, Ruth Bell and Matilda Allen.

The Department of Health supported the Commission in many ways. In particular we thank Una O'Brien, Mark Davies, David Buck, Ray Earwicker, Geoff Raison, Maggie Davies, Steve Feast, Martin Gibbs, Chris Brookes, Anne Griffin and Lorna Demming.

We are indebted to the task groups and working committees that informed the Review. They included: Sharon Friel, Denny Vagero, Alan Dyson, Jane Tunstill, Clyde Hertzman, Ziba Vaghri, Helen Roberts, Johannes Siegrist, Abigail McKnight, Joan Benach, Carles Muntaner, David MacFarlane, Monste Vergara Duarte, Hans Weitkowitz, Gry Wester, Howard Glennerster, Ruth Lister, Jonathan Bradshaw, Olle Lundberg, Kay Withers, Jan Flaherty, Anne Power, Jonathan Davis, Paul Plant, Tord Kjellstrom, Catalina Turcu, Helen Eveleigh, Jonathon Porritt, Anna Coote, Paul Wilkinson, David Colin-Thomé, Maria Arnold, Helen Clarkson, Sue Dibb, Jane Franklin, Tara Garnett, Jemima Jewell, Duncan Kay, Shivani Reddy, Cathryn Tonne, Ben Tuxworth, James Woodcock, Peter Smith, David Epstein, Marc Suhrcke, John Appleby, Adam Coutts, Demetris Pillas, Carmen de Paz Nieves, Cristina Otano, Ron Labonté, Margaret Whitehead, Mark Exworthy, Sue Richards, Don Matheson, Tim Doran, Sue Povall, Anna Peckham, Emma Rowland, Helen Vieth, Amy Colori, Louis Coiffait, Matthew Andrews, Anna Matheson, John Doyle, Lindsey Meyers, Alan Maryon-Davis, Tim Lobstein, Angela Greatley, Mark Bellis, Sally Greengross, Martin Wiseman, Paul Lincoln, Clare Bambra, Kerry Joyce, David Piachaud, James Nazroo, Jennie Popay, Fran Bennett, Hillary Graham, Bobbie Jacobson, Paul Johnstone, Ken Judge, Mike Kelly, Catherine Law, John Newton, John Fox, Rashmi Shukla, Nicky Best, Ian Plewis, Sue Atkinson, Tim Allen, Amanda Ariss, Antony Morgan, Paul Fryers, Veena Raleigh, Gwyn Bevan, Hugh Markowe, Justine Fitzpatrick, David Hunter, Gabriel Scally, Ruth Hussey, Tony Elson, Steve Weaver, Jacky Chambers, Nick Hicks, Paul Dornan, Liam Hughes, Carol Tannahill, Hari Sewell, Alison O'Sullivan, Chris Bentley, Caroline Briggs, Anne McDonald, John Beer, Jim Hillage, Jenny Savage, Daniel Lucy, Klim McPherson, Paul Johnson, Damien O'Flaherty and Matthew Bell.

We are grateful to those who have provided us with information, contacts and data. They included: Edwina Hughes, Gemma Gosling, Neil Blackshaw, Jonathan Campion, Nicola Bent, Duncan Booker, Pauline Craig, Neil Pease, Phil Hatcher, Susie Dye, Steve Cummins, Andrew Connor, Clive Needle, Chris Piper, Pauline Vallance, Angela Mawle, Esther Trenchard-Mabere, Keith Williams, Cathie Shaw, Todd Campbell, Paul Edmondson-Jones, Tommy Gorman, Kerry Townsley, Joseph Dromey, Annette Gaskell, Alison Amstutz, Lia Robinson, Karl Wilkinshaw, Rachel Carse, John Joseph, Jake Eliot, Rob Taylor and Michael Hagen.

We thank the members of the Health Inequalities Programme Board and the Health Inequalities Cross-Government Working Group: Anne Jackson, Bill Gunnyeon, Andrew Lawrence, Daron Walker, Gareth Davies, Patricia Hayes, Liz Brutus, Elspeth Bracken, Rachel Arrundale, Kay Barton, Janice Shersby, Simon Medcalf, Jayne Bowman, Savas Hadjipavlou, Jaee Samant, Andrew Elliott, Helen Bailey, Tom Jeffery, Irene Lucas, Sue Owen, Mike Anderson, Stephen Rimmer, Stephen Marston, Helen Edwards, Chris Warmald, Andrew Ramsey, Steve Gooding, Lionel Jarvis, Jonathan Rees, Harry Burns and Chris Tudor-Smith.

We thank the stakeholders who participated in the policy dialogues and open space event and responded to the consultation; a list of participants and respondents can be found on the Marmot Review website at www.ucl.ac.uk/gheg/marmotreview.

We thank our regional partners including Ruth Hussey, Mike Farrar and Danila Armstrong in the North West and in London Boris Johnson, Mayor of London, Pam Chesters and Helen Davies.

The report was copy-edited by Georgina Kyriacou.

We are grateful to UCL for hosting and supporting the Review team and to the thousands of people and organisations who have contributed to discussions with the team, who have attended presentations, provided feedback, thought and comment and helped shape and inform this Review.

The Commissioners

Michael Marmot (Chair)
Tony Atkinson
John Bell
Carol Black
Patricia Broadfoot
Julia Cumberlege
Ian Diamond
Ian Gilmore
Chris Ham
Molly Meacher
Geoff Mulgan

Table of Figures

Executive summary

Key messages of this Review

1 **Reducing health inequalities is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.**[1]

2 **There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.**

3 **Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.**

4 **Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.**

5 **Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.**

6 **Economic growth is not the most important measure of our country's success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.**

7 **Reducing health inequalities will require action on six policy objectives:**
- **— Give every child the best start in life**
- **— Enable all children young people and adults to maximise their capabilities and have control over their lives**
- **— Create fair employment and good work for all**
- **— Ensure healthy standard of living for all**
- **— Create and develop healthy and sustainable places and communities**
- **— Strengthen the role and impact of ill health prevention**

8 **Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.**

9 **Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.**

Introduction

Reducing health inequalities is a matter of fairness and social justice

Inequalities are a matter of life and death, of health and sickness, of well-being and misery. The fact that in England today people in different social circumstances experience avoidable differences in health, well-being and length of life is, quite simply, unfair. Creating a fairer society is fundamental to improving the health of the whole population and ensuring a fairer distribution of good health.

Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age. So close is the link between particular social and economic features of society and the distribution of health among the population, that the magnitude of health inequalities is a good marker of progress towards creating a fairer society. Taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole of society.

The WHO Commission on Social Determinants of Health which, among other work, was an impetus for the commissioning of this Review by the Department of Health, surveyed the world scene and concluded that 'social injustice is killing on a grand scale'.[2] While within England there are nowhere near the extremes of inequalities in mortality and morbidity seen globally, inequality is still substantial and requires urgent action. In England, people living in the poorest neighbourhoods, will, on average, die seven years earlier than people living in the richest neighbourhoods (the top curve in Figure 1). Even more disturbing, the average difference in disability-free life expectancy is 17 years (the bottom curve in Figure 1). So, people in poorer areas not only die sooner, but they will also spend more of their shorter lives with a disability. To illustrate the importance of the gradient: even excluding the poorest five per cent and the richest five per cent the gap in life expectancy between low and high income is six years, and in disability-free life expectancy 13 years.

Figure 1 also shows the finely graded relationship between the socioeconomic characteristics of these neighbourhoods and both life expectancy and disability-free life expectancy. Not only are there dramatic differences between best-off and worst-off in England, but the relationship between social circumstances and health is also a graded one. This is the social gradient in health. We can draw similar graphs to Figure 1 classifying individuals not by where they live but by their level of education, occupation, housing conditions – and see similar gradients. Put simply, the higher one's social position, the better one's health is likely to be.

These serious health inequalities do not arise by chance, and they cannot be attributed simply to genetic makeup, 'bad', unhealthy behaviour, or difficulties in access to medical care, important as those factors may be. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society.

The starting point for this Review is that health inequalities that are preventable by reasonable means are unfair. Putting them right is a matter of social justice. A debate about how to close the health gap has to be a debate about what sort of society people want.

Action is needed to tackle the social gradient in health

The implications of the social gradient in health are profound. It is tempting to focus limited resources on those in most need. But, as Figure 1 illustrates, we are all in need – all of us beneath the very best-off. If the focus were on the very bottom and social action were successful in improving the plight of the worst-off, what would happen to those just above the bottom, or at the median, who have worse health than those above them? All must be included in actions to create a fairer society.

We are unlikely to be able to eliminate the social gradient in health completely, but it is possible to have a shallower social gradient in health and well-being than is currently the case for England. This is evidenced by the fact that there is a steeper socio-economic gradient in health in some regions than in others, as shown in Figure 2.

To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem.

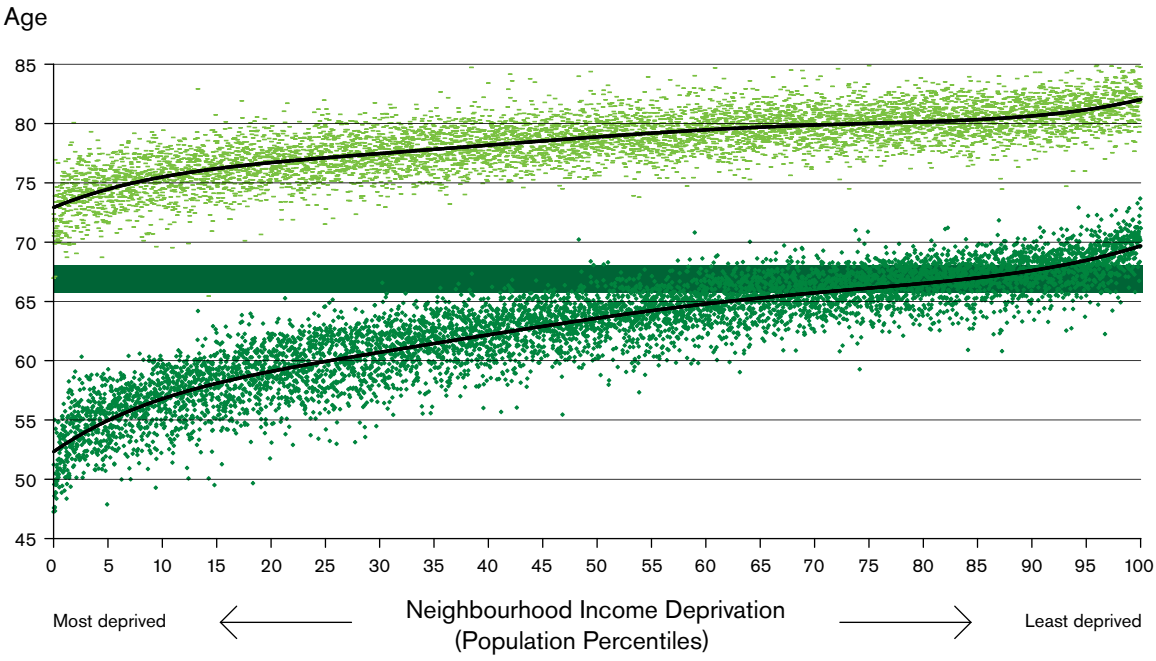
Action on health inequalities requires action across all the social determinants of health

The Commission on Social Determinants of Health concluded that social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources.[3]

These social and economic inequalities underpin the determinants of health: the range of interacting factors that shape health and well-being. These include: material circumstances, the social environment, psychosocial factors, behaviours, and biological factors. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, ethnicity and race. All these influences are affected by the socio-political and cultural and social context in which they sit.[4]

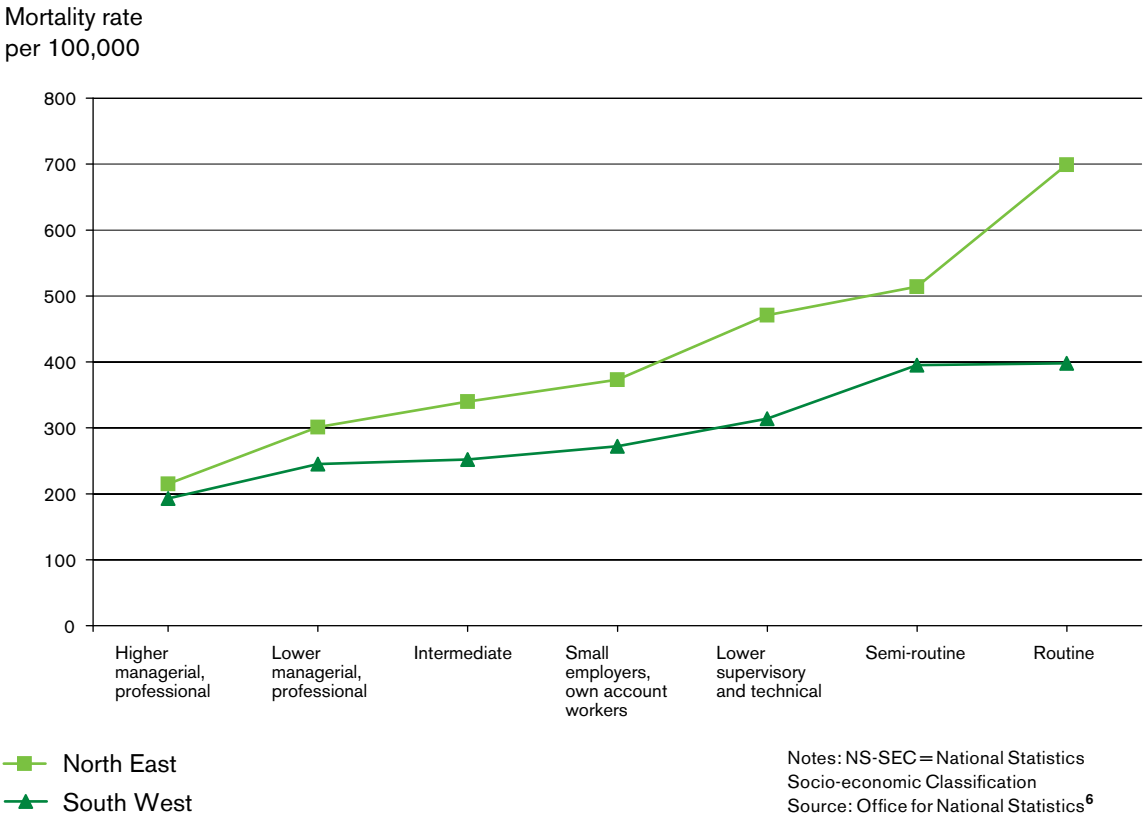
When we consider these social determinants of health, it is no mystery why there should continue to be health inequalities. Persisting inequalities across key domains provide ample explanation: inequalities in early child development and education, employment and working conditions, housing and neighbourhood conditions, standards of living, and, more generally, the freedom to participate equally in the

Figure 1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003



Source: Office for National Statistics[5]

Figure 2 Age standardised mortality rates by socioeconomic classification (NS-SEC) in the North East and South West regions, men aged 25–64, 2001–2003



Notes: NS-SEC = National Statistics Socio-economic Classification
Source: Office for National Statistics[6]

benefits of society. A central message of this Review, therefore, is that action is required across all these social determinants of health and needs to involve all central and local government departments as well as the third and private sectors. Action taken by the Department of Health and the NHS alone will not reduce health inequalities.

The unfair distribution of health and length of life provides compelling enough reason for action across all social determinants. However, there are other important reasons for taking action too. Addressing continued inequalities in early child development, in young people's educational achievement and acquisition of skills, in sustainable and healthy communities, in social and health services, and in employment and working conditions will have multiple benefits that extend beyond reductions in health inequalities.

Reducing health inequalities is vital for the economy

The benefits of reducing health inequalities are economic as well as social. The cost of health inequalities can be measured in human terms, years of life lost and years of active life lost; and in economic terms, by the cost to the economy of additional illness. If everyone in England had the same death rates as the most advantaged, people who are currently dying prematurely as a result of health inequalities would, in total, have enjoyed between 1.3 and 2.5 million extra years of life.[7] They would, in addition, have had a further 2.8 million years free of limiting illness or disability.[8] It is estimated that inequality in illness accounts for productivity losses of £31-33 billion per year, lost taxes and higher welfare payments in the range of £20-32 billion per year[9], and additional NHS healthcare costs associated with inequality are well in excess of £5.5 billion per year.[10] If no action is taken, the cost of treating the various illnesses that result from inequalities in the level of obesity alone will rise from £2 billion per year to nearly £5 billion per year in 2025.[11]

As further illustration, we have drawn on Figure 1 a line at 68 years – the pensionable age to which England is moving. With the levels of disability shown, more than three-quarters of the population do not have disability-free life expectancy as far as the age of 68. If society wishes to have a healthy population, working until 68 years, it is essential to take action to both raise the general level of health and flatten the social gradient.

This report is published in an adverse economic climate. We join our voice to those who say that a crisis is an opportunity: it is a time to plan to do things differently. Austerity need not lead to retrenchment in the welfare state. Indeed, the opposite may be necessary: the welfare state in England, the NHS itself, was born in the most austere post-war conditions. This required both courage and imagination. Today we call for courage and imagination again, to ensure equal health and well-being for future generations.

Beyond economic growth to well-being of society: sustainability and the fair distribution of health

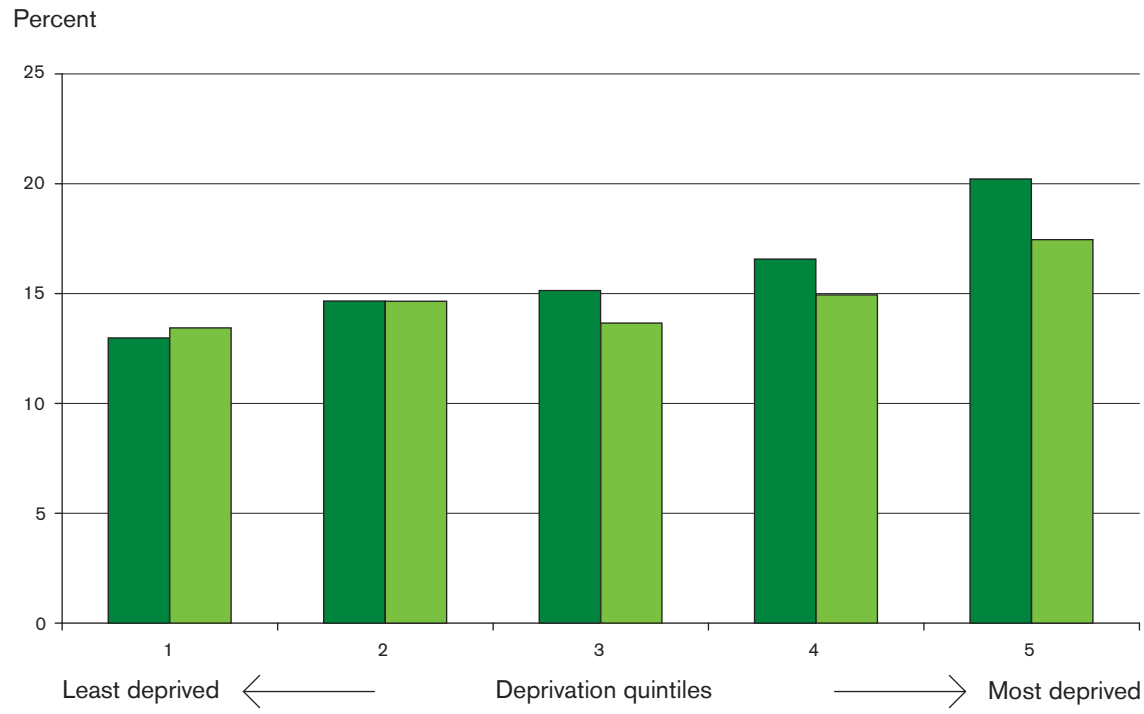
It is time to move beyond economic growth as the sole measure of social success. Not a new idea, it was given new emphasis by the recent Commission on the Measurement of Economic Performance and Social Progress, set up by President Sarkozy and chaired by Joseph Stiglitz, with Amartya Sen and Jean-Paul Fitoussi.[12] Well-being should be a more important societal goal than simply more economic growth. Prominent among the measures of well-being should be levels of inequalities in health.

Environmental sustainability, too, should be a more important societal goal than simply more economic growth. Economic growth without attending to its environmental impact, maintaining the status quo, is not an option for the country or for the planet. Globally, climate change and attempts to combat it have the worst effects on the poorest and most vulnerable. The need for mitigation of, and adaptation to, climate change means that we must do things differently. Creating a sustainable future is entirely compatible with action to reduce health inequalities: sustainable local communities, active transport, sustainable food production, and zero-carbon houses will have health benefits across society. We set out measures that will aid mitigation of climate change and also reduce health inequalities.

Simply restoring economic growth, trying to return to the status quo, while cutting public spending, should not be an option. Economic growth without reducing relative inequality will not reduce health inequalities. The economic growth of the last 30 years has not narrowed income inequalities. And although there is far more to inequality than just income, income is linked to life chances in a number of salient ways. As Amartya Sen has argued, income inequalities affect the lives people are able to lead.[13] A fair society would give people more equal freedom to lead flourishing lives.

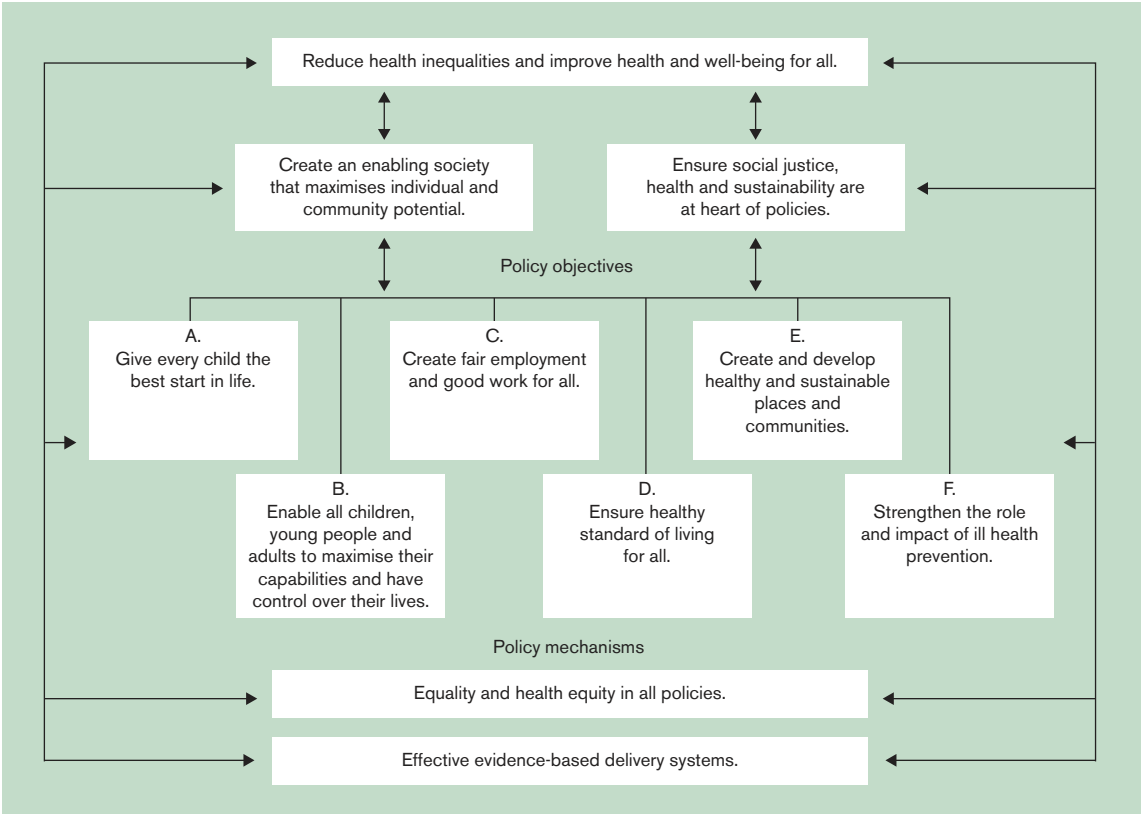
The central ambition of this Review is to create the conditions for people to take control over their own lives. If the conditions in which people are born, grow, live, work, and age are favourable, and more equitably distributed, then they will have more control over their lives in ways that will influence their own health and health behaviours, and those of their families. However, the freedom to flourish is graded. As an example, Figure 3 shows how answers to the General Health Questionnaire are related to deprivation for women in the Health Survey for England in 2001 and 2006 – a score of 4 or more indicates symptoms of mental disturbance.

Figure 3 Age standardised percentage of women with a General Health Questionnaire (GHQ) score of 4 or more by deprivation quintile, 2001 and 2006



Source: Health Survey for England[14]

Figure 4 The Conceptual framework



Six policy recommendations to reduce health inequalities

A framework for action

This Review has twin aims: to improve health and well-being for all and to reduce health inequalities. To achieve this, we have two policy goals:

— To create an enabling society that maximises individual and community potential
— To ensure social justice, health and sustainability are at the heart of all policies.

Based on the evidence we have assembled, our recommendations are grouped into six policy objectives, as shown in Figure 4.

Our recommendations in these six policy objectives are underpinned by two policy mechanisms:

— Considering equality and health equity in all policies, across the whole of government, not just the health sector
— Effective evidence-based interventions and delivery systems.

Action across the life course

Central to the Review is a life course perspective. Disadvantage starts before birth and accumulates throughout life, as shown in Figure 5. Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken. That is our ambition for children born in 2010. **For this reason, giving every child the best start in life (Policy Objective A) is our highest priority recommendation.**

Meanwhile, there is much that can be done to improve the lives and health of people who have already reached school, working age and beyond, as demonstrateed by the evidence presented in the following sections. Services that promote the health, well being and independence of older people and, in so doing, prevent or delay the need for more intensive or institutional care, make a significant contribution to ameliorating health inequalities. For example, the Partnerships for Older People projects have been shown to be cost effective in improving life quality.

Figure 5 Action across the life course

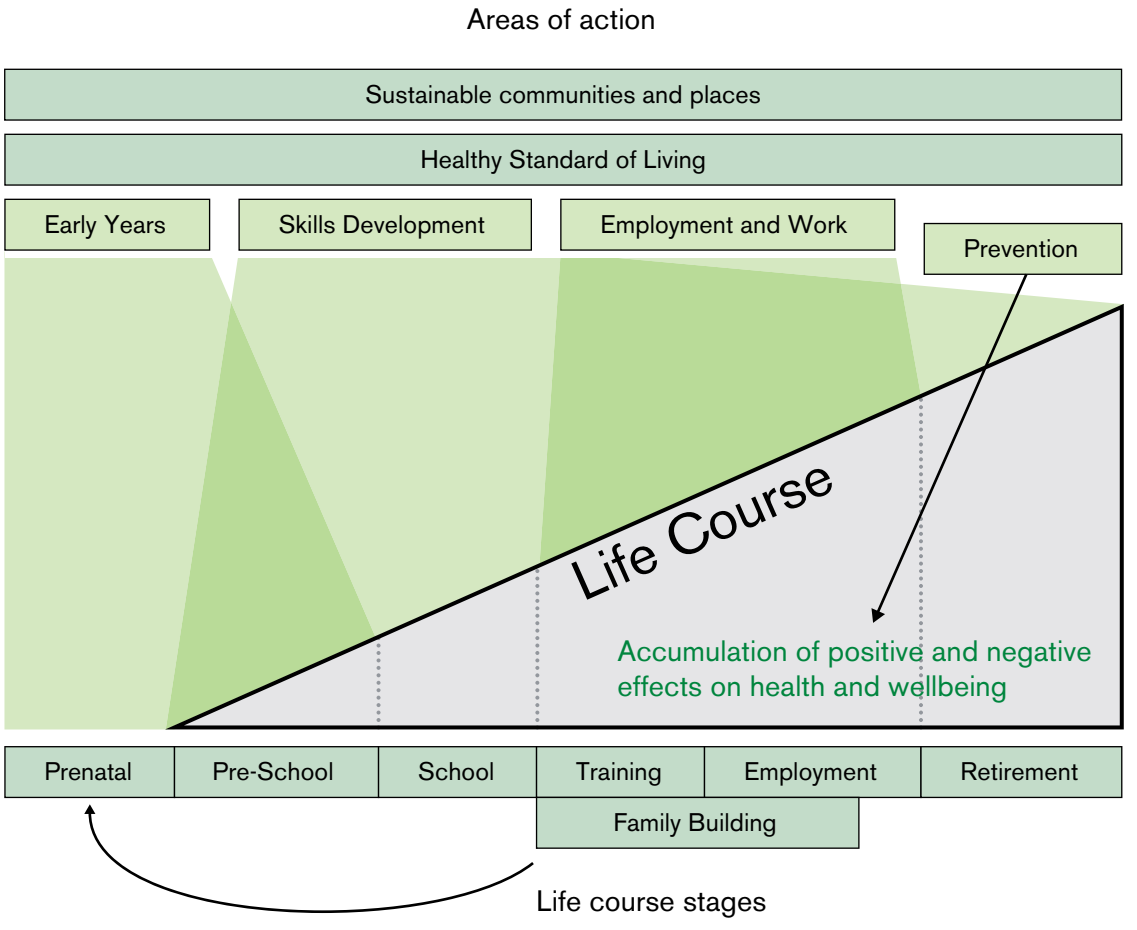


Photo: Anthony Strack/Getty Images

Policy Objective A
Give every child the best start in life

Priority objectives

1 Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.

2 Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.

3 Build the resilience and well-being of young children across the social gradient.

Policy recommendations

1 Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient.

2 Support families to achieve progressive improvements in early child development, including:
— Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
— Providing paid parental leave in the first year of life with a minimum income for healthy living
— Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet social need via outreach to families
— Developing programmes for the transition to school.

3 Provide good quality early years education and childcare proportionately across the gradient. This provision should be:
— Combined with outreach to increase the take-up by children from disadvantaged families
— Provided on the basis of evaluated models and to meet quality standards.

If you are a single parent you don't get to go out that much, you don't really see anybody.

Quote from participant in qualitative work undertaken for the Review, which explored barriers to healthy lives among specific groups living in Hackney (London), Birmingham and Manchester. See Annex 1 and www.ucl.ac.uk/gheg/marmotreview. The remaining quotes in this summary also come from this work.

Inequalities in early child development

Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being– from obesity, heart disease and mental health, to educational achievement and economic status.[15] To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences. Later interventions, although important, are considerably less effective where good early foundations are lacking.[16]

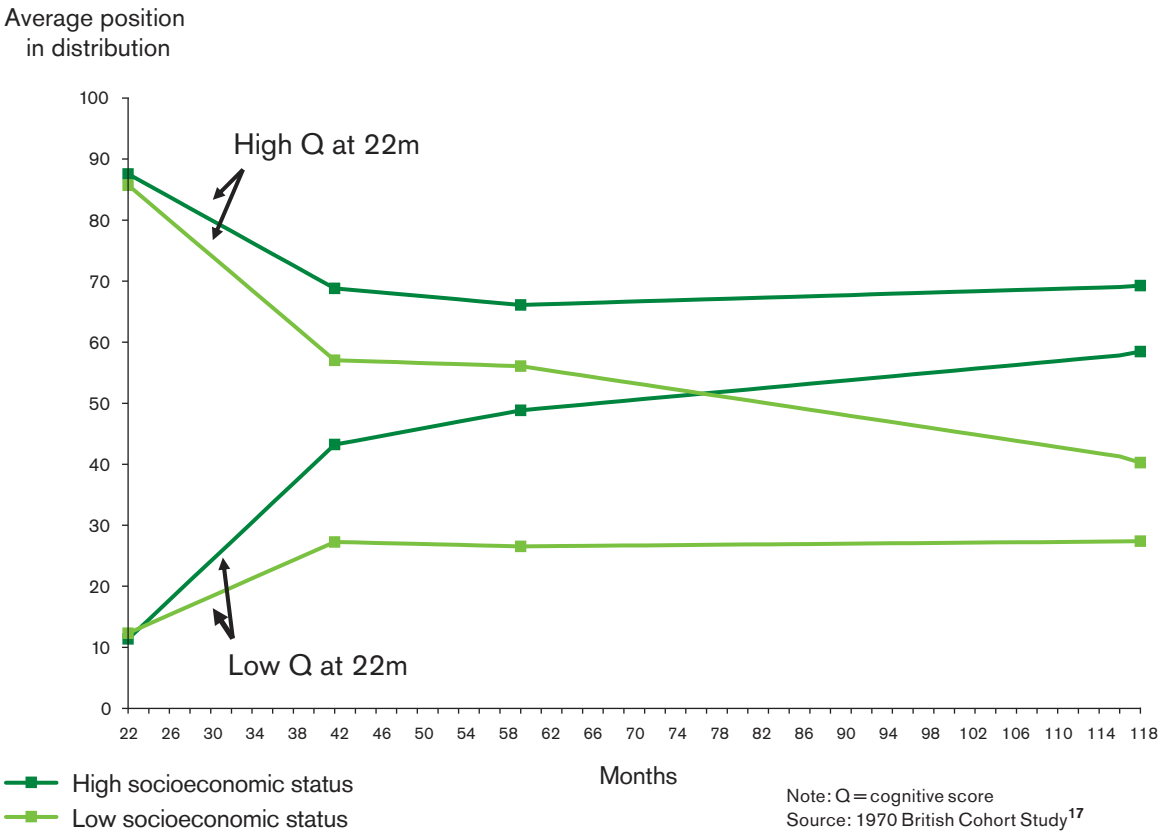
As Figure 6 shows, children who have low cognitive scores at 22 months of age but who grow up in families of high socioeconomic position improve their relative scores as they approach the age of 10. The relative position of children with high scores at 22 months, but who grow up in families of low socioeconomic position, worsens as they approach age 10.

What can be done to reduce inequalities in early child development?

There has been a strong government commitment to the early years, enacted through a wide range of policy initiatives, including Sure Start and the Healthy Child Programme. It is vital that this is sustained over the long term. Even greater priority must be given to ensuring expenditure early in the developmental life cycle (that is, on children below the age of 5) and that more is invested in interventions that have been proved to be effective.

We are therefore calling for a 'second revolution in the early years', to increase the proportion of overall expenditure allocated there. This expenditure should be focused proportionately across the social gradient to ensure effective support to parents (starting in pregnancy and continuing through the transition of the child into primary school), including quality early education and childcare.

Figure 6 Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years



Note: Q = cognitive score
Source: 1970 British Cohort Study[17]

Policy Objective B

Enable all children, young people and adults to maximise their capabilities and have control over their lives

Priority objectives

1 Reduce the social gradient in skills and qualifications.

2 Ensure that schools, families and communities work in partnership to reduce the gradient in health, well-being and resilience of children and young people.

3 Improve the access and use of quality lifelong learning across the social gradient.

Policy recommendations

1 Ensure that reducing social inequalities in pupils' educational outcomes is a sustained priority.

2 Prioritise reducing social inequalities in life skills, by:
— Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education
— Consistently implementing 'full service' extended school approaches
— Developing the school-based workforce to build their skills in working across school–home boundaries and addressing social and emotional development, physical and mental health and well-being.

3 Increase access and use of quality lifelong learning opportunities across the social gradient, by:
— Providing easily accessible support and advice for 16–25 year olds on life skills, training and employment opportunities
— Providing work-based learning, including apprenticeships, for young people and those changing jobs/careers
— Increasing availability of non-vocational lifelong learning across the life course.

If there is no education there are no jobs these days, so it is really worrying. If your children don't get a good education then what's going to happen to them?

(Focus group participant)

Inequalities in education and skills

Inequalities in educational outcomes affect physical and mental health, as well as income, employment and quality of life. The graded relationship between socioeconomic position and educational outcome has significant implications for subsequent employment, income, living standards, behaviours, and mental and physical health (Figure 7).

To achieve equity from the start, investment in the early years is crucial. However, maintaining the reduction of inequalities across the gradient also requires a sustained commitment to children and young people through the years of education. Central to this is the acquisition of cognitive and non-cognitive skills, which are strongly associated with educational achievement and with a whole range of other outcomes including better employment, income and physical and mental health.

Success in education brings many advantages. If we are serious about reducing both social and health inequalities, we must maintain our focus on improving educational outcomes across the gradient.

What can be done to reduce inequalities in education and skills?

Inequalities in educational outcomes are as persistent as those for health and are subject to a similar social gradient. Despite many decades of policies aimed at equalising educational opportunities, the attainment gap remains. As with health inequalities, reducing educational inequalities involves understanding the interaction between the social determinants of educational outcomes, including family background, neighbourhood and relationships with peers, as well as what goes on in schools. Indeed, evidence on the most important factors influencing educational attainment suggests that it is families, rather than schools, that have the most influence. Closer links between schools, the family, and the local community are needed.

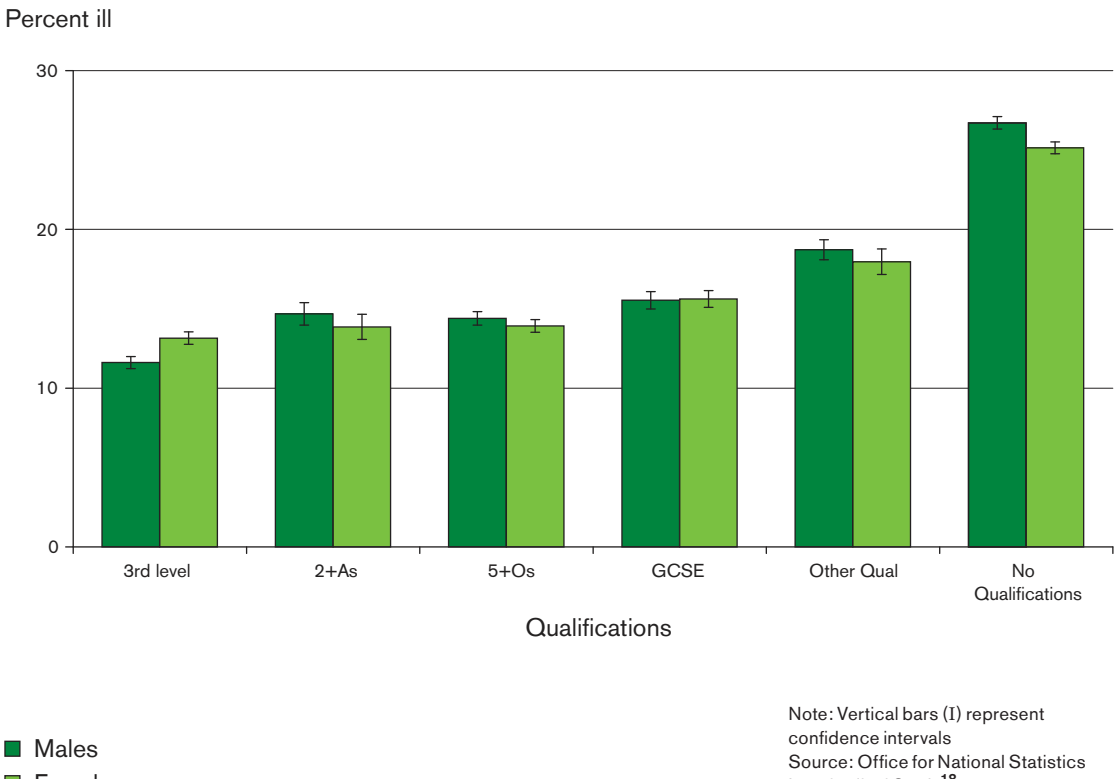
Investing in the early years, thereby improving early cognitive and non-cognitive development and children's readiness for school, is vital for later educational outcomes. Once at school, it is important that children and young people are able to develop skills for life and for work as well as attain qualifications.

Closer links between schools, the family, and the local community are important steps to this achievement. The development of extended services in and around schools is important, but more is needed to develop the skills of teaching and non-teaching staff to work across home–school boundaries and develop the broader life skills of children and young people.

For those who leave school at 16, further support is vital in the form of skills development for work and training, management of relationships, and advice on substance misuse, debt, continuing education, housing concerns and pregnancy and parenting. Such training and support should be developed and located in every community, designed specifically for this age group.

Central to our vision is the full development of people's capabilities across the social gradient. Without life skills and readiness for work, as well as educational achievement, young people will not be able to fulfil their full potential, to flourish and take control over their lives.

Figure 7 Standardised limiting illness rates in 2001 at ages 16–74, by education level recorded in 2001



Note: Vertical bars (I) represent confidence intervals
Source: Office for National Statistics Longitudinal Study[18]

Policy Objective C
Create fair employment and good work for all

Priority objectives

1 Improve access to good jobs and reduce long-term unemployment across the social gradient.

2 Make it easier for people who are disadvantaged in the labour market to obtain and keep work.

3 Improve quality of jobs across the social gradient.

Policy recommendations

1 Prioritise active labour market programmes to achieve timely interventions to reduce long-term unemployment.

2 Encourage, incentivise and, where appropriate, enforce the implementation of measures to improve the quality of jobs across the social gradient, by:
— Ensuring public and private sector employers adhere to equality guidance and legislation
— Implementing guidance on stress management and the effective promotion of well-being and physical and mental health at work.

3 Develop greater security and flexibility in employment, by:
— Prioritising greater flexibility of retirement age
— Encouraging and incentivising employers to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems.

The only [things] I am concerned [about] are the future of my children, the lack of opportunities for the younger generation and the lack of employment – that is very daunting.

(Focus group participant)

Inequalities in work and employment

Being in good employment is protective of health. Conversely, unemployment contributes to poor health. Getting people into work is therefore of critical importance for reducing health inequalities. However, jobs need to be sustainable and offer a minimum level of quality, to include not only a decent living wage, but also opportunities for in-work development, the flexibility to enable people to balance work and family life, and protection from adverse working conditions that can damage health.

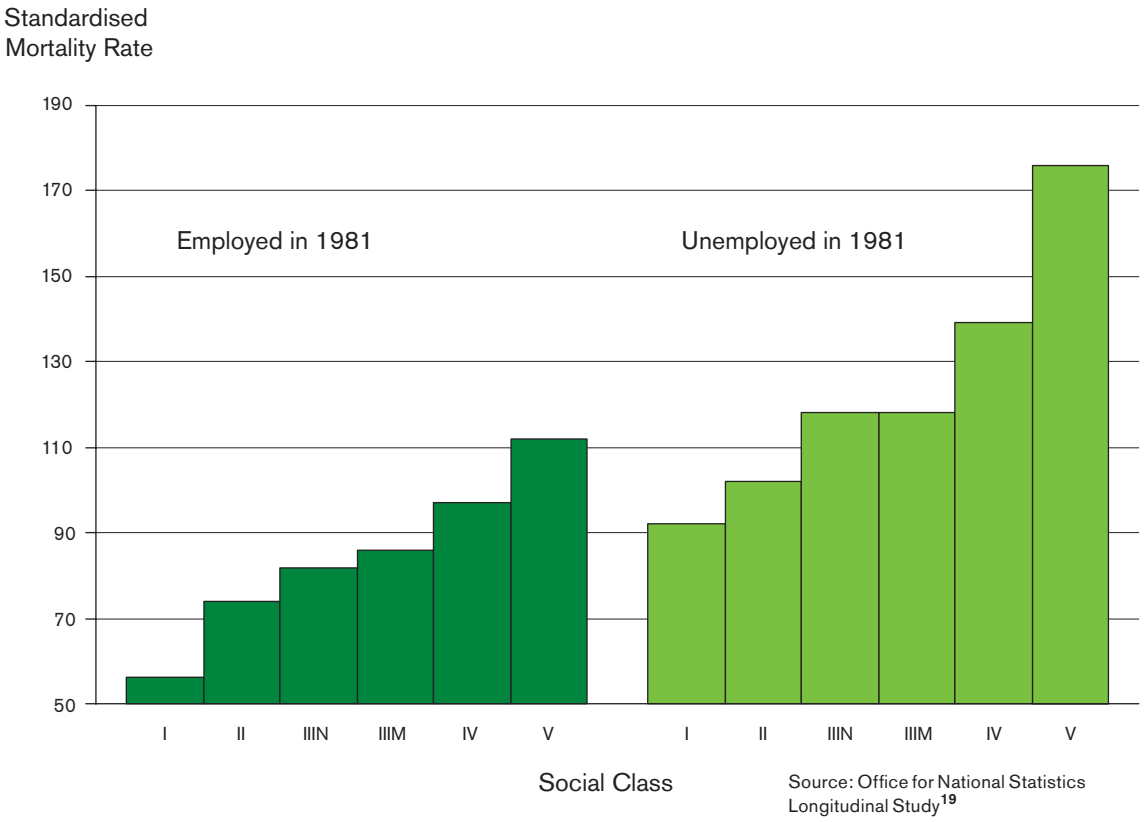
Patterns of employment both reflect and reinforce the social gradient and there are serious inequalities of access to labour market opportunities. Rates of unemployment are highest among those with no or few qualifications and skills, people with disabilities and mental ill-health, those with caring responsibilities, lone parents, those from some ethnic minority groups, older workers and, in particular, young people. When in work, these same groups are more likely to be in low-paid, poor quality jobs with few opportunities for advancement, often working in conditions that are harmful to health. Many are trapped in a cycle of low-paid, poor quality work and unemployment.

The dramatic increase in unemployment in the United Kingdom during the early 1980s stimulated research on the link between unemployment and health. Figure 8 shows the social gradient in the subsequent mortality of those that experienced unemployment in the early 1980s. For each occupational class, the unemployed have higher mortality than the employed.

Insecure and poor quality employment is also associated with increased risks of poor physical and mental health. There is a graded relationship between a person's status at work and how much control and support they have there. These factors, in turn, have biological effects and are related to increased risk of ill-health.

Work is good – and unemployment bad – for physical and mental health, but the quality of work matters. Getting people off benefits and into low paid, insecure and health-damaging work is not a desirable option.

Figure 8 Mortality of men in England and Wales in 1981–92, by social class and employment status at the 1981 Census



Source: Office for National Statistics Longitudinal Study[19]

Policy Objective D
Ensure a healthy standard of living for all

Priority objectives

1 Establish a minimum income for healthy living for people of all ages.

2 Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies.

3 Reduce the cliff edges faced by people moving between benefits and work.

Policy recommendations

1 Develop and implement standards for minimum income for healthy living.

2 Remove 'cliff edges' for those moving in and out of work and improve flexibility of employment.

3 Review and implement systems of taxation, benefits, pensions and tax credits to provide a minimum income for healthy living standards and pathways for moving upwards.

I'm one person who would be better off not working with two kids. I would have more money if I didn't work.

(Focus group participant)

Inequalities in income

Having insufficient money to lead a healthy life is a highly significant cause of health inequalities.[20]

As a society becomes richer, the levels of income and resources that are considered to be adequate also rise. The calculation of Minimum Income for Healthy Living (MIHL) includes the level of income needed for adequate nutrition, physical activity, housing, social interactions, transport, medical care and hygiene. In England there are gaps between a minimum income for healthy living and the level of state benefit payments that many groups receive.

Despite important steps made by the Government to tackle child poverty, the proportion of the UK population living in poverty remains stubbornly high, above the European Union average and worse than in France, Germany, the Netherlands and the Nordic countries. Employment policy has helped, but the UK benefits system remains inadequate.

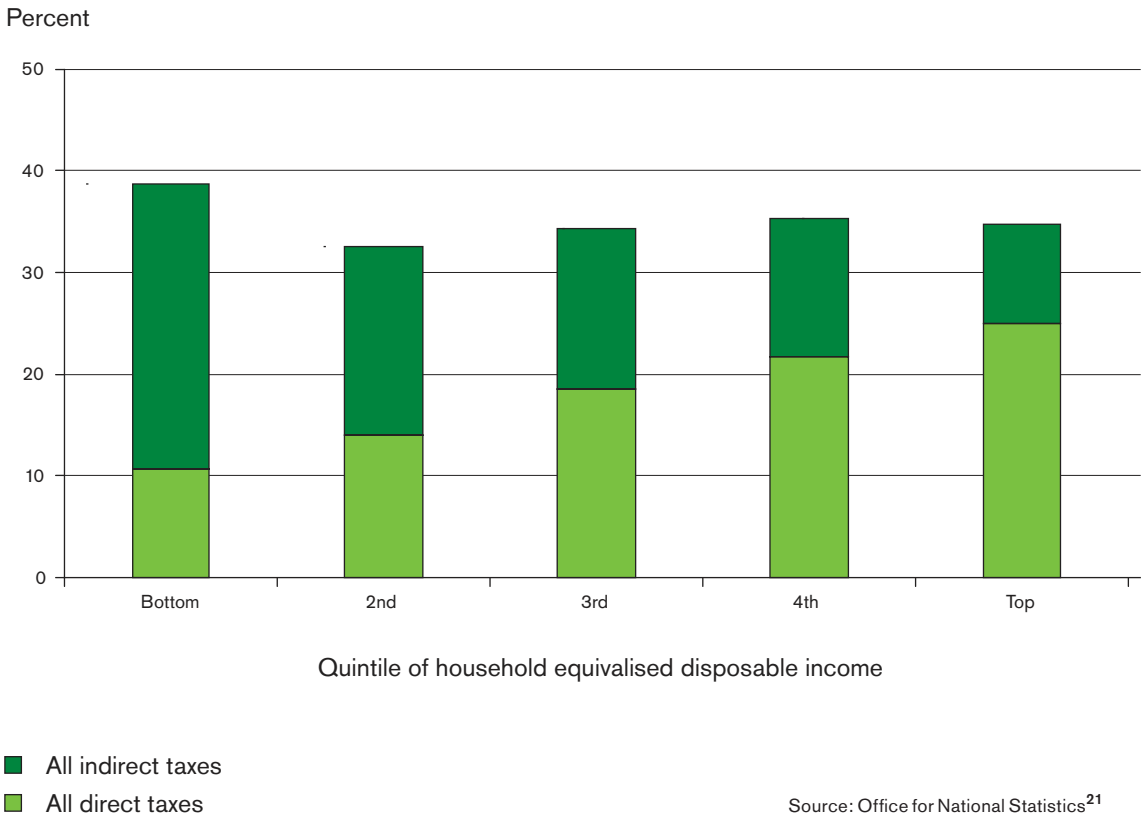
Figure 9 shows that, after taking account of both direct and indirect tax, the taxation system in Britain disadvantages those on lower incomes. The benefits of lower direct tax rates for those on lower incomes are cancelled out by the effects of indirect taxation. People on low incomes spend a larger proportion of their money on commodities that attract indirect taxes. As a result, overall tax, as a proportion of disposable income, is highest in the bottom quintile.

What can be done to reduce income inequalities?

State benefits increase the incomes of the worst off. Since 1998 tax credits have lifted 500,000 children out of poverty. It is imperative that the system of benefits does not act as a disincentive to enter employment. Over two million workers in Britain stand to lose more than half of any increase in earnings to taxes and reduced benefits. Some 160,000 would keep less than 10p of each extra £1 they earned. Lone parents face some of the weakest incentives to work and earn more, because many will be, or worry they will be, subject to withdrawal of a tax credit or means-tested benefit as their earnings rise.

The current tax and benefit system needs overhauling to strengthen incentives to work for people on low incomes and increase simplicity and certainty for families. The Government could do more to redistribute income and reduce poverty without harming the economy by delivering a net tax cut to people who currently face weak incentives to enter work or to increase their low levels of pay. A more progressive tax system is needed, one that includes the direct and indirect incomes that make up a person's income.

Figure 9 Taxes as a percentage of gross income, by quintile, 2007/8



Source: Office for National Statistics[21]

Policy Objective E
Create and develop healthy and sustainable places and communities

Priority objectives

1 Develop common policies to reduce the scale and impact of climate change and health inequalities.

2 Improve community capital and reduce social isolation across the social gradient.

Policy recommendations

1 Prioritise policies and interventions that reduce both health inequalities and mitigate climate change, by:
— Improving active travel across the social gradient
— Improving the availability of good quality open and green spaces across the social gradient
— Improving the food environment in local areas across the social gradient
— Improving energy efficiency of housing across the social gradient.

2 Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.

3 Support locally developed and evidence-based community regeneration programmes that:
— Remove barriers to community participation and action
— Reduce social isolation.

You can see the deprivation. All you have to do is look outside. It is in your face every day – litter everywhere, rats and rubbish, it is a dump… It feels like people around you have no meaning to life. I keep my curtains closed at times. It doesn't give you a purpose to do anything.

(Focus group participant)

Inequalities in neighbourhoods and communities

Communities are important for physical and mental health and well-being. The physical and social characteristics of communities, and the degree to which they enable and promote healthy behaviours, all make a contribution to social inequalities in health. However, there is a clear social gradient in 'healthy' community characteristics (Figure 10).

People want to get involved with that, people will want to support that, people will want to volunteer for that, people want to get education to fit the role so that can grow and I don't want people from outside of the community to do that, I want people from inside the community to do that because it's up to us. We care about it.

(Focus group participant)

What can be done to reduce community inequalities?

Social capital describes the links between individuals: links that bind and connect people within and between communities. It provides a source of resilience, a buffer against risks of poor health, through social support which is critical to physical and mental well-being, and through the networks that help people find work, or get through economic and other material difficulties. The extent of people's participation in their communities and the added control over their lives that this brings has the potential to contribute to their psychosocial well-being and, as a result, to other health outcomes.

It is vital to build social capital at a local level to ensure that policies are both owned by those most affected and are shaped by their experiences.

Building healthier and more sustainable communities involves choosing to invest differently. For example, the Commission for Architecture and the Built Environment estimates that the budget for new road building, if used differently, could provide 1,000 new parks at an initial capital cost of £10 million each – two parks in each local authority in England. One thousand new parks could save approximately 74,000 tonnes of carbon, based on a 10 hectare park with 200 trees.[22]

Much of what we recommend for reducing health inequalities – active travel (for example walking or cycling), public transport, energy-efficient houses, availability of green space, healthy eating, reduced carbon-based pollution – will also benefit the sustainability agenda.

Figure 10 Populations living in areas with, in relative terms, the least favourable environmental conditions, 2001–6

Environmental conditions: river water quality, air quality, green space, habitat favourable to bio-diversity, flood risk, litter, detritus, housing conditions, road accidents, regulated sites (e.g. landfill)

Source: Department for Environment, Food and Rural Affairs[23]

Policy Objective F
Strengthen the role and impact of ill-health prevention

Priority objectives

1 Prioritise prevention and early detection of those conditions most strongly related to health inequalities.

2 Increase availability of long-term and sustainable funding in ill health prevention across the social gradient.

Policy recommendations

1 Prioritise investment in ill health prevention and health promotion across government departments to reduce the social gradient.

2 Implement an evidence-based programme of ill health preventive interventions that are effective across the social gradient by:
— Increasing and improving the scale and quality of medical drug treatment programmes
— Focusing public health interventions such as smoking cessation programmes and alcohol reduction on reducing the social gradient
— Improving programmes to address the causes of obesity across the social gradient.

3 Focus core efforts of public health departments on interventions related to the social determinants of health proportionately across the gradient.

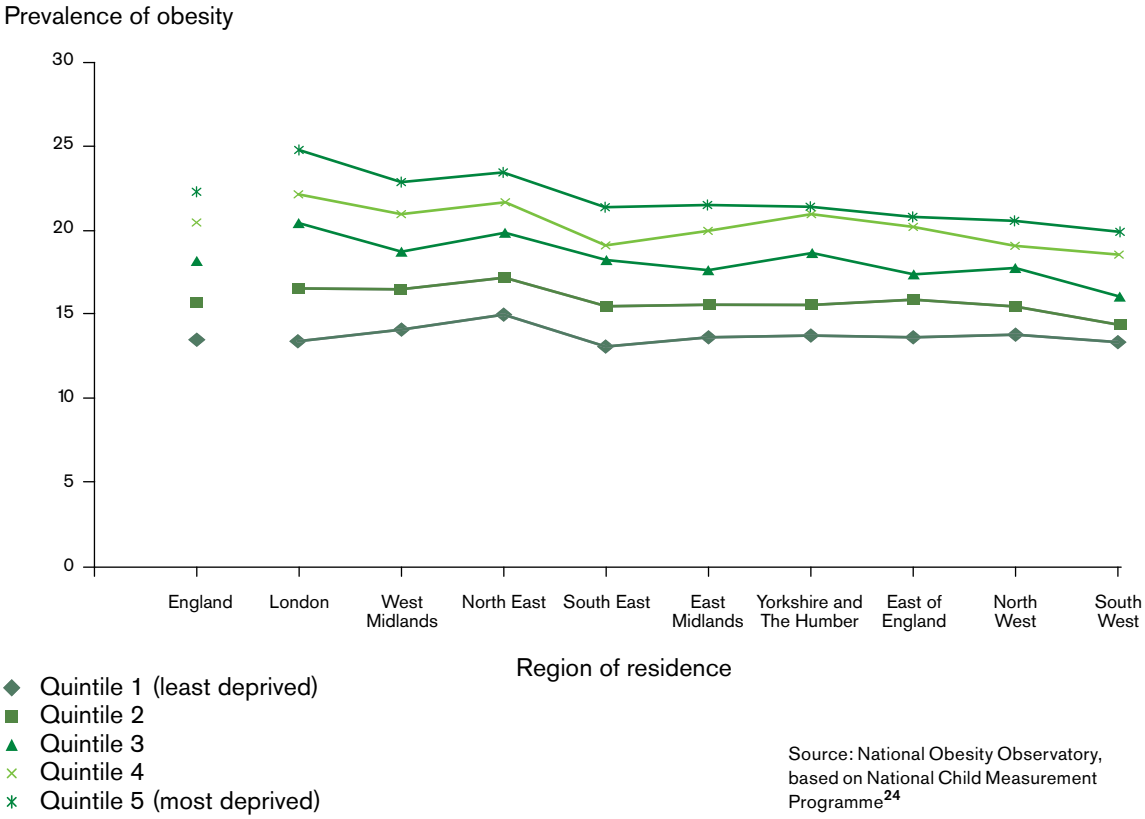
Many of the key health behaviours significant to the development of chronic disease follow the social gradient: smoking, obesity, lack of physical activity, unhealthy nutrition. An example is shown for obesity in Figure 11. Each of the five policy areas of our recommendations are targeted at preventing the social gradient in incidence of illness. In addition, reducing health inequalities requires a focus on these health behaviours.

The importance of investing in the early years is key to preventing ill health later in life, as is investing in healthy schools and healthy employment as well as more traditional forms of ill-health prevention such as drug treatment and smoking cessation programmes. The accumulation of experiences a child receives shapes the outcomes and choices they will make when they become adults.

Prevention of ill health has traditionally been the responsibility of the NHS, but we put prevention in the context of the social determinants of health. Hence, all our recommendations require involvement of a range of stakeholders. Local and national decisions made in schools, the workplace, at home, and in government services all have the potential to help or hinder ill-health prevention.

At present only 4 per cent of NHS funding is spent on prevention. Yet, the evidence shows that partnership working between primary care, local authorities and the third sector to deliver effective universal and targeted preventive interventions can bring important benefits.

Figure 11 Prevalence of obesity (>95th centile), by region and deprivation quintile, children aged 10–11 years, 2007/8



Source: National Obesity Observatory, based on National Child Measurement Programme[24]

Delivery systems

Even backed by the best evidence and with the most carefully designed and well resourced interventions, national policies will not reduce inequalities if local delivery systems cannot deliver them. The recommendations we make depend both on local partnerships and on national cross-cutting government policies.

Central direction, local delivery

Where does responsibility for action lie? There is no question that central, regional, and local government all have crucial roles to play. As we conducted this Review, we formed partnerships with the North West region of England, and with London; both regions are seeking to put the reduction of health inequalities at the centre of their strategy and actions.[25] They will be joined by several other local governments, Primary Care Trusts, and third sector organisations.

The argument was put to us that local practitioners want principles for action rather than detailed, specific recommendations. Local areas suggested they will exercise the freedom to develop locally appropriate plans for reducing health inequalities. The policy proposals made in this Review are intended to provide evidence of interventions that will reduce health inequalities and to give directions of travel without detailed prescription of exactly how policies should be developed and implemented. Similarly, the Review has proposed a national framework of indicators, within which local areas develop those needed for monitoring local performance improvement in their own areas.

Individual and community empowerment

Linked to the question of whether action should be central or local is the role of individual responsibility, often juxtaposed against the responsibility of government. This Review puts empowerment of individuals and communities at the centre of action to reduce health inequalities. But achieving individual empowerment requires social action. Our vision is of creating conditions for individuals to take control of their own lives. For some communities this will mean removing structural barriers to participation, for others facilitating and developing capacity and capability through personal and community development.

There needs to be a more systematic approach to engaging communities by Local Strategic Partnerships at both district and neighbourhood levels, moving beyond often routine, brief consultations to effective participation in which individuals and communities define the problems and develop community solutions. Without such participation and a shift of power towards individuals and communities it will be difficult to achieve the penetration of interventions needed to impact effectively on health inequalities.

Strategic policy should be underpinned by a limited number of aspirational targets that support the intended strategic direction, to improve and reduce inequalities in life and health expectancy and monitor child development and social inclusion across the social gradient.

National health outcome targets across the social gradient

It is proposed that national targets in the immediate future should cover:

- **Life expectancy (to capture years of life)**
- **Health expectancy (to capture the quality of those years).**

Once an indicator of well-being is developed that is suitable for large-scale implementation, this should be included as a third national target on health inequality.

National targets for child development across the social gradient

It is proposed that national targets should cover:

- **Readiness for school (to capture early years development)**
- **Young people not in education, employment or training (to capture skill development during the school years and the control that school leavers have over their lives).**

National target for social inclusion

It is proposed that there be a national target that progressively increases the proportion of households that have an income, after tax and benefits, that is sufficient for healthy living.

National and regional leadership should promote awareness of the underlying social causes of health inequalities and build understanding across the NHS, local government, third sector and private sector services of the need to scale up interventions and sustain intensity using mainstream funding. Interventions should have an evidenced-based evaluation framework and a health equity impact assessment. This would help delivery organisations shape effective interventions, understand impacts of other policies on health distributions and avoid drift into small-scale projects focused on individual behaviours and lifestyle.

Conclusion

Social justice is a matter of life and death. It affects the way people live, their consequent chances of illness and their risk of premature death.

This is the opinion of the Commission on Social Determinants of Health set up by the World Health Organisation. Theirs was a global remit and we can all easily recognise the health inequalities experienced by people living in poor countries, people for whom absolute poverty is a daily reality.

It is harder for many people to accept that serious health inequalities exist here in England. We have a highly valued NHS and the overall health of the population in this country has improved greatly over the past 50 years. Yet in the wealthiest part of London, one ward in Kensington and Chelsea, a man can expect to live to 88 years, while a few kilometres away in Tottenham Green, one of the capital's poorer wards, male life expectancy is 71. Dramatic health inequalities are still a dominant feature of health in England across all regions.

But health inequalities are not inevitable and can be significantly reduced. They stem from avoidable inequalities in society: of income, education, employment and neighbourhood circumstances. Inequalities present before birth set the scene for poorer health and other outcomes accumulating throughout the life course.

The central tenet of this Review is that avoidable health inequalities are unfair and putting them right is a matter of social justice. There will be those who say that our recommendations cannot be afforded, particularly in the current economic climate. We say that it is *inaction* that cannot be afforded, for the human and economic costs are too high. The health and well-being of today's children depend on us having the courage and imagination to rise to the challenge of doing things differently, to put sustainability and well-being before economic growth and bring about a more equal and fair society.

List of abbreviations

DEfRA	Department for Environment, Food and Rural Affairs
DFLE	Disability Free Life Expectancy
GCSE	General Certificate of Secondary Education
GHQ	General Health Questionnaire
MIHL	Minimum Income for Healthy Living
NHS	National Health Service
NS-SEC	National Statistics Socio-economic Classification
ONS	Office for National Statistics

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Fair Society, Healthy Lives
The Marmot Review

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Leeds

This profile gives a picture of health in this area. It is designed to help local government and health services understand their community's needs, so that they can work to improve people's health and reduce health inequalities.

Visit the Health Profiles website for:

- Profiles of all local authorities in England
- Interactive maps – see how health varies between areas
- More health indicator information
- Links to more community health profiles and tools

Health Profiles are produced by the English Public Health Observatories working in partnership.

www.healthprofiles.info

Population 788,000

Mid-2009 population estimate

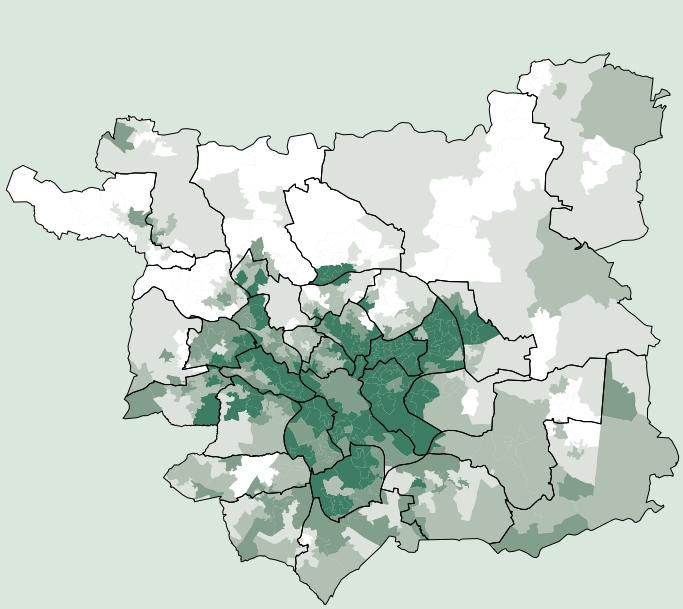
Source: National Statistics website: www.statistics.gov.uk

Leeds at a glance

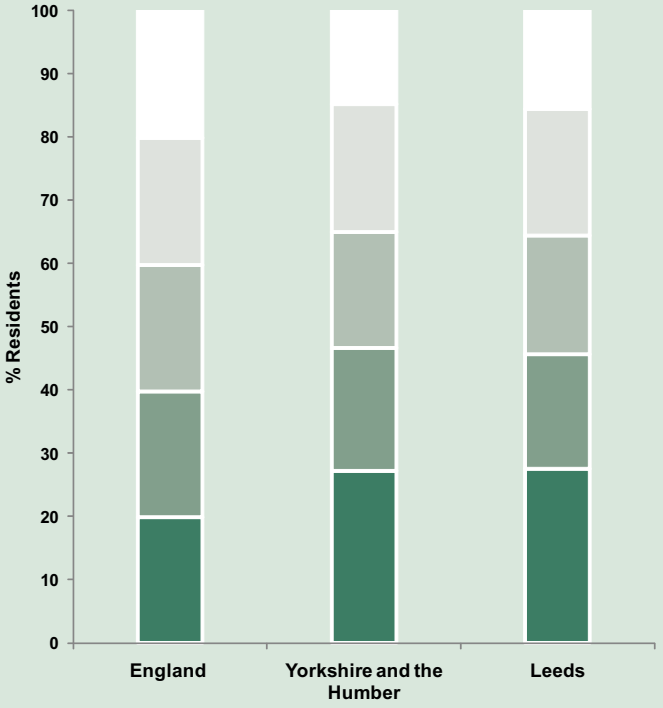
- The health of people in Leeds is generally worse than the England average. Deprivation is higher than average and 33,295 children live in poverty. Life expectancy for both men and women is lower than the England average.
- Life expectancy is 12.2 years lower for men and 8.3 years lower for women in the most deprived areas of Leeds than in the least deprived areas (based on the Slope Index of Inequality published on 5th January 2011).
- Over the last 10 years, all cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen but remain worse than the England average.
- About 20.0% of Year 6 children are classified as obese. A lower percentage than average of pupils spend at least three hours each week on school sport. Levels of teenage pregnancy, GCSE attainment and tooth decay in children are worse than the England average.
- Estimated levels of adult 'healthy eating', smoking and obesity are worse than the England average. Rates of smoking related deaths and hospital stays for alcohol related harm are higher than average.
- Priorities in Leeds include tackling the inequalities gap, smoking and child health. For more information see www.leeds.nhs.uk

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.



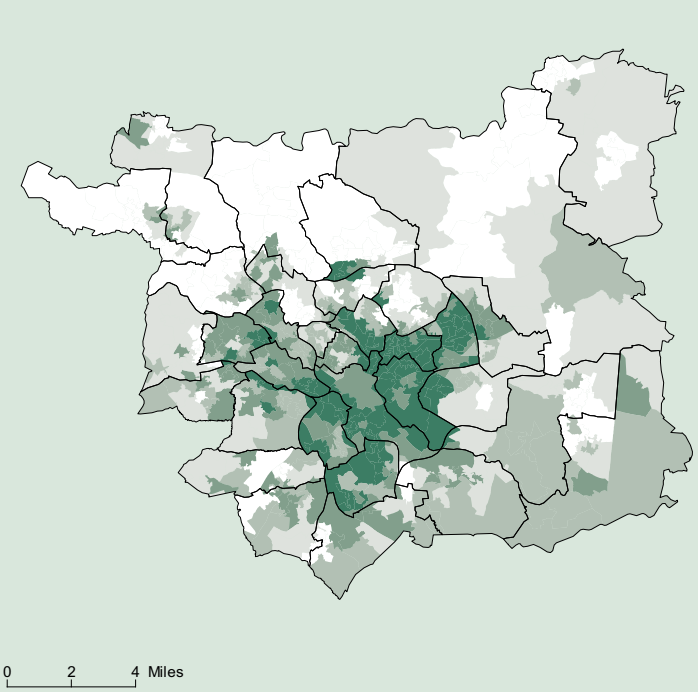
This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



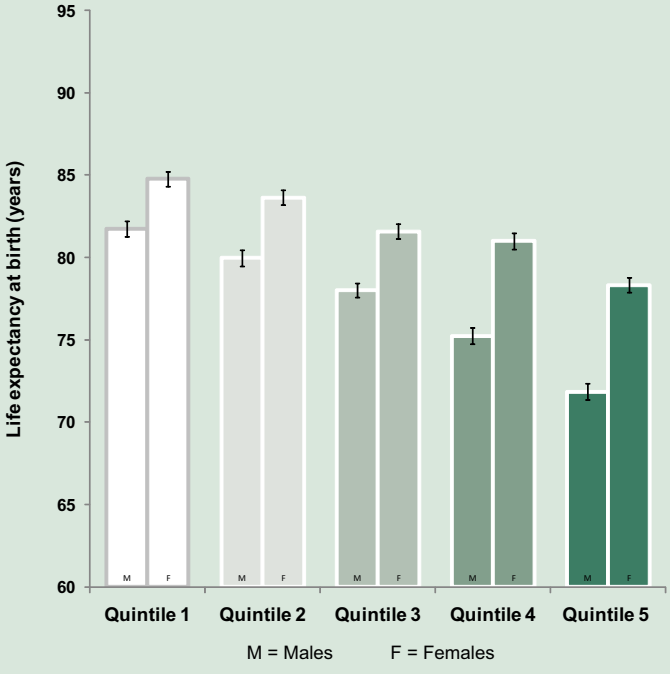
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



This chart shows the life expectancy at birth for males and females (2005-2009) for each of the quintiles in this area.



1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

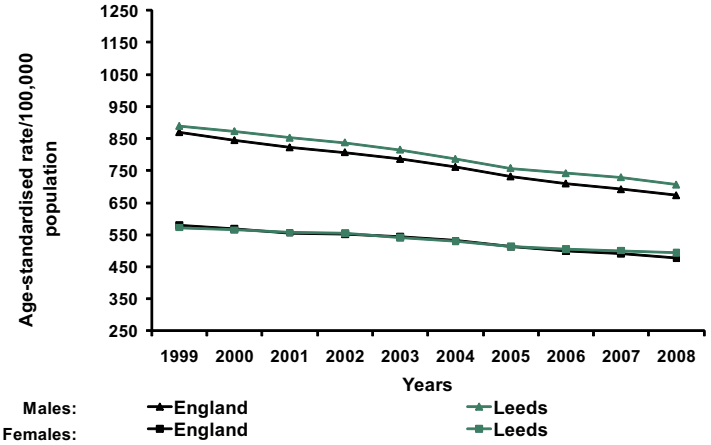
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

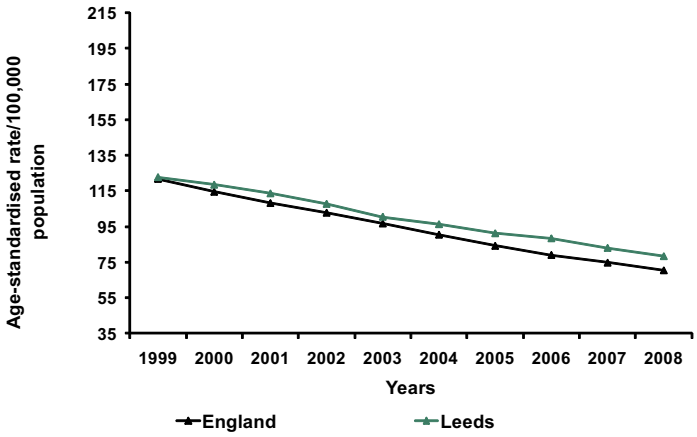
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

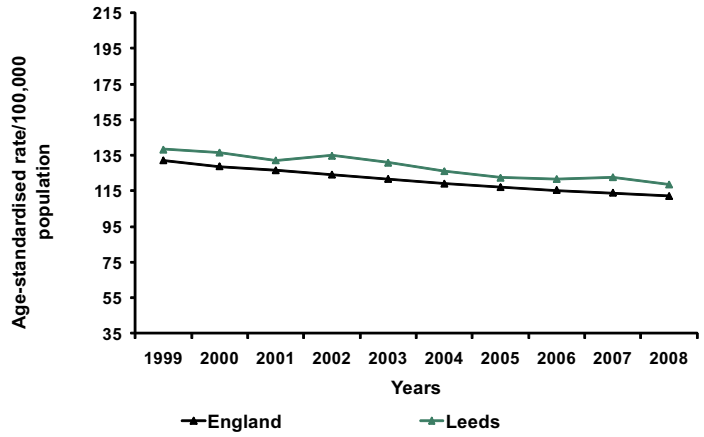
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

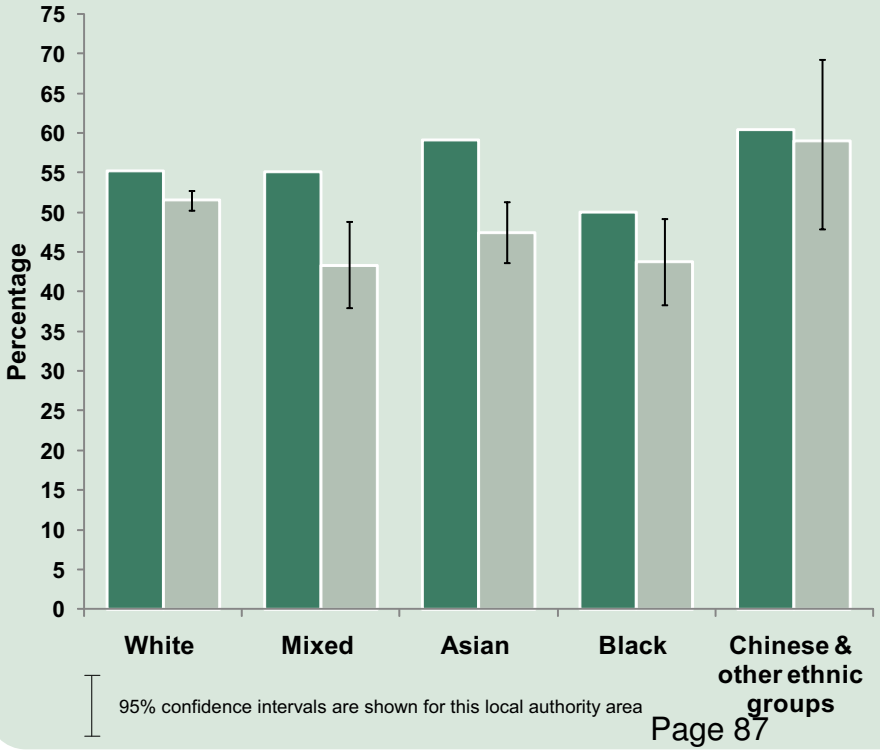


Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2009/10 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.



England
Leeds

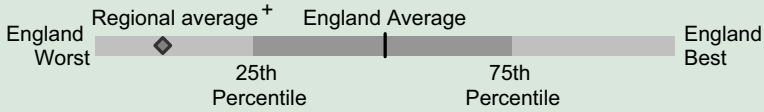
Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	51.5	3,489
Mixed	43.4	137
Asian	47.4	305
Black	43.7	139
Chinese/other	59.0	46

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Leeds

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	203505	27.5	19.9	89.2		0.0
	2 Proportion of children in poverty	33295	22.1	20.9	57.0		5.7
	3 Statutory homelessness	427	1.32	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	4136	50.6	55.3	38.0		78.6
	5 Violent crime	11130	14.3	15.8	35.9		4.6
	6 Long term unemployment	3354	6.2	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	1321	13.7	14.0	31.4		4.5
	8 Breast feeding initiation	7135	73.3	73.6	39.9		95.2
	9 Physically active children	48257	52.3	55.1	26.7		80.3
	10 Obese children (Year 6)	1052	20.0	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	1.1	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	662	48.8	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	23.7	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	30.0	23.6	39.4		11.5
	15 Healthy eating adults	n/a	25.0	28.7	19.3		47.8
	16 Physically active adults	n/a	10.6	11.5	5.8		19.5
	17 Obese adults	n/a	26.0	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	96	13.4	13.1	27.2		3.1
	19 Hospital stays for self-harm	2550	309.4	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	14850	1772	1743	3114		849
	21 Drug misuse	6055	11.1	9.4	23.8		1.8
	22 People diagnosed with diabetes	30216	4.72	5.40	7.87		3.28
	23 New cases of tuberculosis	127	16	15	120		0
	24 Hip fracture in 65s and over	710	455.1	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	350	17.2	18.1	32.1		5.4
	26 Life expectancy - male	n/a	77.7	78.3	73.7		84.4
	27 Life expectancy - female	n/a	82.0	82.3	79.1		89.0
	28 Infant deaths	50	5.17	4.71	10.63		0.68
	29 Smoking related deaths	1282	252.3	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	579	78.4	70.5	122.1		37.9
	31 Early deaths: cancer	864	118.6	112.1	159.1		76.1
	32 Road injuries and deaths	355	45.6	48.1	155.2		13.7

Indicator Notes

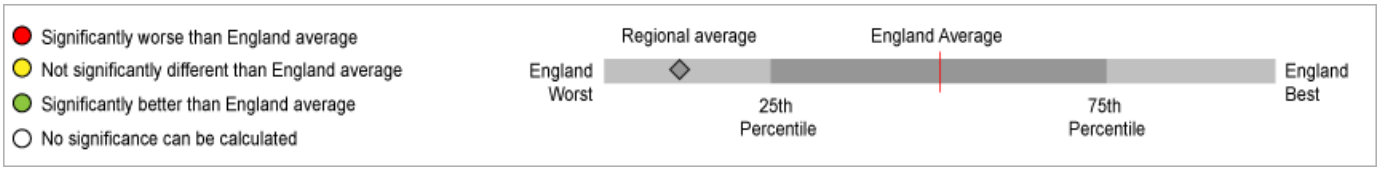
1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

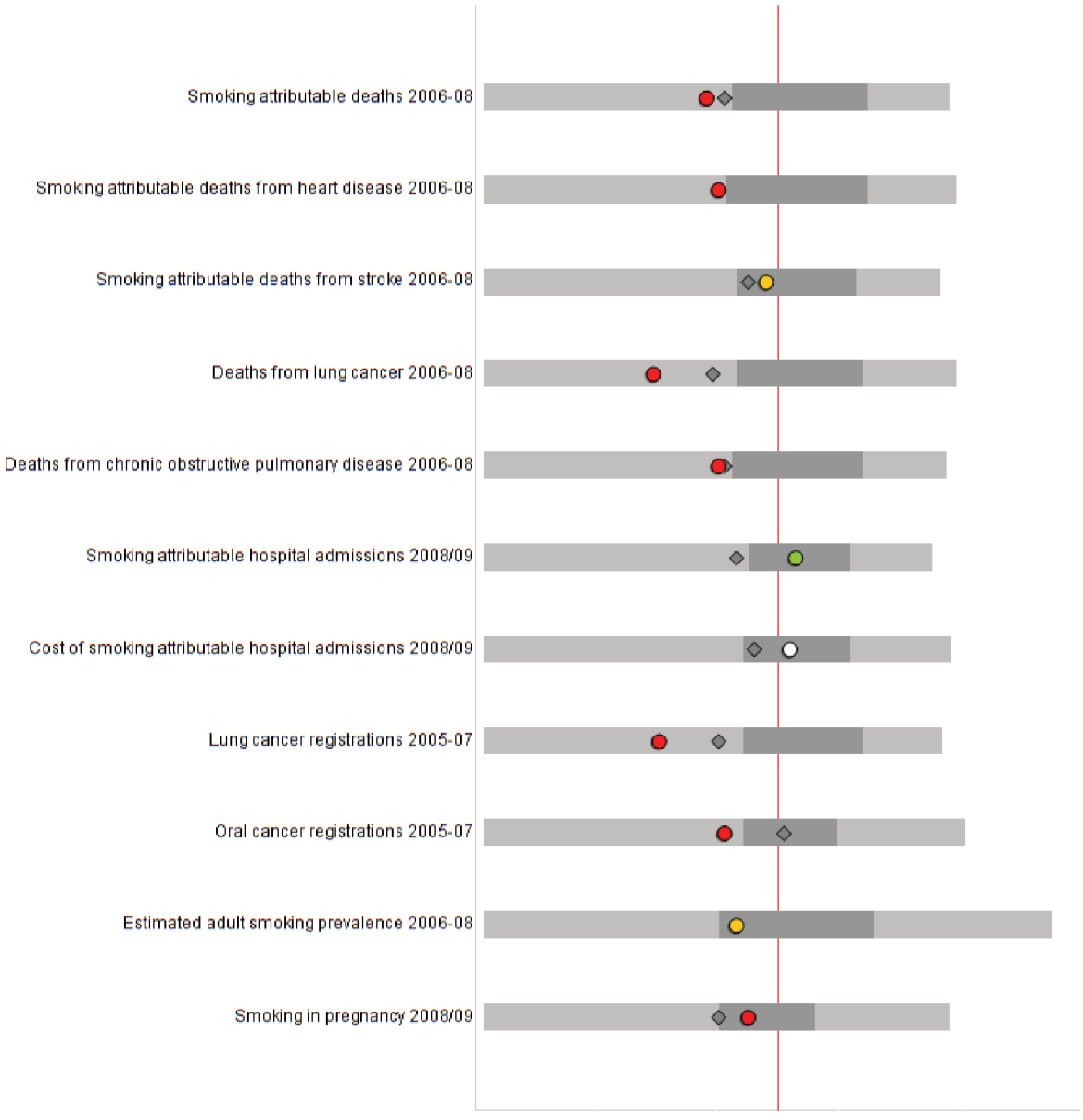
For links to health intelligence support in your area see www.healthprofiles.info More indicator information is available online in The Indicator Guide.

Leeds MCD Tobacco Control Profile

The chart below shows how the indicators for this area compare with the rest of England. The value for each indicator is shown as a circle. The average rate for England is shown by the vertical red line, in the centre of the chart. The range of values for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator, Although a green circle shows this area is significantly better than the England average, it may still indicate an important issue in this locality.

The data for these indicators are shown in table one.





Source: Local Tobacco Control Profiles. Produced by the Association of Public Health Observatories.
Note: Where there are no values shown, this is because the data are not available or have been suppressed.

Table one: Indicator data for - Leeds MCD

Indicator	Value	Regional Average	England Average	England Worst	England Best
Smoking attributable deaths 2006-08	244.4	235.0	206.8	360.3	118.7
Smoking attributable deaths from heart disease 2006-08	39.5	39.8	34.0	62.2	17.1
Smoking attributable deaths from stroke 2006-08	9.9	10.6	9.6	18.9	4.5
Deaths from lung cancer 2006-08	52.0	45.8	38.6	70.7	19.4
Deaths from chronic obstructive pulmonary disease 2006-08	31.9	31.2	26.6	52.3	12.2
Smoking attributable hospital admissions 2008/09	1,182.9	1,439.5	1,265.9	2,451.1	654.1
Cost of smoking attributable hospital admissions 2008/09	32.6	35.3	33.4	56.0	20.3
Lung cancer registrations 2005-07	64.9	56.7	48.0	90.1	24.8
Oral cancer registrations 2005-07	9.8	8.4	8.5	16.2	3.6
Estimated adult smoking prevalence 2006-08	24.0	24.0	22.2	35.2	10.2
Smoking in pregnancy 2008/09	16.6	18.4	14.6	33.5	3.8

Source: Local Tobacco Control Profiles. Produced by the Association of Public Health Observatories. Note: Where there are no values shown, this is because the data are not available or have been suppressed.

Supplementary indicators have been provided in a datapack to assist local areas further in their control of tobacco and tobacco related harm. There is no central collection of local level data for some of these indicators. However data may be available locally. This datapack allows users to collect and input their own data for some indicators to make comparisons with national benchmarks. Other indicators in the datapack have been broken down by sex, age and socio-economic group. To download the datapack go to
http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Tobaccocontrolprofiles.aspx

The tobacco control profiles are part of a series of products produced by APHO that provide local data alongside national comparisons to support local health improvement. For an overview of the health of your local population see the Health Profile for your area at
http://www.healthprofiles.info

If you would like further information on tobacco and health please go to:
http://www.lho.org.uk/LHO_Topics/National_Lead_Areas/NationalSmoking.aspx

LEEDS HEALTH & SOCIAL CARE TRANSFORMATION PROGRAMME

Programme Overview

WHAT IS THE PROGRAMME DESIGNED TO ACHIEVE?

The Leeds Transformation Programme is a city-wide agreement between Health and Social Care partners to work together to deliver the challenges ahead, including increasing quality and innovation and productivity. It is designed to bring key organisations together on this important task; to ensure their full engagement in identifying and delivering the most appropriate solutions to sustain quality while substantially reducing the overall cost in the Leeds health and social care economy by the end of 2014.

In parallel, the city is moving to a new model of health and social care as a result of the national reforms for the NHS and local authority, where we need to focus even further on:

- Improving the health and well being of people in our communities
- Reducing health inequalities and social exclusion
- Improving health and social outcomes through our services
- Achieving savings and cost reductions
- Implementing efficiencies to help meet increasing demand

The programme will be delivered in a constrained financial environment and at the same time needs to ensure that we respond successfully to increasing demands on services.

Demand is growing because of a continued increase in the proportion of people aged over 65 and, in particular over 85 years; new developments in health and care interventions; and trends in 'lifestyle' challenges such as obesity, exercise, smoking, teenage pregnancy and drug and alcohol dependency.

To ensure we can rise to these challenges successfully, we need to fundamentally reshape the way in which health and social care services are delivered in partnership with the people of Leeds.

Through the Transformation Programme, public sector organisations in the city will work, together with third sector colleagues, to pool resources, support integration and deliver services tailored around the needs of individuals and local communities.

The Programme is the means by which, together, we will drive and deliver the transformation of health and social care services with the people of Leeds.

WHICH ORGANISATIONS ARE INVOLVED?

The Programme is being led by NHS Leeds, which has the legal responsibility for improving health across the city. Therefore, the organisations listed below are key partners in the programme and have a seat on the Transformation Board which guides this work:

- NHS Leeds
- Leeds City Council
- Local GP Commissioners

- Leeds Teaching Hospitals NHS Trust
- Leeds Partnerships NHS Foundation Trust
- Leeds Community Health services

The Transformation board is chaired by John Lawler, Chief Executive of NHS Leeds.

WHAT WILL BE THE BENEFITS FOR LOCAL PEOPLE?

Programme success will mean the following benefits will be achieved for the people of Leeds:

- the large number of local people who receive both health and social care services will benefit from more integrated services which are tailored to their needs
- a continued strong focus on quality and safety
- more health and care services delivered in the community and closer to people's homes, when and where appropriate
- front line health and social care services better able to respond to increasing demand through a strong focus on increased productivity and the smarter use of technology in key areas
- tax payers money will be spent in more effective and targeted ways to better meet the needs of individuals and local communities
- local people will be supported to remain independent longer and empowered to take greater personal responsibility for their health and wellbeing.

HOW DO WE INTEND TO WORK TOGETHER?

The Transformation Programme builds upon all the existing improvement work that is going on within the health and social care settings around the city. Things will be done once and well - so if an idea is working in one team, we will extend that idea across into other organisations. To deliver these improvements, all the partners have agreed to use this set of principles to guide collaborative working:

1. Commission and develop services that are based around the needs of the people of Leeds and their communities rather than the needs of the organisations;

2. Look at the totality of investment and resources available to public bodies concerned with health and social care in localities and how these could be better utilised to meet community needs and increasing demands for services;

3. Develop a shared approach to managing the risks and sharing the rewards from designing better ways of delivering services to communities in Leeds and not seek to move costs from one organisation to another;

4. As part of the approach to governance, include an assessment of the impact of proposals to achieve efficiencies within and across individual organisations on others

5. Reduce barriers for all people within communities in Leeds to accessing services and reduce the number of unnecessary or repeat contacts that people need to have with the organisations by increasingly getting it 'right first time'.

2 February 2011

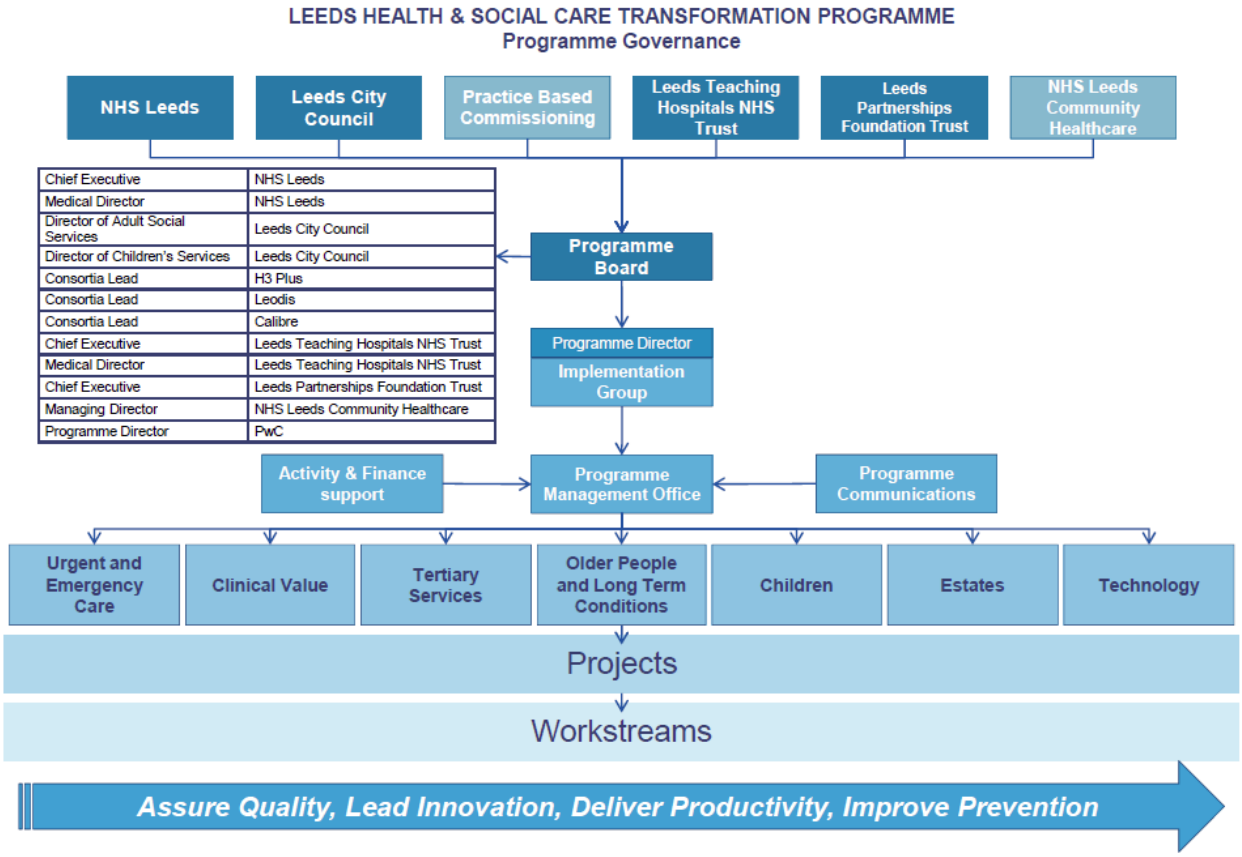
Leeds health and social care transformation programme

Background

The Leeds Transformation Programme is a city-wide agreement between Health and Social Care partners to work together to deliver the challenges ahead, including increasing quality and innovation and productivity.

It builds on the work previously undertaken by the Acute Services Strategic Review (ASSR) whilst addressing a broader agenda. It is designed to bring key organisations together on this important task; to ensure their full engagement in identifying and delivering the most appropriate solutions to sustain quality while substantially improving efficiency and reducing the overall cost in the Leeds health and social care economy by the end of 2013.

The programme governance arrangements are set out below.



The seven key areas (below) have been identified by the Programme Board. Project portfolio teams are currently being established from across the city to oversee the work in each:

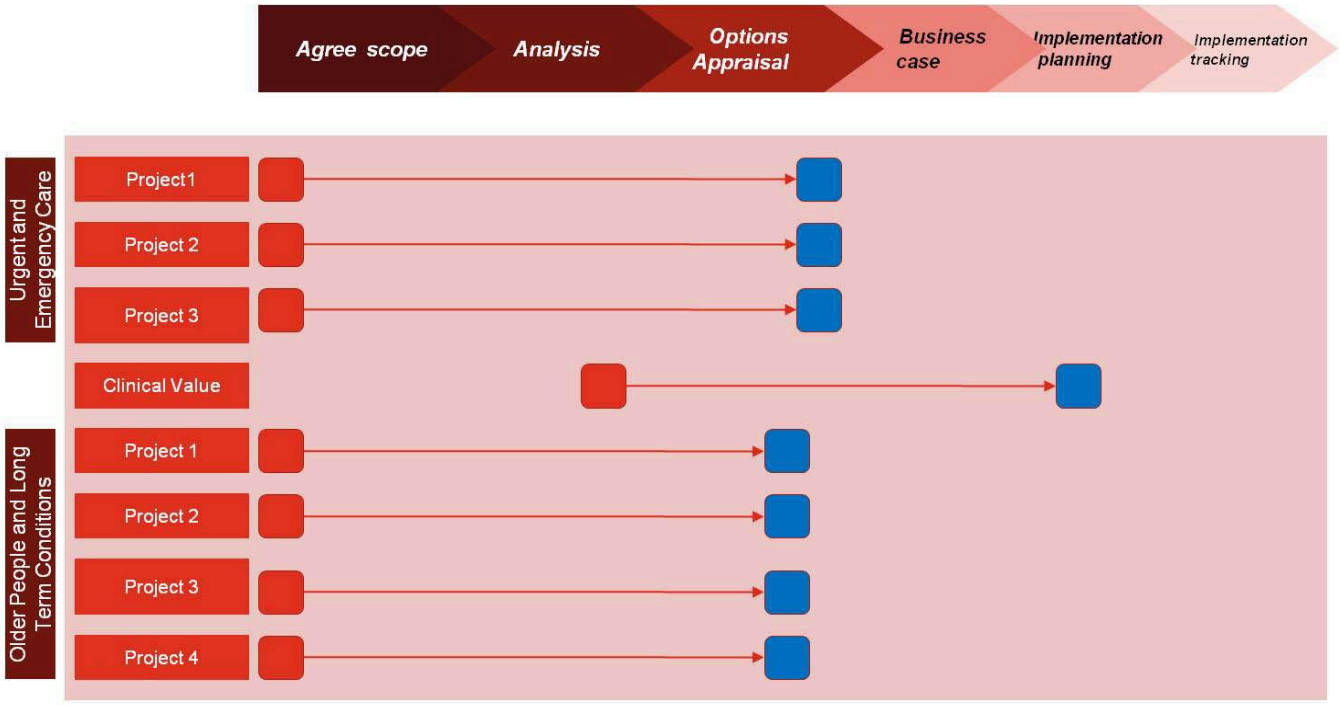
- Urgent and emergency care;
- Clinical values (team already exists);

- Tertiary services;
- Older people and long-term conditions;
- Children;
- Estates; and
- Technology.

During this initial stage of the programme, the work within urgent and emergency care, older people and long-term conditions and clinical values has been prioritised for action.

An evidence-based approach
An evidence-based process will be employed in order to develop and implement the most appropriate service changes. This approach provides clarity around process, and the required steps for implementation of appropriate services with quantifiable benefits across the Leeds system. It allows whole system finance and activity flows to be understood and promotes the development of the largest and highest impact opportunities available to us.

The stages in this process are shown in the chevron arrows in the diagram below. Work is currently being undertaken by PricewaterhouseCoopers (PwC) to ensure that the fullest possible analysis of opportunities is available in the priority areas of urgent and emergency care, and older people and long-term conditions. The clinical values project portfolio is also being supported and used to pilot a programme management office (PMO) approach.



Programme progress

Following an initial period of stakeholder interviews, which focused on understanding challenges to the previous ASSR work, the Leeds Health and Social Care Transformation Board was reconstituted to strengthen governance arrangements and provide a new level of rigour to system-wide service redesign.

The Transformation Board agreed a focus on three priority portfolios:

- Urgent and emergency care (Project portfolio sponsor: Dr Simon Stockill, NHS Leeds);
- Older people and long-term conditions (Project portfolio sponsor: Philomena Corrigan, NHS Leeds); and
- Clinical values (Project portfolio sponsor: Brian Steven, Leeds Teaching Hospitals NHS Trust).

The Transformation Board has signed off a phased approach to delivery, which commenced with the period to mid-February. This includes a logical series of steps which;

- Agrees the high level objectives and scope for the current priority portfolios;
- Requires robust analysis to take place around existing services and potential service redesign, quantifying the value, scale and appropriateness of proposed changes; and
- Produces a detailed option appraisal for each of the priority portfolio areas, highlighting those of greatest benefit in respect of cost saving, quality, scale and opportunity. International and national best practice in these services will also be considered. Some proposed changes may be discounted as a result of this stage.

The objectives and scope of each priority portfolio will be agreed by the Programme Board at their meeting in early February.

PwC are also providing Programme Management Office (PMO) support to the clinical values portfolio as the pathfinder for future programme management arrangements. The arrangements will allow sight of how reporting on progress, activity and savings will take place for the priority areas above. Interdependencies across the whole system will also be mapped as part of the PMO arrangements and will include a review of each organisation's internal plans to avoid the potential for "double counting" of system-wide cost savings.

Next steps

Options Appraisal
The project portfolio teams will undertake an appraisal of the options for service change in the respective priority areas. They will use criteria relating to quality, potential saving and implementation implications to make a recommendation to the Programme Board on which options should be:

- Progressed to business case as a priority;
- Progressed to business case in a second wave; or
- Not progressed at this stage.

Recommendation to Board
These recommendations will be considered at the Leeds Health and Social Care Transformation Programme Board on 7 February 2011. At the subsequent Board meeting a decision will be made on the detailed business cases for these changes, which will set out the objectives, benefits, risks, costs and timescales of each.

Implementation group
Upon agreement of business cases, a programme implementation group will be formed under the chairmanship of a programme director; this is likely to be in late February. The remit of this group will be to oversee the immediate day-to-day implementation of the agreed options across the urgent and emergency care and older people and long-term conditions portfolios, and then roll out implementation across other workstreams and portfolios.

ENDS

Originator: Sheila Fletcher/

Tel: 3952297

Report of the Director of Adult Social Services

Scrutiny Board – Health & Well Being and Adult Social Care

Date: 22nd July 2011

Subject: Future options for long term residential and day care services for older people

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

Executive Summary

1.1 The inquiry into the future of residential care provision for older people conducted by Adult Social Care (ASC) Scrutiny Board in October and November 2010 informed the development of a set of options for change in relation to residential care homes in Leeds.

1.2 The report to Executive Board in December 2010 considered the future requirements of the council's residential and day care services and agreed a set of options, informed by the work undertaken by this inquiry. Executive Board also agreed to begin public consultation on these proposed options.

1.3 Building on previous reports to ASC Scrutiny Board in 2011, this report provides an update on the programme of work developed by ASC to progress and implement the recommendations of Executive Board. Specifically this report addresses;

- the proposed outcomes arising out of the options appraisal undertaken by Adult Social Care (ASC) to bring forward a future option for each residential home and day care centre for older people.

- interim findings from the consultation with the wider general public and stakeholder groups and on the proposed options with those directly affected

2.0 Purpose of this report

2.1 The purpose of this report is to update members of ASC Scrutiny Board on the programme of work developed by ASC to progress and implement the recommendations of Executive Board on the future requirements of older people's residential and day care services, agreed on 15th December 2010.

2.2 As the programme reaches the closing stages of the consultation with those directly affected by the proposals, and in preparation of the submission of recommendations to Executive Board in September 2011, this report seeks the insight and observations of ASC Scrutiny Board and invites them to consider and comment on the issues addressed in the report.

3.0 Background Information

3.1 At its meeting in June 2010, ASC Scrutiny Board agreed to undertake an inquiry into the future provision of older people's residential care services in Leeds. The inquiry accepted that people's expectations around the choice, quality and control over their residential accommodation have increased significantly and that a position of 'no change' in the provision of council-run residential care is not an option. On this basis, a set of criteria was developed and agreed by this board as a sound framework for considering the most appropriate alternative option in relation to each of the 19 residential homes.

3.2 Members of ASC Scrutiny Board agreed at its meeting in on 12th January that it was appropriate to broaden the scope of its inquiry to include the future of day care provision and the requirement for modernisation of this service to meet customer demand while providing a quality service and value for money.

4.0 Main Issues

4.1 Options Appraisal.

4.2 An options appraisal has been undertaken to bring forward a future option for each residential home and day care centre for older people. The appraisal has been undertaken by officers in ASC according to the criteria and requirements agreed by Executive Board on 15 December 2010. The options arising out of this analysis are attached to this report at Appendix 1. In short the options are based on an assessment of the interplay between the following three distinct features;

- strategic – specifically the strategic relevance of the facility
- people – the profile of the needs of the residents, carers and staff
- financial – the financial profile of the facility

5.00 Implications for current residents and users

5.1 These proposals are the basis for detailed consultation with those directly affected, details of which are outlined below. Feedback and key issues arising from the consultation will be fully evaluated to take on board all relevant considerations prior to any final decisions being taken by Executive Board in September 2011.

6.0 Stakeholder Involvement Project – Communication and Consultation

6.1 The whole consultation and engagement process is aimed at seeking the views of all key stakeholders and specifically of those people currently living in residential care homes, day service users, their carers and the staff who provide care and support. The communication and consultation activities for the programme are broken down into two distinct areas:

- The wider consultation
- The detailed consultation – which is further divided into stages, one and two.

6.2 **Analysis of feedback from wider consultation**

6.3 Members will recall that in November 2010 the council consulted on the Spending Challenge following the Government's spending review. Following this, Adult Social Care undertook some broad consultation on its own priorities arising from this financial challenge and the need to modernise services. The consultation, branded `The Future for Adult Social Care in Leeds` took place between February and June 2011 and consisted of the following three main themes.

- The Future for Adult Social Care in Leeds
- Older People's Futures: Residential and Day Care Services
- Charging for Non-Residential Care services

6.4 Seven consultation workshops and six market roadshows were held, attended by over 200 people from the following key stakeholder and interest groups

- Current users of adult social care services directly affected by some of the proposals and members of peer led groups and organisations
- Carers as members of peer led groups and organisations
- Voluntary, Community and Faith organisations
- Independent Sector Providers of adult social services
- Members of staff
- Equality and Diversity groups and organisations

6.5 In addition to these events, a fact sheet and questionnaire was available online through the council's consultation portal, 'Talking Point' from 9 January – 30 April 2011 and also at One-Stop Centres across the city. The outcomes from the consultation workshops and Talking Point questionnaire are available at Appendix 2.

6.6 **Common themes**

6.7 The consultation process has generated a considerable amount of feedback from a wide range of stakeholder groups. At the time of writing a full analysis of this feedback has not been completed however, a number of common themes and issues have emerged. A response to this feedback will be made available to all those who participated in the consultation through a briefing note to be circulated shortly. The analysis of the responses to the consultation has also identified those stakeholders who have not yet participated in the consultation. Steps will be taken to target these groups and interest groups to ensure that they have an opportunity to have their say on the proposals.

6.8 The following are examples of the common themes to emerge from the consultation and the response from ASC

'There should be due consideration for service users, staff and families. Robust consultation and involvement with residents about the proposals are important. The council should look to introduce the proposals gradually.'

We will work with older people and their relatives and carers to ensure any moves are carefully planned and they are supported to make informed choices, to make sure that everyone is relocated somewhere that will fully meet their needs. We will work at a pace that is as comfortable as possible for those people affected, and nothing will happen suddenly or unexpectedly. We are having conversations with everyone directly affected by the proposals and we'll continue to keep people informed and involved.

'Make the savings elsewhere.'

These changes are not just about saving money – although finances are clearly a factor. They are about providing a good standard of service in the future for older people, including

specialised services for those with specific needs – and being able to respond to the fact that many people would prefer to remain living independently and safely in their own homes.

'The standard of services in the independent sector is poor so the services will need to be well monitored.'
Adult Social Care has a responsibility to ensure quality in the independent sector and will continue to work closely with independent providers to make sure that care is provided at a high standard. If a complaint is raised, it will be investigated immediately.

'We need to retain and increase the specialist services – e.g. for people with dementia.'
One of the main reasons we are proposing these changes is because many more people are living longer and living with dementia. To ensure services are in place to support people with greater and more complex needs, we must look very carefully at the cost of services and think about ways that we can do things differently to make sure services are in place to support them.

'Clear information needs to be provided to people and their families at every stage.'
We will make sure that the people who could be affected by the proposed changes are kept informed at every stage. At the end of the consultation and when a decision has been reached, we will communicate this to them promptly so that anyone affected is aware of what's happening.

'The day centre provides a place where older people can go to enjoy a hot meal, get out of the house and socialise with others and meet up with old and new friends. I am concerned that this will be lost. How will this be replaced?'
No one will have their care taken away or receive less care in the future than they do now. Day care centres provide activities and support to older people who are eligible for adult social care support following an assessment of their needs. The council will continue to ensure that these needs are met with a range of services, for example locally provided services in the community, such as Neighbourhood Networks.
We understand people's wishes to stay with friends they have made in the centre over the years and will do everything we can to help friendship groups stay intact or to make sure people have the means to stay in touch. Individuals will be helped by staff at day centres to look at some of the many activities developed by voluntary organisations, for example Neighbourhood Networks. Advice on personal budgets to buy support will also be available

6.9 Detailed consultation with residents, day service users, carers and relatives

6.10 Informed by the outcome of the scrutiny inquiry, Executive Board agreed that for existing residents of residential care homes, users of day services and their families and carers the consultation will;

- seek their views about the actual process and formula for deciding the options for the future running of their residential care home and day centre. This will help identify any gaps and ensure that those affected understand what is being talked about, why the changes are being made and consider how this will affect them as an individual.

- determine the impact of the proposals on individuals and how this might be reduced and the needs of individuals adequately assessed as future plans are developed.

6.11 The second stage, detailed consultation on the proposed options with those directly affected began on 16th May and will run until 5th August 2011. The consultation has been undertaken by staff from the residential homes and day centres, supported by the programme team. One-to-one meetings have been conducted with residents, users of day care and their carers and relatives to explain the proposed option, answer their questions and gather their views. The programme team is working closely with staff in the homes and day centres to ensure that all

residents and service users have an opportunity to discuss their views through the one-to one meetings before the consultation ends on 5th August.

6.12 Care and consideration has been given to any communication issues for each individual resident and day care user. The main focus of the consultation interviews is to capture people's responses to the proposed changes and determine the impact on individuals and how this might be reduced as plans develop. Each individual interview is being logged. Feedback and key issues arising from the consultation will be fully evaluated to take on board all relevant considerations prior to any final decisions being taken by Executive Board in September 2011.

6.13 Consultation with staff

Staff briefings on the proposed options took place during week commencing 9th May. A questionnaire has been approved by the Trade Unions and made available to all staff for completion.

Separate briefings on employee matters will take place concurrently with managers from adult social care. The programme will work closely with trade unions to ensure employee matters are given high priority and regular meetings with trade unions have and will continue to take place.

6.14 Elected Members

6.15 To ensure that future services reflect local needs and opportunities and to allow their local knowledge and experience influence the consultation, officers in ASC made presentations to all 10 area committees in January and February 2011. Steps have been taken to ensure that all elected members are kept fully informed on the proposed options and a briefing note outlining the proposals was circulated to all 99 members on 11 May 2011. In addition, ward members have been invited to attend individual briefings on the proposed options for facilities in their wards. Updates on the programme have also been provided to the meetings of the Area Committee Chairs in April and June 2011.

7.00 Negotiations with NHS Leeds – Intermediate Care

7.1 Since the submission of the Executive Board report in December 2010, further and much more detailed negotiations are taking place with NHS Leeds Care Services aimed at developing a new model of service which seeks to integrate the work of health and social care teams in the same venue of care. The primary focus of the negotiations are in relation to Intermediate Care (IC) (which is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long term residential care, support timely discharge from hospital and maximise independent living). Working in partnership, Leeds City Council and Leeds Community Healthcare are committed to work together to facilitate the further development of IC. Negotiations are continuing to ensure that the financial underpinnings and anticipated benefits of the new integrated model of care are clear for each respective partner.

8.00 Market Engagement

8.1 Since the original Scrutiny Inquiry in 2010 and the publication of the Executive Board report in December 2010, approaches have been made to the Authority by parties expressing interest in some or all of the existing residential care estate and by groups interested in using or operating from current day care facilities. Officers in ASC are engaging in discussions with the market to establish what further interest there might be from organisations interested in developing services using current Local Authority facilities.

10.00 Implications for Council Policy and Governance

10.1 The options presented in the report are the subject of a formal and comprehensive programme of consultation and engagement as set out previously. Clearly, the engagement

with colleagues in NHS Community Health services is also crucial and the fruition of plans for more integrated services will require robust governance arrangements.

10.2 It is proposed that a report detailing the outcome of the second phase of consultation and containing recommendations based on the overall outcome of both the appraisal and consultation will be brought to the September meeting of the Executive Board.

11.0 Legal and Resource Implications

11.1 In discharging its responsibilities under the Human Rights Act, the Authority is required to undertake a comprehensive formal twelve week programme of consultation in relation to the options set out previously in this report. In addition, the Authority is committed to ensure that the care and support needs of any older person affected by the options set out in this report are adequately assessed as an integral part of this process with appropriate advocacy available in support of identifying high quality alternatives where it is agreed this is the most appropriate option.

12.00 Equality Considerations

12.01 An initial Equalities Impact Screening was prepared for the December 2010 Executive Board report against all the equality characteristics as laid down by legislation. At the time of writing, Equality Impact Assessments are being developed from the information gathered through the consultation process and will be reviewed as plans develop.

13.0 Sustainability Implications

13.1 The status quo is considered not to be sustainable, both in terms of the risks of continuing to deliver services in the buildings as they are; and the impact of demographic growth on the existing pattern of service provision. The changing needs and expectations of older people in the city demand that new models of service are developed. Within a developing locality focus, the aim of the programme is to create and implement a coherent vision of current and future local needs and potential sources of supply that best meet local needs and expectations and which offer the best use of council resources.

14.0 Recommendations

14.1 In progressing the development of future options for older people's residential and day care, this report seeks the insight and observations of ASC Scrutiny Board and invites them to consider, comment on and offer any further advice in relation to

- the information contained in this report
- the feedback and comments received through the consultation so far

Background reports

Scrutiny Board reports June 2010, October 2010, November 2010, January 2011 February 2011 and April 2011

Area Committee Chairs reports December 2010, April 2011, June 2011

Executive Board December 2010, Future Options for Long Term Residential and Day Care for Older People

Executive Board November 2010, Government Spending Review 2010

Option Appraisal Outcome Schedule – at a glance

Residential Homes Proposals:

Proposal	West North West Area	South East Area	East North East Area	Citywide totals:
Re-commission	1. Middlecross (D)* 2. Richmond House (IC)*	10. Siegen Manor (D) 11. Harry Booth (IC)	16. Amberton Court (IC) 17. The Green (D)	6
De-commission	3. Kirkland House 4. Westholme 5. Spring Gardens	12. Dolphin Manor 13. Knowle Manor 14. Grange Court		6
Under further review	6. Musgrave Court 7. Burley Willows 8. Manorfield House 9. Suffolk Court	15. Home Lea House	18. Fairview 19. Primrose Hill	7
Totals:	9	6	4	19

Day Services Proposals:

Proposal	West North West Area	South East Area	East North East Area	Citywide totals:
Re-commission	1. Middlecross (D) 2. Calverlands (D) 3. Apna (BME) 4. Richmond House* (IC)	9. Springfield (IC) 10. Laurel Bank (D)	15. Frederick Hurdle (BME) 18. Wykebeck Valley (IC) 17. The Green (D)	9
De-commission	5. Spring Gardens	11. Rose Farm 12. Firthfields	18. Lincolnfields	4
Under further review	6. Radcliffe Lane 7. Queenswood Drive 8. Burley Willows	13. Naburn Court 14. Siegen Manor	19. Doreen Hamilton	6
Totals:	8	6	5	18 + 1 new service

**Richmond House is not currently a Day Service but is proposed to be redeveloped on site*

** D = Dementia*
** IC = Intermediate Care*

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Appendix 2

Older People's Futures: Residential and day care services

Summary of consultation outcomes

The Voluntary, Community and Faith organisations in Leeds

Two events were held for VCF organisations, including Neighbourhood Networks. The main issues raised at these events were as follows

- Ensure that existing specialist services in day centres are not lost.
- If looking at commissioning this service from the Independent Sector, then transport is an issue.
- Ensure that the logistics and process of transferring people to new services are considered and not underestimated
- Need to be aware, and to take into consideration, that day services are often provided as respite for the carer.
- Concerned that reducing services will lead to isolation of people which in turn leads to people having mental health problems.
- Cannot underestimate the issue of peer support for older and disabled people and this is `provided` in day services.
- Concerned about the use of the Independent Sector providing residential care and the quality of care that people will receive. Need to ensure an effective model for inspecting homes.

Independent Sector Providers of Adult Social Care Services

Independent Sector Providers of home care and long term residential and nursing care homes in Leeds were invited to this event.

- Danger of developing into a two tier system – will have centres of excellence and cheap and cheerful.
- There is an increasing dependency at the point of admission and there are therefore cost implications if people are transferred to Independent Sector Provision. Services need to be extended to accommodate this increasing workload (additional staff etc)
- Adult Social Care is cherry picking services that are attractive to investors in the independent sector. This impacts on the long terms viability of independent sector providers.
- Throughout the service, there is a lack of flexibility/resources to meet urgent need.
- It is difficult to plan around sub-acute and end of life care until we know how the GP consortia are going to work.
- Concerns that whilst isolation and social exclusion are increasing issues for people, the Council is proposing to close day services
- The possibility of new models of service provision where healthcare services are delivered into care homes – is this possible?
- Impact on Independent Sector Homes – closures lead to more people at home during the day, therefore need more day time staff – affects the financial viability of Independent Sector providers.

Members of Leeds Involving People

The membership comprises of Service Users, Carers and Patients covering all equality groups.

- Concerns that there will be gaps in services if day services close.
- There were concerns that the residential strategy may be risky as there are a number of Independent Sector Homes in financial difficulty.
- Closing day services will lead to isolation which in turn will lead to mental health issues.

Equality and Diversity Groups

- The communities were interested in the facilities that may be available when services cease. They would be interested in assistance in forming social enterprise organisations or community partnership arrangements, to make community use of these facilities. Aim – to improve community wellbeing and business skills leading to community sustainability.
- Protect employment and train staff for the transition
- Need to move communities from poverty to prosperity – ceasing community's services and closing community facilities impacts on this.

Members of Adult Social Care staff

A significant amount of time was spent discussing the future of Adult Social Care services, so for Older People's Futures: Residential and Day Care Services there was time only to make the presentation and for the question and answer session.

- The people who attend day centres have high needs and are considered vulnerable so there are concerns that their needs will not be met in the community.
- Increasing provision in the private sector will increase work for safeguarding. There are a lot of Stage 1 investigations in the private sector.
- We need to ensure that we do not force more caring on carers at home

Consultation with Leeds Irish Health and Homes communities.

Officers and members of Leeds Involving People attended 2 luncheon clubs for the older Irish community, through their connections with Leeds Irish Health and Homes and Touchstone.

The people attending these events were not used to members of Leeds City Council going out to meet them and get their views. A number of people did not use services and considering themselves independent, did not want to speak to Officers. We were able to speak to a number of people, primarily to deal with the varying issues that they may have in relation to services. Not all issues related to social care services, but we were there representing the Council.

Issues arising that have some relevance to residential and day care services were:

- Would rather that the Council and NHS be a joint healthcare provider – not an independent provider of care services
- If they charge will not use the services
- People who attended day centres were happy there – they trusted staff and carers felt that they too could trust the staff and that their relative was safe and enjoying themselves.

- Worried about service being reduced or having to pay more and thinks that he would struggle to pay for food on top
- Does not matter who provides the service as long as it is of a good quality

Outcomes from the market roadshows

Generally the market stalls offered an opportunity for members of staff (LCC) to meet with members of the public, talk about what issues were important for them (not necessarily adult social care issues) and to provide any information they may need and/or be interested in.

A number of people commented that they thought that it was a good idea that Council staff got out to meet and speak to members of the public, and that they would like to see more of this.

Although a large number of questionnaires were not returned by the public, we consider the events to be successful, for the reasons outlined above.

Otley Market 4th March 2011

Spoke to 67 people. Generally everyone that we spoke to took some information and a briefing/questionnaire, though the return on the questionnaires was low.

Range of people visiting the stall – in terms of age, gender and areas of interest. Were visited by members of staff, carers, service users as well as the general public. People also took the opportunity as we were council employees to ask about other issues such as housing and benefits.

People seeing the stall came and had a look at what information we were providing and in most instances, we had a conversation about their situation, information needs and what was happening in social care.

We have recorded some of the detail of the people that we spoke and the main points of the conversations, below is a summary of the issues that was covered that had some relevance to this issue:

- People were generally unsure/unclear about the social care services that were available and what their relative/cared for person was eligible for.
- Some people said that we should invest in our own services rather than purchase from private sector.
- Concerns about the financial situation for the local authority – felt sorry for the Council having to make the money stretch

Kirkgate market 5/4/11

37 people attended

- The majority of people wanted to discuss their or their relative's situation (though not exclusively) and then generally wanted more information about services
- Concerned about LCC budget cuts.

- Some people attended whose relatives were either in a residential home or a day service and they said that they were fed up of not knowing what was going on. People had received 3 letters in quick succession in December 2010 and then had heard nothing. People were concerned about what would happen to their relative; concerned that their relatives would have to move to a new home when they were settled where they were.

Pudsey Market 29/3/11

Not very well attended – the market was very quiet.

25 people visited the stall

- Carers of people at day services and in LA residential care wanted to know what was going on.
- Gentleman whose disabled wife uses respite care used to go to Richmond House and thought that it was very good. Tried a few other Council homes but did not like them.

Wetherby Market

24 people attended.

In Wetherby we chatted to a few more people but they were not interested as they said that they did not use and did not need services.

- Lady with mum who has just had care services provided said that the care was fantastic
- A number of people stated that although they did not use adult social care services, they had heard that they were very good in Wetherby. This included some people who were visiting from Harrogate.
- People were pleased to see Officers from Adult Social Care out and about and that this kind of work was needed.

Summary of feedback from the completed questionnaires

63 completed questionnaires were received.

In summary, the findings of the consultation show that:

- People generally accept the suggestion that change is necessary particularly in the context of financial constraints and for the reasons outlined in the Fact Sheet that accompanied the questionnaire.
- People have concerns about the standard and quality of provision in independent sector residential care homes
- Some council provision should be kept and mechanisms in place for the council to monitor standards and quality in the independent sector. This will ensure a balanced market in terms of choice and cost.
- The need to strengthen the capacity of the Third Sector to develop community services to cope with increased demand
- People are supportive of the development of specialist services, such as services for people with dementia.

- People are supportive of partnership working with the NHS and the Third Sector although concern expressed that this is managed effectively to achieve joined up working.
- The need to ensure changes to day care do not create social isolation of older people
- Most people indicated that they had mixed views about the options proposed. People's additional comments indicated that they did not agree with the proposals or they raised concerns about alternative provision.
- The need for clear communications about the changes to service users, carers and other stakeholders, particularly that older people's communications needs are met.
- If the proposals do go ahead then consideration needs to be given to the impact that the change will have on service users in particular but also families and members of staff.

Main Issues arising from the consultation

This shows the main issues arising from all of the consultation events and activity that took place between February and June 2011. The issues noted below are the issues that have relevance for Older People's Futures: Residential and Day Care Services

In the commissioning of more services from the Independent Sector, Adult Social Care should consider the following:

- That the provision of services is not just based on price but also quality
- That they consider a more collaborative way of commissioning rather than just a competitive approach. Working in partnership with organisations will better enable Adult Social Care to achieve its objectives and achieve positive outcomes for people.
- The monitoring of services is key to ensuring quality and safeguarding people
- That there should be some equality or equity in the commissioning process so that small organisations (particularly in the voluntary sector) are able to provide services.

In looking at reducing the building based day services, Adult Social Care should consider the impact of such a policy as it may/will result in social isolation, which in turn will lead to an increase in the number of people with mental health problems who will require additional services.

Overall there is a lot of change happening, not just to benefits and Adult Social Care/Leeds City Council needs to factor this change into their own proposals.

Communication and information were important to all Stakeholders, and all wanted to be regularly informed about the transformation of services and changes to policies. Further additional events should be planned to update people

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health and Well-being and Adult Social Care)

Date: 22 July 2011

Subject: Work Schedule

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

1 Purpose of this report

1.1 The purpose of this report is to consider the Scrutiny Board's work schedule for the forthcoming municipal year.

2 Background information

2.1 The previous Agenda items outlined the amendments made to the Overview and Scrutiny function encouraging Scrutiny to be more strategic and outward looking in its operation and focus on the City Priorities.

2.2 Further to the discussions already held during today's meeting, Members are now requested to consider the Board's work schedule for the forthcoming municipal year.

3 Main issues

3.1 The terms of reference for the Scrutiny Boards now determine a number of areas of review to be undertaken by those Scrutiny Boards in the municipal year. On behalf of the Council, the Scrutiny Board (Health and Well-being and Adult Social Care) is tasked with examining and reporting on the following matters to the Executive Board, and if necessary, to the Council:

a) Reducing smoking in the over 18s;
b) Service Change and Commissioning in Adult Social Care;
c) Reducing avoidable admissions to hospital and care homes;
d) The transformation of health and Social Care Services.

3.2 The above areas of review are focused around the City Priorities and therefore come from a strategic approach. However, in addition to the above the Scrutiny Board may also wish to undertake further pieces of Scrutiny work as considered appropriate. In doing so, the Scrutiny Board is advised to consider how such work will impact on its existing workload and the available resources required to carry out the work.

3.3 The Board is also advised to consider the benefits of single item agendas (excluding miscellaneous information and minutes) in order to focus on all the relevant evidence and complete an inquiry in a shorter period of time. There are various mechanisms available to assist the Board in concluding inquiries quickly, such as working groups and site visits.

3.4 Following the Board's discussion during the meeting, the Scrutiny Board is requested to consider the Board's work schedule for the forthcoming municipal year. Consideration will also need to be given to the timing of traditional items of Scrutiny work, including performance monitoring, recommendation tracking and relevant Budget and Policy Framework Plans.

Protocol between the Scrutiny Board and NHS Bodies in Leeds

3.5 The Health and Social Care Act 2001 first introduced the concept of Local Authority scrutiny of health and local NHS services. To assist in this process and to help ensure that Scrutiny remains a positive and challenging process, a draft protocol is attached at Appendix 1, which provides guidance and a common understanding on how Health Scrutiny will operate in Leeds and provide a framework for the scope and style of Scrutiny in the City.

Changes and/or developments of local health services (Health Service Developments Working Group)

3.6 Current legislation places a duty local NHS bodies to make arrangements to involve and consult patients and the public in planning service provision, the development of proposals for changes, and decisions about changes to the operation of services.

3.7 The requirement to consult on service changes and/or developments, includes a duty to consult the designated Health Overview and Scrutiny Board where the NHS body is considering any proposals relating to substantial changes and/or development of local health services.

3.8 In recent years, 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 detailed inquiries, the Scrutiny Board has established a 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.

[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.

- 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 for detailed and specific consideration.

3.9 Within these arrangements it has always been recognised that the statutory duty to consider major (substantial) changes and/ or development of local health services remains the direct responsibility of the Scrutiny Board and not the Working Group.

3.10 In previous years, categories used to identify the significance of any proposed service changes and/or developments have been summarized as follows:

- **Category 4** – major (substantial) variation (e.g. introduction of a new service)
- **Category 3** – significant change (e.g. changing provider of existing services)
- **Category 2** – minor change (e.g. change of location within same hospital site)
- **Category 1** – ongoing improvement (e.g. proposals to extend or reduce opening hours)

3.11 In line with practice from previous years, revised draft terms of reference for the Working Group is attached at Appendix 2 for the Board's consideration. Subject to any identified and agreed amendments, the Board is asked to consider establishing a Working Group (with appropriate membership) in line with the attached draft terms of reference.

3.12 It should be noted that prior to the first meeting of the Scrutiny Board, a working group meeting was convened on 29 June 2011, primarily to consider issues associated with the proposed closure of Ward 1 at Wharfedale Hospital. A copy of the notes from that meeting will be available at the meeting for consideration.

4. Recommendations

4.1 Members are asked to consider the potential scope for each of the areas of review and any additional pieces of Scrutiny work to be undertaken in line with the Board's terms of reference.

4.2 Members are also asked to consider and agree the updated draft Protocol between the Scrutiny Board and NHS Bodies in Leeds (Appendix 1) and the draft Terms of Reference for the Health Service Developments Working Group (Appendix 2).

Background papers

None used

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LEEDS

CITY COUNCIL

Scrutiny Board
(Health and Well-being and Adult Social Care)

Protocol between the Scrutiny Board and NHS Bodies in Leeds

Updated: July 2011

Purpose

The purpose of this protocol is to provide guidance and a common understanding on how Health Scrutiny will operate in Leeds and provide a framework for the scope and style of Scrutiny in the City. In so doing the aim for all parties is to help ensure that Scrutiny remains a positive and challenging process.

Background

The overview and scrutiny function was established through the Local Government Act 2000, which introduced new models of governance and decision-making arrangements for local authorities in England and Wales. In these arrangements, the overall role of the overview and scrutiny function is to hold the Executive Board to account for its decisions and to contribute to evidence-based policy development in the Council.

The Health and Social Care Act 2001 first introduced the concept of Local Authority scrutiny of health and required:

- NHS bodies to consult health local authorities about proposed substantial variations to or substantial developments of health services within their areas; and,
- those local authorities with social services responsibilities to establish an Overview and Scrutiny Committee to respond to consultations by local NHS bodies on proposed substantial variations to or developments of services.

Building on the powers to promote community well-being contained in the Local Government Act 2000, the Health and Social Care Act 2001 provides explicit powers for local authorities to scrutinise health services within their areas as part of their wider role in reducing health inequalities. Currently, the Health Scrutiny Board has been designated to act as Leeds City Council's Overview and Scrutiny Committee responsible for undertaking the health scrutiny role

To assist with the planning and development of effective overview and scrutiny of health and health services, the Department of Health published its guidance *'Overview and Scrutiny of Health – guidance'* in July 2003. This guidance is available from the Department of Health's website.

It should be noted that the NHS, both locally and nationally, is in a period of transition. However, primary legislation is still awaited. As such, it will be necessary to keep this protocol under review to reflect the changing landscape. Nonetheless, the underlying principle of robust and appropriate scrutiny is likely to remain.

Scrutiny Boards (general)

The overall role and function of scrutiny is to hold decision-makers to account and secure improvements in local practice for local people via a contribution to policy development and review. As such, Scrutiny Boards do not have decision-making powers.

Scrutiny Boards will comprise of Elected Members selected to represent the political balance of the local authority. These Members will be the only members of the Board with voting rights and will be selected to serve for a period of 12 months. The membership of the Board will seek to avoid conflicts of interest and where potential

for this exists interests of those Members will be declared and subject to the Council's procedures on these matters[1].

Scrutiny Boards may seek nominations from other representative groups to act as co-opted members of the Board. These nominations may be for the duration of a municipal year and/or on an inquiry by inquiry basis, as set out in the Scrutiny Board Procedure Rules, Leeds City Council Constitution.

Support arrangements

The Scrutiny Support Unit is the primary source of support for, and co-ordination of, the work of the Council's Scrutiny Boards. In summary, the role of the Scrutiny Support Unit is to:

- Provide a research and intelligence function to individual Scrutiny Boards (each of which has been allocated a different area of specialism)
- Manage programmes of Inquiries for each of the Scrutiny Boards
- Manage the presentation of witnesses, research and reports to Scrutiny Boards and/or carrying out research and reports "in house" as appropriate
- Assist Scrutiny Boards to prepare reports of their Inquiries and steering recommendations through the Council's decision making arrangements
- Lead the continuing development of the Overview and Scrutiny function

HEALTH SCRUTINY IN LEEDS

Overview

Scope

Health scrutiny in Leeds covers all aspects of health and health related services provided to the population of Leeds; this includes the planning, provision and operation of services[2] commissioned and provided by NHS bodies and the local authority in Leeds. The primary aims of the health scrutiny function are to identify whether:

- health services reflect the views and aspirations of local communities;
- all sections of local communities have equal access to services;
- all sections of local communities have an equal chance of a successful outcome from services; and,
- any proposals for substantial service changes are reasonable.

The remit of the Scrutiny Board (Heath and Well-being and Adult Social Care) also includes the work undertaken with Adult Social Services. As a function of the Council, such scrutiny arrangements are detailed in the Council Constitution.

NHS Trusts

The Scrutiny Board will not manage the performance of NHS Trusts in the City, or provide another form of inspection. Such functions will be undertaken by other external bodies such as, the Commission for Quality Care, the Strategic Health Authority, the National Institute for Clinical Excellence and the Commission for Health

[1] Leeds City Council Constitution - Scrutiny Board Procedure Rules Section 2

[2] This includes all internally and externally provided services that contribute to the overall health and well-being of the residents and working population of Leeds

Improvement. However, it should be recognised that performance data will often usefully inform Scrutiny inquiries and may be considered as and when appropriate, focussing on improving health and well being across Leeds.

Local Involvement Network

The Local Government and Public Involvement in Health Act 2007 gave a duty to all 150 local authorities in England with social services responsibilities, to enable the formation of a Local Involvement Network (LINk).

LINks will act as the successor to local Patient and Public Involvement Forums (PPIF) but with an extended remit covering social care, and have been established to give communities a stronger voice in how their health and social care services are delivered.

Regulations that established the health scrutiny function[3] state that Scrutiny Boards should take account of all relevant information available. Under provisions in the Local Government and Public Involvement in Health Act 2007, this now includes information identified and provided by the LINk. As such, the relationship between the LINk and the Council's Scrutiny Boards will be key.

An important power of the LINk is the ability to refer relevant matters to the appropriate Scrutiny Board[4]. In turn, this places responsibility on the appropriate Scrutiny Board to acknowledge any such referrals and keep the LINk informed about the progress of any agreed actions. The process for dealing with such referrals is set out in a separate guidance note[5].

Work programme

Although some matters may arise at short notice the Scrutiny Board will publish a forward work programme. The work programme will be considered and, where necessary, revised on a monthly basis. It will subsequently be widely circulate to all key stakeholders.

Where the production of a specific report is requested and/or necessary for a particular Scrutiny Board meeting, then sufficient notice will be given for the preparation of that documentation.

Information to be supplied to the Board

The work of the Scrutiny Board will involve a combination of maintaining an overview of local health issues, including developing awareness of what health bodies are doing, and undertaking in-depth inquiries.

To support the work of the Scrutiny Board, it is likely that members of the Board will require a range of information from NHS bodies, including:

- minutes and reports from Trust Board meetings open to the Public;
- advance notification of proposals for substantial development or reconfiguration[6] of local services;
- notification of current and/or planned service monitoring and review activity within Trusts across the City;

[3] The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations, 2002, HMSO

[4] As set out in the Local Government and Public Involvement in Health Act 2007 and the Local Involvement Networks Regulations 2008

[5] Scrutiny Guidance Note: Requests for Scrutiny, Including Councillor Call for Action (CCfA), Local Crime and Disorder Matters, and Health and Social Care Matters.

[6] Further guidance on the definition of Substantial is provided within this protocol

- information of sufficient detail to enable the Board to discharge its scrutiny role and function.

Where confidential information has been requested by the Scrutiny Board in connection with their inquiries it is incumbent upon NHS bodies to take all reasonable steps to anonymise this information. Where this is not possible the public must be excluded from the meeting whilst the Scrutiny Board considers the confidential information provided.

NHS Officers

It is acknowledged that NHS officers are responsible to a range of bodies. These include NHS Trust Boards, the Strategic Health Authority, the Department of Health and the emerging local involvement network (LINk).

As an integral and essential method for publicly holding local NHS bodies to account, representatives of NHS bodies will answer questions openly and honestly and provide all information that will assist the Scrutiny Board in its consideration of specific matters, including scrutiny inquiries.

The Director of Public Health (DPH)

The DPH role is one of advocacy and leadership that integrates the three domains of health protection, health improvement and health and social care quality. The DPH has responsibility for producing an independent Annual Report on the health of the local population and is charged with working with primary care and local communities to develop their public health capacity and capability.

To assist the Scrutiny Board discharge its role and function, the Director of Public Health is likely to be a key source of information and is likely to be requested to assist the Scrutiny Board in matters under investigation – both in general terms and where the Scrutiny Board is undertaking a particular inquiry. In cases relating to specific inquires, this input will usually be outlined in Terms of Reference for an inquiry. In all cases, notification of any input will be given well in advance.

Attending Scrutiny Board Meetings

Prior to Scrutiny Board meetings

Prior to Board meeting, the Chair receives a briefing from the Scrutiny Support Unit on items to appear on the forthcoming agenda. On occasion NHS officers may be requested to attend this or a separate session to enable the Chair of the Scrutiny Board to be briefed ahead of the Scrutiny meeting.

Scrutiny Board meetings

Scrutiny Board meetings are usually held monthly in a committee room in the Civic Hall. However, from time to time meetings will be arranged at different venues – often dictated by the nature of the inquiries taking place.

Where attendance at a Scrutiny Board meeting is required, a reasonable notice period will be provided for NHS bodies to respond. This period will be at least 15 working days notice of the meeting at which attendance is being requested. Where attendance will require the production of a report then sufficient notice will be given for the preparation of that documentation.

Where the Scrutiny Board requests a response from a local NHS body to whom it has made a report or recommendation, that body will respond to the Board in writing within 28 days of the request.

For all Scrutiny Board meetings the Scrutiny Support Unit will endeavour to give approximate times for when items are likely to be discussed. However, as items may over run, there may be a short waiting time.

Conduct at Scrutiny Board meetings

A separate Member/Officer protocol [7] has been agreed by the City Council. This will be used as the basis for the conduct of Scrutiny Board Members in their dealings with officers from NHS bodies.

Conduct of Scrutiny Board Inquiries

The role of Terms of Reference

The majority of Scrutiny Inquiries have agreed terms of reference. These identify the subject areas members of the Board wish to pursue and are used to inform departments of the Council and NHS bodies of the emphasis of a particular inquiry.

Officers in the Scrutiny Support Unit will liaise with relevant officers of the Council and NHS bodies during the preparation of Terms of Reference to ensure that the focus of the inquiry is relevant and the timing of it appropriate.

Draft Terms of Reference are usually presented to the Scrutiny Board via a written report. This will provide a basis for discussion between officers and the Scrutiny Board. The Scrutiny Support Unit will advise on the particular information required.

Gathering Evidence

The evidence to be gathered will be outlined in the Inquiry's Terms of Reference. This material may be considered at full Scrutiny Board meetings, which are open to the public, and/or by a small working group of Scrutiny Board, tasked with undertaking a specific evidence gathering task. In the latter case Board Members will report their findings to an appropriate full meeting of the Health Scrutiny Board.

The Scrutiny Support Unit will endeavour to give guidance on what will be asked and sometimes possible question areas will be passed on to allow some time for preparation before the meeting. However, Members may follow a related line of discussion and ask other questions on the day.

Preparation of Reports

At the conclusion of an inquiry, where considered appropriate, the Scrutiny Board will produce a preliminary report. This will be drafted by the Scrutiny Support Unit in conjunction with the Scrutiny Board Chair and agreed by the Board. This report will provide a summary of the evidence submitted, along with the Scrutiny Board's conclusions and recommendations. Where the Health Scrutiny Board is considering making recommendations to the Council and/or an NHS body, it will invite advice from a relevant Chief Officer prior to finalising its report and recommendations.

Publication of Report Findings

[7] Leeds City Council Constitution - Section 5

Once it has completed an inquiry, the Scrutiny Board may make reports and recommendations to the Board of the NHS bodies scrutinised and/or relevant decision-makers with the City Council. Any reports made will also be copied to:

- All witnesses/ organisation that supplied information to the Scrutiny Board during the inquiry
- The appropriate member(s) of the Council's Executive Board
- Leeds Director of Public Health
- Local MPs and MEPs
- The Strategic Health Authority (Yorkshire and the Humber)
- Leeds Local Involvement Network (LINk)
- Local voluntary organisations and/ or other organisations that have expressed an interest in the issues dealt with in the report.
- A copy of the report should also be placed in local libraries, on local authority and Strategic Health Authority websites and made available to other local networks so as to be widely available to members of the public.

Response to Reports

Where the Scrutiny Board has sent a report to an NHS body, the NHS body concerned will be required to send its response to the Board within 28 days. The reply should set out the general views of the NHS body on the recommendations, alongside any proposed action or reasons for inaction in response to each specific recommendation made. The NHS response should also be copied to:

- All witnesses/ organisation that supplied information to the Scrutiny Board during the inquiry
- The appropriate member(s) of the Council's Executive Board
- Leeds Director of Public Health
- Local MPs and MEPs
- The Strategic Health Authority (Yorkshire and the Humber)
- Leeds Local Involvement Network (LINk)
- Local voluntary organisations and/ or other organisations that have expressed an interest in the issues dealt with in the report.
- A copy of the report should also be placed in local libraries, on local authority and Strategic Health Authority websites and made available to other local networks so as to be widely available to members of the public.

Consultation with the Scrutiny Board (Health and Well-being and Adult Social Care) by NHS Bodies in Leeds

The Health and Social Care Act (2001), subsequently reinforced by the NHS Act 2006 and the Local Government and Public Involvement in Health Act (2007), places a duty local on NHS Trusts, Primary Care Trusts and Strategic Health Authorities to make arrangements to involve and consult patients and the public in planning service provision, in the development of proposals for changes, and in decisions about changes to the operation of services.

The requirement to consult on service changes and/or developments, includes a duty to consult the Scrutiny Board where the NHS Body has under consideration any proposal for:

- a substantial development of the health service; or,
- a substantial variation in the provision of such a service in the local authority area.

However, levels of service variation and/or development are not defined in legislation and it is widely acknowledged that the term 'substantial variation or development of health services' is subjective, with proposals often open to interpretation. To assist all parties concerned, the following locally developed definitions and examples of service change/ development have been agreed:

- **Category 1** – ongoing improvement (e.g. proposals to extend or reduce opening hours)
- **Category 2** – minor change (e.g. change of location within same hospital site)
- **Category 3** – significant change (e.g. changing provider of existing services)
- **Category 4** – substantial variation (e.g. introduction of a new service)

In seeking to determine whether a development or variation is substantial, the NHS body concerned and the Scrutiny Board will have regard to issues such as (but not limited to):

- the number of people likely to be affected,
- whether changes in the accessibility of services will result; and,
- whether changes in the deployment of the workforce will be necessary.

In addition, any substantial variations or developments of local health care services need to be in the best interests of the local health service and the people it serves, and any consultation with stakeholders needs to be adequate prior to any final decision being made. Where the Health Scrutiny Board has concerns regarding any agreed substantial service changes / developments, there is provision within current legislation for the Scrutiny Board to refer matters to the Secretary of State for Health.

Any such referral must be relating to a substantial service change and/or development and should be seen as an action of last resort. The Scrutiny Board can refer matters to the Secretary of State for Health where the Scrutiny Board:

- Is concerned that consultation on substantial variations/ developments has been inadequate; and/or,
- Considers that any proposal is not in the interests of the local health service.

APPENDIX 2

SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)
HEALTH SERVICE DEVELOPMENTS WORKING GROUP

TERMS OF REFERENCE

1.0 Background

1.1 The Health and Social Care Act (2001), subsequently reinforced and amended by the NHS Act (2006) and the Local Government and Public Involvement in Health Act (2007), places a duty local on NHS Trusts, Primary Care Trusts and Strategic Health Authorities to make arrangements to involve and consult patients and the public in:

- Planning service provision;
- The development of proposals for changes; and,
- Decisions about changes to the operation of services.

1.2 The requirement to consult on service changes and/or developments, also includes a duty to consult the Health Scrutiny Board where the NHS Body has under consideration any proposal for:

- a major development of the health service; or,
- a major variation in the provision of such a service in the local authorities area.

2.0 Scope

2.1 The levels of service variation and/or development are not defined in legislation and it is widely acknowledged that the term 'major variation or development of health services' is subjective, with proposals often open to interpretation.

2.2 To assist Health Overview and Scrutiny Committees, and to help achieve some degree of consistency, the Centre for Public Scrutiny (CfPS) published a scrutiny guide, *Major Variations and Developments of Health Services*[1]. Based on this guidance, and through discussions between NHS Leeds and the Health Scrutiny Board, the following locally developed definitions and examples of service change/ development have been agreed and are summarised in Table 1 (below).

Table 1: Summary of levels of change

Degree of variation	Colour code	Contact with Scrutiny
Category 4 – major (substantial)variation (e.g. introduction of a new service)	Red	Consult
Category 3 – significant change (e.g. changing provider of existing services)	Orange	Engage
Category 2 – minor change (e.g. change of location within same hospital site)	Yellow	Inform
Category 1 – ongoing improvement (e.g. proposals to extend or reduce opening hours)	Green	No

[1] Published in December 2005 and available from the publications section of the CfPS website: http://www.cfps.org.uk/

2.3 The definitions of reconfiguration proposals and stages of engagement/consultation are detailed in Annex 1.

2.4 The overall purpose of the Working Group is to provide an environment that allow local NHS bodies to have an on-going dialogue with Scrutiny, regarding changes and development of local health services. Therefore, the role of the working group can be summarised as follows:

- Considering, at an early stage, any future 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[2]; and,
  - Whether the proposal is in the interests of the local health service.
- Maintaining 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.
- Reviewing the implementation of any agreed service change and/or development, including any subsequent service user feedback.
- Referring any matters of significant concern to the Scrutiny Board, for consideration.

2.5 It should be recognised that the statutory duty to consider major changes remains the responsibility of the Scrutiny Board itself. As such, any major changes and/or variations identified will automatically be referred to the Scrutiny Board for consideration.

2.6 Where a major change and/or development is identified, the view of the Working Group on the relevant Trust's plans for patient and public engagement and involvement, and on whether the proposal is in the interests of the local health service will usefully inform the deliberation of the Scrutiny Board when considering such matters.

3.0 Frequency of meetings

3.1 It is initially proposed that the Working Group will meet on a regular bi-monthly basis, as follows:

- July
- September
- November
- January
- March
- May

3.2 However, due to the nature of the work and the potential timing of proposed service changes and/or developments, it is recognised that the Working Group will adopt a flexible approach and may choose to meet outside this timetable.

[2] This early engagement with Scrutiny will allow 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

3.3 It should also be recognised that the purpose of meeting on a bi-monthly basis is not only to ensure the early engagement of members of the Scrutiny Board with regard to emerging service changes and/or developments, but to ensure the continued involvement in relation to previously identified matters.

4.0 Membership

4.1 The membership of the Health Service Developments Working Group for the duration of the current municipal year (2011/12) is as follows:

- *To be confirmed (TBC)*

5.0 Key stakeholders

5.1 The following key stakeholders have been identified as likely contributors to the Working Group:

- NHS Leeds
- Leeds Teaching Hospitals NHS Trust (LTHP)
- Leeds Partnerships NHS Foundation Trust (LPFT)
- Leeds Community Healthcare NHS Trust
- Director of Adult Social Services (or nominee)
- Director of Public Health (or nominee)

6.0 Monitoring arrangements

6.1 The Scrutiny Board will be kept fully appraised of the activity of the Working Group and regular updates, including reports and minutes from the Working Group, will be provided.

July 2011

Definitions of reconfiguration proposals and stages of engagement/consultation

Definition & examples of potential proposals	Stages of involvement, engagement, consultation			
	Informal Involvement	Engagement		Formal consultation
Major (substantial) variation or development Major service reconfiguration – changing how/where and when large scale services are delivered. Examples: urgent care, community health centre services, introduction of a new service, arms length/move to CFT				**Category 4** Formal consultation required (minimum twelve weeks) **(RED)**
Significant variation or development Change in demand for specific services or modernisation of service. Examples: changing provider of existing services, pathway redesign when the service could be needed by wide range of people			**Category 3** Formal mechanisms established to ensure that patients/service users/ carers and the public are engaged in planning and decision making **(ORANGE)**	Information & evidence base
Minor change Need for modernisation of service. Examples: Review of Health Visiting and District Nursing (Moving Forward Project), patient diaries		**Category 2** More formalised structures in place to ensure that patients/ service users/ carers and patient groups views on the issue and potential solutions are sought **(YELLOW)**	Information & evidence base	
Ongoing development Proposals made as a result of routine patient/service user feedback. Examples: proposal to extend or reduce opening hours	**Category 1** Informal discussions with individual patients/ service users/ carers and patient groups on potential need for changes to services and solutions **(GREEN)**	Information & evidence base		

OSC involved

OSC may be involved

Note: based on guidance within the Centre for Public Scrutiny *Major variations and developments of health services, a guide*