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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 Wednesday, 18th April, 2012 at 10.00 am

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

MEMBERSHIP

Councillors

R Charlwood	-	Moortown;
C Fox	-	Adel and Wharfedale;
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;
L Mulherin (Chair)	-	Ardsley and Robin Hood;
S Varley	-	Morley South;

Co-optees

Joy Fisher	Alliance of Service Users
Sally Morgan	Equality Issues
Betty Smithson	Leeds LINk
Paul Truswell	Leeds LINk

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

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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Head of Governance Services 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 (Health and Wellbeing and Adult Social Care) meeting held on 21st March 2012 (Minutes attached)	1 - 6
7			**LEEDS HEALTH AND SOCIAL CARE TRANSFORMATION PROGRAMME: UPDATE** To consider a report by the Head of Scrutiny and Member Development which provides an update on the Leeds Health and Social Care Transformation Programme (Report attached)	7 - 14

8			**NHS LEEDS PERFORMANCE REPORT - FOLLOW UP** To consider a report by the Head of Scrutiny and Member Development which provides further performance data/ clarification which was requested at the last meeting of this Board (Report attached)	15 - 20
9			**URGENT CARE UPDATE - CONSULTATION** To consider a report by the Head of Scrutiny and Member Development which provides a brief update on the outcome of the engagement and consultation around Urgent Care Services in Leeds and the subsequent decision of the NHS Airedale, Bradford and Leeds (ABL) Board. (Report attached)	21 - 28
10			**REDUCING HEALTH INEQUALITIES - CLINICAL COMMISSIONING GROUPS PERSPECTIVE** To consider a report by the Head of Scrutiny and Member Development which sets out details of draft Priority Action 4e: Ensure equitable access to services that prevent and reduce ill-health and specifically the future role of the emerging Clinical Commissioning Groups (CCGs) in Leeds. (Report attached)	29 - 42
11			**LEEDS TEACHING HOSPITAL NHS TRUST - CARE QUALITY COMMISSION (CQC) COMPLIANCE - UPDATE** To consider a report by the Head of Scrutiny and Member Development which provides additional information requested at the last meeting of the Board around the action plan relating to nursing staff (focusing on Older People's medicine. (Report attached)	43 - 46

12			**CALCULATING PROGRESS IN THE DELIVERY OF PERSONALISED SUPPORT** To consider a report by the Head of Scrutiny and Member Development which provides background information about changes to the calculation of a key performance measure relating to the provision of social care through personal budgets. (Report attached)	47 - 52
13			**SCRUTINY INQUIRY REPORT: REDUCING SMOKING** To consider a report by the Head of Scrutiny and Member Development which sets out the draft Scrutiny Inquiry Report: Reducing Smoking (Cover report attached, inquiry report to follow)	53 - 54
14			**WORK SCHEDULE - APRIL 2012** To consider a report by the Head of Scrutiny and Member Development which sets out the Board's current work programme for 2012/13 Municipal year (Report attached)	55 - 68
15			**DATE AND TIME OF THE NEXT MEETING** Wednesday 16th May 2012 at 10.00am (pre-meeting at 9.30am for all Board Members)	

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

WEDNESDAY, 21ST MARCH, 2012

PRESENT: Councillor L Mulherin in the Chair

Councillors S Armitage, K Bruce
R Charlwood, B Chastney, C Fox, W Hyde,
G Kirkland and S Varley

CO-OPTED MEMBERS
Joy Fisher – Alliance of Service Users
Betty Smithson – Leeds LINk

77 Chair's Opening Remarks

The Chair welcomed all in attendance to the March meeting of the Scrutiny Board (Health and Well-being and Adult Social Care).

78 Late Items

The Chair admitted to the agenda the following supplementary information:

- Agenda item 8 – NHS Airedale, Bradford and Leeds Board Joint Performance report (Minute No. 83 refers)
- Agenda item 8 – Leeds Teaching Hospitals NHS Trust briefing note on actions in response to Care Quality Commission Compliance Inspection – December 2011 (Minute No. 83 refers)
- Agenda item 9 – Briefing note on Health and Looked After Children from NHS Airedale, Bradford and Leeds (Minute No. 84 refers).

79 Declarations of Interest

There were no declarations of interest.

80 Apologies for Absence and Notification of Substitutes

Apologies for absence were submitted by Councillors Chapman, Hussain, Illingworth and Co-opted Member, Sally Morgan. Notification had been received that Councillor Chastney was to substitute for Councillor Chapman.

81 Minutes - 29 February 2012

RESOLVED – That the minutes of the meeting held on 29 February 2012 be approved as a correct record.

82 2011/2012 Quarter 3 Performance Report

The Assistant Chief Executive (Customer Access and Performance) submitted a report which presented a summary of the quarter 3 performance data relevant to the Scrutiny Board (Health and Well-being and Adult Social Care).

The following information was appended to the report:

- Performance reports relating to the City Priority Plan (CPP)
- Adult Social Care Directorate Priorities and Indicators.

The following Executive Member, officers and NHS representative attended the meeting and responded to Members' questions and comments:

- Councillor Yeadon, Executive Member (Adult Health and Social Care)
- John Lennon, Chief Officer – Access and Inclusion, Adult Social Services
- Stuart Cameron-Strickland, Head of Policy, Performance and Improvement, Adult Social Services
- Kim Maslyn, Head of Service – Support and Enablement, Adult Social Services
- Graham Brown, Performance Manager, NHS Airedale, Bradford and Leeds.

The key areas of discussion were:

- Further improvements needed to reduce the number of smokers, the role of the Council in relation to public health and the benefits of cross departmental support. It was reported that there was some success in stopping people smoking through the smoking cessation programmes offered, however it was suggested that reducing the number of people starting smoking in the first instance needed to be addressed.
- The positive impact arising from the ban on smoking in public places and the national advertising campaign on the risks of cigarette smoke.
- Update on the Tobacco Action Strategy and development of local leadership teams.
- The need to establish greater links with youth services and schools in getting the message across.
- Concern that only a small number of midwives had been trained to undertake CO monitoring for pregnant women and the shortage of CO monitors for them to use. It was recommended that this practice should be extended to all midwives and the associated costs of doing so were requested.
- Further data and information requested in relation to giving people choice and control over health and social care services, particularly in relation to personal budgets and how this informed the overall scorecard.

RESOLVED –

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

(b) That the costs associated with training midwives and providing CO monitors, to help monitor and tackle smoking in pregnancy be reported to the next meeting on 18 April 2012.

(c) That the data and information requested in relation to giving people choice and control over health and social care services be reported to the next meeting on 18 April 2012.

83 Leeds NHS Performance Report

The Head of Scrutiny and Member Development submitted a report which presented the latest performance data from NHS Airedale, Bradford and Leeds. The report also provided details of the following areas, highlighted at the December Scrutiny Board meeting:

- Bariatric surgery
- Fractured Neck of Femur operated on within 48 hours
- Stroke care.

Appended to the report was a copy of the Care Quality Commission (CQC) report that identified improvements needed at St. James' University Hospitals (part of Leeds Teaching Hospitals NHS Trust (LTHT)).

The following representatives attended the meeting to present the report and respond to Members' questions and comments:

- Graham Brown, Performance Manager, NHS Airedale, Bradford and Leeds.
- Al Sheward, Divisional Nurse Manager (Medicine) – Leeds Teaching Hospitals NHS Trust
- Karl Milner, Director of Communications and External Affairs – Leeds Teaching Hospitals NHS Trust.

Prior to discussing the item, apologies were provided on behalf of the Executive Director for Delivery and Service Transformation (NHS Airedale, Bradford & Leeds), who had been due to attend the meeting. Apologies were also received on behalf of the Chief Nurse (Leeds Teaching Hospitals NHS Trust) who was unable to attend due to an unannounced Care Quality Commission visit at the Trust.

The key points of discussion were:

- Clarification about some of the acronyms used in the report, highlighted as follows: RTT – referral treatment time; and AAACH – all ages, all causes, mortality.
- Acknowledgement of further improvement needed in relation to fractured neck of femur operated on within 48 hours. The Scrutiny Board was informed that penalties were imposed if targets were not met.

- Greater capacity needed to undertake orthopaedic surgery.
- The positive impact of publicity in the media that raised awareness about strokes and heart disease.
- Strong concern about targets not being met in relation to early intervention in psychosis and the reasons attributed to this.
- Update on LTHT Accident & Emergency waiting times – latest position 95.4%, up from 93.4%. (Members were advised that the national standard from April 2011,had been revised to 95%, from the previous standard of 98%). Further information/ clarification was sought on the data, including the classification of patients that had been removed as part of the data validation process.
- Further work taking place as part of a national programme to attract health visitors into the profession.

In relation to the Care Quality Commission (CQC) report, the following issues were identified:

- Serious concern about staffing shortages, particularly in relation to older persons care. Actions were being taken by the Trust to ensure this was being addressed and that there was a consistency of approach across departments.
- Concern in relation to the logging of sick leave and other types of absence.

(Joy Fisher withdrew from the meeting at 11.55am, Councillor Armitage at 12 noon and Councillor Chastney at 12.03pm, during the consideration of this item.)

RESOLVED –

(a) That the contents of the report and appendices be noted.
(b) That further information regarding the impact of not meeting the early intervention in psychosis target be reported to the next meeting on 18 April 2012.
(c) That more detailed information about the local work being undertaken to promote the health visiting profession and increase the number of health visitors be reported to a future meeting of the Board.
(d) That a further progress report on Fractured Neck of Femur be presented to the Board in the new municipal year.
(e) That consideration be given to receiving a detailed report around delayed hospital discharges in the new municipal year.
(f) That, focusing on older people's care, further information around the nature of the nursing gap at Leeds Teaching Hospitals NHS Trust be reported to the next meeting on 18 April 2012.

84 Health Inequalities - Looked after Children

The Head of Scrutiny and Member Development submitted a report which provided information in relation to health inequalities for Looked After Children.

Appended to the report was a copy of the Looked After Children report to Executive Board on 7 March 2012.

The following Executive Member and officer attended the meeting and responded to Members' questions and comments:

- Cllr Blake, Executive Member (Children's Services)
- Steve Walker, Deputy Director (Safeguarding, Specialist and Targeted Services), Children's Services.

The main points of discussion were:

- Support for young people with mental health needs and links to the work of Child and Adolescent Mental Health Services (CAMHS).
- Support for families through early intervention programmes, case conferencing and clusters.
- Request for information in relation to child placements and teenage conception rate for looked after children.
- Update on the foster carer campaign – review of expressions of interest had taken place in response to changing market. Currently 10 more carers than last year. 38 foster carers currently subject to the Council's approval process.

RESOLVED –
(a) That the contents of the report and appendices be noted.
(b) That the information requested in relation to child placements and teenage conception rate for looked after children be reported to Board.
(c) That further information be invited from Children's Services about the links with CAMHS for circulation to the Board.

85 Work Schedule

A report was submitted by the Head of Scrutiny and Member Development which detailed the Scrutiny Board's work programme for the remainder of the current municipal year.

Appended to the report for Members' information was the current version of the Board's work programme, minutes of the Executive Board meeting held on 7th March 2012, and an extract from the Forward Plan of Key Decisions for the period 1st March 2012 to 30th June 2012.

RESOLVED – That the work programme be approved.

86 Date and Time of the Next Meeting

Wednesday 18th April 2012 at 10.00am with a Pre Meeting for Board Members at 9.30am

(The meeting concluded at 12.40pm.)

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

Date: 18 April 2012

Subject: Leeds Health and Social Care Transformation Programme: Update

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. The transformation of Health and Social Care Services is identified in the Scrutiny Board's Terms of Reference and at its meeting on 22 July 2011, the Board agreed to include the work of the Leeds Health and Social Care Transformation Board within its work schedule for the current year.

Previous reports to the Scrutiny Board

2. At its meeting in September 2011, the Scrutiny Board considered a position statement on behalf of the Transformation Board. This provided an overview of the Leeds Health and Social Care Transformation Programme and outlined the supporting managerial / governance arrangements. The report highlighted five portfolio areas and provided a summary of three priority areas, as detailed below:

Portfolio Area	Summary provided
Older people and long-term conditions;	Yes
Urgent and emergency care;	Yes
Clinical value in elective (planned) care;	Yes
Estates; and,	No
Technology	No

3. In line with the outcome from the meeting in September 2011, a further update report was presented to the Scrutiny Board meeting on 29 February 2012. At that meeting, members of the Scrutiny Board were reminded that the work being carried out by the

Transformation Board represented a city-wide agreement between health and social care partners intended to deliver solutions that sustained quality whilst substantially reducing the overall cost in the city of the health and social care economy by the end of 2014. The following extract from the minutes of that meeting summarise the main issues discussed:

- ***Clinical value in elective care*** *– with the Board being informed that a reduction of around 12,000 face-to-face follow ups had been achieved since 1 April 2011, through using more appropriate and innovative follow-up care, including by telephone and primary care intervention.*

  It was highlighted that the alternatives to face-to-face follow-up appointments had been running for almost 12 months. Members were assured of safeguards in the process and advised that a blanket approach was not being adopted, rather it was for clinically led teams to consider the most appropriate way of following-up appointments, based upon the needs of the individual. Where telephone follow-ups were used, patients would be contacted by hospital staff and asked specific questions. Depending on the responses, a face to face appointment might be made, or a referral made to their GP if considered appropriate.

- ***Urgent and emergency care*** *– that the 49 adult ambulatory pathways had been considered and were now being prioritised around where the greatest impacts were likely to be seen.*
- *It was confirmed that the schedule of ambulatory pathways provided was a nationally defined list of pathways, and other than self harm did not include any other mental health pathways. Other work on mental health was taking place but this was part of a different workstream.*

- ***Older people and long-term conditions*** *– that integrated care was being developed with the aim of providing a better experience for patients. For those with long-term conditions, this involved using available data to predict those who would be at risk of developing health problems and may benefit from a more proactive diagnostic and management of disease approach. Through early intervention and advice, the aim was to help patients to better manage their own health needs.*

  Members were advised that a range of sources were being used to gather local intelligence in order to help predict future illness. This included a number of different agencies, including the ALMOs, and mechanisms were in place for Councillors to alert the NHS and Social Care where there were concerns about constituents.

  Members were further advised that structural changes in the working model were being piloted, as presented elsewhere on the agenda (minute 72 refers). This consisted of integrated teams, co-ordinated by an individual at GP practice level with a wrap around of professional disciplines in order to treat patients holistically.

  It was highlighted that integrated working had been achieved in the area of people with learning disabilities but that to achieve this cultural and organisational change citywide was a significant undertaking.

- ***Diabetes*** *– the improved model of care was nearly complete and reductions in associated secondary care costs had been achieved.*

- ***Home oxygen service*** *– aimed at improving patient care by enabling patients to more effectively manage their own health and reduce the number of hospital-based reviews needed, whilst increasing visits to homes where oxygen use can be monitored more effectively.*

  Members were informed that further advice would be available to clinicians and Adult Social Care staff around home oxygen, through an up-coming Oxygen Awareness Week and the importance of reiterating key messages to patients around safety and smoking cessation.

  It was highlighted that while the Diabetes and Home oxygen service projects were relatively small, the projects provided good examples of where integrated teams were working with patients to develop models of care and assessment.

  The Board welcomed the report, the work being undertaken and the progress reported. However, it was noted that a significant aim of the Transformation Board was to make efficiency savings within the health and social care economy by the end of 2014. This aspect was not addressed in the update provided.

4. The main outcome from the February meeting was that a further report be presented to the April 2012 meeting clearly identifying the efficiencies identified and generated through the work of the Transformation Board and the supporting projects, and where resources have been reinvested to improve the patient experience.

5. The report provided by NHS Airedale, Bradford and Leeds is presented at Appendix 1 to this report and appropriate representatives have been invited to attend the meeting to present and discuss the information provided.

6. It should be noted that that the Chair has requested an additional report from NHS Airedale, Bradford and Leeds be provided to the Scrutiny Board ahead of the meeting, that is written in plain English, with all acronyms explained and provides more explicit details of the savings generated and reinvestment against the portfolio areas and supporting projects detailed in the report presented to the Scrutiny Board in February 2012, as originally requested;

7. Any further information received in advance of the meeting will be circulated as soon as possible.

Recommendations

8. To consider the information presented and determine any additional scrutiny activity that may be required.

Background documents [1]

- Scrutiny Board (Health and Well-Being and Adult Social Care) – Terms of Reference (May 2011)

[1] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

- Report to the Scrutiny Board (Health and Well-Being and Adult Social Care) – The transformation of Health and Social Care Services (21 September 2011)
- Report to the Scrutiny Board (Health and Well-Being and Adult Social Care) – Leeds Health and Social Care Transformation Programme – Update (29 February 2012)
- Scrutiny Board (Health and Well-Being and Adult Social Care) – Minutes of the meeting held on 29 February 2012

APPENDIX 1

NHS Airedale, Bradford and Leeds

	Agenda item	
DATE OF SCRUTINY COMMITTEE MEETING: 18 April 2012	**Category of Paper Tick( )**	
Executive Director Lead: Phil Corrigan, Executive Director of Commissioning	**Decision and Approval**	
Paper Author: Visseh Pejhan-Sykes: Associate Director of Finance	**Position Statement**	
Paper Title: Additional information requested with respect to the PCT QIPP programme by the Leeds City Council Scrutiny Board (Health and Wellbeing and Adult Social Care)	**Information**	
	Confidential Discussion	

SUMMARY

This paper is prepared in response to a query from the Leeds City Council Scrutiny Board (Health and Wellbeing and Adult Social Care) for some further information around the nature of the PCT's QIPP programme during 2011/12.

ACTION REQUIRED

The Committee is requested to:

- **Note the contents** of this paper.

NHS Leeds QIPP Savings for 2011/12

INTRODUCTION

Details of the PCT's QIPP plans and progress against plan are reported in detail every month to the public Board Meeting and are available for general scrutiny.

However, the PCT has been asked for more detail by the scrutiny committee about the nature of these schemes.

REPORTED QIPP

The following information is the latest reported position to the PCT Board:

QUALITY INNOVATION PRODUCTIVITY & PREVENTION (QIPP)				
			Cash Releasing	
ICT/Directorate	Lead Director	RAG Rating	CIP Plan £'000	CIP Forcast £'000
Planned Care	Philomena Corrigan	G	18,417	21,097
Unplanned Care	Philomena Corrigan	G	10,485	11,428
Long Term Conditions	Philomena Corrigan	G	4,929	4,929
Continuing Care	Philomena Corrigan	G	545	545
Mental Health	Philomena Corrigan	G	6,660	6,660
Childrens services	Philomena Corrigan	G	0	0
Safeguarding	Philomena Corrigan	G	0	100
Learning Disabilities	Philomena Corrigan	R	286	0
Non-Clinical Productivity	June Goodson Moore	G	1,200	2,667
Other Workstreams	Kevin Howells	G	11,232	11,382
Primary Care and prescribing	Dr Damian Riley	G	6,702	6,532
TOTAL			60,456	65,340

Additional Information

The following table provides further analysis of the nature of QIPP schemes:

Type of Scheme	£ million	Note
4% Efficiency inherent in deflated tariff with Providers	33	1
Avoided activity through effective management of patient flow activity	5	3
Provider Efficiencies to absorb demographic growth in 11/12	7	2
Pathway redesign, procured services reviews & application of protocols to reduce procedures of limited clinical value	6	3
Pre-committed recurring Investments from previous years reviewed and revised - released reserved investment funding	10	
Prescribing efficiencies	2	
PCT Running costs reductions	2	
TOTAL	**65**	

Notes

1. The NHS Tariff set by the Department of Health recognised a general rate of inflation in costs of 2.5% for NHS Providers. Against this, there is an expectation that NHS Providers generate efficiencies of 4% per annum. The tariff was therefore deflated by 1.5% (plus 2.5% inflation minus 4% efficiency) in 2011/12 against 2010/11 tariffs for services commissioned by the NHS by service providers. The benefit of that deflation is a QIPP in the health system reported by Commissioning bodies. How the 4% target is met by Providers is part of each Organisation's own QIPP programme.

2. In some instances (especially where contractual arrangements are based largely on block contracts) Providers have agreed to QIPP levels equivalent to the annual growth in activity arising from demographic pressures. The additional activity for what is in effect the same contract value represents a QIPP for the Commissioner.

3. Changes to services commissioned including the application of agreed clinical protocols to procedures of limited clinical value, changes to make patient pathways and patient flows more efficient and a review of a series of interconnected services procured to reduce duplication and overlaps have also led to QIPP achievements for NHS Leeds as Commissioners of healthcare services in Leeds

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

Date: 18 April 2012

Subject: NHS Leeds performance report – follow-up

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. At its meeting held on 21 March 2012, the Scrutiny Board (Health and Wellbeing and Adult Social Care) considered the performance report that was due to be considered by the PCT Cluster Board on 22 March 2012.

2. At that meeting the Scrutiny Board identified the following areas where additional information and /or clarification was required:

   - City wide steering group on tobacco
   - Carbon monoxide monitors for staff providing healthcare for pregnant women
   - Smoking prevalence data for under 18's
   - Early intervention service in psychosis
   - Health visitors numbers
   - A&E performance

3. A briefing note prepared by NHS Airedale, Bradford and Leeds addressing the above areas is attached at Appendix 1 to this report.

Recommendations

4. To consider the information presented and determine any additional scrutiny activity that may be required.

Background documents [1]

- Report to the Scrutiny Board (Health and Well-Being and Adult Social Care) – Leeds NHS performance report – Update (21 March 2012)

[1] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

Briefing note on issues followed up from the Health and Adult Social Care Scrutiny Board meeting of 21 March 2012

City wide steering group on tobacco

The Scrutiny Board raised a question about the existence of a citywide group addressing tobacco issues. It now seems clear that the information contained in the Health & Wellbeing performance report card, which stated that "Since 2009 there has been no citywide steering group to drive the tobacco agenda forward …" was not accurate in describing the whole situation.

In fact, the group that existed at that time was disbanded, but another group is established to develop and implement the soon to be launched citywide Tobacco Control Action plan. The Tobacco Control Management Group has members drawn from across key partner organisations, including Clinical Commissioning Groups, West Yorks Trading Standards, LCC Environmental Health and Adult Social Care and Education Leeds. The group also has voluntary sector representation. This group meets regularly and may draw in more players as the action plan is launched. In addition to the citywide steering group, Leeds City Council are currently developing a citywide tobacco control alliance which will involve a still wider range of people who have an interest and are involved in promoting tobacco control .

Apologies are given by NHS Airedale, Bradford & Leeds (NHS ABL) for any misunderstanding that resulted from the performance report card wording, and members of the Scrutiny Board should be assured that the wording will be amended for future versions.

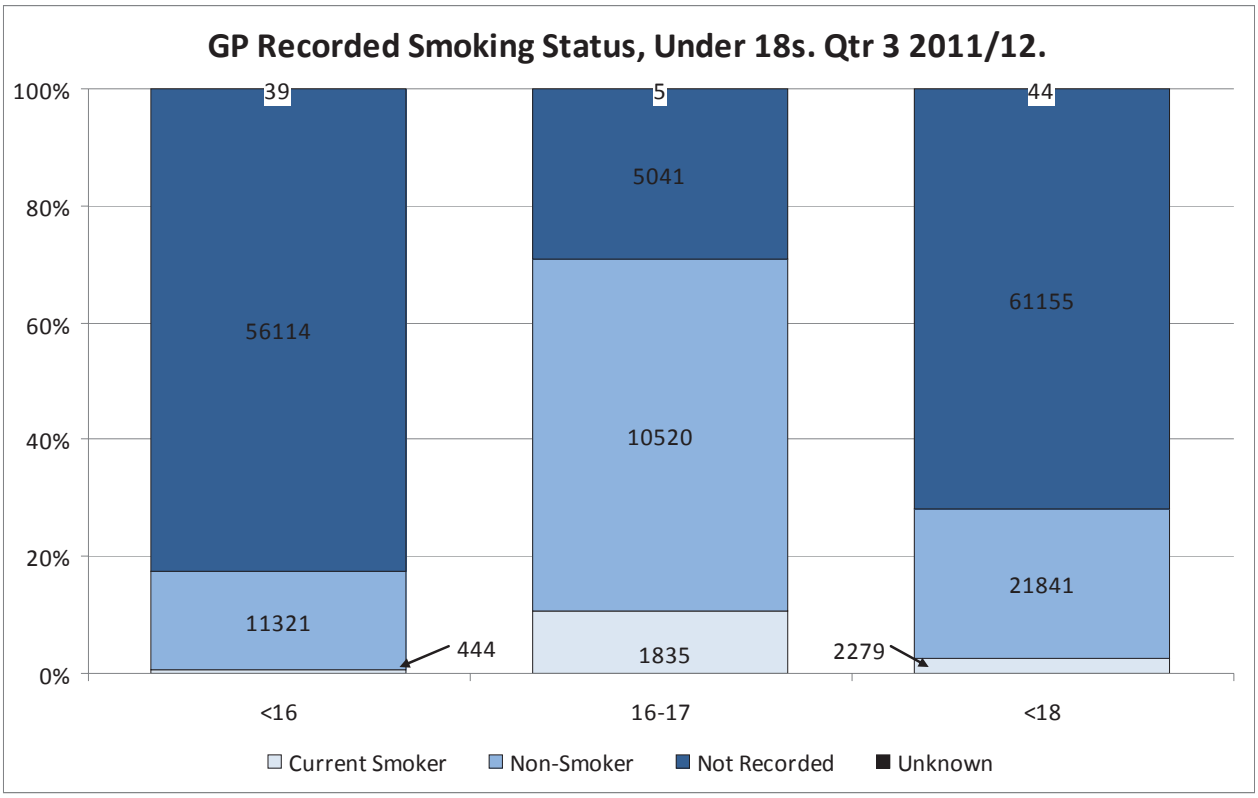
Carbon monoxide monitors for staff providing healthcare for pregnant women

The provision of carbon monoxide (CO) monitors for midwives was raised as a matter of concern by the Scrutiny Board. Further information on this matter has also been provided by Leeds Teaching Hospitals Trust (LTHT). The advice from LTHT points out that CO monitors are recommended by the National Institute for Clinical Excellence (NICE), to support smoking cessation in pregnant women. LTHT currently only have limited numbers, but these are carried by teams working in the most deprived areas of Leeds, that is those areas that have the highest smoking rates.

LTHT and NHS ABL believe it would be desirable for all midwives and other appropriate healthcare professionals to have access to the monitors. In that respect, NHS ABL has developed a business case to provide the monitors. This follows on from a successful trial in Beeston and Chapeltown. The business case is yet to be considered, by the PCTs Clinical Management Executive, though this will take place week commencing 9 April. If approved at that time, the procurement will start as soon as possible and if this is the case, it will be reported to the Scrutiny Board at the earliest opportunity. In anticipation, the smoking service is currently developing a training programme to ensure all community midwives are trained in using the monitors and that they are referring to smoking cessation services appropriately. Assuming the business case is approved, the plan is to roll out this training with the distribution of the monitors.

Smoking prevalence data for under 18's

In response to the question from the Scrutiny Board on younger persons smoking prevalence rates, it has been confirmed that the data shown in the scorecard on smoking covers persons from the age of 16 upwards. The data is drawn from GP records from across Leeds. The chart below shows smoking prevalence data for persons aged less than 16, 16 to 17 and a total for both groups.



The data is the latest available. The number of smokers for those aged under 16, identified using this data is very small, and the number of patients shown as smoking status not recorded is over 80%. Actual numbers are shown within the chart. This is an issue with the dataset, which is drawn from GP records. It seems clear that this data source alone cannot capture the true rate of smokers until there is a more complete record. On the other hand, the data for 16-17 year olds shows a smoking prevalence of around 11%, which may be more accurate. Even in this age group though the rate of persons with their smoking status not recorded is still very high, at around 29%. It is worth noting that the Q3 data for smoking prevalence overall for person aged over 16 years is 22.8%, updating the data used at the Scrutiny Board meeting of 21 March.

Early intervention service in psychosis

The Scrutiny Board expressed concern that the numbers of patients reported to have been seen for December were lower than planned levels. They further required assurance that this did not impact on patients. There was also a query about the age range covered by the data, with specific reference to persons under 18.

In response, it can be confirmed that the gap in service as a result of maternity leave was in fact quite short and that the medical cover element of the service is also not a large part of the service overall.

The drop in numbers seen can be confirmed as natural variation in the number of referrals to the service. Referrals were down for a period and this does happen occasionally. It was not a reflection of reduced capacity, simply the fact that referrals to the service did not materialise. Referrals are via GPs and if patients do not present to GPs, then the number of patients seen and reported goes down. The target is based on an average number, divided over the 12 months of the year, so cannot take account of such variation. It is worth noting that the working relationship in this field between GPs, secondary care and the service itself are reported by all concerned as excellent, so there are no concerns on the part of the PCT in that regard.

It is absolutely clear that no cases were lost or patient not seen, as a result of any service configuration and it is confirmed that the service delivered appropriately.

It can be confirmed that the data covers persons aged from 14, also. Persons aged less than 14 would be seen by the Child and Adolescent Mental Health Service (CAMHS) and are not part of this dataset.

Health visitors

The issue of achievement of the planned target number of health visitors was raised, with assurance that all efforts were being made to reach the required level.

This assurance can be given and the 2011/12 latest data, to the end of Feb 2012, shows that 130.1 whole time equivalent health visitors were employed against a target of 130.5.

This indicates that the provider (Leeds Community Healthcare Trust (LCHT)) is well on track to deliver the 2011/12 target. This is due to significant work to recruit - LCHT are out to constant recruitment. LCHT has also recruited staff nurses to develop and "grow their own" health visitors.

It is worth noting also, there has been significant investment in training places – leading to two intakes per year at Leeds and Sheffield for example - this will produce more health visitors for future years.

A&E performance

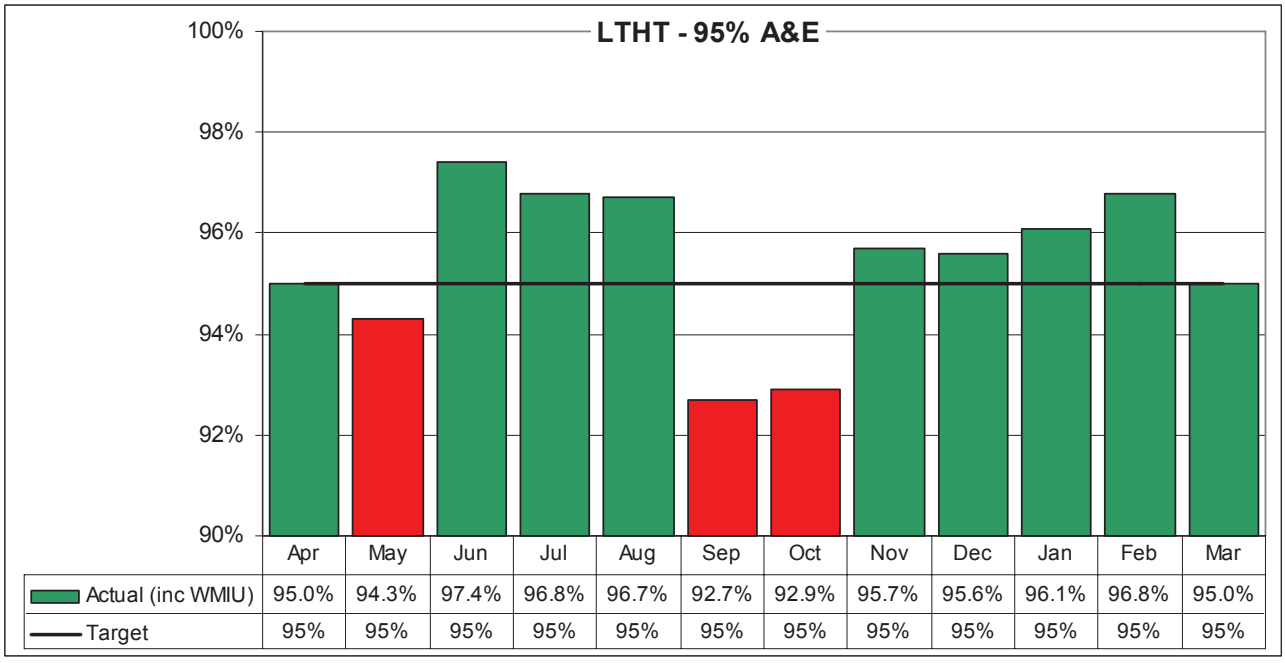
Queries were raised on this as a result of a verbal update given to the meeting, on the matter of A&E performance in Leeds. The queries covered the 98% vs 95% standards and the update to reported performance.

The standard for A&E services for the period up to July 2010 was that 98% of patients who attended an A&E unit would be discharged, transferred or admitted within 4 hours. The newly elected government at the time decided to vary this, following lobbying from clinicians. The argument made was that allowing a 2% tolerance for complex patients was not advantageous to the service and created artificial pressure to deal with patients more quickly than might be ideal. The government agreed and reduced the standard to 95%, leaving a 5% tolerance for complicated cases from July 2010. This standard has been in place since then.

The update on reported performance within the report that was presented to the Scrutiny Board came about because it was discovered that not all activity that could be counted, was.

This examination of data covered two main areas, the first of which was LTHT reported activity, with the result being a retrospective audit of LTHT data, in collaboration with the Department of Health (DH) and the Strategic Health Authority (SHA), which checked back over all LTHT reported activity for 2011/12. As a result, certain errors were discovered. The subsequent corrections made were to the reported numbers of attendances and the reported number of patients waiting more than 4 hours. There were various reasons for the errors, but with fractionally under 200,000 attendances across the two LTHT sites, this is perhaps not surprising. Some of the most significant errors seem to have occurred over the Christmas period, which as members will know is always a period of high pressure in the A&E departments.

The second area of activity that was not counted appropriately was that for activity at Wharfedale Minor Injuries Unit. Following the advice of DH and the SHA, the activity was therefore added in to the total reported for LTHT. The activity at Wharfedale is Type 3 A&E, that is activity that is of a lesser severity, as compared to Type 1 activity such as may be seen at LGI, for example. The DH and SHA have advised that it is appropriate to count activity of this type, in this way, following precedents in other parts of England.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual (inc WMIU)	95.0%	94.3%	97.4%	96.8%	96.7%	92.7%	92.9%	95.7%	95.6%	96.1%	96.8%	95.0%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

The final agreed performance as a result of recasting the data following the audits is shown above. This data replaces earlier reported performance.

This data results in a whole year performance of 95.4%.

Graham Brown
5 April 2012

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

Date: 18 April 2012

Subject: Urgent Care Services – consultation

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. The purpose of the report is to provide a brief update on the outcome of the engagement and consultation around Urgent Care Services in Leeds and the subsequent decision of the NHS Airedale, Bradford and Leeds (ABL) Board.

2. At the Health Service Developments Working Group (HSDWG) meeting on 9 January 2012, it was confirmed that the proposals around Urgent Care Services in Leeds represented a Level 4 (major/ substantial) service changes. As such, the Scrutiny Board was required to be formally consulted on the proposals and provided with an opportunity to formally respond.

Outcome of previous Scrutiny Board meeting (25 January 2012)

3. At the meeting held on 25 January 2012, representatives from NHS Leeds attended the Scrutiny Board (Health and Wellbeing and Adult Social Care) and outlined the consultation options detailed in the documentation presented at that meeting.

4. The Scrutiny Board was advised that the 14-week public consultation period commenced on 5 December 2011 and was due to run until 4 March 2012. Members were advised that the 14-week consultation period was more than the statutorily required 12-week consultation period.

5. The Scrutiny Board was also advised that the NHS Airedale, Bradford and Leeds Trust Board would make a decision on the future provision of urgent care services following analysis of the consultation response.

6. A discussion on the options presented in the consultation document followed and a number of matters highlighted, including:

   - Confirmation that urgent care relates to both physical and mental health;
   - While much of the focus of the consultation document was around the geography or location of future urgent care services across the City, it was important to ensure sufficient consideration of the future quality of services in all urgent care settings across the City;
   - The potential differences in interpretation of 'urgent' between professionals and patients/ the public;
   - Potential to improve the current signage around Lexicon House;
   - Some support for Option C with future provision in East Leeds and the City Centre to replace current provision at Lexicon House.

7. In summarising the discussion at the meeting, the Chair of the Board welcomed the consultation and, in particular the extended consultation period. The Chair recognised that within the Scrutiny Board there had been no clear consensus on a preferred option and therefore a formal consultation response could not be submitted. However, all members of the Scrutiny Board were encouraged to submit individual consultation responses.

NHS Airedale, Bradford and Leeds analysis

8. Following the end of the consultation period on 4 March 2012, NHS Airedale, Bradford and Leeds analysed the outcomes on the engagement activity and presented this to the Trust Board for decision on 22 March 2012. A summary report from NHS Airedale, Bradford and Leeds is attached at Appendix 1.

9. Appropriate representatives from NHS Airedale, Bradford and Leeds have been invited to attend the meeting to present the report and address any questions raised by members of the Scrutiny Board.

Recommendations

10. To note the information presented and determine any additional scrutiny activity that may be required.

Background documents[1]

- Urgent Care Procurement update – NHS Airedale, Bradford and Leeds Trust Board meeting, 22 March 2012 available at: http://www.leeds.nhs.uk/ablcluster/board/Papers/march2012.htm

[1] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

LEEDS HEALTH AND ADULT SOCIAL CARE SCRUTINY BOARD UPDATE

URGENT PRIMARY MEDICAL CARE OUT OF HOURS SERVICE DELIVERY LOCATIONS

18 APRIL 2012

1.0 PURPOSE

1.1 The purpose of this paper is to provide a brief update on the outcome of the engagement on Urgent Primary Care Medical Out of Hours and the subsequent decision of the NHS ABL Board.

2.0 ENGAGEMENT

2.1 Face to face engagement opportunities were delivered as follows:

- Wednesday 25 January 2012 6.00pm until 7.30pm (drop in session - presentation at 6.15pm and 7pm followed by questions and answers) Shaftesbury Medical Centre 78 Osmondthorpe Lane, Leeds LS9
- Saturday 4 February 2012 10:30am until 12:30pm (drop-in session - presentations at 10:45am and 11:45am followed by questions and answers) Denny Room Leeds City Museum, Millennium Square
- Thursday 9 February 2012 6pm until 8pm (drop-in session - presentation at 6.15pm and 7pm followed by questions and answers) Leeds Seventeen Nursery Lane Leeds LS17
- Tuesday 21 February 6pm until 7.30pm (drop-in session - presentation at 6.15pm and 7pm followed by questions and answers) The Morleian Room Morley Town Hall Queen Street Morley Leeds LS27
- There were also stalls for a full day each at Crossgates Shopping Centre, Sainsbury's Moor Allerton and Tescos Bramley during March 2012.
- LIP were separately commissioned to seek the views of the mental health community, older people and South Asian families via focus groups

2.2 30,000 engagement documents were circulated widely across the city. The details are set out in the engagement report. These included the existing urgent care settings. Leeds Local Involvement Network (LINk) were consulted about the engagement process in November 2011. The information was also available on NHS Leeds website and Leeds City Council's Talking Point website.

Some **463** responses were received. A summary of the findings is:

- The location of Lexicon House was poor overall but the facilities there were ok or good
- Some people thought it was a good idea to move the services to hospital sites, but they were concerned about parking there
- Some people were unsure if it was a good idea for extra money to be spent on new urgent care centres, although it was felt that a centre in the East of the City may be of use
- Some people were keen for consideration to be given to using the Seacroft Hospital site for new services
- Overall most people selected option B and the proportions were; option A 27%, option B 41%, option C 32%

2.3 31% of respondents provided their address details. Attached as Annex A is a copy of the postcode analysis of these responses. There is no apparent pattern of preferred options related to the distance from Lexicon House or Leeds 14 areas.

3.0 RATIONALE

3.1 A range of key stakeholders responded to the engagement including Clinical Commissioning Groups, Local Medical Committee and Leeds Community Health Services NHS Trust. These stakeholders all indicated their preference for retaining services on the current sites at the current time (option A). The principal reason given was the potential for confused messages to patients concerning the difference between urgent and emergency care should urgent care services be co-located on main hospital sites.

3.2 Leeds Teaching Hospitals NHS Trust were supportive “philosophically” on co-location on hospitals sites, but were unfortunately unable to provide suitable accommodation at the current time.

3.3 The impact of NHS 111 will only emerge as the new service delivery progresses during 2013/14. However, the intention is to ensure patients access urgent care services which best meet their needs. The pattern of access to all walk in services might then change from the existing provision.

3.4 There are currently five urgent/emergency care centres across the city. In the light of the NHS spending review, any investment in additional centres would need to be prioritised against investments in other health services.

4.0 CONCLUSION

4.1 The ABL Board carefully considered the advantages and disadvantages of each option set out in the Business Case. They concluded that at the current time, the case for changes to the existing Urgent Primary Care Medical Out of Hours service delivery locations

was not made. However, the Board did support the proposal to address the concerns from members of the public concerning signage, exterior lighting and security at Lexicon House. It was agreed that, subject to any necessary planning consents, these should be implemented. In addition, it was agreed that every effort should be made to provide flexibility in future estates and provider contracts. This would enable changes to be made as patterns of urgent care access change, for example the introduction of NHS 111.

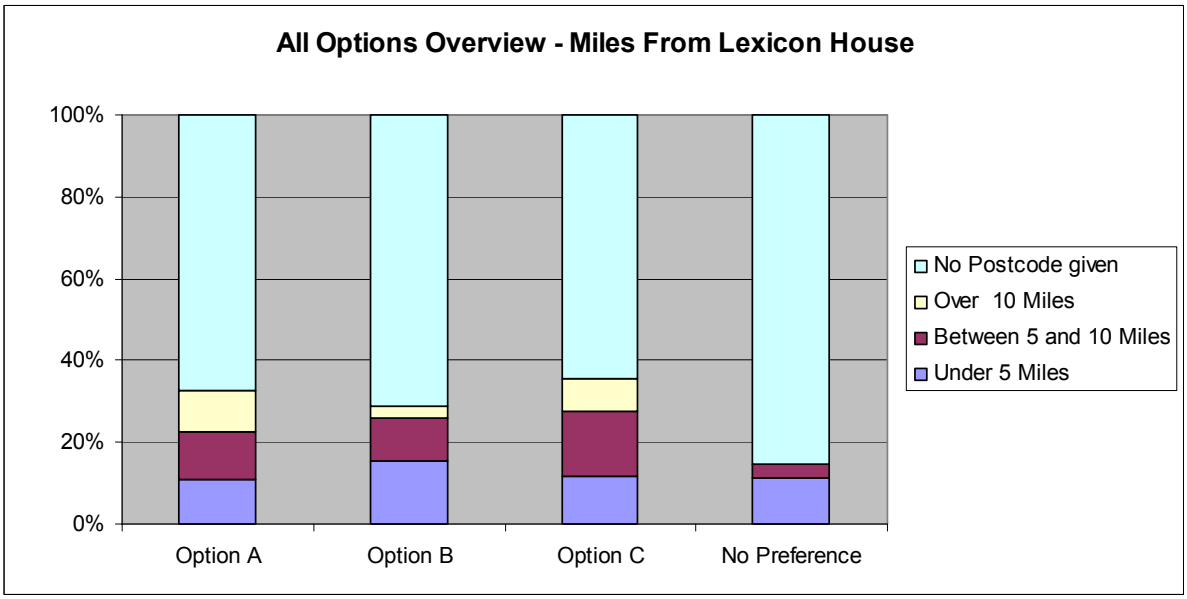
Martin Ford
Urgent Care Lead
Head of Commissioning Long Term Conditions, Cancer and End of Life Care

5 April 2012

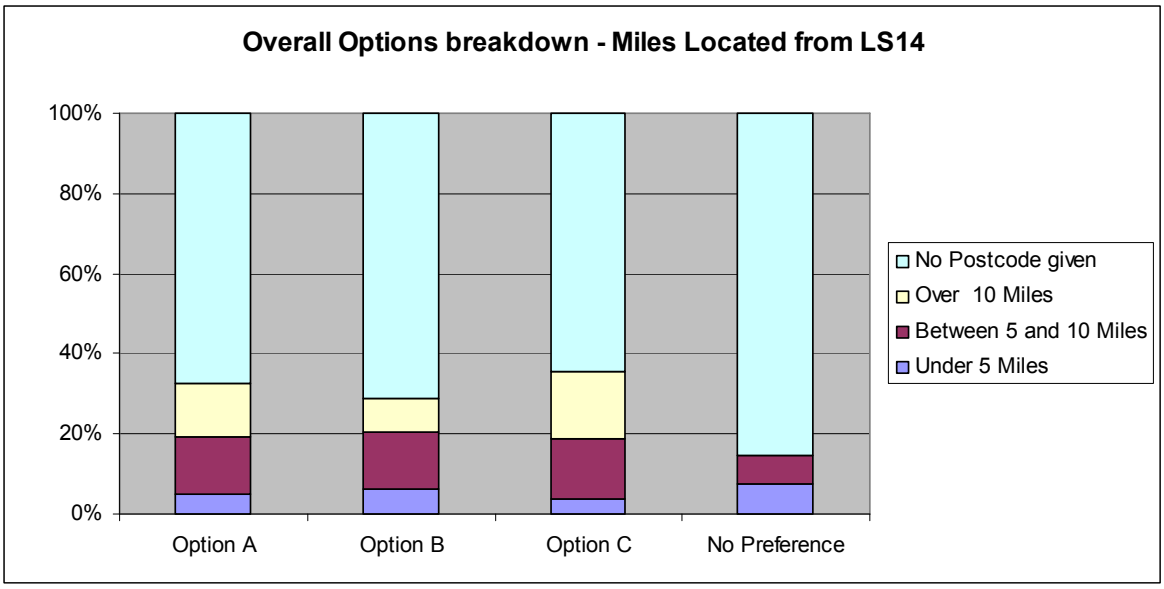
ANNEX A

Urgent Care Engagement Post Code Analysis

1. Only 31% gave postal information allowing us to determine where the responders came from.
2. 69% did not provide personal data therefore we are unable to explicitly define whether there is a coloration between the choice to move the centre and the postal address of the responders.
3. Of the 31% who provided postal address information 4 people did not have a preference to whether the centre moved or not.
4. 5% of the responders did not have a Leeds postcode but did reside in the surrounding area (Bradford and Wakefield)
5. On the whole there was very little variation between the options chosen and the post codes

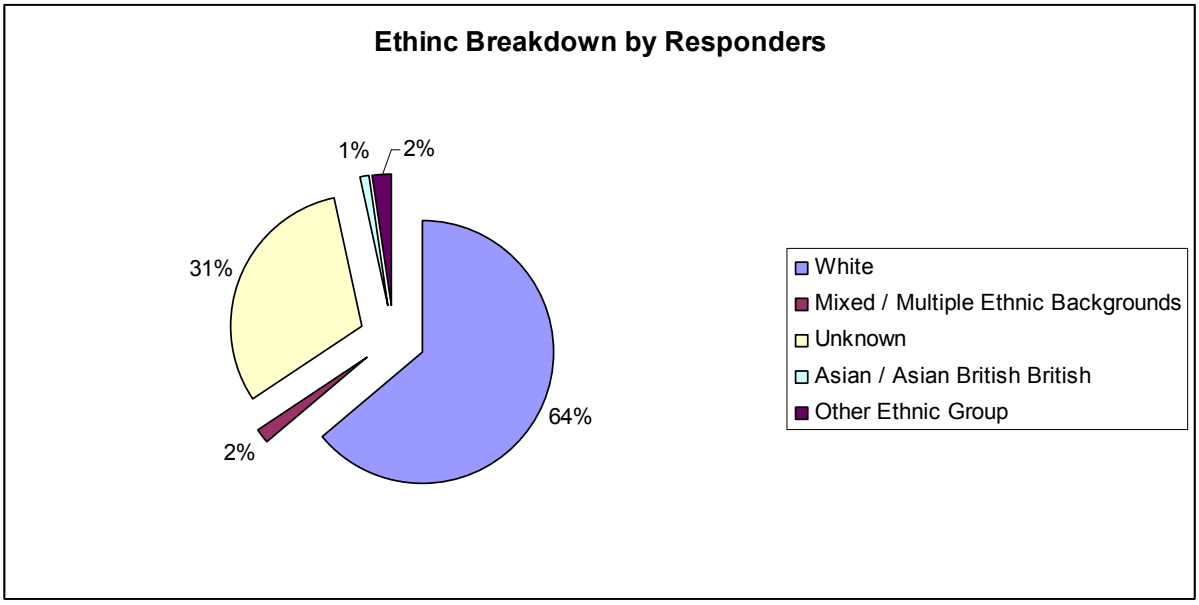


6. Looking at Option C in detail (Additional Site to be located within the LS14 area) we can see from the chart below that in fact only a small percentage reside within 5 miles of LS14 and the majority who favoured Option C actually live over 10 miles away.



Ethnic Breakdown

1. Of the people who responded to the questionnaire we can confirm that 31% did not state their ethnicity.
2. Of those people who did confirm their ethnicity we can confirm that the majority were White (64%).
3. There was an equal breakdown in the other ethic groups who respond mainly from a mixed ethnic background.



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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

Date: 18 April 2012

Subject: Reducing Health Inequalities – Clinical Commissioning Groups perspective

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. In July 2011, the Board identified Reducing Health Inequalities as one of the priority areas for inclusion in its work schedule during the current municipal year.

2. As part of this work the Scrutiny Board has considered the development and production of the Joint Strategic Needs Assessment (JSNA) alongside some of the associated data sets. Specifically the Board also considered details associated with two specific Medium Super Output Areas (MSOAs) from the City to help highlight and demonstrate some of the health inequalities that exist across the City.

Health and Wellbeing City Priority Plan (2011-15)

3. Draft action plans from the Health and Wellbeing City Priority Plan (2011-15) were presented (for information) to the Shadow Health and Wellbeing Board at its meeting on 26 January 2012. The draft action plans focus on delivering the following strategic priorities:

   - Priority Action 1: Help protect people from the harmful effects of tobacco
   - Priority Action 2: Support more people to live safely in their own homes
   - Priority Action 3: Give people choice and control over their health and social care services
   - Priority Action 4: Make sure the people who are the poorest improve their health the fastest

4. Priority Action 4: Make sure the people who are the poorest improve their health the fastest, essentially relates to addressing health inequalities across the City and outlines the following priority actions with a range of supporting activities:

    - Priority Action 4a: Minimise the impact of poverty on health of under 5s
    - Priority Action 4b: Action on housing, transport and environment to improve health and wellbeing
    - Priority Action 4c: Support people back into work and to healthy employment
    - Priority Action 4d: Increase advice and support to minimise debt and maximise income
    - Priority Action 4e: Ensure equitable access to services that prevent and reduce ill-health

5. In the main the above priority areas have been used to provide the focus for a series of working group meetings to deliver this aspect of the Scrutiny Board's work.

6. The purpose of this report is to enable the Scrutiny Board to consider Priority Action 4e: Ensure equitable access to services that prevent and reduce ill-health and specifically the future role of the emerging Clinical Commissioning Groups (CCGs) in Leeds.

7. The draft action plan for Priority Action 4e (Ensure equitable access to services that prevent and reduce ill-health) is attached at Appendix 1. The written submission provided by the Leeds CCGs, namely Leeds North CCG, Leeds South and East CCG and Leeds West CCG, is attached at Appendix 2. Appropriate representatives have been invited to attend the meeting to outline the details presented in Appendix 2 and address any questions identified by the Board.

Recommendations

8. To consider the information presented in this report and supporting appendices and:
    (a) Identify any specific matters for inclusion within the Boards report on Health Inequalities;
    (b) Identify any matters that warrant further scrutiny and determine any associated activity.

Background documents [1]

- Health and Wellbeing City Priority Plan (2011-15) – draft action plans

[1] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

Strategic Priority: 4	H&W Board Sponsor – Ian Cameron Delivery Lead: Brenda Fullard
Make sure that people who are the poorest improve their health the fastest.	

Performance Indicators

Reduce the differences in life expectancy (and healthy life expectancy subject to ONS and Local Authority citizen panel survey) between communities

Priority Action 4e – Ensure equitable access to services that prevent and reduce ill-health

Action Plan 2011/12:

Action	Targeting	Action Owner	Contributing Officers	Milestone or Target
Clinical Commissioning Groups (CCGs) to ensure this priority is embedded within their approach to commissioning and improving the quality of primary care	Target practices (with more than 30% of their practice population living in the most deprived 10% SOAs) Other practices in terms of 'vulnerable' groups	Lucy Jackson (NHS) Jon Fear (NHS) Victoria Eaton (NHS)	Diane Burke Karen Newboult	Actions within CCG commissioning plans- April 2012 Actions agreed in line with improving quality of primary care within
Engage with the NHS and Adult Social Care transformation programme to embed this as a priority across work programme	People identified at high risk of hospital admission through risk stratification	Lucy Jackson (NHS) Victoria Eaton (NHS) Jon Fear (NHS)	Diane Burke Karen Newboult	Within all work streams of NHS and ASC programme

Action	Targeting	Action Owner	Contributing Officers	Milestone or Target
Improve accessibility; and provision of advocacy, information, advice and language support to make effective use of healthy living services	Low income households; people with existing physical and mental health conditions, excluded groups, learning disabilities, families with young children and older people.	Brenda Fullard (NHS)	Staying Healthy Commissioning team (NHS), Mike Sells (LCC) Dan Barnett (Leeds Initiative) Library services (LCC) Baksho Uppal (LCC) Elizabeth Bailey (LCC) Tim Taylor (LCC)	Increase in referrals to healthy lifestyle services
Behavioural and lifestyle programme to increase early diagnosis of cancer	Localities and population groups that experience higher levels of cancer mortality than the rest of Leeds	Brenda Fullard (NHS)	John Fear (NHS) Catherine Foster (NHS), Veronica Lovatt (NHS), Fran Hewitt (NHS), Louise Cresswell (NHS), Matt Callister (LTHT) Dawn Ginns (NHS) Feel Good Factor Healthy Leeds Network Baksho Uppal (LCC)	Increase in early diagnosis of lung cancer
Build the capacity, confidence and skills of individuals, communities and the third sector to take control of their own health and play an active role in the well-being of others	Low income households; people with existing physical and mental health conditions, excluded groups, learning disabilities, older people.	Janette Munton (NHS) Pat Fairfax (LCC)	Locality Health and Wellbeing partnerships Brenda Fullard (NHS) Mick Ward (LCC) Ruth Middleton (NHS)	• Evidence of increased engagement in inter-generational and inter-cultural community activities • Increase the number of vulnerable population groups engaged in co-producing services

Leeds North Clinical Commissioning Group

Leeds South and East Clinical Commissioning Group

Leeds West Clinical Commissioning Group

The Clinical Commissioning Groups perspective on reducing inequalities in Leeds: the contribution of the NHS.

An interim report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

The Clinical Commissioning Groups perspective on reducing inequalities in Leeds: the contribution of the NHS.

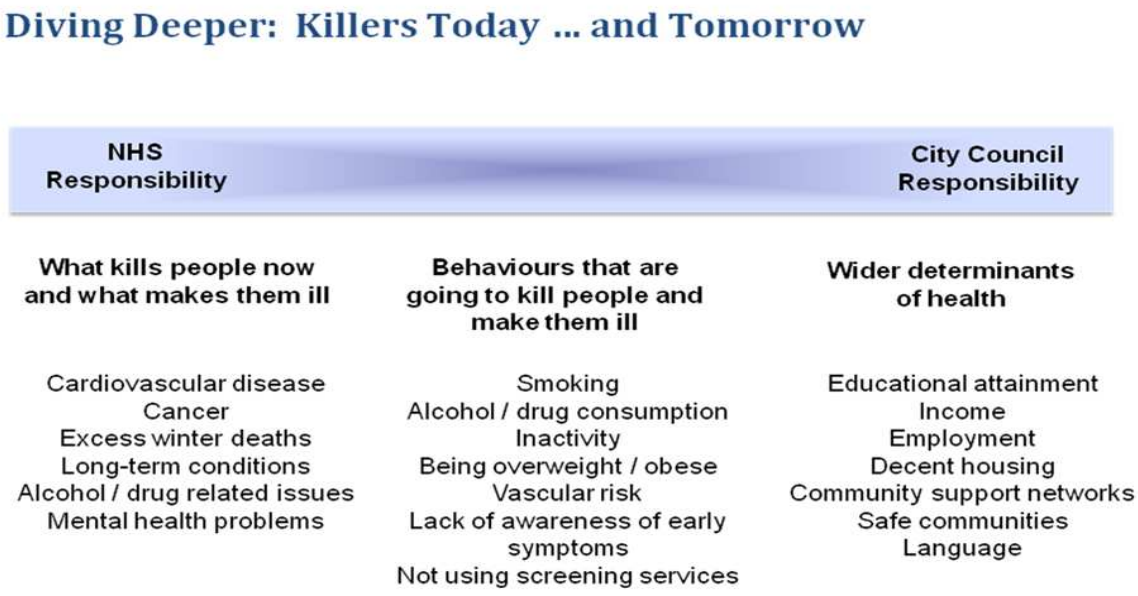
1. The three Clinical Commissioning Groups (CCGs), Leeds North, Leeds South & East and Leeds West endorse the principle of the Marmot Review (Fair Society Health Lives) that inequalities are a matter of life and death, of health and sickness and of well-being and misery. Because of the unique relationship of their member practices with the people of Leeds, the CCGs are very aware that people in different social circumstances experience avoidable differences in health, well-being and length of life, that is, quite simply, unfair.

2. They understand that creating a fairer society is fundamental to improving the health of the whole population and ensuring a fairer distribution of good health and that inequalities in health arise because of inequalities in society – especially in the conditions in which people are born, grow, live, work, and age. Consequently the CCGs recognise the opportunity of a "life course" approach to reducing health inequalities. They are aware that the magnitude of health inequalities is a good marker of progress towards creating a fairer society. The CCGs fully understand that taking action to reduce inequalities in health requires action across the whole of society.

3. Equally the CCGs realise that in commissioning NHS services they have a duty to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services as outlined in the Health and Social Care Act 2012. They recognise that NHS commissioning plans must be influenced by the Joint Strategic Needs Assessment. The CCGs also recognise the need to be engaged in the development of the Joint Health and Wellbeing Strategy, and wish to be actively involved in the Health and Wellbeing Board (including monitoring progress).

4. The CCGs are clear they have a lead role to play in reducing health inequalities in terms of preventing people from dying prematurely whilst reducing the gap between communities as well as supporting people to live healthy lifestyles and make healthy choices. Equally The CCGs recognise the lead role of Leeds City Council in the wider determinants of health and wellbeing and a need to work with partners to deliver improvements against the wider factors that affect health and wellbeing and heath inequalities. The CCGs therefore fully endorse and recognise the contribution to the Leeds City Priority Plan 2011/15, in particular the priority under Health and Wellbeing - to make sure the people who are the poorest improve their health the fastest.

5. The diagram below illustrates the balance between *lead roles* but recognises there are legitimate roles for the NHS and City Council at either end of the spectrum. The CCGs also recognise the need to engage patients, people, their communities, providers of NHS care, as well as the Voluntary, Community and Faith sector and others such as police, businesses and schools.



6. The CCGs are shaping their action plans as part of their authorisation process and this is necessarily a developmental process. The approach will involve commissioning at a micro and macro level. This is best illustrated by the approach to commissioning mental health services. It will involve the proactive, systematic management of common mental health problems in primary care targeting those communities most in need with good partnership working within communities (micro level), plus at macro-level investment/disinvestment in effective specialist mental health services informed by population need, ensuring good access for those populations with high levels of poor mental health.

7. The range of actions the CCGs will be considering as part of the NHS contribution to reducing inequalities include:

What kills people and makes them ill	Behaviours that are going to kill people and make them ill	Wider determinants of Health
Ensuring: 1. Systematic primary care management • Risk stratification of practice population health needs • Integration of Health and Social Care services • Self management enabling people to understand and manage their own health needs 2. Equitable access to specialist services	1. Risk stratification of practice population health needs 2. Systematic approach to behaviour change in primary care 3. Equitable access to specialist services eg smoking cessation, 4. weight management and drugs and alcohol 5. Engage with cancer awareness and early intervention programmes 6. Implementation of NHS Health Check	1. Systematic signposting to services eg debt management, fuel poverty, housing etc 2. Supporting Safeguarding 3. Supporting partnership working 4. Advocacy

8. These and other interventions will contribute to the NHS and Public Health Outcome frameworks key priorities. In addition the CCGs recognise there is national work to develop a child health outcomes framework and will ensure appropriate NHS action once the framework is published.

   (a) Preventing people dying prematurely (NHS and Public Health outcome)
   Objective – reduce numbers of people living with preventable ill health and people dying prematurely while reducing the gap between communities. (*This outcome is to be led by the NHS and is a main role for CCGs)*

   (b) Health Improvement (Public Health outcome)
   Objective – people are helped to live healthy lifestyles, make healthy choices and reduce health inequalities. This outcome is to be led by the Local Authority but CCGs have a key role in ensuring they services are commissioned effectively in relation to their clinical value, and impact on the outcome above. Practices also have a key role in delivering a number of these services and motivating/supporting people to change their lifestyle. (This joint working will be through the Health Improvement Board.)

   (c) Improving the wider determinants of health (Public Health outcome)
   Objective – improvements against the wider factors that affect health and wellbeing and heath inequalities. This outcome will be led by Local Authority with wider partners such as the police, schools, businesses, third sector etc. However the CCGs and its practices have a role in contributing to the headline health inequalities indicators in City Priority Plan i.e. “reduce the differences in life expectancy between communities” and “reduce the difference in unhealthy life expectancy between communities, particularly in terms of signposting and working in partnership with the local agencies within their populations. (This will be a key factor for the CCGs Stakeholder Engagement strategies).

Key local issues

9. The key issues related to each CCGs population are shown at Appendix A. The CCGs recognise that city wide coordination is vital in delivering reduction of inequalities but are aware that this can also present a risk of diluting the necessary focus on key segments of the local populations. CCGs will therefore be taking great care to balance commissioning at a local level with the city wide responses required to deliver this agenda. This will necessarily involve working with local partners including local Councillors, Area Committees, Area Partnerships, the Third Sector, Schools and statutory bodies such as the police.

Conclusion

10. This approach to addressing health inequalities builds upon current practice and learning in Leeds. The approach is developed within the new political and organisational context of CCG development and new responsibilities for health and wellbeing for Leeds City Council. Local action plans will be developed for each CCG, together with local partners. This approach will be developed and supported as part of the ‘core offer’ of Healthcare Public Health Advice to CCGs within the new public health arrangements.

References

http://www.publications.parliament.uk/pa/cm201011/cmbills/132/11132.24-30.html#j036a accessed 28 March 2012

http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review accessed 28 March 2012

Headlines on health needs for Leeds North CCG population

Gap in life expectancy – is not narrowing

For Leeds North CCG this gap is 9.5 years – however for males there is a 13.3 years. The highest mortality rate is in Seacroft North (which is the second highest in the city, and the lowest mortality rate is in Wetherby West.

Just over a fifth of the population of Leeds North CCG live in the most deprived quintile of Leeds

Impact of population increase – for example 55% increase in over 75s; 25% rise in birth rate in the last 10 years – impact for health and social care especially when combined with wider factors that influence health - increasing numbers of older people living on their own; impact of fuel poverty etc

Different communities – Citywide 18% of the population are from BME communities. For Leeds North CCG - from Origins date 78% of the population is made up of British origin, (slightly lower than the Leeds average). The origin group that is higher than Leeds average is from South Asia

Key health and well being issues:

Specific conditions:

Overall premature mortality rates decreasing but gap between Leeds and Leeds deprived for long term conditions not closing and in some cases increasing. The highest number of mortality in the population is due to ischemic heart disease, then cerebrovascular disease and then respiratory .Across the CCG population age standardised rates for CHD, Cancer and diabetes are near to the Leeds average with rates for COPD being below that for Leeds. However there is great variation within the CCG which will be seen in the practice profiles .COPD, CHD and diabetes rates are rising higher than the Leeds average, Cancer rates are rising slower than the Leeds average

Behaviours

Smoking and obesity are rising slower – with recorded smoking rates even decreasing

Wider factors that influence health – increasing fuel poverty and social isolation

Service utilisation

Example - Emergency admission follow a similar pattern of increase (except for the 16 – 65 year olds for Leeds – but are below the Leeds average, compared to outpatient first attendance which are above the Leeds average- except for children which is similar. Future work will consider the pattern of different service usage in relation to population need.

Headlines on Health Needs for Leeds West CCG Population

1. Life expectancy gap

    - Within the population of Leeds West CCG, there are communities with some of the lowest average life expectancy rates in Leeds. For example, out of 108 MSOA in the city, Armley and New Wortley has the 2nd lowest life expectancy within the city for men – 70.8 years.
    - The differences in life expectancy within the LWCCG population are wide, e.g. the gap in male life expectancy is 13.3 years (based on MSOA level data).
    - 23% of the LWCCG's population are within the "Hard pressed" category (ACORN profile)

2. The distribution of need is scattered across the population of LWCCG, and is best captured through data on a smaller geography. The levels of health need within these areas are amongst the greatest within the city. Data on a whole CCG level often masks this variation of need when combined with the rest of the CCG population.

3. As well as inequalities in health between geographical communities within the LWCCG population, there are also communities with specific need eg offenders, students and gypsies and travellers

4. The prevalence of some Long Term Conditions (specifically COPD, CHD and diabetes) within the whole population of LWCCG is lower than the Leeds average. However, more local data contained within the MSOA profiles shows higher rates of Long Term Conditions in some communities eg Farnley, Broadleas, Ganners, Sandfords. Other areas within the LWCCG population reflect very different needs e.g. in Hawksworth Village, Tranmere Park numbers of Adult Social Care Referrals are relatively high.

5. The LWCCG health profile is informed by the emerging local health profiles as part of the JSNA process. The Leeds JSNA includes a wider range of data and shows, for example, higher rates of mental health problems and substance use within Inner West Leeds.

6. There are significant differences in healthy lifestyle behaviours relating to health, which are predominantly linked to levels of deprivation. For example, within the areas of Bramley Hill Top, Raynville and Wyther Park all rates for smoking, obesity and alcohol admissions are above Leeds average.

7. Within the LWCCG population, higher levels of health need is closely associated wider factors affecting health eg poor health outcomes, low income and low educational attainment are often inter-related, for example in Armley and New Wortley.

Headlines on health needs for Leeds South and East CCG population

Health Needs Assessment

Know Your Numbers

258,436 Patients

50 % Male

44 Practices

40 % Population considered living in "Hard-Pressed" conditions

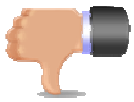
9.5 Years Difference Between Highest and Lowest Life Expectancy

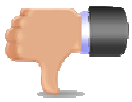
81 % of LS&E Black African population live in deprived Leeds

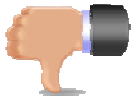
Health Needs Assessment

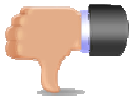
Population Health

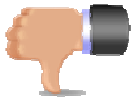
Leeds S&E Utilisation and Prevalence Rates Compared with Leeds

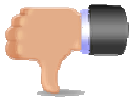
A&E Attendances 

Obesity 

Outpatient First Attendances 

Smoking 

Inpatient Emergency Admissions 

Chronic Diseases * 

* Includes Diabetes, CHD, and COPD

Diving Deeper: Health Inequalities

Edward Garforth-East

Baby	Aged 10	Aged 20	Aged 45	Aged 60
Born to non smoking parents, healthy weight	High educational attainment, plays lots of sport	At university with 10 x A* at GCSE. Plays rugby and eats a healthy diet	Fit and wealthy executive	Retired early. Will live at least 6 years longer than Cody

Cody Gipton

Baby	Aged 10	Aged 20	Aged 45	Aged 60
Mother smokes, born with low birth weight	Low educational attainment. Growing up in poverty	Left school with no qualifications, casual worker, drinks, smokes and takes drugs	Weighs 18 stone, has high cholesterol, early stage type 2 diabetic	Dies at least 6 years earlier than Edward from a heart attack

6.3 miles apart

Major Conclusions

Insights	Implications
• Health inequalities are at levels inexcusable in this day and age with the expertise and knowledge we have in our health system	• Addressing health inequalities is central to our identity as a champion for health and as the voice of the population
• Our patients are in much poorer health compared with the rest of Leeds and this will only worsen with the aging population and rising incidence of lifestyle and chronic diseases	• Embracing prevention and empowering patients to better manage their own health is necessary to achieve financially sustainable health economy
• City wide coordination is vital but can present a risk of diluting the necessary focus on key segments of the Leeds S&E population	• We need better, more integrated coordination of primary, secondary, social and preventive care for patients at home (or as close to home as possible) and at general practices
• Blurred division of accountability between the NHS and Local Council creates sub-optimal outcomes	• Continue to invest in capabilities that will enable our transformation from a reactive to proactive mode of managing the health economy

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

Date: 18 April 2012

Subject: Leeds Teaching Hospitals NHS Trust – Care Quality Commission (CQC) compliance update

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. At its meeting held on 21 March 2012, the Scrutiny Board (Health and Wellbeing and Adult Social Care) considered a local NHS performance report. This included details of a Care Quality Commission (CQC) compliance report relating St. James' University Hospitals (part of Leeds Teaching Hospitals NHS Trust (LTHT)), published In January 2012.

2. It was reported to the Scrutiny Board that the CQC had identified that improvements were needed at St. James' University Hospitals because government standards were not being met and concerns were raised in relation to the following essential standards:

    - Outcome 04 - Care and welfare of people who use services (moderate concerns)
    - Outcome 08 - Cleanliness and infection control (minor concerns)
    - Outcome 13 – Staffing (moderate concerns)

3. Representatives from LTHT attended the meeting and outlined how the concerns raised by the CQC were being addressed. A briefing note was circulated that summarised recent improvements and further specific actions needed to maintain compliance with the above essential standards, where moderate concerns had been reported.

4. In considering the information presented at the meeting in March 2012, the Scrutiny Board requested the following additional information around the action plan relating to nursing staff (focusing on Older People's medicine):

   - the nature of any gap between the staffing blueprint and current establishment;
   - sickness levels; and,
   - staff turnover

5. Representatives from LTHT have been invited to attend the meeting to outline the information requested.

Care Quality Commission (CQC) warning to Leeds Teaching Hospitals NHS Trust (LTHT) following inspection

6. On 29 March 2012, Leeds City Council received notification of a press release issued by the CQC in respect of a separate inspection at Leeds Teaching Hospitals NHS Trust. This is attached at Appendix 1. Details were reported in the local media on the following day, 30 March 2012.

7. Following discussions with the CQC, it has been confirmed that the final inspection report is unlikely to be available ahead of the Scrutiny Board meeting. However, given the nature of the issues already identified in the press release and the previous discussions at the Scrutiny Board in March 2012, representatives from the CQC and LTHT have been invited to the meeting to discuss the matters in more detail.

8. Representatives from the service commissioner, NHS Airedale, Bradford and Leeds have also been invited to attend the meeting.

Recommendations

9. To consider the information presented and determine any additional scrutiny activity that may be required.

Background documents [1]

- None used

[1] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

APPENDIX 1

Press release – Thursday 29 March 2012

CQC issues warning to Leeds Teaching Hospitals NHS Trust following inspection

- **Regulator demands hospital trust takes action to improve**

The Care Quality Commission (CQC) has issued a formal warning to Leeds Teaching Hospitals NHS Trust stating that it must do more to improve standards of care or face further action.

The warning follows an unannounced CQC inspection at Leeds General Infirmary, Great George Street, on 29 February and 1 March 2012.

Inspectors visited to check on what progress had been made in relation to concerns raised with the trust at the time of an earlier inspection.

On their latest visit CQC found that improvements were still needed. Inspectors observed that people's needs were not always being met and this was due to poor care and sometimes insufficient staff.

- Some patients told inspectors that they were dissatisfied with the care and support they had received, and they related this to there being a shortage of staff.
- Inspectors saw that the needs of some elderly patients in orthopaedic wards were not responded to appropriately or promptly.
- Inspectors saw that some patients' wishes were ignored by nursing staff.
- A review of staffing rotas on wards 53 and 55 revealed that both wards had been frequently operating under the Trust's planned staffing levels.
- It was unclear whether all patients had been properly involved in discussions with staff about their individual needs.
- Nursing and medical notes were not well organised and this made it more difficult for nursing staff to adequately meet patients' needs.

Jo Dent, CQC Regional Director for Yorkshire and Humberside, said:

"The law says that these are the standards that everyone should be able to expect. Providers have a duty to ensure they are compliant.

"We will be returning to the trust to follow up on progress and, when we do, we will expect the trust to be able to demonstrate it has made improvements.

"This warning sends a clear message that Leeds Teaching Hospitals NHS Trust needs to address these issues or face serious consequences.

"CQC has a range of legal powers it can use if it is found the required progress has not been made. Where necessary we will use these powers to protect the people who use this service."

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Leeds CITY COUNCIL

Report author: Stuart Cameron-Strickland

Tel: 2243342

Report of Director of Adult Social Services

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 18 April 2012

Subject: Calculating progress in the delivery of Personalised Support

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☐ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. National policy changes and local priorities for adult social care have generated a broader range of services and greater complexity in how individuals receive their services. This has impacted upon the measure of progress in delivering social care through personal budgets.

2. A national review of performance measures and national data returns for adult social care is underway but has not yet reported. There is increasing variance between authorities about how to interpret national guidance for the production of this measure. Steps are being taken to develop a more consistent interpretation within the region which enable more accurate benchmarking of performance and more accurate reporting of progress to the Scrutiny Board (Health and Wellbeing and Adult Social Care).

3. Leeds has recalculated its data to create greater consistency with other authorities. Although the data will not been finally validated until the end of the financial year, the revised performance as at February 2012 for 'the proportion of people using social care who receive self directed support' is 47.8%

Recommendations

4. Members are asked to note the issues raised in this report.

1 Purpose of this report

1.1 This report was requested by members at the Scrutiny Board (Health and Wellbeing and Adult Social Care) meeting on the 21st March 2012 to provide background information about changes to the calculation of a key performance measure relating to the provision of social care through personal budgets

1.2 The report provides Members with the background and details of consequent amendments to reported performance of the Council in respect of its drive to deliver greater personalisation within adult social care services.

2 Background information

2.1 Recent national government policy, sector led guidance and local priorities are transforming the way that adult social care is being delivered. Public reports of performance form a key method for citizens to hold local Council's to account for their of progress in delivering policy changes; for the adult social care sector to be able to compare performance and for national government to assess the impact of policy changes and investment.

2.2 For many years the Department of Health has required local authorities to provide annual data returns to enable it to measure progress in the implementation of national policy. This data provides the basis for the national Adult Social Care Outcomes Framework performance measurements which provide the basis for demonstrating the sector's achievements. National data returns are subject to regular and frequent review as policy changes and social care practice develops.

2.3 The local priorities for improvement for social care in Leeds are outlined in the Health and Wellbeing Priority plan and within the Council Business Plan. These have been influenced by national and sector policy commitments and shaped by local need and strategies for delivery. The performance reports received by scrutiny board employ measures of progress against national and local priorities for delivery, including *''Giving people choice and control over their health and social care needs''*

3 Main issues

3.1 Over the past few years there has been significant changes in national policy for adult social care and consequently the approaches to measuring progress are being amended to reflect the emerging standards for service delivery. The NHS Information Centre is currently leading a 'zero-based review' of social care data collections which aims to deliver reforms and improvements to the national data set for social care, from 2012/13 onwards. The sector is currently in an interim position in this respect as it awaits the outcome of this review.

3.2 A key measure of performance which is employed locally and nationally is "The proportion of people using social care who receive self directed support" This is defined as the number of service users and carers who, at any time in the year, received self directed support, as a percentage of the number of people who, at any point in the year, received a community based service or a carers specific service. This measure supports the drive towards personalisation outlined in the

Vision for adult social care, and *'Think Local Act Personal'* by demonstrating the success of councils in providing personal budgets and direct payments to individuals using assessed services.

3.3 The Local Authority circular, LAC(DH) (2008)1: Transforming social care states that;

> *'In the future, all individuals eligible for publicly funded adult social care will have a personal budget (other than in circumstances where people require emergency access to provision); a clear, upfront allocation of funding.'*

3.4 The measure has two elements. Firstly it counts the number of people receiving self directed support. To be counted as receiving self-directed support, the person (adult, older person or carer) must either:

- be in receipt of a direct payment; or
- have in place a personal budget which meets all the following criteria:

1. The person (or their representative) has been informed about a clear, upfront allocation of funding, enabling them to plan their support arrangements; and
2. There is an agreed support plan making clear what outcomes are to be achieved with the funding; and
3. The person (or their representative) can use the funding in ways and at times of their choosing.

This calculation is substantially unchanged by the proposal contained in this report.

3.5 The second element of the measure is 'the number of people receiving community care services'. Guidance relating to the calculation of this performance measure includes all service users classified as receiving community based services as defined within the *Referrals, Assessments, and Packages of Care* (RAP) national return. Community care services are:

- Services that are provided or commissioned by social services and are part of a care plan following a Community Care assessment and;

- Their care must be managed by the Council.

Community Care services include; homecare, daycare, direct payments, short term residential care (not respite) and other community based services. In addition all carers who receive carer specific services are included. It is this element of the calculation that has been amended.

3.6 At a national level. work is underway to improve the data collections which support this measure, so that refinements in future years will better reflect progress on personalisation, and support analysis against the Think Local, Act Personal concordat. The Department of Health have indicated their intention to revise the measure to focus only on those for whom self-directed support and direct payments are appropriate, which is not possible from the current data

collections. This will give a better representation of the progress of the personalisation agenda and enable fairer benchmarking between councils.

3.7 The NHS Information Centre acknowledge in their current guidance for data collections that Adult Social Care services are now provided in many ways and that Local Authorities should take care to exclude significant groups of these from their calculations.The interpretation of guidance about this measure has been a source of debate within the sector. National guidance for the Adult Social Care Outcomes Framework acknowledges the difficulties with the current definition.

> *'There are established issues with the data definitions in relation to this measure, which means that care must be taken when interpreting the information for analysis and benchmarking.*
>
> *The denominator of the current measure is based upon a definition of people receiving community-based services which includes some individuals for whom self-directed support may not be appropriate, for instance those receiving some one-off, short-term or universal services such as equipment and reablement. This means the overall proportion does not reflect the true extent of the provision of self-directed support to those who are eligible, and it is not possible to reach 100%.'*

3.8 This issue reflects the impact of recent policy changes, and in particular an expectation that, people and their communities should play a bigger role in supporting themselves and others; the broadening range of social care services and providers and delivery through partnership arrangements with health agencies. Many new targeted services have emerged which are not 'community support' including crisis support; re-ablement/ intermediate care and safeguarding. The introduction of these new ways of delivering social care have led the directorate to review its interpretation of the guidance to ensure that it is remaining consistent with the measure's spirit and definition.

3.9 In the Autumn of 2011, Leeds consulted with other local authorities in the region about their interpretation of the rules for this measure. This demonstrated that there were inconsistencies throughout the region, but in particular Leeds appeared to be including groups of adult social care service users in the cohort for measurement which they were no-longer including. In order to enable Leeds to compare its performance against its comparator authorities in the region, it needs to employ an interpretation of national guidance for the measure which is more consistent with those authorities.

3.10 Our review concluded that the following amendments to the interpretation of the guidance should be made:

- Services which are provided as a part of a care plan following a Community Care Act Assessment should be included.
- This would exclude people receiving reablement services, telecare and a range of other services, including users of sitting services, respite, meals, etc.
- Professional support by a social worker should only be included if it is following a current assessment or part of a broader care plan.

- People receiving major items of equipment which are reviewable should be included in the cohort. People receiving other equipment only should not be included unless the person requires ongoing involvement to use it.
- Carers should be included where they have had a review or assessment and a carers specific service and/or advice and information.

3.11 Under the previous arrangements, data for the period April 2011 to February 2012 would suggest that Leeds will provide support for approximately 15,557 people in receipt of community services. Of these, 5,921 or 38.1% have had some form of personal budget during the period. Current estimates of the impact of taking the steps outlined above would reduce the cohort of people receiving community care to 12,200 people, of whom 5,825 or 47.8% have personal budgets.

3.12 At the point of writing this report this data should be regarded as indicative only as it is still subject to full end of year data validation and further work is taking place to provide more detailed rules for inclusion within the cohort.

4 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 This report provides an update for members about work to revise the interpretation of a national and local performance measure in the light of major policy changes and to maintain consistency with other local authorities within the region. This has implications for the calculation of a performance indicator regularly reported to the board. It is therefore not a decision requiring public consultation, however, all performance information is provided to the public via the council's website, and nationally through the NHS Information Centre website

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 This report refers to a reinterpretation of the rules relating to a performance measure. It does not effect access routes to service. The uptake of personal budgets by ethnic minority groups, gender, age and disability will continue to be monitored to ensure no unforeseen impact is generated. An equality impact screening tool has been completed to support this.

4.3 Council policies and City Priorities

4.3.1 This report provides an update on progress about work to revise the interpretation of a national and local performance measure of progress in delivering one of the council and city priorities in line with the council's performance management framework.

4.4 Resources and value for money

4.4.1 There are no specific resource implications from this report; however it outlines developments which will enable the authority to more accurately compare its performance in regard to providing social care through personal budgets with that of other regional authorities.

4.5 Legal Implications, Access to Information and Call In

4.5.1 There are no specific legal implications of the content of this report. Calculations of national and locally reported data are subject to internal and external audit. Reports of performance against this measure are published on the council and Leeds Initiative websites.

4.6 Risk Management

4.6.1 This report outlines action which is being taken to reduce the risk of reporting an inaccurate position in respect to the Council's progress in delivering more personalised social care in line with national and local policy.

5 Conclusions

5.1 This report provides information for Members about action which is being taken to ensure that accurate performance information is being provided to them in relationship to progress in increasing the proportion of people receiving their adult social care through personal budgets. The report suggests that significant developments in national policy have impacted upon the way that social care is expected to be delivered and that these have required the authority to review the way it calculates its base information. Consultation with regional authorities has revealed that Leeds has become out of step with other authorities with regard to the interpretation of the guidance for defining the associated performance measure. A revised preliminary calculation for the performance measure has been undertaken and this suggests that Leeds is now performing at 47.8% of all community care service users or their carers receiving some or all of their services through personal budgets.

6 Recommendations

6.1 Members are asked to note the issues raised in this report.

7 Background documents[1]

- Transparency in Outcomes: a framework for adult social care (2010)
- Think Local Act Personal (2010)
- Adult Social Care Outcomes Handbook of definitions (November 2011).
- Leeds City Council Business Plan – 2011-15
- City Priority Plan – 2011-15

[1] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

Date: 18 April 2012

Subject: Scrutiny Inquiry Report: Reducing Smoking

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. Reducing Smoking in the over 18s is identified in the Scrutiny Board's Terms of Reference. At its meeting on 22 July 2011, the Board agreed that the Board work should also include consideration of reducing smoking in the under 18s.

2. At its meeting in January 2012, the Scrutiny Board considered the draft Leeds Tobacco Action Plan and heard from the Joint Director of Public Health and representatives from West Yorkshire Joint Services (Trading Standards).

3. The Scrutiny Board has also received information associated with tackling smoking prevalence through other work areas including health inequalities and performance monitoring. Details from the work of the Board are being used to draft a report (to follow) to be presented at the meeting.

Recommendations

4. To amend and/or agree the Scrutiny Inquiry report and any associated recommendations on Reducing Smoking.

Background documents [1]

[1] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

- Scrutiny Board (Health and Well-Being and Adult Social Care) – Terms of Reference (May 2011)
- Health and Wellbeing City Priority Plan (2011-15) – draft Priority Action 1: Help protect people from the harmful effects of tobacco

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

Date: 18 April 2012

Subject: Work Schedule – April 2012

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. In July 2011, the Board identified the following priority areas for inclusion in its work schedule during the current municipal year:
   - Reducing smoking in the over 18s (as detailed in the Board's Terms of Reference agreed by Council);
   - Service Change and Commissioning in Adult Social Care (as detailed in the Board's Terms of Reference agreed by Council);
   - Reducing avoidable admissions to hospital and care homes (as detailed in the Board's Terms of Reference agreed by Council);
   - The transformation of Health and Social Care Services (as detailed in the Board's Terms of Reference agreed by Council);
   - Consultation (across adult social care and health);
   - Health inequalities; and,
   - Leeds Crisis Centre (follow-up on the work from the previous Adult Social Care Scrutiny Board).

2. These were presented as a draft work schedule at the to the September meeting of the Scrutiny Board. **An updated work schedule is attached as Appendix 1**. This should be considered as a live document and may be subject to change, to reflect any changing and/or emerging priorities identified by the Scrutiny Board. As such, it should be noted that the work schedule is likely to be subject to change throughout the municipal year.

3. Attached at **Appendix 2 is the Council's current Forward Plan (1 April 2012 – 31 July 2012)** relating to the Board's portfolio and terms of reference.

4. A summary of each of the main areas of inquiry detailed on the work schedule are presented below:

Reducing smoking

5. The draft Leeds Tobacco Action Plan was presented and discussed by the Scrutiny Board at its previous meeting on 25 January 2012. A summary of the discussion was detailed in the minutes presented to the Scrutiny Board meeting on 29 February 2012. A draft report is presented elsewhere on the agenda.

Service Change and Commissioning in Adult Social Care and Reducing avoidable admissions to hospital and care homes

6. A series of reports about the integration of health and social care services were considered at the Scrutiny Board meeting in February 2012. A summary of the discussion was detailed in the minutes of that meeting presented to the previous Scrutiny Board. These will be used to draft a report on behalf of the Board, which will be presented to a future Scrutiny Board meeting for agreement.

7. Other activity in the area includes general input into the Health Service Developments Working Group, where matters detailed on the Council's forward plan are included as part of the horizon scanning of future service changes/ developments.

The transformation of Health and Social Care Services

8. An update on the work of the Transformation Board and associated projects / work streams that are coordinated by NHS Leeds was presented and considered at the Scrutiny Board meeting in February 2012. A further report detailing the efficiencies generated and re-investment in services resulting from the transformation projects has been requested and is presented elsewhere on the agenda.

9. The Scrutiny Board may wish to consider incorporating this aspect of its work into the report on Service Change and Commissioning in Adult Social Care and Reducing avoidable admissions to hospital and care homes (referred to above).

Scrutiny Board inquiry: Consultation

10. The Board held its second (and final) session associated with this inquiry at its December 2011 meeting. It is intended that a draft report and any associated recommendations will be presented to a future meeting.

Scrutiny Board inquiry: Health inequalities

11. Health inequalities was identified as a specific work area at the Board's meeting in July 2011. To date, the Board has considered the development and production of the Joint Strategic Needs Assessment (JSNA), in addition to some of the data sets available as a result. The Scrutiny Board specifically considered details associated with two specific Medium Super Output Areas (MSOAs) from the City to help highlight and demonstrate the inequalities that exist across the City.

12. It should be noted that draft action plans from the Health and Wellbeing City Priority Plan (2011-15) were presented (for information) to the Shadow Health and Wellbeing Board at its meeting on 26 January 2012, which included Priority Action Plan 4 – Make sure the people who are the poorest improve their health the fastest. This

priority essentially relates to addressing health inequalities across the City. Within this priority area, the following priority actions are outlined with a range of supporting activities:

- Priority Action 4a: Minimise the impact of poverty on health of under 5s
- Priority Action 4b: Action on housing, transport and environment to improve health and wellbeing
- Priority Action 4c: Support people back into work and to healthy employment
- Priority Action 4d: Increase advice and support to minimise debt and maximise income
- Priority Action 4e: Ensure equitable access to services that prevent and reduce ill-health

13. In the main the above priority areas have been used to provide the focus for a series of working group meetings to deliver this aspect of the Scrutiny Board's work.

14. Priority Action 4e: Ensure equitable access to services that prevent and reduce ill-health and specifically the future role of the emerging Clinical Commissioning Groups (CCGs) in Leeds, is included elsewhere on the agenda.

Leeds Crisis Centre (follow-up on the work from the previous Adult Social Care Scrutiny Board)

15. As agreed at the October 2011 meeting, in lieu of an inquiry into the impact of the closure of the Crisis Centre, the Director of Adult Social Care was asked to submit a monitoring report to the Scrutiny Board. This was considered at the previous Scrutiny Board meeting, with a further 6-month progress report requested.

Health Service Developments Working Group

16. In July 2011, the Scrutiny Board established a working group to consider proposed NHS service changes and/or developments and the required level of public engagement and involvement, alongside progress and implementation of agreed developments. Meeting dates and associated arrangements for the new municipal year will need to be considered in the near future.

Request for Scrutiny: Arrangements for meeting needs of blind and visually impaired people in Leeds

17. Following the request for scrutiny received and considered at the October 2011 meeting, a site visit to Fairfax House took place on 9 December 2011 and a working group meeting took place on 16 January 2012. The findings of the working group, along with a series of recommendations were agreed by the Scrutiny Board at it previous meeting (25 January 2012) and presented to the Executive Board on 10 February 2012.

18. Follow-up to this aspect of the Board's work will be scheduled for the new municipal year. It should be noted that in the event of any significant changes to the scrutiny arrangements for the new municipal year, both in terms of membership and remit, this may be subject to discussion and agreement with the relevant Scrutiny Board.

Recommendations

19. To consider the information presented in this report and supporting appendices, in order to amend and/or agree the work schedule detailed at Appendix 1.

Background documents [1]

- None used

[1] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

APPENDIX 1

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

Work Schedule for 2011/2012 Municipal Year

	Schedule of meetings/visits during 2011/12		
	April	**May**	
Area of review (detailed in the Scrutiny Board Terms of Reference)			
Reducing smoking in the over 18s	Draft SB report and recommendations to be agreed		
Service Change and Commissioning in Adult Social Care		Draft SB report and recommendations to be agreed	
Reducing avoidable admissions to hospital and care homes			
The transformation of Health and Social Care Services	Update report from NHS Leeds on efficiency savings and reinvestment	Draft SB report and recommendations to be agreed (TBC)	
Board initiated piece of Scrutiny work (if applicable			
Future options for long term Residential and Day Care Services for Older People			
Consultation (across adult social care and health)		Draft SB report and recommendations to be agreed (TBC)	
Health inequalities		Draft SB report and recommendations to be agreed	
Leeds Crisis Centre			

Key: SB – Scrutiny Board (Health and Well-Being and Adult Social Care) Meeting WG – Working Group Meeting

APPENDIX 1

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

Work Schedule for 2011/2012 Municipal Year

	Schedule of meetings/visits during 2011/12		
	April	**May**	
Request for Scrutiny: Arrangements for meeting needs of blind and visually impaired people in Leeds			
National review of Children's Neurosurgery		Consideration of proposed standards and service specification as part of the preparation for establishing clinical networks (TBC)	
Recommendation Tracking			
Performance Monitoring	Follow-up on matters raised on 21 March 2012.		

Key: SB – Scrutiny Board (Health and Well-Being and Adult Social Care) Meeting WG – Working Group Meeting

Leeds
CITY COUNCIL

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

1 April 2012 – 31 July 2012

LEEDS CITY COUNCIL

FORWARD PLAN OF KEY DECISIONS

For the period 1 April 2012 to 31 July 2012

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)
Award of contract to Leeds Partnership Foundation Trust for the care and support services to adults with learning disabilities To invoke contract procedure rule 31.4 (to allow waiver of contracts procedure rule 13)	Director of Adult Social Services	1/4/12	Department of Health requirement for 2011/12. The following boards were advised of the requirement: • Council Executive Board Report 2009 • Joint Commissioning Strategic Board April 2009 • Leeds Learning Disability Partnership Board 19 June 2009	Report to the Director of Adult Social Services	janet.wright@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)
Leeds Community Equipment Service Partnership Agreement Approval of the Director of Adult Social Services to agree to Leeds City Council continuing to be a partner with NHS Leeds in the provision of community equipment services	Director of Adult Social Services	1/4/12	Adult Social Care, NHS, Children's Service, User Involvement	Report to the Director of Adult Social Services	Sarbjit Kaur katie.cunningham@leeds.gov.uk
Yewtree and Rosewood Extra Care Provision To award a contract to Methodist Homes Association to provide 65 housing tenancies for older people residing in the Moor Allerton extra care housing provision	Director of Adult Social Services	26/4/12	Project Board and the Health and Social Care Executive Board Member	Report to the Director of Adult Social Services	susan.gamblen@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)
Capital Expenditure: Harry Booth House To approve the spend of £585,000, the inclusion of these monies in the capital plan was approved at Exec Board in Feb 2012, for the refurbishment of Harry Booth House to nursing home standard fully funded by Health monies.	Executive Board (Portfolio: Adult Health and Social Care)	16/5/12	Consultation on the change of use for Harry Booth House was undertaken as part of the Better Lives for Older People residential and day care consultation between May and August 2011. The proposal was agreed by the Executive Board in September 2011. The consultation included a full Equalities Impact Assessment of the proposals that formed a part of the Executive Board Report.	The report to be issued to the decision maker with the agenda for the meeting	michele.tynan@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)
Charges for Non-Residential Adult Social Care Services To set out the work undertaken on the further review of charges approved by Executive Board in July 2011 and request Executive Board to approve proposals that will be subject to public consultation	Executive Board (Portfolio: Adult Health and Social Care)	18/7/12	A three-month public consultation period will take place on the proposals before Executive Board is asked to approve any changes. The consultation will involve service users and carers, service user and carer led groups and forums, VCFS organisations, partner organisations, staff and elected members. Consultation methods will be tailored to the stakeholder groups and will include briefing documents, the opportunity to respond in writing or electronically via Talking Point, and group discussions. Elected members are involved in developing the proposals for consultation through a cross party Members Advisory Board	The report to be issued to the decision makerwith the agenda for the meeting	Ann Hill Ann.hill@leeds.gov.uk

NOTES

Key decisions are those executive decisions:

- which result in the authority incurring expenditure or making savings over £250,000 per annum, or
- are likely to have a significant effect on communities living or working in an area comprising two or more wards

Executive Board Portfolios	Executive Member
Resources and Corporate Functions	Councillor Keith Wakefield
Development and the Economy	Councillor Richard Lewis
Environmental Services	Councillor Mark Dobson
Neighbourhoods Housing and Regeneration	Councillor Peter Gruen
Children's Services	Councillor Judith Blake
Leisure	Councillor Adam Ogilvie
Adult Health and Social Care	Councillor Lucinda Yeadon
Leader of the Conservative Group	Councillor Andrew Carter
Leader of the Liberal Democrat Group	Councillor Stewart Golton
Leader of the Morley Borough Indep	Councillor Robert Finnigan

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

LEEDS CITY COUNCIL

BUDGET AND POLICY FRAMEWORK DECISIONS

Decisions	Decision Maker	Expected Date of Decision	Proposed Consultation	Documents to be considered by Decision Maker	Lead Officer
Vision for Leeds	Council	To be confirmed	Via Executive Board, all Scrutiny Boards	Report to be issued to the decision maker with the agenda for the meeting	Assistant Chief Executive (Planning, Policy and Improvement)
Council Business Plan	Council	July 2013	Via Executive Board, all Scrutiny Boards	Report to be issued to the decision maker with the agenda for the meeting	Assistant Chief Executive (Policy, Planning and Improvement)
Health and Wellbeing City Priority Plan	Council	July 2013	Via Executive Board, Scrutiny Board (Health & Wellbeing and Adult Social Care), Leeds Initiative Board, Health and Wellbeing Board	Report to be issued to the decision maker with the agenda for the meeting	Director of Adult Social Care

NOTES:

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

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