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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, 20th February, 2013 at 10.00 am**

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

**MEMBERSHIP**

**Councillors**

| | | |
|---|---|---|
| P Truswell | - | Middleton Park; |
| G Hussain | - | Roundhay; |
| T Murray | - | Garforth and Swillington; |
| J Walker | - | Headingley; |
| C Fox | - | Adel and Wharfedale; |
| K Bruce | - | Rothwell; |
| J Illingworth (Chair) | - | Kirkstall; |
| S Varley | - | Morley South; |
| S Bentley | - | Weetwood; |
| M Robinson | - | Harewood; |
| Vacancy | - | |

**Co-optees**

| | |
|---|---|
| Joy Fisher | Leeds LINk |
| Sally Morgan | Equality Issues |
| Betty Smithson | Leeds LINk |
| Emma Stewart | Alliance of Service Users and Carers |

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

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# A G E N D A

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|---|---|---|---|---|
| 1 | | | **APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS**<br><br>To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded).<br><br>(* 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**<br><br>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.<br><br>2 To consider whether or not to accept the officers recommendation in respect of the above information.<br><br>3 If so, to formally pass the following resolution:-<br><br>**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:-<br>**No exempt items on this agenda.** | |

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| 3 | | | **LATE ITEMS**<br><br>To identify items which have been admitted to the agenda by the Chair for consideration.<br><br>(The special circumstances shall be specified in the minutes.) | |
| 4 | | | **DECLARATION OF DISCLOSABLE PECUNIARY AND OTHER INTERESTS**<br><br>To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-18 of the Members' Code of Conduct. Also to declare any other significant interests which the Member wishes to declare in the public interest, in accordance with paragraphs 19-20 of the Members' Code of Conduct | |
| 5 | | | **APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES**<br><br>To receive any apologies for absence and notification of substitutes. | |
| 6 | | | **MINUTES OF THE PREVIOUS MEETING**<br><br>To confirm as a correct record, the minutes of the meeting held on 23rd January 2013. | 1 - 6 |
| 7 | | | **LOCAL HEALTHWATCH - HEALTHWATCH LEEDS**<br><br>To consider a report of the Head of Scrutiny and Member Development updating the Scrutiny Board on the arrangements for establishing a local HealthWatch organisation in Leeds from April 2013. | 7 - 38 |

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| 8 | | | **PUBLIC HEALTH TRANSITION IN LEEDS**<br><br>To consider a report of the Head of Scrutiny and Member Development providing the Scrutiny Board with an update on the transition and transfer of Public Health responsibilities to Leeds City Council from April 2013. | 39 - 56 |
| 9 | | | **NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE GUIDANCE**<br><br>To consider a report of the Head odf Scrutiny and Member Development providing the Scrutiny Board with an outline of the role of the National Institute for Clinical Excellence (NICE) and recently published guidance aimed at local authorities. | 57 - 60 |
| 10 | | | **WORK SCHEDULE - FEBRUARY 2013**<br><br>To consider a report of the Head of Scrutiny and Member Development on the Board's work schedule for February 2013. | 61 - 76 |
| 11 | | | **DATE AND TIME OF THE NEXT MEETING**<br><br>Wednesday 27th March 2013 at 10.00am in the Civic Hall, Leeds<br>(Pre meeting for Board Members at 9.30am) | |

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

**WEDNESDAY, 23RD JANUARY, 2013**

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

Councillors S Bentley, K Bruce, C Fox, T Murray, P Truswell, S Varley and J Walker

**CO-OPTED MEMBERS**:

Joy Fisher, Leeds LINk
Sally Morgan, Equality Issues
Emma Stewart, Alliance of Service Users and Carers

**75 Chair's Opening Remarks**

The Chair welcomed everyone to the January meeting of the Scrutiny Board (Health and Well-being and Adult Social Care).

**76 Declaration of Disclosable Pecuniary and other Interests**

Joy Fisher declared an interest in relation to the item regarding Services for Blind and Visually Impaired People in Leeds (Minute 79 refers) due to her alliance role with the National Federation of the Blind (Leeds Branch).

**77 Apologies for Absence and Notification of Substitutes**

Apologies for absence were received on behalf of Councillors S Armitage, G Hussain, M Robinson and Mrs B Smithson.

There were no substitute members in attendance.

**78 Minutes of the Previous Meeting**

**RESOLVED –** That the minutes of the meetings held on 21st November 2012 and 19th December 2012 be confirmed as a correct record.

**79 Services for Blind and Visually Impaired People in Leeds**

Referring to Minute 40 of the meeting held 26 September 2012, the Head of Scrutiny and Member Development submitted a report on recent correspondence received from the acting Chair of the National Federation of the Blind (Leeds and District Branch), in order that the Scrutiny Board might determine what, if any, further scrutiny activity may be required.

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

- Update on recommendations following deputation to Scrutiny by the National Federation of the Blind (16 January 2012) – Report of Director of Adult Social Services – Scrutiny Board (Health and Wellbeing and Adult Social Care) – dated 25 July 2012, but considered at the meeting held on 26 September 2012.
- Letter from Acting Chair, National Federation of the Blind (Leeds and District Branch) to the Board's Principal Scrutiny Adviser dated 9 November 2012.

The following representatives were in attendance and responded to Member's queries and comments:

- Hilary Adolfson (Chair Person), National Federation of the Blind (Leeds and District Branch)
- Ann Steel (Treasurer) – National Federation of the Blind (Leeds and District Branch)

The Board's Principal Scrutiny Adviser presented the report and provided a brief update to the meeting.

At the request of the Chair, Ms Steel outlined the concerns which were detailed in the letter dated 9 November 2012 which was appended to the report. In addition to the concerns outlined in the letter, Ms Steel also informed the Board that, in the view of the National Federation of the Blind (Leeds and District Branch), services for blind and visually impaired people in Leeds had deteriorated since the award of the new contract and the closure of Shire View had resulted in a detrimental effect on all service users. Specific issues highlighted included:

- Service user views (from previous service users) regarding the new arrangements;
- Service user consultation (prior to new contract arrangements being ut in place);
- Delayed decisions regarding the future of Shire View;
- Arrangements for signposting newly registered deafblind to services (e.g. accommodation based services at Fairfax House);

It was suggested that the Scrutiny Board may wish to consider undertaking (or requesting) a full impact assessment for the Deafblind, Blind and partially sighted as a matter of urgency.

In summary, specific reference was made to the following issues:-

- Clarification of the number of service users using the service under the new contract arrangements
- The view expressed that an impact assessment was the right course of action to fully assess the impact of the recent changes to service/ award of the contract
- The loss of the facility at Shire View had, in the view of the National Federation of the Blind (Leeds and District Branch), resulted in a loss

of specific social groups and general cohesion among some members of the deafblind, blind and visually impaired communities.
- The impact on the number / location of social groups previously housed at Shire View, the associated costs and available support.
- The need for a building to be centrally accessible where a social environment could take place with little or no segregation.
- The need for further dialogue between service users and relevant officers from Adult Social Care regarding current arrangements and service provision.

In concluding, the Chair invited representatives from the National Federation of the Blind (Leeds and District Branch) to submit further written details of their concerns to the Principal Scrutiny Adviser for submission to Adult Social Care for a response to be provided to a working group on a date to be determined.

**RESOLVED**-

a) That the contents of the report and appendices be noted.
b) That the Services for Blind and Visually Impaired People in Leeds issue be referred to a working group for detailed discussion upon the confirmation of the issues raised by the National Federation of the Blind (Leeds Branch), together with the response from Adult Social Care.

**80 Dementia in Leeds**

Referring to Minute 21 of the 25th July 2012 meeting, the Head of Scrutiny and Member Development submitted a report providing an update on the progress of the Leeds' draft Dementia Strategy – *Living Well with Dementia in Leeds (2012-2015)* and an overview of work to date and future plans for dementia-friendly Leeds.

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

- Living Well with Dementia in Leeds – Our Local Strategy (2012-2015) – Consultation Response to Draft Strategy (Appendix 1 refers)
- Dementia-friendly Leeds – Report of Director of Adult Social Services and Director of Public Health – Executive Board – 9th January 2013 (Appendix 2 refers)

The following representatives were in attendance:

- Councillor Christine Macniven (Chair) – Leeds Dementia Board
- Mick Ward (Head of Commissioning) – Leeds City Council, Adult Social Services
- Tim Sanders (Integrated Commissioning and Transformation Manager, Dementia) – NHS Leeds and Leeds City Council

At the request of the Chair, the Head of Commissioning briefly outlined the background issues and informed the meeting that a number of useful comments made at the July 2012 meeting had been incorporated within the Draft Strategy.

The Integrated Commissioning and Transformation Manager, Dementia provided the meeting with a summary of the key issues contained in the Executive Board report discussed at the meeting held on 9 January 2013. Specific issues raised included:

- Dementia Strategy and action plan due to be presented to the Dementia Board on 30 January 2013;
- Short-term grant funding for over 20 neighbourhood networks and other third sector partners to support work around dementia;
- Double capacity with the Council's peer support service;
- Additional carer support worker at NHS Leeds

Councillor Macniven also addressed the Board and welcomed the fact that the Clinical Commissioning Groups (CCG's) were setting targets towards the outcomes of dementia in Leeds and highlighted proposals for the Rothwell area to work towards becoming a dementia friendly area, building on the work already undertaken in the dementia friendly café in the area.

Members of the Scrutiny Board discussed the information presented and issues around dementia in general. In summary, specific reference was made to the following issues:

- Explicit support for carers within the overall strategy;
- Costs and funding (both short and longer-term), associated with implementing the finalised strategy and supporting delivery plan;
- Early diagnosis and targeted screening across the City;
- Raising awareness of the 'Dementia Friendly City' aspiration – and the practical implications;
- The impact of increased diagnosis and demand for services;
- Issues associated with staff awareness and training around dementia, not just across the health and social care sector;
- The role of advocacy work, including the power of attorney, to help support dementia suffers.

The Scrutiny Board noted that many of the issues raised at the meeting would be incorporated within the finalised strategy and delivery plan and that discussions were on-going between Leeds City Council and its partners around funding issues.

In concluding discussions, the intention to report back to the Scrutiny Board the finalised strategy and delivery/ action plan was noted. It was suggested that following receipt and consideration of the finalised documents, the Scrutiny Board might then identify any particular or specific areas on which to focus in the future.

**RESOLVED**-

a) That the contents of the report and appendices be noted.
b) That the Director of Adult Social Services be requested to submit a further report to a future meeting, presenting the finalised Leeds' Dementia Strategy and Action Plan.

**81 Work Schedule - January 2013**

The Head of Scrutiny and Member Development submitted a report which presented the Scrutiny Board's outline work schedule for the remainder of the current municipal year.

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

- Scrutiny Board (Health and Wellbeing and Adult Social Care) 2012/13 Municipal Year – Work Schedule (Appendix 1 refers)
- Executive Board minutes of meeting held on 9th January 2013 (Appendix 2 refers)

The Principal Scrutiny Adviser informed the Board that he had received the following documents as at today's date:

- Yorkshire Ambulance Service – Information for Stakeholders – Proposal to Relocate the YAS Hazardous Area Response Team (HART) Base in Yorkshire
- Authorisation of Clinical Commissioning Groups (CCG) in Leeds – Letter from the NHS dated 23 January 2013

He informed the meeting that in relation to the Yorkshire Ambulance Service, the deadline for specific questions was 25th January 2013. At the request of the Board he agreed to consult with Yorkshire Ambulance Service regarding future service proposals and consultation with the Scrutiny Board.

The Scrutiny Board also discussed the changing local NHS landscape in terms of organisations and future responsibilities. This included discussions around the following areas:

- The local Clinical Commissioning Groups (CCGs);
- *Convening a meeting (or series of meetings) of the* Health Service Development Working Group; The development of local HealthWatch and transition between the existing Local Involvement Network;
- The transfer of Public Health responsibilities to the Council from April 2013 and associated transitional arrangements;

**RESOLVED** –

a) That the contents of the report and appendices, including the Executive Board minutes presented, be noted.
b) That, with the inclusion of the areas identified at the meeting, the work schedule as presented be approved.

c) That in relation to the issue regarding the authorisation of Clinical Commissioning Groups (CCG) in Leeds, this matter be referred to a working group for detailed discussion and to invite appropriate representatives to attend. That the Services for Blind and Visually Impaired People in Leeds issue be referred to a working group for detailed discussion upon the confirmation of the issues raised by the National Federation of the Blind (Leeds Branch), together with the department's response.
d) That reports regarding the future arrangements for local HealthWatch and Public Health be requested for the February meeting of the Board.

**82 Date and Time of the Next Meeting**

Wednesday 20th February 2013 at 10.00am in the Civic Hall, Leeds
(Pre meeting for Board Members at 9.30am)

(The meeting concluded at 12 noon)

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

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

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

**Date: 20 February 2013**

**Subject: Local HealthWatch – HealthWatch Leeds**

| | | |
|---|---|---|
| Are specific electoral Wards affected?<br>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?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☒ No |

## 1 Purpose of this report

1.1 The purpose of this report is to update the Scrutiny Board (Health and Wellbeing and Adult Social Care) on the arrangements for establishing a local HealthWatch organisation in Leeds from April 2013.

## 2 Main issues

2.1 At is meeting in January 2013, the Scrutiny Board requested an update on the progress towards establishing a local HealthWatch organisation in Leeds from April 2013, including any transitional arrangements necessary to ensure a smooth transition from Leeds Local Involvement Network (LINk) to the new organisation.

2.2 Attached at Annex A is a report from the Director of Adult Social Services that:

- Updates the Scrutiny Board on the procurement of a local Healthwatch organisation for Leeds (to be known as Healthwatch Leeds).
- Advices the Scrutiny Board of the next steps for the transition from the Leeds Local Involvement Network to Healthwatch Leeds.
- Proposes arrangements for the development of the relationship between the Scrutiny Board (Health and Wellbeing and Adult Social Care), the Scrutiny Board (Children and Families), the Health and Wellbeing Board and Healthwatch Leeds.

2.3 Appropriate officers from Adult Social Care will be in attendance to present the report and address any queries identified by the Scrutiny Board.

2.4 In addition, representatives from the Touchstone Consortium have also been invited to attend the meeting to

- Help discuss the new (emerging) local HealthWatch arrangements;
- Provide an overview of the initial work to be done during the mobilisation period; and,
- Commence the dialogue about how Leeds HealthWatch and the Scrutiny Board might work together.

Arrangements for effective local HealthWatch

2.5 As outlines in the report from the Director of Adult Social Services, in July 2012 the Centre for Public Scrutiny (CfPS) undertook a `Scrutiny Development Area` project with the Scrutiny Board in relation to the emerging roles of Scrutiny Board and local Healthwatch and how an effective relationship can be established and maintained. The notes from that project are attached at Appendix 1 of the report from the Director of Adult Social Services.

2.6 In addition, the CfPS have produced a guide '10 questions to ask if you're scrutinising arrangements for effective local Healthwatch'. The guide, attached as Annex B for information, is designed to help Health Overview and Scrutiny Committees develop a range of high-level questions around arrangements for local Healthwatch. The guide aims to cover all the relevant issues, however it not be relevant to ask all the questions listed and/or to follow the sections sequentially.

Other considerations

2.7 Members will be aware (in broad terms) that the report of the full public inquiry into the failings at the Mid Staffordshire Foundation Trust was published on 6 February 2013. The inquiry, led by Robert Francis QC, looks at the role of commissioning, supervisory and regulatory bodies and why serious problems at the trust were not identified and acted on sooner.

2.8 While the formal Government response is awaited, which may include subsequent legislative changes, from the summary the CfPS have identified the following key recommendations affecting Scrutiny directly:

***Rec 47*** *The Care Quality Commission should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information resource. For example, it should further develop its current 'sounding board events'.*

***Rec 119*** *Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.*

***Rec 147*** *Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.*

***Rec 149*** *Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.*

***Rec 150*** *Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should*

*actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action.*

***Rec 246** Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch.*

2.9 While the formal Government response to the Francis Inquiry is awaited, which may include subsequent legislative changes, and the Scrutiny Board may wish to give more detailed consideration to the implications of the Francis Inquiry at an appropriate time in the future, these details may usefully help inform the discussion around local HealthWatch at this time.

## 3 Recommendations

3.1 Members are asked to consider the details presented in this report and discussed at the meeting and determine any appropriate further scrutiny activity at this time.

## 4 Background papers[1]

None used

[1]The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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Leeds CITY COUNCIL

Report author: Janet Somers
Tel: 2478690

**Report of: Director of Adult Social Services**

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

**Date: 20th February 2013**

**Subject: Healthwatch Leeds**

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

**Summary of main issues**

1. In January 2012 a delegated decision was made to undertake a procurement exercise in Leeds to commission a local Healthwatch organisation. The procurement exercise is now complete and a preferred bidder has been identified.

2. The contract will be awarded on or around February 8th 2013, following the call-in period which ends on February 4th 2013. From the date that the contract is awarded, that is from early February to the end of March 2013 (known as the mobilisation period); Officers will work with the preferred bidder and the Leeds Local Involvement Network (LINk) to ensure an effective transition from the LINk to Healthwatch Leeds.

3. As the procurement process has been completed and the transition from the Leeds LINk to Healthwatch Leeds is underway, we can look forward to what an established local Healthwatch will look like post 1st April 2013 and how it is starting to influence the commissioning and provision of local health and social care services.

4. Healthwatch Leeds will not solely be responsible for this, the Scrutiny Boards (Health and Well-Being and Adult Social Care, and Children and Families) and the Health and Wellbeing Board also have a role to play in the way that local services are planned and delivered. How they interact with each other will have a direct influence on improving outcomes for communities and people who use services.

**Recommendations**

5. The Board is asked to:

5.1. Note the contents of this report.

5.2. Consider the proposals to work in partnership with Healthwatch Leeds and the Health and Wellbeing Board to develop clarity around roles and responsibilities and to develop a collaborative way of working.

5.3. Consider inviting representatives of Healthwatch Leeds' independent Board to provide an update on their strategic vision and direction at an appropriate time.

## 1 Purpose of this report

1.1 To update the Scrutiny Board on the procurement of a local Healthwatch organisation for Leeds (to be known as Healthwatch Leeds).

1.2 To inform the Scrutiny Board of the next steps for the transition from the Leeds Local Involvement Network to Healthwatch Leeds.

1.3 To propose arrangements for the development of the relationship between this Scrutiny Board, Scrutiny Board (Children and Families), the Health and Wellbeing Board and Healthwatch Leeds, for the purpose of improving outcomes for communities and the people of Leeds in relation to their health and social care needs.

## 2 Background information

2.1 The Health and Social Care Act 2012, makes provision for the establishment of local Healthwatch organisations in all 152 local authority areas. Local Authorities are under a duty to ensure that there is an efficient and effective local Healthwatch organisation in their areas by April 1st 2013.

2.2 Local Healthwatch organisations will replace Local Involvement Networks (LINKs), which will cease to operate on March 31st 2013. The duties, roles and responsibilities of the LINk will transfer to local Healthwatch, which will also be given new roles and responsibilities under the Act. These are:

- local Healthwatch will be a corporate body carrying out statutory functions;
- having a statutory seat on the Health and Wellbeing Board;
- being integral to the preparation of the Joint Strategic Needs Assessment and the Leeds Joint Health and Wellbeing Strategy;
- provide information and advice to the public about accessing health and social care services and choice in relation to these services;
- make the views and experiences of people known to Healthwatch England helping it carry out its role as national champion;
- make recommendations to the Care Quality Commission to carry out special reviews or investigations into areas of concern;
- Apart from enter and view activities, all of the local Healthwatch services will be available to children and young people.

2.3 In November/December 2011 the Council consulted with its NHS partner organisations on the options available to the local authority to commission local Healthwatch. In addition, we undertook benchmarking work with other local

authorities in the Yorkshire & Humberside region regarding their preferred option for commissioning local Healthwatch.

2.4 The outcome of this engagement was reported to the Director of Adult Social Services on December 5th 2011 for a delegated decision. The decision was made to undertake a procurement exercise for delivering Healthwatch Leeds.

2.5 In July 2012 the Centre for Public Scrutiny undertook a `Scrutiny Development Area` project with the Scrutiny Board in relation to the emerging roles of Scrutiny Board and local Healthwatch and how an effective relationship can be established and maintained. The notes from that project are attached at Appendix 1 for information.

2.6 A two stage procurement exercise was undertaken in 2012. Seven organisations/consortia were successful at the Pre-Qualification Stage (PQQ) and 5 of these organisations/consortia submitted a tender bid at the Invitation to Tender stage.

2.7 The outcome of the procurement exercise was that a preferred bidder was identified, and the Delegated Decision Notice was signed on the 14th January 2013. The decision is subject to call-in and this period ends February 4th 2013.

2.8 The preferred bidder for Healthwatch Leeds is the Touchstone Consortium, which includes Leeds Involving People, Leeds Metropolitan University and Inclusion North.

2.9 The Touchstone Consortium will be awarded a licence by the Care Quality Commission, to operate as Healthwatch Leeds on the 1st April 2013.

2.10 The Health and Social Care Act 2012 also imposes a responsibility on local authorities to commission NHS Complaints Advocacy from 1st April 2013, with the freedom to decide how to commission, based on local circumstances and need.

2.11 In Leeds the decision was made to commission NHS Complaints Advocacy from the advocacy consortium, Advonet. One of the signposting functions of Healthwatch Leeds will be to refer people to the NHS Complaints Service, should it be needed/required. The contract with Advonet clearly states that it will work with Healthwatch Leeds and will provide it with information relating to the use of its service.

## 3 Main issues

3.1 The main ambition for local Healthwatch is that they drive up the quality of local services resulting in improved experience and outcomes for the people who use them. The main resources that local Healthwatch will have to achieve this will be the people involved in them and the knowledge, skills and competencies that they bring or develop during their involvement.

3.2 The formation of Healthwatch Leeds is not happening from scratch. There is a history of patient and public involvement in health and social care which have developed over many years, the most recent structure being LINks. Since their

creation in 2008, LINks have done considerable work building valuable relationships and expertise that need to be transferred to Healthwatch Leeds.

3.3 Leeds City Council is therefore committed to the successful transition of the current LINk members/volunteers and their identified work plan priorities, into Healthwatch Leeds. Like the Department of Health, the authority wishes to ensure that there is continuity of existing arrangements.

3.4 In addition to the outcomes which are required to be delivered by Healthwatch Leeds (please refer to Appendix 2), the Service Specification for Healthwatch Leeds, requires the following:

- that the preferred bidder works with the local authority, the LINk and the LINk Host organisation to prepare a Transition Plan for the transfer of LINk volunteers who wish to have a role in Healthwatch Leeds.

- that arrangements be made to transfer the Leeds LINk knowledge base across to Healthwatch Leeds for April 1st 2013; and

- that the on-going projects and activities identified by the LINk forms part of Healthwatch Leeds' initial Work Plan.

3.5 In 2012 a `Looking Forward with LINk and Healthwatch` event was held for the members/volunteers of the Leeds LINk, assisted by an Officer from Adult Social Care. There were two main aspects to the event: identifying the projects and activities that the Leeds LINk would seek to transfer to Healthwatch Leeds; and identifying issues relating to the transfer of volunteers to Healthwatch Leeds.

3.6 The outcomes of the event will be shared with the preferred bidder and will form the basis of the Transition Plan. The local authority, the Leeds LINk, the LINk Host organisation and the preferred bidder will meet as soon as possible after the award of the contract to take this issue forward.

3.7 Volunteers from the Leeds LINk, from other existing networks and from the general public will have a range of volunteering opportunities available to them in Healthwatch Leeds, and they will be supported by a training, development and supervision plan.

3.8 To support the transition to Healthwatch Leeds and the implementation of Healthwatch Leeds on April 1st 2013, a Healthwatch Implementation Steering Group has been established, with representatives from relevant organisations to assist in the delivery of some additional key functions and arrangements, other than the transfer of the LINk legacy, which includes:

- The development and the establishment of an initial information, advice and signposting service.

- The development of KPIs to ensure that Healthwatch Leeds meets the stated contract/service outcomes.

- Developing partnership working with key organisations and Boards such as the Health and Wellbeing Board and the Health and Well-being and Adult Social Care Scrutiny Board. This will enable us to better understand the independent but complimentary roles and responsibilities of the Boards and Healthwatch Leeds and to ensure that they work together in a collaborative way.

- Development of the initial Work Plan. The service specification requires Healthwatch Leeds to develop its annual work plan in a collaborative way with voluntary and community groups, the local authority, health agencies and other partners. Evidence must be provided that the programme of activity is based on local priorities that meet local need.

3.9 The Health and Social Care Act 2012 has brought unprecedented change, leading to hundreds of bodies being abolished, created or restructured. The new system comes into force in April 2013. This will lead to a number of new obligations for the local authority, including a duty to commission a local Healthwatch organisation and an independent NHS Complaints Advocacy service for Leeds.

3.10 Whilst the Act is set and the new system is beginning to emerge, there is still much that is not yet clear. Secondary legislation and guidance has been provided in respect of Healthwatch and NHS Complaints Advocacy, but is still anticipated for other areas. Some of the new organisations have been established for several months in `shadow` form but are still identifying priorities, establishing their own understanding of the new system and where they fit in.

3.11 Despite the uncertainty, this provides us with an opportunity to shape roles and relationships; to look at how the Boards and Healthwatch Leeds can work collaboratively to avoid duplication and to improve outcomes for communities and people who use services.

## 4 Corporate Considerations

### 4.1 Consultation and Engagement

4.1.1 A range of stakeholders have been involved in the development and procurement of Healthwatch Leeds through their representation on the Project Team, the Evaluation Panel, the Project Board and the Healthwatch Leeds Steering Group. This includes representatives from the Third Sector, NHS Commissioning and Provider organisations (existing and emerging), Children's services and lay people.

4.1.2 The local authority has engaged with a broad range of stakeholders using a variety of methodologies to enable effective engagement including:

- Leeds LINk members/volunteers

- Service Users, Carers, patients and the general public

- Members of the Healthy Leeds and Healthy Leeds Lives networks

- The Third Sector and the communities that they support
- Elected members including a Cross Party Advisory Panel
- Health and Well-Being and Adult Social Care Scrutiny Board. Two Healthwatch development sessions were held with members of the Board, supported/facilitated by Officers and the Centre for Public Scrutiny.
- Partner organisations including NHS current and emerging commissioning and provider organisations.
- Benchmarking with other local authorities

4.1.3 The outcomes of the consultation and engagement activity have informed the production of the service specification and the questions asked of bidders during the procurement process. In addition to this, the successful tenderer will be provided with details of the outcomes of the engagement activity that has taken place to help inform service delivery.

4.1.4 Members Briefings were provided at key points throughout the procurement exercise to ensure that Elected Members were kept fully informed of developments.

**4.2 Equality and Diversity / Cohesion and Integration**

4.2.1 An Equality, Diversity, Cohesion and Integration Screening has been undertaken and was completed in December 2012.

4.2.2 The screening tool outlined the consultation and engagement activity that had been undertaken to inform the development of the service specification and the questions to be asked of organisations at the Invitation to Tender stage. It identifies some of the different communities that we have engaged with.

4.2.3 The service specification and contractual Terms and Conditions identify and stipulate the need for services that are accessible to all the people of Leeds to ensure that they have access to the information and advice that they need and to enable them to share their views Healthwatch Leeds.

4.2.4 In addition, Healthwatch Leeds will be required to ensure that its governance arrangements are inclusive of the different communities of Leeds, ensuring that people are involved in the decision making as well as providing their views about services.

4.2.5 The service will be expected to provide evidence to demonstrate that Healthwatch Leeds is recognised as an effective and inclusive brand, championing health and social care issues and best practice and that it can demonstrate appropriate engagement techniques and accessibility towards all residents of Leeds including children, younger people, adults, older people and carers. (This will need to include individual representation and engagement of representative groups).

**4.3 Council policies and City Priorities**

4.3.1 The Health and Social Care Act requires all local authorities to have a local Healthwatch organisation in place by the 1st April 2013. Healthwatch Leeds will be a statutory partner of the Health and Well Being Board, and as such will work with partner organisations to develop and implement the Joint Strategic Needs Assessment and the Leeds Joint Health and Well Being Strategy.

4.3.2 Healthwatch Leeds will be a key organisation in ensuring that for Leeds to be the best city, we need to make sure that the health and wellbeing of the people of Leeds can thrive and this means making sure that the people can access high quality health and social care services.

Healthwatch Leeds will contribute towards the City Priority Plan 2011 – 2015, ensuring that Leeds is the:

i) Best City…for Health and Well Being. For Leeds to be the best city, we need to make sure that the health and wellbeing of the people of Leeds can thrive and this means making sure that the people can access high quality health and social care services. In addition, through the provision of its information, advice and signposting service, it will help to ensure that people have more choice and control over their health and social care services;
ii) Best City… for Children and Young people, helping to ensure that the voices, needs and priorities of children and young people are heard and inform the way that we make decisions and take action in relation to health and social care services.
iii) Leeds is the Best City… for Business. Healthwatch Leeds will develop a volunteer base that will assist people in developing skills. In addition it will offer a certificate for volunteering in its organisation that will assist people in accessing job opportunities.
iv) Best City for…communities. Healthwatch Leeds will develop opportunities for communities to be involved in health and social care services and in the setting of local and national policy in these service areas.

**4.4 Resources and value for money**

4.4.1 Funding for Healthwatch Leeds will be through the government's grant allocation to local authorities and so will not be ring fenced. At the time of going out to tender (November 2012) the indicative funding was £297,000 (previously paid to LINks) and £164,000 for the provision of information and advice. Confirmation of the funding will not be available until January/February 2013.

4.4.2 The government has indicated what funding will be available for local Healthwatch organisations, until 31st of March 2015 only, as this is in line with the timetable for government's spending review. Following the spending review, local authorities will be notified of any changes to the funding for local Healthwatch organisations.

4.4.3 The services provide regular performance monitoring information to demonstrate the quality of support offered. Performance will be measured against a number of key outcomes, details of which are attached in Appendix 2.

## 4.5 Legal Implications, Access to Information and Call In

4.5.1 A Designated Decision Notification has been signed off by the decision maker and was subject to call-in. The call-in period ended Monday February 4th 2013.

## 4.6 Risk Management

4.6.1 This procurement process was conducted in accordance with the Council's Contract Procedure Rules in order to ensure that a fair, open and transparent process was undertaken.

4.6.2 A risk register was created this was updated and presented to the Project Board at regular intervals.

## 5 Conclusions

5.1 We have undertaken a robust procurement exercise to identify a suitable provider for the Healthwatch Leeds contract. The recommended organisation has demonstrated its ability to meet the requirements of the service specification and the identified outcomes of the service.

5.2 We will be working with the Leeds LINk and the Touchstone consortium to ensure a smooth and effective transition.

## 6 Recommendations

6.1 The Board is asked to:

6.1.2 Note the contents of this report.

6.1.3 Consider the proposals to work in partnership with Healthwatch Leeds and the Health and Wellbeing Board to develop clarity around roles and responsibilities and to develop a collaborative way of working.

6.1.4 Consider inviting representatives of Healthwatch Leeds' independent Board to provide an update on their strategic vision and direction at an appropriate time.

Background documents[1]

None

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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# Scrutiny Board (Health and Wellbeing and Adult Social Care)

## Healthwatch workshops 23 and 30 July 2012

## What is Healthwatch?

- Healthwatch **is the new consumer champion for both health and social care.**
- **Its prime role is to influence commissioners and outcomes for patients – using patient ad public involvement as a tool to this end.**

## Process

We held two workshops:

- To feed into the tender process for Healthwatch
- To develop ideas for future working together with Healthwatch

Each workshop comprised briefings on the context for Healthwatch and the developing tender process, with group discussions on the way forward and next steps.

## Notes from discussions and group work:

## What do we want local Healthwatch to be?

- "representative" – but need to be clear what this means – groups? Ages? Ethnicity? Geography?
- a body that does not duplicate others
- able to tap into and take forward LINk work and networks
- "the go to agency of choice for bodies seeking patient and public views, eg CCGs
- the focal point for information and advice
- accountable
- "Independent" – of the Council etc
- well linked with the Scrutiny Board for Health And Wellbeing and Adult Social Care – should a Member from this sit on Healthwatch?
- A good communicator as it needs to try and ensure that (all of) the citizens of Leeds are aware of what it is and what it does
- Effective at raising awareness of its role among patients, patient groups, and the general public.
- Effective at influencing quality in the NHS
- Not too large a governing body as to be unwieldy.

**What do we want local Healthwatch to do?**

- Build on LINks role and networks – encourage LINk Members to get involved in Healthwatch
- Find creative ways to involve in a wider range of people eg young people, minority ethnic groups, 3rd sector
- If appropriate, incorporate other providers and other existing provision in the Healthwatch brand (eg 3rd sector information providers)
- "Add value" – focussing on outcomes and improving the patient experience rather than rather than (just) data-gathering
- Influence the Health and Wellbeing Strategy, which itself will flow from the Joint Strategic Needs Assessment
- Recognise and manage conflicts of interest
- Manage expectations – be realistic!
- Able to spot themes and patterns and bring them to the attention of appropriate bodies eg the providers, CQC, the Health and Wellbeing Board, the Scrutiny Board for Health And Wellbeing and Adult Social Care
- Build effective partnerships with elected members, for example Area Committees.
- Engage more with communities
- Bring together information on people's experience of using complaints processes
- Help people with early stages of their complaints – if capacity
- Align (some of) their work with the City's health priorities such as reducing obesity and health inequalities; promote the public health agenda.
- Link with other statutory and other organisations that commission or provide services that influence the wider health determinants.

There was a recognition that things take time – the CHC achieved impact and recognition partly because it was around for 30 years. It is important to be realistic about what can be achieved how fast.

There was a concern that LINks may lose members and momentum in the transition period.

There was also a concern about risks due to the very tight timescales, which had arisen from central government's changes to specifications and processes.

It was noted that scrutineers generally suffer from the lack of a budget for research and effectively rely on the capacity of the body(s) scrutinised to provide information – no easy answer was forthcoming

**Specifics that we would like to contribute to the tender for bids to provide the Healthwatch service– which is to be evaluated on quality rather than price**

Questions for tender bidders which could form part of the qualitative tender evaluation process and tap into their creativity and innovation:

Please state what ideas you have on:

- How will you address the challenge of raising awareness of Healthwatch's role?
- How would you plan to develop and grow a "representative" body?
- How will you be inclusive of the "harder to reach/hear" groups?
- How can you demonstrate that you will recruit officers who have a genuine interest in health and social care?
- How will you assure the independence of Healthwatch so that it is able robustly to challenge the Council as a service provider and commissioner?
- How will you determine the priorities of the new body?
- How will you build partnership relationships eg with the Scrutiny Board (Health And Wellbeing and Adult Social Care)
- (If appropriate) how will you demonstrate skills in complaints advocacy and resource providing support at all stages of a complaint?

The issue of the Healthwatch Leeds governing body was discussed in terms of who would be a member and in what capacity. The potential role for a member of Scrutiny, the Director of Public Health and Elected Members (portfolio holder) was briefly discussed.

**Additions to draft Healthwatch values and behaviours requested by the Members of the Scrutiny Board:**

Values: Empowering people and communities – and the voluntary sector
Behaviours: focusing on integrated care pathway outcomes.

**Ideas for working together with Local Healthwatch**

- Exchange our schedules of meetings

- July meeting (annually) to consider programme ideas and prioritise together. Agree who can best do what - could be stages along the commissioning route, Review of a condition/patient pathway, etc.

- Sustain the practice of having 2 co-optees from Link on Scrutiny Board – and ask Healthwatch to reciprocate. Create a spec of what are the expectations of co-ioptees.

- Proactively invite Healthwatch members to observe a Scrutiny Board meeting (and vice versa), explain expectations/what they will be expected to do, and hold brief social event at the end

- Hold a Scrutiny Board meeting at Healthwatch premises?

- Make joint visits to organisations eg to hear staff concerns after CQC has flagged up a possible issue,

- Possible joint workshops

- Possible protocol (short) to capture ideas for good working relationships – no existing protocols.

**July 2012**

**APPENDIX 2**

# Healthwatch Leeds Performance Outcomes

i) Health and social care services are demonstrably influenced by the impact of the consumer voice, co-ordinated through Healthwatch Leeds and measurable outputs can be evidenced.

ii) A strong consumer voice for health and social care is effectively championed at Health and Wellbeing Board meetings.

iii) Healthwatch Leeds is recognised as an effective and inclusive brand, championing health and social care issues and best practice.

iv) Healthwatch Leeds develops strong and effective relationships with commissioners and providers of health and social care.

v) Through Healthwatch Leeds residents of Leeds have straightforward access to the support, advice and information they need to give them choice and control about health and social care service.

vi) Through Healthwatch Leeds, residents of Leeds feedback on improved customer experiences of health and social care services and greater satisfaction in health and social care provision.

vii) Healthwatch Leeds can demonstrate appropriate engagement techniques and accessibility towards all residents of Leeds including children, younger people, adults, older people and carers. (This will need to include individual representation and engagement of representative groups).

viii) The LINk volunteers that choose to migrate to Healthwatch Leeds are retained, new volunteers are actively recruited and leadership, opportunities and development for volunteering is provided in the context of public and patient involvement.

ix) It is easier for people and communities to understand the range of ways to be involved in health and social care services, for example membership of Foundation Trusts, Patient and Public Involvement Groups.

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# 10 questions to ask if you're scrutinising...

cfps Centre for Public Scrutiny
accountability, transparency, involvement

# ...arrangements for effective local Healthwatch

## The Centre for Public Scrutiny

The Centre for Public Scrutiny is an independent charity that promotes transparent, inclusive and accountable public services and celebrates excellent and effective scrutiny across the public sector. We support individuals, organisations and communities by creating networks and forums and sharing learning through published guidance, consultancy, training and events. Our website www.cfps.org.uk contains the largest online collection of scrutiny reviews and reports as well as other resources that show more about what scrutiny can do for you.

# Contents

# Introduction

This guide is one of a series designed to help Overview and Scrutiny Committees (OSCs) carry out their scrutiny work around various healthcare, social care and health improvement topics.

This guide is designed to help OSCs develop a range of high-level questions around arrangements for local Healthwatch. The aim of the guide is to help OSCs learn from the experiences of others and to assist them to scope scrutiny reviews, based on some key questions. It aims to cover all the relevant issues, but please adapt it to suit local circumstances. For example, it may not be relevant to ask all the questions listed here or to follow the sections sequentially

## Why should Overview and Scrutiny Committees review arrangements for effective local Healthwatch?

Greater involvement of local people is at the heart of the Government's agenda to modernise health and social care. The White Paper 'Equity and Excellence' (Department of Health, 2010) made a commitment to put local clinicians and communities at the heart of the planning and delivery of healthcare, social care and health improvement. This approach aims to strengthen the development of services by empowering people who use services and the public to influence the services they receive and to shape the future pattern of health and social care in their areas.

Local Healthwatch will have a key role in strengthening the voices of people who use services and communities, building on the experience of Local Involvement Networks.

Local Healthwatch will have a stake in Health and Wellbeing Boards and will also be a component of the local 'web of accountability'. Overview and scrutiny committees (OSCs) have an interest in ensuring that the arrangements for local Healthwatch are effective in their areas.

## Legal framework for local Healthwatch

Under the Health and Social Care Bill[1], local Healthwatch will be established through a duty placed on local authorities with social care responsibilities to secure that a local Healthwatch organisation carries out activities in their areas and that the arrangements operate effectively and represent value for money. The Secretary of State for Health has provided funding through the Area Based Grant to support the development of local Healthwatch.

## Useful Information

### Healthwatch Transition Plan

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126325.pdf

### Guidance

http://healthandcare.dh.gov.uk/guidance-on-developing-local-healthwatch-groups/

### Smoothing the way – Developing local Healthcare through lessons from local involvement networks

http://www.cfps.org.uk/publications?item=6999&offset=125

1 As at November 2011 the Health and Social Care Bill was subject to Parliamentary Approval

## Councils and local Healthwatch

Subject to Parliamentary approval, relationships between local Healthwatch and councils are likely to operate at a number of levels:

1. Local Healthwatch organisations commissioned by councils that will judge whether local Healthwatch operates effectively and provides value for money.

2. Local Healthwatch referring issues about health and social care services to appropriate OSCs of councils.

3. Councils as commissioners of adult social care responding to local Healthwatch requests for information, reports and recommendations.

4. Councils as providers of adult social care services allowing local Healthwatch to 'enter and view' premises in certain circumstances and responding to reports and recommendations.

5. Local Healthwatch part of Health and Wellbeing Boards, with collective responsibility for producing joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies (JHWSs) that will guide council social care commissioning plans.

6. Council officers and councillors participating in local Healthwatch activities and clarity about potential conflicts of interest.

7. Councils engaging and involving people who use services and communities. Local Healthwatch deciding how their activities relate to existing structures and methods.

## Ten questions to ask

The following 10 questions aim to help OSCs focus on the key areas to scrutinise in relation to the responsibilities of councils to commission local Healthwatch organisations that are effective and provide good value for money. Although these are questions for Executive Councillors and senior officers, OSCs may wish to seek views from LINk participants and host organisations so that they can use the lessons from LINks to inform the development of local Healthwatch.

### 1. Establishing and sustaining local Healthwatch

The questions below aim to help OSCs establish how councils are planning for effective local Healthwatch and how they plan to sustain effective arrangements that represent good value.

- How do you know what a successful local Healthwatch organisation will look like?
- Which organisational model do you think is appropriate for local Healthwatch?
- Are you letting local people and groups influence the development of the arrangements for local Healthwatch?
- Have you reduced funding for existing LINk activities and how much are you allocating to develop local Healthwatch?
- Is there an indicative timeline for commissioning local Healthwatch and a shared commitment to overcome conflict?

### 2. Judging effectiveness and value of local Healthwatch

The questions below aim to help OSCs establish how councils plan to judge the effectiveness and value of local Healthwatch.

- How will you know whether local Healthwatch arrangements are effective and providing value for money?
- What information will you use to make these judgements about local Healthwatch?
- What will happen if local Healthwatch is not judged to be effective or providing value?

## 3. Supporting local Healthwatch

The question below aims to help OSCs establish council's understanding about the support needs of local Healthwatch.

- How confident are you that local Healthwatch will have the capacity and support to take part in Health and Wellbeing Boards, consider health and social care issues and take on additional functions?

## 4. Managing local Healthwatch arrangements

The questions below aim to help OSCs establish how much of the allocation for local Healthwatch is being retained by councils.

- How have you historically allocated the funding provided by the Department of Health through Area Based Grant for LINk activity?
- If you held back any funding, how did you assess that this was a reasonable amount?
- Are you planning to allocate all the funding from DH through Area Based Grant to local Healthwatch?

## 5. Conflicts of interest

The questions below aim to help OSCs establish where the responsibility for commissioning and managing local Healthwatch arrangements sit within the council and how potential conflicts of interest are anticipated and managed.

- Which department has responsibility to commission and manage local Healthwatch arrangements?
- How will you ensure there is no 'conflict' between managing local Healthwatch arrangements and the activities of local Healthwatch in relation to adult social care and the contribution of local Healthwatch to Health and Wellbeing Boards?

## 6. Funding local Healthwatch

The questions below aim to help OSCs establish the levels of funding that are available to local Healthwatch.

- How are you ensuring that local Healthwatch allocates budgets to cover health and social care issues and additional functions?
- What percentage of the allocation for local Healthwatch is actually available for local Healthwatch activities?

## 7. Outcomes from local Healthwatch

The question below aims to help OSCs establish to what extent funding for local Healthwatch is helping to meet the objectives for local Healthwatch to be inclusive and diverse.

- How do you evaluate how effectively local Healthwatch understands and is meeting the needs of local people and groups?

## 8. Awareness of local Healthwatch

The questions below aim to help OSCs establish how councils are ensuring that providers of adult social care are aware of local Healthwatch.

- How are you managing changes to provider contracts to ensure they respond to local Healthwatch and allow them to 'enter and view' adult social care premises?
- How have you ensured that providers are developing relationships with local Healthwatch?

## 9. Building on other community activity

The questions below aim to help OSCs establish the arrangements that councils have to build local Healthwatch in to existing community engagement activity.

- How are you ensuring local Healthwatch builds on existing relationships and resources and does not duplicate activity?
- How will local Healthwatch gather and present a wide range of views rather than relying on a few individuals to represent views?

## 10. Comparing approaches

The questions below aim to help OSCs establish whether the approach to local Healthwatch is reasonable in the context of approaches taken elsewhere.

- Are you sharing and learning from good practice examples with neighbours, comparable authorities or local Healthwatch Pathfinders?
- How will local Healthwatch develop relationships with neighbouring LHWs and others with common areas of interest in order to share and learn from good practice?
- If comparisons have been made with practice elsewhere, what lessons were learnt for the future?
- What might you do differently in your approach to local Healthwatch from the approach to LINks?

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November 2011
L11-564

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

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

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

**Date: 20 February 2013**

**Subject: Public Health transition in Leeds**

| | | |
|---|---|---|
| Are specific electoral Wards affected?<br>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?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☒ No |

## 1 Purpose of this report

1.1 The purpose of this report is to provide the Scrutiny Board with an update on the transition and transfer of Public Health responsibilities to Leeds City Council from April 2013.

## 2 Main issues

2.1 As part of the Health and Social Care Act 2012, many Public Health responsibilities will transfer from Primary Care Trusts (due to be abolished from 1 April 2013) to appropriate local authorities.

2.2 The new public health system, will see local authorities take the lead for improving health, coordinating local efforts to protect the public's health and ensuring health services promote population health. At the same time, Public Health England will be created to deliver a range of services – including health protection, providing information and intelligence, and supporting the development of the public health workforce. A summary of the new public health system (published by the Department of Health in December 2011) is attached at Appendix 1.

2.3 In January 2012, the Public Health Outcomes Framework was published in order to help quantify the impact and effectiveness of public health services. A summary of the Public Health Outcomes Framework is attached at Appendix 2. As the responsibility for improving public health transfers to local authorities, it is likely that the Outcomes Framework will be used to help judge the progress of local authorities in this regard.

2.4 In January 2013, ring-fenced public health allocations for local authorities were announced for 2013/14 and 2014/15. Details of the grant allocations are attached at Appendix 3.

2.5 Given the fairly imminent transfer of Public Heath responsibilities to Leeds City Council, the Director of Public Health has been invited to attend the Scrutiny Board meeting to outline progress in this transition and address any associated matters raised by the Scrutiny Board in this regard.

## 3 Recommendations

3.1 Members are asked to consider the details presented in this report and discussed at the meeting and determine any appropriate further scrutiny activity at this time.

## 4 Background papers[1]

None used

[1]The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Department of Health

# The new public health system: summary

## What we are trying to achieve

We face significant challenges to the public's health and wellbeing. Rising levels of obesity, misuse of drugs and alcohol, high levels of sexually transmitted infections and continuing threats from infectious disease have a heavy cost in health, life expectancy and a large economic burden through costs to the NHS and lost productivity. Improving public health and wellbeing and developing sustainable services will be a key contribution to meeting the challenges to the public finances.

The Government has an ambitious programme to improve public health through strengthening local action, supporting self-esteem and behavioural changes, promoting healthy choices and changing the environment to support healthier lives. This document provides an overview of these changes and links to more detailed material to support implementation of the reforms.

In summary the reforms will see:

- local authorities taking the lead for improving health and coordinating local efforts to protect the public's health and wellbeing, and ensuring health services effectively promote population health. Local political leadership will be central to making this work
- a new executive agency, Public Health England will:
  - deliver services (health protection, public health information and intelligence, and services for the public through social marketing and behavioural insight activities)
  - lead for public health (by encouraging transparency and accountability, building the evidence base, building relationships promoting public health)
  - support the development of the specialist and wider public health workforce (appointing Directors of Public Health with local authorities, supporting excellence in public health practice and bringing together the wider range of public health professionals)
- the NHS will continue to play a full role in providing care, tackling inequalities and ensuring every clinical contact counts
- the Government's Chief Medical Officer will continue to provide independent advice to the Secretary of State for Health and the Government on the population's health
- within Government, the Department of Health will set the legal and policy framework, secure resources and make sure public health is central to the Government's priorities.

The focus will be on outcomes. A new Public Health Outcomes Framework will set out key indicators of public health from the wider determinants of health through to effectiveness in reducing premature mortality. Our overall goals will be to increase healthy life expectancy and reduce health inequalities.

The Public Health Outcomes Framework will be published in January 2012 and will be aligned with the NHS Outcomes Framework and the Adult Social Care Outcomes Framework.

## Local responsibilities

Local authorities will have a new duty to promote the health of their population. They will also take on key functions in ensuring that robust plans are in place to protect the local population and in providing public health advice to NHS commissioners.

Through the health and wellbeing board they will lead the development of joint strategic needs assessments and joint health and wellbeing strategies, which will provide the means of integrating local commissioning strategies and ensuring a community-wide approach to promoting and protecting the public's health and wellbeing.

Giving local authorities this key role allows action to build on local knowledge and experience and aligns public health responsibility with many of the levers to tackle the wider determinants of health and health inequalities.

To enable them to deliver these new public health functions local authorities will employ Directors of Public Health, who will occupy key leadership positions within the local authority.

The appointment process will be run jointly with Public Health England (on behalf of the Secretary of State for Health) to ensure that the best possible people are appointed to these key positions. Many local authorities have already made joint Director of Public Health appointments, and others are moving to take delegated responsibility for public health teams ahead of the statutory transfer of responsibility. We continue to encourage such action.

Real improvement will be secured by local authorities putting the public's health into their policies and decisions. However, they will also have responsibilities for commissioning specific public health services and will be supported with a ring-fenced public health grant.

While local authorities will be largely free to determine their own priorities and services, they will be required to provide a small number of mandatory services (sexual health services, NHS health checks, National Child Measurement Programme, providing public health advice to NHS Commissioners and ensuring plans are in place to protect the health of the public).

A ring-fenced public health grant will support local authorities in carrying out their new public health functions. We will make shadow allocations to local authorities for 2012/13 to help them prepare for taking on formal responsibility in 2013/14.

Shadow allocations for local authorities in 2012/13 will be published to support planning for the transition.

## How does Public Health England fit in?

Public Health England will be created as a new integrated public health service. It will bring together the national health protection service and nationwide expertise across all three domains of public health. We are setting out the mission and values we expect Public Health England to deliver. Public Health England will be an advocate

for public health – its actions will be based on the highest professional and scientific standards and it will promote a culture of subsidiarity, focused on supporting local action, with national action only where it adds value.

Public Health England will have three key business functions:
1. It will deliver services to protect the public's health through a nationwide integrated health protection service, provide information and intelligence to support local public health services, and support the public in making healthier choices.
2. It will provide leadership to the public health delivery system, promoting transparency and accountability by publishing outcomes, building the evidence base, managing relationships with key partners, and supporting national and international policy and scientific development.
3. It will support the development of the public health workforce, jointly appointing local authority Directors of Public Health, supporting excellence in public health practice and providing a national voice for the profession.

Public Health England will bring together the wide range of public health specialists and bodies into one integrated public health service. Its organisational design will feature:
- a national office including national centres of expertise and hubs that work with the four sectors of the NHS commissioning board
- units that act in support of local authorities in their area
- a distributed network that allows Public Health England to benefit from locating its information and intelligence and quality assurance expertise alongside NHS and academic partners across the country.

Public Health England will be an executive agency of the Department of Health. It will have its own Chief Executive who will have operational independence.

Public Health England will have non-executive directors on its advisory board. The non-executives will support the Chief Executive in his/her role as accounting officer and provide an independent challenge. The Chief Medical Officer will provide independent advice to the Secretary of State for Health on the population's health and on the public health system as a whole, including Public Health England's role within it.

Public Health England's status will depend on its ability to provide high-quality, impartial, scientific and professional advice. To demonstrate its commitment to transparency and the highest professional standards, Public Health England will proactively publish its expert scientific and public health advice on relevant issues, and its advice to professionals and the public.

## The NHS still has a role in public health

The NHS will continue to play a key role in improving and protecting the public's health. The provision of health services and ensuring fair access to those services will contribute to improving health and reducing inequalities.

The NHS will also continue to commission specific public health services and will seek to maximise the impact of the NHS in improving the health of the public, making every clinical contact count.

The NHS Future Forum is currently

considering how the NHS can contribute to improving the health of the public. Its interim findings have been published and are available.

## The public health workforce

The success of the public health system will depend on harnessing the skills and energies of public health staff and on those staff building the effective relationships needed to make public health part of everyone's core business.

There is a diverse public health workforce, working for a wide range of employers. In managing the transition to the new system we need to ensure all staff are treated fairly and have access to the exciting opportunities to shape a 21st century public health service.

We are working closely with staff representatives and local government to ensure fair and transparent processes, and appropriate terms and conditions. We have published a Human Resources Concordat setting out key principles and will follow this with Local Government Transition Guidance and an initial People Transition Policy for Public Health England. The final People Transition Policy will follow formal agreement to the new terms and conditions.

Maintaining a vibrant professional public health workforce into the future will underpin the success of the reforms. The workforce strategy will be key to this and will be subject to specific consultation from January 2012.

## Making it happen

Subject to the passage of the Health and Social Care Bill, these statutory changes will take place from 1 April 2013. Yet there is much that can be done to implement the reforms through local agreement before April 2013. We encourage all partners to engage actively in delivering the new systems and new ways of working in 2012/13.

There are a number of key milestones for the transition including:

- completion of transition plans for transfer of public health to local authorities – March 2012
- Public Health England's Chief Executive appointed – April 2012
- Public Health England structure agreed – May 2012
- pre-appointment processes complete – October 2012
- formal transfers of statutory responsibilities – 1 April 2013.

We will continue to develop our plans for the public health system in collaboration with our stakeholders and details will be published accordingly.

Stay in contact with our progress in establishing the new system at http://healthandcare.dh.gov.uk/category/public-health

DH Department of Health

*Produced: December 2011*
*Gateway reference: 16912*

# The Public Health Outcomes Framework for England, 2013-2016

The responsibility to improve and protect our health lies with us all – government, local communities and with ourselves as individuals.

There are many factors that influence public health over the course of a lifetime. They all need to be understood and acted upon. Integrating public health into local government will allow that to happen – services will be planned and delivered in the context of the broader social determinants of health, like poverty, education, housing, employment, crime and pollution. The NHS, social care, the voluntary sector and communities will all work together to make this happen.

## The new framework

The new Public Health Outcomes Framework that has been published is in three parts. Part 1 introduces the overarching vision for public health, the outcomes we want to achieve and the indicators that will help us understand how well we are improving and protecting health. Part 2 specifies all the technical details we can currently supply for each public health indicator and indicates where we will conduct further work to fully specify all indicators. Part 3 consists of the impact assessment and equalities impact assessment.

## Informed by consultation

We received many responses to our consultation on outcomes. There was widespread welcome for our approach, including the focus on the wider determinants of health combined with many constructive proposals for improving it. In this framework, we also bring further clarity to the alignment across the NHS, Public Health and Adult Social Care Outcome Frameworks, while recognising the different governance and funding issues that relate to these.

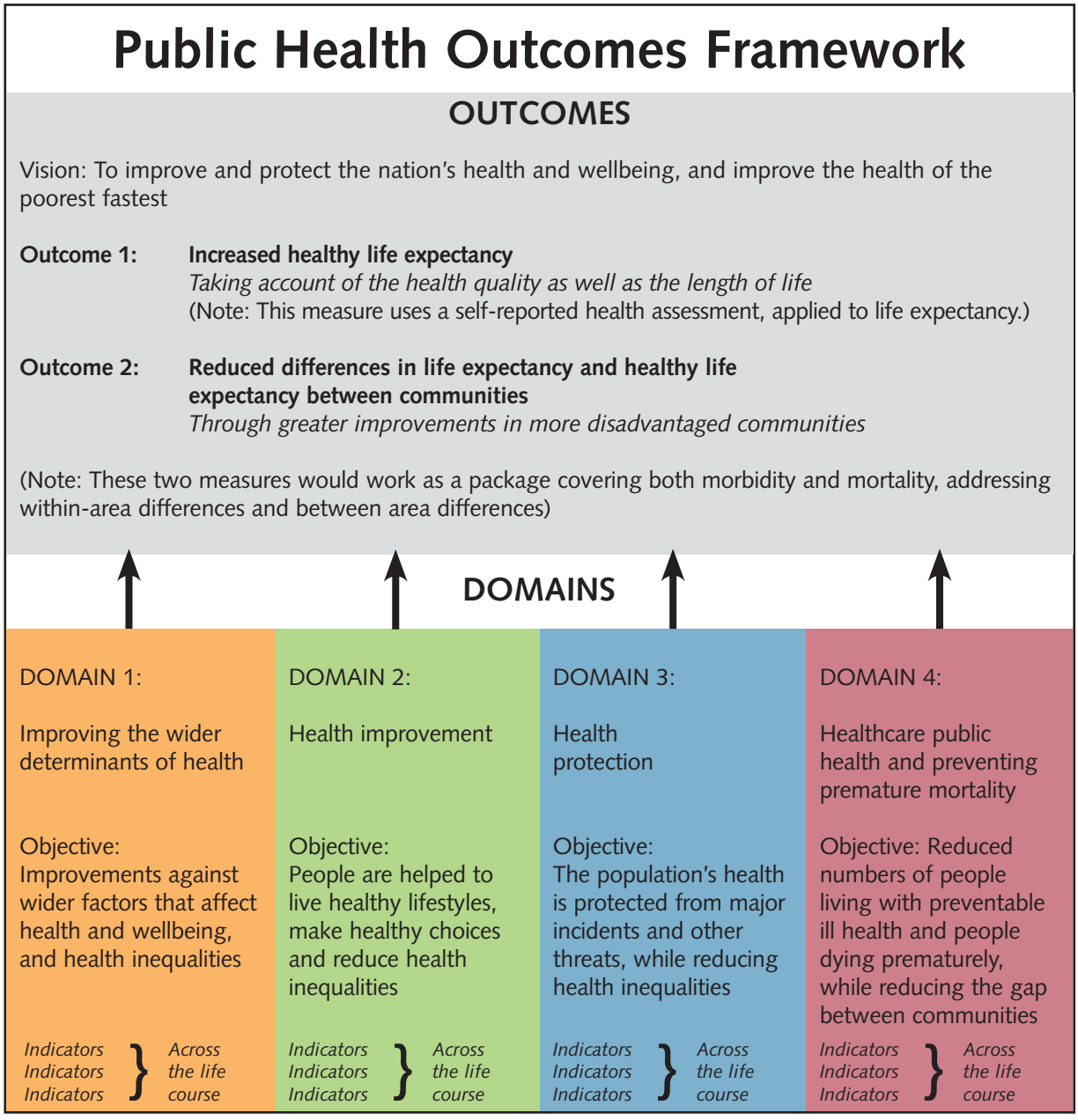
In *Healthy Lives, Healthy People: Update and way forward* the Government promised to produce a number of policy updates setting out more detail on the new public health system. The Public Health Outcomes Framework is part of this series of updates that set out what we would want to achieve in a new and reformed public health system.

The framework follows on from two preceding web-based updates in the series on the roles and function for local government and the Director of Public Health, and how Public Health England will support all parts of the new system to improve and protect the public's health.

The whole system will be refocused around achieving positive health outcomes for the population and reducing inequalities in health, rather than focused on process targets, and will not be used to performance manage local areas.

The Public Health Outcomes Framework sets the context for the system, from local to national level. The framework will set out the broad range of opportunities to improve and protect health across the life course and to reduce inequalities in health that still persist (see graphic below).

Much of the proposed new public health system that is described in the document depends on the provisions of the Health and Social Care Bill, which has yet to be passed by Parliament.



## High-level outcomes

The framework focuses on the two high-level outcomes we want to achieve across the public health system and beyond.

These two outcomes are:
- increased healthy life expectancy
- reduced differences in life expectancy and healthy life expectancy between communities.

These outcomes reflect the focus we wish to take, not only on how long we live – our life expectancy, but on how well we live – our healthy life expectancy, at all stages of the life course.

Our second outcome focuses attention on reducing health inequalities between people, communities and areas in our society. We are using both a measure of life expectancy and healthy life expectancy so that we are able to use the most reliable information available to understand the nature of health inequalities both within areas and between areas.

*Produced: January 2012*
*Gateway reference: 16891*



While we will be able to provide information on the performance against both these outcomes, the nature of public health is such that the improvements in these outcomes will take years – sometimes even decades – to see marked change.

So we have developed a set of supporting public health indicators that help focus our understanding of how well we are doing year by year nationally and locally on those things that matter most to public health, which we know will help improve the outcomes stated above.

These indicators are grouped into four domains:
- improving the wider determinants of health
- health improvement
- health protection
- healthcare public health and preventing premature mortality.

Indicators have been included that cover the full spectrum of what we understand public health to be, and what we can realistically measure at the moment.

We intend to improve this range of information over the coming year and we have set out in this document how we intend to do that, with the continued engagement and involvement of our partners at the local and national levels.

This framework focuses on the respective role of local government, the NHS and Public Health England, and their delivery of improved health and wellbeing outcomes for the people and communities they serve.

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Date 10 January 2013

Dear colleague,

We are writing to inform you that today we have published the 2013-14 and 2014-15 ring-fenced grants to local authorities for their public health responsibilities. Announcing allocations for the next two years will provide you with greater certainty of future resources enabling you to plan for initiatives that may be better delivered across more than one year.

This Government has an ambitious vision to help people live longer, healthier and more fulfilling lives, and to improve the health of the most vulnerable fastest. Local leadership is critical to achieving this vision. Supported by your Director of Public Health, you will be the local leader of the new public health system. You are best placed to understand the needs of your community and it will be your responsibility to tackle the wider determinants of health at a local level, putting people's health and wellbeing at the heart of everything you do - from adult social care to transport, housing, planning and environment. The money you receive will allow you to transform the lives of local people through commissioning a wide range of innovative services.

The allocation covers both services mandated through regulation and all other services that you may wish to commission locally. These will be prioritised according to need in your area and we have left it for you to decide what proportion of spending should be devoted to different services. Currently, on average, about one third of spending is connected to mandated services, leaving a significant opportunity to commission services that meet the needs of your population. Services not currently covered by the mandating regulations include obesity, smoking cessation and substance misuse. This is a major opportunity for you to work with local partners, such as the voluntary sector, Police and Crime Commissioners and the private sector, to deliver these critical services resulting in better outcomes for your population.

Despite difficult financial circumstances, we are pleased to inform you that we have been able to provide an above inflation growth representing a major investment in health and the prevention of illness. In each year every local authority will see real terms growth. This is on top of an updated 2012-13 baseline that is now just over £2.5 billion, significantly above the estimate of £2.2 billion that we published in February last year.

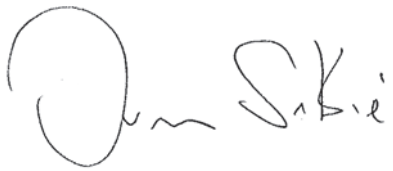
You can find the allocations, broken down to individual council, here - http://www.dh.gov.uk/health/2013/01/public-health-budgets/

Where egregious errors in the estimated baseline have been noted, or if they become apparent during 2013-14, we will look to local partners to use their commissioning flexibilities to manage the pressure resulting from the mis-allocated resources. If local commissioners can present clear evidence of such an error then we will look at making appropriate adjustments to the 2014-15 allocations.

The allocation is built on the advice of the independent Advisory Committee on Resource Allocation (ACRA). ACRA's interim recommendations went through an intensive engagement during the summer, generating some important changes that we believe will be welcomed by the public health and local government communities.

Attached to this letter is the Grant Circular which sets out the broad context for the reforms and the grant's purpose. Also included is the Grant Determination which contains the Conditions that will govern the use of the grant. This covers both the financial control requirements and the reporting arrangements that will apply to the ring-fenced public health grant from April 2013. In addition, full details of the public health ring-fenced grants, the Grant Circular and reporting conditions can be found on the Department of Health website along with ACRA's final recommendations and supporting papers.

Yours sincerely,



Jeremy Hunt
Secretary of State for Health

Duncan Selbie
CEO, Public Health England

Public health Grants to Local Authorities 2013-14 and 2014-15

| Local Authority | 2013-14 opening baseline | 2013-14 opening baseline per head | 2013-14 opening distance from target | 2013-14 target per head | 2013-14 increase | 2013-14 grant | 2013-14 grant per head | 2014-15 target per head | 2014-15 increase | 2014-15 grant | 2014-15 grant per head | 2014-15 closing DFT | Cumulative growth 2013-14 and 2014-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £000s | £s | % | £s | % | £000s | £ | £ | % | £000s | £ | % | % |
| Hartlepool | 8,030 | 87 | 29.1% | 71 | 2.8% | 8,255 | 89 | 75 | 2.8% | 8,486 | 91 | 22.3% | 5.7% |
| Middlesbrough | 15,498 | 111 | 41.9% | 82 | 2.8% | 15,932 | 114 | 86 | 2.8% | 16,378 | 117 | 35.7% | 5.7% |
| Redcar and Cleveland | 10,330 | 76 | 52.7% | 53 | 2.8% | 10,620 | 79 | 55 | 2.8% | 10,917 | 81 | 46.0% | 5.7% |
| Stockton-on-Tees | 12,365 | 63 | 17.0% | 57 | 2.8% | 12,711 | 65 | 61 | 2.8% | 13,067 | 67 | 9.3% | 5.7% |
| Darlington | 6,798 | 64 | 17.9% | 57 | 2.8% | 6,989 | 66 | 60 | 2.8% | 7,184 | 67 | 11.7% | 5.7% |
| County Durham | 43,320 | 83 | 81.3% | 49 | 2.8% | 44,533 | 86 | 51 | 2.8% | 45,780 | 88 | 72.5% | 5.7% |
| Northumberland | 12,688 | 40 | 5.9% | 40 | 2.8% | 13,043 | 41 | 42 | 2.8% | 13,408 | 42 | 0.7% | 5.7% |
| Gateshead | 14,981 | 74 | 29.3% | 61 | 2.8% | 15,401 | 76 | 64 | 2.8% | 15,832 | 78 | 23.0% | 5.7% |
| Newcastle upon Tyne | 20,157 | 71 | 6.5% | 70 | 2.8% | 20,721 | 73 | 74 | 2.8% | 21,301 | 74 | 0.7% | 5.7% |
| North Tyneside | 9,818 | 48 | -4.4% | 53 | 6.1% | 10,417 | 51 | 55 | 3.7% | 10,807 | 53 | -5.0% | 10.1% |
| South Tyneside | 12,223 | 82 | 50.8% | 57 | 2.8% | 12,565 | 84 | 60 | 2.8% | 12,917 | 86 | 44.4% | 5.7% |
| Sunderland | 20,093 | 73 | 30.1% | 59 | 2.8% | 20,656 | 75 | 61 | 2.8% | 21,234 | 76 | 24.5% | 5.7% |
| Halton | 8,279 | 65 | 0.4% | 69 | 2.8% | 8,510 | 67 | 71 | 2.8% | 8,749 | 69 | -3.4% | 5.7% |
| Warrington | 9,173 | 44 | -8.1% | 51 | 9.6% | 10,052 | 49 | 53 | 3.9% | 10,439 | 50 | -5.0% | 13.8% |
| Blackburn with Darwen | 12,428 | 84 | 13.9% | 77 | 2.8% | 12,776 | 86 | 82 | 2.8% | 13,134 | 88 | 7.8% | 5.7% |
| Blackpool | 16,981 | 119 | 57.3% | 80 | 2.8% | 17,457 | 123 | 83 | 2.8% | 17,946 | 126 | 51.5% | 5.7% |
| Cheshire East | 11,568 | 31 | -14.8% | 38 | 10.0% | 12,725 | 34 | 40 | 10.0% | 13,998 | 37 | -6.8% | 21.0% |
| Cheshire West and Chester | 11,968 | 36 | -9.6% | 42 | 10.0% | 13,165 | 40 | 44 | 5.3% | 13,861 | 42 | -5.2% | 15.8% |
| Bolton | 16,631 | 59 | -7.4% | 67 | 8.9% | 18,115 | 64 | 70 | 4.4% | 18,906 | 67 | -5.1% | 13.7% |
| Bury | 8,315 | 44 | -9.2% | 51 | 10.0% | 9,147 | 49 | 54 | 5.2% | 9,619 | 51 | -5.2% | 15.7% |
| Manchester | 36,459 | 71 | -24.8% | 100 | 10.0% | 40,105 | 78 | 105 | 10.0% | 44,116 | 86 | -18.3% | 21.0% |
| Oldham | 12,326 | 54 | -18.5% | 70 | 10.0% | 13,559 | 60 | 74 | 10.0% | 14,915 | 65 | -11.9% | 21.0% |
| Rochdale | 13,637 | 64 | -2.8% | 69 | 4.5% | 14,256 | 67 | 73 | 3.7% | 14,777 | 69 | -5.0% | 8.4% |

| Local Authority | 2013-14 opening baseline | 2013-14 opening baseline per head | 2013-14 opening distance from target | 2013-14 target per head | 2013-14 increase | 2013-14 grant | 2013-14 grant per head | 2014-15 target per head | 2014-15 increase | 2014-15 grant | 2014-15 grant per head | 2014-15 closing DFT | Cumulative growth 2013-14 and 2014-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £000s | £s | % | £s | % | £000s | £ | £ | % | £000s | £ | % | % |
| Salford | 15,523 | 64 | -13.5% | 79 | 10.0% | 17,075 | 71 | 82 | 10.0% | 18,777 | 77 | -6.1% | 21.0% |
| Stockport | 11,607 | 41 | -4.8% | 45 | 6.5% | 12,360 | 43 | 47 | 3.8% | 12,834 | 45 | -5.0% | 10.6% |
| Tameside | 10,413 | 47 | -26.3% | 67 | 10.0% | 11,454 | 51 | 69 | 10.0% | 12,600 | 56 | -18.9% | 21.0% |
| Trafford | 9,894 | 43 | 1.8% | 45 | 2.8% | 10,171 | 44 | 46 | 2.8% | 10,456 | 45 | -1.7% | 5.7% |
| Wigan | 22,393 | 70 | 24.5% | 59 | 2.8% | 23,020 | 72 | 62 | 2.8% | 23,665 | 73 | 18.9% | 5.7% |
| Knowsley | 15,495 | 106 | 48.4% | 75 | 2.8% | 15,929 | 109 | 77 | 2.8% | 16,375 | 111 | 44.1% | 5.7% |
| Liverpool | 39,210 | 84 | -0.1% | 89 | 2.8% | 40,308 | 87 | 94 | 2.8% | 41,436 | 89 | -4.5% | 5.7% |
| St. Helens | 12,335 | 70 | 28.4% | 57 | 2.8% | 12,680 | 72 | 60 | 2.8% | 13,035 | 74 | 22.0% | 5.7% |
| Sefton | 18,880 | 69 | 36.4% | 53 | 2.8% | 19,408 | 71 | 55 | 2.8% | 19,952 | 73 | 33.0% | 5.7% |
| Wirral | 25,019 | 78 | 32.6% | 62 | 2.8% | 25,720 | 80 | 64 | 2.8% | 26,440 | 82 | 28.0% | 5.7% |
| Cumbria | 12,887 | 26 | -36.5% | 43 | 10.0% | 14,176 | 28 | 45 | 10.0% | 15,594 | 31 | -30.6% | 21.0% |
| Lancashire | 56,412 | 48 | -0.2% | 50 | 2.8% | 57,991 | 49 | 53 | 3.1% | 59,801 | 50 | -4.9% | 6.0% |
| Kingston upon Hull, City of | 21,347 | 83 | 16.4% | 75 | 2.8% | 21,945 | 85 | 79 | 2.8% | 22,559 | 87 | 10.0% | 5.7% |
| East Riding of Yorkshire | 7,583 | 22 | -28.4% | 33 | 10.0% | 8,341 | 25 | 34 | 10.0% | 9,175 | 27 | -20.9% | 21.0% |
| North East Lincolnshire | 9,435 | 59 | 4.1% | 60 | 2.8% | 9,700 | 61 | 63 | 2.8% | 9,971 | 62 | -1.0% | 5.7% |
| North Lincolnshire | 7,825 | 46 | -1.3% | 49 | 3.1% | 8,071 | 48 | 52 | 4.9% | 8,464 | 49 | -5.1% | 8.2% |
| York | 6,037 | 30 | -24.1% | 42 | 10.0% | 6,641 | 33 | 44 | 10.0% | 7,305 | 36 | -17.6% | 21.0% |
| Barnsley | 12,969 | 55 | -2.9% | 60 | 4.6% | 13,571 | 58 | 63 | 4.9% | 14,243 | 60 | -5.2% | 9.8% |
| Doncaster | 19,113 | 63 | 13.8% | 58 | 2.8% | 19,648 | 65 | 61 | 2.8% | 20,198 | 66 | 9.1% | 5.7% |
| Rotherham | 13,415 | 52 | 3.1% | 53 | 2.8% | 13,790 | 53 | 55 | 2.8% | 14,176 | 54 | -1.8% | 5.7% |
| Sheffield | 28,571 | 51 | -2.0% | 55 | 3.8% | 29,665 | 53 | 57 | 3.6% | 30,748 | 54 | -5.0% | 7.6% |
| Bradford | 28,677 | 54 | -13.2% | 65 | 10.0% | 31,545 | 59 | 69 | 10.0% | 34,699 | 65 | -6.5% | 21.0% |
| Calderdale | 8,935 | 43 | -12.5% | 52 | 10.0% | 9,829 | 47 | 54 | 8.6% | 10,679 | 51 | -5.8% | 19.5% |
| Kirklees | 20,842 | 49 | -6.9% | 55 | 8.4% | 22,603 | 53 | 57 | 4.1% | 23,527 | 55 | -5.0% | 12.9% |
| Leeds | 33,504 | 43 | -20.0% | 57 | 10.0% | 36,855 | 48 | 60 | 10.0% | 40,540 | 52 | -14.3% | 21.0% |
| Wakefield | 19,679 | 59 | 10.3% | 57 | 2.8% | 20,230 | 61 | 60 | 2.8% | 20,797 | 62 | 3.7% | 5.7% |
| North Yorkshire | 17,497 | 29 | -7.2% | 33 | 8.7% | 19,021 | 31 | 34 | 3.7% | 19,732 | 32 | -5.0% | 12.8% |
| Derby | 11,970 | 47 | -21.1% | 63 | 10.0% | 13,167 | 52 | 66 | 10.0% | 14,484 | 56 | -14.5% | 21.0% |
| Leicester | 18,177 | 55 | -22.6% | 74 | 10.0% | 19,995 | 60 | 78 | 10.0% | 21,995 | 66 | -15.7% | 21.0% |

| Local Authority | 2013-14 opening baseline | 2013-14 opening baseline per head | 2013-14 opening distance from target | 2013-14 target per head | 2013-14 increase | 2013-14 grant | 2013-14 grant per head | 2014-15 target per head | 2014-15 increase | 2014-15 grant | 2014-15 grant per head | 2014-15 closing DFT | Cumulative growth 2013-14 and 2014-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £000s | £s | % | £s | % | £000s | £ | £ | % | £000s | £ | % | % |
| Rutland | 1,015 | 26 | 23.0% | 23 | 2.8% | 1,044 | 27 | 23 | 2.8% | 1,073 | 28 | 17.2% | 5.7% |
| Nottingham | 26,343 | 85 | 8.7% | 82 | 2.8% | 27,081 | 87 | 85 | 2.8% | 27,839 | 89 | 4.0% | 5.7% |
| Derbyshire | 33,736 | 43 | 16.1% | 39 | 2.8% | 34,680 | 45 | 41 | 2.8% | 35,651 | 46 | 11.4% | 5.7% |
| Leicestershire | 18,370 | 28 | -11.7% | 33 | 10.0% | 20,206 | 30 | 35 | 8.2% | 21,863 | 33 | -5.7% | 19.0% |
| Lincolnshire | 26,244 | 36 | -3.2% | 39 | 4.9% | 27,542 | 38 | 41 | 3.5% | 28,506 | 39 | -5.0% | 8.6% |
| Northamptonshire | 24,399 | 34 | -16.3% | 43 | 10.0% | 26,839 | 38 | 45 | 10.0% | 29,523 | 41 | -9.1% | 21.0% |
| Nottinghamshire | 34,178 | 43 | 4.4% | 43 | 2.8% | 35,135 | 44 | 45 | 2.8% | 36,119 | 45 | -0.8% | 5.7% |
| Herefordshire, County of | 7,542 | 40 | 21.4% | 35 | 2.8% | 7,753 | 42 | 36 | 2.8% | 7,970 | 42 | 16.2% | 5.7% |
| Telford and Wrekin | 10,327 | 61 | 27.6% | 50 | 2.8% | 10,616 | 63 | 53 | 2.8% | 10,913 | 64 | 21.9% | 5.7% |
| Stoke-on-Trent | 19,154 | 76 | 18.6% | 68 | 2.8% | 19,690 | 78 | 72 | 2.8% | 20,242 | 80 | 11.1% | 5.7% |
| Shropshire | 8,135 | 26 | -17.2% | 33 | 10.0% | 8,948 | 29 | 35 | 10.0% | 9,843 | 32 | -9.0% | 21.0% |
| Birmingham | 76,494 | 70 | 3.7% | 71 | 2.8% | 78,636 | 72 | 74 | 2.8% | 80,838 | 73 | -1.2% | 5.7% |
| Coventry | 16,211 | 49 | -22.3% | 67 | 10.0% | 17,832 | 54 | 69 | 10.0% | 19,615 | 59 | -14.9% | 21.0% |
| Dudley | 17,954 | 57 | 33.9% | 45 | 2.8% | 18,457 | 59 | 46 | 2.8% | 18,974 | 60 | 28.9% | 5.7% |
| Sandwell | 18,931 | 60 | -8.5% | 69 | 10.0% | 20,816 | 66 | 73 | 4.7% | 21,805 | 69 | -5.1% | 15.2% |
| Solihull | 9,373 | 45 | 23.4% | 38 | 2.8% | 9,635 | 46 | 40 | 2.8% | 9,905 | 47 | 18.0% | 5.7% |
| Walsall | 13,622 | 50 | -9.9% | 59 | 10.0% | 14,984 | 55 | 61 | 5.6% | 15,827 | 58 | -5.3% | 16.2% |
| Wolverhampton | 18,259 | 72 | 18.4% | 65 | 2.8% | 18,770 | 75 | 67 | 2.8% | 19,296 | 76 | 13.3% | 5.7% |
| Staffordshire | 30,549 | 36 | -4.1% | 39 | 5.8% | 32,322 | 38 | 41 | 3.1% | 33,313 | 39 | -4.9% | 9.0% |
| Warwickshire | 20,638 | 37 | 2.1% | 38 | 2.8% | 21,216 | 38 | 40 | 2.8% | 21,810 | 39 | -1.5% | 5.7% |
| Worcestershire | 25,103 | 44 | 29.6% | 36 | 2.8% | 25,806 | 45 | 38 | 2.8% | 26,528 | 46 | 23.0% | 5.7% |
| Peterborough | 7,678 | 41 | -26.7% | 58 | 10.0% | 8,446 | 45 | 61 | 10.0% | 9,291 | 48 | -20.0% | 21.0% |
| Luton | 10,797 | 51 | -19.9% | 68 | 10.0% | 11,877 | 56 | 70 | 10.0% | 13,065 | 61 | -12.9% | 21.0% |
| Southend-on-Sea | 6,661 | 38 | -19.7% | 50 | 10.0% | 7,327 | 42 | 52 | 10.0% | 8,060 | 45 | -11.9% | 21.0% |
| Thurrock | 7,215 | 44 | 1.1% | 46 | 2.8% | 7,417 | 46 | 48 | 2.8% | 7,624 | 46 | -2.9% | 5.7% |
| Bedford | 6,069 | 38 | -15.7% | 47 | 10.0% | 6,676 | 41 | 49 | 10.0% | 7,343 | 45 | -8.1% | 21.0% |
| Central Bedfordshire | 9,604 | 37 | 3.8% | 37 | 2.8% | 9,873 | 38 | 39 | 2.8% | 10,149 | 38 | -1.0% | 5.7% |
| Cambridgeshire | 19,432 | 31 | -7.7% | 35 | 9.3% | 21,230 | 33 | 37 | 5.0% | 22,299 | 35 | -5.2% | 14.8% |
| Essex | 47,377 | 33 | -1.3% | 36 | 3.2% | 48,874 | 34 | 37 | 2.8% | 50,242 | 35 | -4.9% | 6.0% |

| Local Authority | 2013-14 opening baseline | 2013-14 opening baseline per head | 2013-14 opening distance from target | 2013-14 target per head | 2013-14 increase | 2013-14 grant | 2013-14 grant per head | 2014-15 target per head | 2014-15 increase | 2014-15 grant | 2014-15 grant per head | 2014-15 closing DFT | Cumulative growth 2013-14 and 2014-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £000s | £s | % | £s | % | £000s | £ | £ | % | £000s | £ | % | % |
| Hertfordshire | 31,109 | 27 | -24.7% | 38 | 10.0% | 34,220 | 30 | 39 | 10.0% | 37,642 | 33 | -17.0% | 21.0% |
| Norfolk | 28,987 | 33 | 1.3% | 35 | 2.8% | 29,798 | 34 | 36 | 2.8% | 30,633 | 35 | -3.0% | 5.7% |
| Suffolk | 24,876 | 34 | 14.2% | 31 | 2.8% | 25,572 | 35 | 33 | 2.8% | 26,289 | 35 | 8.1% | 5.7% |
| City of London | 1,606 | 186 | 580.4% | 29 | 2.8% | 1,651 | 192 | 29 | 2.8% | 1,698 | 185 | 529.9% | 5.7% |
| Barking and Dagenham | 11,746 | 60 | -14.3% | 74 | 10.0% | 12,921 | 66 | 76 | 10.0% | 14,213 | 71 | -6.7% | 21.0% |
| Barnet | 12,835 | 35 | -5.9% | 39 | 7.5% | 13,799 | 37 | 40 | 3.9% | 14,335 | 38 | -5.0% | 11.7% |
| Bexley | 6,260 | 26 | -30.8% | 40 | 10.0% | 6,886 | 29 | 42 | 10.0% | 7,574 | 32 | -24.7% | 21.0% |
| Brent | 17,835 | 56 | 2.2% | 58 | 2.8% | 18,335 | 58 | 59 | 2.8% | 18,848 | 59 | 0.0% | 5.7% |
| Bromley | 12,258 | 39 | 16.7% | 35 | 2.8% | 12,601 | 40 | 36 | 2.8% | 12,954 | 40 | 10.8% | 5.7% |
| Camden | 24,951 | 108 | 53.0% | 74 | 2.8% | 25,649 | 111 | 79 | 2.8% | 26,368 | 112 | 42.3% | 5.7% |
| Croydon | 17,813 | 48 | 1.9% | 50 | 2.8% | 18,312 | 49 | 52 | 2.8% | 18,825 | 50 | -2.4% | 5.7% |
| Ealing | 20,793 | 60 | 9.6% | 58 | 2.8% | 21,376 | 62 | 59 | 2.8% | 21,974 | 63 | 6.4% | 5.7% |
| Enfield | 11,783 | 36 | -19.7% | 48 | 10.0% | 12,961 | 40 | 50 | 10.0% | 14,257 | 43 | -13.6% | 21.0% |
| Greenwich | 16,616 | 64 | -8.9% | 74 | 10.0% | 18,277 | 71 | 77 | 4.3% | 19,061 | 73 | -5.1% | 14.7% |
| Hackney | 28,215 | 112 | 35.0% | 88 | 2.8% | 29,005 | 115 | 91 | 2.8% | 29,818 | 117 | 29.4% | 5.7% |
| Hammersmith and Fulham | 19,846 | 108 | 82.1% | 63 | 2.2% | 20,287 | 111 | 66 | 2.8% | 20,855 | 114 | 72.4% | 5.1% |
| Haringey | 16,254 | 62 | -6.6% | 70 | 8.2% | 17,587 | 67 | 72 | 3.4% | 18,189 | 68 | -5.0% | 11.9% |
| Harrow | 8,576 | 35 | -1.7% | 37 | 3.5% | 8,874 | 36 | 38 | 3.1% | 9,146 | 36 | -4.9% | 6.6% |
| Havering | 8,030 | 33 | -18.2% | 42 | 10.0% | 8,833 | 36 | 44 | 10.0% | 9,717 | 39 | -9.7% | 21.0% |
| Hillingdon | 14,865 | 52 | 4.5% | 53 | 2.8% | 15,281 | 54 | 55 | 2.8% | 15,709 | 54 | -0.8% | 5.7% |
| Hounslow | 11,640 | 44 | -20.7% | 59 | 10.0% | 12,804 | 48 | 59 | 10.0% | 14,084 | 52 | -11.7% | 21.0% |
| Islington | 24,063 | 112 | 30.7% | 90 | 2.8% | 24,737 | 115 | 95 | 2.8% | 25,429 | 116 | 22.3% | 5.7% |
| Kensington and Chelsea | 20,074 | 126 | 199.2% | 45 | 2.8% | 20,636 | 130 | 46 | 2.8% | 21,214 | 133 | 190.8% | 5.7% |
| Kingston upon Thames | 8,802 | 52 | 38.6% | 40 | 2.8% | 9,049 | 53 | 41 | 2.8% | 9,302 | 54 | 30.6% | 5.7% |
| Lambeth | 24,208 | 78 | -3.3% | 85 | 5.1% | 25,438 | 82 | 89 | 3.9% | 26,437 | 84 | -5.0% | 9.2% |
| Lewisham | 19,009 | 66 | 5.0% | 67 | 2.8% | 19,541 | 68 | 70 | 2.8% | 20,088 | 69 | -1.3% | 5.7% |
| Merton | 8,740 | 42 | 8.1% | 41 | 2.8% | 8,985 | 43 | 41 | 2.8% | 9,236 | 43 | 5.3% | 5.7% |
| Newham | 21,580 | 68 | -18.1% | 87 | 10.0% | 23,738 | 75 | 91 | 10.0% | 26,112 | 81 | -10.9% | 21.0% |
| Redbridge | 9,431 | 32 | -27.2% | 47 | 10.0% | 10,374 | 35 | 47 | 10.0% | 11,411 | 38 | -18.8% | 21.0% |

| Local Authority | 2013-14 opening baseline | 2013-14 opening baseline per head | 2013-14 opening distance from target | 2013-14 target per head | 2013-14 increase | 2013-14 grant | 2013-14 grant per head | 2014-15 target per head | 2014-15 increase | 2014-15 grant | 2014-15 grant per head | 2014-15 closing DFT | Cumulative growth 2013-14 and 2014-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £000s | £s | % | £s | % | £000s | £ | £ | % | £000s | £ | % | % |
| Richmond upon Thames | 7,467 | 39 | 24.6% | 33 | 2.8% | 7,676 | 40 | 34 | 2.8% | 7,891 | 40 | 18.1% | 5.7% |
| Southwark | 20,700 | 68 | -3.6% | 75 | 5.4% | 21,809 | 72 | 78 | 5.2% | 22,946 | 74 | -5.2% | 10.9% |
| Sutton | 8,119 | 41 | -1.4% | 44 | 3.3% | 8,384 | 43 | 44 | 2.8% | 8,619 | 43 | -3.1% | 6.2% |
| Tower Hamlets | 30,528 | 113 | 22.7% | 97 | 2.8% | 31,382 | 116 | 100 | 2.8% | 32,261 | 116 | 16.2% | 5.7% |
| Waltham Forest | 10,146 | 38 | -39.8% | 67 | 10.0% | 11,161 | 42 | 68 | 10.0% | 12,277 | 45 | -33.6% | 21.0% |
| Wandsworth | 24,064 | 76 | 39.4% | 58 | 2.8% | 24,738 | 78 | 60 | 2.8% | 25,431 | 80 | 32.5% | 5.7% |
| Westminster | 29,557 | 128 | 145.5% | 55 | 2.8% | 30,384 | 132 | 58 | 2.8% | 31,235 | 133 | 127.3% | 5.7% |
| Medway | 11,973 | 44 | -13.2% | 54 | 10.0% | 13,170 | 49 | 56 | 8.4% | 14,280 | 52 | -5.8% | 19.3% |
| Bracknell Forest | 2,520 | 22 | -42.0% | 39 | 10.0% | 2,772 | 24 | 41 | 10.0% | 3,049 | 26 | -36.9% | 21.0% |
| West Berkshire | 3,983 | 25 | -20.9% | 34 | 10.0% | 4,381 | 28 | 35 | 10.0% | 4,819 | 30 | -14.1% | 21.0% |
| Reading | 6,787 | 43 | -28.3% | 63 | 10.0% | 7,466 | 47 | 67 | 10.0% | 8,212 | 52 | -22.5% | 21.0% |
| Slough | 4,534 | 31 | -48.2% | 64 | 10.0% | 4,988 | 34 | 65 | 10.0% | 5,487 | 37 | -43.0% | 21.0% |
| Windsor and Maidenhead | 2,901 | 20 | -43.7% | 37 | 10.0% | 3,192 | 22 | 38 | 10.0% | 3,511 | 23 | -38.4% | 21.0% |
| Wokingham | 3,490 | 22 | -19.3% | 28 | 10.0% | 3,839 | 24 | 30 | 10.0% | 4,223 | 26 | -13.1% | 21.0% |
| Milton Keynes | 7,263 | 28 | -36.6% | 47 | 10.0% | 7,989 | 31 | 49 | 10.0% | 8,788 | 33 | -31.5% | 21.0% |
| Brighton and Hove | 17,690 | 64 | 2.7% | 66 | 2.8% | 18,185 | 66 | 69 | 2.8% | 18,695 | 67 | -2.9% | 5.7% |
| Portsmouth | 15,309 | 73 | 18.9% | 65 | 2.8% | 15,737 | 75 | 68 | 2.8% | 16,178 | 77 | 13.7% | 5.7% |
| Southampton | 13,078 | 54 | -7.9% | 62 | 9.4% | 14,313 | 59 | 65 | 5.2% | 15,050 | 62 | -5.2% | 15.1% |
| Isle of Wight | 5,761 | 41 | 26.4% | 34 | 2.8% | 5,922 | 42 | 36 | 2.8% | 6,088 | 43 | 20.7% | 5.7% |
| Buckinghamshire | 14,256 | 28 | -18.1% | 36 | 10.0% | 15,681 | 30 | 37 | 10.0% | 17,249 | 33 | -9.5% | 21.0% |
| East Sussex | 23,190 | 43 | 32.9% | 34 | 2.8% | 23,839 | 45 | 36 | 2.8% | 24,507 | 46 | 27.6% | 5.7% |
| Hampshire | 33,412 | 25 | -17.7% | 32 | 10.0% | 36,753 | 27 | 33 | 10.0% | 40,428 | 30 | -10.5% | 21.0% |
| Kent | 45,312 | 30 | -19.4% | 40 | 10.0% | 49,843 | 33 | 41 | 10.0% | 54,827 | 36 | -10.5% | 21.0% |
| Oxfordshire | 24,534 | 37 | -1.1% | 39 | 3.0% | 25,264 | 38 | 41 | 3.3% | 26,086 | 39 | -4.9% | 6.3% |
| Surrey | 21,125 | 18 | -42.4% | 33 | 10.0% | 23,237 | 20 | 35 | 10.0% | 25,561 | 22 | -36.8% | 21.0% |
| West Sussex | 25,971 | 31 | 0.6% | 33 | 2.8% | 26,698 | 32 | 34 | 2.8% | 27,445 | 33 | -4.1% | 5.7% |
| Bath and North East Somerset | 6,279 | 35 | -3.9% | 39 | 5.6% | 6,632 | 37 | 40 | 4.3% | 6,914 | 38 | -5.1% | 10.1% |
| Bristol, City of | 24,830 | 57 | -10.8% | 67 | 10.0% | 27,313 | 62 | 69 | 6.6% | 29,122 | 66 | -5.4% | 17.3% |
| North Somerset | 6,964 | 33 | -4.3% | 37 | 6.0% | 7,381 | 35 | 38 | 2.9% | 7,593 | 36 | -4.9% | 9.0% |

| Local Authority | 2013-14 opening baseline | 2013-14 opening baseline per head | 2013-14 opening distance from target | 2013-14 target per head | 2013-14 increase | 2013-14 grant | 2013-14 grant per head | 2014-15 target per head | 2014-15 increase | 2014-15 grant | 2014-15 grant per head | 2014-15 closing DFT | Cumulative growth 2013-14 and 2014-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £000s | £s | % | £s | % | £000s | £ | £ | % | £000s | £ | % | % |
| South Gloucestershire | 6,070 | 23 | -28.1% | 33 | 10.0% | 6,677 | 25 | 34 | 10.0% | 7,345 | 27 | -20.7% | 21.0% |
| Plymouth | 10,145 | 39 | -24.8% | 55 | 10.0% | 11,160 | 43 | 58 | 10.0% | 12,276 | 47 | -19.6% | 21.0% |
| Torbay | 6,956 | 52 | 35.6% | 41 | 2.8% | 7,150 | 54 | 43 | 2.8% | 7,351 | 55 | 29.2% | 5.7% |
| Bournemouth | 6,856 | 36 | -31.0% | 56 | 10.0% | 7,542 | 40 | 59 | 10.0% | 8,296 | 44 | -25.7% | 21.0% |
| Poole | 5,731 | 38 | 15.8% | 35 | 2.8% | 5,892 | 39 | 36 | 2.8% | 6,057 | 40 | 11.4% | 5.7% |
| Swindon | 7,174 | 33 | -26.3% | 48 | 10.0% | 7,891 | 37 | 49 | 10.0% | 8,680 | 40 | -19.1% | 21.0% |
| Cornwall | 17,353 | 32 | 1.6% | 33 | 2.8% | 17,839 | 33 | 34 | 2.8% | 18,339 | 33 | -2.6% | 5.7% |
| Isles of Scilly | 69 | 30 | 28.7% | 24 | 2.8% | 71 | 31 | 26 | 2.8% | 73 | 31 | 20.8% | 5.7% |
| Wiltshire | 12,055 | 25 | -16.1% | 32 | 10.0% | 13,261 | 28 | 33 | 10.0% | 14,587 | 30 | -7.3% | 21.0% |
| Devon | 18,862 | 25 | -10.9% | 29 | 10.0% | 20,748 | 27 | 31 | 6.3% | 22,060 | 29 | -5.4% | 17.0% |
| Dorset | 12,197 | 29 | 6.1% | 29 | 2.8% | 12,538 | 30 | 29 | 2.8% | 12,889 | 31 | 4.7% | 5.7% |
| Gloucestershire | 19,269 | 32 | -8.2% | 36 | 9.6% | 21,126 | 35 | 37 | 3.2% | 21,793 | 36 | -4.9% | 13.1% |
| Somerset | 12,821 | 24 | -19.8% | 31 | 10.0% | 14,103 | 26 | 32 | 10.0% | 15,513 | 29 | -11.9% | 21.0% |
| England | 2,521,222 | 47 | 0.0% | 49 | 5.5% | 2,660,000 | 49 | 51 | 5.0% | 2,793,000 | 51 | 0.0% | 10.8% |

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

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

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

**Date: 20 February 2013**

**Subject: National Institute for Clinical Excellence guidance**

| | | |
|---|---|---|
| Are specific electoral Wards affected?<br>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?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☒ No |

## 1 Purpose of this report

1.1 The purpose of this report is to provide the Scrutiny Board with an outline of the role of the National Institute for Clinical Excellence (NICE) and recently published guidance aimed at local authorities.

## 2 Main issues

2.1 The Health and Social Care Act transfers public health responsibilities to local government from April 2013 and gives NICE new responsibilities to produce guidance for social care. As a result of these changes NICE is now increasingly relevant to those working in local government, whether as an officer, an elected member or councillor, or a member of a Health and Wellbeing Board or Health Overview and Scrutiny Committee.

2.2 NICE is looking closely at how it can understand and work more closely with local government, and has created a reference group to help improve that relationship and guide it in developing products that are useful and relevant. NICE has created a new section of its website for those working in local government to keep up to date with its work and to provide a single point to access information, NICE guidance and other tailored resources for local government.

2.3 NICE has developed public health briefings for a range of different topics. The briefings are meant for local authorities and their partner organisations in the health and voluntary sectors, in particular those involved with health and wellbeing boards. The briefings will be relevant to local authority officers and councillors, directors of public health, and commissioners and directors of adult social care and children's services. Briefings are also likely to be relevant to members of local authority scrutiny committees and may also be used alongside the local joint strategic needs assessment to support the development of joint health and wellbeing strategies.

2.4 The following briefings have been published to date:

| Number | Topic | Date Issued |
|---|---|---|
| PHB 1 | Tobacco | July 2012 |
| PHB 2 | Workplace health | July 2012 |
| PHB 3 | Physical activity | July 2012 |
| PHB 4 | Health inequalities and population health | October 2012 |
| PHB 5 | NICE guidance and Public Health Outcomes | October 2012 |
| PHB 6 | Alcohol | October 2012 |
| PHB 7 | Behaviour change | January 2013 |
| PHB 8 | Walking and cycling | January 2013 |

2.5 Copies of the above guidance/ briefings are available on request and some copies will be made available at the Scrutiny Board meeting for reference purposes. However, the details are likely to be particularly relevant when the Scrutiny Board is undertaking any specific work relevant to the areas identified.

2.6 It should also be noted that there are a number of additional briefings in development, which will be finalised and published in the coming months. These briefings are as follows:

| Topic | Expected publication date |
|---|---|
| Return on investment | TBC |
| Effective partnerships | TBC |
| Obesity | March 2013 |
| Contraceptive services | TBC |
| Health equity audit | TBC |
| Spatial planning | May 2013 |

Previous Scrutiny Board recommendations

2.7 It is perhaps worthwhile reminding members of the Scrutiny Board that in May 2010, members of the former Scrutiny Board (Health) identified the following recommendation:

*That, by December 2010, in collaboration with the Director of Public Health, the Director of Adult Social Services (as the lead for Health):*

*(a) Makes an assessment of the extent to which all NICE public health guidance and recommendations (as they relate to local authorities) have been disseminated and used to inform the delivery of services, either directly or through appropriate policies, across the Council.*

*(b) Designs and implements a robust assurance process to ensure the appropriate distribution and consideration of any future NICE guidance, appropriate to the Council.*

2.8 The above recommendation formed part of the inquiry report 'Promoting Good Public Health: The Role of the Council and its Partners' published in May 2010. The following response to the recommendation and associated updates were reported during the municipal year 2010/11.

***September 2010:***

*This recommendation is agreed. The Scrutiny Board (Health) has noted the important role of NICE in providing national evidence of effectiveness on the promotion of good health and the prevention and treatment of ill health. As part of the Governments White Paper on the NHS and the subsequent review of arm's length bodies, the future role of NICE has been seen as crucial, and will be put on an even firmer statutory footing by establishing it in primary legislation. Its role will expand scope to include social care standards. A member of the NHS Leeds Public Health Directorate will take forward the recommendation from September 2010, working closely with LCC staff. The intention is to complete this work by December 2010. A Public Health trainee has been identified to take forward this work which will commence in September, with completion by December 2010.*

***December 2010:***

*Options have now been developed and are under discussion, within NHS Leeds and LCC. The preferred option requires additional resources, which have not been identified at this stage.*

1. *Dissemination of NICE guidance to NHS Leeds, LCC and VCS contacts (i.e. not a full assurance process).*
2. *Dissemination with a piloted assurance process in one area (possibly alcohol guidance).*
3. *Full assurance process for implementing and monitoring NICE guidance, supported by a new NICE Public Health Group as dedicated support officer.*

*A report outlining these options in full has been drafted and will be considered by the Health Improvement Board shortly.*

***April 2011:***

*The options presented in the November 2010 report: 'NICE Public Health guidance: An assurance process proposal for NHS Leeds and Leeds City Council' will be discussed at the next meeting of the Health Improvement Board in May 2011.*

2.9 Given the imminent transfer of Public Health responsibilities to the Council (i.e. in April 2013), members of the Scrutiny Board may wish to revisit this recommendation and consider any arrangements likely to be in place from April 2013.

## 3 Recommendations

3.1 Members are asked to consider the details presented in this report and discussed at the meeting and determine any appropriate further scrutiny activity at this time.

## 4 Background papers[1]

None used

[1]The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

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

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

**Date: 20 February 2013**

**Subject: Work Schedule – February 2013**

| | | |
|---|---|---|
| Are specific electoral Wards affected?<br>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?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☒ No |

## 1 Purpose of this report

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

## 2 Main issues

2.1 An updated work schedule is attached at Appendix 1 for consideration. This incorporates the areas previously discussed and identified for inclusion in the work schedule.

2.2 The following details provide a summary update of some specific areas that the Scrutiny Board has previously considered and/or requested an update. It also provides details of issues that have recently been highlighted and in which the Scrutiny Board may have a legitimate interest.

Review of Children's Congenital Cardiac Services

2.3 As members are aware, the scrutiny work associated with the Review of Children's Congenital Cardiac Services has been undertaken through a Joint Health Overview and Scrutiny Committee (JHOSC) for Yorkshire and the Humber. The JHOSC has been Chaired by the Chair of Leeds City Council's Scrutiny Board (Health and Wellbeing and Adult Social Care) and primarily supported through Leeds City Council's Scrutiny Support Office.

2.4 The outcome of the review resulted in a decision to reconfigure surgical centres that would see the closure of the existing surgical centre at the Leeds Children's Hospital within Leeds General Infirmary. The decision was made in July 2012.

2.5 The JHOSC has produced two detailed reports, published in October 2011 and November 2012 (previously presented to the Scrutiny Board), which have been used

to support a referral to the Secretary of State for Health. The Secretary of State for Health has asked the Independent Reconfiguration Panel (IRP) to undertaken a review of the decision and provide its advice by 28 March 2013.

2.6 As part of its review, members from the IRP heard from a number of stakeholders during a two-day visit to Leeds. This included oral evidence and a lengthy discussion with members of the JHOSC on 29 January 2013.

2.7 The advice from the IRP and any associated decision from the Secretary of State for Health will be reported to the Scrutiny Board once these details become available. This is unlikely to be before the end of April 2013, although there are no definitive timescales once the IRP has issued its advice to the Secretary of State for Health.

A Review of NHS services for Adults with Congenital Heart Disease (ACHD)

2.8 As previously reported to the Scrutiny Board, following on from the Review of Children's Congenital Cardiac Services, a similar review relating to services to adults is currently underway.

2.9 In May 2012, NHS Specialised Services published a newsletter regarding the review of services for Adults with Congenital Heart Disease (ACHD) and some early engagement work took place in Summer 2012 – seeking general views on a proposed model of care and the draft national designation service standards.

2.10 The engagement document also provided an indicative timeline for the review and subsequent decision. It was expected that national public consultation would take place in Summer/ Autumn 2013, with a decision on the future of ACHD services expected toward the end of 2013. However, recent contact with NHS Specialised Services has revealed an estimated 4/5 month slippage in the timetable.

2.11 A further stakeholder newsletter/ formal update was expected in late December 2012/ early January 2013. This has not yet been published.

2.12 It should be noted that at a future meeting, the Scrutiny Board (Health and Wellbeing and Adult Social Care) is likely to be asked to consider the merits of establishing a further Joint Health Overview and Scrutiny Committee to consider and respond to specific proposals around the ACHD review. The timing of this may be affected by a number of factors, including the overall progress of the review and any decision from the Secretary of State for Health in relation to the Review of Children's Congenital Cardiac Services.

Services for blind and visually impaired people across Leeds

2.13 Following the Scrutiny Board's consideration of issues raised by the National Federation for the Blind (Leeds and District Branch) at its previous meeting (23 January 2013), further confirmatory details of some of the issues raised have been received. This information has been passed to Adult Social Care so that a written response can be provided.

2.14 Plans to organise a working group meeting to consider all the information continue. Any further update on these arrangements will be provided at the meeting.

Adult Social Care – Consultation on Charging for Non-Residential Services

2.15 In November 2012, the Scrutiny Board asked for further information around any proposed changes to 'care ring services' as part of the overall consultation on Charging for Non-Residential Services.

2.16 Attached at Appendix 2 is a briefing from Adult Social Care regarding the overall consultation on Charging for Non-Residential Services and plans for taking this work forward.

2.17 In terms of consultation and engagement, the briefing note highlights a Members Advisory Board and a Service Expert Advisory Group. Membership details for both bodies are presented below.

| **Members Advisory Board** | **Service Expert Advisory Group** |
|---|---|
| Cllr Yeadon (Chair) – Labour Group | Alliance of Service Experts and involved with previous charging reviews |
| Cllr Macniven – Labour Group (from June 2012) | Leeds LINk and involved with previous charging review |
| Cllr Latty – Conservative Group | Carers |
| Cllr M Hamilton - Liberal Democrats Group (to May 2012) | Carers, older people and involved with previous charging reviews |
| Cllr Lay - Liberal Democrats Group (from June 2012) | People with learning disabilities |
| Cllr A Blackburn – Green Group | Mental Health Day Services |
| Cllr Varley – Morley Borough Independents | Older People |
| | Younger physically disabled people |

Mid Yorkshire Hospitals Trust Information

2.18 The NHS Calderdale, Kirklees and Wakefield District Cluster Board has approved a public consultation on plans to ensure local hospital services are clinically sustainable and able to provide high quality care into the future.

2.19 As there are some Leeds patients who border the Wakefield boundary who choose to use Mid Yorkshire Trust's services, some information about the plans and associated consultation is attached at Appendix 3.

2.20 It is planned to continue to keep the Scrutiny Board (Health and Wellbeing and Adult Social Care) informed of activity undertaken by The Mid Yorkshire Hospitals NHS Trust. If required, arrangements can be made for appropriate NHS representatives to meet with the Scrutiny Board to discuss the plans and consultation process in more detail.

Unplanned dental services in West Yorkshire

2.21 Members will be aware of the imminent abolishment of primary care trusts. As a result, the primary care commissioning function is being transferred to the West

Yorkshire Area Team (WYAT), which is a subordinate body accountable to the NHS Commissioning Board. Therefore, from 1 April 2013, all dental services will be commissioned by the WYAT, including the provision of unplanned or urgent dental services to the population of West Yorkshire.

2.22 At present the 5 former West Yorkshire Primary Care Trusts (PCT) areas: Bradford & Airedale; Leeds; Calderdale; Kirklees; and Wakefield, each have an existing unplanned or urgent dental service operating within their current boundaries. Each of these service contracts comes to end on 31 March 2014, after which the primary care commissioners in the WYAT will need to ensure that these services are re-procured. It should be noted that there is a certain degree of variation in unplanned or urgent dental services currently commissioned across the 5 former West Yorkshire PCT areas.

2.23 As the provision of unplanned or urgent dental care services has to be re-procured/ commissioned in April 2014, the NHS is keen to proactively undertake a review of the existing services in each area, with a view to develop and design a unified and standardised unplanned or urgent dental care services for West Yorkshire.

2.24 As such, it is planned to begin engaging with stakeholders and patients from across West Yorkshire from 1 February 2013 for a period of three months. After such time, the aim is to design a fully informed unplanned or urgent dental service specification for the whole of West Yorkshire, and subsequently seek formal ratification in time for the impending procurement (planned to commence in early June 2013).

2.25 It is likely that the Scrutiny Board will wish to understand the context of unplanned or urgent dental services within the context of dental services overall and how these may be developed on a similar basis (i.e. across West Yorkshire). Members are also likely to want to understand the context of any proposals to change the service, compared to current provision. Consideration may also need to be given to any joint scrutiny arrangements with other West Yorkshire authorities that may be necessary.

Coroners' Rule 43 - Inquests

2.26 Members may be aware that the Scrutiny Board has been invited to take part in a new project - established by the National Association of LINk Members (NALM) - to gather information about Coroners' Rule 43 recommendations and the response to them by local bodies to which they are made.

2.27 The key objective of the project is to ensure that the actions taken - and the lessons learned as a result of these recommendations - are placed in the public arena and used as a learning tool and a source of valuable data for Local Healthwatch, Commissioners, Health and Wellbeing Boards and Overview and Scrutiny Committees.

2.28 The specific issues relevant to the Scrutiny Board relate to the following recommendation made by the West Yorkshire Coroner (in May 2012) to Leeds Teaching Hospitals NHS Trust (LTHT):

> *To consider a review of the role of the Delivery Suite Co-ordinator in taking responsibility for arranging a doctor's review of transfers from the ante-natal ward to the delivery suite, if there are suspicious or pathological traces:*

*undertaking an independent review if a patient with a pathological trace is reported by a midwife and whether doctors reviewing cardiotocography traces should record categorisations.*

2.29 LTHT has been requested to the provide (a) the Trust's response to the recommendation, and (b) outline progress against any agreed actions. Any details received will be provided to members of the Scrutiny Board for consideration. Any information received is likely to help the Scrutiny Board determine whether the matter should be added and considered as a formal agenda item at a future meeting, or addressed though an alternative mechanism.

2.30 Nonetheless, in considering any information provided by the LTHT, members of the Scrutiny Board might equally wish to consider (any of) the following points:

- The process (locally) for disseminating Rule 43 recommendations and where the responsibility lies in terms of informing the Health and Wellbeing Board, Local HealthWatch and the Scrutiny Board.

- While Rule 43 recommendations may not always directly relate matters traditionally associated with public health, given the new public health responsibilities for the Council, whether or not there is a specific role for the Director of Public Health and any associated processes for raising awareness.

- How service commissioners are made aware of these recommendations and if/how that will change under the new commissioning arrangements from April 2013.

Health and Social Care Act 2012 – Health Scrutiny Regulations

2.31 Following the publication of the Health and Social Care Act 2012 and subsequent Department of Health consultation on the associated health scrutiny regulations and guidance, the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 were published on 8 February 2013 and are available using the following link: **http://healthandcare.dh.gov.uk/hwbs-health-scrutiny-regulations-2013/**

2.32 The publication of these regulations enables local authorities to finalise local preparations for health and wellbeing boards and health scrutiny arrangements. It should be noted that the Local Government Association (LGA) and Association of Democratic Services Officers (ADSO) are jointly publishing a practical guide to support local authorities in interpreting and implementing constitutional and governance aspects of the legislation. This will be published on their respective websites in the near future.

2.33 Meanwhile, officers of the Council have started to consider the detailed implications of the regulations and any further information will be provided to the Scrutiny Board as and when this becomes available.

Executive Board minutes

2.34 At the previous meeting, members of the Scrutiny Board considered the minutes from the Executive Board meeting held on 9 January 2013. The next Executive Board is scheduled for 15 February 2013, therefore the minutes from that meeting were not

available before the despatch of this report. The minutes from the Executive Board meeting will be made available at the meeting.

2.35 It should be noted that the work schedule is likely to be subject to change throughout the municipal year, to reflect any emerging issues and/or any changes in the Scrutiny Board's priorities.

## 3 Recommendations

3.1 Members are asked to consider the current outline work schedule and the details presented in this report and agree the work schedule, incorporating any amendments if/ where appropriate.

## 4 Background papers[1]

None used

[1]The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

**Scrutiny Board (Health and Wellbeing and Adult Social Care) 2012/13 Municipal Year** **Appendix 1**

| | Schedule of meetings/visits during 201213 | | |
|---|---|---|---|
| **Area of review** | **December** | **January** | **February** |
| **Dementia in Leeds** | | Update on Strategy and Dementia friendly city<br>SB 23 January 2013 @ 10 am | |
| **Mental Health Services in Leeds** | | | WG – date to be determined |
| **Loneliness and Social Isolation** | | | WG – date to be determined |
| **Public Health and Planning responsibilities** | | | |
| **Review of Partnership effectiveness and associated arrangements** | | | |
| **Other (details defined)** | Care Quality Commission – local activity report<br>SB 19 December 2012 @ 10 am<br><br>Quality Accounts: Updates on progress/ priorities identified in 2012 from:<br>• LTHT<br>• LYPFT<br>• LCH<br>• YAS (particularly focus on Patient Transport Service performance/ progress)<br>To include commissioner assurance – NHS ABL/ CCGs.<br>SB 19 December 2012 @ 10 am | | Public Health transition update – to include details of any Public Health funding allocations that may have been announced.<br>SB 20 February 2013 @ 10 am |

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

**Updated: February 2013**

**Scrutiny Board (Health and Wellbeing and Adult Social Care) 2012/13 Municipal Year** **Appendix 1**

| | Schedule of meetings/visits during 201213 | | |
|---|---|---|---|
| **Area of review** | **December** | **January** | **February** |
| **Briefings** | | Health Service Developments Working Group<br>WG date to be determined | Health Service Developments Working Group<br>WG date to be determined |
| **Budget & Policy Framework Plans** | | | |
| **Recommendation Tracking** | | | |
| **Performance Monitoring** | • 2012/13 Quarter 2 performance report<br>• NHS Airedale Bradford and Leeds Cluster – performance report<br><br>SB 19 December 2012 @ 10 am | | |



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

**Updated: February 2013**

**Scrutiny Board (Health and Wellbeing and Adult Social Care) 2012/13 Municipal Year** **Appendix 1**

| | Schedule of meetings/visits during 201213 | | |
|---|---|---|---|
| **Area of review** | **March** | **April** | **May** |
| **Dementia in Leeds** | | Update on Strategy and Action Plan<br>SB 24 April 2013 @ 10 am | |
| **Mental Health Services in Leeds** | | | |
| **Loneliness and Social Isolation** | | | |
| **Public Health and Planning responsibilities** | | | |
| **Review of Partnership effectiveness and associated arrangements** | Annual Assessment by the SB<br>SB 27 March 2013 @ 10 am | | |
| **Other (details defined)** | Progress update against the Local Account SB 27 March 2013 @ 10 am<br><br>Draft Quality Accounts for 2012/13 from:<br>• LTHT<br>• LYPFT<br>• LCH<br>• YAS<br>To include commissioner assurance – NHS ABL/ CCGs. (TBC) | Update on progress against the Leeds Tobacco Action Plan and previous Scrutiny Board recommendations.<br><br>Outcome of work around Services for the Blind and Visually Impaired<br>SB 24 April 2013 @ 10 am | |
| **Briefings** | Health Service Developments Working Group<br>WG date to be determined | Health Service Developments Working Group<br>WG date to be determined | |
| **Budget & Policy Framework Plans** | | | |
| **Recommendation Tracking** | | | |

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

**Updated: February 2013**

| | | | |
|---|---|---|---|
| **Performance Monitoring** | • 2012/13 Quarter 3 performance report<br>• NHS Airedale Bradford and Leeds Cluster – performance report<br>SB 27 March 2013 @ 10 am | | |



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

**Updated: February 2013**

# Adult Social Care
# Consultation on Charging for Non-Residential Services
## Briefing Note

1 Reasons for the Charging Review

1.1 Although changes were made to the Adult Social Care charging policy in 2009 & 2011, customers in Leeds continue to pay less than in most authorities. Also, the demands on social care services are increasing and government funding to councils is reducing. In this context, in July 2012 Executive Board approved a consultation process on further proposed changes. At this stage no decisions on any changes to charges have been made.

1.2 There are some anomalies in the current charging arrangements that give rise to potential inequities e.g.

- Charges are made for respite care provided in a residential home, but respite care provided in community settings such as sitting services in the customer's home do not currently attract a charge
- The services people receive through mental health day centres are not currently treated as chargeable services, but this is not consistent with day services for other client groups

2 Scope of the Review & Consultation Proposals

2.1 The Council has direct responsibility for setting customer charges for services provided to meet assessed social care needs following a care assessment and for any other services for which the Council is the provider. These services are within the scope of this charging review. For social care services commissioned by the Council that are not necessarily accessed via a care assessment the Council will seek to achieve consistency in charging arrangements through the commissioning process. This process will follow on from the current charging review rather than being dealt with as part of this review.

2.2 The proposals for consultation are:

- introducing new charges for some services that are currently free, and
- changing the way that we charge people and how much they will be asked to pay towards the services that they receive

2.3 The proposed new charges are:

| | Indicative Charges | Mainly Charged for Elsewhere |
|---|---|---|
| Home Based Sitting Services | | |
| Shared Lives Outreach | £13.00 per hour daytime, £14.50 waking night-time | Yes |
| Shared Lives Day Support | £13.00 per hour | |
| Mental Health Services | | |
| Directly provided day services | £9.00 per session (group), £18.00 per hour (one to one) | Yes |
| Care Ring & Telecare | | |
| Care Ring (1st generation - pendant alarm) | £2.00 per week + £1.20 equipment rental (+VAT) | Yes |
| Telecare (2nd generation - peripheral monitors) | £3.00 per week + £2.50 equipment rental | Yes |
| Telecare (3rd generation - GPS system) | £9.00 per week + £3.50 equipment rental | Yes |
| Telecare Just Checking (usually short-term) | £9.00 per week + £7.50 equipment rental | Yes |
| Mobile Response Service | £3.00 per week | Yes |

2.4 For mental health housing support services there is a proposed increase in the charge from £13.00 per hour to £18.00 per hour to reflect the cost of providing the service.

2.5 The two proposed changes to the financial assessment methodology are:

- Adopting the same approach to capital (savings and investments) as is used for residential assessments (but excluding the value of a person's home)
- Assessing 100% of disposable income (after allowances for daily living, housing and disability related costs) as being available to contribute towards care services (currently 90%)

3 Impact of Proposals

3.1 These proposals would generate estimated net additional income the Council of £2.7m in a full year. As with previous charging reviews, the additional income arising from the proposals within this review will be reinvested to support service improvements and help to mitigate future financial pressures within Adult Social Care services.

3.2 For customers who have been financially assessed 3,450 (65%) would see no change in their payments. For 140 people (2%), mainly those with savings over £23,250, the increase would be more than £50 per week.

3.3 The impact of the proposals to introduce new charges cannot be determined accurately as the substantial majority of customers are not receiving other chargeable services and so have not been financially assessed. Overall, 43% of people who are financially assessed do not contribute towards their care services. The Care Ring charge was proposed in the consultation to be applicable to all customers without being subject to a financial assessment, unless it forms part of a care package to meet eligible social care needs.

3.4 When changes have been made to charges previously, transitional arrangements have been put in place to limit the impact on existing customers initially to give them time to adjust to the new charges. These phased arrangements will apply to any changes arising from this review.

4 Consultation Approach, Outcomes & Decision Making Timescales

4.1 The consultation process is being supported by a Service Expert Advisory Group. This group has reviewed the overall consultation approach and the consultation documentation that was sent to customers. It is now considering the feedback received through the consultation process and preparing a report on it. The group is also supporting the preparation of the Equality, Diversity, Cohesion and Integration Impact Assessment.

4.2 A Members Advisory Board with representatives from all political groups has also been overseeing the charging review from the outset and will consider the final proposals before they are submitted to Executive Board.

4.3 The consultation period was September to December 2013. Consultation documents outlining the proposals and seeking feedback on their potential impact were sent to approximately 20,000 customers and just over 3,000 have been returned. Drop-in sessions for customers have taken place across the city and focus groups have been held with VCFS organisations and other stakeholder groups.

4.4 The consultation process has yielded a wealth of information that is currently being analysed and shared with the Service Expert Advisory Group. The main concerns raised in the consultation relate to affordability and this is a particular issue for Care Ring as people would not be financially assessed. The charging review team is looking into possible ways of mitigating the impact of this proposal. People living in sheltered accommodation also raised concerns about whether they would be able to opt out of the service or whether it was a requirement in their tenancy. Environments & Neighbourhoods have confirmed that people living in sheltered accommodation will be able to exercise their choice about whether to use Care Ring in the same way as people living elsewhere.

4.5 Taking account of the consultation feedback and the Equality, Diversity, Cohesion and Integration Impact Assessment the charging review team is considering whether any changes to the original proposals should be recommended to Executive Board.

4.6 A report with final recommendations is currently scheduled for Executive Board in April 2013. All customers will be advised of the outcome and given a minimum of one month's notice of any changes that will affect them.

NHS
Airedale, Bradford and Leeds

30 January 2013

## Mid Yorkshire Clinical Services Strategy

Please find information below for the Leeds Health and Wellbeing and Adult Social Care Scrutiny Board about a consultation that The Mid Yorkshire Hospitals NHS Trust will be undertaking. The NHS Calderdale, Kirklees and Wakefield District Cluster Board has approved a public consultation on plans to ensure local hospital services are clinically sustainable and able to provide high quality care into the future.

The proposed changes are detailed below and information has been provided by colleagues in the NHS Calderdale, Kirklees and Wakefield PCT Cluster.

The plans were put together by The Mid Yorkshire Hospitals NHS Trust and outline their business case for changes to the way services are provided. During 2012 the Trust had looked at two main options for change, working with clinicians, staff, patients, public and community representatives to finalise their preferred option.

Jo Webster, Accountable Officer for NHS Wakefield Clinical Commissioning Group is leading the process, and the Clinical Commissioning Groups (CCGs) which will be taking over responsibility from the primary care trusts in April were part of the decision making.

### Details and purpose of proposed changes

The proposed changes aim to strengthen the services that are provided to the most seriously ill and injured patients, and make sure that tests, planned treatments and outpatient care are available as close to home as possible. This would mean separating planned and unplanned services, with Pinderfields becoming the major centre for:

- emergency and complex surgery
- inpatient emergency medicine
- critical care
- colorectal surgery
- inpatient children's services
- consultant-led births

Pontefract and Dewsbury would become centres for planned care with increased diagnostics and more operations. Both hospitals would also have an emergency department providing open access for a range of conditions including some ambulance attendances.

Pinderfields would continue to provide consultant-delivered emergency care with full resuscitation facilities and deal with critically ill and injured patients. Both Dewsbury and Pontefract Hospitals would deliver emergency care via a mix of doctors and advanced nurse practitioners. There would also be consultants during the day and on-call as well as full resuscitation facilities available. The three hospitals would operate as an emergency care network.

- Consultant-led maternity care will be centralised at Pinderfields Hospital, with midwife-led units at Dewsbury, Pontefract and Pinderfields. Antenatal (before the birth) and postnatal care (after the baby has been born) would still be provided locally at all three hospitals and in GP practices and community clinics.
- Neo-natal services (for very poorly and premature babies) would be located with consultant-led maternity care at Pinderfields.

- Inpatient services for children would be centralised at Pinderfields Hospital. This includes surgery for children, which is already centralised at Pinderfields, and inpatient medical care. Dewsbury would have a short stay unit for children who may need to be observed by a clinical team for a few hours.
- Complex, emergency and major surgery (generally requiring the backup of critical care) would take place in Pinderfields. Dewsbury Hospital would offer most planned inpatient surgery (including orthopaedics from the Dewsbury area) but there would be no emergency or complex surgery. Pontefract Hospital would offer planned orthopaedic operations, including those requiring an inpatient stay and some short-stay surgery from other surgical specialties.

**What are the benefits for patients?**
The Mid Yorkshire Hospitals Trust has been working hard to make sure that services are high quality, responsive and accessible, based on sound clinical evidence of what will give the best results. The proposed changes would:

- save more lives, improve experience and deliver better outcomes for patients
- secure long term clinical sustainability of all three hospitals
- allow Trust to meet national care standards and best practice.
- improve access to planned care
- provide an integrated network of emergency care giving fast access to the most appropriate level of care
- make the best use of available resources
- address the workforce challenges and support a move towards 24hour/7 day consultant cover in major specialities
- ensure services are provided as efficiently as possible, making a significant contribution to financial viability
- reduce the risk of local services being lost altogether and protect specialist services

**What work has been done to inform the development of the proposals?**

**Process / timeline**

- **2011** - five options were initially identified and engaged on, based on addressing recommendations from a previous National Clinical Advisory (NCAT) NCAT review.

- **Early 2012** the Trust realised further steps were needed to ensure that services were clinically safe and provided the best patient outcomes now and for the future. They also recognised that they needed to work through how the changes could contribute to the financial challenges within the local health system. On this basis, they looked again at clinical evidence from across the country, examined the rigorous standards set nationally and took stock of our resources, including both finances and clinicians.

- **May/June 2012**: This led the Trust to two options which have been discussed widely throughout the remainder of the year with national experts, members of the public, patient representatives and politicians. This work concluded that there is only option that would achieve the aim of achieving sustainable clinical excellence as well as being financially viable.

- **Jan 2013.** An Outline Business Case was put together on this basis and presented to a meeting of the NHS Calderdale, Kirklees and Wakefield District Board (the commissioners) on January 10 2013. The Board approved the recommendation that the single option should go to public consultation

**What is the clinical evidence on which the proposals are based?**
National Clinical Advisory (NCAT) review 2009/10 - recommended that more services should be brought together on one site, including acute surgery and children's services. Also made a number of recommendations for changes to the way planned and emergency care is organised, to help reduce waiting times, minimise the number of cancelled operations and bring down infection rates.

Review of women's services 2011, led by experts from Southampton University Hospital NHS Trust - recommended that obstetric services should also be centralised to provide the best care for women, which was then reinforced by guidance from the Royal College of Obstetricians and Gynaecologists.

**Engagement and consultation to date**
Patients and stakeholders have been involved in developing options and identifying the preferred option for consultation. Analysis of patient flows indicated that patients from some Leeds areas were users of some of the services in question so the Leeds CCGs became directly involved in the process from November 2011 and plans for the pre-consultation campaign expanded to target patients in these areas.

This has predominantly been done through a telephone survey, where participants were recruited to a demographically-representative profile, and also invited to attend a deliberative event in December to discuss the options in more detail. Analysis of the findings will include a Leeds-specific breakdown and is expected to be completed by the end of January.

**Engagement and consultation future**
- March 2013 to June 2013 – formal consultation. To include Leeds patients and Leeds stakeholders. NHS Calderdale, Kirklees and Wakefield District has been provided with a full list of elected members, community and voluntary sector organisations and other key stakeholders in the postcodes which fall into the Leeds boundary but use some Mid Yorkshire Trust services. Full communication and engagement plan will be available if required.

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