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

Meeting to be held in Civic Hall, Leeds, LS1 1UR on Wednesday, 27th March, 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;

Co-optees (Non voting)

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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Produced on Recycled Paper

A G E N D A

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

3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES - 20TH FEBRUARY 2013** To confirm as a correct record, the minutes of the meeting held on 20th February 2013. **(Copy to follow)**	
7			**CHARGES FOR NON-RESIDENTIAL ADULT SOCIAL CARE SERVICES** To receive and consider a report from the Director of Adult Social Services informing the Scrutiny Board of the outcomes of the stakeholder consultation and engagement on the Adult Social Care charging review for non-residential services.	1 - 38
8			**2012/13 QUARTER 3 PERFORMANCE REPORT** To receive and consider a report from the Assistant Chief Executive (Customer Access and Performance) providing a summary of performance against the strategic priorities relevant to the Health and Well-being and Adult Social Care Scrutiny Board.	39 - 60

9			**SCRUTINY INQUIRY - STRATEGIC PARTNERSHIP BOARDS** To receive and consider a report from the Head of Scrutiny and Member Development outlining the strengths and areas for development in relation to the Health and Well-being Board.	61 - 116
10			**WORK SCHEDULE - MARCH 2013** To receive and consider a report from the Head of Scrutiny and Member Development outlining the Scrutiny Board's work schedule for the remainder of the municipal year.	117 - 188
11			**DATE AND TIME OF THE NEXT MEETING** Wednesday, 24th April 2013 at 9.30am (Pre-meeting for all Board Members at 9.30am)	

Leeds CITY COUNCIL

Report author: Ann Hill
Tel: 24 78555

Report of the Director of Adult Social Services

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

Date: 27th March 2013

Subject: Charges for Non-Residential Adult Social Care Services

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

Summary of Main Issues

1. This report informs Scrutiny Board of the outcomes of the stakeholder consultation and engagement on the Adult Social Care charging review for non-residential services.
2. The extensive stakeholder consultation and engagement has been overseen by an all party Members Advisory Board and a Service Expert Advisory Group. The attached report sets out in detail the way in which the consultation and engagement process has been undertaken and the outcomes from it.
3. The main concern expressed in the consultation responses relates to the affordability of the proposals and the impact this may have on people's use of services.
4. A Scrutiny Board Working Group on 12th April is proposed to consider the charging proposals that will be submitted to Executive Board on 24th April. This will enable members of Scrutiny Board to provide any comments for inclusion in the Executive Board report.

Recommendations

5. Scrutiny Board is asked to:

   a) Note the outcomes of the stakeholder consultation and engagement on the Adult Social Care charging review for non-residential services.
   b) Make nominations for the proposed Scrutiny Board Working Group on 12th April

1. Purpose of this report

1.1. The purpose of this report is to inform Scrutiny Board of the outcomes of the stakeholder consultation and engagement on the Adult Social Care charging review for non-residential services.

2. Background information

2.1. In July 2012 Executive Board approved a consultation process on proposed changes to charges for non-residential Adult Social Care services as set out in section 3 below. The proposals for consultation were designed to bring Leeds into line with the substantial majority of other authorities and to address the anomalies within the current charging arrangements.

2.2. A briefing note was submitted to Scrutiny Board on 20th February outlining the scope of the charging review, the consultation approach and proposals and the review timetable.

3. Consultation Process, Proposals and Outcomes

3.1. The proposals approved by Executive Board in July 2012 to be consulted on are:

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

3.2. The proposed new charges that were consulted on were:

Service	Proposed Charge
CareRing and Telecare	
CareRing (Pendant Alarm)	£3.84 per week (including VAT)
Telecare (Peripheral Monitors)	£5.50 per week
Telecare (GPS Systems)	£12.50 per week
Telecare (Just Checking)	£16.50 per week
Mobile Response Service	£3.00 per week
Home-based Sitting Service	
Shared Lives service: Outreach	£13.00 per hour daytime £14.50 waking night-time
Shared Lives service: Day Support	£13.00 per hour
Mental Health Services	
Directly provided day services	£9.00 per group session £18.00 per hour one-to-one support

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

3.4. The two proposed changes to the assessment methodology were as follows:

- 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%)

3.5. The stakeholder consultation and engagement has been overseen by an all party Members Advisory Board and a Service Expert Advisory Group.

3.6. The attached report sets out in detail the way in which the consultation and engagement process has been undertaken and the outcomes from it. The Service Expert Advisory Group has been provided with full details of the consultation outcomes and is preparing a report on the key issues that it wants to highlight for Executive Board to consider when it makes a decision on the charging review.

3.7. The charging review outcomes and final recommendations are scheduled for Executive Board on 24th April.

3.8. The main issue raised in the consultation relates to the affordability of the proposals. These affordability concerns were related to a significant percentage of people expressing the view that they would cancel, consider cancelling or reduce their services if the consultation proposals went ahead.

3.9. Almost 4,000 feedback forms were received and the main outcomes from them were as follows:

- 61% of respondents said that the proposals would have an impact on their daily lives and 31% said that they would not affect their daily lives.
- 24% of respondents said that they would cancel their service, 19% said they would consider cancelling and 3% said they would reduce the services that they use.
- 28% of respondents said that the proposals would not affect their use of services.
- 47% of respondents said that the proposals would have an impact on their carers/family members and 46% said that they did not think that the proposals would affect their carers/family members.
- 26% of respondents raised concerns about the affordability of the proposals.

3.10. The views expressed by customers at the drop-in events and meetings and by other stakeholders generally covered the same issues as the feedback forms.

3.11. The original consultation proposals are being reviewed in the light of the consultation outcomes before final recommendations are made to Executive Board. The outcomes of the consultation have also informed the Equality, Diversity, Cohesion and Integration Impact Assessment that was prepared in conjunction with the Service Expert Advisory Group.

4. Scrutiny Board Input

4.1. A Scrutiny Board Working Group on 12th April is proposed to consider the charging proposals that will be submitted to Executive Board on 24th April. This will enable members of Scrutiny Board to provide any comments for inclusion in the Executive Board report.

5. Corporate Considerations

5.1. Consultation and Engagement

5.1.1. The attached report sets out the extensive stakeholder consultation and engagement that has been undertaken.

5.2. Equality and Diversity / Cohesion and Integration

5.2.1. An Equality, Diversity, Cohesion and Integration Impact Assessment has been prepared and this will form an appendix to the Executive Board report that will make final recommendations on the charging review.

5.3. Council Policies and City Priorities

5.3.1. This charging review will contribute to the Health and Wellbeing City Priority Plan through generating additional income to support more people to live safely in their own homes. It will also contribute to the Council's Business Plan priority of spending money wisely.

5.4. Resources and Value for Money

5.4.1. There are no resource implications arising from this report. The resource implications of the final charging review proposals will be included in the Executive Board report.

5.5. Legal Implications, Access to Information and Call In

5.5.1. There are no legal implications arising from this report. The legal implications of the final charging review proposals will be included in the Executive Board report.

5.6. Risk Management

5.6.1. There are no risk management issues arising from this report. Any risk management issues arising from the final charging review proposals will be included in the Executive Board report.

6. Conclusions

6.1. Extensive stakeholder consultation and engagement has taken place on the proposals set out in the July 2012 Executive Board report. The main issue arising from the consultation is the affordability of the proposals and the implications this may have for customers' continued use of services.

7. Recommendations

7.1. Scrutiny Board is asked to:

a) Note the outcomes of the stakeholder consultation and engagement on the Adult Social Care charging review for non-residential services.
b) Make nominations for the proposed Scrutiny Board Working Group on 12th April

8. Background Documents[1]

8.1. There are no background documents for this report.

[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

Adult Social Care

Charging Review for Non-Residential Services 2012 / 13

Report on the Consultation and Engagement

March 2013

1. Executive Summary

1.1. In July 2012, Executive Board gave approval for Adult Social Care to consult with Stakeholders on a number of proposals relating to its charges for non-residential Adult Social Care services.

1.2. From July 2012 to March 2013, Officers from Adult Social Care have engaged with a range of stakeholders to ascertain how the proposals to amend the charges will affect:

- People who use the services
- The carers and family members of people who use the services
- The services themselves

1.3. A range of methodologies were used to give stakeholders (particularly service users, members of day services and carers) a number of opportunities for them to have their say.

1.4. The feedback that has been obtained from the engagement activities has been collected and analysed, and forms the basis of this report.

1.5. The key findings of the consultation are:

- A significant percentage of service users believe that they cannot afford the proposed charges and /or the changes to the council's financial assessment methodology
- A significant percentage of service users believe that they will need to cease or reduce their use of services as a direct result of the proposals.

2. The Context of the Charging Review Consultation and Engagement

2.1. The Government assumes that local councils will ask people to pay towards the cost of their services and the amount of money that the Government gives councils to provide services is reducing. This means that without people paying towards their services we would not be able to provide the level and quality of services to people who need them.

2.2. Each Council decides how to charge people and what to charge them for the services that they receive, but they have to follow the government's guidance on how to do this. In Leeds people pay less towards the cost of their social care services than other similar Councils. This means that Leeds does not have as much money to spend on services as other similar Councils.

2.3. Charging Reviews have been undertaken previously in 2008/09 and 2011 which involved consulting with service users, carers and a range of interested stakeholders. Three of the clear outcomes from the previous consultations that were undertaken that are relevant to this review are:

- people did not agree with charging for adult social care services;
- people did not agree with increasing the amount that they contribute towards the cost of their services;
- people did not agree with their savings being used to calculate their contribution and they felt that some people who had not saved were being subsidised by those who had saved

2.4. The changes made to the Charging Policy in 2009 and 2011 brought Leeds more in line with other authorities, but our income from customer contributions remains lower than the core cities average. This impacts on the funding available to the Council to fund Adult Social Care services.

2.5. There are three main reasons for income for charges in Leeds being lower:

- There are some services in Leeds for which charges are not made
- There are some anomalies within the current charging arrangements which mean that service users are charged differently for similar services
- The financial assessment methodology takes a lower amount of people's income and savings into account than in most authorities

2.6. There are two main differences between the financial assessment methodology in Leeds and that of most other authorities:

- Most comparator authorities take 100% of disposable income (after allowances for daily living, housing and disability related costs) as being available to contribute towards care services compared with 90% in Leeds
- All comparator authorities use the same approach to capital (savings and investments) as is used for residential assessments, but in Leeds higher capital thresholds are used.

2.7. There are some anomalies in the current charging arrangements that give rise to potential inequities. For example, 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.

2.8. In July 2012, the Executive Board approved a consultation process on proposed changes to charges for non-residential Adult Social Care services. The proposals for consultation were designed to bring Leeds in line with the substantive majority of other authorities and to address the anomalies within the current charging arrangements.

2.9. The proposals approved by Executive Board in July 2012 to be consulted on 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

2.10. The proposed new charges that were consulted on were:

Service	Proposed Charge
CareRing and Telecare	
CareRing (Pendant Alarm)	£3.84 per week (including VAT)
Telecare (Peripheral Monitors)	£5.50 per week
Telecare (GPS Systems)	£12.50 per week
Telecare (Just Checking)	£16.50 per week
Mobile Response Service	£3.00 per week
Home-based Sitting Service	
Shared Lives service: Outreach	£13.00 per hour daytime £14.50 waking night-time

Service	Proposed Charge
Shared Lives service: Day Support	£13.00 per hour
Mental Health Services	
Directly provided day services	£9.00 per group session £18.00 per hour one-to-one support

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

2.12. The two proposed changes to the assessment methodology were as follows:

2.12.1. Applying the Department of Health Charging for Residential Accommodation Guide (CRAG) approach to taking into account savings and investments (excluding the value of a person's home)

- People would pay in full for their care if they had savings above £23,250 rather than above £46,500 as they do currently
- People with savings between £14,250 and £23,250 will pay more based on their savings (a notional amount of £1 will be added to their weekly income for every £250 in savings between these two thresholds compared with every £500 of savings currently)

2.12.2. Assessing 100% of people's disposable income (after allowances for daily living, housing and disability related costs) as being available to contribute towards care services rather than the current 90%.

3. The Consultation and Engagement Process

3.1. The role of the Advisory Groups

3.1.1. In July 2012, following approval by Executive Board to consult on the new charging proposals, two advisory groups were established:

- the Members Advisory Board
- Service Expert Advisory Group

3.1.2. The Members Advisory Board had representation from the five political parties and it met from November 2011 to March 2013. The purpose of the board was to oversee the charging review, including the consultation process and outcomes.

3.1.3. The Service Expert Advisory Group met from July 2012 to March 2013. The membership of the group represented:

- A number of user led groups, that is the Leeds Local Involvement Network, The Alliance of Service Experts and Leeds Involving People;
- A number of service user groups, that is learning disabilities, mental health, older people, younger disabled people and carers;
- The service users that would potentially be affected by the proposals.

3.1.4. The purpose of this group was to advise Adult Social Care on the following aspects of the Charging Review:

- The accessibility and clarity of the publicity and explanations of the review process;
- The accessibility of the consultation process;

- The accessibility of the report of the consultation findings
- The impact that the proposals could potentially have on people (which would contribute to the Equality, Diversity, Cohesion and Integration Impact Assessment).

3.1.5. The Service Expert Advisory Group has produced their own report on their involvement in the process and the key messages that they would like to emphasise from the findings. This report is included within the Executive Board report.

3.2. Approaches to People Potentially Affected by the Proposals

3.2.1 Consultation and Engagement Principles

In the planning and undertaking of the consultation and engagement activity a number of principles were adopted:

- To ensure that all service users who could be affected by the proposals were informed of the proposals and were provided with an opportunity to let the Council know how they would affect them.
- To ask people how the proposals may affect them and their family and/or carers to gain a better understanding of the impact of the proposals.
- Where possible, to provide specific information to service users on how the proposals may affect them.
- To provide a number of opportunities/ways in which people could contribute to the community engagement
- To ensure, as far as we were able, that the data/information that we had available on service users, was as up to date/relevant as possible, including information relating to people's equality characteristics.
- To involve representatives of service users and carers in the planning and analysis of the community engagement.
- To involve Elected Members through an all party Advisory Group in overseeing the consultation process and outcomes.
- To have a flexible approach to the community engagement, adjusting to local needs and requirements.

3.1.2 Prior to the distribution of the consultation information, work was undertaken to clean up the data and information that was held by Adult Social Care in relation to the people who use services. This was to minimise the risk of sending documents out to people no longer in receipt of services.

3.1.3 Information was sent to all service users who may be affected by the proposals, that is, everyone who had received a financial assessment, and people who were in receipt of the services we were considering introducing a charge for, with an opportunity for them to have their say about the proposals.

3.1.4 Five different information packs were produced, one for each of the following categories of service user:

- People who have been financially assessed
- CareRing and Telecare
- Shared Lives
- Mental Health Day Services
- Mental Health Housing Support.

3.1.5 21,469 packs of information were sent out to services users.

The information packs that were distributed to service users contained:

- A covering letter providing introductory details
- A sheet for people who may wish to request the information in alternative languages
- Details of who to contact with any queries and the dates and times of the drop-in sessions held across the city
- An information sheet setting out the proposals
- A feedback form for people to tell us their views about the impact of the proposals
- A pre-paid reply envelope.

3.1.6 For people who had received a financial assessment, the Council was able to notify them specifically on how the proposed changes to the financial assessment methodology would affect them financially.

3.1.7 The feedback forms and briefing documents were developed with the Service Expert Advisory Group and the Service User and Carer Editorial Board.

3.1.8 The feedback forms focussed on asking people how the proposals would affect them and not whether they agreed with the proposals. A copy of the Feedback Form is attached at Appendix 1. Responses were made using free text and these responses were then analysed which identified themes emerging from the responses.

The majority of feedback forms were sent through the post, except in Mental Health Day Services where the majority of forms were distributed through the day centres.

3.1.9 A Freephone number allocated to the Financial Assessment Team enabled people to contact the team to discuss the potential impact of the proposals on their individual financial situation and to complete a Feedback Form via the telephone. In addition this was used as the general telephone number for raising any issues on the proposals and to request documents in different languages and formats.

3.1.10 An e-mail account was created for the Charging Review. This was an additional method for people to raise any issues, to request documentation in different formats and to submit a completed form electronically.

3.1.11 People were also offered the opportunity to request a visit from an Officer who would assist in completing the form with the individual in their own home or at a place of their choosing.

3.1.12 A number of drop in events were held across the city based on areas of Leeds that had the highest concentration of people who used services and that were also accessible by public transport. Details of all the consultation events held are set out in Appendix 2. In respect of Mental Health Day Services, drop-in events were held in each of the three day centres (The Vale, Lovell Park and Stocks Hill).

The purpose of the drop-in events was to provide people with an opportunity to discuss the issue, receive assistance to complete the feedback form, and to identify the potential impact in them personally. Officers from the Financial Assessment Team attended the drop-in events to offer guidance to people on how the proposals may affect them.

3.1.13 Three meetings were held for people living in sheltered housing accommodation at their request or at the request of elected members.

3.1.14 Meetings were also held in Mental Health Day Centres in conjunction with officers leading on the modernisation of day services. These were held in addition to the drop-in events held in these centres.

3.2 Approaches to other interested stakeholders

3.2.2 Briefing documents were provided to Elected Members, managers and staff in Adult Social Care, NHS Commissioners, NHS provider organisations, and to the Housing ALMOs. Stakeholders had the opportunity to provide a written reply to the proposals.

3.2.3 Officers attended a number of existing meetings that included:

- Adult Social Care Managers, including managers of services where charges were proposed
- Carers at the Carers Expert Advisory Group
- NHS Commissioner and Provider organisations at the Telecare Development Group and the Equipment Partnership Board
- Community Groups at the Social Care Community Forum for Race Equality.

3.2.4 Specific meetings were also arranged to discuss the proposals and the potential impact on service users and services with the following stakeholder groups:

- Elected Members
- NHS Commissioner and Provider organisations that included representatives of the Yorkshire Ambulance Service, Leeds Teaching Hospitals Trust, Leeds and York Partnership Foundation Trust, Leeds Community Healthcare and NHS Airedale, Bradford and Leeds.
- Third Sector Mental Health Service Providers
- ALMO Chief Executives
- Supporting People Alarm Call Providers
- Adult Social Care members of staff

4. The Consultation and Engagement Outcomes

4.1. Overview

4.1.1. 21,469 Feedback Forms were distributed to service users.

Details of the breakdown of forms distributed between the services affected by the proposals are attached at Appendix 3. The details show that the highest number of forms were distributed to people using the CareRing/Telecare service (14,599 - 68%) whilst the highest percentage of feedback form returns came from the Shared Lives Service (23%). A summary of the consultation responses from the feedback forms is attached at Appendix 4.

4.1.2. Overall the response rate was 18% (3,963 forms). A lower proportion of people using financially assessed services responded to the consultation (12%) compared with people using other services (range 15% to 23%). The lowest response rates were from mental health day centres (15%) and people who have been financially assessed (12%). There are two possible reasons for this:

- Officers met with members of Mental Health Day Services at a number of meetings and drop-in events at their centres. This provided an opportunity for people to have their say at face-to-face meetings with Officers.
- People who have received a financial assessment received information from the Council on how the proposals would specifically affect them.

4.1.3. As there was a wide ranging number of responses between the various groups of people potentially affected by the proposals, work was undertaken to identify any statistically significant variations and the results of this are attached at Appendix 5.

4.1.4. At the same time as officers were consulting on the issue of the Charging Review consultation was being undertaken on the modernisation of Mental Health Day Services. In addition, the CareRing service was in the process of upgrading its equipment in people's homes. This meant that the Charging Review consultation picked up issues relating to both of these service changes: the Charging Review project team referred these issues to the appropriate services.

The Main Overarching Themes arising from all the Feedback Forms

4.1.5. The proposals will have an impact on a high percentage of people who responded to the consultation. *Impact on Daily Lives:*

- 61% of respondents (2,194 people) said that the proposals would have an impact on their daily lives, and 31% (1,111 people) said that it would not affect their daily lives.
- A higher proportion of those attending mental health day centres (81%) and using mental health housing support services (85%) said the proposals would impact on their daily lives than those using CareRing/Telecare (60%), Shared Lives (68%) or financially assessed services (59%).

4.1.6. *Affordability.* Overall 26% of people responding (1,044 in total) raised concerns about the affordability of the proposals. A number of people who responded perceived that they would not be able to afford to continue to use the service or that they would continue to use the service and pay the charge but make adjustments elsewhere in their lives. Some of the service users stated that it would affect their daily lives with examples including it affecting people's social life, and / or other services that they buy to help them live at home, such as cleaners and gardeners. However, this was not true for all of the people who responded as some people acknowledged, through additional comments, that the Council would have to charge for services. A higher proportion of responses from people using CareRing/Telecare (36%), Shared Lives (33%) and mental health day services (39%) indicated that affordability was a reason for the impact of the proposals on their daily lives than for people using financially assessed services (22%) and mental health housing support services (21%).

4.1.7. *Cancellation of services.* Overall 24% of those responding (742 people) said that they would cancel their services. 19% of those responding (608 people) said that they would consider cancelling and 3% (94 people) said that they would reduce their services.

Any cancellation of services, as a result of this perceived inability to afford the charges, would be to the detriment of people's mental and physical wellbeing, and to their independence and security. A lower proportion of people using financially assessed services indicated that they would cancel their service (10%) compared with the users of Care Ring/telecare (26%), Shared Lives (37%) and mental health day services (40%)

4.1.8. *Impact on Carers.* 47% of those who responded (1,197 people) via the feedback forms said that the proposals would have an impact on their carers / family members and 46% (1,183) said that they did not think that the proposals would affect their carers / family members. On this issue, a higher proportion of people using Shared Lives services (84%) indicated that the proposals would impact on their carers than people using other services (range 43% to 54%). The main reasons people gave for the impact of the proposals were stress, worry and loss of peace of mind for their

carers / family members and their carers / family members having to take on more caring responsibilities.

4.1.9. *Not charging for services:* Although stakeholders were not asked whether they agreed with the proposals or not, a number of them made additional comments saying that they did not agree with charging for services on the basis that:

- They were currently free
- They were vital services
- People perceived that they had paid for these services, either directly through their rent (in the case of people living in sheltered accommodation and Care Ring) or through their Council Tax or other contributions to the government.

<u>The main themes arising from the other consultation and engagement methods</u>

4.1.10. *Affordability:* Stakeholders were concerned about the ability of service users and/or carers to pay for the service, or that they may perceive that they cannot afford the services. Service users and carers stated that the proposals would both affect their daily lives and their use of the services.

4.1.11. *Cancellation of services*. The main risk identified by all stakeholder groups was that people who need services would cancel them and that this would have an impact on the service users and / or carers and also on the wider health and social care system.

In the statutory and third sectors, this risk was also raised along with a concern that the cancellation of services would lead to an increasing demand for their services which they could not absorb.

Of main concern to the NHS commissioning and provider representatives was the impact on emergency services and the potential for delayed discharge into a safe environment.

4.1.12. *Re-consideration of the proposals*. The consultation responses showed that people and organisational representatives were not wholly opposed to the proposals, but were concerned about the level of charge proposed and the timescale over which the changes would be implemented.

A number of suggestions were made by the people and the groups that were consulted, including the Service Expert Advisory Group. The Equality, Diversity, Cohesion and Integration Impact Assessment that accompanies this report provides details of how these proposals have been dealt with.

4.2. Changes to the Financial Assessment Methodology

4.2.1. Generally the services that people were contributing towards were well thought of, with people recognising the role that the services played in helping maintain people in their own homes.

<u>The main findings from the Feedback Forms</u>

4.2.2. People who had been financially assessed accounted for 26% of the forms issued (that is 5,654). A lower proportion of people using financially assessed services responded (12%) compared with people using other services (range 15% to 23%)

4.2.3. The feedback from the overall consultation on this issue showed that the main concern of people was the affordability of the proposals. Of those completing the feedback forms 16% (108 people) expressed concerns they could not afford the

charges or would find it difficult to pay and 20% (141 people) said that it would affect their disposable income to spend on other things.

- People were asked if the proposals would affect their daily life. 59% (372) of people who responded to via the feedback forms stated that it would and 35% (219) saying that it would not affect their daily life.
- Of the comments received in relation to whether the proposals would affect people's use of services, 10% of people (58) stated that they would cancel their services, 17% (99) said they would consider cancelling and 9% (52) said they would reduce their services.
- 39% of respondents (229) said that the proposals would not affect them and 15% (89) said that they would keep their services. For some people the additional proviso was that charges did not increase by much more in the future otherwise they would then become un-affordable. A higher proportion of people using financially assessed services said that they would keep them (15%) than those who said they would cancel (10%).

4.2.4. There was no significant difference between those respondents who said that the proposals would impact on their carers (45% - 214 people) and those who said that they would not (48% - 229 people).

4.2.5. Some people would not just be affected by the proposed changes to the financial methodology, but also by charging for services that had been provided free of charge. 462 people have been identified as affected by more than one of the new charge proposals as well as the financial assessment changes, the majority being people using Care Ring as well as financially assessed services.

4.2.6. Although we did not ask people whether they agreed or not with the proposals, we received a number of comments on the issue more generally of whether charges should be made for care services. They can be summarised as follows:

- People should contribute towards the services they receive and hopefully the charge will not be too high.
- The Council should not charge for services for older and disabled people.
- The Council should not implement the proposals in winter because of high energy bills.
- People want a better standard of services if they either have to pay or if they have to pay more.
- The Council should look at other ways of making savings, for example the Council Tax or the Christmas Lights.
- It was important to retain the cap at the current level to ensure that services for people with high needs do not become unaffordable.

<u>The main finding from the other consultation and engagement methods</u>

4.2.7. It was the view of some members of staff that whilst the Council's financial assessment methodology might be seen as being fair with regard to service users whose pensions, savings and investments were products of a different economic era, working age people of today will not have the same returns or benefits when they retire and so will be less financially secure.

4.3. New Care Ring and Telecare Charges

4.3.1. Generally, the people consulted believe that Care Ring and Telecare are vital services for people living in the community. They value the safety and security that

these services give to vulnerable people either with physical and / or mental health needs living on their own or with a family member / carer.

4.3.2. People who had needed to activate their Care Ring alarm generally spoke highly of the service and how it had helped them in the past. NHS commissioners and providers see these services as intrinsic to the delivery of their own services, ensuring, for example, that people can be discharged home without unnecessary delay into a safe environment.

4.3.3. The view of NHS and Adult Social Care members of staff was that Care Ring and Telecare were provided as part of a wider health and social care service, maintaining people for as long as possible, as independently as possible, in their own homes. Therefore any impact on the service would have a wider impact on the health and social care sector.

4.3.4. Not all people in receipt of Care Ring valued the service. A number or people, particularly (but not wholly) those living in Sheltered Housing accommodation, stated that they had not asked for the service and, at that point in time, did not need the service.

The main findings from the Feedback Forms

4.3.5. The highest number of people potentially affected by the proposals are in receipt of Care Ring and/or Telecare services. Of the 21,469 feedback forms issued, 68% (14,599) were issued to people using Care Ring and/or Telecare services. 21% of forms issued to Care Ring / Telecare service users were returned completed (that is 3,052).

4.3.6. People were asked if the proposals would affect their daily life. 60% (1672) of people who responded to this question said that it would affect their daily life with 31% (853) saying that it would not, or would not significantly, affect their daily lives.

4.3.7. A common perception amongst service users was that they would not be able to afford the proposals. 853 people (28%) who completed the feedback forms raised affordability concerns and 384 (13%) said that the proposals would affect their disposable income to spend on other things. People referred to the general cost of living as well as their static limited income as reasons for un-affordability. Some disabled people raised the issue of the cost of being disabled.

4.3.8. As a result of the un-affordability a number of service users said that they would cancel or reduce their services. 26% of respondents (614 people) said that they would cancel their service, 20% (472) said they would consider cancelling and 1% (16 people) said they would reduce their services. However, of the people who commented on the impact on the use of their services 19% (443) recognised that they needed the service and so would pay to keep the service. 27% (628) said that the proposals would have no impact on their use of services.

4.3.9. 20% (621) of respondents stated that not having the service would impact on their peace of mind, security and independence.

4.3.10. There was no significant difference between those respondents who said that the proposals would impact on their carers (46% - 880 people) and those who said that they would not (47% - 905 people). The biggest issue was carers feeling more stress and losing peace of mind.

The main findings from the other consultation and engagement methods:

4.3.11. The majority of people attending the open drop-in events (but not the Mental Health Day Services events) used Care Ring and telecare services, with the majority of people living in Sheltered Housing accommodation. People living in this type of accommodation raised some specific issues:

- They believed that they had already paid for the service as part of their rent
- Care Ring is a part of the fixtures of their accommodation and so on this basis they asked if they would still be charged for the service;
- Some people said that they did not need the service so would want it removing or would not wish to pay even if it was part of the fixtures.
- The system had been updated recently and so they thought that the charge was linked to the upgrade.
- Some people were concerned that if they could not afford to pay for the service, as it was a necessary part of the accommodation, then they would have to leave.

The feedback from the consultation on the charging proposals was complicated by the issue many people had in relation to Care Ring including the on-going upgrades to the system.

4.3.12. The issue of whether service users would perceive that they could afford the proposals was raised by stakeholders at consultation events.

4.3.13. A range of Officers from the NHS and Adult Social Care were concerned that a large number of people would cancel the services and that this could have a number of impacts on their services. Scenarios included:

- more people using the 999 or 111 numbers and the impact that this would have on ambulance services and accident and emergency and the associated cost of this;
- more people being admitted to hospital as a consequence of admission to A&E;
- more people requiring admission to residential or nursing care homes;
- the impact on Sheltered Housing re: potentially greater fire risk if people disconnected their equipment

The charging review should take into account the cost to the whole health and wellbeing care system.

4.3.14. Officers were also concerned about the negative impact that the cancelling of services would have on people, referring to the impact on their health and wellbeing, and their ability to remain independent in their own homes. These concerns echoed the statements of the people who completed the feedback forms.

4.3.15. A view was expressed by members of staff at their consultation event, that the `just checking` equipment and monitoring services should be free, as it is the council and health services that use these for assessment purposes.

4.3.16. Some people (too small a percentage to note) suggested alternatives to the proposals that would still generate income for the Council, specifically:

- Lower the charge per week
- No charge for existing service users but introduce a charge for new people
- Charge people each time they activate their alarm instead of a weekly charge.

4.4. New Charges for Mental Health Day Services

4.4.1. There was a view from the people who used the services that there was little choice for people in terms of day services in the community. Members of the day services were also going through other changes related to the modernisation of their services and the welfare benefits reform. Overall they felt overwhelmed by the amount of change and found it difficult to distinguish the potential impact of the charging review as being separate from the service changes that were happening.

4.4.2. A number of the current members of day services use the centres for support, for a safe place to go and to meet their social care needs with people who understand them. There was general concern therefore that many people would not be eligible for services, following a care assessment, and that they would be asked to leave services. Officers from the Council assured members of day services that that people currently using the service will not lose their access to the service.

4.4.3. The Third Sector providers of mental health services thought that the direct payments system fit in very well with the recovery model of mental ill-health as old style day services encouraged dependency. However, they also believed that day services are the only form of social interaction that some people have and/or can cope with; people can become very isolated if they cannot use the services.

<u>The main findings from the Feedback Forms</u>

4.4.4. People who were members of mental health day services accounted for 3% of the total number of feedback forms issued. There was a 15% return on the number of forms issued (105). The numbers involved in analysing the returns are therefore relatively small.

4.4.5. 81% (78) of the people who responded on whether the proposals would affect their daily life said that they would, with 19% (18) saying that it would not affect their daily life.

4.4.6. 45% (47) of people responding said they could not afford the proposals.

4.4.7. 40% of respondents (38 people) said that the proposals would lead to them cancelling their service, 17% (16) said they would consider cancelling and 13% (12) said they would reduce services. 15% (14) said that the proposals would not affect their use of services and 8% (8) said that they would pay the charge and keep the service.

4.4.8. If people cancelled or reduced their services due to the charging proposals, 33% of respondents (35 people) stated that it would affect their mental and physical wellbeing, which was a higher proportion than for those people using all other services except mental health housing support services.

4.4.9. Some people referred to having to rely more on health or emergency services; this meant working with people that did not know them well and did not understand them.

4.4.10. The services were viewed as a vital lifeline for people and that if they could no longer use services then they would become isolated and their mental ill-health would get worse.

4.4.11. There was no significant difference between those respondents who said that the proposals would impact on their carers (54% - 37 people) and those who said that they would not (42% - 29 people).

The main findings from the other consultation and engagement methods

4.4.12. The Third Sector representatives noted that the mental health needs of people who use the services can fluctuate quite dramatically. They added that it was therefore important that people can access services again quickly without going through another care assessment or financial assessment.

4.4.13. The community and BME groups that we consulted with reflected this concern and felt that because of this inconsistency services should not be charged for. However, they did state that they saw the rationale for applying a policy to all service user groups to ensure equality.

4.4.14. It was proposed that charges should not be introduced for mental health service users who are in crisis (that is those service users who are a danger to themselves or to others). The Council should have a policy/procedure for delaying/phasing in the introduction of charges until the service user's condition has stabilised.

4.4.15. Given that there is a proposed charge of £18.00 per hour (including over-heads) for staff assisting service users to recover from their mental ill-health, then the Council should publicise less expensive options for people using their direct payments to employ Personal Assistants to help them recover.

4.5. Increased charges for Mental Health Housing Support Services

4.5.1. Issues relating to this service were not raised at the range of consultation events that were held. The only comments therefore that we have in relation to charging for these services is from the feedback forms.

The main findings from the Feedback Forms

4.5.2. People using these services accounted for 1% of the total number of forms issued (168). There was a 16% return of completed forms, which at 27 is a small number to analyse.

4.5.3. People were asked if the proposals would affect their daily life. 85% (23) of respondents stated that the proposals would affect their daily life and 11% (3) said that the proposals would not affect their daily life.

4.5.4. Of the people who commented on how the proposals would affect them, 52% (14 people) said that they would affect their physical and mental health, which was a higher proportion than for those people using all other services except mental health day services. 33% (9 people) raised concerns about the affordability of the proposals.

4.5.5. 73% of respondents (16 people) stated that the proposals would affect their use of the services and they would cancel, consider cancelling or reduce the services. 23% (5) stated that it would pay the charge and continue with the service.

4.5.6. There was no significant difference between those respondents who said that the proposals would impact on their carers (43% - 9 people) and those who said that they would not (52% - 11 people).

4.6. New Charges for Shared Lives Services

4.6.1. There was a general view that Carers save the government and the Council money by providing informal care services and that this should be taken into consideration when making proposals about charging for carers services. It seems counterproductive to some people to introduce charge for those minimal preventative services that enable carers to fulfil this function.

4.6.2. A number of carers use Shared Lives to enable them to go shopping, meet a friend, or undertake some daily activities. The view of some people was that it was highly likely that Carers would not pay the proposed charge of £13.00 an hour to go to the shops.

4.6.3. The issue of affordability was also the major concern for carers using these services.

4.6.4. If carers were to stop caring as they no longer continued to be supported to do so, then this would result in most costly services being provided to the cared for person.

4.6.5. Carers also commented that the free services that are available to them makes them feel valued by society generally when many have left work early, resulting in a reduced income, to care for their (generally) family member.

The main findings from the Feedback Forms

4.6.6. Carers using Shared Lives services accounted for 2% of the total number of forms issued. There was a 23% return on the number of forms issued to people using this service.

4.6.7. People were asked if the proposals would affect their daily life. 68% (49) of people who responded to this question said that the proposals would impact on their daily life and 25% (18) of people said that the proposals would not impact on their daily life.

4.6.8. 32% (27) of respondents raised concerns about the affordability of the proposals.

4.6.9. 12% of respondents (10 people) said that the proposals would affect their mental and physical wellbeing and 17% (14 people) said that it would decrease their quality of life.

4.6.10. 37% of respondents (27 people) stated that they would cancel their services, 23% (17) said they would consider cancelling and 10% (7) said that they would reduce their services. 14% (10) said that the proposals would not affect their use of the service.

4.6.11. A higher proportion of people using Shared Lives services (84%) indicated that the proposals would impact on their carers than people using other services (range 43% to 54%). Of those responding 28% (24 people) said they would have to take on extra caring responsibilities, 17% (14) said their carer would have no respite and 15% (13) said it would affect their carer's mental and physical health.

5. Conclusions

5.1. The Council has consulted with a range of stakeholders on the proposals to make changes to the charging policy in respect of non-residential adult social care services.

5.2. In September 2012, feedback forms and supporting information was sent out to 21,469 people in receipt of non-residential care services. We achieved an overall response rate of 18%. However, this was not the only method by which people could make their views know, but it was the one most utilised by service users, with the exception of mental health day service users.

5.3. People's main concern, irrespective of which part of the proposals would affect them, was that they would not be able to afford the services. This could result in the reduction or cancellation of services or people making savings in other important areas of their lives. It should be noted, however, that whilst these were the main concerns they were not directly expressed by the majority of respondents.

5.4. The largest number of concerns were raised in relation to the Care Ring and Telecare services, which a number of different groups of stakeholders believed were vital to enable people to live safely in their own homes with perhaps minimum support. Many stakeholders, including people who use the Care Ring and Telecare services, were concerned that people would cancel their services and this would result in an impact on the wider health and wellbeing sector.

5.5. The main issues arising from the consultation and engagement for the Council are as follows:

- To look at how the proposals can be made affordable to people who uses the services.
- The timing of the introduction of the changes.
- The potential for people to cancel services
- How to effectively communicate the changes should the proposals be approved by the Executive Board.

Appendix 1

Feedback Form

Adult Social Care
Charging for Non-Residential Services
Feedback Form

Leeds City Council is considering making changes to the way we charge people for non-residential services and the services that we charge for.

We want to hear how these proposals may affect you, your carers or your family. Having read the enclosed letter and information sheet, could you please complete this feedback form and return it to our consultation team in the self addressed envelope provided (you do not need to put a stamp on it).

If you would prefer to complete a feedback form electronically, then you can complete one on-line at https://consult.leeds.gov.uk . Or you can download a copy of this feedback form from this website and send it electronically to charging.review@leeds.gov.uk

We aim to be accessible to everyone. If you would like this document in Braille, Large Print, on tape or in electronic format, or in a language other than English please contact Leeds City Council on **0800 1381910** (freephone number).

Please return this form by 31st October 2012.

1. How the proposals may affect me.

1.1 If the proposals are approved do you think that they may affect your daily life at home, and if you think that they could, how will it be affected?

1.2 If the proposals are approved do you think that they may affect your use of services, and if you think that they could, how will they be affected?

2. How the proposals may affect my carers or family

2.1 If the proposals are approved do you think that they may affect your carers or your family, and if you think that they could, how will they be affected?

3. Which of the proposals may affect me?

3.1 To help us understand the responses that you have provided above, can you please let us know which of the following statements applies to you: (please tick all boxes that apply)

	This applies to me
I pay something towards my services	
I have capital over £14,250	
I have capital over £23,250	
I use Care Ring services	
I use Telecare services	
I attend mental health day services	
I use the mental health housing support service	
I use the Shared Lives home based sitting service	

4. Any other comments

4.1 Please let us know if there is anything you may want us to take into consideration in the review of our charging policy, including how the changes may impact on you or someone that you know or care for.

5. About me

The Council is committed to ensuring that all of its services are delivered fairly. We are asking the following questions to help us understand the views of the various communities and interested groups within Leeds.

5.1 Can you please let us know who has completed this form? (please tick one box)

	This applies to me
I currently receive services	
I am a Carer of someone receiving services (informal or unpaid)	
I am a family member of an adult who receives services	
I work for/with a voluntary community or faith organisation (third sector organisation)	

5.2 Are you completing this form on behalf of a person who uses adult social care services, or for yourself?

	This applies to me
On behalf of a service user	
For myself	

If you are completing this form on behalf of a service user, please answer the following questions about them, not about yourself.

5.3 Which gender are you?

	Please tick one box
Male	
Female	
Prefer not to say	

5.4 Please tick the box which best describes your ethnic origin

<table>
<tr><td colspan="2">A White

British
Any other White background - please write below

………………</td><td colspan="2">B Mixed/ multiple ethnic group

White and Asian
White and Black African
White and Black Caribbean
Any other mixed/multiple ethnic group – please write below
…………………………</td><td colspan="2">C Asian or Asian British

Bangladeshi
Chinese
Indian
Kashmiri
Pakistani
Any other Asian background – please write below

…………………………</td></tr>
<tr><td colspan="3">D Black or Black British
African
Caribbean
Any other Black background – please write below

……………………………..</td><td colspan="3">E Other ethnic groups

Arab
Gypsy or Traveller
Any other background – please write below

…………………………………………</td></tr>
<tr><td colspan="6">I prefer not to say ¤</td></tr>
</table>

5.5 Please indicate which age-range you are in:

	Please tick one box
Under 25	
25 – 40	
41 – 64	
65 – 79	
80 or over	
Prefer not to say	

5.6 Do you consider that you have a disability, long term condition or age related care or support needs?

	Please tick one box
Yes	
No	
Prefer not to say	

If you have said yes, you consider yourself to be disabled, so what is the nature of your impairment?
Physical impairment Visual impairment Hearing impairment Mental health condition Learning disability Long-standing illness or health condition
I prefer not to say ¤

Thank-you very much for taking the time to complete this feedback form. Please return it in the envelope provided by 31st October 2012. You do not need to put a stamp on the envelope. Any information that is provided by you in this feedback form is confidential and will only be used to help us to understand the impact of our proposals.

If you would like to receive some feedback following the completion of this consultation exercise, then please provide your contact details. If you are replying on behalf of a group or an organisation please give the details of the person co-ordinating the response.

Name:	E-mail address:
Address:	Telephone number:

Appendix 2

Charging Review – Consultation Events Summary

Drop-In Events

Date	Venue
5th October	Civic Centre, Pudsey
5th October	St Chad's Parish Centre, Headingley
5th October	Town Hall, Leeds
18th October	Margaret & Arnold Ziff Centre, Moortown
18th October	St James Church, Seacroft
18th October	Miners Welfare Hall, Garforth
24th October	Shine, Harehills
24th October	Hamara Healthy Living Centre, Beeston
24th October	TownHall, Morley

Ad-Hoc Events (Specific Requests)

Date	Venue/Attendees
8th October	Churchville House, Micklefield (Aire Valley Homes tenants)
25th October	The Willows,Horsforth (West North West Homes tenants)
2nd November	Northfield Community Centre, Robin Hood (Aire Valley Homes tenants)

Mental Health Day Services Events
N.B. Those below were specifically on the charging review. Information on the charging review was also presented at the day services consultation events on 11th September and 16th/17th October.

Date	Venue
9th October	The Vale Day Centre
9th October	Stocks Hill Day Centre
11th October	Lovell Park Day Centre

VCFS Events

Date	Venue/Attendees
19th October	St Georges Centre Mental Health VCFS Organisations
13th December	Mental Health VCFS Organisations

Other Events

Date	Event
8th October	Members Seminar
1st November	Staff Workshop
1st November	Care Ring & Telecare Event (health partners invited)
7th November	Social Care Equality Forum
22nd November	Meeting with Dosti
27th November	Supporting People Alarm Call Providers
28th November	Voluntary Sector Mental Health Service Users
12th December	ALMO Chief Executives
13th December	Carers Workshop
12th January	Carers Leeds Information Café

Agenda Items on Meetings

Date	Meeting
19th July	Telecare Development Group
2nd October	Adult Social Care Commissioning Managers
20th November	Carers Expert Advisory Group
4th December	Equipment Partnership Board
29th January	Adult Social Care Commissioning Managers

Appendix 3

Charging Review 2012 - Feedback Forms Summary

	Number Issued	Percentage Issued	Number Returned	Percentage Returned
Care Ring/ Telecare	14,599	68%	3,052	21%
People who have been financially assessed	5,654	26%	694	12%
Shared Lives	370	2%	85	23%
Mental Health Day Services	678	3%	105	15%
Mental Health Housing Support	168	1%	27	16%
TOTAL	**21,469**	**100%**	**3,963**	**18%**

N.B. Some feedback forms were returned without any comments being provided and these are not included in the table above.

Appendix 4

Feedback Form Summary

		Total for all Services			Care Ring/Telecare			Financial Assessments		
		No.	% Forms	% Reasons	No.	% Forms	% Reasons	No.	% Forms	% Reasons
	Number of feedback forms	**3,963**			**3,052**			**694**		
Q .1.1	**Impact on daily life**									
	Don't know	100	2.8%		63	2.3%		32	5.1%	
	Don't use/need service	169	4.7%		161	5.8%		7	1.1%	
	No	1,111	30.9%		853	30.8%		219	34.8%	
	Not significantly	17	0.5%		17	0.6%			0.0%	
	Yes	2,194	61.1%		1,672	60.4%		372	59.0%	
		3,591	**100.0%**		**2,766**	**100.0%**		**630**	**100.0%**	
	No answer	372			286			64		
		3,963			**3,052**			**694**		
	Impact reasons									
	Financially/can't afford	1,044	26.3%	33.8%	853	27.9%	36.2%	108	15.6%	22.4%
	Less disposable income	557	14.1%	18.0%	384	12.6%	16.3%	141	20.3%	29.2%
	Adversely affect physical mental health	148	3.7%	4.8%	55	1.8%	2.3%	34	4.9%	7.0%
	Feel won't get help when need it/reduced peace of mind	331	8.4%	10.7%	308	10.1%	13.1%	18	2.6%	3.7%
	Not affected now but worry about future bills etc	82	2.1%	2.7%	43	1.4%	1.8%	31	4.5%	6.4%
	Provides/removed independence/ won't feel safe without service	351	8.9%	11.4%	313	10.3%	13.3%	28	4.0%	5.8%
	Still need service so pay	149	3.8%	4.8%	118	3.9%	5.0%	28	4.0%	5.8%
	Cancel service	213	5.4%	6.9%	174	5.7%	7.4%	26	3.7%	5.4%
	Won't be able to stay in own home	56	1.4%	1.8%	48	1.6%	2.0%	8	1.2%	1.7%
	Service not essential	15	0.4%	0.5%	11	0.4%	0.5%	1	0.1%	0.2%
	Decreased quality of life/ affect social & leisure activities	126	3.2%	4.1%	41	1.3%	1.7%	56	8.1%	11.6%
	Affect ability to complete household tasks	16	0.4%	0.5%	11	0.4%	0.5%	4	0.6%	0.8%
		3,088	**77.9%**	**100.0%**	**2,359**	**77.3%**	**100.0%**	**483**	**69.6%**	**100.0%**

		Total for all Services			Care Ring/Telecare			Financial Assessments		
		No.	**% Forms**	**% Reasons**	**No.**	**% Forms**	**% Reasons**	**No.**	**% Forms**	**% Reasons**
Q. 1.2	**Impact on services**									
	Cancel service	742	23.7%		614	26.0%		58	10.0%	
	Consider cancelling	608	19.4%		472	20.0%		99	17.0%	
	Reduce service	94	3.0%		16	0.7%		52	8.9%	
	May have to move	13	0.4%		9	0.4%		4	0.7%	
	Keep service	542	17.3%		443	18.7%		89	15.3%	
	No effect	886	28.3%		628	26.6%		229	39.3%	
	Yes	94	3.0%		69	2.9%		14	2.4%	
	Don't know	157	5.0%		113	4.8%		37	6.4%	
		3,136	**100.0%**		**2,364**	**100.0%**		**582**	**100.0%**	
	No answer	827			688			112		
		3,963			**3,052**			**694**		

		Total for all Services			Care Ring/Telecare			Financial Assessments		
Q. 2.1	**Impact on carers**									
	Yes	1,197	46.5%		880	45.5%		214	44.8%	
	No	1,183	46.0%		905	46.7%		229	47.9%	
	Not significantly	8	0.3%		8	0.4%			0.0%	
	Don't know	90	3.5%		60	3.1%		27	5.6%	
	No family or carers	94	3.7%		83	4.3%		8	1.7%	
		2,572	**100.0%**		**1,936**	**100.0%**		**478**	**100.0%**	
	No answer	1,391			1,116			216		
		3,963			**3,052**			**694**		

		Total for all Services			Care Ring/Telecare			Financial Assessments		
		No.	% Forms	% Reasons	No.	% Forms	% Reasons	No.	% Forms	% Reasons
	Impact reasons									
	Stress/worry for carer/family	463	11.7%	33.8%	365	12.0%	37.8%	70	10.1%	26.0%
	Family/carer have to take on more caring responsibilities	299	7.5%	21.8%	160	5.2%	16.6%	96	13.8%	35.7%
	Lose peace of mind that service user safe/not notified of incidents	313	7.9%	22.8%	297	9.7%	30.7%	14	2.0%	5.2%
	Unable to leave service user alone	33	0.8%	2.4%	29	1.0%	3.0%	2	0.3%	0.7%
	Affect mental/physical health of carer	43	1.1%	3.1%	12	0.4%	1.2%	15	2.2%	5.6%
	No longer able to continue being the carer	17	0.4%	1.2%	2	0.1%	0.2%	10	1.4%	3.7%
	No respite for carer	28	0.7%	2.0%	1	0.0%	0.1%	9	1.3%	3.3%
	Carer may have to give up work/reduce hours	14	0.4%	1.0%	6	0.2%	0.6%	6	0.9%	2.2%
	Carer not feel valued	2	0.1%	0.1%		0.0%	0.0%		0.0%	0.0%
	Sitter expected to do different tasks/reduced employment for sitters	6	0.2%	0.4%		0.0%	0.0%	2	0.3%	0.7%
	Carer/sitter a valued friend/support	8	0.2%	0.6%	1	0.0%	0.1%	1	0.1%	0.4%
	May lose paid carer or reduce the hours they work	8	0.2%	0.6%	3	0.1%	0.3%	4	0.6%	1.5%
	Have to pay for care outside the family	15	0.4%	1.1%	11	0.4%	1.1%	4	0.6%	1.5%
	Family live long distance away	66	1.7%	4.8%	50	1.6%	5.2%	14	2.0%	5.2%
	Affect family/carer financially	55	1.4%	4.0%	29	1.0%	3.0%	22	3.2%	8.2%
		1,370	**34.6%**	**100.0%**	**966**	**31.7%**	**100.0%**	**269**	**38.8%**	**100.0%**

		Shared Lives			Mental Health Day Services			Mental Health Housing Support		
		No.	% Forms	% Reasons	No.	% Forms	% Reasons	No.	% Forms	% Reasons
	Number of feedback forms	**85**			**105**			**27**		
Q .1.1	**Impact on daily life**									
	Don't know	4	5.6%			0.0%		1	3.7%	
	Don't use/need service	1	1.4%			0.0%			0.0%	
	No	18	25.0%		18	18.8%		3	11.1%	
	Not significantly		0.0%			0.0%			0.0%	
	Yes	49	68.1%		78	81.3%		23	85.2%	
		72	**100.0%**		**96**	**100.0%**		**27**	**100.0%**	
	No answer	13			9					
		85			**105**			**27**		
	Impact reasons									
	Financially/can't afford	27	31.8%	32.9%	47	44.8%	38.5%	9	33.3%	21.4%
	Less disposable income	10	11.8%	12.2%	14	13.3%	11.5%	8	29.6%	19.0%
	Adversely affect physical mental health	10	11.8%	12.2%	35	33.3%	28.7%	14	51.9%	33.3%
	Feel won't get help when need it/reduced peace of mind	1	1.2%	1.2%	2	1.9%	1.6%	2	7.4%	4.8%
	Not affected now but worry about future bills etc	5	5.9%	6.1%	2	1.9%	1.6%	1	3.7%	2.4%
	Provides/removed independence/ won't feel safe without service	3	3.5%	3.7%	5	4.8%	4.1%	2	7.4%	4.8%
	Still need service so pay	1	1.2%	1.2%	2	1.9%	1.6%		0.0%	0.0%
	Cancel service	7	8.2%	8.5%	5	4.8%	4.1%	1	3.7%	2.4%
	Won't be able to stay in own home		0.0%	0.0%		0.0%	0.0%		0.0%	0.0%
	Service not essential	3	3.5%	3.7%		0.0%	0.0%		0.0%	0.0%
	Decreased quality of life/ affect social & leisure activities	14	16.5%	17.1%	10	9.5%	8.2%	5	18.5%	11.9%
	Affect ability to complete household tasks	1	1.2%	1.2%		0.0%	0.0%		0.0%	0.0%
		82	**96.5%**	**100.0%**	**122**	**116.2%**	**100.0%**	**42**	**155.6%**	**100.0%**

		Shared Lives			Mental Health Day Services			Mental Health Housing Support		
		No.	% Forms	% Reasons	No.	% Forms	% Reasons	No.	% Forms	% Reasons
Q. 1.2	**Impact on services**									
	Cancel service	27	37.0%		38	40.0%		5	22.7%	
	Consider cancelling	17	23.3%		16	16.8%		4	18.2%	
	Reduce service	7	9.6%		12	12.6%		7	31.8%	
	May have to move		0.0%			0.0%			0.0%	
	Keep service	2	2.7%		8	8.4%			0.0%	
	No effect	10	13.7%		14	14.7%		5	22.7%	
	Yes	7	9.6%		4	4.2%			0.0%	
	Don't know	3	4.1%		3	3.2%		1	4.5%	
		73	**100.0%**		**95**	**100.0%**		**22**	**100.0%**	
	No answer	12			10			5		
		85			**105**			**27**		

		Shared Lives			Mental Health Day Services			Mental Health Housing Support		
		No.	% Forms	% Reasons	No.	% Forms	% Reasons	No.	% Forms	% Reasons
Q. 2.1	**Impact on carers**									
	Yes	57	83.8%		37	53.6%		9	42.9%	
	No	9	13.2%		29	42.0%		11	52.4%	
	Not significantly		0.0%			0.0%			0.0%	
	Don't know	2	2.9%		1	1.4%			0.0%	
	No family or carers		0.0%		2	2.9%		1	4.8%	
		68	**100.0%**		**69**	**100.0%**		**21**	**100.0%**	
	No answer	17			36			6		
		85			**105**			**27**		

		Shared Lives			Mental Health Day Services			Mental Health Housing Support		
		No.	**% Forms**	**% Reasons**	**No.**	**% Forms**	**% Reasons**	**No.**	**% Forms**	**% Reasons**
	Impact reasons									
	Stress/worry for carer/family	7	8.2%	8.6%	18	17.1%	40.9%	3	11.1%	30.0%
	Family/carer have to take on more caring responsibilities	24	28.2%	29.6%	15	14.3%	34.1%	4	14.8%	40.0%
	Lose peace of mind that service user safe/not notified of incidents	2	2.4%	2.5%		0.0%	0.0%		0.0%	0.0%
	Unable to leave service user alone	1	1.2%	1.2%	1	1.0%	2.3%		0.0%	0.0%
	Affect mental/physical health of carer	13	15.3%	16.0%	3	2.9%	6.8%		0.0%	0.0%
	No longer able to continue being the carer	5	5.9%	6.2%		0.0%	0.0%		0.0%	0.0%
	No respite for carer	14	16.5%	17.3%	3	2.9%	6.8%	1	3.7%	10.0%
	Carer may have to give up work/reduce hours	1	1.2%	1.2%	1	1.0%	2.3%		0.0%	0.0%
	Carer not feel valued	2	2.4%	2.5%		0.0%	0.0%		0.0%	0.0%
	Sitter expected to do different tasks/reduced employment for sitters	4	4.7%	4.9%		0.0%	0.0%		0.0%	0.0%
	Carer/sitter a valued friend/support	5	5.9%	6.2%		0.0%	0.0%	1	3.7%	10.0%
	May lose paid carer or reduce the hours they work	1	1.2%	1.2%		0.0%	0.0%		0.0%	0.0%
	Have to pay for care outside the family		0.0%	0.0%		0.0%	0.0%		0.0%	0.0%
	Family live long distance away		0.0%	0.0%	1	1.0%	2.3%	1	3.7%	10.0%
	Affect family/carer financially	2	2.4%	2.5%	2	1.9%	4.5%		0.0%	0.0%
		81	**95.3%**	**100.0%**	**44**	**41.9%**	**100.0%**	**10**	**37.0%**	**100.0%**

Appendix 5

Charging Review Consultation Feedback

STATISTICALLY SIGNIFICANT VARIATIONS

The variations outlined below are those that are "statistically significant", i.e. real differences that are bigger than the "margins of error". When comparing the views of small groups of respondents the differences need to be larger to be "statistically significant" than for larger groups of respondents. The numbers of responses to the feedback forms was wide ranging, from 3,052 for Care Ring and telecare to 27 for mental health housing support services, so statistical significance testing was undertaken to ensure that the variations reported are real variations.

Response Rates

- A lower proportion of people using financially assessed services responded (12%) compared with people using other services (range 15% to 23%)
- A higher proportion of people using Shared Lives services responded compared with people using financially assessed services (12%) and mental health day services (15%).

Impact on Daily Lives

- Across all groups of respondents, a higher proportion of people said that the proposals would impact on their daily life (61% overall) than people who said that it would not have an impact (31% overall)
- A higher proportion of those attending mental health day centres (81%) and using mental health housing support services (85%) said the proposals would impact on their daily lives than those using Care/Ring telecare (60%), Shared Lives (68%) or financially assessed services (59%)
- A higher proportion of responses from people using Care Ring/telecare (36%), Shared Lives (33%) and mental health day services (39%) indicated that affordability was a reason for the impact of the proposals on their daily lives than for people using financially assessed services (22%) and mental health housing support services (21%)
- A higher proportion of responses from people using mental health day services (29%) and mental health housing support services (33%) indicated that their physical or mental health would be adversely affected by the proposals compared with people using other services (range 2% for people using Care Ring/telecare to 12% for people using Shared Lives)
- A lower proportion of responses from people using Care Ring/telecare (2%) indicated that their quality of life and/or social or leisure activities would be adversely affected by the proposals compared with people using other services (range 8% to 17%)

Impact on Services

- A higher proportion of people using financially assessed services said that they would keep them (15%) than those who said they would cancel (10%), but for people using all other services more people said that they would cancel services than people who said that they would keep them

- A lower proportion of people using financially assessed services indicated that they would cancel their service (10%) compared with the users of Care Ring/telecare (26%), Shared Lives (37%) and mental health day services (40%)
- A higher proportion of people using Care Ring/telecare (19%) and financially assessed services (15%) indicated that they would keep their services than users of the other services (range 0% to 8%)
- A higher proportion of people using financially assessed services (39%) indicated that the proposals would not affect their use of services
- The proportion of people indicating that the proposals would not impact on their use of services was lower for people using Shared Lives (14%) and mental health day services (15%) than for people using mental health housing support services (23%) and Care Ring/telecare (27%)

Impact on Carers

- A higher proportion of people using Shared Lives services (84%) indicated that the proposals would impact on their carers than people using other services (range 43% to 54%)
- A higher proportion of responses from people using Care Ring/telecare (38%) and mental health day services (41%) indicated that the proposals would increase stress and worry for their carers(s) compared with people using other services (range 9% to 30%)
- A lower proportion of responses from people using Care Ring/telecare (17%) indicated that their family or carer(s) would have to provide more care compared with people using financially assessed services (36%), Shared Lives (30%) and mental health day services (34%)
- A higher proportion of responses from people using Shared Lives services (17%) indicated that their carers would not receive respite if the proposals went ahead compared with people using Care Ring/telecare (0%) or financially assessed services (3%)
- A higher proportion of responses from people using Shared Lives services (16%) indicated that the physical/mental health of their carers would be affected if the proposals went ahead compared with people using Care Ring/telecare (1%), financially assessed services (6%) or mental health housing support services (0%)

Variations Based on Equality Characteristics

Impact on Daily Lives

- There were no differences between men and women in the proportion responding who said that the proposals would impact on their daily lives
- A higher proportion of people responding of working age (69%) said that the proposals would impact on their daily lives than people aged 80 or over (60%)
- A higher proportion of people with disabilities (64%) said that the proposals would impact on their daily lives than people who do not have disabilities (45%)
- A lower proportion of white British people (61%) said that the proposals would impact on their daily lives than people from other ethnic groups (76%)

Impact on Services

- A higher proportion of men (25%) than women (20%) said they would cancel their service
- A higher proportion of people under 65 (29%) than people aged 65 and over (21%) said they would cancel their service
- A higher proportion of people 65 to 79 (29%) than people aged 80 and over (16%) said they would cancel their service
- There were no differences between people with disabilities and people who do not have disabilities in the proportion responding who said that they would cancel their service
- There were no differences between white British people and people from other ethnic groups in the proportion responding who said that they would cancel their service

Impact on Carers

- There were no differences between man and women in the proportion responding who said that the proposals would impact on their carers
- A higher proportion of people aged under 65 (55%) than people aged 65 and over (44%) said that the proposals would impact on their carers
- A higher proportion of people with disabilities (48%) than people who do not have disabilities (27%) said that the proposals would impact on their carers
- A higher proportion of people from other ethnic groups (64%) than white British people (45%) said that the proposals would impact on their carers

Report author: Heather Pinches

Tel: 274638

Report of Assistant Chief Executive (Customer Access and Performance)

Report to Health and Wellbeing and Adult Social Care Scrutiny Board

Date: 27th March 2013

Subject: 2012/13 Q3 Performance Report

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

Summary of main issues

1. This report provides a summary of performance against the strategic priorities for the council relevant to the Health and Wellbeing and Adult Social Care Scrutiny Board.

Recommendations

2. Members are recommended to:

   - Note the Q3 performance information and the issues which have been highlighted and consider if they wish to undertake further scrutiny work to support improvement over the coming year in any of these areas.

1 Purpose of this report

1.1 This report presents to scrutiny a summary of the quarter three performance data for 2012-13 which provides an update on progress in delivering the relevant priorities in the Council Business Plan 2011-15 and City Priority Plan 2011-15.

2 Background information

2.1 The City Priority Plan 2011 to 2015 is the city-wide partnership plan which sets out the key outcomes and priorities to be delivered by the council and its partners. There are 21 priorities which are split across the 5 strategic partnerships who are responsible for ensuring the delivery of these agreed priorities. The Council Business Plan 2011 to 2015 sets out the priorities for the council - it has two elements - five cross council priorities aligned to the council's values and a set of directorate priorities and targets.

2.2 This report includes 2 appendices:

- Appendix 1 – Performance Reports for the 4 Health and Wellbeing City Priority Plan Priorities
- Appendix 2 – Adult Social Care Directorate Priorities and Indicators

3 Main issues - Quarter 3 Performance Summary

Council Business Plan

3.1 **Adult Social Care Directorate Priorities and Indicators –** there are 12 directorate priorities and 6 are assessed as green, 5 amber and 1 is red. The red priority is:

- 'Help people with poor physical or mental health to learn or relearn the skills for daily living'. The indicator for this priority 'Increase the number of people successfully completing a programme to help them relearn the skills for daily living' is also rated as red.

Members will recall from previous discussions that this relates to activity associated with council **Reablement Services.** The number of people accessing the service remains below target. The service will, however achieve the required budget savings for this year and a comprehensive set of plans are in place to stretch performance next year. There is emerging evidence of under reporting activity in the service. A major data review is underway and the results of this will inform the end of year report. Work is also being undertaken to re-evaluate targets which were influenced by national guidance. Productivity and service size have impeded progress, in addition to other service delivery issues. A collective agreement has been agreed with the trade unions and the introduction of more efficient rota patterns, travel patterns and split shift arrangements will lead to service improvement. These changes will be implemented in 2013. An upward trend in performance is expected for the remainder of the year.

3.2 The Directorate reports two other areas where it has performance indicators rated as red. These include:

- Increase percentage service users who feel that they have control over their daily life.

Further improvement has been seen in quarter three in the percentage of service users and carers with control over their own budgets and this is now on track to meet the target. Surveys show, however, that a proportion of service users and carers do not feel that they have as much control over their daily life as they would want: A range of work continues to extend choice and control to all service users and their carers. New service users and carers are being routinely provided with information regarding the costs of their support plan and provided with the option to take cash payments. Access to direct payments for carers has been extended via the carers centre and projects are being progressed to better support access to cash payments via community groups and providers to broker services. Technology and systems are also being developed and fine-tuned to support, capture and report self-directed support. Consultation about improving service user choice is continuing through discussions with service users and through a survey in collaboration with Lancaster University. This will inform future priorities for improvement to extend choice and control to service users and their carers.

- Delivery of efficiency savings for directly provided services

3.3 Leeds Adult Social Care has developed a very clear vision for the future of services. An overall plan for the directorate has been developed and service transformation projects which direct resources to those who are most in need is in progress. In addition to internal plans work with health partners continues with a focus upon integration to ensure timely support and prevention. An ambitious plan with stretch targets to achieve efficiency savings was formulated for 2012/13. Whilst we currently look unlikely to deliver this, The Directorate is still on track to deliver a balanced budget at the end of the year. As at quarter 3, 24.4% (£1.2k) achieved.

City Priority Plan

3.4 There are 4 priorities in the City Priority Plan relevant to Health and Wellbeing and Adult Social Care Board and of these 2 are assessed as green, 1 is amber and is 1 is red. The red priority is health inequalities:

- **Health Inequalities**

Overall life expectancy in Leeds is increasing however there is a much lower level of life expectancy for those living the most deprived areas of Leeds and the absolute gap between these statistics is increasing. The key causes of premature mortality are cardiovascular disease, cancer, and respiratory disease. All premature mortality data for these diseases in Leeds have a significant gap between the rates in the non deprived areas and the deprived areas of Leeds. On average men living in the less deprived areas of Leeds

can expect to live 12.4 years longer than men living in the most deprived areas of the city. For women the gap is 8.4 years. Causes of mortality from these diseases are multifaceted and include the impact of the wider determinants of health such as housing, transport, employment and poverty, as well an individual's lifestyle (in relation to smoking/alcohol/physical activity and healthy eating), and their access to appropriate and effective services.

3.5 **Support more people to live safely in their own homes:** This priority has improved its rating in the last quarter going from amber and static to green and improving. Leeds remains on target to continue to reduce the number of bed weeks care in residential and nursing care homes for older people supported by the local authority. Leeds has fewer people in receipt of permanent residential and nursing care than both the national average for England and its comparators and its performance is the best in the region.

Other Issues

3.6 **Public Health Transfer:** The Leeds Public Health Transition Plan as endorsed by NHS North of England has four components – governance; transfer of public health responsibilities; maintaining performance and public health development; developing; supporting and engaging with the new public health system. Implementation of the Transition Plan continues through a robust programme management approach. Progress is in line with local targets and national milestones. Now that the legal basis of the transfer has been agreed, HR processes have commenced. Public health staff have begun to be physically relocated to Council buildings and this will continue on a phased basis until the end of March 2013. Due diligence work has been undertaken to enable the safe transfer of all contracts to Leeds City Council. The ring fenced public health grant has been announced for 2013/14 and for 2014/15. The public health budget for 2013/14 has been agreed by Full Council on 27th February 2013.

3.7 **Leeds Local Account for Adult Social Care 2012/13:-** The Local Account for Leeds, 'Better Lives Explained' includes details of work to improve services for people with social care and support needs.

3.8 Since its publication in October 2012, action has been taken to improve access to information about support and services. This includes development of a new web based service which will enable people to purchase their social care and support directly on line. This is due to become available to the public by the summer of 2013. The Council has also completed a review of leaflets and other written communications with the public about social care and support services.

3.9 Joint area teams of staff from adult social care and the community health trust have been established across the city enabling easier access to services across health and social care.

3.10 The new Holt Park Active service is currently being developed and will be opened later this year. This provides a model for a universal community based service which will integrate support for people with a wide range of health and social care needs.

3.11 The council and its health partners are jointly commissioning a new advocacy consortia to deliver advocacy across all client groups, advocacy for specific targeted groups, support for advocacy providers and a new single point of contact for staff and users from April 1st 2013.

3.12 A range of work is underway to integrate health and social care support to help prevent admission to hospital and support people following an accident or illness. The first joint Intermediate Care Centre (ICS) is in the process of being set up in South Leeds and negotiations are on-going regarding a possible two further services. This will provide city wide coverage of specialist short term residential based rehabilitation and reablement services..

3.13 A new model for mental health services based upon a recovery model and a shift towards more community based support has been subject to extensive consultation and will be implemented from September 2013.

3.14 The council continues to cultivate closer partnership working with developers and service providers to ensure that all the housing needs of older residents across the whole city are met. The council's approach combines its own investment in new affordable housing and the use of surplus land to encourage developers to invest in building specialist housing for older people in areas of the city where there are currently gaps in provision or where future gaps can be predicted now.

3.15 The local authority has carried out work to identify demand, capacity, quality and cost across the whole housing and care sector for older people. This showed that demand for long term residential care is decreasing, but highlighted an increase in demand for intermediate and specialist care. It also identified the need to expand the available extra care housing in the city. The Council has started a 12 week formal consultation with residents and their families/carers at the affected local authority The proposals currently under formal consultation are:

- The potential closure of Amberton Court, Burley Willows, Fairview, Manorfield House, Musgrave Court, and Primrose Hill;
- The potential transfer of Home Lea House to another community-based organisation; and,
- The potential to develop Suffolk Court as a specialist intermediate care unit in partnership with the NHS.

The information gathered will be pulled together to form recommendations, which will be presented to executive board later in the year for decisions with regard to the future of these facilities.

3.16 A fees and quality framework has been developed and put into place for all residential care homes which are commissioned by the Council. Homes must achieve a high standard of care to be accepted onto the framework and are encouraged to further improve through the option of applying for additional payments if they comply with a higher set of standards. A robust and regular programme of monitoring against standards will be put in place to assure high standards are maintained.

3.17 The Council has been working closely with community based organisations to extend the range of social care and support services in the community. Four Social Enterprises have been established during 2012 and a number of Neighbourhood Networks are looking to extend their roles to include community brokerage, which will enable people to use direct payments to access personal care support in community services. A review of trading options for some services currently directly managed by the authority is also underway.

4 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 This is an information report and as such does not need to be consulted on with the public. However all performance information is published on the council's and Leeds Initiative websites and is available to the public.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 This is an information report and not a decision so due regard is not relevant. However, this report does include an update on equality issues as they relate to the various priorities.

4.3 Council policies and City Priorities

4.3.2 This report provides an update on progress in delivering the council and city priorities in line with the council's performance management framework.

4.4 Resources and value for money

4.4.1 There are no specific resource implications from this report; however, it includes a high level update of the Council's financial position. This is in terms of the cross council priority within the Business Plan of "spending money wisely".

4.5 Legal Implications, Access to Information and Call In

4.5.1 All performance information is publicly available and is published on the council and Leeds Initiative websites. This report is an information update providing Scrutiny with a summary of performance for the strategic priorities within its remit and as such is not subject to call in.

4.6 Risk Management

4.6.2 The Performance Report Cards include an update of the key risks and challenges for each of the priorities. This is supported by a comprehensive risk management process in the Council to monitor and manage key risks. These processes also link closely with performance management.

5 Conclusions

5.1 This report provides a summary of performance against the strategic priorities for the council relevant to the Health and Wellbeing and Adult Social Care Scrutiny Board.

6 Recommendations

6.1 Members are recommended to:

- Note the Q3 performance information and the issues which have been highlighted and consider if they wish to undertake further scrutiny work to support improvement over the coming year in any of these areas.

7 Background documents[1]

7.2 City Priority Plan 2011 to 2015

7.3 Council Business Plan 2011 to 2015

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

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Meeting: Health and Wellbeing Board

Outcome: people live longer and have healthier live

Population: All adults in Leeds

Priority: Help protect people from the harmful effects of tobacco.

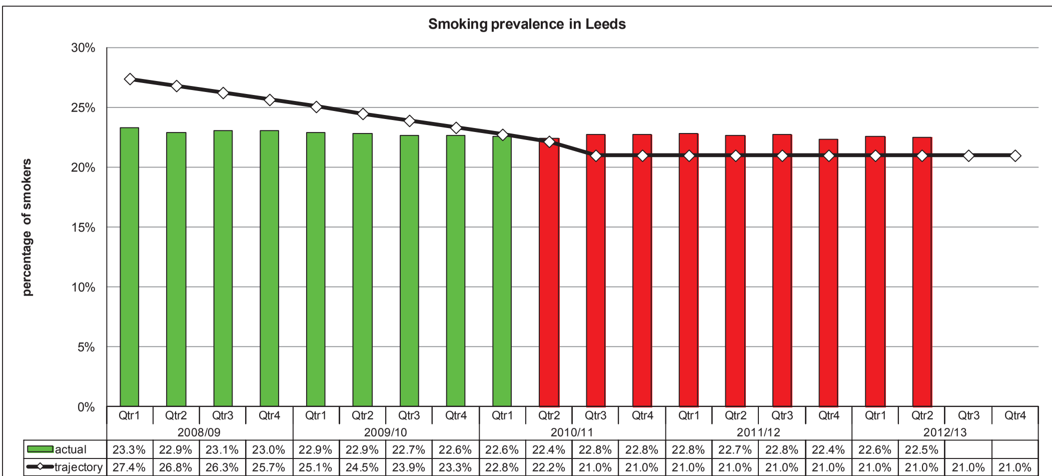
Why and where is this a priority? Tobacco use is the primary cause of preventable disease and premature death, not only to smokers but also to the people around them through the damaging effects of second-hand smoke. Smoking is the single biggest cause of inequalities in death rates between the richest and poorest in our communities. Although levels of smoking have fallen since the 1960s there are still 23% of adults living in Leeds.

Overall Progress: RAG rating

Headline Indicator: Reduce the number of adults over 18 that smoke

Story behind the baseline

- Leeds is currently experiencing a plateau in smoking prevalence, which is reflected in the national trend. Some areas of the country are starting to see an increase in smoking rates; this is particularly noticeable in some northern areas, highlighting the need to continue to prioritise **all** areas of tobacco control if further reduction is to be achieved.
- Nationally the number of quit attempts being made is also in gradual decline over the longer term. In recent years, there has been a year-on-year decline in the proportion of smokers making quit attempts, from 42.5% in 2007 to 33.5% in 2011[24]. The average number of quit attempts made by smokers each year has similarly been falling, from 0.65 in 2007 to 0.50 in 2011 (West, R. *Smoking Toolkit Study*, www.smokinginengland.info
- The 4 week quit rate target for Leeds for 2011/12 was achieved and showed an improvement on 10/11 by 1.4%. In 2012/13 we continue to experience a reduction in numbers accessing services. A similar pattern to Q1 has been experienced in that the accumulative (Q1 and Q2) total of people accessing services has dropped by 17% (1929 compared with 2340 in the same period from the previous year).



	2008/09 Qtr1	Qtr2	Qtr3	Qtr4	2009/10 Qtr1	Qtr2	Qtr3	Qtr4	2010/11 Qtr1	Qtr2	Qtr3	Qtr4	2011/12 Qtr1	Qtr2	Qtr3	Qtr4	2012/13 Qtr1	Qtr2	Qtr3	Qtr4
actual	23.3%	22.9%	23.1%	23.0%	22.9%	22.9%	22.7%	22.6%	22.6%	22.4%	22.8%	22.8%	22.8%	22.7%	22.8%	22.4%	22.6%	22.5%		
trajectory	27.4%	26.8%	26.3%	25.7%	25.1%	24.5%	23.9%	23.3%	22.8%	22.2%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%

What do key stakeholders think?

Tackling Tobacco in Belle Isle – Although Belle Isle experiences the highest smoking prevalence in Leeds, data shows good access to services compared with the rest of the city and that the area is experiencing a 1% year on year decline in prevalence. However, more work is needed to see further improvement. A workshop was held in Nov 2012 which was well attended by a range of agencies to discuss new actions to tackle tobacco use in the area. From this a locality action plan will be developed.

What we did

Environment Tobacco Smoke For the last quarter we have had 11 smoking related service requests (one less than the previous quarter). Requests relate to licensed premises (3), shisha bars (3) and other enclosed spaces (5).
We have also carried out a number of raids based on previous service requests and intelligence gathered. Two raids have resulted in case files being prepared for legal action, one lead to a warning being given and a fourth was aborted for operational reasons. More raids will be planned in partnership with other agencies as resources allow.

New Actions

Leeds Let's Quit Campaign To compliment the DH New Year quit smoking campaign, Leeds will be launching a local campaign called *Leeds Let's Quit* which will encourage people to order a quit kit either via www.leedsletschange.co.uk or from their local pharmacy. Posters and postcards will be distributed in numerous pubs, clubs and shopping centres as well as community venues e.g. GPs, pharmacies, children's centres, libraries, leisure centres and one stop centres.

Leeds Let's Change Leeds Community Healthcare have been piloting a single point of access into lifestyle services, including smoking services, with specialist teams

Niche Tobacco Use In addition to the delivery of an awareness raising programme about the harmful effect of niche tobacco, Leeds Smoking Services will be offering a programme of support for people who wish to stop,. This work will contribute to the national research programme to establish an evidence base for effective interventions for this group.

Brief Intervention Training for all community midwives was completed. This included the distribution of Carbon Monoxide monitors to enable midwives to assess smoking status and encourage referrals to service as per NICE Guidance.

Trading Standards Across the city a total of 16 test purchases were undertaken which resulted in one sale of cigarettes to an underage test purchaser.

As part of the Armley and Middleton project a final round of test purchasing was undertaken. In total, 57 test purchases were attempted which resulted in 6 illegal sales, a failure rate of just over 10%.

Smoke Free Homes: Health For All have been successful in securing the tender to deliver Smokefree Homes in Beeston, Holbeck, Chapeltown and Belle Isle. Health for All will focus on raising awareness of the impact of second hand smoke on children and will encourage families to make their homes and cars free of second hand smoke. Intensive work will begin in April 2013

including primary care mental health, podiatry and the musculo skeletal service.
Along side staff training, early indications are showing the project has resulted in increased numbers of staff referring patients into services.

Children and Young People Plan (CYPP) A proposal to include tobacco, alcohol and drugs (substance misuse) as a new priority on the CYPP - with a headline indicator, has been approved by Children's Services Leadership Team, and submitted for approval by the Children's Trust Board in February.
An OBA planning session on the Leeds Drug Action Plan with wider stakeholder groups is being planned.

LTHT's Smoking Control Policy has been reviewed and was approved in November.
Updates included ensuring clear signposting information for managers and staff wanting to quit (e.g. Leeds Let's Change website), guidance on e-cigarettes and reiterating current position on smoke free workplaces. The LTHT NRT policy has also been updated and is now included on the Leeds Health Pathways website along with the NHS Stop Smoking Service referral form for easy access by all NHS staff.

What worked locally /Case study of impact

Third Sector – NHS Leeds Commissioned Activity Healthy Living Network Leeds has been working with Lloyds pharmacy in New Wortley, Armley and Freeman's pharmacy in Lower Wortley. Community Health Educators (CHEs) have been providing weekly, 2-hour, drop-in sessions and have been effectively engaging with local people and informing them about NHS health services. Throughout quarters 1, 2 & 3 this work has resulted in a large number of people being referred into healthy living services. This work has included referring 20 people, living in deprived neighbourhoods in West Leeds, to the NHS Stop Smoking Service who would otherwise not have accessed this service for support to quit.

Risks and Challenges *any significant risks from the existing risk registers and/or any current challenges or issues with an impact on delivery*

- Although a comprehensive tobacco action plan has been developed to include activity and actions suggested in the national plan there is a need for further investment to be able to deliver the plan on the scale needed to significantly change prevalence.
- **Although regional funding has recently been secured** to support Leeds becoming involved with the Action on Smoking and Health (ASH) assessment scheme (CLeaR) we have yet to identify 2 appropriate people to be trained as peer assessors. This is resulting in a delay in delivering both a self and peer assessment of tobacco control activity in Leeds.

CITY PRIORITY PLAN REPORT CARD

Meeting: Health and Wellbeing Board

Population: All adults in Leeds

Outcome: People are supported by high quality services to live full, active and independent lives.

Priority: Support more people to live safely in their own homes.

Why and where is this a priority: The vision for the future is to enable people, regardless of age, with complex health and social care needs, including those with mental health needs, to be cared for at home or closer to home avoiding the need for unplanned hospital attendances and admissions and reducing the need for long term admission to residential or nursing care homes.

Overall Progress:
GREEN

The Story behind the Baseline

There has been an overall downward trend in the number of older people starting to require financial support by the Local Authority for permanent admission to care homes over the last seven years Whilst numbers have increased slightly over the last quarter this is an expected seasonal variation and the indicator is still meeting target. Overall progress against the priority is good with progress being made this quarter on a number of milestones

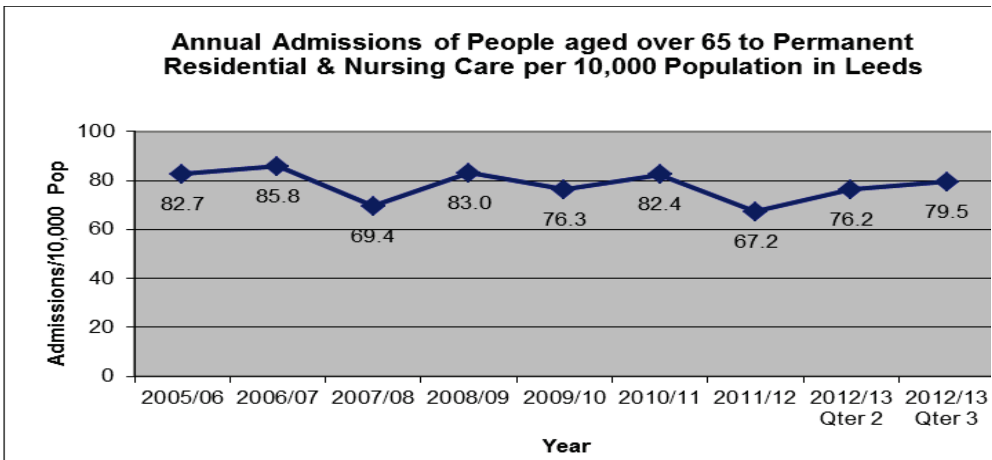
An analysis of average bed weeks purchased for older people show that:

- Leeds commissioned 138,996 bed weeks in older people's care homes in 2011/12. This is a reduction of 3.2% over the previous year.
- Permanent nursing care bed weeks for older people reduced from 48,915 to 46,764 (4.4%) over the previous year.
- Permanent bed weeks for older people in local authority managed homes fell from 27,212 in 2010/11 to 22,932 in 2011/12 (15.7%).
- The number of permanent bed weeks commissioned in the independent sector remained almost the same as the previous year.
- At 31st March 2012 the Council supported 2,368 older people permanently in care homes. This is a reduction of 5.5%.

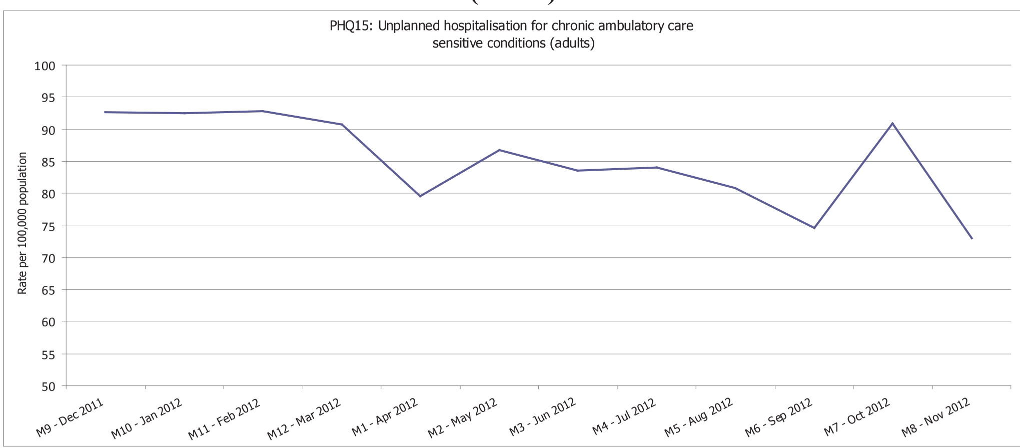
The figures suggest that older people are retaining independence for longer periods and are requiring care home support at later stages in their lives. Over the last few years the city has faced a number of challenges which have increased pressures upon the Local Authority to support people with their care. These include rising demographic pressures; an increasing number of older people who had previously funded their own residential and nursing care exhausting their own resources, and ongoing changes to the health delivery infrastructure generating short term pressures on community services as hospital ward places are reduced and investment is transferred into community alternatives.

The Ambulatory Care Pathways Transformation Portfolio is still within the design and implementation stages. Strong links continue with integrated health and social care for the long term conditions ensuring opportunities for prevention of admission are maximised. The impact of the portfolio will be delivered in future years, The graph opposite illustrates the current position.

Headline Indicators:



PHQ15: Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)



What we did:

A report has been produced on the effectiveness of joint working between the Leeds Teaching Hospital Trust (LTHT), Adult Social Care and Leeds Community Healthcare. As a result, a Strategic Discharge Group has been established with representation from LTHT, LCH and ASC. One of the primary drivers in this is to develop a common language around discharge and also to look at some of the 'pinch points' around the hospital pathway. This work is on-going and reports into the Urgent Care Stakeholder Management group and ultimately the Health and Social Care Board.

A consultation regarding the proposed AT hub has been completed. The results will be used to further inform developments and included useful insights and positive messages regarding the development. The final decision for whether to go ahead with the hub will be taken by council leaders later this year.

Twelve neighbourhood teams of health and social care staff have been established across the city.

Through the Leeds Health and Social Care Transformation Programme the following key actions have been undertaken:

- The initial findings of the stock take of the Leeds Health and Social Care Transformation Programme were presented to the Board.
- A citywide Director of Finance sub group of the Transformation Programme Board has been established.
- An update on the Dementia portfolio was provided to the Leeds Health and Social Care Transformation Programme Board outlining the 4 work streams which will be undertaken utilising transformation funding.

What worked locally /Case study of impact:

David is 59 years old and lives in Seacroft. He has several ongoing health issues including a heart condition, asthma and chronic obstructive pulmonary disease (COPD).

Before David was diagnosed, he was generally quite healthy. He enjoyed getting out and about and, in his words, "could probably have run a marathon or two". But as his condition deteriorated, David found it harder to do simple things like lifting or even walking. He became more and more reliant on health services. He was known to his GP and had to make regular visits to hospital.

"I was becoming limited in what I could do. I'd always been very independent so I found it hard to adjust. I was doing everything myself as my wife was poorly herself – you could say it was like the blind leading the blind. "But now everything has changed. My community matron has been working closely with adult social care to put a system in place that means I can have some independence and control back in my life. I now have carers that come to visit me four times a day. "Most importantly, I've been given machines at home that help me with my breathing. I also have a bed, like the ones you have in hospital, with a tray, a reclining chair and wheelchair. "Life has changed, and although I'll never go back to how I used to be, it's certainly made it much easier for me to manage."

What do key stakeholders think - The key messages from stakeholders:

Help people to continue to live independently in their own homes by meeting local needs locally, providing support closer to people's homes means public money can be used more efficiently and effectively. People need access to high quality information to allow them to make informed choices about how and where they receive care.

New Actions:

Work by Adult Social Care and Leeds Community Healthcare NHS Trust to open the first joint intermediate care service continues. Refurbishment works are progressing and the programme dates are on schedule. Construction work commenced in October 2012 and works handover for fit out will be in February 2013.

The pathway for Mental Health reablement will go live during January 2013. Work continues to develop a reablement service and align capacity and demand within the SkILs service. A pilot project to investigate the impact of home care suspensions (on full rate) during reablement was approved. The pilot will run for six months starting in March 2013 and report will come back in October 2013, with an interim report in July. Work is also on going with LCH to integrate reablement with Intermediate Care Services, as part of overarching Health and Social Care Integration work.

Through the Leeds Health and Social Care Transformation Programme the following key actions will be undertaken:

- Continuation of the stocktake of the Leeds Health and Social Care Transformation Programme
- Baseline and performance metrics to be developed to measure the impact of the Dementia work streams.
- Evaluation of the current Dementia Pathway

Data Development A programme of work has been established to develop the appropriate Information management and technology enablers for integrated working with the NHS. Achievements so far include the NHS number captured on the social care record, progress on the IG Toolkit, local network connections between the council and all NHS organisations in Leeds and the procurement of software, which can be used to collate and analysis data from both organisations.

Risks and Challenges:

- Adult Social Care and Health Partners fail to develop and maintain effective partnership working and processes at locality and city-wide strategic level to reduce health inequalities.
- There is a risk of inadequate resources being available to support the Leeds Health and Social Care Transformation Programme and project infrastructure and the implementation stage of the projects during the transition to the new national commissioning architecture.
- Adults' Social Care fails to deliver the whole of its Business Systems Transformation Programme.

Meeting: Health and Wellbeing Board

Outcome: People are supported by high quality services

Population: All adults in Leeds

Priority: Give people choice and control over their health and social care services to live full, active and independent lives services.

Why and where is this a priority The vision for the future is to enable people, regardless of age, with complex health and social care needs, including those with mental health needs, to be cared for at home or closer to home and to have increased choice and control over their health and social care services

Overall Progress: GREEN

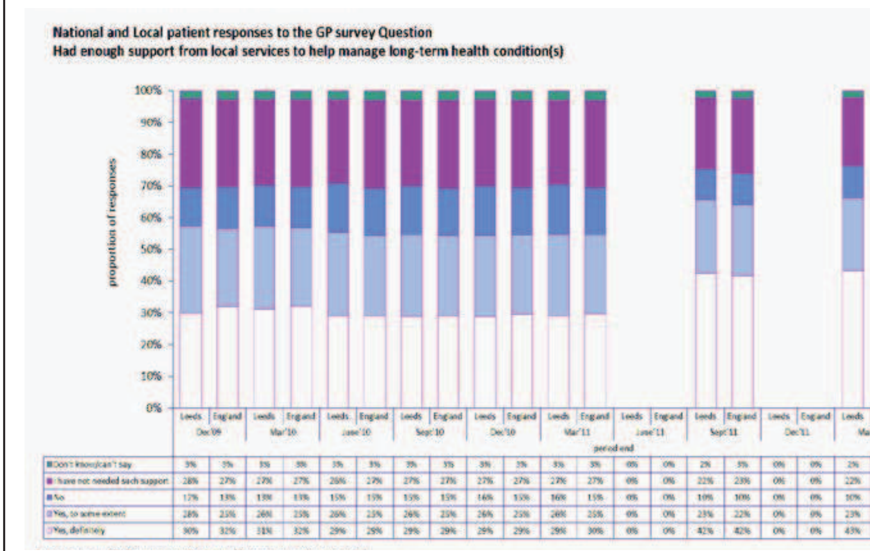
Story behind the baseline:

Long term conditions account for 70% of health and social care costs, and almost three quarters of the gap in life expectancy between those living in the most deprived areas of Leeds and Leeds overall.

The statistics for Leeds continue to follow the national trend. Between March 2012 and September 2012 there has been a 1% increase in the number of patient responses where people are feeling they are not receiving the support they feel they need to manage their long term condition. The number of responses where patients feel they are to some extent or definitely having enough support to help manage long term health condition(s) has remained static during this period. (See graph opposite).

'Transforming Social Care' LAC (DH) (2008) outlined the national policy for all social care service users to be given the opportunity to choose their support arrangements through self directed support. Leeds has been extending choice to service users, final figures for the year end 2011/12 show that the target of 45% has been exceeded, with 52% of eligible community based service users being in receipt of self directed support. Provisional data published by the National Adult Social Care Intelligence Service (NASCIS) for 2011/12 shows Leeds to be amongst the top performers of comparative authorities for both the overall percentage of people receiving self directed support and the proportion who specifically get a cash payment. The national average is around 42% for all and 13% for cash payments, whilst Leeds achieved around 52% and 18% respectively.

Headline Indicator: Increase the proportion of people with long-term conditions feeling supported to be independent and manage their condition.



What do key stakeholders think:

A survey was undertaken regarding Self Directed Support. The majority of people asked (65%) understood the concept of personal budgets and of the remaining number 19% couldn't remember having things explained and 7% said it was explained but they struggled to understand. 9% said that it wasn't explained.

When asked about the reasons for choosing the council to arrange services (if they did) the majority (55%) said that it was their choice. Of the rest, 17% liked the idea of having more control but were worried about finding the right services, or receiving the right advice. The remaining number (in roughly equal proportions) didn't really understand the other options, didn't have other options explained or thought that buying and arranging their own support sounded too hard.

What we did:

Leeds ASC published its second Local Account and the Better Lives programme and communications have been launched. The account is produced in collaboration with service users and provides a public account of what ASC does, its progress against priorities and an outline of its future plans. Improvements in accessing information continue, during the quarter a Leeds Wellbeing Portal was launched which enables access to the full range of organisations and support for health and wellbeing.

Adult Social Care is committed to 'Better lives through Enterprise.' In addition to providing investment grants for social enterprises, a whole range of initiatives are being developed to increase opportunities for vulnerable people to be involved in communities, to incentivise community based initiatives which support vulnerable people and to encourage strengthened links across the range of public and private partners. A number of private firms, including Marks and Spencer's and First Direct are providing resources and volunteers to engage in community services such as the Neighbourhood Networks.

A consultation regarding the transformation of the Mental Health day services was completed in December. The primary aim of this transformation programme is to deliver a recovery model aimed at keeping people well and offering a more varied choice of service provision. The service will work with each person to understand what keeps them well. It will strive to make sure that the service user is at the heart of developing their own support plan, working towards building a fulfilling life, wishes, aspirations and goals.

Through the Leeds Health and Social Care Transformation Programme, all integrated Health and Social Care Demonstrator sites were established by December 2012.

What worked locally /Case study of impact:

Sir John Oldham came to Leeds to see how integration is working in Leeds. In line with the National Long Term conditions model led by Sir John, Leeds is bringing together; risk profiling, creating integrated neighbourhood teams and providing support so people can manage their own symptoms and improve quality of life. Sir John spoke to co-located health and social care staff to get a flavour of how they have been delivering joined up services. He was also provided with a presentation of how practices are using risk profiling to take a preventative approach to treating patients.

Sir John said, '*One of the things I admire about Leeds is that you have leaders from hospitals, community services, social care and primary care driving this change throughout the city. ... To my mind Leeds is the best example in the country of doing that, so I'm using your model as an example.'*

New Actions:

'Making it Real,' is a national vehicle for driving progress in delivering personalised social care services. In Leeds consultation is being undertaken via discussions with groups and a survey in collaboration with Lancaster University. The survey results will be due early this year. This will determine priorities for improvement. A Leadership Forum for Making it Real and Better Lives is being established including representation from services users, carers, elected members and senior officers and a project team will report to it, an inaugural meeting will be held on the 18th January.

Older Peoples Residential and Day Services Programme presented a report to CLT in October 2012, and Cabinet on the 12th November outlining the emerging options appraisal undertaken by Adult Social Care for council run residential homes and day-care centres for older people and to provide an opportunity for officers and members to consider an respond to before seeking approval from Labour Group and Executive Board.

LCC Executive Board agreed plans to build a new specialist day centre in Rothwell for people with learning disabilities with complex needs. A feasibility study was undertaken which concluded that the most cost effective option was to demolish the existing building and rebuild.

An update on the evaluation of the Integrated Health and Social Care Teams will be presented to the Leeds Health and Social Care Transformation Programme Board.

Data Development: A programme of work has been established to develop the appropriate Information management and technology enablers for integrated working with the NHS. Achievements so far include the NHS number captured on the social care record, progress on the IG Toolkit, local network connections between the council and all NHS organisations in Leeds and the procurement of software, which can be used to collate and analysis data from both organisations.

Risks and Challenges:

- Adult Social Care fails to manage the changing service and workforce requirements through its internal transformation programme to deliver personalised services within available financial resources.
- Adult Social Care and Health Partners fail to develop and maintain effective partnership working and processes at locality and city-wide strategic level to reduce health inequalities
- Adults' Social Care fails to deliver the whole of its Business Systems Transformation Programme.
- Insufficient or poor quality Business Intelligence has a detrimental effect on the ability to meet overall objectives.
- There is a risk of inadequate resources being available to support Leeds Health and Social Care Transformation Programme and project infrastructure and the implementation stage of the projects during the transition to the new national commissioning architecture.

2012/13 QUARTER 3 — CITY PRIORITY PLAN REPORT CARD — HW4

Meeting: Health and Wellbeing Board

Population: All people in Leeds

Outcome: Best City for Health and wellbeing

Priority: Make sure that people who are the poorest improve their health the fastest.

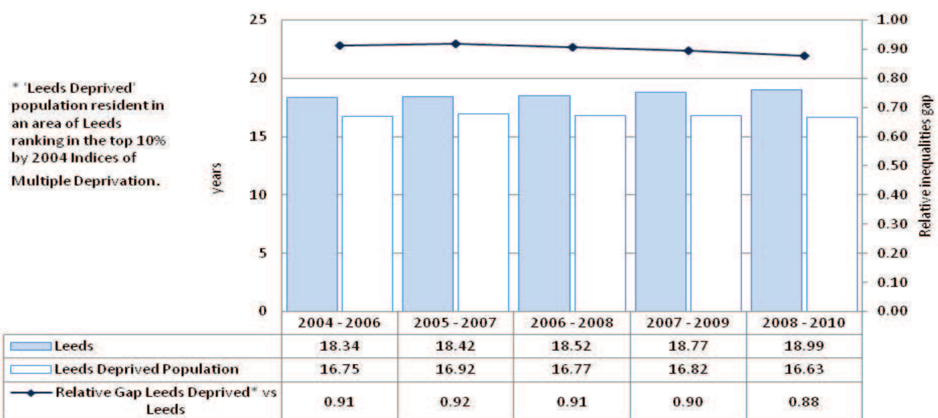
Why and where is this a priority. 20 % of the population of Leeds live in the 10% most deprived Super Output Areas (SOAs) in England accounting for approximately 150,000 people. There are also significant numbers of vulnerable people living across Leeds. There are range of social, economic and environmental factors that affect their health and wellbeing and which are contributing to the growing health inequalities within Leeds for men and women by areas of deprivation: 1)There is a 10.1 year gap in life expectancy for men between City & Hunslet and Harewood (71.6 years:81.7years) 2)There is a 9.6 year gap in life expectancy for women between City & Hunslet and Adel/Wharfedale (76.1year:85.7years)

Overall Progress: RAG rating Red

Headline Indicator

- Reduce the differences in life expectancy between communities
- Reduce the difference in healthy life expectancy between communities

Story behind the baseline: Overall life expectancy in Leeds is increasing however there is a much lower level of life expectancy for those living the most deprived areas of Leeds and the absolute gap between these statistics is increasing. The key causes of premature mortality are cardiovascular disease, cancer, and respiratory disease. All premature mortality data for these diseases in Leeds have a significant gap between the rates in the non deprived areas and the deprived areas of Leeds. For some diseases such as respiratory and stroke mortality rates are showing an increase. Causes of mortality from these diseases are multifaceted and include the impact of the wider determinants of health such as housing, transport, employment and poverty, as well an individual's lifestyle (in relation to smoking/alcohol/physical activity and healthy eating) , and their access to appropriate and effective services.



	2004 - 2006	2005 - 2007	2006 - 2008	2007 - 2009	2008 - 2010
Leeds	18.34	18.42	18.52	18.77	18.99
Leeds Deprived Population	16.75	16.92	16.77	16.82	16.63
Relative Gap Leeds Deprived* vs Leeds	0.91	0.92	0.91	0.90	0.88

What do key stakeholders think. The Vision for Leeds consultation confirmed that the public expected:

• people have the opportunity to get out of poverty; • education and training helps more people to achieve their potential; • communities are safe and people feel safe; • all homes are of a decent standard and everyone can afford to stay warm; • healthy life choices are easier to make; • people are motivated to reuse and recycle; • there are more community-led businesses that meet local needs; • local services, including shops and healthcare, are easy to access and meet people's needs; • local cultural and sporting activities are available to all; and • there are high quality buildings, places and green spaces, which are clean, looked after, and respect the city's heritage, including buildings, parks and the history of our communities.

What we did

Limit impact of poverty on children under 5 yrs:

- **Early Start Service:** expansion of HV workforce continues in line with the trajectory. Early Start pathways detailing the service offer to Looked After Children and describing Pre birth assessment support completed. A comprehensive Early Start workforce development plan written. The roll out of Preparation for Birth and beyond community based antenatal programme on track.
- **Family Nurse Partnership:** NHS commitment to sustain and expand FNP confirmed and the programme continues to successfully recruit and work with eligible teen parents. Group FNP continues to be a success in terms of numbers attending.
- **Infant Mortality:** 5 year data on the IM rate in deprived Leeds continues to show a decline, and is now at 5.5 deaths per 1000 live births. Pathways detailing the targeted support available to Gypsy, Roma and Travellers new parents completed and being implemented. Materials to promote the importance of not co-sleeping when under the influence of alcohol and drugs developed and distributed, including beer mats for use in pubs over the festive period. The Breastfeeding peer support project expansion is progressing well.

Increase advice and support to minimise debt and maximise income

- Fuel poverty now apriority in the draft health and wellbeing strategy.
- Electronic toolkit to support frontline workers in providing consistent messages to vulnerable people over winter, about staying warm and well. rolled out across Leeds as part of the Winter planning process
- Systematic referral systems embedded and strengthened within Leeds Community Health Care and 35 Energy champions have been identified and trained
- DH funding was successfully bid for to develop a pilot project with the CAB network to offer joint fuel tariff, debt and income maximisation advice over the winter period.

Healthy Employment

- Continued work to expand of Leeds Occupational Health Advisory Service
- Information now with agencies supporting people into work to increase access to healthy lifestyle and mental health services
- Actions to include health at work in Account Management Process agreed

Ensure equitable access to services that improve health

- Leeds Wellbeing Portal launched providing comprehensive directory of health and wellbeing services

What worked locally /Case study of impact

New Actions

Limit impact of poverty on children under 5 yrs:

- **Early Start Service:** Quality assurance visits to take place with Early Start Teams in January. Infant Mental Health Service will deliver Babies, Brains and Bonding training city wide, to support all ESTs in their work with parents. 3 further teams will be engaged to rollout 'Preparation for Birth and Beyond', resulting in programme being available from 9 community bases by March 31st 2013.
- **Infant Mortality**: Leeds will be assessed for Baby Friendly Initiative level 3 accreditation in the first quarter of 2013. A breast feeding peer coordinator role will be recruited. Brief intervention training with Children Centre staff, new 'teen friendly' materials and expansion of Leeds smoke free homes programme will contribute to reducing smoking prevalence in pregnancy. Insight work to be completed and leaflets, web pages and audio resource produced to increase understanding of the risks associated with consanguinity.
- **FNP**: From April 2013, the commissioning of FNP will move to the NHS Commissioning Board, and transfer to LCC Public Health from April 2015. Currently no clarity about how the NHSCB will undertake this role.

Increase advice and support to minimise debt and maximise income

To establish how to further strengthen energy champion approach in ASC/NHS integrated teams as the programme is rolled out across the city.

Healthy Employment

- Develop toolkit to increase economic development through improving health and wellbeing of staff
- Working well to be included under the Civic Enterprise. tool kit
- Identify 2 key businesses in a position to take forward 'Working Well'

Ensure equitable access to services that improve health

To review evaluation report with a view to extending the work on case finding of lung cancer in Inner East / Inner South Leeds until 2014

Improving equality monitoring in primary care

Targeting to those most in need in IHSC programme including work with neighbourhood networks; asset mapping placed on Leeds Directory; referral to high impact interventions e.g. fuel poverty; healthy lifestyles etc.

Data Development

- Detailed reports on outputs from NHS Health Check to be completed
- Results from Healthy Lifestyle survey using the Citizens Panel and extended use of survey with priority populations

Risks and Challenges

- Reduced incomes for households in Leeds as a result of the economic climate and the national changes to benefits and tax credits system
- Sustainability of and scale of funding available to meet the needs of the size of the population in Leeds
- Increase in energy prices and other costs living with increases risk to health and wellbeing of more vulnerable people
- Impact of economic recession

2012/13 Adult Social Care Directorate Scorecard **Reporting Period : Quarter 3 2012/13**

Contribution to Cross Council Priorities	Progress Summary	Overall Progress	Supporting Measures	Target	Q1	Q2	Q3	Q4	Executive Portfolio
Appraisals	There have been significant efforts in December 2012 to achieve the response rate of 95%. This is significantly above the LCC response rate of 83%. However there are still c90 mid term appraisals not complete and these are being reviewed by the each Head of Service. A number of manager workshops have been scheduled for Q4 in readiness for the full appraisal cycle in April 2013. Specific manager briefings are being held to prepare for the performance ratings element of the appraisal.	Green	Every year 100% of staff have an appraisal	100%	N/A	100% (Annual Appraisal)	95% (Mid Year Review)		Neighbourhoods, Planning and Support Services
Staff Engagement	Engagement score at 74% is on target and compares favourably with the corporate score of 68%. Response rate remains low at 22%. The Directorate Leadership Team has approved a number of engagement events	Amber	Extent to which the council is delivering what staff need to feel engaged	74%	71%	71%	74%		Neighbourhoods, Planning and Support Services
Consultation	There was 100% compliance with the criteria. There were good examples of evidencing the process and results of consultation.	Green	Every year we will be able to evidence that consultation has taken place in 100 per cent of major decisions affecting the lives of communities	100%	100%	100%	100%		Leader
Equality	There was 100% compliance with the performance indicator. The QA carried out on the reports clearly showed that there is good evidence that the Directorate is complying with the requirements of the performance indicator. There are some very good examples of narrative which explicitly references how equality considerations have been made, have they are used to improve service delivery and to target services for under represented groups. The outcomes from the QA exercise will be discussed with the Directorate inform future reports.	Green	Every year we will be able to evidence that equality issues have been considered in 100 per cent of major decisions	100%	100%	80%	100%		Leader
Keep within budget	Overall this directorate is projecting a balanced position, although the delivery in full of all budgeted savings carries a degree of risk	Green	No variation from agreed directorate budget in the year	£0	£49k	£49k	£45k		Leader

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Directorate Priorities	Progress Summary	Overall Progress	Supporting Measures	Target	Q1	Q2	Q3	Q4	Executive Portfolio
Deliver the Health and Wellbeing City Priority Plan	Arrangements continue to be put in place to introduce a Health and Wellbeing Board (HWB) in 2013 in line with legislation. The statutory requirements of the board have been outlined and discussions undertaken regarding any local requirements which the board maybe required to include in it's remit. Discussions regarding governance arrangements for the HWB have also been undertaken but will be influenced by secondary legislation in January. The full council will appoint the HWB in May 2013. A recommendation has been made to the chief executive for provision of Leeds Healthwatch. The award will be made on the 4th February.	Green	N/A	N/A	N/A	N/A	N/A	N/A	Health and Well Being
Help people with poor physical or mental health to learn or relearn skills for daily living See also Intermediate CIC Bed Programme (rated red at Q3) and a range of projects within the Better Lives for Integrated Services Programme.	Adult Social Care and Leeds Community Healthcare NHS Trust continue to work towards opening the first joint intermediate care service at Harry Booth house continues. The service will provide intensive short-term support to people recovering from illness and prevent hospital admissions and support people to return home following a period of illness in hospital. Refurbishment works are progressing and the programme dates are on schedule. Construction work commenced in October 2012 and works handover for fit out will be in February 2013. All pathways into reablement are now open apart from Mental Health. Work continues to develop a Mental Health reablement service and align capacity and demand within the SkILs service. DLT approved a pilot project to investigate the impact of home care suspensions (on full rate) during reablement. The pilot will run for six months starting in March 2013 and report will come back to DLT in October 2013, with an interim report in July. Work is also ongoing with LCH to integrate reablement with Intermediate Care Services, as part of overarching Health and Social Care Integration work.	Red	Increase the number of people successfully completing a programme to help them relearn the skills for daily living.	2,000	187	191	274		Adult Social Care / Health and Well Being
Extend the use of personal budgets	Making it Real,' is a national vehicle for driving progress in delivering personalised social care services. A Leadership Forum for Making it Real and Better Lives has been established and including representation from services users, carers, elected members and senior officers. In Leeds consultation is being undertaken via discussions with groups and a survey in collaboration with Lancaster University. The survey results have been received early this year and will inform priorities for improvement to extend choice and control to service users and their carers. A range of work continues to extend choice and control to all service users and their carers. New service users and carers are being routinely provided with information regarding the costs of their support plan and provided with the option to take cash payments. Access to direct payments for carers has been extended via the carers centre and projects are being progressed to better support access to cash payments via community groups and providers to broker services. Technology and systems are also being developed and fine tuned to support, capture and report self directed support.	Amber	Increase percentage of service users and carers with control over their own care budget	70%	42%	51%	62%		Adult Social Care
			Increase percentage service users who feel that they have control over their daily life.	85%	68%	69%	70%		

Improve the range of daytime activities for people with eligible needs	A consultation regarding the transformation of the Mental Health day services was completed in December. The primary aim of this transformation programme is to deliver a recovery model aimed at keeping people well and offering a more varied choice of service provision. The service will work with each person to understand what keeps them well. It will strive to make sure that the service user is at the heart of developing their own support plan, working towards building a fulfilling life, wishes, aspirations and goals. LCC executive board agreed plans to build a new specialist day centre in Rothwell for people with learning disabilities with complex needs. A feasibility study was undertaken which concluded that the most cost effective option was to demolish the existing building and rebuild.	Green	N/A	N/A	N/A	N/A	N/A	N/A	Adult Social Care / Health and Well Being
Ensure more people with poor physical or mental health remain living at home or close to home for longer	The Shared Lives scheme helps people to continue to live full and independent lives without having to use residential care. The scheme supports 170 carers who offer support to 550 people by inviting them into their own homes. Dorothy is a shared lives carer, she said, 'Being a shared lives worker is very varied and my husband and enjoy many different aspects of it. It's been rewarding to have a part in helping people with learning disabilities reach their full potential and gain independence.' Betty has been visiting her shared lives carers for almost two years. She says, 'I can do exactly what I want to do, going out , going shopping, or just saying in for a chat and coffee. Lately Sheila has accompanied me to hospital appointments which has been a great help.' A consultation regarding the proposed AT hub has been completed. The results will be used to further inform developments and included useful insights and positive messages regarding the development. The final decision for whether to go ahead with the hub will be taken by council leaders later this year.	Green	Reduce number of bed weeks care in residential and nursing care homes for older people supported by the local authority	138,000	128,469	133,925	137,989		Adult Social Care / Health and Well Being
Support adults whose circumstances make them vulnerable to live safe and independent lives	A project has been established with health partners to improve joint arrangements for accessing and sharing information which will support the protection of vulnerable adults across agencies. Initial options have been developed and appraised. Work will commence to secure resources and put in place arrangements. Adult Social Care Meals at Home service has linked with West Yorkshire Trading Standards to support 'Scams and Fraud Education for Residents' (SAFER) project. The staff will join part of a growing network of front-line staff acting as the 'eyes and ears' of the community to identify where vulnerable people maybe subject to scams or fraud. The meals staff will also be providing customers with information to help people including making them aware of common forms of fraud and tips about how to protect themselves.	Amber	Increase percentage of safeguarding referrals which lead to a safeguarding investigation	45.0%	29.5%	31.0%	32.0%		Adult Social Care / Health and Well Being

Ensure resources are efficiently matched and directed towards those with greatest need	Leeds Adult Social Care has developed a very clear vision for the future of services. An overall plan for the directorate has been developed and service transformation projects which direct resources to those who are most in need is in progress. In addition to internal plans work with health partners continues with a focus upon integration to ensure timely support and prevention. An ambitious plan with stretch targets to achieve efficiency savings was formulated for 2012/13. Whilst we currently look unlikely to deliver this, ASC is still on track to deliver a balanced budget at the end of the year. As at quarter 2, 17.7% (£0.9k) achieved, year end projection 56.5% (£2.8m)	Amber	Delivery of efficiency savings for directly provided services	£7.2m	£0.6m	£0.9m	£1.2m		Adult Social Care
Provide easier access to joined-up health and social care services	A report has been produced on the effectiveness of joint working between the Leeds Teaching Hospital Trust (LTHT), Adult Social Care and Leeds Community Healthcare. As a result, a Strategic Complex Discharge Group has been established with representation from LTHT, LCH and ASC. One of the primary drivers in this is to develop a common language around discharge and also to look at some of the 'pinch points' around the hospital pathway. This work is on-going and reports into the Urgent Care Stakeholder Management group and ultimately the Health and Social Care Board.	Amber	Reduce number of delayed discharges from hospital due to adult social care only (per 100,000 adult population per week)	1.50 (9.28 people per week)	1.92	2.16	2.45		Adult Social Care / Health and Well Being
People with social care needs receive coordinated and effective personalised support from local health and wellbeing agencies	Departmental Leadership Team received a report articulating an overarching target model for integrated services as a whole across ASC and LCH. As part of the overarching Transformation Programme, projects have been established to develop a Gateway function, Neighbourhoods Teams and an integrated Reablement, Recovery and Rehabilitation service. These functions will all form part of the new integrated pathway across the city. Additional elements proposed include a joint Rapid Response service and joint administrative support. Sir John Oldham came to Leeds to see how integration is working. Sir John led the development of the National Long Term conditions model and Leeds is following the model in combining: risk profiling, creating integrated neighbourhood teams and providing support so people can manage their own symptoms and improve quality of life. Sir John spoke to co-located health and social care staff to get a	Green	Increase proportion of older people (65 and over) who were still at home 91 days after leaving hospital into rehabilitation services	90.0%	89.5%	86.0%	90.0%		Health and Well Being
Encourage existing and new kinds of enterprise to develop in the Leeds care market which will provide a variety of services that are geared to respond to people's specific needs.	Adult Social Care is committed to 'Better lives through Enterprise.' In addition to providing investment grants for social enterprises, a whole range of initiatives are being developed to increase opportunities for vulnerable people to be involved in communities, to incentivise community based initiatives which support vulnerable people and to encourage strengthened links across the range of public and private partners. A number of private firms, including Marks and Spencer's and First Direct are providing resources and volunteers to engage in community services such as the Neighbourhood Networks. Leeds Adult Social Care and public health colleagues are looking at the possibility of developing a phone application which enables the public to locate and access health services in Leeds and supports consultation and feedback.	Green	N/A	N/A	N/A	N/A	N/A	N/A	Adult Social Care

Create a mosaic of types of housing (including residential and extra care) with support suited to and adaptable for people’s changing needs.	Older Peoples Residential and Day Services Programme presented a report to CLT in October 2012, and Cabinet on the 12th November outlining the emerging options appraisal undertaken by Adult Social Care for council run residential homes and day-care centres for older people and to provide an opportunity for officers and members to consider an respond to before seeking approval from Labour Group and Executive Board. Leeds Adult Social Care continues to support improvements in the quality of service and life for people in residential accommodation. A recent initiative has been the Sporting Memories Network (SMN) is working across 15 care homes across Leeds to test out an alternative approach to reminiscence therapy. The network will train staff, volunteers and relatives to deliver sports related reminiscence activities using local and national archives, images, reports and memorabilia. Through the project a unique archive of resources are being gathered which maybe used for future reminiscence work.	Amber	N/A	N/A	N/A	N/A	N/A	N/A	Adult Social Care
Creating the environment for partnership working so that a range of Adult Social Care and Health services will become more closely integrated and people’s experience of the support they receive in older age, illness or disability will be more positive	From April 2013 Leeds City Council will take on their leadership for Public Health under the Health and Social Care Act. The Leeds Public Health Transition Plan as submitted to, and endorsed by, NHS North of England, has four components – transfer of public health responsibilities; maintaining performance and public health development; developing; supporting and engaging with the new public health system; governance. There will be an office of the DPH, Corporate and Support functions alongside customer and legal eservices. The DPH will be accountable to the Chief Executive with political leadership from Cllr Mulherin. The operating model that has been agreed is to have a hub and spoke model with all staff accountable to the DPH and aligned with Local Authority Directorates to ensure full integration of work programmes wherever possible to max the new public health role across local authority including delivery of the 5 mandatory functions. Staff will also be aligned to the 3 Clinical Commissioning Groups (working as part of the Health Care Public Health Advice Service) and the 3 LCC areas .Where feasible staff will be co-located.	Green	N/A	N/A	N/A	N/A	N/A	N/A	Adult Social Care / Health and Well Being

City Priority Plans	Overall Progress	Headline Indicator	Q1	Q2	Q3	Q4	Executive Portfolio
Make sure that more people make healthy lifestyle choices.	Amber	Reduce the number of adults over 18 that smoke.	22.4%	22.6%	22.5%		Health and Well Being
Support more people to live safely in their own homes.	Green	Reduce the rate of emergency admissions to hospital.	See report card	See report card	See report card		Adult Social Care / Health and Well Being
		Reduce the rate of admission to residential care homes.	See report card	76.20%	79.50%		
Give people choice and control over their health and social care services.	Green	Increase the proportion of people with long-term conditions feeling supported to be independent and manage their condition.	42%	43%	43%		Adult Social Care / Health and Well Being
Make sure that people who are the poorest improve their health the fastest.	Red	Reduce the differences in life expectancy between communities	See report card	See report card	tbc		Health and Well Being

Self Assessment

Agenda Item 9

Leeds CITY COUNCIL

Report author: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

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

Date: 27 March 2013

Subject: Scrutiny Inquiry – Strategic Partnership Boards

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

Summary of main issues

1. The Scrutiny Board Procedure Rules state that all Scrutiny Boards will act as a "critical friend" to the relevant Strategic Partnership Board and consider and report on the following areas:

   - What contribution the Partnership Board is making to tackle poverty and inequality, and the progress being made against this
   - How successfully the Board's partnership arrangements are working
   - To what extent are significant benefits being seen from partnership working? How has partnership working ensured increased pace of change to address the issue in hand?

2. A common approach is being adopted for Scrutiny Boards in exercising their "critical friend" role, in order that outcomes can be compared and contrasted between Partnership Boards. However, it is also acknowledged that each Strategic Partnership Board is at a different stage in its development and maturity.

3. During March 2013, Scrutiny Boards will receive reports from the relevant Strategic Partnership Board and have the opportunity to question the chair and members of the Partnership Board and support officers.

Date	*Scrutiny Board*	*Strategic Partnership Board*
11 March	Safer and Stronger Communities	Safer and Stronger Communities
14 March	Children and Families	Children's Trust Board
21 March	Sustainable Economy and Culture	Sustainable Economy and Culture
26 March	Housing and Regeneration	Housing and Regeneration
27 March	Health & Wellbeing and Adult Social Care	Health and Wellbeing Board

4. The attached report provides background information on the history and development of the (currently shadow) Health and Wellbeing Board. The report also presents information which will assist the Scrutiny Board in assessing strengths and areas for development for the Partnership Board in respect of the three key questions set out in paragraph 1 above.

5. Given the developing nature of Health and Wellbeing Boards nationally, and to further assist the Scrutiny Board in assessing the future partnership arrangements, a copy of the joint Local Government Association (LGA) and Association of Democratic Services Officers (ADSO) publication *'Health and wellbeing boards: A practical guide to governance and constitutional issues',* is also provided with this report.

6. Following the scrutiny sessions in March, each Scrutiny Board will produce a summary report of its findings. The Scrutiny Support Unit will then prepare a cover report drawing out any common threads and best practice emerging from the individual inquiry sessions. The full report will be presented to Council, as the commissioning body for this piece of scrutiny inquiry work. Each Strategic Partnership Board will also receive their respective individual report, along with the cover report, and will be requested to respond to any scrutiny recommendations in the normal manner.

7. In December 2012 a review of partnership arrangements was undertaken. It concluded that:
   - The Leeds Initiative Board should be replaced by a wider Best City Leadership Network; this would involve more stakeholders in less frequent meetings focussing on the big 'State of the city' issues which face the city.
   - Best City summits will be held drawing on partners from the network to tackle issues of joint interest.
   - The Leeds Initiative brand should be retired, and the partnerships should be referred to as 'Best City Partnerships'.
   - The 5 strategic partnership boards shall not be changed, however they shall be managed in future by the relevant directorates

8. The outcome of the review does not change the focus of this scrutiny exercise. The partnerships are an important focus for the delivery of the city's key aims. Scrutiny Boards acting as the "critical friend" of the partnerships will help further progress the agenda under the new arrangements.

Recommendation

9. The Scrutiny Board is requested to use the attached information and the discussion with representatives from the Strategic Partnership Board to inform its contribution to the scrutiny report on strategic partnership boards.

Background documents[1]

10. 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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Report author: Rob Kenyon

Tel: 0113 2474209

Report of: **The Shadow Health and Wellbeing Board**

Report to: **Health and Wellbeing and Adult Social Care Scrutiny Board**

Date: **27 March 2013**

Subject: **Review of Partnership Boards**

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

Summary of main issues

- This report responds to the request from the Health and Wellbeing and Adult Social Care Scrutiny Board to review of the progress of the Leeds Shadow Health and Wellbeing Board.

- A common approach is being adopted for Scrutiny Boards in exercising their “critical friend” role, in order that outcomes can be compared and contrasted between Partnership Boards. However it is also acknowledged that each Strategic Partnership Board is at a different stage of its development and maturity.

- Unlike other boards, the substantive purpose of the Shadow board is to prepare the way for the formal Health and Wellbeing board which will become a statutory subcommittee of the council after the relevant legislation becomes enacted in April 2013.

- As an early adopter and national exemplar, the partnership has been developing plans for the formal Board. The exact nature of how the board will operate and what it will focus on will be influenced by the relevant secondary legislation governing H&WB boards, which is due to be laid before parliament in January 2013. A final report outlining the proposed governance arrangements and plans for the board will be presented at full council in May 2013. The formal H&WB board will then be able to agree its strategy and begin to measure its progress.

- In December 2012 a review of partnership arrangements was undertaken. It concluded that:
    - The Leeds Initiative Board should be replaced by a wider Best City Leadership Network; this would involve more stakeholders in less frequent meeting focusing on the big “State of the City” issues which face the city
    - That Best City summits will be held drawing on partners from the network to tackle issues of joint interest
    - That the Leeds Initiative brand should be retired, and the partnerships should be referred to as ‘Best City Partnerships’
    - That the 5 strategic partnership boards shall not be changed, however they shall be managed in future by the relevant directorates

- The outcome of the review does not change the focus of this scrutiny exercise. The partnerships are an important focus for the delivery of the Council’s key aims. Scrutiny Boards acting as the “critical friend” of the partnerships will help further progress the agenda under the new arrangements.

- In this context, the following report addresses progress to date of the shadow arrangements in preparation for assuming its statutory role, and how it might address the particular themes that have been outlined as areas of interest by Scrutiny.

Recommendations

Members are requested to take note of the:

a. Context of the shadow board as a preparatory vehicle for the establishment of the statutory Health and Wellbeing Board from April 2013.

b. High profile that the work of the board has received nationally and the influence it has had on shaping national guidance.

c. Preparatory work that the shadow board has undertaken in Leeds to ensure that the full board can move forward at pace with its statutory duties once it is established.

1.0 **Purpose of this report**

1.1 This report presents a summary of the progress against the questions raised by scrutiny, of the Leeds Shadow Health and Wellbeing Board, namely:

Q1. What contribution the Partnership Board is making to tackle poverty and inequality, and the progress being made against this?

Q2. How successfully the Boards partnership arrangements are working?

Q3 To what extent are significant benefits being seen from partnership working? How has partnership working ensured increased pace of change to address the issue in hand?

2.0 Background information

2.1 Under the Health and Social Care Act 2012, Leeds City Council must establish a Health and Wellbeing Board (HWB) as a formal Leeds City Council committee, appointed by full Council after April 2013.

2.2 In preparation, the Leeds Shadow Health and Wellbeing Board was established on 14th October 2011 as one of five strategic partnership boards reporting to Leeds Initiative Board.

2.3 The move to formal committee status is a change from the current arrangements of the shadow HWB. However, to enable the new board to discharge its legal duties, there is a need to retain the spirit of joint working within the constraints of the statutory framework; the emphasis being to enable shared ownership, contribution and co-operation by all partners

2.4 **Shadow Health and Wellbeing Board**

2.5 The shadow Health and Wellbeing Board acts as an advisory body to Leeds City Council's Executive Board, the NHS Airedale, Bradford and Leeds Board and the Clinical Commissioning Groups.

2.6 Until the Board assumes its statutory responsibilities, it will ensure the effective introduction of the formal statutory Health and Wellbeing Board and oversee relevant transitional arrangements for health, social care and public health until the new arrangements are in place for the NHS.

2.7 The current membership is

- Cllr Lisa Mulherin, Executive Member for Health & Wellbeing, Leeds City Council (chair);
- Cllr Judith Blake, Executive Member for Children's Services, Leeds City Council;
- Cllr Stewart Golton, Leader of the Liberal Democrat Party, Leeds City Council;
- Cllr Graham Latty, Health and Wellbeing Lead, Conservative Party, Leeds City Council;
- Cllr Lucinda Yeadon, Executive Member for Adult Health and Social Care, Leeds City Council;

- Dr Jason Broch, Leeds North Clinical Commissioning Group;
- Ms Susie Brown, Third Sector Leeds (as a commissioner)
- Dr Ian Cameron, Director of Public Health, NHS Leeds / Leeds City Council;
- Dr Andy Harris, Leeds South and East Clinical Commissioning Group;
- Mr John Lawlor, Chief Executive, NHS Airedale, Bradford and Leeds;
- Ms Pat Newdall, Leeds Local Involvement Network – public, service users and carers (this will move to HealthWatch once established);
- Dr Gordon Sinclair, Leeds West Clinical Commissioning Group;

Officers in attendance include:
- Ms Sandie Keene, Director of Adult Social Services, Leeds City Council;
- Mr Nigel Richardson, Director of Children's Services, Leeds City Council.
- Mr Rob Kenyon, Head of Partnerships and OE

The Health and Wellbeing Board

2.8 The Health and Wellbeing Board will aim to improve health and care services, and the health and wellbeing of local people. It will provide strong leadership and support effective partnership working on delivering the aspirations of the Vision for Leeds, to be the best city in the UK. One of its key objectives is to join up activities to ensure that we can achieve the best possible results for the people of Leeds.

2.9 The exact nature of how the board will operate and what it will focus on will be influenced by the relevant secondary legislation governing H&WB boards, which is due to be laid before parliament in January 2013. A final report outlining the proposed governance arrangements and plans for the board will be presented at full council in May 2013.

2.10 However, it is likely that the H&WBB will be required to undertake the following duties:
- to encourage integrated working[1] in relation to arrangements for providing health, health-related or social care services;
- to prepare and publish a joint strategic needs assessment (JSNA)[2];
- to prepare and publish a joint health and wellbeing strategy (JHWS)[3];
- to provide an opinion to the authority on whether the authority is discharging its duty to have regard to the JSNA, and the JHWS, in the exercise of its functions[4];
- to review the extent to which each Clinical Commissioning Group (CCG) has contributed to the delivery of the JHWS[5];
- to provide an opinion to each CCG on whether their draft commissioning plan takes proper account of the JHWS[6];
- to provide an opinion to the NHS Commissioning Board on whether a commissioning plan published by a CCG takes proper account of the JHWS[7];

[1] In accordance with Section 195 Health and Social Care Act 2012. This includes encouraging arrangements under Section 75 National Health Service Act 2006 (the NHSA 2006).
[2] Section 116 Local Government and Public Involvement in Health Act 2007 (the LGPIHA 2007)
[3] Under Section 116A LGPIHA 2007
[4] Under Section 116B LGPIHA 2007
[5] Under Section 14Z15(3) and Section 14Z16 NHSA 2006
[6] Section 14Z13(5) NHSA 2006
[7] Section 14Z14 NHSA 2006

- to prepare a local pharmaceutical needs assessment[8]; and
- *to exercise any other functions of the authority which are referred to the Board by the authority.*

3.0 Main issues

Q1. What contribution is the Leeds Shadow Health and Wellbeing Board making to tackle poverty and inequality, and the progress being made against this?

3.1 It should be noted that there are a number of actions already underway that will fall under the remit of the H&WBB in future. Likewise there are issues that the H&WBB will champion but which will be undertaken on its behalf through other Boards or partnership structures. In this context of the developing arrangements for the H&WBB, progress has been made in a number of areas:

Joint Strategic Needs Assessment

3.2 Preparing and publishing a JSNA will be a statutory duty for the H&WBB. The Shadow H&WBB has overseen the publication of a revised JSNA for Leeds. This is the primary process for identifying needs, informing priorities and developing commissioning strategies to improve Health and Wellbeing and tackle poverty and health inequality across the city of Leeds.

3.3 The JSNA found that Poverty impacts upon the lives of more than 35,000 children and young people in Leeds, reducing their life chances and the potential of Leeds as a great city.

3.4 The causes of child poverty are complex and require concerted partnership effort to tackle them. Child poverty must be everybody's business.

3.5 Six recommendations for action emerge from the needs assessment:
- Give every child the best start in life.
- Raise the levels of aspiration and achievement faster for children growing up in poverty.
- Offer target groups clear pathways into sustainable work.
- Meet families housing needs more quickly and effectively.
- Increase family support services to vulnerable families and those at risk of poor outcomes.
- Maximise income and benefit for families in poverty and on low incomes.

3.6 Action taken includes:

3.6.1 **Best Start in Life:**

- The infant mortality rate in "deprived Leeds" has declined rapidly, exceeding the local target of 7.5 deaths per 1000 live births by 2012, with the current rate being 5.5 deaths per 1000 live births. This has been achieved through a broad

[8] Section 128A NHSA 2006

programme of partnership work focussed on: reducing smoking in pregnancy, reducing teenage pregnancy, ensuring early access to maternity services, overcrowding, addressing maternal obesity, co sleeping, and the risks associated with consanguinity. In particular, work has been targeted into two local areas with high levels of deprivation and high infant mortality rates in Beeston Hill and Chapeltown.

- The Health Visiting workforce has been significantly expanded in line with a national target, from 114 wte in 2010 to 141 wte in December 2012. A further 42 posts will be recruited by 2015. Health Visiting and Children's Centre Services have been integrated to form into Early Start Teams (EST) with joint allocation meetings being held and a new EST Family Offer being developed and implemented.

- Mainstream funding has been agreed to continue and expand provision of the Family Nurse Partnership programme in Leeds when funding for the national randomised controlled trial ends in January 2013, with the service currently providing intensive support to approximately 120 first time teen parents in the city.

- A new community based antenatal programme, Preparation for Birth and Beyond, has been piloted and plans are in place to offer the programme city wide over the coming year.

3.6.2 **Employment and Adult Skills**

- Launched the Apprenticeship Training Agency which will improve the availability and accessibility of Apprenticeships. This will be fully operational from end January 2013
- Worked with Jobcentre Plus to establish Workclubs in areas of the city where other jobsearch support is minimal/unavailable
- Established The Point as a learning facility for young people and adults, complemented by 1:1 guidance and jobsearch support facilities
- Developed a programme of engagement activities for young people at The Hub
- Established the Community Learning Trust Board to increase the range of stakeholders influencing provision in localities
- Linked in with the roll out of welfare reform awareness activities to promote jobsearch support services
- Developing local 'recruitment hub and satellite' model in support of projected growth in retail sector

3.6.3 **Financial support**

- Established a Community Development Finance Institution (CDFI) in Leeds, in order to expand the availability of affordable financial services to low income households.
- Credit union increased membership for quarter ended September 2012 and total number of members was 25,708 (of which 177 are new and 4,306 are

junior). 1,294 loans were granted to financially excluded groups in this quarter valued at £522,483.

- Funded the setup costs for a telephone advice gateway with one common phone number for use across all advice agencies. Volunteers now operating three days a week (Mon, Tue, Fri) for 6 hours each day.
- A report was presented to the Executive Board on 5 September regarding the extent of legal money lending in the city.
- Mailout completed to approximately 9,500 households who are likely to be eligible for the Government Warm Front scheme to try and increase take-up of heating and insulation measures through that scheme whilst still available.

3.6.4 **Housing and Neighbourhoods**

- Implemented agreement between Housing services and Children's services to prevent evictions and subsequent entries to the social care system
- Staff development programme for those working on domestic violence
- Project to support families affected by domestic violence operational in 2 clusters
- Work with high impact alcohol users is progressing across the city.
- Assessed current system for identifying pregnant women and families in most need when engaging with community based drug and alcohol services (ADS). Process is in place to enable women to access specialist support.

3.7 A second statutory function of the board will be prepare and publish a Joint Health & Wellbeing Strategy (JHWS) for Leeds.

3.8 This strategy will provide the framework for commissioners to underpin their commissioning plans for the city. The H&WBB will not be responsible for the associated detailed action plans, but will need to review and report on the extent to which commissioners' plans reflect the JHWS. The H&WBB will need to measure progress against the intended outcomes of the JHWS in order to influence actions across the partnership.

3.9 In preparation for these duties, the Shadow board has prepared a draft JHWS. This has been strongly influenced by the JSNA. It is clear from this that life expectancy is increasing faster in the most affluent areas compared to the speed of increase in the most deprived thereby widening the gap. Therefore the overarching principle for all the outcomes of the JHWS is:

- "People, who are the poorest, will improve their lives the fastest".

3.10 Progress against this principle will demonstrated by 'Differences in life expectancy between communities'.

3.11 There are 5 outcomes, 15 priorities and 22 indicators included in the draft JHWS.

3.12 During the shadow period, mechanisms for measuring the progress of the JHWS are being established across the partnership in time for it to be published after legislation becomes enacted in April 2013.

Q2. How successfully the Board's partnership arrangements are working?

3.13 The board aims to create a culture where partnership work, in the interests of local people, is built into the way that all agencies, sectors and organisations work.

3.14 A key feature of the H&WBB will be that all its members will have voting rights (subject to secondary legislation). The government says that this is to enable H&WBB to operate on a truly partnership footing, and is a significant departure from existing council committees.

3.15 The H&WBB will bring together partners from new organisations, in new roles, and under new legislation. In keeping with other emerging boards across the country, the shadow board recognised early on that the success of the H&WBB would be heavily affected by the quality and depth of relationships between members of the board. Therefore the partnership commissioned a development programme for board members enable the board to establish clear ways of working, values and behaviours that will enable the board to realise its ambitions.

3.16 As part of this programme, the board (in small groups) has visited a number of organisations and communities to enable it to begin to hardwire engagement into how it works. This has enabled opportunities for greater insight into how the partnership arrangements might add value to its strategic role.

3.17 The formal development programme will finish at the end of March and has already received national accolade for its approach to board development. A formal review will take place at the end of the programme.

3.18 A communications and engagement strategy for the board will be considered in January which has been developed in partnership.

3.19 Whilst the success of partnership working cannot be measured solely in terms of participation, the shadow board has an attendance rate of 91%, demonstrating excellent engagement.

3.20 The Board has also contributed to the development of a national self-assessment audit tool for Health and wellbeing boards which will be able to shed further light on the success of partnership arrangements in future.

Q3. To what extent are significant benefits being seen from partnership working? How has partnership working ensured increased pace of change to address the issue in hand?

3.21 H&WBBs will only be able to take on their duties from April 2013. However, as an early implementer and national exemplar, the Leeds shadow board has already undertaken a number of actions demonstrating benefits to the partnership including the following:

- Reached a shared understanding of the financial situation and the implications for health and wellbeing in the city
- Prepared and published the JSNA

- Received a report on the progress on Health and Social Care Transformation programme and comment on future direction of travel
- Received a report on the CCG perspectives on priorities for Leeds and update on transition process
- Reviewed the citywide tobacco and alcohol action plans
- Set the strategic vision for Healthwatch Leeds
- Led a national learning set for health and wellbeing boards, and published national guidance on 'Making the best use of collective resources'.
- Received a report from the Children's Trust Board outlining opportunities for joint working arrangements
- Prepared a draft Joint Health & Wellbeing Strategy (see appendix 1)
- Received a report from the three local health and wellbeing partnerships
- In January 2013 the Board will undertake a simulation of one of its statutory functions by reviewing the extent to which commissioning plans for 2013/14 take due regard of the draft JHWS.

4.0 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 Members of the Shadow Health and Wellbeing board were consulted in preparing this report.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 The H&WB board will have a statutory duty to promote integration which is likely to include service provision, commissioning and intelligence. The board will champion equality and diversity through its overarching aim to reduce health inequalities.

4.3 Council policies and City Priorities

4.3.1 The H&WB board will incorporate the city priorities into its JHWS. It is likely that the budget and policy framework will require amendment to incorporate the JHWS subject to secondary legislation.

4.4 Resources and value for money

4.4.1 The H&WB Board has overseen the coordination of national guidance for H&WB boards by publishing 'Making the best use of our collective resources'. This will be used to help integrate further, commissioning decisions between partners to ensure that the city make the best use of the 'Leeds pound' and 'Leeds Assets'.

4.5 Legal Implications, Access to Information and Call In

4.5.1 Establishing a H&WB board will require changes to the constitution. It is anticipated that the necessary secondary legislation to enable the council to establish the board will be laid before parliament in January 2013.

4.6 Risk Management

4.6.1 That the necessary legislation is not laid in time or is not of sufficient clarity to enable the council to establish the formal board.

5.0 Conclusions

5.1 The Leeds shadow health and wellbeing board is undertaking significant preparations for assuming its statutory duties from April 2013. In the meantime it is making substantial progress in creating the necessary conditions for achieving the duties of the board.

6.0 Recommendations

6.1 Scrutiny are requested to take note of the:

d. Context of the shadow board as a preparatory vehicle for the establishment of the statutory Health and Wellbeing Board from April 2013.

e. High profile that the work of the board has received nationally and the influence it has had on shaping national guidance.

f. Preparatory work that the shadow board has undertaken in Leeds to ensure that the full board can move forward at pace with its statutory duties once it is established.

7.0 Background documents[9]

7.1 None

[9] 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.

Appendix 1: **Leeds Joint Health and Wellbeing Strategy** **Draft VII. 10.10.12**

Vision for health & wellbeing: Leeds will be a healthy and caring city for all ages

Principle in all outcomes: People who are the poorest, will improve their health the fastest

Indicator: Reduce the differences in [healthy] life expectancy between communities

Key: Red = City priorities four year priority, Blue = City Priority indicator

Outcomes (5)	Priorities (15)	Indicators (22)
1. People will live longer and have healthier lives	1. Support more people to choose healthy lifestyles	1. Percentage of adults over 18 that smoke.
		2. Rate of alcohol related admissions to hospital *
	2. Ensure everyone will have the best start in life	3. Infant mortality rate
		4. Excess weight in 10-11 year olds
	3. Ensure people have equitable access to screening and prevention services to reduce premature mortality	5. Rate of early death (under 75s) from cancer.
		6. Rate of early death (under 75s) from cardiovascular disease
2. People will live full, active and independent lives	4. Increase the number of people supported to live safely in their own home	7. Rate of hospital admissions for care that could have been provided in the community *
		8. Permanent admissions to residential and nursing care homes, per 1,000 population
	5. Ensure more people recover from ill health	9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation
	6. Ensure more people cope better with their conditions	10. Proportion of people feeling supported to manage their condition
3. People's quality of life will be improved by access to quality services	7. Improve people's mental health & wellbeing	11. The number of people who recover following use of psychological therapy
	8. Ensure people have equitable access to services	12. Improvement in access to GP primary care services
	9. Ensure people have a positive experience of their care	13. People's level of satisfaction with quality of services
		14. Carer reported quality of life
4. People will be involved in decisions made about them	10. Ensure that people have a voice and influence in decision making	15. The proportion of people who report feeling involved in decisions about their care
	11. Increase the number of people that have more choice and control over their health and social care services	16. Proportion of people using NHS and social care who receive self-directed support
5. People will live in healthy and sustainable communities	12. Maximise health improvement through action on housing, transport and the environment	17. The number of properties achieving the decency standard
	13. Increase advice and support to minimise debt and maximise people's income	18. Number of households in fuel poverty
		19. Amount of benefits gained for eligible families that would otherwise be unclaimed *
	14. Increase the number of people achieving their potential through education and lifelong learning	20. The percentage of children gaining 5 good GCSEs including maths & English
	15. Support more people back into work and healthy employment	21. Proportion of adults with learning disabilities in employment
		22. Proportion of adults in contact with secondary mental health services in employment

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Local Government Association

ADSO Association of Democratic Services Officers

Health, adult social care and ageing

Health and wellbeing boards

A practical guide to governance and constitutional issues

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1. Introduction

This guide is a joint publication by the Local Government Association (LGA) and the Association of Democratic Services Officers (ADSO). The content has been shared with the Department of Health (DH) and the Department for Communities and Local Government (DCLG). The purpose of this document is to provide a guide to governance and constitutional issues arising from the legislation, including the Health and Social Care Act 2012 and the regulations under section 194 of that Act.

This guide is intended to support councils in a practical way in interpreting and implementing constitutional and governance aspects of the legislation. It has no statutory standing, nor does it constitute non-statutory guidance. It is too soon in the development of health and wellbeing boards to reach a consensus on what best practice should look like. Rather, the examples we use in the guide are intended to cover a range of possible ways of addressing constitutional and other issues and to indicate some questions that councils and health and wellbeing board members will need to consider.

For the avoidance of doubt, this guide does not constitute legal advice. Councils will need to obtain their own legal advice on any matters of a legal nature arising in connection with the establishment and operation of health and wellbeing boards and the relevant legislation.

Underlying principles of boards

A number of principles underlie the creation of health and wellbeing boards. These include:

- shared leadership of a strategic approach to the health and wellbeing of communities that reaches across all relevant organisations
- a commitment to driving real action and change to improve services and outcomes
- parity between board members in terms of their opportunity to contribute to the board's deliberations, strategies and activities
- shared ownership of the board by all its members (with commitment from their nominating organisations) and accountability to the communities it serves
- openness and transparency in the way that the board carries out its work
- inclusiveness in the way it engages with patients, service users and the public.

The legislation was aimed at allowing considerable flexibility to councils and their partners on health and wellbeing boards to set up and run boards that conform to these principles in a way that suits local circumstances. This means that a range of options will be possible.

Functions of boards

The Health and Social Care Act 2012 gives health and wellbeing boards specific functions. These are a statutory minimum and further functions can be given to the boards in line with local circumstances. The statutory functions are:

- To prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), which is a duty of local authorities and clinical commissioning groups (CCGs).
- A duty to encourage integrated working between health and social care commissioners, including providing advice, assistance or other support to encourage arrangements under section 75 of the National Health Service Act 2006 (ie lead commissioning, pooled budgets and/or integrated provision) in connection with the provision of health and social care services.
- A power to encourage close working between commissioners of health-related services and the board itself.
- A power to encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services.
- Any other functions that may be delegated by the council under section 196(2) of the Health and Social Care Act 2012. For example, this could include certain public health functions and/or functions relating to the joint commissioning of services and the operation of pooled budgets between the NHS and the council. Such delegated functions need not be confined to public health and social care. Where appropriate, they could also, for example, include housing, planning, work on deprivation and poverty, leisure and cultural services, all of which have an impact on health, wellbeing and health inequalities.

In developing the governance, constitutional and other arrangements for boards, councils and boards should bear in mind these core functions and how they may best be facilitated in the context of existing local partnerships and the way in which the new local health improvement landscape is developing. Some shadow boards have been tightly focused on a small range of functions and specific priorities.

Others have taken on a wider brief, for example in relation to wellbeing generally. In some cases, the focus of shadow boards builds on the Local Strategic Partnerships (LSPs) or arrangements with which these have been replaced. For example, some areas have retained LSPs, which have been working well in drawing together partners across a number of sectors. In cases such as this, health and wellbeing boards may be focused on specific priorities deriving from their core functions. In other areas, health and wellbeing boards are now seen as the overarching local body which will take on at least part of the role of the LSP.

In these cases, boards are likely to have very widely drawn terms of reference, not confined to their core statutory functions.

In some areas, shadow health and wellbeing boards have decided to take an approach to issues such as joint commissioning which looks at the bigger picture and does not get involved in operational matters, believing that current local arrangements for detailed commissioning are sufficiently robust to undergo the transition to the new local NHS. In other areas, shadow health and wellbeing boards are taking the opportunity to prepare to strengthen joint commissioning arrangements and oversee their delivery through sub-structures of the board. A broad, strategic or a more 'hands-on' approach are both compatible with the regulations. (See the sections below on relationships and sub-committees and delegation for more detail.)

While the health and wellbeing board is required to discharge the council's and CCG's duties of undertaking JSNAs and developing JHWSs, it may be considered appropriate also to consult the full council. Doing so could improve the local transparency and accountability of the work of the health and wellbeing board. This could help to gain cross-party support of the strategies and the commissioning intentions on which they are based.

Ways of working

Councils and their partners on health and wellbeing boards can take advantage of the flexibility allowed by the regulations to develop ways of working that genuinely reflect the wishes of their members and the needs of the communities they serve. Boards should, of course, conduct their business in a way that is appropriate to their statutory role and is effective in fulfilling their functions. It is also important that their members and members of the public who attend meetings should understand what is happening and the issues being discussed and that they should feel able to participate where appropriate. For example, certain agenda items may lend themselves to a participatory style of discussion that could include members of the public or an opportunity for different board members to present and lead discussion of an issue.

Health and wellbeing boards are intended to be a genuinely new model of partnership working – it is in this spirit that the legislation will need to be implemented.

2. The regulations

The regulations relating to health and wellbeing boards are published as Statutory Instrument 2013 No. 218 entitled, The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/218/contents/made

The regulations modify certain legislation as it applies to health and wellbeing boards and disapply certain legislation in relation to the boards. The provisions which are modified or disapplied are in the Local Government Act 1972 and the Local Government and Housing Act 1989.

Under section 194 of the Health and Social Care Act 2012, a health and wellbeing board is a committee of the council which established it and for the purposes of any enactment is to be treated as if appointed under section 102 of the Local Government Act 1972. It is therefore a 'section 102 committee', as it is sometimes called within local government. However, the regulations modify and disapply certain provisions of section 102 and other sections of the Local Government Act 1972 and also provisions of the Local Government and Housing Act 1989 in relation to health and wellbeing boards.

This means that it is best not to think of health and wellbeing boards according to the strict model of other section 102 committees, but to think of them as a basic section 102 committee with some differences. The sections below discuss the characteristics shared by health and wellbeing boards with other council committees and where they do or may diverge under the new regulations.

The modifications and disapplications which apply to health and wellbeing boards within the regulations generally also apply to sub-committees and joint sub-committees of boards.

3. Establishment of health and wellbeing boards and carrying out of functions

What the legislation says

Under the Health and Social Care Act 2012, upper-tier and unitary councils in England must establish a health and wellbeing board. Its functions should include the statutory functions outlined above and any other functions that the council wishes to delegate to it. Additional functions may be added by the council at later dates and this will need to be allowed for in a health and wellbeing board's terms of reference. Constitutional matters such as terms of reference will also need to be discussed with the whole council.

The functions of encouraging integrated and close working are conferred directly on health and wellbeing boards. The Health and Social Care Act 2012 also requires that councils and CCGs discharge their functions of developing JSNAs and JHWSs through health and wellbeing boards, ie that the boards discharge these functions of local authorities and CCGs. The council and CCG will want to retain oversight to ensure the functions are discharged properly. They will also need to provide input, for example as to the scope of the functions, through evidence to inform JSNAs; and by taking actions to meet the identified needs.

Options

Health and wellbeing boards can choose a variety of methods to develop their JSNAs and JHWSs. Many shadow boards have held informal seminars or public engagement conferences to involve a wide range of participants in initial brainstorming about priorities. Many have also set up a strategy group to oversee the development of these assessments and strategies and to ensure that they are fit for purpose. Such groups are likely to include CCG representatives and either Directors of Public Health, Adult Social Services and Children's Services or their nominees ie officers in their departments. They could also include district councillors or councillors with responsibilities for these portfolio areas. Strategy groups or task groups could also include representatives of the voluntary sector and/or local Healthwatch and, for example, researchers from local universities or regional public health networks who are helping develop and interpret demographic information.

Bristol shadow Health and Wellbeing Board hosted a stakeholder conference involving board members and other stakeholders such as local universities and third sector representatives who are not members of the board, to discuss priorities for the board's first JHWS. Voluntary and community sector organisations in Bristol also organised an event to feed into the development of the strategy. The priorities identified are now being developed by a small strategy group chaired by a GP member of the Health and Wellbeing Board, supported by officers and reporting regularly to the board. A draft strategy will be published for formal public consultation before being finalised.

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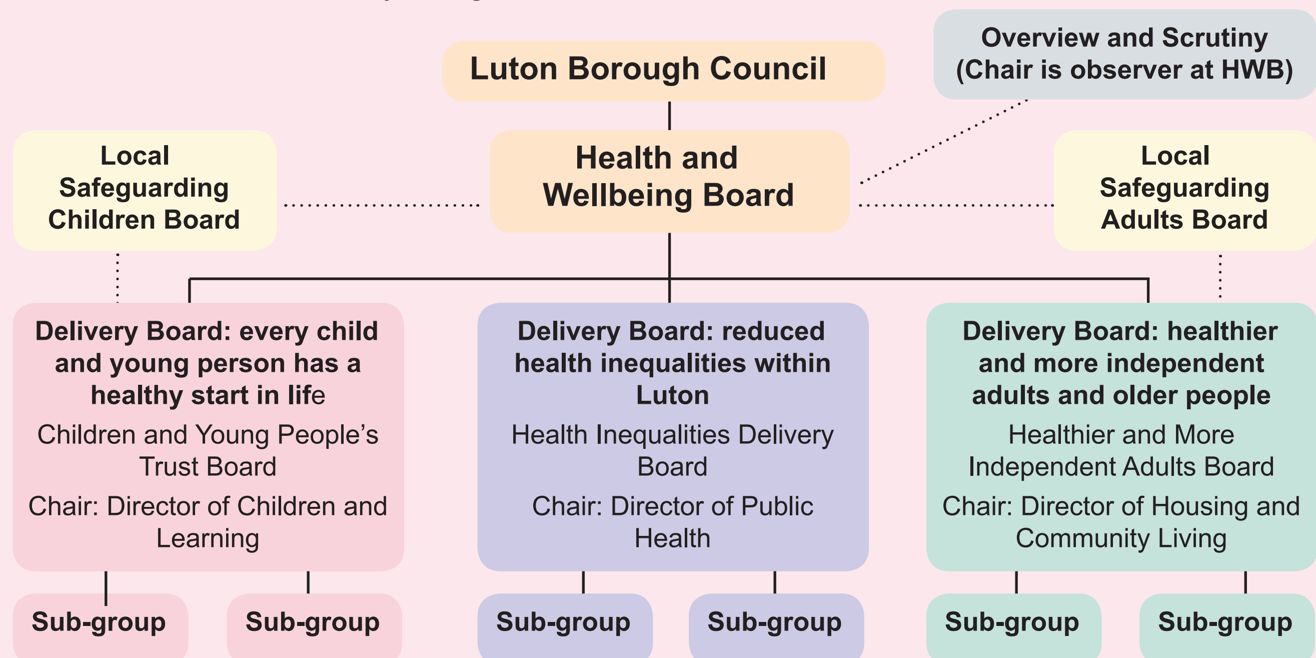
Integrated working between health and social care will need close oversight during the transition from PCTs to CCGs and beyond. Commissioners in councils and PCTs are likely to have joint commissioning activities for which successor arrangements will need to be made. Some shadow health and wellbeing boards are proposing to subsume these joint commissioning structures as sub-committees of the board. This will require formal delegation of functions by the council executive (or full council, for councils not operating executive arrangements) to the board. Lead commissioning by social care or the NHS on behalf of both parties, pooling of budgets and integrated commissioning are all permitted under section 75 of the National Health Service Act 2006.

Luton has used the establishment of its shadow Health and Wellbeing Board to develop new structures across the council and its partners to support a wide range of activities on health and wellbeing. The diagram below shows the intended structures from April 2013. The delivery boards sitting under the Health and Wellbeing Board are not formal sub-committees, but groups set up by the lead officers to support the implementation of JHWSs. Any budgets are those which are already delegated to officers for services.



Contact: **Bren McGowan**, Partnership Manager: Bren.Mcgowan@luton.gov.uk

Key issues to consider

- ✓ Have you timetabled an item in your council's schedule of forthcoming meetings to discuss the establishment of your health and wellbeing board?
- ✓ Is there a common understanding in your council and among health and wellbeing board members of the board's status as a committee and its core functions? How will the core functions and provision for the delegation of additional functions be included in the board's constitution and terms of reference?
- ✓ Is there appropriate provision for the board's structures, for example through sub-committees or working groups, to support its core functions eg to develop JSNAs and JHWSs and to encourage integrated working?
- ✓ Has there been discussion of what the role of the board will be in relation to joint commissioning? Will any part of this role require delegation from the executive/ mayor/council to the board?
- ✓ Is your council and its executive aware of the option to delegate additional functions to the board? Have there been or will there be opportunities for discussion of what, if any, these might be?

Further information

Health and Social Care Act 2012 and explanatory notes: http://tinyurl.com/c9dpdp5

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013: http://www.legislation.gov.uk/uksi/2013/218/contents/made

LGA, 'Get in on the Act: Health and Social Care Act 2012': http://tinyurl.com/d3z2tzm

Products from the National Learning Network for health and wellbeing boards:
'Support and resources for Health and wellbeing boards': http://tinyurl.com/by7oc8c

'A guide to governance for health and wellbeing boards': http://tinyurl.com/at7dyon

'Operating principles for Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies':
http://tinyurl.com/azthskh

Department of Health, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – draft guidance:
http://tinyurl.com/atktxlu

4. Membership and voting

What the legislation says

It is clear from the Health and Social Care Act 2012 that health and wellbeing boards are different to other section 102 committees, in particular in relation to the appointment of members. Specifically, the Act:

- sets a core membership that health and wellbeing boards must include:
  - at least one councillor from the relevant council
  - the director of adult social services
  - the director of children's services
  - the director of public health
  - a representative of the local Healthwatch organisation (which will come into being on a statutory footing on 1 April 2013)
  - a representative of each relevant clinical commissioning group (CCG)
  - any other members considered appropriate by the council
- requires that the councillor membership is nominated by the executive leader or elected mayor (in councils operating executive arrangements) or by the council (where executive arrangements are not in operation) with powers for the mayor/leader to be a member of the board in addition to or instead of nominating another councillor
- under the regulations (Regulation 7) modifies sections 15 to 16 and Schedule 1 of the Local Government and Housing Act 1989 to disapply the political proportionality requirements for section 102 committees in respect of health and wellbeing boards – this means that councils can decide the approach to councillor membership of health and wellbeing boards
- requires that the CCG and local Healthwatch organisation appoint persons to represent them on the board
- enables the council to include other members as it thinks appropriate but requires the authority to consult the health and wellbeing board if doing so any time after a board is established
- the NHS Commissioning Board must appoint a representative for the purpose of participating in the preparation of JSNAs and the development of JHWSs and to join the health and wellbeing board when it is considering a matter relating to the exercise, or proposed exercise, of the NHS Commissioning Board's commissioning functions in relation to the area and it is requested to do so by the board.

The Local Government Act 1972 does not allow officers to be members of local authority committees. Regulation 5(1) removes this restriction in relation to health and wellbeing boards by disapplying section 104(1) of the 1972 Act to enable the local authority directors specified in the 2012 Act to become members of health and wellbeing boards.

Regulation 6 modifies the Local Government and Housing Act 1989 (section 13(1)) to enable all members of health and wellbeing boards or their sub-committees to vote unless the council decides otherwise. This means that the council is free to decide, in consultation with the health and wellbeing board which members of the health and wellbeing board should be voting members.

Voting arrangements would need to be agreed by the whole council. In considering whether to make any variation to the provision that all members of the board, including non-councillor members, may vote, the council will wish to bear in mind the aim of giving parity of esteem to all members of the board.

Options

Membership

The regulations disapply the requirement for political proportionality. However, cross-party engagement in health and wellbeing boards is clearly going to be important in achieving health improvement and wellbeing objectives for the whole population. There is no restriction on the number of councillor members boards may have under the core membership specified in the legislation. However, membership of boards is only one option among many for engaging a range of councillors from different parties.

Many shadow boards have wanted to stay small and focused and have therefore not included additional members. This may be an issue especially in two-tier areas where councils might wish to appoint district councillors but do not want the board to become unmanageably large. Nonetheless, in the spirit of inclusiveness and shared ownership of boards, a number of upper-tier and unitary councils are appointing councillors from across the political spectrum, including opposition parties, to shadow boards.

Some boards are finding different ways to involve councillors beyond the core statutory membership, for example, by offering opportunities for the whole council to discuss JSNAs and JHWSs or by asking scrutiny committees to look at different aspects of health and wellbeing and make recommendations to the board.

The health and wellbeing board can, in agreement with the full council, appoint additional members and, should the full council wish to add further members after the board is established on the principles of inclusiveness and shared ownership (under section 194 of the Health and Social Care Act 2012) it would need to consult the health and wellbeing board before doing so. Department of Health information (see further information below) on the powers and duties of boards states that the health and wellbeing board could invite other CCGs to join or input into the health and wellbeing board if they have a large number of registered patients living within the council area, if it considers it appropriate.

Additional representatives could include other groups or stakeholders with particular skills, perspectives or key statutory responsibilities who can support the work of boards, such as criminal justice agencies, relevant district councils, local representatives of the voluntary sector, clinicians or providers (whilst seeking to avoid potential conflicts of interest in relation to providers). A paper from the National Learning Network for health and wellbeing boards (referenced below) discusses ways of engaging with NHS, other public sector, voluntary sector and private sector providers, including through membership of the board or its sub-groups.

In addition to the core statutory members, Darlington's shadow Health and Wellbeing Board has invited the following to be members of the board:

- a voluntary sector representative
- a representative of the opposition parties on Darlington Borough Council
- the Faculty lead for health and social care, Teesside University
- the newly-elected police and crime commissioner.

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Barnsley's shadow Health and Wellbeing Board is chaired by the Leader of the Council. In addition to the core statutory members, the following are members:

- Executive Members of the Council for Children, Young People and Families and Adults and Communities
- the chief executive of the council
- a representative of Barnsley Hospital Trust
- a representative of South West Yorkshire Partnership Foundation Trust (Community Health)
- the chair of the CCG (who is the vice chair of the Board)
- the chief officer of the CCG
- a representative of South Yorkshire Police
- two Local Involvement Networks representatives pending the development of local Healthwatch.

Contact: **Martin Farran,** Executive Director of Adults and Communities
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Bedford Borough Council's elected Mayor chairs its shadow Health and Wellbeing Board. The members of the board include the council's portfolio holders for children and for adult services. In addition, the council's Chief Executive is a member and the representation from the CCG includes the Chair of the Bedford locality, the Chief Operating Officer and the Clinical Director. Chief Executive of Bedford Borough Council (Philip Simpkins) believes that a wider membership over and above the statutory requirements will provide strategic vision and strong leadership for health services within the Bedford Borough area.

Contact: **Phil Simpkins**, Chief Executive
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In Leicestershire, the county councillors on the shadow Health and Wellbeing Board are all currently members of the Cabinet and represent the same political group. There are no places for opposition members on the Board. The quorum for meetings is a quarter of the membership including at least one councillor from the county council and one representative of the Clinical Commissioning Groups.

Contact: **Rosemary Palmer**, Senior Committee Officer
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Bath and North East Somerset's shadow Health and Wellbeing Board has a small membership, and is chaired by the council's Cabinet Member for Wellbeing. The Board is made up of councillors from the leading political group of the council, council officers, the CCG, public health and shadow local Healthwatch. Councillors from other political groups attend board meetings as observers. Providers do not have a seat on the Board, but their expertise and input into the work of the Board is valued. The Board has committed to a range of engagement methods with providers, service users and the public from regular programmed stakeholder events to smaller service specific conversations.

Contact: **Andrea Wolfenden**, Programme and Strategy Officer, Policy and Partnerships
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In addition to the members defined in the legislation, Plymouth's shadow Health and Wellbeing Board has invited other partners from across the city to join the Board. These include representatives from:

- Plymouth Community Housing (the city's largest social housing provider)
- Plymouth Community Healthcare
- Devon and Cornwall Police
- Plymouth Hospitals NHS Trust
- University of Plymouth
- voluntary and community sector.

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Voting

The intention behind the legislation is that all members of health and wellbeing boards should be seen as equals and as shared decision makers. Acknowledging that health and wellbeing boards are about bringing political, professional and clinical leaders and local communities together on an equal basis, a number of councils are proposing to include in the terms of reference or constitutions of their health and wellbeing boards an explicit commitment to decision making by consensus where possible. Nonetheless, councils still have the right to decide that certain members of boards should not be able to vote. In reaching a decision about voting rights, there are a number of issues that councils will wish to consider.

In a small number of areas, concerns have been raised about the idea of council officers (ie the directors of children's services, adult services and public health) voting alongside councillors. Some of the concern arises from the fact that the primary role of officers is to provide impartial professional advice to councillors. Voting against a cabinet member might be thought to compromise officers' professional detachment. Another concern is that officers may feel uncomfortable about voting in opposition to councillors who appoint them to their posts and to whom they are accountable in their day-to-day professional work. Nonetheless, council officers will be members of the board and will need to conform to its requirements (see section 5 on codes of conduct below).

In considering the issue of voting, councils may wish to bear in mind the underlying principle of parity between board members and how that principle could be supported where some members do not have voting rights. It is also worth noting that executive and non-executive directors of NHS trusts participate equally in joint decision making on the boards of these trusts. Although the roles are not quite the same as those of council officers and councillors, they may offer lessons for health and wellbeing boards. Nonetheless, councils remain free to make a distinction between the voting rights of councillors and other board members when giving directions under the regulations.

Concerns about the voting rights of service provider members of health and wellbeing boards (for those that have chosen to extend membership to service providers) have also been expressed. Most shadow boards do not have provider members, but in the case of the minority that currently do, the usual requirements about declarations of interest would apply. Councils could decide, as a matter of principle, that provider members should not have voting rights on the grounds of potential conflicts of interest.

In some areas, the role of providers of services is highly controversial and political, particularly where big changes in the NHS landscape are taking place or are likely in the future. In other areas, long-established providers are seen as having an essential contribution to make to the deliberations of health and wellbeing boards. The options of restricting voting rights to certain categories of board member should assist councils to developing an approach to voting that is appropriate to local circumstances. See the publication from the National Learning Network on engaging with providers (referenced below) for more discussion of this issue.

The terms of reference for Cheshire East's shadow Health and Wellbeing Board include the potential for board members to exercise their voting rights and, subject to the board's approval, for 'associate' members (ie non councillor members) to vote when appropriate. However, the board believes that resorting to voting rights could indicate that there are difficulties in collaborative working and in understanding each other's viewpoints. Therefore, the board's emphasis throughout is that its decisions and recommendations should ideally be determined through open debate and consensus.

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Durham Health and Wellbeing Board's terms of reference include a quorum of five members. Decisions will be reached by consensus. If a consensus cannot be reached the Chair will then call for a vote and a simple majority will prevail. The Chair will have a second casting vote if a simple majority is not reached.

Contact: **Peter Appleton**, Head of Policy, Planning and Performance, Adults, Wellbeing and Health
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In Plymouth, partners on the shadow Health and Wellbeing Board have signed up to the principle that decisions and recommendations will be reached on a consensus basis.

In exceptional circumstances and where decisions cannot be reached by a consensus of opinion and/or there is a need to provide absolute clarity to executive bodies, voting will take place and decisions will be agreed by a simple of all members (councillors and co-opted members) present.

Contact: **Ross Jago**, Democratic Support Officer
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Key issues to consider

- ✓ Do all health and wellbeing board members understand the principles that underpin the board's membership and voting arrangements?
- ✓ Do councils and health and wellbeing board members understand the regulations and what the options are for councils in respect of board membership and voting?
- ✓ Do non-council board members understand the complexities of the councillor/officer relationship and why councils need to give some thought to developing a new kind of relationship through health and wellbeing boards?
- ✓ Do non-council board members understand the meaning of and principles underlying democratic accountability?
- ✓ Have you made provision for your leader/ elected mayor to nominate and for your council to formally appoint councillor members to your health and wellbeing board?
- ✓ Have you considered issues of cross-party engagement in the health and wellbeing board's work and have you come to a clear decision?
- ✓ Has there been any discussion of whether to include providers as board members and, if so, any voting issues that may arise?
- ✓ In two-tier areas, has there been any discussion of whether/how to include district councillors as members of the board?
- ✓ Have councillors and shadow board members discussed the issue of whether boards should have voting and non-voting members?

Further information

Department of Health, 'The general duties and powers of health and wellbeing boards': http://tinyurl.com/a284982

From the National Learning Network for health and wellbeing boards:
'Stronger together: how health and wellbeing boards can work effectively with local providers': http://tinyurl.com/bark38s

5. Codes of conduct and conflicts of interest

What the legislation says

The regulations under section 194 of the Health and Social Care Act 2012 do not modify or disapply any legislation relating to codes of conduct and conflicts of interest. This means that legislation in relation to these issues will apply to health and wellbeing boards.

All councillors and co-opted members of council committees are required to comply with a code of conduct. Under the Localism Act 2011(section 27 (4)), all non-councillor members of health and wellbeing boards who are entitled to vote on any question that fails to be decided at any meeting of the board would be 'co-opted members' for these purposes. This means that all voting members of health and wellbeing boards will be governed by the local authority's code of conduct. The code of conduct for each council sets out the conduct expected of members and co-opted members when they are acting in that capacity.

Section 28(6) of the Localism Act 2011 requires those codes of conduct to be consistent with the Seven Principles of Public Life. Within these rules, it is for individual councils to decide what their codes of conduct say. The legislation requires councils (other than parish councils) to have in place arrrangements to investigate, and take decisions on, allegations of a failure to comply with the authority's code of conduct.

Codes of conduct must also contain the provisions the council considers appropriate in respect of the registration and disclosure of pecuniary and other interests.

Section 29 of the Localism Act 2011 requires the monitoring officer of a relevant authority to establish and maintain a register of interests of members and co-opted members of the authority. Section 30 requires a member or co-opted member to notify council's monitoring officer of disclosable pecuniary interests on taking office.

Section 31 requires a member or co-opted member of a relevant council to disclose a disclosable pecuniary interest that they are aware of (apart from a sensitive interest — see section 32), at a meeting or if acting alone, where any matter to be considered relates to their interest. It prohibits a member from participating in discussion or voting on any matter relating to their interest or, if acting alone, from taking any steps in relation to the matter (subject to any dispensations — see section 33).

This will apply to members of health and wellbeing boards and might, for example be relevant in relation to members' financial interests in matters on which the boards will be deliberating, such as contracts with providers of services.

Section 34 makes it a criminal offence if a member or co-opted member fails, without reasonable excuse, to comply with requirements under section 30 or 31 to register or declare disclosable pecuniary interests, or take part in the local authority's business at meetings or when acting alone when prevented from doing so.

The principles of these requirements are consistent with the requirement on CCGs in relation to conflicts of interest. CCGs are under duties in relation to registers of interests and conflicts of interest. The NHS Commissioning Board is under a duty to issue guidance to CCGs on the exercise of their functions in relation to conflicts of interests and CCGs must have regard to such guidance.

It should also be noted that the public law notions of predetermination and bias will also apply: non-council members may not be familiar with these concepts.

Options

Councils will need to make clear to health and wellbeing board members that the council's code of conduct and requirements on Disclosable Pecuniary Interests apply to them and what this means. Non-councillor members of boards may be bound by other codes of conduct and professional standards. For example, the General Medical Council (GMC) provides advice for members of the medical profession on standards of professional conduct for doctors and the Health and Care Professions Council (HCPC) sets standards for members of the social work profession and of health care professions.

Representatives of local Healthwatch may require support and guidance on how to get the best from their seat at the board. Building on the learning and experiences of others who have been involved with shadow boards, Healthwatch England will be providing guidance for the local Healthwatch member on the health and well being board. This will be linked to guidance on how to influence by building an evidence base.

Most people who have sat on public sector governing bodies will be familiar with the Seven Principles of Public Life, and health and wellbeing board members may already be bound by the principles in their other roles.

Newcomers to public sector governance may welcome a briefing on these issues as part of a health and wellbeing board development programme. It may also be helpful to offer members an opportunity to explain to each other what their own professional and any other accountability responsibilities are. For the purpose of transparency and openness, it will be important to publicise accountability responsibilities. Boards are encouraged to consider summarising these responsibilities for the public (for example, on a board or council website).

Councillors and others who have served on public bodies will also have experience of having to declare an interest, including pecuniary interests, in relation to the bodies on which they serve; and will be familiar with what is expected of them in relation to potential conflicts of interest when certain matters are under discussion.

Other members of health and wellbeing boards will be less familiar with such practices and will need to be briefed and perhaps also reassured that the responsibilities involved are not onerous, that agendas will be published in advance (so that they can take advice if necessary), and that council officers can advise about what does and does not need not be declared. Particular advice may be required in relation to CCG members of health and wellbeing boards who are also service providers and may be delivering or bidding for contracts to provide services which the board will be discussing. Council officers who are not used to having to register and declare interests may also need advice as to what they should declare, for example, in relation to voluntary sector organisations on whose governing bodies they may sit and which may be bidding for service contracts.

Warwickshire currently has a partners' code which is based on the existing members' code of conduct and requires the same standards of behaviour in relation to declaration of interests and participation in meetings.

Contact: **Paul Williams**, Democratic Services Team Leader
Paulwilliamscl@warwickshire.gov.uk

Key issues to consider

✓ Have your health and wellbeing board members been briefed (or do you have plans to brief them) on the council's code of conduct and do they understand that it applies to them?

✓ Do the individual members understand what they should register on the register of interests and when and how they should declare an interest in specific agenda items?

✓ Have board members been given contact details for an officer who can advise them on which interests to declare and how and when to do so?

✓ Have board members had (or will they have) an opportunity to understand each other's professional accountability and the standards to which they are answerable?

✓ Are there clear arrangements for deciding on agenda items and circulating agendas in advance (see the next section for more detail)?

Further information

The Localism Act Explanatory Notes: http://tinyurl.com/b37v2sp

The Committee on Standards in Public Life – seven principles of public life: http://tinyurl.com/cjg5uyg

Department of Communities and Local Government – illustrative text for a code of conduct: http://tinyurl.com/a7hwv9y

Department of Communities and Local Government, 'Openness and transparency on personal interests: a guide for councillors': http://tinyurl.com/a3x485d

NHS Commissioning Board, 'Managing conflicts of interest: Towards Establishment: Technical appendix 1' (for CCGs): http://tinyurl.com/aaym3hc

6. Transparency and openness

What the legislation says

The regulations under the Health and Social Care Act 2012 do not modify legislation in relation to transparency requirements in relation to health and wellbeing boards. This means that they are subject to the same requirements of openness and transparency as other section 102 committees:

- in addition to the requirements relating to codes of conduct under the Localism Act 2011 mentioned above, the Local Government Act 1972 imposes requirements on committees of certain councils in relation to making copies of agendas and reports of meetings open to inspection by the public
- the Freedom of Information Act 2000 provides a general right of access to information held by public authorities
- regulations under the Local Government Act 2000 make provision for public access to meetings and to information relating to decisions of council executives and their committees
- the Equality Act 2010 requires specified public bodies, when exercising functions to have due regard to eliminating conduct prohibited by the Act and advancing equality of opportunity and fostering good relations between people who share protected characteristics and those who do not
- the Data Protection Act 1998 makes provision for the regulation of the processing of information relating to individuals.

Regulation 3 of the regulations modifies section 101(2) of the Local Government Act 1972 to clarify that health and wellbeing boards can appoint sub-committees to discharge their functions in accordance with section 102 of the 1972 Act.

Provisions that apply to committees also apply to any sub-committees that may be set up under them, since boards may delegate some decision-making powers to sub-committees.

The provisions described above do not apply to less formal sub-structures such as working parties which do not make decisions, but simply report and make recommendations to boards. It is usual, nonetheless, to keep similar records of the activities of working parties to those kept for sub-committees, for future reference.

In Leicestershire there are four sub-boards and two steering groups which sit directly beneath the shadow board:

- Staying Healthy Board
- Integrated Commissioning Board (Adults and Older People)
- Substance Misuse Board
- Leicester, Leicestershire and Rutland Health Protection Group (this is a sub board of the health and wellbeing boards in Leicester, Leicestershire and Rutland)
- Health and Wellbeing Board Steering Group (co-ordinates the day to day operation of the board's business and provides executive support to board meetings)
- JSNA and JHWS Steering Group.

These sub-boards take the lead on delivering specific outcomes, although the Health and Wellbeing Board will be held ultimately responsible for the achievement of all health related outcomes.

Contact: **Rosemary Palmer**, Senior Committee Officer
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Wandsworth has opted for a tripartite structure: a board including all the members who will be required by statute, with a smaller joint commissioning executive responsible for operational matters and a wider health partnership for engagement around major policy issues, especially JSNAs and JHWSs.

Contact: **Richard Wiles**, Health Policy Team Leader
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The intention in Barnsley is for the Health and Wellbeing Board to identify the totality of spend on health and social care and to use this on a pooled/aligned basis to address the needs of the Barnsley population. Due to the strategic nature of the Board, a series of supporting sub groups will take elements of the work forward, on behalf of the Board, and report back periodically to inform policy direction and resource allocation. This includes a senior strategic development group – effectively the executive group reporting to the main (currently shadow) Board. The role of this executive group is to ensure that implementation and actions are delivered by those responsible and to pull together the different agencies' 'transformation plans' into a whole system plan which supports the Health and Wellbeing Board in delivering its vision and outcomes. In addition, a joint commissioning group is being developed to co-ordinate the use of public funding and resources.

Contact: **Martin Farran**, Executive Director of Adults and Communities
Martinfarran@barnsley.gov.uk

Essex has established an executive board that sits under the shadow Health and Wellbeing Board and provides the capacity to deliver the HWB's strategy. The shadow Health and Wellbeing Board is also currently exploring a network approach to engagement with providers and other stakeholders as well as locality board arrangements aligned to either district council boundaries or clusters of districts in alignment with the CCG boundaries.

Contact: **Clare Hardy**, Senior Manager for Health and Wellbeing
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Warwickshire's shadow Health and Wellbeing Board does not have any formal sub-committees. Instead it has opted for a system of panels and steering groups which it believes are a good way of developing an advisory framework for the board for the following reasons.

The full board meets for two hours six times a year. As its workload has grown, so has the ability to give key areas the attention they require. Only by establishing some form of alternative working arrangements is it possible to cover the work.

Panels can be made up of people with the knowledge and interest to focus on specific topics.

Panels may focus on single issues or on different communities, based around the priorities set by the future JHWSs.

Contact: **Paul Williams**, Democratic Services Team Leader
Paulwilliamscl@warwickshire.gov.uk

Options

As board members will be aware, the principles of openness and transparency are not just about conforming to the letter of the law. Many people are put off by complex formal meetings which can rapidly become incomprehensible to observers, with frequent reference to board papers and use of shorthand and jargon. Both councils and the NHS – and now shadow health and wellbeing boards – have developed more inclusive ways of running meetings that actively involve the public. Decisions can still be taken and minuted in a way which conforms to requirements, but is more open and welcoming than formal committee meetings. Formats could include:

- café-style roundtable discussions in which members of the public are invited to participate
- presentations at which observers may ask questions and give their views
- devoting part of a decision-making meeting to listening to the experiences of service users and the public
- providing important board papers in an 'easy read' format to facilitate participation by, for example, people with learning disabilities
- providing a leaflet explaining how meetings will work, who will be present, how members of the public can contribute etc.
- webcasts of board meetings with mini-videos by board members explaining issues they are discussing.

Some PCT boards in recent years have begun each board meeting with an individual

case study to try to ensure that the decisions they take are based on the lived experience of service users. Local authority scrutiny committees frequently offer opportunities to members of the public and service users to talk about their experiences and how services could be improved, a model that could also be helpful to health and wellbeing boards. One option for increasing public involvement is to involve service users, their organisations and the public in working groups or task groups set up for specific purposes, for example, working groups focused on developing the board's public engagement strategy.

One issue that is likely to come under discussion by health and wellbeing boards is how, when they must meet in public, boards can have early and frank discussions on complex and sensitive issues without starting rumours or raising concerns amongst stakeholders before issues and options are understood fully, are ready for consultation or decision. This may be a particular concern for CCG representatives and other board members who have not had experience of serving on committees under similar transparency requirements.

Councils are subject to provisions under the Local Government Act 1972 which provides for access to meetings, reports and documents, subject to specified confidentiality provisions. Councils have extensive experience of operating under transparency requirements while retaining the option of having some discussions in private.

One way of doing this is to alternate meetings held in public at which decisions are taken, with less formal workshops or seminar sessions which take place outside the board, for both brainstorming and board learning and development. This is not to say that public board meetings need to be conducted with rigid formality, as discussed above.

Some shadow boards, particularly those which have a large and inclusive membership, have set up executive sub-groups to progress the formal decisions made by boards at their public meetings. For large boards which meet formally on a bi-monthly basis, some such executive arrangement may be considered essential to the effectiveness of the board.

Equally, boards will want to ensure that the option of holding some informal exploratory or planning workshops in private is not used to exclude stakeholders inappropriately. Indeed, 'task and finish' groups or working parties can be a way of including people with an interest and experience in the topic under review, with reports and recommendations being made to boards for public discussion and decision. Many shadow boards have set up such working parties to bring forward proposals or to help prepare draft JSNAs and JHWSs from 2013. Others have set up working groups to develop a public engagement strategy for the board's approval.

Some shadow boards are using the option of setting up sub-committees to make proposals for future arrangements for joint commissioning.

The shadow Health and Wellbeing Board for East Sussex has been meeting in public and is also webcast. In addition to full board members, attendees are involved in board meetings, to ensure the board can involve the district and borough councils, voluntary and community sector representation in the discussions and debate. The board put in place a formal review for December 2012 to ensure that any learning from the shadow process as well as from others can be built into the statutory board from April 2013.

Contact: **Barbara Deacon**, Policy Officer, Chief Executive's Office
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Wandsworth's shadow Health and Wellbeing Board alternates formal meetings of the board with informal seminars – which operate outside standard governance procedures and without formal decision-making powers. The board envisages the need for this split in meeting type continuing beyond the commencement of the board's statutory status. Members believe that as relatively new bodies, health and wellbeing boards are benefitting from an energy and enthusiasm that will not exist in the long term unless the space for creative thinking is protected.

Contact: **Richard Wiles**, Health Policy Team Leader
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Key issues to consider

- ✓ Are health and wellbeing board members aware of the duties of transparency and openness placed on boards by the legislation listed above?
- ✓ Has the board considered and developed formats for running its public meetings in a more inclusive way?
- ✓ Has the board considered whether it wants to set up any standing sub-committees and/or working parties which might draw in additional stakeholders to contribute to the work of the board?
- ✓ Has the board developed an approach to exploring sensitive issues before they become public?

Further information

Department of Communities and Local Government, 'Making local councils more transparent and accountable to local people' – summary of and links to legislation and government policy:
http://tinyurl.com/apn2ko5

Office of the Information Commissioner – website has guidance on the Freedom of Information and Data Protection Acts:
http://tinyurl.com/4omgo28

7. Accountability and relationships between health and wellbeing boards, other council structures and partnerships

What the legislation says

Health and wellbeing boards are not committees of a council's cabinet. Therefore, their decisions do not need to go on the cabinet's key decision list or forward plan. However some councils may choose to delegate additional functions to the board. In these cases councils will need to adhere to the requirements of all of the applicable legal frameworks.

As overview and scrutiny can consider functions which are the responsibility of the council's executive as well as those which are not, and as there are additional scrutiny powers in relation to scrutiny of health, the discharge of functions by health and wellbeing boards fall within the remit of scrutiny but the core functions are not subject to call in as they are not executive functions.

Involving the public (people who live or work in the area) in JSNAs and JHWSs is a statutory requirement under the Local Government and Public Involvement in Health Act 2007 and is a form of ongoing accountability for boards.

Options

Health and wellbeing boards will need to think carefully about how best to relate to existing governance arrangements, both within councils and across partnerships. Although organograms with reporting lines do not in themselves build good working relationships, it will be helpful to clarify formal relationships between boards and different local governance structures from the outset.

Although not committees of cabinets, health and wellbeing boards will be making an important contribution to councils' overarching priorities and will be the means by which councils implement their duties to prepare and produce JSNAs and JHWSs. Because of this, boards will need to establish very strong working relationships with leaders, cabinets and elected mayors where relevant. This may take the form of membership of the board, or of regular meetings between the chair of the board and the council leader or elected mayor and/or regular reports to cabinet.

It will be important to develop a means of ensuring that the priorities in the JSNAs and JHWSs are aligned with other council and local NHS strategies and those of other strategic bodies for the area, including those relating to children's services, safeguarding boards, community safety partnerships and local enterprise partnerships and others. Some areas have retained a local strategic partnership which acts as the overarching co-ordinating body.

Other areas have given a co-ordinating role to the shadow health and wellbeing board and intend to give it to statutory health and wellbeing boards. Others have 'dotted line' reporting between various strategic bodies, where one body reports on its activities to another although the former is not formally accountable to the latter.

Relationships with local Healthwatch, the NHS Commissioning Board and CCGs will be facilitated by their representatives on health and wellbeing boards, but boards will also want to develop broader and deeper relationships at both a strategic and operational level.

As mentioned above, boards will need to develop an understanding with CCGs about how they take forward their duty to encourage integrated working – this may need more than a bi-monthly strategic meeting at board level which many shadow boards have instituted. Boards will therefore need to think about an operational as well as a strategic approach to the whole system and, specifically, about their relationship with joint commissioning structures.

There will need to be a three-way relationship between health and wellbeing boards, scrutiny committees (particularly health overview and scrutiny committees) and local Healthwatch. Some areas have begun to develop protocols or memoranda of understanding between the three elements of this relationship to ensure clarity and mutual understanding of roles and responsibilities.

As well as scrutinising the work of boards, scrutiny committees may also be in a position to assist boards to understand their populations better. For example, a health and wellbeing board could ask a health overview and scrutiny committee to investigate through a scrutiny review the low uptake of a particular service in certain geographical areas and make recommendations to the council, the CCG or the board and others as to how uptake might be increased (see the Centre for Public Scrutiny publication referenced below for more options).

In Bath and North East Somerset, there is agreement between the chairs of the shadow Health and Wellbeing Board, Wellbeing Scrutiny and shadow local Healthwatch to develop supportive arrangements that work towards the same goal of reducing health inequality. This means that the work programmes of the Board, Wellbeing Scrutiny and Healthwatch will be shared and loosely aligned to create pathways for influence, whilst maintaining independence and the role of scrutiny.

Contact: **Andrea Wolfenden**, Programme and Strategy Officer, Policy and Partnerships
Andrea.Wolfenden@bathnes.gov.uk

Health and wellbeing boards will be accountable not only to councils, but also to the communities they serve. They will need to consider the most appropriate methods of responding to these various accountabilities. For example, it may be good practice to report the activities of a health and wellbeing board through presenting its minutes to council meetings. Accountability to patients and the public is likely to be carried out through an ongoing engagement strategy, informing the way in which the board works, its priorities and membership. Some boards are setting up sub-committees or working groups to progress their engagement with patients and the public and co-opting additional voluntary sector members to contribute their expertise and network with local communities.

Boards will also want to develop mechanisms for evaluating and reporting to stakeholders on their own performance.

Birmingham Council and PCT have recognised the intrinsic link between improved health and wellbeing and access to suitable employment. For this reason, consideration is being given, in the first formal year, of giving a seat on the Health and Wellbeing Board to the Local Enterprise Partnership (LEP). At present, representatives of the LEP are invited to take part in the Health and Wellbeing Board Operations Group. This is the group that filters agenda items for the shadow Board, but also prioritises issues for consideration in JSNAs. This group has a wide range of interests represented on it to reflect the diverse range of stakeholders that influence health and wellbeing.

Contact: **Darren Wright**, Senior Programme Manager, Health and Wellbeing Board and Community Engagement
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Cornwall has confined its Health and Wellbeing Board membership to those who will form the core statutory membership. However, the board is developing links to stakeholders and the public through other established partnerships and networks. The board is also developing links to the Local Enterprise Partnership and emerging Local Nature Partnership, recognising the inter-connectedness of the three strategies. The board has begun to develop its brand to distinguish itself from the council and to reflect the partnership nature of the board.

Contact: **Simon Mansell**, Principal Legal Officer, Corporate Governance
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Barnsley's shadow Health and Wellbeing Board's relationship with One Barnsley, the Local Strategic Partnership, is being explored in detail. The plan is to adapt the current LSP delivery partnerships to report into the Health and Wellbeing Board as appropriate, for example, in the future, there is the potential to include the Community Safety Partnership. Furthermore, there is also the intention to develop an integrated commissioning function and an integrated intelligence function (wider than traditional JSNAs) which will also support the LSP and economic strategy as well as the Health and Wellbeing Board.

Contact: **Martin Farran**, Executive Director of Adults and Communities
Martinfarran@barnsley.gov.uk

Key issues to consider

- ✓ Is there clarity about the health and wellbeing board's formal relationships, including reporting arrangements and joint working, with internal council structures, including cabinets and scrutiny, CCGs, local Healthwatch and other partnership boards whose work has a significant health impact?
- ✓ Has the board considered what existing or new mechanisms can be used to progress its specific duties to encourage integrated working and to prepare JSNAs and JHWSs?
- ✓ Is there an agreed process by which the board will consider and comment on the council's and CCG's commissioning plans?
- ✓ How will the board make itself accountable to its constituent members and to local communities?
- ✓ Has the board considered developing a protocol or memorandum of understanding on roles and responsibilities and relationships with scrutiny and local Healthwatch?
- ✓ Are there performance systems in place to evaluate and report on the board's performance in relation to its objectives?

Further information

Outputs of the National Learning Network for health and wellbeing boards:
'A guide to governance for health and wellbeing boards': http://tinyurl.com/at7dyon

'Operating principles for JSNAs and JHWSs': http://tinyurl.com/bzhyw7l

'Encouraging integrated working to improve services for adults and older people: a practical guide for health and wellbeing boards': http://tinyurl.com/aotkf8y

'Health and wellbeing boards and criminal justice system agencies: building effective engagement': http://tinyurl.com/d9xhgj3

'Patient and public engagement: a practical guide for health and wellbeing boards': http://tinyurl.com/bdvhcvo

LGA, 'A new development tool for health and wellbeing boards': http://tinyurl.com/a5wjvtd

Centre for Public Scrutiny, 'Local Healthwatch, health and wellbeing boards and health scrutiny – roles, relationships and adding value': http://tinyurl.com/c8u3e6k

8. Health and wellbeing boards in two-tier areas

What the legislation says

The Local Government and Public Involvement in Health Act 2007 imposes a duty on health and wellbeing boards to involve district councils in the development of JSNAs. The legislation does not specify district councils' involvement in developing JHWSs, but it is in keeping with the spirit of the legislation and of a broad and inclusive approach to health improvement and to tackling health inequalities that districts should be included in JHWSs and in the work of boards in general.

Options

The functions of district councils and their relationships with their communities make them central to the health and wellbeing of those communities. Some district councils have public health units and/or staff. All have environmental health teams and are involved in local child and adult safeguarding boards. But even when their services don't have 'health' in their title, district councils have powers and responsibilities which are essential to the effective delivery of health and wellbeing services. As with upper-tier authorities, district councils have their own strategies and networks for engaging with local residents to consult them about priorities and the quality of services.

Health and wellbeing boards in two-tier local government areas will need to find ways of working with district councils and tapping into their engagement with stakeholders, to ensure that the health impact of district councils' functions is maximised to ensure services are integrated between counties, districts and the NHS and are planned around individuals, rather than around administrative units.

There is a wide range of options available to health and wellbeing boards to include district councils in their governance structures:

- some shadow health and wellbeing boards offer places to district councils, usually offering two or three places to be shared by a greater number of district councils, the members being nominated by the district councils in agreement with each other
- some shadow health and wellbeing boards invite district councils to send observers to board meetings and to participate in informal board learning and development sessions
- district council representatives, either councillors, officers or both, can also be offered places on sub-structures of the board, including sub-committees or working parties set up specifically to look at partnership work and integration of services between the local tiers of local government and the NHS

- all health and wellbeing boards will need to devise mechanisms for involving district councils in the development of JSNAs and, where appropriate, JHWSs.

Leicestershire's shadow Health and Wellbeing Board includes two district councillors. There is a designated district council chief executive who:

- co-ordinates the work of the district councils in relation to health issues
- is a member of the health and wellbeing steering group which plans for agendas and the forward workplan of the health and wellbeing board
- actively support the two councillors representing districts on the health and wellbeing board.

Contact: **Rosemary Palmer**, Senior Committee Officer
Rosemary.Palmer@leics.gov.uk

Lincolnshire has two district council leaders who have responsibility for representing seven districts on the shadow Health and Wellbeing Board. Districts have taken it upon themselves to set up arrangements to support the work of the health and wellbeing board with support from the individual public health link allocated to that district.

Contact: **Jennie Chapman**, Partnership Manager
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Kent is one of a small number of areas in which shadow Health and Wellbeing Boards have been established at district level and relating to CCG boundaries. The South Kent Coast Health and Wellbeing Board covers the Dover and Shepway district council areas and its title reflects the CCG boundaries that it covers. This and the other CCG/district level health and wellbeing boards will be established as formal sub-committees of the county health and wellbeing board.

Contact: **Caroline Davis**, Strategic Business Adviser
Caroline.Davis@kent.gov.uk

In Warwickshire, three district councillors represent the five districts/boroughs on the shadow Health and Wellbeing Board.

Contact: **Paul Williams,** Democratic Services Team Leader
Paulwilliamscl@warwickshire.gov.uk

Key issues to consider

- ✓ Has the health and wellbeing board considered how district councils will be involved in the board's work, either through membership of the main board, through its sub-structures or through other forms of engagement?
- ✓ Are any district council representatives appointed to the board or its sub-structures clear on their role and how they will feed back and represent the views of all the districts in the area?
- ✓ What mechanisms will be used to involve district councils specifically in the development of JSNAs and, where appropriate, JHWSs?
- ✓ How will the board implement its duty to promote integrated working between commissioners of health and social care services in relation to those aspects of district councils' work that impacts on or complements health and social care services?
- ✓ Has consideration been given to involving district councils in the board's patient and public engagement strategy?
- ✓ What regular communications channels will the board establish with district councils?

Further information

LGA District Councils' Network Public Health Survey (November 2012) (includes information on inclusion of district councils in health and wellbeing boards): http://tinyurl.com/abdrxzs

Appendix – Questions and answers on detailed and technical issues

Question: Who establishes a health and wellbeing board?

The Health and Social Care Act 2012 puts a statutory requirement on upper-tier and unitary local authorities in England, the council of the Isles of Scilly and the Common Council of the City of London to establish a health and wellbeing board, and provides that these boards be treated as if they were a committee appointed under section 102 of the Local Government Act 1972.

Question: Who appoints the members of the health and wellbeing board?

Currently regulations provide that the function of making appointments under section 102 of Local Government 1972 Act is not to be the responsibility of the executive. So appointments to the health and wellbeing board are the function of the council rather than the executive in executive arrangements.

The Health and Social Care Act 2012 sets out membership of the health and wellbeing board on the face of the Act and it is thus clear that the boards are different to other section 102 committees in certain respects. In particular the Health and Social Care Act 2012:

- Sets a core membership for each health and wellbeing board. This includes the Directors of Public Health, Adult Social Services and Children's Services, a representative of each relevant Clinical Commissioning Group (CCG) and a representative of local Healthwatch for the area, in addition to at least one elected representative, ie a councillor and, in councils with executive arrangements, the Mayor or Leader in addition to or instead of a councillor.
- Requires that the CCG and local Healthwatch must appoint a person to represent them.
- Requires that the councillor membership is nominated by the Leader or Mayor where councils operate executive arrangements, and by a council in other cases.
- Enables the council to include other members as it thinks appropriate but the council must consult the health and wellbeing board if doing so any time after the board is established. In some local areas, for example, there are plans to include representatives of criminal justice, foundation trusts or VCS providers on health and wellbeing boards.

- Enables the health and wellbeing board to appoint additional members as it thinks appropriate.

Question: Who can vote on a health and wellbeing board? Who agrees voting and other procedures for the health and wellbeing board?

Secondary legislation will disapply current restrictions that limit voting on section 102 committees to councillors, in relation to health and wellbeing boards.

The effect of this will be to create a default position where all members of a health and wellbeing board can vote unless the local authority otherwise directs. Thus the secondary legislation also allows local flexibility for a local authority to direct, for example, that officer members of a health and wellbeing board, or members in addition to those in the statutory core membership, do not hold voting rights. The local authority would need to consult the health and wellbeing board before making the direction.

Question: What are the functions of the health and wellbeing boards?

Health and wellbeing boards have three types of functions.

1. Preparation of Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs)
The Local Government and Public Involvement in Health Act 2007 provides that these are functions, both of local authorities and their partner clinical commissioning groups.

Local government legislation makes provision about the exercise of local authority functions. The default position under section 9D(2) of the Local Government Act 2000 is that subject to any provisions made by that Act or subsequent enactments, any function of the local authority which is not specified in regulations under subsection (3) of section 9D is to be the responsibility of an executive of the authority under executive arrangements. In the case of JSNAs and JHWSs, another enactment, section 196(1) of the Health and Social Care Act 2012, directly provides that these functions are to be exercised by the health and wellbeing board. In our view therefore, these are not the responsibility of the executive in executive arrangements.

As undertaking these processes and preparing their outputs is a function of the health and wellbeing board, there is no statutory requirement for the local authority or CCG to separately sign them off. However, many local areas will want to get sign off from the local authority and CCG as part of the process of building ownership of the JSNA and JHWS process – and to help ensure the priorities will be translated into action through commissioning plans.

2. Functions as to promoting integrated working
These functions are conferred directly on health and wellbeing boards under section 195 of the Health and Social Care Act 2012.

3. The discharge of other local authority functions
Section 196(2) of the Health and Social Care Act 2012 provides that a local authority may arrange for the health and wellbeing board to exercise any functions exercisable by the authority.

Question: What functions other than the statutory functions can be delegated to health and wellbeing boards?

The legislation does not indicate which other functions a council might delegate to a health and wellbeing board under section 196(2) of the Health and Social Care Act 2012. The most likely functions for delegation are those relating to commissioning of social care and aspects of public health services, especially joint commissioning of services with the NHS or functions relating to wider determinants of health, such as housing, that affect the health and wellbeing of the population. The council would have to act reasonably in exercising the power to delegate.

Question: The Act says that the leader/elected mayor should 'nominate' councillor members to health and wellbeing boards. Does this mean, the council as a whole does not have a say?

The Health and Social Care Act 2012 has given the role of nomination to the Mayor/Leader and the role of appointing to the council. So those respective roles must be respected. While the function of making appointments under section 102 of the 1972 Act is not the function of the executive, the 2012 Act sets out membership of the health and wellbeing board on the face of the Act and it is thus clear that the boards are different to other section 102 committees.

In particular the 2012 Act:

- Sets a core membership for each health and wellbeing board. This consists of the Directors of Public Health, Adult Social Services and Children's Services, a representative of each relevant Clinical Commissioning Group (CCG) and a representative of local Healthwatch for the area, in addition to at least one elected representative which is a councillor and/or the Mayor/Leader (in executive arrangements).
- Requires that the CCG and local Healthwatch must appoint a person to represent them.
- Requires that the councillor membership is nominated by the Leader or Mayor where councils operate executive arrangements, and by a local authority in other cases.
- Enables the local authority to include other members as it thinks appropriate (for example in some local areas there are plans to include representatives of criminal justice, foundation trusts or VCS providers on health and wellbeing boards) but requires the local authority to consult the boards if doing so any time after a board is established.
- Enables the health and wellbeing board itself to appoint additional members as it thinks appropriate.

Question: Can members of health and wellbeing boards send substitutes to board meetings?

The approach to substitution is for local determination. Under the local government legislation, the appointment of section 102 committees is not the responsibility of the executive. In the case of health and wellbeing boards, councillor members are nominated by the leader or mayor (in executive arrangements) and by the local authority in other cases. There is provision for local Healthwatch and CCGs to appoint persons to represent them on the boards. Additional members can be appointed to the board. The regulations are silent on the issue of substitution.

Where substitution does take place, this will need to be done in a way that does not result in unlawful delegation of the boards' functions ie functions being discharged by anyone other than the (properly constituted) boards themselves. Further, the practice of frequently sending substitutes to meetings is generally disliked by governing bodies in general, as it disrupts the continuity of dialogue and debate and may even result in contradictory decisions at different times. This is particularly true when a new committee, such as a health and wellbeing board is being set up and a process of 'institution building' is under way, with members trying to get to know and understand each other's perspectives.

However, councils and boards will also want to take an approach to substitution that recognises the seniority of board members and the pressures on their time, and, in some cases, pressures that may arise from living with long-term health conditions or caring for others. For other committees, councils usually have a scheme of substitution under which named substitutes are agreed in advance.

Question: Are health and wellbeing boards subject to scrutiny?

Generally, yes. In committee systems local authorities must ensure that overview and scrutiny committees have power to review and scrutinise decisions made or other action taken in connection with the discharge of any functions of the local authority. In executive arrangements local authorities must ensure that overview and scrutiny committees can review and scrutinise decisions or action in connection with discharge of functions whether or not they are the responsibility of the executive. Local authorities will have additional powers in relation to scrutiny of health. We expect that local authorities' scrutiny arrangements will be considering both the work of health and wellbeing boards, and the contribution of partners on the boards (CCGs and local authorities) to delivering JSNAs and JHWSs.

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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: 27 March 2013

Subject: Work Schedule – March 2013

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

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, along with some provisional issues for consideration.

2.2 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.

Update on issues considered by the Scrutiny Board

2.3 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

2.4 Members will be aware of the recent High Court ruling that found in favour of Save Our Surgery (SOS) Ltd. in its action brought against the Joint Committee of Primary Care Trusts (JCPCT), namely that:

2.5 The full judgement is attached at Appendix 2 for members' information. It should be noted that a further 'remedy hearing' is scheduled for the day of the Scrutiny Board

meeting (i.e. 27 March 2013). The judge's decision on redress is expected to be made on the day of the hearing.

2.6 As members are already 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.

2.7 The outcome of the review resulted in a decision by the JCPCT 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.

2.8 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 asked the Independent Reconfiguration Panel (IRP) to undertaken a review of the decision and, initially, provide its advice by 28 March 2013. However, given the most recent development in the High Court, the Secretary of State for Health has written to the Chair of the IRP, extending the deadline for reporting until 30 April 2013. A copy of the letter is attached at Appendix 3 for information.

2.9 The JHOSC is meeting again on 10 April 2013 where it will not only consider the implications of the outcome of the remedy hearing, but also consider how the implementation phase of the review is being taken forward. At that meeting, the JHOSC will also consider whether or not it wishes to make any further representation to the IRP.

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

2.10 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.

2.11 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.

2.12 At the meeting in February 2013, members of the Scrutiny Board were provided with a further stakeholder newsletter published in February 2013. Since that meeting, further contact has been made with NHS Specialised Services requesting a formal response to a number of issues, including the following:

(a) Under the new working arrangements, which part of the NHS will be responsible for taking forward the review?
(b) Notwithstanding overall responsibility for the review, will aspects of the review be discharged to other bodies? If so, which ones and how will these be established?

(c) What will be the overall governance and decision-making arrangements for the review?
(d) Please confirm the revised review timetable.
(e) Please confirm when further stakeholder newsletters are planned.

2.13 While the request for the information has been acknowledged, a substantive response has not yet been received. Members will be advised of any response as soon as practicable.

2.14 As previously reported, 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

2.15 A working group meeting is planned to take place on 21 March 2013, involving representatives from the National Federation of the Blind (Leeds and District Branch) and officers from Adult Social Care. An update from the working group will be provided at the meeting.

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

2.16 Further to the briefing note from Adult Social Care presented at the meeting in February 2013, a report detailing the outcome of the consultation is presented elsewhere on the agenda for consideration. As set out in that report, a working group meeting is proposed for 12 April 2013.

Mid Yorkshire Hospitals Trust Information

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

2.18 The formal 12-week public consultation commenced on 4 March 2013 and will run until 31 May 2013. Copies of the consultation document are available on request.

2.19 As previously reported, 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

2.20 As reported to the previous Scrutiny Board, 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.

2.21 With the imminent abolishment of Primary Care Trusts (PCTs), the West Yorkshire Area Team (WYAT), which is a subordinate body accountable to the NHS Commissioning Board, will become responsible for commissioning all dental services from 1 April 2013, including the provision of unplanned or urgent dental services to the population of West Yorkshire.

2.22 Engagement with stakeholders and patients from across West Yorkshire commenced on 1 February 2013 for a period of three months. The aim being to design an 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).

2.23 Since the last Scrutiny Board meeting, there has been limited progress in establishing arrangements for members to consider the proposals and potential implications for Leeds' patients. Any further progress will be reported to the meeting.

Coroners' Rule 43 - Inquests

2.24 Further to the details presented to the previous meeting, Leeds Teaching Hospitals NHS Trust (LTHT) has provided details of the Trust's response to the recommendation and an outline of progress against any agreed actions.

2.25 Arrangements for providing this information to members of the Scrutiny Board as being considered, in 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.

Executive Board minutes

2.26 Executive Board minutes from the meeting held on 13 March 2013 are attached to this report for information/ consideration.

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	**March 2013**	**April 2013**	**May 2013**
Dementia in Leeds			Update on Strategy and Action Plan SB – date TBC
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 SB 27 March 2013 @ 10 am		
Other (details defined)	Working Group - Services for the Blind and Visually Impaired: 21 March 2013 @ 2pm Progress update against the Local Account: SB 27 March 2013 @ 10 am Charges for Non-Residential Adult Social Care Services: SB 27 March 2013 @ 10 am	Update on progress against the Leeds Tobacco Action Plan and previous Scrutiny Board recommendations. Working Group - Charges for Non-Residential Adult Social Care Services – 12 April 2013 @ 12:30pm	Outcome of work around Services for the Blind and Visually Impaired SB – date TBC
Briefings	Health Service Developments Working Group – 12 March 2013		Draft Quality Accounts for 2012/13 from: • LTHT • LYPFT • LCH • YAS To include commissioner assurance – NHS ABL/ CCGs. (TBC)

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

Updated: March 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 2013**	**April 2013**	**May 2013**
Budget & Policy Framework Plans			
Recommendation Tracking			
Performance Monitoring	• 2012/13 Quarter 3 performance report SB 27 March 2013 @ 10 am		

Matters to be consider not yet scheduled:

- Older People's Housing and Care
- Better Lives for the people of Leeds - Residential Care for Older People - formal statutory consultation on the proposed options
- Better Lives for the people of Leeds - Day Centres for Older People - formal statutory consultation on the proposed options
- Cycling development in Leeds

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

Updated: March 2013

Neutral Citation Number: [2013] EWHC 439 (Admin)

Case No: CO/10505/2012

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 07/03/2013

Before :

THE HON. MRS JUSTICE NICOLA DAVIES DBE

- -

Between :

R on the application of Save our Surgery Limited	**Claimant**
- and -	
Joint Committee of Primary Care Trusts	**Defendant**
Newcastle Upon Tyne Hospitals NHS Foundation Trust	**Interested Party**

- -
- -

Philip Havers QC and Jeremy Hyam (instructed by **Hempsons Solicitors**) for the **Claimant**
Dinah Rose QC and Marina Wheeler (instructed by **Capsticks Solicitors**) for the **Defendant**
Fenella Morris QC (instructed by **Samuel Phillips Solicitors**) for the **Interested Party**

Hearing dates: 11th, 12th, 18th February 2013

- -

Approved Judgment

Mrs Justice Nicola Davies :

1. The claimant seeks to quash the decision of the defendant, the Joint Committee of Primary Care Trusts (the JCPCT) made on 4 July 2012 which identified seven specialist centres in England for the future performance of paediatric cardiac surgery. Those centres are to be located in Bristol, Birmingham, Liverpool, Newcastle, Southampton and London (two centres) ("the Decision"). Of twelve options considered in a consultation process the JCPCT decided that Option B, an option excluding Leeds General Infirmary (Leeds) but including the Freeman Hospital (Newcastle) would provide the best quality care.

Factual Background

2. The 2001 Report of the Public Inquiry into deaths at Bristol Royal Infirmary chaired by Professor Sir Ian Kennedy noted that healthcare services for children were "fragmented and uncoordinated" and made a series of recommendations. Reports by groups of experts in 2003, 2006 and 2007 recommended re-organisation of the centres providing paediatric cardiac surgery services. The consensus was, that in order to achieve better and safer results, surgical expertise needed to be concentrated in fewer, larger centres. A minimum number of surgeons were needed in each centre to ensure adequate cover. Each needed to perform a minimum number of procedures per year to ensure sufficient expertise. In order to achieve the stated aims of a high quality sustainable service with equitable access the number of surgical centres in England would have to be reduced and local arrangements for non-surgical centres would have to be strengthened.

3. In response to such concerns in 2008 the NHS Medical Director, Sir Bruce Keogh, acting on behalf of the NHS Management Board requested the NHS National Specialised Commissioning Group (NSCG) to review the provision of paediatric congenital cardiac services. The review became known as the "Safe and Sustainable Review" (the Review). The Review was led by a project team (the NSC team) and was assisted by specialist groups which included:

   - The Steering Group: this primarily provided clinical advice. It was chaired by Dr Patricia Hamilton and comprised 25-30 members of professional and lay associations and commissioners from around the country;

   - The Standards Working Group: a sub group of the Steering Committee led by clinicians whose role was to research and develop a framework of clinical and service standards;

   - An Independent Assessment Panel (the "Kennedy Panel") chaired by Professor Sir Ian Kennedy whose role was to review the existing providers of paediatric congenital cardiac services ("PCCS") and evaluate their compliance with the proposed service standards currently and in the future. The panel was comprised of experts in paediatric cardiac surgery, paediatric cardiology, paediatric

anaesthesia/paediatric intensive care, paediatric nursing together with lay representatives and NHS commissioners.

4. In 2010 the JCPCT was established as the formal consulting body with responsibility for the conduct of the consultation of the Review and for taking decisions on issues the subject of the consultation. On 1 March 2011, the JCPCT published a Consultation Document entitled "Safe and Sustainable: A New Vision for Children's Congenital Heart Services in England" (the Consultation Document). The essence of the proposal was that the number of centres providing paediatric cardiac surgical services be reduced from eleven to seven and that the paediatric congenital cardiac service be reconfigured into one of a number of national configuration options.

The Legal Challenge

5. The claimant is a shell company created solely for the purpose of this litigation. Its funds are raised from public contributions and it draws upon the support of many local people, a petition signed by 600,000, together with local MPs and clinicians. The preliminary work in respect of this challenge was carried out by the Children's Heart Surgery Fund (CHSF) but following advice from the Charity Commissioners the CHSF had no further involvement in the proposed litigation. The defendant challenges the standing of the claimant to act in these proceedings.

6. The claimant does not challenge the merits of the Decision. The challenge is to the consultation process which preceded the Decision and its product, namely the Decision. The claimant's contention is that the same were flawed by:

   a) procedural unfairness – a failure to disclose sub-scores awarded by the Kennedy Panel which were the key to understanding the "material differences" in "Quality" between the centres considered in the configuration assessment. This failure deprived the consultees of the opportunity to make intelligent and informed responses, which, had they been taken into account by the JCPCT, at the very least may and probably would have had a significant influence on the outcome of the configuration assessment;

   b) a failure to take into account material considerations: a failure by the JCPCT itself sufficiently to inquire into and then take into account the supposed "material differences" in "Quality" between the centres which were being considered in the configuration assessment by failing to have regard to the Kennedy Panel sub-scores and by relying on mistaken and erroneous advice/assurance from Professor Sir Ian Kennedy.

7. For the purposes of these proceedings the claimant does not challenge the decision that it is Leeds **or** Newcastle as the one northern centre. In the event that the decision is quashed the claimant would contend that both could continue to provide these services.

8. The defendant contends that the consultation process was fair, all relevant considerations were properly taken into account by the JCPCT when the decision was made. The overall scores awarded by the Kennedy Panel were disclosed to consultees and were considered by the defendant as was a detailed report prepared by the Kennedy Panel. The report identified the areas of strength and weakness in compliance with identified criteria which it had assessed on the evidence provided to it by the centres. The report provided sufficient information to enable consultees to comment intelligently on the proposals for reconfiguration of the service.

9. Fairness does not oblige a decision maker to disclose all underlying materials which have informed advice provided to the decision maker. Such a requirement is particularly inappropriate where the advice itself, and the reasons for it, have been disclosed; where the advice consists of an exercise of individual and collective expert judgment, rather than an objectively verifiable analysis of data; where the information being assessed has been provided by the consultees themselves; and where the decision maker has not had access to, or relied upon, the material in question. There is no principle of fairness that requires the disclosure to consultees of material which has not been considered or relied upon by the decision maker. The logic of the claimant's case is that not only the sub-scores but also the working notes and individual scores of members of the Kennedy Panel together with all the evidence considered by them ought to have been disclosed to consultees.

10. The application for judicial review was issued on 2 October 2012. On 21 November 2012 HHJ Mackie QC sitting as a Deputy High Court Judge made an order which included the following:

    i) Newcastle Upon Tyne Hospitals NHS Foundation Trust be joined as an interested party;

    ii) A rolled up hearing to determine the application for permission and the substantive claim be heard.

11. Having considered the submissions I grant permission to the claimant to apply for judicial review.

Legal Framework

12. Sections 1 and 3 of the National Health Service Act 2006 require the Secretary of State for Health to provide or secure certain medical services. By regulation 3 of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trust and Administration Arrangements) (England) Regulations 2002 (SI 2002 / 2375), as amended, that function has been substantially delegated to Primary Care Trusts ("PCTs"). Section 242 (2) (b) of the 2006 Act imposes a duty on each body to which it applies which includes PCTs, to consult persons to whom services are being or may be provided on "*the development and consideration of proposals for changes in the way those services are provided*".

13. Paragraph 10.3.2 of the Department for Health Overview Scrutiny of Health Guidance provides that :

> "…where a proposed service change spans more than one PCT, they will need to agree a process of joint consultation. The Board of each will need to formally delegate responsibility to a Joint Committee, which would act as a single entity. Following consultation the Joint PCT Committee will be responsible for making the final decision on behalf of the PCTs for which it is acting."

14. Specialised paediatric cardiology and cardiac surgery services are "specialised services", commissioned regionally by Specialised Commissioning Groups ("SCGs"), which are constituted as joint committees of PCTs in their catchment area. The NSCG coordinates the work of the SCGs and oversees, when necessary, pan-regional commissioning.

Lawful Consultation

15. The law imposes obligations of fairness upon any consultation exercise, the requirements of a lawful consultation were identified by the Court of Appeal in *R v North and East Devon Health Authority, ex parte Coughlan [2001] 1QB 213*:

> *"108 It is common ground that, whether or not consultation of interested parties and the public is a legal requirement, if it is embarked upon it must be carried out properly. To be proper, consultation must be undertaken at a time when proposals are still at a formative stage; it must include sufficient reasons for particular proposals to allow those consulted to give intelligent consideration and an intelligent response; adequate time must be given for this purpose; and the product of consultation must be conscientiously taken into account when the ultimate decision is taken (R v Brent London Borough Council ex parte Gunning (1985) 84 LGR 168)…*
>
> *112...It has to be remembered that consultation is not litigation: the consulting authority is not required to publicise every submission it receives or (absence and statutory obligation) to disclose all its advice. Its obligation is to let those who have a potential interest in the subject matter know in clear terms what the proposal is and exactly why it is under positive consideration, telling them enough (which may be a good deal) to enable them to make an intelligent response. The obligation although it might by quite onerous, goes no further than this."*

16. In *Devon County Council v Secretary of State for Communities and Local Government [2010] EWHC 1456 (Admin)* Ouseley J. stated:

> *"68. What needs to be published about the proposal is very much a matter for the judgment of the person carrying out the consultation to whose decision the courts will accord a very broad discretion…But, in my judgment, sufficient information to enable an intelligible response requires the consultee to know not just what the proposal is in whatever detail is necessary, but also the factors likely to be of substantial importance to the decision, or the basis on which the decision is likely to be taken…*
>
> *70...: a flawed consultation exercise is not always so procedurally unfair as to be unlawful; R (Greenpeace) v Secretary of State for Trade and Industry [2007]Env LR 29, Sullivan J…the true test is whether the consultation process was so unfair that it was unlawful…"*

17. Within the context of this case the claimant identified the "factors" (paragraph 68) as representing the Kennedy sub-scores. The defendant contends that they represent the factors developed in the Consultation Document namely accessibility, deliverability, sustainability and quality; the sub-scores are the underlying assessment of these factors.

18. In *R v Secretary of State for the Home Department ex parte Doody [1994] 1.A.C 53.* the challenge was to decisions of the Secretary of State by serving prisoners as to the minimum terms of imprisonment which they would have to serve prior to their cases being reviewed. Lord Mustill dealt with the issue of what fairness required in the context of the case and stated at p.560 (e):

> *"….(2) The standards of fairness are not immutable. They may change with the passage of time, both in the general and in their application to decisions of a particular type. (3) The principles of fairness are not to be applied by rote identically in every situation. What fairness demands is dependent on the context of the decision and this is to be taken into account in all its aspects…(5) Fairness will very often require that a person who may be adversely be affected by the decision will have an opportunity to make representations on his own behalf either before the decision has taken with a view to producing a favourable result; or after it is taken, with a view to procuring its modification; or both. (6) Since the person affected usually cannot make worthwhile representations without knowing what factors may weight against his interest fairness will very often require that he is informed of the gist of the case which he has to answer...*
>
> *The respondents acknowledge that it is not enough for them to persuade the court that some procedure other than the one adopted by the decision maker would be better or more fair. Rather, they must show that the procedure is actually unfair.*

> *The court must constantly bear in mind that it is to the decision maker, not the court, that Parliament has entrusted not only the making of the decision but also the choice as to how the decision is made…"*

19. The defendant relies upon the above passage in support of its contention that it is the gist of the case of which consultees have to be informed. The claimant does not accept that the 'gist of the case' is sufficient for the purpose of a consultation exercise, *Doody* was not a consultation case it was a challenge to a decision.

20. The defendant also relies upon the authority of *Bushell and Another v Secretary of State for the Environment [1980] AC 75* Lord Diplock p.95:

> *"What is fair procedure is to be judged not in the light of constitutional fiction…but in the light of the practical realities as to the way in which administrative decisions involving forming judgments based on technical considerations are reached…"*

Bushell did not involve a consultation process, the issue was one of fairness at an inquiry.

21. In *R (Eisai) v National Institute for Health and Clinical Excellence and Others [2008] EWCA CIV 438* the claimant pharmaceutical company held the UK marketing authorisation for a drug used in the treatment of Alzheimer's disease. NICE decided that it was not cost efficient and published guidance to that effect. The claimant challenged the procedure by which NICE had reached its decision contending that as a consultee of NICE, it should have had access to a fully executable version of the economic model that NICE had used to determine the cost effectiveness of the drug, rather than the only partly executable version which NICE had made available to all consultees. It was an important feature of *Eisai* that throughout the consultation process, the claimant had asked for a copy of the fully executable version of the model. Richards LJ cited the above passages in *ex-parte Coughlan* and continued:

> *" 26. The mere fact that information is "significant" does not mean that fairness necessarily requires its disclosure to consultees…nevertheless the degree of significance of the undisclosed material is obviously a highly material factor.*
>
> *27. What fairness requires depends on the context and the particular circumstances; see for example, R v Secretary of State for Education, ex-parte M [1996] ELR 162, at pp. 2006-2007, where Simon Brown LJ emphasised the need to avoid a mechanistic approach to the requirements of consultation…*
>
> *30. …The fact that the material in question comes from independent experts is plainly relevant to the overall assessment, but it was a combination of factors – including the*

> *requirement of a high degree of fairness…the crucial nature of the advice, the lack of good reason for non-disclosure, and the impact on the applicants- which led to what was on the facts a fairly obvious conclusion…*
>
> *65…even if one accepts the possibility that release of the fully executable version would add two to three months to the appraisal process, that has to be viewed in the context of an already lengthy process…I do not think that either the additional time or the additional cost to NICE should weigh heavily in the balance in deciding whether fairness requires release of the fully executable version. If fairness otherwise requires release of the fully executable version, the court should in my view be very slow to allow administrative consideration of this kind to stand in the way of its release.*
>
> *66…procedural fairness does require release of the fully executable version of the model. It is true that there is already a remarkable degree of disclosure and of transparency in the consultation process; but that cuts both ways, because it also serves to underline the nature and importance of the exercise being carried out. The refusal to release the fully executable version of the model stands out as one exception to the principle of openness and transparency that NICE has acknowledged as appropriate in this context. It does place consultees…at a significant disadvantage in challenging the reliability of the model. In that respect it limits their ability to make an intelligent response in something that is central to the appraisal process…"*

22. The request by the claimants in *Eisai* for disclosure of the relevant model was contrasted with the position of the claimant in *R (Easyjet) v Civil Aviation Authority and Others [2009] EWCA CIV 1361* in which the claimant's challenge was based upon the fact that the defendant had acted unfairly in failing to consult the airlines. After its own stated deadline for accepting representations from any party had passed, the defendant obtained and took into account material evidence from BAA explaining their underlying calculations for additional security costs. The defendant did not inform the airlines about this material, nor was there any opportunity to scrutinize or comment upon it. The essential factual difference between *Eisai* and *Easyjet* was that in *Eisai* the claimant had made clear that it wanted to see and comment on the fully executable version of the model whereas in *Easyjet* the airlines were content to leave the completion of the process of scrutinising and assessing the security costs to the defendant without any further input from them.

23. The court recognised that the airlines had played a full part in the consultation process prior to the identified deadline. It found that the process was not unfair and relied upon the fact that the airlines were content for the defendant to complete the final stage of the process without any further input during which period further submissions

were received upon which they did not comment. Of note is the following identified by Maurice Kay LJ [74]:

> *"…what fairness demands is dependent on the context of the decision.*
>
> *The decision in the present case does not impact on personal liberty, a person's home, the use which a property owner may make of his property or the right to conduct a business. Its context is the regulation by a statutory body of one aspect of the process charged by a private monopoly supplier to its customers…the ultimate issue is not the provision or non provision of a service. It is simply the charge that may be levied by the airports per passenger*
>
> *[73] This puts the decision of the CAA at the "soft" end of the spectrum…fairness should reflect the context as I have described it. It is for this reason that I reject Mr Béar's submission that the present case is on all fours with Eisai where the regulatory decision was effectively as to whether or not the company should be enabled to market their drug within the NHS. I see that as a significantly more intrusive decision which is more likely to attract a higher level of procedural fairness…"*

24. As to the refusal of the JCPCT to consider the sub-scores the claimant relies upon the authority of *Kaioa & Others v West & Another [1985] 159 C.L.R 550* Brennan J stated at 628:

> *"a person whose interests are likely to be affected by an exercise of power must be given an opportunity to deal with relevant matters adverse to his interests which the repository of the power proposes to take into account in deciding upon its exercise;… the person whose interests are likely to be affected does not have to given an opportunity to comment on every adverse piece of information, irrespective of its credibility, relevance or significance…nevertheless in the ordinary case where no problem of confidentiality arises an opportunity should be given to deal with adverse information that is credible, relevant and significant to the decision to be made. It is not sufficient for the repository of the power to endeavour to shut information of that kind out of his mind and to reach a decision without reference to it. Information of that kind creates a real risk of prejudice, albeit unconscious, and it is unfair to deny a person whose interests are likely to be affected by the decision an opportunity to deal with the information…"*

25. In *Lambeth London Borough Council v Ireneschild [2007] EWCA CIV 234* an issue of procedural unfairness arose based upon the fact that the respondent was not

provided with an opportunity to address the provisional views of the author of an assessment of her care and accommodation needs. Hallett LJ relied upon the fact that the material in the assessment was essentially derived from the respondent herself as one of the factors in deciding that there had been no unfairness. The defendant submits that the process identified is similar to the facts of the present challenge: the claimant was told what the issues were; was asked relevant questions and given an opportunity to put forward its best answers. The claimant contends that this was not a consultation case, the document was an internal report by one of the authority's own officers. Hallett LJ regarded as significant the fact that the process allowed for representations to be made after the assessment had been completed, it was not a final determination of an entitlement.

26. As to what has to be demonstrated: in *R (Smith) v North Eastern Derbyshire NHS Trust [2006] EWCA CIV 1291* May LJ stated that in such a challenge

> *"The defendants would have to show that the decision would inevitably have been the same and the court must not unconsciously stray from its proper province of reviewing the propriety of the decision making process into the forbidden territory of evaluating the substantial merits of the decision…"*

27. In considering the authorities cited by the parties I have paid particular attention to and given weight to those which consider a challenge to the consultation process. From the authorities the following principles can be identified:

i) The issue for the court is whether the consultation process was "so unfair it was unlawful" – *Devon County Council*;

ii) Lawful consultation requires that: i) it is undertaken at a time when proposals are still at a formative stage; ii) it must include sufficient reasons for particular proposals to allow those consulted to give intelligent consideration and an intelligent response; iii) adequate time must be given for this purpose; iv) the product of the consultation must be conscientiously taken into account when the ultimate decision is taken;

iii) Disclosure of every submission or all of the advice received is not required. Save for the need for confidentiality, those who have a potential interest in the subject matter should be given an opportunity to deal with adverse information that is credible, relevant and significant to the decision to be made. The degree of significance of the information is a material factor;

iv) The fact that the information in question comes from an independent expert or from the consultee is relevant but it is a combination of factors including fairness, the crucial nature of the advice, the lack of good reason for non disclosure and the impact upon consultees which are to be considered upon the issue of fairness;

v) What fairness requires is dependent on the context of the decision; within that the court will accord weight and respect to the view of the decision-maker;

vi) If the person making the decision has access to information but chooses not to consider it, that of itself, does not justify non-disclosure; it will be for the court to consider the reason for non-disclosure;

vii) A consultation process which demonstrates a high degree of disclosure and transparency serves to underline the nature and importance of the exercise being carried out; thus, non-disclosure, even in the context of such a process, can limit the ability of a consultee to make an intelligent response to something that is central to the appraisal process;

viii) The more intrusive the decision the more likely it is to attract a higher level of procedural fairness;

ix) If fairness requires the release of information the court should be slow to allow administrative considerations to stand in the way of its release.

The Assessment and Consultation Process

28. In March 2010 the draft service Standards were published following which each of the existing surgical centres was sent a Self-Assessment Template. The purpose of the exercise was to enable each centre to supply information and evidence to demonstrate that it met specified core criteria derived from the Standards or would be able to meet them in the future.

Self Assessment Template

29. The template contained an explanation of the evaluation process and the method of scoring, including the weightings to be applied to the scores. The text included the following:

> "**2. Evaluation process and scoring**
>
> Evaluation process
>
> The evidence you supply in this exercise will be assessed as part of the evaluation process we will undertake, and will therefore ultimately inform the final recommendation. The entire evaluation process has 2 discrete stages – Assessment Evaluation and Configuration Evaluation. This process will fulfil the first stage of the Assessment Evaluation.
>
> The second stage of the Assessment Evaluation will be visits by the Assessment Panel to each centre… for one day in order to

review the current service against the criteria specified in the self-assessment. The visit will give the Panel the opportunity to meet all members of the team, to see the service in operation, and to gain assurance against all reported development opportunities in the self-assessment document…

It should be noted that the criteria and scoring process for the Configuration Evaluation have not yet been determined. This will be communicated to all stakeholders in due course. However, the criteria and scoring for the Configuration Evaluation is separate from the Assessment Evaluation. The information supplied in the assessment stage of the process will not have any direct bearing on the scoring of the configuration evaluation process."

…**Scoring**

Scores will be allocated against each criterion, which will come together as a final score for each centre. The scoring process will take place as follows:

Before the assessment visit, each member of the Panel will score these self assessment submissions using the criteria detailed below.

An assessment of the financial viability of the proposals will be conducted by the NSC Team and supplied to the Panel for their consideration, alongside the completed self assessments.

Subsequently, during the assessment visits, the first stage scores will be validated by each member of the assessment panel, as a result of what they see, hear and observe during the day.

The scores will then be cross checked between all panel members at the end of each visit, to ensure consistency and rationality.

Feedback will be given to each individual centre by letter to the Chief Executive when all assessment visits to all centres have concluded (July 2010).

Individual scores for each centre will help identify the configuration options, which will then be tested against criteria such as ease of access, affordability and deliverability, and risks of reconfiguration. The exact scoring mechanism for this stage has yet to be determined.

For the Self Assessment Evaluation Stage, each question within the 9 self assessment criteria will be scored individually, as indicated below:

1. Inadequate (no evidence to assure panel members)
2. Poor (limited evidence supplied)
3. Acceptable (evidence supplied is adequate but some questions remain unanswered or incomplete)
4. Good (evidence supplied is good, and the panel are assured that the centre has a good grasp of the issues)
5. Excellent (evidence is exemplary)

Each question within that criterion will then be weighted according to the stated multiplier, in order to reach a final score for each question. The sum of these final scores will be the total score for that criteria.

The total scores for each criterion will come together as a final score for each centre…

3. How the Criteria for Self Assessment were derived

The criteria that this template asks for evidence against are as follows:

1. Leadership and Strategic Vision
2. Strength of Network
3. Staffing and Activity
4. Independent Services
5. Facilities and Capacity
6. Age Appropriate Are
7. Information and Choice
8. Excellence of Care
9. Deliverability and Achievability

Criteria 1 and 9 are derived from the need to review the strength of the organisation, in terms of its future sustainability and ability to ensure continuous improvement.

Criteria 2-8 as derived from the full designation standards document, which is detailed at Appendix 1. The designation standards document describes the proposed future model of care for Paediatric Cardiac Surgery Services. The standards will, in effect, be used for two purposes:

> As a tool for assessment
>
> A number of the standards are "core requirements" in order to pass the assessment evaluation stage of the process, and to be able to move forward to the configuration evaluation. These are represented by criteria 2 to 8.
>
> As a commissioning service specification
>
> Once the reconfiguration is complete, and centres are designated, they will be expected not only to have the core requirements in place, but also to demonstrate to commissioners how they will achieve the standards, within timescales specified. The standards document will therefore be used as an ongoing commissioning service specification which will be managed through local performance management processes."

30. Criteria 1-8 contained sub-criteria. 'Leadership and Strategic Visions' contained 11, the remaining criteria contained 3 identical sub-criteria briefly described as:

    a) Current achievements against standards

    b) Development plans

    c) Meet the minimum of 400 procedures.

31. Leeds and Newcastle submitted their Self-Assessment Templates in March-May 2011. SCG commissioners were asked to provide commentary on the assessments as a form of validation. Centres were sent two subsequent Templates: a Financial Template, and a Template relating to Nationally Commissioned Services (NCS). The NCS template asked centres if they wished to be considered as providers for paediatric cardiothoracic transplantation (provided at the time by Great Ormond Street Hospital "GOSH" and Newcastle), extra-corporeal membrane oxygenation (ECMO) (provided by GOSH, Newcastle and Leicester) and complex tracheal surgery (only provided at GOSH).

Kennedy Panel assessment

32. On receipt of the Self-Assessments, Kennedy Panel members individually allocated initial scores to each centre's submissions. They visited the centres: "We interrogated the centres on the information they had provided to us, to see what the story was behind the figures and data provided". (Witness Statement, Professor Sir Ian Kennedy). The statement continues:

> "…Using the evidence that we had been given and had gathered, the Independent Panel members assessed the centres current performance in meeting the Standards and the robustness and achievability of the centres' development plans for meeting the Standards, if they were not currently met…We were as interested in the centres' ability to meet them in the future, and the realism and feasibility of their ambitions in this respect…Each sub-score constituted a judgment on a number of factors, and the views of the different experts on the Independent Panel – drawing from their own experience - on those factors. The scores were composite of these factors…"

Each centre was said to be scored independently of the others. The final consensus score was the result of discussion.

33. Weightings (identified in the template) were applied to the scores by the NSC team. Sensitivity analyses were applied to test the robustness of the process.

34. The sub-scoring for Newcastle and Leeds was as follows:

Criteria	**Newcastle**		**Leeds**	
	consensus	**weighted**	**consensus**	**weighted**
1.	**45**	**99**	**36**	**78**
2.	**10**	**45**	**11**	**48**
3.	**8**	**73**	**8**	**73**
4.	**11**	**48**	**14**	**62**
5.	**12**	**56**	**9**	**42**
6.	**10**	**29**	**11**	**31**
7.	**9**	**27**	**11**	**31**
8.	**12**	**48**	**9**	**36**
9.	**0**	**0**	**0**	**0**
	117	**425**	**109**	**401**

35. The Steering Group convened to consider the applications to provide Nationally Commissioned Services (NCS). It reported in July 2010 that the three current providers of services, (GOSH, Leicester and Newcastle) were delivering good outcomes, NCS should be maintained in these locations if possible. At that time it was considered that Birmingham could develop a transplant and ECMO service if required.

36. In August 2010, each centre received initial feedback on the Kennedy Panel assessments by letter from the Director of National Specialised Commissioning which stated that compliance with the standards had been scored, and a summary of findings specific to the centre was provided. Centres were informed that the ninth criterion, "deliverability and achievability", which focused on the financial affordability of

proposals submitted by the centres, had not been scored by the Kennedy Panel, and would instead form part of the consideration by the JCPCT in developing proposals for reconfiguration.

37. On 28 September 2010 the Kennedy Panel attended the meeting of the JCPCT to report on the outcome of the assessments. The JCPCT were given the final consensus scores (but not the sub-scores). The centres were ranked as follows:

Evelina	535
Southampton	513
Birmingham	495
Great Ormond Street	464
Royal Brompton	464
Bristol	449
Newcastle	425
Liverpool	420
Leicester	402
Leeds	401
Oxford	237

38. The minutes of the JCPCT meeting record discussion relating to disclosure of the sub-scores:

> "Dr Carroll requested the Committee be given access to the subcomponents of the panel's original scorings. Mr Glyde said a summary report had been offered to members at a previous meeting but not taken up by members. Ms Claire stated that she did not wish to see the detail: she believed that the expert's interpretation was authoritative. Sir Ian Kennedy highlighted the risk of judicial review; the process was undermined if data was provided when experts had been appointed to make a judgment. Ms Llewellyn shared Sir Ian Kennedy's concerns. Asked if the detail was disclosable under the Freedom of Information Act, Mr Glyde said he believed that it would be once the process was concluded.
>
> Ms Christie suggested that the summary report of key findings from each centre be provided by the panel Sir McKay endorsed Ms Christie's suggestion and advised the Committee to be disciplined in resisting requesting further detail once the summary was provided."

39. Professor Sir Ian Kennedy's evidence as to the advice which he gave at the meeting was that the JCPCT should limit their judgment to the context in which they had the opportunity to test the evidence. The JCPCT was free to use the conclusions and report as they wished but "questioning the scores themselves would take them into an area in which they were not expert." Sir Ian's recollection of the reference he made to the risk of judicial review in the minutes was "…this was a caution that the process as

a whole needed to be conducted fairly, and with considerable care, and of the dangers of JCPCT acting beyond its expertise."

40. In December 2010, the Kennedy Panel produced the "Report of the Independent Expert Panel" ('the Kennedy Report'). It set out the total scores and a narrative assessment of each centre's compliance with the specified criteria. For each centre, there was an overview followed by an assessment of compliance and gaps in compliance in relation to each of the individual template questions. This was shared with the centres and made public in January 2011.

41. Professor Sir Ian Kennedy described his report as "a very substantial piece of qualitative analysis of each centre against these standards. It analysed whether the centres could meet the standards now or in the future. The full report provides an explanation for the scores, and would enable an informed challenge to our findings of fact – as mounted by Leeds Teaching Hospitals NHS Trust in its response to the consultation…"

42. The summary for Leeds noted the following:

> "**Areas of compliance**
>
> The Network is currently very strong and the trust has good relationships with all key stakeholders
>
> All critically interdependent services are currently co-located
>
> The PICU currently meets core PICU standards and there are two separate rotas for anaesthetists
>
> The Trust has good facilities that can sustain an increase in activity to 400 procedures per year
>
> The Trust had implemented best practice from Ohio
>
> **Areas of weaker compliance**
>
> The Trust did not demonstrate innovative working practices
>
> The Trust has no plans to use telemedicine for paediatric cardiac surgery
>
> Waiting lists at the trust are long
>
> There are concerns about future staffing capacity in PICU and theatres
>
> The trust has no transition nurse
>
> The Trust did not sufficiently describe an academic research portfolio"

43. The main body of the report described areas in which Leeds complied with the standards, including co-location of relevant paediatric services on one hospital site, compliance with the paediatric intensive care standards, a strong network, and a stand-alone paediatric retrieval service. Areas of non-compliance identified for Leeds included an unsustainable model of paediatric intensive care, inefficient working practices, limited confidence in the leadership within the service, limited evidence of the strategic importance of paediatric cardiology services to the Trust, limited evidence of relevant academic research and clinical innovation, limited confidence in the Trust's ability to develop a larger congenital heart network and limited confidence in the Trust's development plans and its understanding of the scale of the challenge in this regard.

44. The summary for Newcastle noted:

> **"Areas of compliance**
>
> The Trust has a strong record of delivering high quality services and had a strong clinical governance structure
>
> The Trust demonstrated highly innovative work, especially with regard to the use of Berlin Hearts. It was the first centre to set up a cardiac genetics database. The estates strategy was strong
>
> All services are co-located as per the standards
>
> **Areas of weaker compliance**
>
> Because of the small and specialist nature of the PICU it has insufficient staffing levels to maintain a consultant led service
>
> There was limited information about how the trust would work with other hospitals in the network, including hos the IT strategy and transition would be applied within the network, and how it would resolve the concerns working with Carlisle.
>
> There is no clinical psychologist or Children's Cardiac Specialist Nurse"

Configuration options assessment

45. Between July 2010 and February 2011 the JCPCT, under the chairmanship of Sir Neil McKay, considered the options for the national configuration of the service. In July 2010, the JCPCT agreed that the following principles should apply:

    i) Each option (cluster of centres) should ensure that all centres included within in it are able to carry out a minimum of 400 procedures per year, ideally 500 and options should contain six or seven centres;

ii) Due to the size of its catchment population, London requires at least two centres;

iii) Oxford should be discounted due to sub-optimal quality and lack of contribution to access times;

iv) Birmingham to remain in all options due to high referrals from a large catchment population;

v) Bristol and Southampton are mutually exclusive but one required in all options to serve local populations;

vi) Two sites are required in the "North" but patient numbers are insufficient to sustain three: for demographic and geographic reasons, options to include Liverpool and *either* Newcastle or Leeds.

46. At a JCPCT meeting on 11 January 2011 two additional criteria were applied which required, *inter alia*, that options must include a minimum of three centres capable of providing ECMO services, two centres providing transplant services and one providing complex tracheal surgery. The JCPCT then considered which of the viable options should be put forward for consultation. The options were scored against weighted evaluation criteria which were the product of consultation undertaken by the NSC team. The following evaluation criteria (in order of importance) were agreed for assessing the options:

i) Quality:

(a) centres will deliver a high quality service;
(b) innovation and research are present;
(c) clinical networks are manageable;

ii) Deliverability:

(a) high quality NCSs will be provided;

(b) the negative impact on other interdependent services will be kept to a minimum, as will negative impacts on the workforce;

iii) Sustainability:

centres are likely to perform at least 400-500 procedures; will not be overburdened and will be able to recruit and retain newly qualified staff.

iv) Access and travel times:

negative impact of travel times for elective admissions are kept to a minimum; retrieval standards are complied with.

47. "Quality" contained three elements. The Kennedy Panel consensus scores for each centre were used by the JCPCT to score the "high quality service" element within the option ranked first of the four. Options were scored on the basis of the extent to which they met the criteria: ranging from: 1 (some elements met) – to 4 (criteria exceeded). Weightings were applied to the scores for each of the four criteria to reach a total score for each option. Options were then ranked.

48. On 16 February 2011, the JCPCT met in public to discuss and agree the Pre Consultation Business Case (PCBC) and the Consultation Document. The four reconfiguration options proposed were:

Option A: Newcastle, Liverpool, Leicester, Birmingham, Bristol, London x 2
Option B: Newcastle, Liverpool, Birmingham, Bristol, Southampton, London x 2
Option C: Newcastle, Liverpool, Birmingham, Bristol, London x 2
Option D: Leeds, Liverpool, Birmingham, Bristol, London x 2

Consultation Evaluation

49. The Consultation Document "Safe and Sustainable: A New Vision for Congenital Heart Services in England" issued on 1 March 2011, set out the process by which these options had been identified, and the evidence which had informed the proposals. The analysis was supported by the PCBC. The consultation took place between 1 March to 1 July 2011. During the four month consultation period about 50 public events were held, 77,000 responses were received. Events held in Leeds attracted many participants, including representatives of CHSF. Issues such as transport infrastructure, travel times and the co-location of paediatric and adult services on one site at Leeds were raised at the events in Leeds. No query or issue arose in respect of the Kennedy Panel's sub-scores. Consultation responses were analysed by Ipsos MORI and presented in a written report.

Consultation responses

50. Leeds submitted a detailed response to the consultation, arguing its case for retention of Leeds as a centre for paediatric cardiac surgery whilst raising concerns about the review process. It identified advantages in retaining Leeds, and where it had the edge over Newcastle. In a section headed "Issues and concerns in relation to the Safe and Sustainable process" the following was stated:

> "In broad terms our concerns relate to
>
> Matters of factual accuracy and consistency.
>
> Matters of scope, context and approach in the review and with the options appraisal.
>
> 3.1 Matters of factual accuracy and consistency

> The final report received from Professor Ian Kennedy's Review in January 2011 was different from the draft letter about the report that the Trust had commented on in 2010 and contained a number of inaccuracies around the PICU configuration and specialist nurse posts. Although the Trust had responded to the inaccuracies in the draft letter, a number of them were not corrected in the final report from Sir Ian Kennedy. There was not an opportunity to correct the final report before this information was placed in the public domain, and indeed members of the Safe and Sustainable team have repeated this information in the media.
>
> Despite requests, the details of Sir Ian Kennedy's expert panel's scores for Leeds have not been shared with us nor have the errors been rectified. The Pre Consultation Business Case (PCBC) and the final consultation document attempt to describe the process and assumptions that the JCPCT used to shortlist the final four options that had been put to the public…"

It should be noted that there had been no previous request by Leeds for disclosure of the details of the Kennedy Panel's scores.

51. Within the same part of the response complaint was made that the ratings given to access and travel times were not consistent with Leeds own polling; challenge was made to the inclusion of Newcastle in three of the four options when it was said that it could only just reach 400 procedures whereas Leeds could easily deliver over 500 and it was noted that the Kennedy Panel had scored current networks in a differential way based on current practice and track records, whereas the scoring of the options had not adopted this approach but had given all potential options the same score.

52. Comments on matters of "scope" included challenge to the definition of co-location used by the Kennedy Panel; the failure to take adequate account of the population density of Leeds; and assumptions about patient flows. The response also questioned how, if the Kennedy Panel had decided not to score centres on deliverability or achievability, matters such as impact on the workforce, recruitment etc. would be considered.

53. Leeds proposed an alternative configuration option which replaced Newcastle with Leeds. It did not challenge the principle that Leeds and Newcastle were mutually exclusive as stated in the Consultation Document. Finally, Leeds set out in detail its proposals for future network arrangements, the Kennedy Panel having identified that as a gap in compliance.

54. Sharon Cheng, Director of CHSF submitted a response to the consultation which expressed strong support for the Leeds centre. The response echoed points made by Leeds, drawing attention to the "gold-standard" co-location of children's services at Leeds and its extensive cardiac network. The view was also expressed that the

provision of NCS had been allowed to dominate. The CHSF response did not challenge the assessments of the Kennedy Panel nor did it ask for the Kennedy sub-scores.

55. On 29 June 2011, the JHOSC submitted an initial response to the consultation which questioned the definition of co-location and predicted patient flows from the region. It noted the high level of surgical activity at Leeds, and suggested that too great an emphasis was being placed on NCSs. After the end of the public consultation, the JHOSC made a number of requests for further information which included a request for the sub-scores from the Kennedy Panel. The JHOSC's full response to the consultation, submitted on 5 October 2011, noted its concern that requests for information, such as the sub-scores agreed by the Kennedy Panel, had not been met.

56. Thereafter, the JHOSC complained to the Secretary of State pursuant to Regulation 5 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 that the JCPCT's consultation with the JHOSC had been inadequate and that information requested, including the sub-scores, had not been provided in advance of the consultation deadline. The IRP, considered the complaint, and advised the Secretary of State that it did not recommend a full review into the matters raised. The IRP noted that the detailed breakdown of the Kennedy Panel sub-scores had not been seen by the JCPCT: "…it was not material to the production of the consultation document, nor will it be material to the decision making process. The JCPCT's commitment to release this information once it has made its final decision is, in our view, reasonable." The Secretary of State accepted the IRP's advice and informed the JHOSC on 23 February 2012. No challenge has been brought to the decision of the Secretary of State.

Further Kennedy Panel Assessment

57. In August 2011, following submissions from consultees, the JCPCT requested that the Kennedy Panel consider and advise further in relation to three specific matters: (i) alleged factual inaccuracies in the assessments of the Leeds and Leicester centres, (ii) the definition of co-location used by the Panel and (iii) its application in relation to 3 provider centres: the Royal Brompton in London, the Glenfield Hospital in Leicester and the Freeman Hospital in Newcastle. The Panel was asked to consider if any statements of fact required revision and whether there be revision to the previous scoring.

58. The Kennedy Panel met to consider these matters. Its Report ("Report of Sir Ian Kennedy's Panel in Response to Questions by the Joint Committee of Primary Care Trusts" dated 17 October 2011) rejected the suggestion of factual inaccuracy. It noted that questions had been raised previously about its assessment of PICU reconfiguration at the Leeds centre and its specialist nurse posts – but it had rejected these.

The Price Waterhouse Cooper (PwC) Report

59. In May 2011, PwC were commissioned to review assumptions about patient flows and clinical networks in the four configuration options being consulted upon. The work focused on 22 postcodes which were broadly equidistant to two or more surgical units. The Newcastle network was of particular concern, because some users of the Leeds unit expressed a preference during the consultation to travel to centres other than Newcastle, should Leeds close. The report found that all networks could be delivered with different degrees of risk. It recognised more reluctance to consider travelling to Newcastle than to other centres. It also found 96% of clinicians stated that they would refer in line with the networks envisaged, and that parents would follow the advice of referring clinicians. Accordingly PwC concluded that, if managed, all the networks in the four options could work.

KPMG work: sensitivity testing and option appraisal

60. KPMG carried out sensitivity testing and in-depth analysis following the consultation process taking into account the issues raised by consultees and the alternative options being considered. The scoring of "Quality" was altered to take account of the concern of consultees that it had not received adequate prominence. The principle that Newcastle and Leeds were mutually exclusive remained. New assumptions and options were considered. Option G (including Leeds rather than Newcastle) was one of the new options introduced and scored. Option B received the highest overall score as it scored highest for quality and deliverability. Option G scored well for quality and highest for travel and access and came second in the overall scoring.

The Advisory Group for National Specialised Services ('AGNSS') Report

61. The cessation of paediatric cardiac surgery at three of the providers would necessitate the re-location of one or more of three NCS that require on-site back-up from a consultant congenital cardiac surgeon. AGNSS advised the JCPCT that whereas ECMO services could be developed at Birmingham, there were significant risks in a proposal to move Paediatric Cardiothoracic Transplant and 'Bridge to Transplant' services from Newcastle. AGNSS noted the conclusion reached by Birmingham Children's Hospital, the only other potential provider of transplant services in England, that it was not able to sufficiently address these complex risks. AGNSS also advised the JCPCT that Newcastle provided excellent clinical outcomes for transplant services and had developed expertise in aspects of paediatric cardiothoracic transplantation that were unique to the United Kingdom.

The Decision Making Business Case ('DMBC')

62. In June 2012 the Safe and Sustainable Review of Children's Congenital Cardiac Services in England was completed in the form of a decision making business case. It included the core recommendation that Option B should be implemented and the designation of congenital heart networks led by the centres contained within it. It was not made public until after the Decision in July 2012. Its purpose was to summarise the key evidence and issues from the consultation and assist the JCPCT in its decision-making. Six new options were considered viable, formally scored and put forward for consideration. These included Option G which contained the same centres as Option B, save that Newcastle was substituted by Leeds. When scored, Option B

remained the highest scoring option followed by Option G. Nine sensitivities were tested, and the options rescored. In each of these exercises, Option B remained the highest scoring option.

63. Section 12, headed "Testing the evidence for option B", advised:

> "[A]lthough the scoring process has consistently highlighted option B as the highest scoring option the JCPCT should not regard the scoring process as determinative. Rather the JCPCT's decision should be based on a consideration of all of the available evidence in the round, including the evidence for and against alternative options".

Relevant matters considered in this section included the importance placed by consultees on quality, the definition of co-location, ways to mitigate increased travel times, population density and projections, the "validity of the Newcastle network" and advice relating to the NCSs.

64. The DMBC identified the importance of high quality care as being one of the most frequently mentioned issues for respondents discussing either specific hospitals or the options more generally. Its importance was reflected in the following at page 154:

> " Some respondents suggested that the outcome of the Kennedy's Panel Report was that there was no material difference across the centres, such as the suggestion that "*all centres are within 95% of the top scoring centre"*…
>
> Such was the concern of how the JCPCT should reflect the findings of the panel around the scoring of "quality" that the chair of the Panel, Professor Sir Ian Kennedy wrote to the JCPCT in October 2011:
>
> *"the panel is of the view that it's report has identified important differences in the extent to which the centres can meet the quality standards in the future: panel members have reflected these differences in their scores and in the report. It is our view that the outcome of the panel's work would be rendered redundant were the JCPCT to interpret the report's conclusions thus finding that there are no material differences across the centres and their ability to meet the quality standards in the future. This interpretation would not be justified. To repeat, there are important differences.*
>
> It is therefore proposed that the sub-criteria "high quality service" has the greatest influence on the total score for quality based on a strong theme from respondents during consultation – that "quality" of service should be the most important of the JCPCT's considerations…".

65. In relation to NCS, the DMBC noted that under Option B transplant services would remain in their current locations. It recalled previous advice from the Steering Group that changes to NCS could be managed but noted that this assumed an alternative safe provider. Whilst Birmingham had been considered a possible alternative, recent capacity testing by the NCS team questioned this, and Birmingham itself doubted that it could develop a Transplant and "Bridge to Transplant" service to replace the Newcastle service within a three year time-frame.

The Decision

66. On 4 July 2012 the JCPCT met in public to consider and agree the recommendations of the Review, including which option to adopt for the reconfiguration of paediatric cardiac surgical services. In his witness evidence, Sir Neil McKay, Chair of the JCPCT, identified the key issues considered at the meeting and why the JCPCT chose option B:

> "There were two key reasons for the JCPCT favouring option B over option G. The issues were quite finely balanced, but the JCPCT was satisfied that the differences were conclusive. Firstly, and as demonstrated by the scoring, option B was the higher scoring option for quality. The second reason related to nationally commissioned services (NCS) and in particular the risks around relocating cardiothoracic transplant services, which would be needed if cardiac surgery services at Newcastle ceased"

Of that risk Sir Neil McKay stated:

> "the importance of retaining a safe transplant service was such that the scoring process carried out by the JCPCT (and the earlier quality assessment) would have needed to show a material difference in favour of option G, or there would have had to be another significant countervailing argument in favour of option G in order to counterbalance the risk. Again the issue of transplant was not itself determinative (that is, we did not decide on the basis of the issues relating to Birmingham's ability to undertake transplants) but it was a significant consideration".

Claimant's Case
Ground 1

67. In summary the claimant's position is:

(i). Without the scores the consultees could not sensibly, intelligently, or meaningfully respond to all that they had to in respect of the total scores and the Kennedy Report;

(ii). The scores were being used comparatively. It is not the claimant's case that the JCPCT were not entitled to rely on comparative scorings but if so it is a further

reason to disclose the sub-scores so as to enable centres to see how they compare and comment upon their comparisons;

(iii). The more information that is given the more intelligible and meaningful the response. The more productive and more transparent the consultation exercise the more information will be generated and thus improve the quality of the decision making;

(iv). During the consultation exercise Leeds requested the sub-scores as did the JHOSC and CHSF subsequently. If Leeds thought the scores were relevant what good reason was there to refuse disclosure. If disclosure were deemed appropriate after the consultation it makes no sense to have withheld the sub-scores prior to the decision making when disclosure could have been meaningful.

68. The Kennedy Panel's scores were important. They were relied upon by the JCPCT as a proxy for "quality", high quality service was given the highest weighting to reflect its importance. The scores fed directly into the final decision and were ultimately determinative of it.

69. In October 2011 Professor Sir Ian Kennedy wrote to the JCPCT indicating that there were important differences between the centres which were reflected in the scores. No consultee, in possession of the Kennedy narrative and only the total scores, could properly understand the "material differences" still less make informed and intelligent consultation responses in respect of the accuracy, or validity of the ranking process, as the absence of the sub-scores rendered it impossible for any centre to know how it had scored upon individual criterion. As to the defendant's argument that the information used by the Panel emanated from Leeds; the provision of the information cannot and does not provide any indication of the scoring subsequently attached by independent assessors.

70. Leeds were the most affected centre because they came bottom in the ranking, Oxford having been excluded. As the scores were relevant to the assessment, the breakdown of the scoring should have been disclosed to the centres whether or not the JCPCT proposed to look at it. If there is a public law duty to make information available to a consultee disclosure cannot be denied simply because one party does not wish to look at that information.

71. The claimant relies on the importance of the scoring against a background in which the chair of the JCPCT at a meeting in November 2011 is noted as having said:

> "Members had heard that financially there was little to discriminate between options G and B and that they were the best value for money. While there were many issues to be addressed in implementation, there was no showstopper to suggest that either option B and G could not work…"

Further, on 23 April 2012 the JCPCT met, by this time the advice from AGNSS had been received. It is noted that:

> "the Secretariat's advice to the Committee was that the relocation of the paediatric transplant service was not "a showstopper"; i.e. the issue of relocation of NCS should not dictate the final list of options for consideration on 4 July. However, AGNSS's advice was very strong evidence which should be fed into the scoring process around deliverability and into a consideration of the options generally".

72. As there was no 'showstopper' and Professor Sir Ian Kennedy had identified 'material differences' Leeds required proper disclosure in order to respond to an aspect of the process which had become central to the appraisal. Following disclosure and consideration of the sub-scores the claimant contends that it has concerns and doubts as to a) the accuracy of the scoring, b) the fairness of using the Kennedy scores as a comparative ranking tool and c) on the evidence then available to the JCPCT a fair comparative assessment of quality as between Leeds and Newcastle should not have ranked Leeds lower than Newcastle.

73. During the course of the hearing Leading Counsel on behalf of the defendant, the interested party and the Court pressed the claimant as to precisely what the case was as to concerns which could or would have been raised had the sub-scores been disclosed. As a result a schedule was prepared by the parties which represents, in summary, the claimant's case as to the points which would have been raised following disclosure of the sub-scores. The schedule is attached to this judgement as Annexe1.

Reason for non-disclosure of scores

74. The reason for non disclosure given by Professor Sir Ian Kennedy is noted in the JCPCT minutes of 28 September 2010. The subsequent refusal of disclosure by the IRP and the Secretary of State relies upon the fact that as the detailed breakdown of the scores had not been seen by the JCPCT it would or could not be material to the decision making process and thus did not need to be disclosed. It is the claimant's case these are plainly bad reasons.

Was it inevitable that the outcome would have been the same

75. The short answer is no, nor does the defendant contend that it was. In his statement Sir Neil McKay stated "even if the quality assessment (based in part on the findings of the Independent Panel) or the scoring more generally had favoured Option G in my view this may not have been enough to draw the JCPCT into choosing Option G". The claimant relies upon the use of the word "may", it being said that that is sufficient to justify a quashing of the decision for unfairness. The issues of ECMO, transplantation and the advice of AGNSS could never have been the 'trump cards' as was acknowledged in the advice that was given to the JCPCT to the effect that there were no "showstoppers".

Appendix One

76. During the course of these proceedings Newcastle's Self Assessment Template was disclosed. In respect of each of the core requirements: e.g. strength of network, staffing and activity, etc. the final question in each section was "Would your ability to meet this core requirement be affected by meeting the minimum stated volume of 400 paediatric cardiac surgical procedures a year? In identical form, in response to each such question are these words: "See appendix one outlining the Director of Finance's initial estimate of resources required to meet the quality standards and to increase activity."

77. In his written evidence Professor Sir Ian Kennedy identified the task of the Panel as including future compliance and the feasibility of proposals for such compliance. Appendix One represented the financial background to any future proposal. The Court was informed that the Kennedy Panel had not seen, and it follows, had not considered the content of Appendix One. No reason was advanced as to why this was.

78. The claimant's contention is that Appendix One indicated whether or not future compliance could be achieved, thus proper consideration of its content was of critical importance. Further, this part of the assessment of the core requirements was worth, after weighting, more than 47.5 % of the total available for "Quality". Shorn of the financial information provided by each centre Newcastle's answers to this question are simply statements of good intention which cannot properly reflect upon the comparative quality of the centres given the direct and important link of available funding. Thus, how can the scores fairly be relied upon as the determinative criteria in the configuration assessment? This is another cogent submission which an informed consultee such as Leeds is likely to have wished to make to the JCPCT having seen the sub-scores and the disparity in scoring.

Ground (2) Failure by the JCPCT itself to scrutinise or properly take into account the Kennedy sub-scores.

79. There was a duty on the JCPCT to carry out sufficient inquiry into the matter that was under consideration in *Secretary of State for Education and Science v. Tameside Metropolitan Borough Council* [1977] AC 1014. A material failure to take into account relevant considerations will justify the quashing of a decision – see *R(Alconbury) v. Secretary of State for the Environment Transport and the Regions* [2010] UKHL 23.

80. Where advice is proffered to a decision-maker – (here, by Professor Sir Ian Kennedy in 2011), an improper reason given by that adviser which exerts influence on the decision-maker may vitiate the consultation process or cause the decision-maker to fail to take into account relevant and material information which will vitiate the decision– *R(Evans) v. Lord Chancellor* [2011] EWHC 146 (Admin); *Goldsmith v. Wandsworth Borough Council* [2004] EWCA Civ 1170.

81. The claimant relies upon the following:

(i) Initially, at least, the JCPCT, or some members of it, thought that there was an expectation that the Kennedy sub-scores and underlying methodology would be disclosed;

(ii) To the JCPCT's knowledge, interested consultees had requested disclosure of the Kennedy sub-scores and this request had been refused;

(iii) Sir Ian Kennedy had expressly advised the JCPCT that there were '*important differences'* between the centres but had also advised them not to seek to look at the underlying data for fear of judicial review. That advice was bad. The JCPCT had an obligation to scrutinise and assess the information which underlay the Kennedy scoring, particularly as it then sought to compare and rank centres when Professor Sir Ian Kennedy had explained that the centres had not been scored one against the other;

(iv) As the JCPCT had only the Kennedy Report (or a digested summary of it) there was no way of ascertaining what the '*important differences'* between the centres were. The 'key' to understanding the weight which the Panel had allocated to aspects of 'compliance' or 'gaps in compliance' were the Kennedy sub-scores;

(v) The reliance on the advice of Professor Sir Ian Kennedy, meant that the JCPCT did not scrutinise the use of the Kennedy scores and the ranking table when they should have done so, in view of the fact that:

(a) The Self-Assessment Template had stated that the scores would not be used directly in the configuration assessment, when in fact that is precisely how those scores were being used;

(b) The Kennedy Panel itself had made clear that the Panel had not scored the centres against each other but in isolation and on their own merits;

(c) The Kennedy scores were now being used as the proxy for 'high quality service' in the configuration assessment which necessarily ranked Options against each other, and by necessary implication, would depend on a comparative ranking between centres. Thus the only relevant difference between Option B and Option G, the two highest scoring configuration options, was that Option B included Newcastle in substitution for Leeds. In short the configuration assessment quickly turned into a Leeds vs. Newcastle 'play-off', a fact recognised by the JCPCT itself (April 2012).

82. The JCPCT had a duty properly to scrutinise the use of the scores in the configuration process and to understand what were the '*material differences'* between the centres which the Kennedy Panel insisted were so important. They failed to discharge their duty to take into account a plainly material consideration, the sub-scores, which were the key to their understanding (a) how the respective scores had been arrived at and (b) whether those scores could properly be used for a comparative assessment in the way they were.

Defendant's Case
Grounds One and Two

83. Disclosure of the Kennedy Panel's sub-scores was not necessary to render the consultation process fair. In particular:

(i) Fairness does not oblige a decision-maker to disclose to consultees the underlying material which has informed judgments or assessments made by those who have advised the decision-maker, it does not even require the disclosure of the advice itself. In any event, disclosure of the advice, and a summary of the reasons for it, was done in this case, and is sufficient. Fairness does not require the disclosure of material which has not been considered or relied upon by the decision-maker;

(ii) Consultees were provided with sufficient information to make informed and intelligent responses to the consultation; they did in fact make such representations;

(iii) The information analysed by the Kennedy Panel was derived from the centres themselves: they were aware of the detail of such information; consultees had all the information concerning the assessments of the Kennedy Panel which was available to and relied on by the defendant;

(iv) Disclosure of the sub-scores would not have promoted sound or efficient decision-making, and would have been disproportionate.

84. The sub-scores did not add in any material way to the information placed before consultees. They were not "the key" to understanding the supposed "material differences" in quality between the centres or the Kennedy Report. Consultees were provided with sufficient information to enable them to understand the areas of strength and weakness identified by the Kennedy Panel in relation to each centre, and the differences between them. Most of the points now advanced by the claimant could have been, and in some instances were, advanced on the basis of the information provided to consultees. The history of the consultation shows that consultees were not prevented from probing the qualitative assessment made by the Kennedy Panel. Leeds, CHSF and other supporters of the centre made detailed representations as to why they felt the quality of Leeds had been underestimated, including by comparison with Newcastle. Challenges to the process were pursued. The Kennedy Panel reconsidered matters put to it and the defendant sought further advice from others, including PwC.

85. The configuration assessment depended on a number of criteria, of which quality was only one. The scores for "high quality service" depended on the number of the high or lowest ranking centres which were included in each option. Reliance is placed upon Sir Neil McKay's evidence that when the Decision was made, scores were only one mechanism used to inform the defendant's thinking:

> "Although the Independent panel's work was a major part of the assessment of "quality" it had no bearing on the JCPCT's assessment of deliverability, as set out below. I want to make it clear again that it was not just the scores themselves that informed the JCPCT's conclusions. The final decision was the product of two years of analysis and evaluation by the JCPCT,

> in the largest single service reconfiguration analysis that the NHS has undertaken to date".

86. The Kennedy scores were not determinative of the configuration assessment. If this were correct, it would be expected that the Brompton Hospital would appear in the reconfigured option, having been ranked fourth equal with GOSH. Equally there would be no place for Liverpool ranked fourth from the bottom below Newcastle.

87. In the configuration assessment, a very significant factor in preferring Option B to Option G was that Newcastle was one of only two centres to provide the nationally-commissioned transplant and bridge to transplant service. It was essential to retain two centres for this service, and the evidence before the JCPCT showed that transferring the service to another centre would carry significant safety risks. Thus, even if disclosure of the Kennedy Panel sub-scores might have permitted additional representations on the relative quality of Leeds and Newcastle to be made, it is very unlikely that such submissions would have affected the Decision.

88. Disclosure of the sub-scores was not necessary to render the process fair, it was unlikely to improve the quality of the decision-making. The sub-scores were not material which the JCPCT was obliged to take into account when making its decision.

89. Further, the decision not to disclose the sub-scores has already been the subject of independent scrutiny by the IRP and thereafter the Secretary of State. No challenge has been brought to the decision of the Secretary of State, although Councillor Illingworth, the Chair of the JHOSC, seeks to make the same complaint in his evidence in these proceedings.

Reason for non disclosure

90. As Sir Ian Kennedy explained, the aim was to safeguard the integrity of the process. The reference to judicial review was "a caution that the process as a whole needed to be conducted fairly, and with considerable care, and of the dangers of the JCPCT acting beyond its expertise". Sir Neil McKay's view was that the narrative in the Kennedy Report was sufficient; it was this which informed its decision-making. As Professor Sir Ian Kennedy had pointed out to "check" their work would have required the JCPCT to have access to all the evidence to which the Kennedy Panel had access. This was impossible and disproportionate. The JCPCT was entitled to entrust the task of assessment to an expert Panel, and to consider the Panel's report of the outcome of that work, and its final judgments (the overall scores) on each centre. The material considerations, to which the JCPCT was obliged to and did have regard were the views of the Panel and the reasons why it had formed those views.

91. The receipt of a "flood" of such material from consultees would have greatly increased the complexity, length and cost of the consultation process, to no public benefit. Not only was the decision not to consider or disclose the sub-scores one which the defendant was entitled to make: it was a sensible and proportionate decision, conducive to efficient decision-making.

Disclosure would have made no difference

92. On the facts, it cannot sensibly be argued that disclosure of the sub-scores would have altered the Decision of the JCPCT to chose Option B:

(a) Sensitivity testing undertaken to address the complaint that the merits of Leeds as a centre had been underestimated, still resulted in Option B scoring higher than Option G;

(b) The Kennedy Panel assessment and scores were only one element in the decision to select Option B. A vital element in evaluating the configuration options was that Newcastle provided NCS; in particular a transplant and bridge to transplant service, which the JCPCT was advised could not safely be developed at an alternative centre within acceptable time scales. The JCPCT was entitled to give this factor considerable weight.

93. In the circumstances, there is no realistic prospect that disclosure of the sub-scores would have affected the decision of the JCPCT.

Appendix One

94. The assumption that Appendix One was relevant material which the Kennedy Panel had to assess in order to evaluate Newcastle's response to the identified question (c) is incorrect. What the question required was an explanation from each centre of the way in which its services and facilities would have to be extended and how they would implement such expansion including the risks attendant upon it in order to meet the minimum number of 400 procedures per year. It did not require the centres to state how the expansion would be funded. The fact that Newcastle referred to Appendix One, a financial appendix, in respect of its answer to question (c) does not make the document relevant to the Kennedy Panel's assessment of those answers. The Kennedy Panel did assess question (c) as demonstrated by the witness statement of Professor Sir Ian Kennedy and the analysis in the Kennedy Report which contains judgments of the centre's development plans. The financial appraisal of the centres was carried out by the Secretariat/ NSC Team in conjunction with the centres and local commissioners and the conclusion was that all potential configuration options were affordable.

Ground Two

95. The following additional points, were made in response to Ground Two. The defendant relied on the judgment of the independent experts it had appointed but also had available to it the full explanation of their judgment and reasoning. It challenged and scrutinised the advice received to the extent that it was both necessary and proportionate to do so. The JCPCT was entitled to entrust the task of assessment to the Panel and to consider the Report of the outcome of that work and its final judgment. The material considerations to which the JCPCT was obliged to have regard and did; were the view of the Panel and the reasons why it had formed those views. It is not accepted that the advice given by Professor Sir Ian Kennedy was bad

advice, in any event, it is irrelevant. The question for the court under Ground Two is whether the sub-scores were or were not a material consideration to which the defendant was obliged to have regard.

The Interested Party

96. The Newcastle Upon Tyne NHS Foundation Trust comprises a cluster of hospitals in Newcastle which include the Freeman Hospital and within it the site of the Cardiothoracic Centre, the Children's Heart Unit and the Institute of Transplantation; other specialist units include the Northern Centre for Cancer Care, the Liver Unit and the Great Northern Children's Hospital. The interested party had not intended to become involved in these proceedings but following service of a number of witness statements by the claimant which were said to contain inaccurate and professionally derogatory information the Trust felt an obligation to set the record straight. The interested party filed a number of statements properly identifying the facilities and the care provided at Newcastle. It is the only Trust in the country to provide all cardiac care from conception, through birth, childhood and adulthood. The Freeman Hospital is one of only two children's cardiac pulmonary transplant units in the UK, it is among the top 5 centres in the world, within this field and has an international reputation.

97. In skilful and succinct submissions Miss Morris QC on behalf of the interested party sought to identify its strengths as a centre and in general terms supported the case for the defendant. During the course of these proceedings there appear to be a retraction, of sorts, of part of the evidence given by one of the claimant's witnesses in respect of Newcastle. Mr Havers QC made clear that it was no part of the claimant's case to cast aspersions on the quality of the care or the facilities provided by Newcastle. The Court was grateful for the clarification. In view of this clarification and the interested party's support for the case of the defendant, I hope I do no disservice to the quality of its submissions if I specifically consider the submissions made on behalf of the defendant.

The claimant's standing within these proceedings

98. The defendant submits that the claim should be dismissed because the claimant does not have a sufficient interest in the matter to which it relates contrary to Section 31 (3) of the Senior Courts Act 1981 which provides that the court should not grant [permission] unless it considers that the applicant has a sufficient interest in the matter to which the application relates. The defendant submits that the claimant is a shell company, founded solely for the purpose of this litigation. It has taken no part in the consultation process. As a corporate entity it has no involvement in the provision of paediatric cardiac services, it is not affected by the decision which it seeks to challenge.

99. It is unclear who the claimant is or whose interests it represents. The claimant is supported by representatives of the Leeds' centre of the CHSF and the Chairman of the JHOSC. CHSF's response to the Consultation Document made no reference to nor request for the Kennedy Panel's sub-scores. The JHOSC's request and subsequent

complaint in respect of the sub-scores was dealt with by the Secretary of State in respect of whose decision no challenge has been raised.

100. As to the Petition on which the claimant relies it is the defendant's contention that the Petition was organised and submitted by CHSF. The financial contribution came largely from CHSF which is unable to bring this claim because of advice received from the Charity Commission in September 2012 namely that bringing the claim might be incompatible with the aims of the charity whose object is the "advancement of the relief of sick children, and adults with congenital heart conditions, within the Area of Benefit"; the point being that Newcastle came within the same area. Further the Petition states its support for the Leeds centre but there is nothing to suggest that the signatories support the de-designation of Newcastle.

101. The claimant contends that it has sufficient interest. Sufficient interest is the remedy afforded by judicial review; in this case the quashing of the reconfiguration decision on the grounds that the consultation process was unfair and flawed. The claimant plainly has an interest in that remedy. The majority, if not all of the individuals who have contributed to the fighting fund, together with the Directors of the claimant, would have a direct sufficient interest in their own right had they brought the claim as individuals. Some of those individuals are clinicians, others are members of the public. The adverse costs in litigation are such that no citizen of ordinary means would prudently contemplate bringing this litigation as an individual. Incorporation was and is the proper means of allowing the interests of a substantial number of persons who consider the defendant's decision to be unfair and unlawful to be jointly represented. There is no obvious better placed challenger, in fact there is no other challenger.

102. I am satisfied that the claimant has sufficient interest in these proceedings. The claimant represents many individuals who have contributed financially in order to bring these proceedings. It includes individuals who have been or could be directly affected by the closure of the Leeds Unit and clinicians who work within the unit. Incorporation, following the intervention of the Charity Commission, was a proper means of allowing the interests of a substantial number of such persons to pursue this litigation.

Conclusion

103. This was a comprehensive consultation, lasting a matter of months and prompting 77,000 responses. Thought and care was given to the consultation process both as to its content and implementation. When considered necessary, independent work or advice was commissioned; professional groupings provided advice when requested. Those responsible for, and involved in, the setting up and implementation of this process aimed to provide one which was informed, detailed and transparent.

104. One aspect of the process were the assessments of the relevant centres provided in the form of scores by the Kennedy Panel. As an independent panel, primarily comprised

of experts in the relevant field, it is accepted that their scoring would involve the exercise of professional judgment. As the process of evaluation developed, the importance of the criteria of quality increased and within it the sub-criterion of high quality service for which the Kennedy scores were a proxy.

105. The minutes of the JCPCT meeting 1 September 2010 note that Oxford was to be excluded from all options because it scored so significantly lower than its nearest comparator. Sir Neil McKay was asked whether any other centres should be excluded, given that quality became more important amongst closely ranked centres. It is recorded that he "summarised that quality would have to be the distinguishing factor…".

106. In the DMBC, Ipsos Mori reported of the public consultation that:

> "the quality of care provided was the most frequently mentioned issues for respondents discussing either specific hospitals or the options more generally. In fact, quality of care featured heavily throughout the consultation responses, as each of the questions posed in response form and in the letters and emailed requests submitted. There was a strong belief amongst many that quality should be the deciding factor in service planning."

107. To reflect the importance to be attached to this criteria "Quality" was given a weighting of 39/ 100 whereas Sustainability was given 25, Deliverability 22 and Access and Travel 14. Of the Quality criterion the DMBC records that the sub-criterion for "high quality service has the greatest influence on the total score for quality based on the strong theme from respondents during the consultation – that "quality" of service should be the most important of the JCPCT's considerations…"

108. The DMBC identified the total scores for 'Quality' as being:

1. Option B 3
   Option G 2

2.

	Option B	Option G
High quality service	3	2
Innovation and research	3	3
Clinical networks	2	3
	8	8

The totals of the sub-criteria scores were identical. It was the weighting given to 'high quality service' which resulted in an additional point for the overall score for 'Quality' for Option B. Immediately below the table it was stated that the proposed scores for the sub-criterion of high quality service were based on the scores applied by Professor Kennedy's Panel.

109. In my view these figures demonstrate:

a) the comparative closeness of the scoring;
b) the weighting attached to 'high quality service' reflective of its importance in the context of the overall scoring;
c) the significance attached to the Kennedy Panel's scores in the scoring of 'Quality', itself an important factor.

I do not accept the defence description of the sub-scores as being no more than 'underlying workings'. They provided the basis for the consensus score which was ultimately used as one of the most valuable and thus significant tools in the assessment of 'Quality' of the respective centres.

110. The DMBC advised the JCPCT to consider the extent to which each option included the three highest scoring centres (which would increase an option score) and the three lowest scoring centres in any option (which would lower an option score). Liverpool, Leicester and Leeds, in that order, were the lowest scoring. Newcastle was immediately above Liverpool, fourth from bottom. The point made on behalf of the defendant was that in order for there to be any real change not only would Newcastle have to come down the rankings, Leeds would have to move up. It is, however, of note that although Leeds was at the bottom of the rankings Newcastle was just outside the last three, some five points ahead of Liverpool.

111. The closeness of the scoring and the relationship of those scores to Leeds was noted at the public meeting of the JCPCT on 4 July 2012. The note of the meeting includes the following:

> "Mr Buck noted that the proposed scores for B and G were three and two respectively and the only difference was the presence of Leeds. Miss Banks confirmed this; Leeds had scored less well than Newcastle in the Kennedy Assessment which was the reason for this result. Mr Glyde explained that the report was in the public domain but the Committee had decided not to consider the sub-scores so it could not respond as to the specific strengths and weaknesses in each trust. For that reason, KPMG had focused on the overall score, which had placed Newcastle higher than Leeds in terms of overall compliance with standards. However, the next agenda item would explore the submissions put to the Committee of the relevant strengths of its service compared to Newcastle."

The claimant relies on this entry as demonstrating the point at the core of its challenge. The scoring is close, the only difference between B and G being the presence of Leeds which scored less well by reason of the Kennedy assessment. Crucially, the JCPCT acknowledged that it could not respond to the specific strengths and weaknesses in Leeds and Newcastle because it had decided not to consider the sub-scores. Mr Havers QC summarised the position thus: QED.

112. The question for this Court is: did the duty of fairness require disclosure of the Kennedy Panel's sub-scores? The sub-scores represented an expert evaluation which translated into a score which was the purpose of the assessment exercise. In my view the following matters are relevant to this question:

    i) The score assumed increasing importance and thus significance in the evaluation process and was ultimately determinative of the difference in the 'Quality' score as between Leeds and Newcastle;

    ii) The importance of 'Quality' has to be considered against a background in which a) it was identified as an important component by the many respondents to the consultation process; and b) 'important' and 'material differences' between the centres were said to have been identified by the Kennedy Panel, hence the advice given in October 2011 and recorded in the DMBC;

    iii) The DMBC advised the JCPCT that 'high quality service' had the greatest influence on the total score for 'Quality' and that 'quality of service' should be the most important of the JCPCT's considerations;

    iv) The Chair of the JCPCT identified 'two key reasons' for favouring Option B, the first being B's higher scoring for 'Quality';

    v) This was a consultation process relating to the provision of paediatric cardiac surgical services; a matter of the highest importance to any child requiring such care and his or her family.

113. Leeds, together with the other centres, was given a Self-Assessment Template which provided considerable detail as to the process. It completed the Template, received feedback and, subsequently, the total score and the narrative contained in the Kennedy Report. Was this sufficient? Leeds did not consider it to be so because in its response to the Consultation Document it requested the sub-scores, the JCPCT refused the request. I do not regard Leeds' request as unreasonable. I accept the claimant's contention that 'Quality' was not well differentiated in the Kennedy Panel scoring. The narrative in the Kennedy Report identified areas of compliance and non-compliance, but, this was not an audit, it was scoring.

114. As to the submission that as the information emanated from Leeds it would know what it was providing; this, in my view, misses the fundamental point namely that Leeds did not know how such information was being evaluated and scored. On any view the information was of relevance. For the reasons identified it became significant in the context of the process.

115. The sub-scores provided the clearest indication of the Panel's judgment upon separate sub-criteria. The fact that such scoring contained an exercise of professional judgment

does not preclude it from being a useful guide to the assessment still less prevent any request for reassessment or reappraisal. As evidence of the JCPCT's willingness to revert to the Kennedy Panel when queries arose relevant to their assessment are the instances when the JCPCT referred questions from Leeds and Leicester for further consideration. A similar process could have been carried out in respect of any queries upon sub-scores. Had this been done Leeds would have been better informed as to how to direct its response upon specific issues which became central to the appraisal process.

116. The submission that, in any event, the importance of the transplantation work at Newcastle would have 'trumped' the Leeds bid is at odds with the comment of Sir Neil McKay that following the AGNSS Report there were no 'showstoppers' and by his concession identified in paragraph 75 above. Further, the argument that disclosure of the sub-scores would have made no difference to the final result given that Option B maintained its highest score during sensitivity testing ignores the point that within such testing the same scores based upon the same sub-scores were being used.

117. For the reasons identified in paragraphs 112-116 above I am satisfied that fairness did require disclosure of the sub-scores to enable Leeds to provide a properly focussed and meaningful response. The refusal of the JCPCT to a specific request by Leeds for disclosure was, in my view, ill judged. The JCPCT was on notice of the importance of the criteria of 'Quality' and within it the use being made of the Kennedy Panel scores. With these considerations in mind, even if the JCPCT chose not to look at the sub-scores, consultees should have been given such an opportunity.

Scores used as comparators

118. In essence the claimant's case is that as the scores were being used by the JCPCT as comparators as between the centres this adds weight to the argument for disclosure of the sub-scores. There is no good evidence as to the thinking or practice of the JCPCT upon this point. A Secretariat briefing paper was relied upon but that goes only so far and is not direct evidence of what the JCPCT thought. In any event, the claimant, having succeeded upon the substance of Ground One, this submission takes the case little further.

Appendix One

119. The inclusion of Appendix One in the claimant's case arose following disclosure of Newcastle's Self Assessment Template. It was not identified at the outset of these proceedings. It has not been directly commented upon in witness statements provided by the defendant, that is an observation not a criticism. In the absence of specific evidence I proceed with a considerable degree of caution. In my view there is force in the defence submission that reference to the financial appendix was not relevant to question (c). If that is correct, why did Newcastle include the reference in its identical answers to the same specific question? As the evidence stands there is no satisfactory, or indeed, any answer. The defendant contends that this issue has nothing to do with

the non-disclosure of the Kennedy Panel's sub-scores, it is the claimant's case that it would have further added to the need to disclose those sub-scores. Given the unsatisfactory evidential position relating to this late point I do not believe the Court is in a position to make a determination.

Ground 2

120. The sub-scores provided the basis for the consensus score which was ultimately one of the most significant tools in the assessment of 'Quality' of the respective centres. The JCPCT knew that one of its observers (Dr Carroll) had raised the issue of scrutiny of the sub-scores, as had consultees. The JCPCT also knew that 'Quality' was becoming more significant as the process developed. In my view, and commensurate with their duty to properly scrutinise and assess all relevant evidence, the JCPCT should have considered the sub-scores. The JCPCT's stance, to the effect: 'it is appropriate to leave this to the experts', failed to reflect the significance of the sub-scores in that they provided the basis of what ultimately was the difference of one point in the critical 'Quality' scoring as between Leeds and Newcastle. If the JCPCT wished for clarification it could have sought the assistance of the Kennedy Panel. It follows, and I so find, that the sub-scores were a material consideration. Accordingly I find that the claimant succeeds upon its challenge upon Ground Two.

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Annexe One

A. Witness complaint about KP assessment of Leeds	**B. Communication of KP assessment during the Review**	**C. Was the issue addressed during the Review?**	**D. Claimant's response to D's submission**
Leadership and Strategic Vision KP was wrong to criticise the Trust's strategy as not giving sufficient emphasis to paediatric cardiac surgery: **Hunter** §21 [5/13/213]	Feedback letter [8/9/79] Kennedy Panel Report December 2010 [1/8/201]	Not raised by Trust (see Hunter w/s §21 [5/13/214]	C scored 3/5. 'Acceptable' C. did not know this. It appeared from the KP narrative 'compliance' that 'The Trust's overall strategy is clear, and demonstrates a clear direction of Travel for the Trust as a whole' One might have thought a score of '4' or '5' was appropriate. One couldn't guess that the matter mentioned in narrative would result in a score of '3' acceptable. Had Leeds known the scores they could have made submissions on this point as said in Hunter's statement.
Strength of Network KP was wrong to criticise the Trust's lack of plans to provide an effective Network in the north: **Hunter** §40.1- 40.3 [5/13/223-225	Feedback letter [8/9/79] KP Dec 2010 Report "no robust development plans" [1/8/204]	Response to consultation includes section on "future network arrangements" [3/1/12]	Having identified that the existing network was 'strong' Leeds only scored, 4, 4, 3 for the respective questions. 4 when they might reasonably have thought they would score 5, and 3, on the most weighted question, when they might reasonably have scored at least 4. Had they had the scores, Leeds could have focussed on these issues in their consultation response and sought a re-marking of these aspects of the assessment based on further evidence.

A. Witness complaint about KP assessment of Leeds	B. Communication of KP assessment during the Review	C. Was the issue addressed during the Review?	D. Claimant's response to D's submission
			Without the scores they did not know to what extent, if at all, the identified 'gaps in compliance' weighed with the Panel. They were have been shooting in the dark.
Staffing and Activity KP was wrong to criticise staffing capacity in PICU **Hunter** §41-43 [226-227]	Feedback letter [8/9/79] KP Dec 2010 Report – does not meet minimum activity thresholds and concerns about consultant cover for PICU [1/8/206]	Correspondence about PICU configuration alleged to be "factually inaccurate" [10/13/250-251, 10/15/256-257, and 10/19/271], KP Report October 2011 [3/4/63-64]	Again it is the scores that explain what weight if any, is attached to particular issues. The 400+ staffing and activity question was worth a maximum of 80 points. Leeds scored 3 x 16 =48), and would been able cogently to argue for a 4. That alone would have resulted in Leeds obtaining 16 more points overall. Leeds would have argued that objectively they should have scored better than Newcastle, on the basis of the evidence given. Newcastle however also scored 3. No such argument could be made without the scores.
Staffing and Activity KP was wrong to criticise the division of the PICU: **Blackburn** §10 [5/14/229-234]; **Darowski** §8-9, 11 [5/8/142-144]	Feedback letter [8/9/79] "concern about sustainability of current model for paediatric intensive care across two sites" KP Dec 2010 Report [1/8/206-207]	As above	Again, without the scores this is rather a meaningless item of 'non-compliance'. Based on the evidence it is able to provide Leeds would have been able to argue for a re-mark upwards. It seems that when KP agreed to recognise that the two PICUs were divided by a corridor

A. Witness complaint about KP assessment of Leeds	B. Communication of KP assessment during the Review	C. Was the issue addressed during the Review?	D. Claimant's response to D's submission
			and not located in different hospitals they did not concede that the thrust of the criticism should be withdrawn. Armed with the scores they could have pointed out that they provided consultant cover and Newcastle did not.
Interdependent Services KP failed to appreciate the value of co-location: **Darowski** §§13-15 [5/8/145-147]	KP Dec 2010 Report [1/8/167, 207]	Responses to consultation: Leeds [3/1/1-3, 8]; Darowski (Paediatric Critical Care Network) [16/15/276a-c]; CHSF [3/2/34-35]; JHOSC [12/5/43-46]. KP Report October 2011 [3/4/65-68] DMBC [3/7/169]	The point here is that it was the scores that mattered in comparison to Newcastle. Leeds scored 5,5,4 to Newcastle's 4,4,3. Leeds would have been able to argue in a focussed way for a 5, re. the 400+ question, where the only relevant criticism was the panel did not feel assured that there were strong plans in place to achieve the move of patients to the network. Leeds would also have been able to point out that the differential between Leeds and Newcastle did not represent what it perceived as the gulf between the centres.
Facilities and Capacity KP was wrong to mark Leeds down for having long waiting lists: **Illingworth** (2) §16(i) [5/10/166-167]	KP Dec 2010 Report "long-waiting lists ...not sufficiently identified as a risk [1/8/202] and "inefficiencies in current working practices" [1/8/209]	Not responded to by Leeds JHOSC response to consultation [12/5/47]	Again without the scores (Leeds in fact scored 3,3,3 to Newcastle's 4,4,4), Leeds could not mount a focussed attack on the supposed compliance deficiencies that resulted in a lower score. The issue (in the comparative

A. Witness complaint about KP assessment of Leeds	B. Communication of KP assessment during the Review	C. Was the issue addressed during the Review?	D. Claimant's response to D's submission
			assessment between Newcastle and Leeds) was worth 14 points overall. One can see from the KP report that Newcastle had a key gap in compliance '*concerns over capacity in PICU*'. Which does not appear to be reflected in its uniformly higher scores. Indeed one learns from Newcastle's self assessment template that an additional wing was required that could only be accommodated subject to funding **[CB1/2/28].** As Leeds has now learnt, the KP did not assess the financial viability of these plans at all.
Leadership and Strategic Vision Score for Estates and IT was unfair: recently reconfigured services and creation of Children's Hospital showed great leadership and vision Hunter §22-26 [5/13/214]	Feedback letter [8/9/79], Dec 2010 report [1/8/201]	Leeds refer to estate reconfiguration and Children's Hospital in self-assessment Template [1/3/45] and in Response to consultation [3/1/2-3] Hunter did not submit document referred to in her w/s §21	The same point as already made above. Without the scores Leeds could not know the importance or weight attached by the Panel to the matters identified in its narrative report. The focussed comments Leeds would have been able to make are articulated by Ms Hunter. They would have allowed Leeds to submit that Leeds ought to have scored 4 rather than 3 on two or three separate aspects of the assessment.
Strength of Network Differential in scores	Submission (formulated in §7	Submission made in Leeds' response to	The points above are repeated. Without the

A. Witness complaint about KP assessment of Leeds	B. Communication of KP assessment during the Review	C. Was the issue addressed during the Review?	D. Claimant's response to D's submission
should be greater: Illingworth §§39-41 [5/10/176]; Hunter §§27-40.3 [5/13/217-225]; Watterson (4) §§9-12 [5/9/154]	Counsel's written note 11.02.13) relies on KP Dec 2010 Report See also Note on PwC Report	consultation [3/1/7-8]; and JHOSC [17/1/17 §32]	scores, it is impossible to know what if any weight has been attached to what aspects of the identified 'compliance' or 'gaps in compliance' either in respect of Leeds in isolation, or in comparison with Newcastle. Leeds would have had a strong argument for a re-mark where Leeds only scored 4,4,3 to Newcastle's 3,4,3.
<u>Staffing and Activity</u> Scores not fair reflection of reality given Leeds had more staff and operating with waiting lists: Illingworth §42 [5/10/177], Hunter §42	Submission has no factual basis: centres have same staff patient ratio. See Kennedy w/s §35 [6/6/48] is a qualitative not numerical assessment KP Report Dec 2010 identified waiting lists as a risk [1/8/209]	Response to consultation compared L with N PICU [3/1/11]	Again, the point relates to the actual scores given under each heading. Armed with the scores a focussed criticism could be made that Leeds had been undervalued by the assessment panel on the basis of the objective evidence.
<u>Facilities and Capacity</u> Unclear why Newcastle scored so much higher than Leeds: Illingworth §42 [5/10/177]	No substantive submission is made. Sub-scores do not answer the question posed – why Newcastle scored higher		The sub-scores reveal that Leeds 3,3,3, scored lower than Newcastle 4,4,4, on each sub-question. Whether these are fair comparative scores knowing what Leeds knows about its own facilities and what it can read from the KP report about Newcastle's is precisely the sort of focussed submission Leeds would have been able to make.
<u>Age Appropriate Care</u> Scores do not reflect differences between the centres – Leeds children are	KP Dec 2010 report makes it clear Freeman is not an adult hospital. Hunter's repeated	Point made in Response to consultation [3/1/2-3]	Leeds scored 4,4,3, Newcastle 3,4,3. Yet Leeds children are treated in a dedicated

A. Witness complaint about KP assessment of Leeds	B. Communication of KP assessment during the Review	C. Was the issue addressed during the Review?	D. Claimant's response to D's submission
treated in a dedicated Children's hospital: Watterson §30-32 ; Hunter §44 [5/13/227]	assertion to contrary is incorrect. See Hasan (1) [5/16/249-253, 257] and (2)[5/17/297 - para 5.10: Watterson misunderstands relationship: Freeman unit operates as part of the Children's Hospital]		hospital and Newcastle is not. How Newcastle managed to score 4, to Leeds 3, on development plans is unexplained by the Kennedy narrative which says '*the panel did not deem all development plans complete as they did not demonstrate a grasp of the risks associated with sustaining the provision of age appropriate care'* **[CB1/8/169]** Leeds would have been able to make a focussed submission for a re-mrk, and an increase from 3 to 4.
<u>Interdependent services</u> Score did not properly reflect the differences: notably that Leeds is a single-site hospital Illingworth (2) §41(c) [5/10/177], failed appreciate value of co-location Darowski §§14, 16, 17 [5/8/146]	KP approach to assessment of co-location in Dec 2010 report [1/8/167, 207]	Point made by many respondents to consultation eg Leeds Response [3/1/1-3, 8]; JHOSC [12/5/43-46] Darowski [16/15/276a-c] Revisited in KP Report Oct 2011 [3/44/65-68]	The points above are repeated.
<u>Information and choices</u> Leeds should have got a higher score on "choices" to show respect for review's patient choice agenda; Watterson §47 [5/1/20]	The PwC work on patient flow is irrelevant to this criterion. This criterion is about ensuring patients and their families have access to good information and support	CHSF made the submission in consultation that indicated networks went against principle of patient choice [3/2/37] Considered and rejected by D (decided that was consistent with principle): DMBC [3/7/110] and 4/7 meeting [3/9/281-282]	PwC is not irrelevant. It is objective evidence that undermines the assumption that the Kennedy Panel truly assessed quality. The points above apply as to focussed submissions on issues by reference to the scores. On Information and Choices Leeds scored 4,4,3, to Newcastle's 3,3,3. The real focus would have been on

A. Witness complaint about KP assessment of Leeds	B. Communication of KP assessment during the Review	C. Was the issue addressed during the Review?	D. Claimant's response to D's submission
			Leeds' score of 3 on the 400+ question, particularly in the light of the very positive KP 'compliance' narrative at [**CB1/8/211]** and the limited area of non-compliance identified on the same page. This alone would have been worth 5 points.

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From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

DH Department of Health

POC1_767604, 767305 & 767306

The Lord Bernard Ribeiro
Chair
Independent Reconfiguration Panel
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London
SW1A 2NS

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15 MAR 2013

Dear Lord Ribeiro,

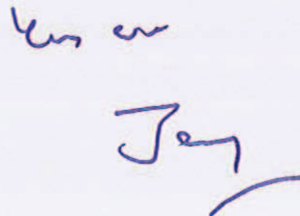
"SAFE AND SUSTAINABLE REVIEW OF CHILDREN'S CONGENITAL HEART SERVICES" – IRP REVIEW

I have always made it clear that the deadline for the Panel reporting back to me would be subject to further instruction as necessary in reflecting judicial review proceedings brought against the Joint Committee of Primary Care Trusts by Save Our Surgery Limited.

Given the recent decision by the Court to award in favour of Save Our Surgery Limited, I am today asking the Panel to report to me no later than 30 April 2013. Extending the deadline will allow the Panel and others to take account of the Judge's decision on redress, which we understand will be set down on 27 March 2013 and allow them to consider what implications this may have in moving forward.

Extending the deadline will allow the Panel and others to take account of the Judge's decision on redress on 27 March 2013 and to consider what implications this may have in moving forward.

I look forward to hearing from you.



JEREMY HUNT

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EXECUTIVE BOARD

WEDNESDAY, 13TH MARCH, 2013

PRESENT: Councillor K Wakefield in the Chair

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

191 Exempt Information - Possible Exclusion of the Press and Public

RESOLVED – That, in accordance with Regulation 4 of The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, the public be excluded from the meeting during consideration of the following parts of the agenda designated as exempt on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the public were present there would be disclosure to them of exempt information so designated as follows:-

(a) Appendix 1 to the report entitled, 'Acquisition of the Engine House, Giotto Tower, Verona Tower and Little Chimney at Tower Works, Globe Road, Holbeck, LS11 5QG', referred to in Minute No. 198 is exempt in accordance with paragraph 10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that it contains information relating to the financial or business affairs of any particular person (including the authority holding that information). It is considered that the public interest in maintaining the content of Appendix 1 as exempt outweighs the public interest in disclosing the information. This report relates to a property transaction, which in some cases could be deemed to be highly sensitive where competing parties are involved. In this particular case there are no competing parties, but one item of information in appendix 1 could be considered to be exempt and should be treated as such (and the Homes and Communities Agency (HCA) has requested that it be dealt with in this way). This is that the sum of dowry, if available in the public domain, could have an adverse impact on other transactions which the HCA is proposing.

192 Declaration of Disclosable Pecuniary Interests

There were no Disclosable Pecuniary Interests declared to the meeting, however:-

In relation to the item entitled, 'Housing Delivery', Councillor Golton drew the Board's attention to his membership of the Oulton and Woodlesford Neighbourhood Forum, which is involved in the Neighbourhood Plan process. (Minute No. 201 refers).

In relation to the item entitled, ‘Local Welfare Scheme’, Councillor A Carter drew the Board’s attention to the fact that a family member was in receipt of Council Tax Benefit. (Minute No. 211 refers).

193 Minutes

RESOLVED – That the minutes of the meeting held on the 15th February 2013 be approved as a correct record, subject to the replacement of the words ‘western route’ with ‘eastern route’ within Minute No. 176, entitled, ‘High Speed Rail Phase 2 (HS2) Announcement, 28 January 2013’.

DEVELOPMENT AND THE ECONOMY

194 Kirkgate Market Strategy

Further to Minute No. 42, 27th July 2011, the Director of City Development submitted a report setting out proposals for the redevelopment and refurbishment of Kirkgate Market, whilst also providing information on the short and longer term management arrangements for the Market.

With regard to proposals around the future management structure of the market, Members discussed the options for a future management model, considering the potential role which could be played by the traders. In conclusion, it was undertaken that a further report would be submitted to the Board in due course, in order to enable Members to consider this matter in more detail.

A Member reported the concerns that some traders had relayed to him in respect of how their leases may be affected by the proposals, and requested that contact was made with those traders in order to address such concerns.

RESOLVED –

(a) That in principle agreement be given to the proposed improvements to the interior of the Market, as summarised within paragraph 5.1 of the submitted report, in order that the project can be progressed and a detailed planning application submitted (completion of RIBA Work Stage D – Design Development), and also to enable the introduction of the scheme into the Capital Programme.

(b) That in principle agreement be given to progress the improvements to George Street, as outlined within paragraph 5.2 of the submitted report, as a separate project (approval from Executive Board will be sought subsequently to introduce this as a separate scheme into the Capital Programme).

(c) That agreement be given to continue to hypothecate future years markets surplus, as detailed within the submitted report, in order to fund prudential borrowing, which in turn will fund the capital costs of the redevelopment and refurbishment proposals.

(d) That in principle agreement be given to putting in place an alternative management structure within Leeds City Council, with a further report

being submitted to the Board in due course, in order to enable the Board to determine detailed proposals.

(e) That approval be given to an injection of £1,615,000 into the Capital Programme and approval also be given to the incurring of expenditure of £1,615,000 for the first phase of backlog maintenance and upgrade works in the Market, to progress the scheme design proposals to RIBA Stage D for the proposed redevelopment and refurbishment of the Market and also for the developer procurement competition for the George Street frontage.

195 Submission of the Transport and Works Act Order Application for the New Generation Transport (NGT) Scheme

Further to Minute No. 93, 17th October 2012, the Director of City Development submitted a report which sought approval for the submission of the Transport and Works Act Order (TWAO) application and associated Planning and Highway applications for the New Generation Transport (NGT) Scheme. In addition, the report sought approval for the necessary authority to spend £19,200,000 from within the existing Capital Programme in order to meet the Council's share in the development costs to progress the scheme to the start of the construction phase. Finally, the report also sought authority for the Council to enter into a Joint Venture Agreement (JVA) with Metro for the development of NGT and also for the Director of City Development to be provided with the necessary authority enabling him to finalise the detail of the JVA.

The Board noted the proposals in place to undertake a range of further consultation exercises, together with the legislative procedures which needed to be concluded.

Responding to requests that all affected communities needed to have the opportunity to engage in clear and meaningful consultation on this issue, assurances were given that such opportunities would continue to be provided, with the Executive Member for Development and the Economy and the Chair of the West Yorkshire Integrated Transport Authority offering to discuss related matters with community groups as appropriate.

A Member highlighted the need to ensure that the project's business model continued to be reviewed in light of any demographic changes that continued to occur across the city.

With regard to future consultation exercises scheduled for Belle Isle, a request was made that such consultation covered a wider geographical area than just the Belle Isle community.

RESOLVED –

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

(b) That approval be given for a report to be presented to Full Council recommending the submission of the required Transport and Works

Act Order (TWAO) and associated applications for NGT to the Secretary of State for Transport.

(c) That expenditure of £19,200,000 from within the existing Capital Programme to meet the Council's share in the development costs to progress the scheme to the start of the construction phase be approved, subject to the Director of City Development and the Director of Resources receiving regular updates in relation to proposed expenditure throughout the development phase.

(d) That approval be given for the Council to enter into a JVA with Metro for the development of NGT, and that the necessary authority be delegated to the Director of City Development in order to enable him to finalise the detail of the JVA in accordance with the Heads of Terms. In addition, and subject to the Council approving the submission of the TWAO, the necessary authority also be delegated to the Director of City Development in order to allow him to take all such steps as may be necessary or expedient to carry the Resolution into effect (including all those steps required for the Council to apply for and thereafter to promote the Order).

ENVIRONMENT

196 Deputation to Council - Leeds Children's Mayor regarding the Winning Manifesto: "Leeds Offers Fun, Free Fitness for the Family"

The Director of Environment and Neighbourhoods submitted a report setting out the Council's response to the deputation presented to full Council on 16th January 2013 in respect of the winning Manifesto from the Leeds Children's Mayor entitled, "Leeds Offers Fun, Free Fitness for the Family".

The Board paid tribute to Oliver Larking, Leeds Children's Mayor, for the proposals which made up his winning manifesto and for the enthusiastic and confident way in which he had delivered his deputation speech to the Council meeting.

Members highlighted the potential role of Ward Councillors in helping to deliver the proposals via the use of Section 106 contributions, whilst the Board welcomed the way in which the proposals cut across both the environmental and also the health and wellbeing agendas.

RESOLVED –

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

(b) That the following actions be approved:-
- To include reference to health and fitness when carrying out consultation on relevant schemes; and
- To promote the inclusion of outdoor fitness equipment as an important means to encourage people to enjoy the outdoor environment and get fit at the same time.

(c) That a letter be forwarded to Oliver, thanking him for all of his efforts in respect of his winning manifesto and deputation to Council, whilst also advising him of the outcomes arising from the Council's response.

197 Tackling Fuel Poverty and Reducing CO2 Emissions: Home Energy Conservation Act Further Report 2013

The Director of Environment and Neighbourhoods submitted a report providing an update on the new Home Energy Conservation Act (HECA) requirements and also presenting the content of the Leeds City Council 'Further Report 2013' for approval, prior to its formal submission to the Secretary of State for Energy and Climate Change.

Members welcomed the positive work which continued to be undertaken in this area.

RESOLVED –

(a) That the contents of the submitted report and the associated appendices be approved, with approval also being given for the relevant documents being published on the Council's website as the 'Leeds City Council Home Energy Conservation Act Further Report'.

(b) That contracts be awarded to the 3 highest scoring bidders (assessed using a 50/50 price/quality split) to manage and deliver the interim Green Deal framework project.

(c) That approval be given for £20,000 of the existing 'Wrap Up Leeds' budget being transferred from 2012-13 to 2013-14, in order to support the Green Deal framework.

(d) That the necessary authority be delegated to the Director of Environment and Neighbourhoods which will enable him to take operational decisions to ensure that the Green Deal framework operates effectively.

DEVELOPMENT AND THE ECONOMY

198 Acquisition of the Engine House, Giotto Tower, Verona Tower and Little Chimney at Tower Works, Globe Road, Holbeck LS11 5QG

The Director of City Development submitted a report advising of a request received from the Homes and Communities Agency (HCA) that the Council accepted the transfer of four Listed Buildings into its ownership at Tower Works, Globe Road, Holbeck. The transfer of the buildings would be accompanied by a financial dowry funded by the Department of Communities and Local Government (DCLG) and would result in the Council and the HCA working in partnership to bring forward the redevelopment of the Tower Works and the wider Holbeck Urban Village. In addition, the report detailed the reasons and terms for the transfer and recommended that the Council accepted the freehold transfer of the buildings, and how the buildings should be managed in the future.

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

RESOLVED –

(a) That approval be given for the Council to accept the freehold transfer of ownership from the HCA of buildings known as the Engine House, Giotto Tower, Verona Tower and Little Chimney at Tower Works, Globe Road, Holbeck, subject to the financial dowry offered by the HCA being of a sufficient sum and no less than the amount identified in exempt Appendix 1 to the submitted report.

(b) That approval be given to the principle of the Giotto Tower, Verona Tower and Little Chimney being placed within a trust, established to maintain the buildings in perpetuity, with the Council acting as full trustee.

(c) That in the context of paragraphs 6.1 and 6.2 of the submitted report, in the event that any matters require formal approval between Executive Board approval of the transaction and completion, then authority be given for these matters to be dealt with by the Director of City Development under the appropriate scheme of delegation, with the concurrence of the Executive Member for Development and the Economy and the Director of Resources.

(The matters referred to within this minute were not eligible for Call In as the HCA had requested that the buildings be transferred to the Council by the end of the 2012/13 financial year, this being 28th March 2013. The HCA had imposed this deadline as the dowry available from DCLG to accompany the transfer was only available until the end of the financial year. In the event of such decisions being Called In, then it would not be possible to meet the HCA deadline and the dowry would be lost. Therefore, this matter was deemed urgent, on the basis that any delay would seriously damage the Council's, or the public's interests).

NEIGHBOURHOODS, PLANNING AND SUPPORT SERVICES

199 Police Community Safety Officers (PCSOs) Service Level Agreement 2013/14

The Director of Environment and Neighbourhoods submitted a report which sought authority to enter into a Service Level Agreement (SLA) with the Office of the West Yorkshire Police and Crime Commissioner (OPCC) for 2013/14, and for this to be extended annually thereafter up to 31st March 2016, subject to Council budgets and an ongoing commitment from the OPCC to sustain current PCSO levels and local partnership arrangements.

Responding to a Member's enquiry, officers provided the Board with an update on the actions being taken to identify and tackle environmental crime.

RESOLVED –

(a) That expenditure of up to £1,514,000 in 2013/14 be approved, in order to provide a 30% contribution towards the costs of 165 PCSO's (5 per Ward) across the city, by means of a Service Level Agreement (SLA) with the Office of the West Yorkshire Police and Crime Commissioner (OPCC).

(b) That approval be given for this arrangement to be rolled forward on an annual basis for up to three years (to 31st March 2016), subject to annual Council budget approval and an ongoing commitment from the West Yorkshire Police and Crime Commissioner to maintain current PCSO levels and to continue to develop local partnership working.

(c) That in moving forward, approval be given for an annual inflation increase being included as part of the budget setting process (budgets permitting) in order to maintain PCSO numbers.

200 Leeds Local Development Framework: Authority Monitoring Report 2012

Further to Minute No. 155, 14th December 2011, the Director of City Development submitted a report presenting for approval and for the purposes of publication on the Council's website, the 2012 Leeds Local Development Framework Authority Monitoring Report, pursuant to Regulation 34 of the Town and Country Planning (Local Planning) (England) Regulations 2012.

Members welcomed the robustness of the report and the fact that the Strategic Housing Land Availability Assessment (SHLAA) Partnership was to include a wider political representation.

RESOLVED – That the 2012 Leeds Local Development Framework Authority Monitoring Report, as appended to the submitted report, be approved for the purposes of publication on the Council's website, pursuant to Regulation 34 of the Town and Country Planning (Local Planning) (England) Regulations 2012.

201 Housing Delivery

The Director of City Development submitted a report setting out proposals on how Leeds would improve its housing offer in terms of broadening its supply of land and promoting housing delivery. Within this overall context and in noting the conclusions drawn from the Authority Monitoring Report (AMR) 2012, the submitted report explored how Leeds' housing land portfolio and housing delivery could be enhanced, which included the establishment of criteria for the potential release of some Protected Area of Search (PAS) sites for development.

As part of the introduction to the report, the Executive Member for Neighbourhoods, Planning and Support Services emphasised the Council's commitment to ensuring the successful delivery of housing provision in Leeds, but in addition, provided assurances that the status of some PAS sites would be protected.

Following this, the Executive Member for Neighbourhoods, Planning and Support Services proposed the introduction of an addition to the policy criteria detailed within the submitted report, namely that when permission was granted to develop PAS sites, such permission be for a duration of 2 years, rather than the current 5 years, in order to avoid landbanking.

Further to the proposal above, a request was made for a second addition to be incorporated into the policy criteria, specifically, the insertion of a clause which would enable the Council to refuse permission to develop PAS sites for ‘any other material planning reasons’, in order to protect the interests of the Council and others.

Having considered the respective proposals to amend the policy criteria as detailed within the submitted report, it was

RESOLVED – That the policy criteria for the potential release of PAS sites, as detailed within paragraph 3.3 of the submitted report, be approved, subject to the inclusion of criteria which:

(i) reduces from 5 years to 2 years the period by which any permission granted to develop PAS sites remains valid; and

(ii) enables the Council to refuse permission to develop PAS sites for ‘any other material planning reasons’.

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

202 Proposal to Modernise Cottingley Springs

Further to Minute No. 69, 5th September 2012, the Director of Environment and Neighbourhoods submitted a report which sought approval to inject £1,116,000 into the Council’s Capital Programme for the purposes of refurbishing Cottingley Springs, whilst the report also sought authority to spend the £1,116,000 sum, in order to progress the capital scheme.

RESOLVED –

(a) That approval be given for the injection of this scheme, totalling £1,116,000, into the Capital Programme, to be funded from £890,000 of Homes and Communities Agency (HCA) grant, and £226,000 from prudential borrowing.

(b) That authority to spend the £1,116,000 sum be approved, in order to progress the scheme detailed within the submitted report.

(The matters referred to within this minute were not eligible for Call In, because if such decisions were open for Call In and were subsequently Called In, then this would put at risk the timescales set by the HCA to start on site by 25th March 2013. The Call In process could not be concluded in time for the deadline and therefore the grant funding would be at risk. Therefore, this matter was deemed urgent, on the basis that any delay would seriously damage the Council’s, or the public’s interests).

CHILDREN'S SERVICES

203 Outcome of Annual consultation on school admissions arrangements for September 2014

The Director of Children's Services submitted a report which sought approval of the Local Authority School Admissions Policy and co-ordinated arrangements for September 2014, together with the arrangements for in-year applications.

The Executive Member for Children's Services highlighted the intention to undertake further work in order to ensure that better support was provided to young carers throughout the city.

RESOLVED – That the Local Authority Admissions Policy and co-ordinated arrangements for September 2014, together with the arrangements for in-year applications, be approved. Specifically:-

(i) Approval be given to the clarifications around medical priority and infant and junior sibling links;

(ii) Approval be given to the admissions arrangements for in-year applications, including the delegation of the power to convey offers and refusals to community and voluntary controlled schools with effect from September 2013;

(iii) It be noted that further work will be undertaken to determine appropriate wording and definitions to provide better support for young carers in obtaining a place at an accessible school.

204 Update on Children's Services' Obsessions - Reducing the need for Children to be looked after (Help Children to live in safe and supportive families)

The Director of Children's Services submitted a report providing an update on the Children's Trust obsession to safely and appropriately reduce the need for children and young people to be in care. In addition, the report also provided an update and analysis upon the number of looked after children in the care of the Council, whilst outlining the progress made on the actions taken by Children's Services, with support from key partners, to safely and appropriately reduce the number of looked after children in Leeds.

The Executive Member for Children's Services highlighted the positive outcomes which were being achieved as a result of the work undertaken to recruit foster carers in the city. In addition, the Board noted that the Council had recently met all 7 of the Leading Improvements for Looked After Children (LILAC) standards.

Responding to a Member's comments regarding the Council's allowances framework for foster carers, officers undertook to provide the Member in question with further detail on this issue.

RESOLVED – That the approach outlined within the submitted report be endorsed, and that the progress made to safely and appropriately reduce the number of looked after children in Leeds be noted.

205 Proposal to Change the Status of Bramley CE (VC) Primary School from Voluntary Controlled to Voluntary Aided

The Director of Children's Services submitted a report which sought approval of the proposals published by the Governing Body of Bramley St. Peter's Church of England (VC) Primary School to change the school's status from Voluntary Controlled to Voluntary Aided.

RESOLVED – That the proposal published by the Governing Body of Bramley St. Peter's Church of England Primary School to change the school's status from Voluntary Controlled to Voluntary Aided, with an implementation date of 15th April 2013, be approved.

206 Investing in Young People: Future Direction for Youth Services in Leeds

The Director of Children's Services and the Director of City Development submitted a joint report proposing a fundamental redesign of youth provision in Leeds that affirmed the continuing key role of the youth service, strengthened the role of Area Committees and clusters, pulled together existing services through a co-ordinated approach and enabled the enhancement of universal, targeted and specialist youth services. In addition, the report sought approval for the proposed direction enabling the necessary restructuring to take place during 2013.

Members welcomed the proposals detailed within the report, specifically the continued role which could be played by the Breeze brand, the co-ordinated offer being proposed, the ringfencing of the budget proposed to be allocated to Area Committees and the involvement of young people in the associated decision making processes.

The Executive Member for Children's Services emphasised the active role intended to be played by Scrutiny Board (Children and Families) in monitoring the implementation of the changes to youth service provision.

RESOLVED –

(a) That the comprehensive consultation and assessment work undertaken to develop a new vision for the 'youth offer' in Leeds be noted, and that the continuing commitment to youth services as a key strand of the child friendly Leeds ambitions be endorsed.

(b) That the new 'youth offer', as outlined within the submitted report be approved, bringing together a more co-ordinated approach to universal services, improved targeted and specialist provision, through an enhanced role for Area Committees and clusters and a stronger use of the Breeze brand.

(c) That the Director of Children's Services and the Director of City Development be delegated responsibility, in consultation with the relevant Executive Board Members, to implement the remodelling of Council run youth services and those provided by key partners, in order to deliver the new approach, with full staff and Union engagement also being ensured throughout this process.

(d) That the proposal for discussions between the Executive Member for Children's Services and Area Committees about how to best enable the expenditure of £2,540,000 on targeted youth work across local areas in Leeds, be endorsed.

(e) That a new allocation to the overall Area Committee budget of £250,000 in 2013/14 and £500,000 in 2014/15 be approved, which will be ringfenced for youth activities, with a clear expectation that young people will help to shape the decision making around the spending of this resource, against an agreed set of outcomes.

LEISURE AND SKILLS

207 Inspiring a Generation - A Sporting Legacy for Leeds: Progress Report

Further to Minute No. 70, 5th September 2012, the Director of City Development and the Director of Children's Services submitted a joint report outlining the progress which had been made in relation to the proposals for a sporting legacy for Leeds, building upon the successes of the London 2012 Olympic and Paralympic Games which were outlined within the report entitled, "Inspire a Generation", presented to Executive Board shortly after the conclusion of the 2012 Games.

Responding to a Member's enquiry, the Board noted the work which was being undertaken with cycling organisations as part of the initiative. In addition, the Board noted the intention for a report to be submitted to the April 2013 meeting with regard to the 'Leeds Let's Get Active' programme.

RESOLVED –

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

(b) That the progress made within this field, as outlined within the submitted report, be noted.

(c) That the principles for the allocation of grant funding for the "Inspire a Generation Legacy Fund" be approved.

(d) That the extended rate relief proposals, as set out within Table 1 of the submitted report, be approved.

(e) That the proposals for the 'Leeds Let's Get Active' initiative be noted and that a further report on this matter be submitted to the Board in April 2013.

(f) That officers be requested to further explore the benefits of holding a focussed 'Sport and Business Summit', linking in to the 'Best City' initiative and the build up to the Tour de France Grand Depart in 2014.

ADULT SOCIAL CARE

208 Healthwatch Leeds

The Director of Adult Social Services, the Director of Children's Services and the Director of Public Health submitted a joint report providing information on the outcome of the Local Authority's procurement exercise to commission a local Healthwatch organisation and an NHS Complaints Advocacy service for Leeds. In addition, the report provided details of the progress made to date to develop local Healthwatch in Leeds, including the implementation of its key functions, roles and responsibilities in preparation for 1st April 2013. Finally, the report also provided assurances in respect of the development of the role of Healthwatch in conjunction with Scrutiny and the Health and Wellbeing Board.

The Executive Member for Adult Social Care paid tribute to the work which had been undertaken by all those involved in the Leeds Local Involvement Network (LINk).

In considering the report, a request was made that representatives from Healthwatch Leeds were periodically invited to attend future Executive Board meetings, as and when appropriate.

RESOLVED –

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

(b) That the plans to develop the role of Healthwatch Leeds with specific reference to working with Scrutiny Boards (Health and Wellbeing and Adult Social Care) and (Children and Families), and the Health and Wellbeing Board, as recommended in the report to Scrutiny Board (Health and Wellbeing and Adult Social Care) on the 20th February 2013, be noted.

HEALTH AND WELLBEING

209 The Transfer of Public Health from the Primary Care Trust to Leeds City Council

The Director of Resources submitted a report providing an update on the transfer of public health functions, resources, assets and liabilities to the Council under the statutory process, as set out within the Health and Social Care Act 2012. In addition, the report sought approval to delegate decision making to the Chief Executive in respect of the approval of the final agreed list of resources, assets and liabilities transferring to the Council under the Health and Social Care Act 2012.

RESOLVED –

(a) That the contents of the submitted report, together with the functions, budget, resources and assets and liabilities due to transfer on 1st April 2013 be noted.

(b) That the relevant decision making authority be delegated to the Chief Executive, in order to enable him to approve:-
(i) the Transfer Scheme relating to staff; and
(ii) the Transfer Scheme relating to assets and liabilities.

(c) That it be noted that the Council will award new contracts for existing services where they expire prior to 31st March 2013, which will be approved under the Officer Delegation Scheme.

RESOURCES AND CORPORATE FUNCTIONS

210 Financial Health Monitoring 2012/2013 - Month 10 Report

The Director of Resources submitted a report setting out the Council's projected financial health position for 2012/13 after ten months of the financial year.

RESOLVED - That the projected financial position of the authority after ten months of the financial year, be noted.

211 Local Welfare Scheme

Further to Minute No. 106, 17th November 2012, the Director of Resources submitted a report providing an update on the outcome of the consultation undertaken and the progress made towards establishing administrative arrangements to support a Local Welfare Scheme to provide support for families and vulnerable people faced with unforeseen difficulties or emergency situations. In addition, the report sought approval for a number of initiatives to be developed that were aimed at creating greater sustainability and increasing advice and support, with such initiatives to be funded from within the overall devolved funding for local schemes.

Responding to a Member's enquiry, the Board was provided with information around the expected provision of Food Banks across the city, and the potential role that the Council could play in respect of such provision alongside key partners.

In considering the submitted report, the Chair requested that the Board be provided with an evaluation of the scheme's performance at the appropriate time, once it was operational.

RESOLVED –

(a) That the local welfare scheme, as set out within Appendix 1 to the submitted report, be approved.

(b) That the development of initiatives, as set out within paragraph 3.15 of the submitted report, along with the earmarking of funds from the devolved funding to support the initiatives, be approved.

(c) That a short pilot scheme which would see applicants referred for advice and support where this was felt beneficial, be approved.

(d) That the necessary authority be delegated to the Director of Resources in order to enable him to:-
(i) Vary the earmarked funding based on data provided from the first 3 months operation of the local welfare scheme; and
(ii) Allocate funding to approved initiatives with a requirement that Executive Board receives reports evaluating the progress and outcomes from funded initiatives.

212 Regional Economic Intelligence Unit - Evaluation of Transfer

Further to Minute No. 261, 16th May 2012, the Assistant Chief Executive (Customer Access and Performance) submitted a report providing an update on the evaluation of the sustainable operational performance of the Regional Economic Intelligence Unit (REIU) in the eighteen month trading period following the formal transfer of the function from Yorkshire Forward to Leeds City Council on 1st November 2011. Specifically, the report provided an update on: the full year (2012/2013) funding position and revenue profile of the unit; the forecast 2013/2014 revenue profile of the unit, the contribution of the team to work across the Council; and, the future opportunities for developing the team's contribution further.

Responding to a Member's enquiry, the Board was provided with clarification around the Unit's initial eighteen month trading account, the sources of the work which had been undertaken by the Unit and how the Unit's resource would be determined by the future demand for its services.

In conclusion, it was requested that a further update report be provided to the Board evaluating the Unit's performance at the 6 month point of the financial year.

RESOLVED –

(a) That the positive outcome which the REIU has delivered in balancing its revenue budget and delivering a small trading surplus be noted.

(b) That the trading model which underpins the sustainability of the REIU's work, be noted.

(c) That the Board notes and approves the arrangements in place to ensure that ongoing monitoring of the REIU will be undertaken via the Council's normal budget monitoring arrangements.

(d) That a further update report be provided to the Board evaluating the Unit's performance at the 6 month point of the financial year.

DATE OF PUBLICATION: 15TH MARCH 2013

LAST DATE FOR CALL IN OF ELIGIBLE DECISIONS: 22ND MARCH 2013 (5.00 P.M.)

(Scrutiny Support will notify Directors of any items called in by 12.00 p.m. on 25th March 2013)

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