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Leeds CITY COUNCIL

SCRUTINY BOARD (ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

Meeting to be held in Civic Hall, Leeds, LS1 1UR on Tuesday, 8th September, 2015 at 12.30 pm

(A pre-meeting will take place for ALL Members of the Board at 1.30 p.m.)

MEMBERSHIP

Councillors

C Anderson - Adel and Wharfedale;
B Flynn - Adel and Wharfedale;
P Gruen (Chair) - Cross Gates and Whinmoor;
A Hussain - Gipton and Harehills;
G Hussain - Roundhay;
S Lay - Otley and Yeadon;
C Macniven - Roundhay;
B Selby - Killingbeck and Seacroft;
A Smart - Armley;
E Taylor - Chapel Allerton;
S Varley - Morley South;

Co-opted Member (Non-voting)

Dr J Beal - Healthwatch Leeds

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

Agenda compiled by:
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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Head of Governance Services at least 24 hours before the meeting).	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND 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.**	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**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 - 28 JULY 2015** To confirm as a correct record the minutes of the Scrutiny Board (Adult Social Services, Public Health, NHS) meeting held on 28 July 2015.	1 - 10
7			**CHAIR'S UPDATE** To receive an update from the Chair on any scrutiny activity since the previous Board meeting that is not specifically included elsewhere on the agenda.	11 - 12
8			**CARE QUALITY COMMISSION INSPECTION OUTCOMES** To consider a report from the Head of Scrutiny and Member Development summarising Care Quality Commission inspection reports published since the Board meeting in July 2015.	13 - 80

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**PRIMARY CARE** To consider a report from the Head of Scrutiny and Member Development introducing a range of information to inform the Board's Primary Care inquiry.	81 - 114
10			**PUBLIC HEALTH BUDGET UPDATE** To consider an update from the Director of Public Health regarding the Council's 2015/16 Public Health budget and response to the recent Department of Health consultation.	115 - 136
11			**WORK SCHEDULE** To consider a report from the Head of Scrutiny and Member Development introducing the Scrutiny Board's work schedule for the remainder of the current municipal year, 2015/16.	137 - 146
12			**DATE AND TIME OF NEXT MEETING** Tuesday, 20th October 2015 at 2pm (pre-meeting for all Board Members at 1.30pm)	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
			THIRD PARTY RECORDING Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts on the front of this agenda. Use of Recordings by Third Parties – code of practice a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title. b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.	

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SCRUTINY BOARD (ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

TUESDAY, 28TH JULY, 2015

PRESENT: Councillor P Gruen in the Chair

Councillors C Anderson, R Grahame, A Hussain, M Iqbal, S Lay, B Selby, A Smart and E Taylor

11 Chair's Opening Remarks

The Chair opened the meeting by welcoming all those present and invited formal introductions.

12 Late Items

There were no late items.

13 Declaration of Disclosable Pecuniary Interests

There were no disclosable pecuniary interests declared to the meeting, however the following matters were brought to the attention of the Scrutiny Board for information:

- Cllr Selby highlighted he was Chair of Leeds' Community Equipment Partnership.
- Cllr G Hussain outlined that a close family member was an employee within the local NHS.

Both members remained present for the duration of the meeting.

14 Apologies for Absence and Notification of Substitutes

Apologies for absence and notifications of substitutes were reported as follows:

- Cllr B Flynn – no substitute member attending
- Cllr G Hussain – Cllr R Grahame attending as a substitute member
- Cllr C Macniven – Cllr M Iqbal attending as a substitute member
- Cllr S Varley – no substitute member attending
- Dr John Beal – HealthWatch Leeds

15 Minutes - 23 June 2015

The draft minutes from the previous meeting held on 23 June 2015 were presented for consideration.

The following matters arising were highlighted at the meeting:

- Minute 7 – co-opted members. The Chair advised the Scrutiny Board of the notification that Mr Richard Taylor had been nominated as HealthWatch Leeds' 2nd non-voting co-optee to sit on the Board. It was noted that Mr Taylor was unable to attend the meeting.
- Minute 9 – Health Service Developments Working Group. The Chair advised the Scrutiny Board that the Working Group was likely to meet in mid-August.

RESOLVED –

(a) That the matters arising highlighted at the meeting be noted.
(b) That the minutes of the Scrutiny Board (Adult Social Services, Public Health, NHS) meeting held on 23 June 2015, be approved as an accurate and correct record.

16 Minutes of Health and Wellbeing Board - 10 June 2015

The minutes of the Health and Wellbeing Board meeting held on 10 June 2015 were presented for consideration.

The following matters arising were highlighted and briefly discussed at the meeting:

- Minute 10 – Health and Social Care winter pressures in Leeds: building a resilient system.

  The potential relevance to the Scrutiny Board's work around Integrated Health and Social Care Teams was highlighted.

- Minute 12 – Leeds Joint Strategic Needs Assessment (JSNA) 2015 Draft Executive Summary: Cross Cutting Themes.

  The Chair highlighted and queried how the City's planned expansion in housing would be reflected in JSNA process.

RESOLVED –

(a) That the minutes of the Health and Wellbeing Board meeting held on 10 June 2015 and the matters highlighted at the meeting be noted.

17 Minutes of Executive Board - 24 June and 15 July 2015

11 The minutes from the Executive Board meetings held on 24 June 2015 and 15 July 2015 were presented for consideration.

RESOLVED –

(a) That the minutes from the Executive Board meetings held on 24 June 2015 and 15 July 2015 be noted.

18 Chair's Update Report - July 2015

The Chair presented a verbal update on the scrutiny activity since the June meeting not otherwise included on the Board's meeting agenda. In particular, the Chair raised the following matters:

- The new Congenital Heart Disease (CHD) review outcome – making reference to the NHS England Board decision, the Chair paid tribute to previous Chairs and members involved in raising public awareness of previous proposals, resulting in a reconsideration of the previous decision. The Chair confirmed that the new CHD review was now entering its implementation phase and it was intended that the Joint Health Overview and Scrutiny Committee (JHOSC) for Yorkshire and the Humber would maintain an overview of progress and future plans.
- The recent announcement of Urgent Care Vanguards – including West Yorkshire. The Chair planned to seek a briefing from local Clinical Commissioning Groups on the scheme and any local implications.
- The continued delay in the announcement of the Care Quality Commission (CQC) inspection outcome for Yorkshire Ambulance Service NHS Trust. The inspection took place in January 2015, yet the outcome and judgement had not been reported. The Chair proposed to write to the CQC for an explanation and to seek assurance around the inspection process.
- The reported dispute between Leeds and York Partnership NHS Foundation Trust (LYPFT) and the Vale of York Clinical Commissioning Group regarding the procurement process for services in York. The Chair proposed to contact the necessary bodies involved to be fully briefed on the matters reported in the local media.

RESOLVED – That the verbal update provided at the meeting be noted and any actions proposed by the Chair be agreed.

NB Cllr S Lay joined the meeting at 2:15pm during consideration of this item.

19 Leeds Integrated Health and Social Care Teams

The Director of Adult Social Services and the Executive Director of Operations at Leeds Community Healthcare NHS Trust submitted a joint report regarding the establishment and operation of the integrated health and social care teams across the City.

The following representatives were in attendance during consideration of this item:

- Cllr Lisa Mulherin – Executive Member for Health, Wellbeing and Adults
- Cath Roff (Director of Adult Social Services) – Adult Social Services, Leeds Council

- Shona McFarlane (Chief Officer (Access and Care Delivery)) – Adult Social Services, Leeds Council
- Kim Adams (Programme Manager (Health Integration)) – Adult Social Services, Leeds Council
- Paul Morrin (Director of Integration) – Leeds Community Healthcare NHS Trust

The Director of Adult Social Services gave a brief introduction of the report detailing the 2/3 year journey around integrated health and social care teams across the City and the future challenges, including:

- Developing and implementing an integrated performance management framework.
- Making best use of existing and/or new estate.
- Working with different information technology (IT) systems and infrastructure.
- Combining joint working with primary care and mental health services.

The Scrutiny Board discussed the information presented in the report and outlined at the meeting, raising a number of issues, including:

- The impact of organisational culture within a change programme.
- Issues around making the best use of existing and/or new estate and the potential link to the Council's development of Community Hubs.
- The specific involvement of GPs as part of the integrated approach.
- The membership and role of the Integration Programme Board, along with the need for a clearer outline of future actions and associated timescales.
- The use of flexible solutions to meet the needs of different areas of the City.
- The relationship between the outcomes framework and an integrated performance management framework.
- Joint working around hospital discharges, re-ablement and service planning (including winter pressures).

RESOLVED –

(a) That the progress and next steps outlined in the report – with particular reference to the achievements to date, the identified actions required around estates, performance and the future plans, be noted.
(b) That, in conjunction with the Chair, the Principal Scrutiny Adviser works to scope the Boards inquiry around the work of the City's integrated health and social care teams.

20 Inquiry into the Provision of Emotional Wellbeing and Mental Health Support Services for Children and Young People in Leeds (June 2015) - Response to Report and Recommendations

The Principal Scrutiny Adviser submitted a report that summarised the previous Board's inquiry into the Provision of Emotional Wellbeing and Mental Health Support Services for Children and Young People in Leeds. The report

also introduced commissioners' initial response to the report and recommendations.

The following representatives were in attendance during consideration of this item:

- Cllr Lisa Mulherin – Executive Member for Health, Wellbeing and Adults
- Jane Mischenko (Commissioning Lead (Children & Maternity Services)) –NHS Leeds Clinical Commissioning Groups
- Paul Bollom (Head of Commissioning and Market Management) – Children's Services, Leeds City Council

The Commissioning Lead (Children & Maternity Services) addressed the Board and gave further background relevant to the commissioning and scrutiny reviews. It was also highlighted that some of the detail of the improvement plan was reliant upon national guidance – initially expected in June 2015, but now anticipated in mid-August 2015.

The Scrutiny Board discussed the response to the inquiry recommendations, raising a number of issues, including:

- Access to services and the level of need across the City.
- Funding requirements in the longer-term.
- Raising awareness and elected member training.
- Transitional arrangements from services for children to adult services.
- Availability of support for parents and carers.
- The importance of continuing to hear the voice of service users and other stakeholders – including practitioners.
- Concern regarding the certainty of the response provided – in particular around timescales.

RESOLVED –

(c) That the progress outlined in the response and discussed at the meeting be noted.
(d) That the initial response is reviewed and firmer timescales agreed.
(e) That the outcome of the review (in (b) above) be reflected in the Scrutiny Board's future work programme.

NB Cllr S Bentley joined the meeting at 3:00pm as consideration of this item commenced.

21 Maternity Strategy for Leeds (2015-2020)

The Principal Scrutiny Adviser submitted a report that introduced Leeds Maternity Strategy (2015-2020) and an accompanying briefing note. A statement provided on behalf of the Director of Public Health was also submitted to the Scrutiny Board.

The following representatives were in attendance during consideration of this item:

- Cllr Lisa Mulherin – Executive Member for Health, Wellbeing and Adults
- Jane Mischenko (Commissioning Lead (Children & Maternity Services)) –NHS Leeds Clinical Commissioning Groups
- Ian Cameron (Director of Public Health) – Public Health, Leeds City Council

The Commissioning Lead (Children & Maternity Services) introduced the item and presented the background in developing the strategy, including the maternity health needs assessment produced in 2014. As part of the introduction, the following matters were highlighted:

- The current birth rate in Leeds had stabilised around 10,000 births per year.
- The strategy had been informed by:
  - An examination of available evidence and the current policies.
  - The involvement of traditionally 'hard to reach' groups.
- The strategy was expressed in terms of nine (9) key priorities, with a programme plan to underpin the strategy under development.

The Scrutiny Board discussed the strategy and the matters highlighted at the meeting, raising a number of issues, including:

- The relevance of the strategy in relation to giving every child in Leeds the best start, and the universal / targeted services approach.
- Specific reference to fathers and partners as part of the strategy.
- The relative importance of each of the priority areas within the strategy.
- The lack of any reference to the availability and use of resources (or funding) as part of the strategy.
- The proposal to present the strategy to the Health and Wellbeing Board in September 2015.

RESOLVED –

(f) That the Maternity Strategy for Leeds (2015-2020) and the matters discussed at the meeting be noted.

(g) That a progress update be provided to the Scrutiny Board in line with the Scrutiny Board's work schedule.

NB Cllr C Anderson left the meeting at 3:55pm during consideration of this item.

At the conclusion of this item the meeting was briefly adjourned at 4:15pm. The meeting recommenced at 4:25pm.

22 Children and Young People's Oral Health Plan

The Director of Public Health submitted a report that introduced the draft Leeds Children and Young People Oral health Promotion Plan. The draft plan outlined a preventative programme from 0-19 that aimed to ensure every child in the city has good oral health.

The following representatives were in attendance during consideration of this item:

- Ian Cameron (Director of Public Health) – Public Health, Leeds City Council
- Steph Jorysz (Advanced Health Improvement Specialist) – Leeds City Council
- Jackie Moores (Advanced Health Improvement Specialist) – Leeds City Council

The Advanced Health Improvement Specialist introduced the item and presented the background in developing the oral health plan, alongside some of the key issues identified. As part of the introduction, the following matters were specifically highlighted:

- The Vision, Outcome and Objectives of the plan were summarised in the 'plan on a page' – presented at Appendix A.
- Levels of tooth decay among children and young people in Leeds were worse than the England average.
- Inequalities across Leeds were also significant.
- The oral health of children and young people in Leeds was comparable to other core cities and slightly below average when compared to statistical neighbours.

The Scrutiny Board discussed the draft plan and the matters highlighted at the meeting, raising a number of issues, including:

- Significant concern at the levels of tooth decay and relative poor oral health among children and young people in Leeds.
- The need to use all available channels to raise awareness of the levels of tooth decay and relative poor oral health among children and young people in Leeds.
- Suggestions to increase awareness through the Schools Forum, School Clusters, School Governors, the Youth Parliament and the Children's Services Scrutiny Board.
- Raising awareness while not seeking to apportion blame for the levels of tooth decay and relative poor oral health among children and young people in Leeds.
- Issues associated with the fluoridation of the local water supplies with the aim of improving oral health.
- Consistency of dental practice, specifically in relation to the use and application of fluoride varnish.
- The role of NHS England in commissioning preventative dental treatments in relation to children and young people.
- Work of the oral health promotion team.

RESOLVED –

(h) That the draft Leeds Children and Young People Oral health Promotion Plan and the associated matters discussed at the meeting be noted.
(i) That the suggestions for raising awareness discussed at the meeting be progressed appropriately.
(j) That a 6-month progress update be provided and incorporated within the Scrutiny Board's work schedule.

NB Cllr A Hussain left the meeting at 4:45pm and Cllr S Bentley left the meeting at 4:50pm, during consideration of this item.

23 Public Health Budget Update

The Principal Scrutiny Adviser submitted a brief report introducing a briefing note from the Director of Public Health regarding a proposed £200M in-year saving requirement across local authority public health expenditure across England.

Dr Ian Cameron (Director of Public Health) was in attendance during consideration of this item.

The Director of Public Health gave an introduction and confirmed that consultation around how the savings target would be achieved/ implemented had not yet been received but was expected to be imminent.

It was highlighted that should the savings target be achieved on a simple percentage share basis, Leeds contribution was likely to be around £2.8M during 2015/16.

The Scrutiny Board discussed the information presented in the report and the update provided at the meeting. Members raised a number of concerns, including:

- The difficulties associated with achieving new savings targets in-year – i.e. once annual budgets had already been agreed.
- The potential impacts on agreed contracts.
- The timing and likely nature of the consultation.
- The likely impact on other areas and both commissioner and provider organisations within the local health and social care economy.

RESOLVED –

(k) That the information presented be noted.
(l) That the Scrutiny Board maintains an overview of the consultation process – contributing where appropriate.
(m) That, following the outcome of the consultation process, the Scrutiny Board considers its future role around local implementation.

NB Cllr R Grahame left the meeting at 4:55pm during consideration of this item.

24 Work Schedule

The Principal Scrutiny Adviser provided a report that introduced a draft work schedule for the remainder of the municipal year.

The Chair advised the Board that the draft work schedule captured a number of the areas highlighted and discussed at the Board's initial meeting in June 2015 and he was keen to involve members of the public in the Board's work – particularly in relation to more detailed inquiries. Members of the Board agreed with this approach.

Cllr Selby raised the matter of the practical implications and financial impact on Adult Social Services of a recent court judgement in relation to 'Deprivation of Liberty' processes, and recommended a report be presented to the Scrutiny Board in order to raise awareness of the issues and implications.

The Chair made reference to a number of potential work areas highlighted by Cllr B Flynn (who was unable to attend the meeting). It was felt that a number of matters identified could be incorporated into the existing draft work schedule, including Leeds Teaching Hospitals NHS Trust progress against recommendations from the Care Quality Commission inspection in 2014, and cancer wait times. However, the Board would not have capacity to consider 'whistleblowing' as a specific work area.

RESOLVED – That, subject to any necessary adjustments arising from discussions at the meeting, the Board's work schedule (as presented) be agreed.

25 Date and Time of Next Meeting

Tuesday, 8 September 2015 at 12:30pm (pre meeting for all Board Members at 12:00noon)

At conclusion of the meeting, the Chair thanked all Board members for their attendance and contribution to the discussion.

(The meeting concluded at 5:05pm)

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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 (Adult Social Services, Public Health, NHS)

Date: 8 Septmeber 2015

Subject: Chairs Update Report – September 2015

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 outline some of the areas of work and activity of the Chair of the Scrutiny Board since the Scrutiny Board meeting in June 2015.

2 Main issues

2.1 Invariably, scrutiny activity often takes place outside of the formal monthly Scrutiny Board meetings. Such activity can take the form of working groups, but can also include specific activity, actions and meetings involving the Chair of the Scrutiny Board.

2.2 The purpose of this report is to provide an opportunity to formally update the Scrutiny Board on such activity since the last meeting, including any specific outcomes. It also provides an opportunity for members of the Scrutiny Board to identify and agree any further scrutiny activity that may be necessary.

2.3 The Chair and Principal Scrutiny Adviser will provide a verbal update at the meeting, as required.

3. Recommendations

3.1 Members are asked to:

a) Note the content of this report and the verbal update provided at the meeting.
b) Identify any specific matters that may require further scrutiny input/ activity.

4. Background papers[1]

4.1 None used

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

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 8 September 2015

Subject: Care Quality Commission – Inspection Outcomes

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 provide members of the Scrutiny Board with details of recently reported Care Quality Commission inspection outcomes for health and social care providers across Leeds.

2 Summary of main issues

2.1 Established in 2009, the Care Quality Commission (CQC) regulates all health and social care services in England and ensures the quality and safety of care in hospitals, dentists, ambulances, and care homes, and the care given in people's own homes. The CQC routinely inspects health and social care service providers, publishing its inspection reports, findings and judgments.

2.2 To help ensure the Scrutiny Board maintains a focus on the quality of health and social care services, the purpose of this report is provide an overview of recently reported CQC inspection outcomes for health and social care providers across Leeds. Procedures are being established locally to ensure the timey reporting of inspection outcomes on a monthly basis.

2.3 Appendix 1 provides a summary of recently published reports for consideration by the Scrutiny Board. However, the full inspection reports for the following organisations are provided:

Waterloo Manor Independent Hospital

2.4 Waterloo Manor Independent Hospital provides low secure and rehabilitation services for women with mental disorders and complex needs. It provides specialist services for a national catchment of patients (i.e. not just Leeds patients). The main commissioner of services is NHS England. The CQC inspection was undertaken in February 2015 and the report published in August 2015. A copy of the full inspection report is appended to this report.

2.5 Since March 2014, there have been ongoing safeguarding concerns regarding the provider and, as the host authority, Leeds City Council's Adult Social Services Directorate has been working with the provider since that time. However, the main commissioner of services is NHS England.

2.6 Guidance from the National Quality Board highlights the role of local authority overview and scrutiny committees in maintaining an oversight of quality and their involvement in quality surveillance activities. However, this tends to focus on the provision of local health and social care services for local people. The guidance is less clear in relation to the provision of specialist services provided to a catchment of patients beyond the local authority boundaries where the service may be delivered.

2.7 However, given the host responsibilities of Leeds City Council in relation to safeguarding, and in the absence of any definitive guidance, it perhaps seems reasonable to adopt a similar approach when considering oversight through overview and scrutiny. As such, representatives from the provider have been invited to attend the meeting to address any questions from members of the Scrutiny Board.

Yorkshire Ambulance Service NHS Trust

2.8 Yorkshire Ambulance Service provides an accident and emergency service to respond to 99 calls, patient transport services and an emergency operations centre (call handling service). The Trust also provides a Resilience and Hazardous Area Response Team (HART) and an NHS 111 core service. The Trust provides services across thirteen local authority areas within Yorkshire and the Humber and services are commissioned by Clinical Commissioning Groups (CCGs), with Wakefield CCG acting as the lead commissioner across the Yorkshire and Humber region.

2.9 The CQC inspection was undertaken in January 2015 and the report published in August 2015. A copy of the full inspection report is appended to this report.

2.10 Prior to publication of the report, the CQC convened a quality summit with key stakeholders to discuss its findings from the inspection and to allow the Trust to outline its initial response. Local authority overview and scrutiny committees are included as a key stakeholder in this process. However, given the geographical area covered by the Trust, it was agreed that Wakefield Council would lead from a scrutiny perspective. A note from the quality summit is appended to this report.

2.11 It is planned that Wakefield Council will receive and monitor the Trusts action plan, with the input from the Chairs' of other local authority overview and scrutiny committees. As such, representatives from the Trust have not been invited to formally attend the meeting. Any comments from the Board will be sent to Wakefield Council.

3. Recommendations

2.1 That the Scrutiny Board considers the report and the detail presented at the meeting, and determines any further scrutiny activity and/or actions, as appropriate.

4. Background papers[1]

4.1 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.

APPENDIX 1

SUMMARY OF RECENT CARE QUALITY COMMISSION (CQC) INSPECTION REPORTS

Publication Date	Organisation	Type of provider	Outcome	Web link to the report
29 July 2015	Homecare Support – Leeds (LS7 2AH)	Homecare	Good	http://www.cqc.org.uk/location/1-456708711
31 July 2015	Springfield Care Home (LS25 1EP)	Residential Care	Requires improvement	http://www.cqc.org.uk/location/1-154091843
31 July 2015	Spinney Residential Home (LS12 3QH)	Residential Care	Requires improvement	http://www.cqc.org.uk/location/1-112270555
17 Aug. 2015	Waterloo Manor Independent Hospital (LS25 1NA)	Hospital - mental health	Inadequate	http://www.cqc.org.uk/location/1-156620871
18 Aug. 2015	Ethical Homecare Solutions (LS7 3DX)	Homecare	Requires improvement	http://www.cqc.org.uk/directory/1-321807303
18 Aug. 2015	Hopton Court (LS12 3UA)	Residential Care	Requires improvement	http://www.cqc.org.uk/directory/1-309428606
18 Aug. 2015	Owlett Hall (BD11 1ED)	Nursing Home	Requires improvement	http://www.cqc.org.uk/directory/1-141599363
20 Aug. 2015	Oakwood Hall (LS8 2PF)	Nursing Home	Requires improvement	http://www.cqc.org.uk/directory/1-123576529
21 Aug. 2015	Yorkshire Ambulance Service NHS Trust (WF2 0XQ)	Ambulance Service	Requires improvement	http://www.cqc.org.uk/provider/RX8

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Waterloo Manor Limited

Waterloo Manor Independent Hospital

Quality Report

Waterloo Manor Independent Hospital, Selby Road, Garforth, Leeds, LS25 1NA.

Tel: 0113 287 6660
Website: www.inmind.co.uk

Date of inspection visit: 11,12,19,20 February 2015
Date of publication: 17/08/2015

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital — Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

We rated Waterloo Manor Independent Hospital as **Inadequate**:

Patients were cared for in unsuitable environments that compromised their health and well-being. Dirty wards with tired furnishings were not conducive to patients' recovery.

Managers had no plan to reduce the number of fixtures on the ward that could be used by patients to tie a ligature. Also no action was taken to reduce the risk to patients with suicidal thoughts and behaviours.

Staff did not maintain comprehensive risk assessments.

Staff did not manage medication safely and no action was taken on reports from external agencies with a monitoring role to oversee audit and safe practices in relation to medication.

The senior management team did not ensure that learning from serious incidents was always shared with front-line staff. This meant that these staff members did not always benefit from learning the lessons of investigations into incidents, meaning poor or unsafe practices could be repeated.

Staff did not plan, assess, or provide care to an adequate standard. For example, they did not seek the advice of professionals where patients' physical health care needs were potentially compromised, particularly in relation to nutrition, weight management, and healthy life choices.

Patients were transferred from one ward to another during their admission without proper planning or communication. This affected the continuity of care and increased the possibility of making mistakes because historical information, care planning, and relationships between key workers and patients were disrupted.

Staff did not demonstrate a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). When staff did assess the mental capacity of a patient to consent to care, their assessment was often not thorough enough.

The overall leadership and management of wards was poor. There were limited systems to audit the quality of care or to listen to patients' concerns and complaints, and insufficient action was taken to improve the overall quality of care.

The service had an improvement plan, developed since the previous Care Quality Commission inspection, but the senior management team did not monitor this closely enough and key actions were not carried out. Staff were not clear when or how improvements were taking place, this meant that improvements to the service were not happening quickly enough.

The senior management team had looked for reassurance on progress in the hospital since the last inspection rather than seeking assurance and taking control and responsibility for the areas of non compliance which had been identified.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

The wards were not safe environments for a number of reasons. They had 'blind spots' where staff could not easily observe patients and maintain safety. They also contained fixtures and fittings that patients at risk of suicide could use to attach a ligature.

Wards were dirty and not routinely cleaned. Some wards did not have a recognisable cleaning protocol. These wards presented an increased risk of infection as cleaning was not being monitored or audited in a systematic way.

The services' risk register had identified damaged furniture as a major concern, however, the service had not taken appropriate action to rectify this.

Staff did not recognise concerns and failed to act appropriately in response to incidents or near misses. When concerns were raised or things went wrong, the response to reviewing and investigating causes was insufficient or slow. There was little evidence of learning from events with a lack of clear actions taken to improve safety.

There were frequent staff shortages of appropriately skilled staff and poor management of agency staff.

Patients were not effectively safeguarded from abuse or the possible risk of abuse occurring.

Staff did not effectively assess, monitor or manage risks to patients.

Are services effective?

Inadequate

We rated effective as inadequate because:

Patients' care and treatment did not fully incorporate current evidence-based guidance, standards or practice.

There was no use of effective evidence based tools used to assess the quality of care patients' received to ensure their outcomes were positive. For example, some patients with risks related to their physical health did not have adequate care plans to meet their needs. There was no focus or professional support in relation to nutrition and diet..

The management of the hospital did not prioritise the training and development of staff, this had an impact on their ability to provide

Summary of findings

high quality care. Staff did not receive adequate supervision and appraisal. Without the appropriate training, patients were receiving care from staff who did not have the skills or knowledge needed to deliver high quality, safe and effective care.

Staff teams provided care in isolation rather than in an integrated way. There was a lack of cohesive working between key members of the multi disciplinary team.

Staff had limited knowledge and understanding of the Mental Health Act 1983 Code of Practice because training had not been identified as a priority.

Are services caring?

Inadequate

We rated caring as inadequate because:

Patients did not feel cared for and feedback about staff interactions was negative.

Some patients said that they had experienced being bullied by staff or other patients at the hospital.

Care plans were not holistic and person centred. Care plans did not demonstrate that patients were adequately involved in developing their care and treatment. Feedback from the family and carer surveys showed that the the hospital was not involving them sufficiently or engaging them collaboratively in care planning as appropriate.

Patient's preferences were not always listened to, or acted upon.

Are services responsive?

Inadequate

We rated responsive as inadequate because:

There were no protocols in place for moving patients between wards within the hospital. This meant that patients were at risk of receiving inappropriate treatment or care because moves were frequently made quickly and without proper planning. This resulted in patients being cared for by staff who were unfamiliar with their needs .

There were no plans in place to effectively manage the discharge of patients from the hospital. Without proper plans the service could not ensure that patients' needs would be appropriately met and so put them at risk of being detained in services for longer than clinically necessary or appropriate.

We found wards to be dirty with damaged furniture. The environment did not therefore promote or enhance patients' recovery.

Patients, families and carers did not believe their complaints were listened to or responded to appropriately.

Summary of findings

The service did ensure people had access to religious representatives and interpreters, but patients said meal choices in relation to cultural identity were limited.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

Staff were not aware of the care provider's over arching vision and values. The service was unable to present us with a credible statement of vision or guiding values.

The governance arrangements and their purpose were unclear. There was no effective process in place to review key issues, such as the strategy, values, objectives, plans or governance framework.

The staffing culture in the hospital was poor. It was recognised by senior managers as a serious concern, however, they were unable to evidence any clear strategy or action plan to address this. There appeared to be an inability on the part of the senior managers to recognise and address, or improve, the culture and ways of working within the hospital. Communication between the staff delivering the care and treatment and the senior management team of the hospital was poor.

Summary of findings

Service	Rating	Why have we given this rating?

Inadequate

Waterloo Manor Independent Hospital

Detailed findings

Services we looked at
Long stay/rehabilitation mental health wards for working-age adults

Low secure mental health wards for working-age adults

Detailed findings

Contents

Background to Waterloo Manor Independent Hospital

Waterloo Manor Independent Hospital provides low secure and rehabilitation services for women with mental disorders and complex needs.

The hospital consists of:

- Three low secure wards: Cedar (12 beds), Maple (13 Beds) and Larch (8 beds).
- Three locked rehabilitation wards: Beech (6 beds), Holly (4 beds), Hazel (8 beds).
- One open rehabilitation ward: Lilac (5 beds).

The hospital has a total of 56 beds.

The service had been inspected three times since it was registered in October 2010.

At the time of the last inspection, Waterloo Manor Independent Hospital did not meet the essential standards relating to:

- care and welfare of people who use the service (Regulation 9)
- safeguarding people from abuse (Regulation 11)
- management of medicines (Regulation 13)
- staffing (Regulation 22)
- supporting workers (Regulation 23)
- assessing and monitoring quality (regulation 10)
- records (Regulation 21).

These compliance actions were inspected as part of the comprehensive review and the requirements remained unmet.

Our inspection team

The Lead Inspector was Graham Hinchcliffe

Deputy Inspector Barry Wilkinson

The team that inspected Waterloo Manor Independent Hospital consisted of eight people: one expert by experience, three inspectors, one Mental Health Act reviewer, two nurses, and one consultant psychiatrist.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Detailed findings

Before the inspection visit we reviewed information that we held about these services and asked a range of other organisations such as NHS England and Clinical Commissioning Groups for information.

During the inspection visit, the inspection team:

- visited all seven wards, looked at the quality of the ward environment, and observed how staff were caring for patients.
- spoke with 24 patients who were using the service.
- spoke with the charge nurses or acting charge nurses for each of the wards.
- spoke with 22 other staff members; including doctors, nurses, and senior managers.
- interviewed the divisional directors with responsibility for this service.
- observed two hand-over meetings and one multi-disciplinary meeting.

We also:

- looked at 20 treatment records of patients.
- looked at a range of policies, procedures and other documents relating to the running of the service.

Inadequate

Are services safe?

Our findings

Safe and clean environment

Ward environments were not adequately safe or clean. We inspected all ward areas and observed that there were areas which patients had access to that could not be safely observed. Overall, wards lacked enough parabolic mirrors to ensure all areas of the ward could be observed, including potential blind spots. We saw examples within incident reports where patients took opportunities to harm themselves in the absence of safe and effective staff observation.

There were no qualified nurses based in the communal ward areas where patients had unrestricted access. We observed qualified nursing staff spending time in the ward office and not engaging with patients on the wards or carrying out core nursing tasks. We did not observe nursing staff effectively leading staff teams to ensure wards were well organised and structured. This meant staff were not following the organisation's observation policy, dated October 2014, to ensure the safety and well-being of patients.

Incident records that showed a number of serious incidents, involving the use of ligatures, had occurred in the service during the months prior to our inspection. We asked the service to provide us with the exact number of incidents which had occurred in the service over a 12 month period involving ligatures and other self-harm activity. The service did not have this information available when it was requested, despite repeated attempts from inspectors to obtain the information.

Staff carried out assessments of ligature risks on all wards in May 2014. The ligature assessments had identified many high level risks on all wards. The service took some action to address the risks identified, such as the replacing of some shower taps. There were plans in place to conduct a larger programme of works to address many of the existing risks. However, the plans had no clear time scales stating when the actions to reduce the risks should be completed. We raised concerns directly to the senior management team regarding ligature points in high risk areas.

The permanent staff we spoke to knew where ligature cutters were located and told us that they knew how to use them. However, due to high numbers of agency staff employed within the hospital, there was an increased risk that some staff would not be able to identify and use ligature cutters in an emergency.

Communal areas were dirty. We found dirt and debris under kitchen appliances, furniture that was broken or damaged, bathrooms in patient bedrooms that had mould and stagnant water on the floors and walls. There was what appeared to be blood stains on a door frame of one ward. Ward cleaning was not consistent across the hospital. For example, some wards had domestic cleaning staff with daily cleaning schedules in place which were monitored, other wards had domestic cleaning staff who cleaned twice weekly, but there were no cleaning schedules in place to allow monitoring of cleaning. Patients cleaned communal areas of wards, however, there were no protocols in place to ensure patients cleaned effectively.

The cleanliness of the wards and standard of furniture had repeatedly been brought to the attention of the senior management of the hospital through patient meetings and governance meetings and had been placed on a risk register, however, no action had been taken to address the inadequate standards within the ward environments. Patients told us that they were unhappy with the ward cleanliness and standard of furniture provided.

We concluded that the poor environment impacted on the health, well-being and recovery of the patients at Waterloo Manor Independent Hospital.

There was no consideration of any quality of life indicators to assess the health and well-being of patients.

Emergency equipment, including oxygen, was in place. It was checked daily to ensure it was fit for purpose and could be used effectively in an emergency. Medical devices and emergency medication were also checked daily. However, training records we looked at showed 76% of staff had received training in life support. The service did not have any processes for ensuring agency staff had received training relevant to the care and treatment to be provided at Waterloo Manor hospital.

Staff had personal alarms to use in the event of an emergency, however one member of staff was working alone with patients in an isolated area of the hospital and

did not have access to a personal alarm. We raised this as an urgent concern to the management team and as a consequence the member of staff was provided with an alarm.

Safe staffing

The service carried out a review of nurse staffing levels, this was used to set staffing levels on each of the wards. We reviewed the staff information available to us prior to our inspection and saw that staffing levels were in line with the levels and skill mix determined by the service as safe.

However, we could not establish if staffing levels on individual wards were adequate, as we found staff were regularly moved around the hospital to meet the needs of wards, and it was not possible, based on the information provided, to understand how frequently staff were being moved. There were no records kept of times nursing staff were deployed to other wards. Inspectors repeatedly requested information on how staffing levels were determined on a daily basis and what tool was used. The service did not have this information available despite repeated requests by inspectors.

The hospital managers told us they had a high number of staff vacancies across the service, which included nurses and health care assistants, but could not tell us what the staffing gap was, only that it was "high". They told us that the vacancies resulted in a significant use of temporary agency staff. We looked at minutes of board meetings, these stated that the service struggled to recruit and retain nursing staff. The service covered 263 shifts with bank and agency staff for the low secure service and 351 shifts for the rehabilitation services.

Three charge nurses told us they could not obtain additional staff when the needs of patients changed unless a senior manager agreed to the request. Hospital managers stated that the company directors placed financial constraints upon them. Hospital managers also told us that they lacked autonomy to address concerns regarding staffing levels, which meant there were instances when staffing shortages occurred. We asked how frequently this happened, but hospital managers could not to provide us with any specific details.

Temporary agency staff, who had not worked on a ward at the hospital before, were given a brief induction to the ward. This included orientation to the layout of the ward. They were provided with written guidance on the local health, safety, and security procedures for the wards. They were expected to read these at the start of their shift. It did not provide sufficient detail to ensure staff were adequately informed about the nature and responsibilities of the ward. Hospital managers told us that temporary agency staff were responsible for the daily management of the ward and although the service tried only to use nursing staff who had worked in the hospital previously, this was not always guaranteed.

All of the patients in the hospital presented risks to themselves or others, and at times may have required the use of physical intervention. Since staffing rotas did not make clear which staff had training in the use of physical interventions it was impossible to say whether there were enough staff with the right skills on duty. Also it was unclear if agency staff had received the same intervention training as permanent staff and the hospital management team could not provide us with any assurances.

Patients using the service could not always take up agreed escorted leave as there were not always enough staff to escort them. We asked for information to clarify how many times leave was cancelled due to short staffing over a three month period. The information provided simply stated “many cancelled”. The service could not tell us exact numbers or how they analysed this information to review staffing levels to ensure patient leave was supported.

All nursing staff we spoke with told us the majority of patients were offered a one-to-one meeting with a member of staff every day. However, many patients told us they did not have sufficient one-to-one time with staff because staff were unavailable. The service could not provide us with any information about any quality assurance systems in place to monitor one-to-one time with patients.

Regarding arrangements for accessing emergency medical assistance, medical staff told us that in the event of an emergency the service accessed emergency services, used local GP services, or used out of hours services.

Assessing and managing risk to patients and staff

We spoke with patients on all the wards we visited. A few patients felt unsettled and unsafe after incidents on the wards. These included patient on patient assaults and bullying occurring by other patients. There were reports of staff bullying patients. Records we examined showed that the service had upheld 22 allegations of abuse by staff towards patients between January 2014 and January 2015.

Inadequate

Are services safe?

Only six of these allegations were reported to the local safeguarding authority. No safeguarding alerts had been made by senior managers or nursing staff, despite some allegations being serious in nature, such as staff being verbally abusive to patients and failing to follow a patient's diabetic regime.

There were 46 other allegations of patients stating that they were being bullied by other patients since January 2014. Fifteen patients told us they did not feel supported or listened to by staff when raising concerns about their safety.

The service had identified bullying on the wards as an issue and set up patient forums. However, these were only in their infancy at the time of our inspection and it was unclear if they were proving to have a positive effect. Staff told us the forums were positive and bullying appeared to have reduced. However, we asked what tools were used to formulate the assessment, but none were in place.

While staff stated they had received training in safeguarding adults and children, records we saw showed it was not always up to date. Some staff received training in 2011 with no further updates evident since.

The service also had a confidential whistleblowing line staff could use if they felt patient safety was compromised. However, the service had only been used on two occasions at the time of our visit. Staff told us they did not feel confident their concerns would be taken seriously if they used the whistle blowing service and therefore often said nothing, or made referrals to other agencies to take action, such as the CQC.

Patients did not describe the service positively. They talked about being bullied by staff, both permanent and temporary, about being insulted and treated in a disgraceful manner. We brought the patient feedback to the attention of senior managers in the organisation. We spoke with the safeguarding lead for the organisation who told us that staff required additional training because it was not always evident staff knew how to report incidents of abuse.

Managers told us safeguarding was discussed at ward meetings and it was a standing item on the agenda. They also told us safeguarding discussions with staff also took place during supervision to ensure staff had sufficient awareness and understanding of safeguarding procedures.

However, when we requested to look at ward meetings we found they had no agenda and there was an overall lack of staff supervision and we could not evidence that safeguarding being discussed.

We were told that each patient had a risk assessment completed on admission. We looked at patient records and each contained assessments of their individual risks.

Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was managed. For example, the level and frequency of observations of patients by staff were increased. Individual risk assessments that we reviewed took account of patients' previous history, as well as their current mental state. However, despite these being in place the credibility was compromised because there were three assessments in place that staff regarded as risk assessments and each assessment was contradictory of the other, which meant there was no consistent approach to managing risk.

Risk assessments were generally updated, but we saw four examples where they were not current. A generic risk assessment tool was used for assessing patients who were going on leave from the hospital. However, this did not take into account the individual risks of each patient or effectively consider the risks prior to a patient going on leave. We saw an example in one patient's record where they had failed to return from leave and placed themselves at risk of harm. The risk assessment completed prior to the person leaving was not sufficiently robust and failed to take into account the patients risk profile.

We observed a morning handover on two wards. Some staff turned up late and important information was not repeated, therefore, these staff did not receive the necessary information to meet the patients' changing needs. There was no discussion of current risks and no discussion around the patients' care and treatment. The overall handover process was inadequate.

Staff told us there was a problem with some patients taking illegal drugs when patients left the ward. This posed a possible risk of drugs being brought into the hospital by patients returning from leave. However, staff we spoke with were confident that the use of drugs on wards was low due to security measures in place that all staff were aware of.

Inadequate

Are services safe?

There was a policy in place in respect of searching premises, patients and/or their property; this was up to date. The policy described the search procedure and the use of drug detection.

Staff told us there was a greater emphasis within the service on the use of de-escalation techniques, which resulted in a reduction of the number of times patients were restrained. Guidance published by the Department of Health in April 2014 called "Positive and Safe" includes new guidance on the use of face-down restraint. Senior staff told us that the guidance on restraint was being revised. Further work was needed on this to reduce the risk of physical and psychological harm to patients and staff. Records we looked at were unclear on the number of incidents that included the use of de-escalation techniques which then escalated to the use of restraint over the past year. We could not confirm if the use of restraint had reduced and the service did not have a clear audit to demonstrate the use of de-escalation or restraint.

We reviewed the medicine administration records of several patients on wards we visited. We spoke with the visiting pharmacist about medication management. The pharmacist informed us that they were not invited to attend or contribute to the medicines management meetings at the hospital. The minutes of monthly medicines management meetings from the last six months prior to our inspection visit confirmed this. We were also informed that the pharmacist completed a weekly audit of medicines management. They raised issues every week about the untidiness of clinic rooms and the temperature of the storage facility, but no action was taken to make any changes. We asked to see the pharmacy audits and action plans but these were not provided to us despite repeated requests from inspectors to hospital managers.

On Hazel ward the clinic room was used as a staff office and storage area for coats and bags. There were cups in the clinic sink that staff had used for drinks, these were alongside medication spoons and utensils. There was no apparent consideration of how inappropriate this was in relation to managing infection control and basic hygiene.

We could not always find evidence that the Responsible Clinician had discussed treatment with patients, or assessment of their capacity to consent to treatment. For example, a Responsible Clinician had prescribed up to 175% of the British National Formulary (BNF) in regards to an anti-psychotic drug and recorded that "the client agrees to ECG and bloods". There was no record stating the patient consented to the treatment provided or whether or not they had the mental capacity to do so. On one ward there was an overall absence of recorded reviews of medication when they were prescribed over BNF limits by the Responsible Clinician.

Patients on Maple ward told us that they did not receive much information about their medication and were not always consulted on the medication and treatment provided and were not therefore always aware of possible side effects that they should be aware of.

Track record on safety

Between the 7 January 2014 and 2 January 2015 there had been 56 serious untoward incidents identified by the service.

Eight Incidents related to incidents of self harm.

24 incidents of patient on patient abuse.

Four sexual related incidents.

12 incidents of abuse by staff.

Three incidents of patients being absent without leave.

Five incidents of another nature such as financial abuse and historic disclosures of abuse.

Reporting incidents and learning from when things go wrong

Staff we spoke with on all wards could describe how they reported incidents and told us about log books, which were then uploaded onto an electronic system. All nursing staff told us there was no overview of incidents reported on their wards. They described how graphs showing incidents and trends were produced by one consultant psychiatrist. However, they did not understand the information provided and failed to see how it was beneficial or useful. We took time to review the data and found the system complex and while the information demonstrated a reduction in incidents for some patients, it was unclear how the information was collected.

Nursing staff told us that the feedback they received about incidents was inconsistent because they often were not informed about incidents across the hospital. They told us there were weekly lessons learnt meetings. We attended one of the meetings and found there was no discussion regarding incidents which had occurred, or even any

sharing of information regarding incidents. The meeting was poorly structured, there was no agenda, no focus for discussion, and no focus on patient safety. The meeting was chaired by a senior manager within the service but there was a lack of preparation prior to the meeting.

Inadequate

Are services effective?

Our findings

Assessment of needs and planning of care

The assessment of patient's needs and planning of care was inadequate.

We looked at the physical health care needs of patients and found they were not sufficiently assessed. For example 15 patients we reviewed had a Body Mass Index (BMI) between 30 and 50 and had health conditions associated with obesity, such as diabetes. A person with a BMI of 30 or over is regarded as clinically obese and, therefore, in order to remain healthy, a weight reduction programme and health promotion are essential. There was no input from a dietician in any of the care plans we reviewed.

We looked at relative/carer satisfaction survey which was undated but was a period of up to June 2014. Some of the comments highlighted were " visits and outing cancelled suddenly, physical health neglected, appointments missed or not made". Other comments were "staff are unqualified for their positions". The comments highlighted by relatives and carers from June 2014 were reflected in our inspection of the service

Eight nursing staff, including charge nurses, told us that they did not understand the risk assessment tools used and how these should inform patient's care plans. The psychologist and the occupational therapists had compiled assessment and treatment plans, but these were not incorporated by the nursing staff into effective care plans for the patients.

Care records were not always up to date. For example, the front sheet of patient information for five patients had not been updated since the patients had moved wards within the hospital. The dates of admission to the ward were not listed accurately. We also found 'AWOL information' did not contain the most up to date risk factors as listed in the care plans as these had not been updated since admission for some patient's.

Best practice in treatment and care

Wards did not have any lead nurse for physical health to ensure patients needs were met. Regular physical health checks were not actively taking place because staff did not have the suitable skills to ensure this was done effectively. They had not received training in physical healthcare and this was confirmed by senior managers . We saw one record where training had been sourced but we were told by senior managers that it was not completed. The senior manager could not explain to inspectors why the training had not been completed.

The hospital cook had not received any training on healthy eating. We looked at the food available on the four weekly menu and saw that there was only 'plated salad' as a healthy option each day. Many patients that we spoke with told us that there were not enough healthy options and that they were concerned about their weight. Minutes of the patient community meetings from Cedar, Hazel, Larch and Maple from December 2014 to February 2015 showed on multiple occasions that patients had expressed a desire for more healthy food options.

We observed during the inspection that an activity on offer was baking cakes. Patients who were at risk of further weight gain were encouraged to participate in this activity and it was deemed by staff as supporting patients with daily living skills. We questioned a senior manager about the appropriateness of the activity being offered given the health and well-being of many patients. We were told the service had a healthy eating programme. We were shown the details of the programme, but it was not an effective plan as it simply consisted of a poster detailing when a healthy eating group was due to commence . No staff had received training in obesity, healthy eating, diet or nutrition and yet were expected to give advice to patients.

We looked at the care plan of one patient who had unexplained continence problems. There was no input from a continence nurse and no care plan in place to manage incontinence. Failing to manage continence correctly can have a negative impact, such as development of pressure sores, additionally there can be issues of dignity and respect for the patient which should be carefully and sympathetically considered.

One patient required referral to a sexual health clinic. Staff told us and records showed an appointment had been made, but the appointment was not attended and staff were not able to give a suitable explanation as to why not. No further appointment had been made.

The wards did not use any recognised systems such as for example Modified Early Warning Signs (MEWS) to identify

physical health concerns. Because no such systems were in place, if a patient's physical health was deteriorating or giving cause for concern, this may not have always been identified.

Patients could access psychological and occupational therapies as part of their treatment. Psychologists and occupational therapists were part of the ward team. However two occupational therapists we spoke with told us they did not feel valued by nursing staff. They told us that intervention plans as well as advice and guidance was readily ignored.

The ward staff assessed patients using the Health of the Nation Outcome Scales (HoNOS). These covered 12 health and social domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions. However staff did not understand how to use the information and had not been trained to use HoNOS. All the nursing staff we spoke with told us they thought it was another tool to carry out risk assessments; HoNoS is not a risk assessment tool.

The service had implemented 'Total Team Therapy',however, none of the staff we spoke with, other than some of the hospital management team, were able to tell us about this approach to care. Most staff showed a lack of awareness of or understanding of Total Team Therapy, therefore, it was not particularly well embedded into the service.

Skilled staff to deliver care

Staff were not appropriately skilled or supervised to ensure patients received safe high quality care.

Staff told us that clinical supervision was given on a one to one basis or at 'reflective practice' groups which were held on a weekly basis. We attended a reflective practice group on 20 February 2015 at 1pm. There was no set agenda for the group or minutes taken. There were no previous records of minutes taken. The discussion within the meeting was about problems within the hospital and was not about clinical matters.

Staff told us, and records we looked at confirmed, that there was limited management supervision in place available for staff. The information provided showed only 56% of staff had received supervision over a 12 month period.

Throughout the inspection we spoke with staff on all seven wards about appraisals. Insufficient numbers of staff had received an appraisal within the last 12 months.

We were provided with a copy of the appraisal database as at week commencing 8 February 2015.

- 21 out of 74 permanent health care staff had not had an appraisal within the last 12 months.
- Six out of 19 nursing staff had not received and appraisal within the last 12 months.
- 12 out of 44 other (management and admin staff) had not received an appraisal within the last 12 months).
- ·No bank staff had received an appraisal.

The training records we looked at saw staff from records of the 19 February 2015 showed that there were large gaps in mandatory training such as:

- · First Aid; 78% of staff had up to date training.
- · Moving and handling; only 15% of staff had up to date training
- · Management of Actual or Potential Aggression;70% of staff had up to date training
- · Health and safety; 74% of staff had up to date training
- · Mental Capacity Act; 48% of staff had an up to date training

No staff received training in physical healthcare or HoNOS.

Multi-disciplinary and inter-agency team work

Patient records included advice and input from different professionals involved in patients' care. Patients we spoke with confirmed they were supported by a number of different professionals on the wards,such as nurses, health care workers, occupational therapists, psychologists and psychiatrists. Information provided by the MDT was not formulated into any robust nursing care plan.

We observed one MDT meeting and found there was sharing of information about patients with a focus on reviewing their progress. Different professionals worked together effectively to assess and plan patients care and treatment. However, our findings were that this appeared to be an exclusive way of working for one psychiatrist who was the hospital clinical director and this way of working was not consistent across the hospital. Records we examined in relation to 15 patients under other psychiatrists did not demonstrate the same collaborative way of working.

Inadequate

Are services effective?

We did not observe inter-agency work taking place such as care co-ordinators attending meetings. This did not appear to regularly occur from the records we examined or was not clearly recorded.

Adherence to the MHA and the MHA Code of Practice

Records showed that only 48% of staff received training on the Mental Health Act and the Code of Practice.

We could not find evidence of capacity assessments regarding the consent and use of medication in the patients' notes. We did not see any capacity assessment forms for this purpose. Also we could not find evidence that statutory consultees were recording in the patient's file their discussion with the visiting Second Opinion Approved Doctors. We were equally concerned that staff were not aware that this was required by the Code of Practice.

The use of anti-psychotic medication for some patients was high and at times above British National Formulary (BNF) limits. Although this was properly authorised it's usage should be reviewed and recorded at agreed regular interval. Patients should always be made aware of any use over BNF limits unless the reasons for not informing them are clearly documented in the patient's notes.

Information on the rights of people who were detained was displayed in wards and independent advocacy services were available to support patients.

We saw evidence on patient files that patients had appealed to the Mental Health Review Tribunal and had contact with solicitors for advice and support with this process.

We could not find the renewal of detention documents for one patient whose detention was due for renewal in December 2014. We were told that the documents had not yet been filed and they were not found during our visit.

Good practice in applying the MCA

Some staff told us they had received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff were not aware of any audits taking place to monitor the use of the MCA 2005.

We looked at the records of two patients where we had identified concerns regarding the application of the MCA 2005 and found the staff knowledge to be very limited. For example one patient who required physical intervention for personal care had neither a capacity assessments or a best interest assessment, nor input from an independent mental health advocate.

Inadequate

Are services caring?

Our findings

Kindness, dignity, respect and support

Patients told us that staff did not always treat them with respect. They told us that their privacy and dignity was not always considered and often felt unable to raise concerns about the attitudes of staff towards them. Records we looked at showed that out of 106 complaints made within the 12 months prior to our inspection, 48 of them related to allegations of abuse by staff. 22 of these allegations had been upheld by the organisation, but only six had been referred to the local safeguarding authority for independent investigation. The allegations made were against temporary and permanent staff.

We observed staff interacting with patients and found there was an overall lack of engagement. We found that patients spent hours of time sat around with very little to do. Staff appeared to lack interest and did not engage in providing good quality care to patients. For example, we observed staff over an 18 hour period over three days and found staff spent considerable time sat on sofas in communal areas with up-to eight patients at a time and they were not seen to offer activities or motivate patients to participate in anything therapeutic, other than baking cakes which was detrimental to some patients health and well-being.

The involvement of people in the care they receive

Care plans were not personalised, holistic or person centred. On some wards patients had made written comments about their care plans. Patients we spoke with on different wards were generally aware of the content of their care plans, although five patients said they had not seen them and were unaware of its contents. Some care plans had been signed by patients to say they understood their care and treatment.

Staff told us patients were encouraged to involve relatives and friends in care planning if they wished however we did not see any input into care plans from patient relatives/ carers. Comments from a relative and carer survey in June 2014 had comments such as " I don't know if I am happy with her treatment, nobody tells me anything"; "I have requested updates on a regular basis, but get told nothing".

Details of local advocacy services were displayed in all the wards. Patients told us they were supported to access an advocate if they wished. We saw the advocates had raised a number of complaints on patients' behalf, such as needing new plates and cutlery. However, no action had been taken to address these patients' complaints.

We saw all wards had weekly community meetings where it was formally recorded that patients did not engage in the meetings, as they believed their views were not taken into account or acted upon. We saw examples in meeting minutes where patients complained about no action being taken to resolve issues such as healthy diet options or the standard of furniture and cleanliness on wards. Patients told us they did not feel listened to.

We did observe staff respond to one patient who was in distress in a calm and respectful manner. They de-escalated the situation by listening to and speaking quietly to the patient.

When staff spoke to us about patients, they discussed them in a respectful manner but were not always able to tell us about their care and treatment plans in sufficient detail to evidence appropriate understanding of individual's needs; an enhanced understanding is needed in order to manage individual risks appropriately.

Inadequate

Are services responsive?

Our findings

Access and discharge

The service had an admission policy. Staff we spoke with told us that they often felt patients referred to the service were not suitable either due to their complex needs or physical healthcare requirements. Staff told us this made delivering care to a high standard was often compromised. There were patients in the service who had learning disabilities and Asperger's syndrome who were at more risk of not having their needs met because staff had not received any training in these areas.

We looked at the discharge arrangements across all wards and found in all the care records we looked at that none of the patients had discharge plans in place. Furthermore, there was no information within the care plans detailing the needs of patients and the services they require in order to progress towards discharge. We found some patients had been detained at the service for a period of up to five years without any clear plans for discharge. The average length of stay was 24 months for secure services and 10 months for rehabilitation services.

Some patients experienced several moves between wards for non-clinical reasons during their stay at the hospital. Of these, some were transferred during the night and/or went to wards where they did not know, or were not known by, the multidisciplinary team. There were informal agreements rather than a clear protocol on the management of transfers between wards. This meant that transfers between wards were not managed in a planned or co-ordinated way. This type of poor management can lead to patients needs not being met.

The facilities promote recovery, comfort, dignity and confidentiality

The wards had a full range of rooms and equipment. This included space for therapeutic activities and treatment. However, during our inspection we did not observe patients accessing any rooms other than communal sitting areas where they were observed by staff.

The service had a number of rooms which could be used by patients to meet their relatives/friends/carers. There was also a family room where children could visit. This was located away from all wards.

The service had multi-faith rooms that were also used as staff handover rooms and meeting rooms. The rooms were not being used for the intended purpose and did not reflect patients' religious and cultural needs appropriately.

Each ward had access to a phone and patients had access to it.

All the wards offered access to an outside space, which included a smoking shelter. However, we found some of the areas to be in a state of disrepair. The areas were not clean and many were littered with used cigarette ends with no apparent system to ensure that these areas should be maintained appropriately.

Food was served at specific meal times. We found that, where patients may be absent from hospital, during meal times for reasons such as medical appointments and granted leave, upon their return, the choice in meals was limited. Patients told us the food was not to a good standard. They often felt it was unhealthy and that there was insufficient choices available. Records we looked at showed that food was often complained about and the meals provided were not of a healthy nutritious nature. Patients who were of particular faith or culture had limited choice in food, there was nothing specific on the menus we looked at which took into account patients' religion and culture.

Weekly activity programmes were advertised on all wards and the activities were discussed as a “day planner” for each ward. Records were kept of daily activities provided on the wards and a register of who had participated. Staff told us that planned activities were sometimes cancelled at busy times because of a lack of staff available to run them. We did not observe patients participate in any activities on the wards during the course of our inspection. Patients sat around in chairs being observed by staff who appeared to make little effort to engage them in any kind of meaningful activities.

Patients also had access to occupational therapy. An occupational therapist was assigned to each ward and conducted individual assessments of patients’ needs. Two of these therapists told us that patients were more interested in taking leave so they could purchase crisps and fizzy drinks than engage in therapy sessions such as walking groups, swimming and gym sessions. They told us nursing staff did not encourage patients to use their leave effectively. It was acknowledged by senior managers that

activities were often not participated in unless it was section 17 leave where patients could access the local area to purchase fizzy drinks and crisps. It was equally acknowledged that no audits of activities were carried out by the service to measure engagement and effectiveness.

Meeting the needs of all people who use the service

The service had an external organisation providing support to those who defined themselves as lesbian, gay, bisexual and transgender. However, it was unclear how the wards were representing safe wards through inclusion for all. Patients told us that bullying between patients occurred because of sexual orientation. We saw examples in incident records to support what we had been told.

Attempts were made to meet patients' individual needs including cultural, language and religious needs. Contact details for representatives from different faiths were available within the hospital. Local faith representatives visited patients where a request had been made.

Interpreters were available to staff and were used to help assess patients' needs and explain their rights, as well as their care and treatment.

Listening to and learning from concerns and complaints

As stated in other areas of this report, complaints and concerns were not listened to, responded to or investigated effectively. Patients knew how to raise concerns and make a complaint but told us that they had stopped complaining "because nothing ever happens when you do". Feedback from family and carers was similar to what patients told us. For example in a survey June 2014 people said "when I complain it seems you take no notice" and "I find specific complaints made not really addressed adequately". There were no positive comments to note.

Inadequate

Are services well-led?

Our findings

Vision and values

The organisation's vision and values for the service were not evident. They were not displayed around ward areas and staff we spoke with other than senior managers had no knowledge of what the vision and values were.

Several staff suggested that communication was mostly one way, from the board down to the wards. They were not sure whether messages travelled effectively in the opposite direction and told us they felt they were not listened to.

Senior managers acknowledged that there was a poor culture in the hospital and that they believed certain staff were intentionally attempting to sabotage the reputation and credibility of the hospital. We were told that where issues regarding individuals had been identified then disciplinary action was being taken. However, there was still no effective plan implemented to ensure that the communication between staff and management improved. There equally appeared to be a lack of recognition from senior managers of their own shortfalls and contribution to the negative culture between some staff and management. By not providing suitable training and supervision as well as not listening to concerns raised by staff through the complaints process, the senior managers had allowed the poor culture to prevail.

Good governance

The overall governance for the service was inadequate. The wards had access to systems of governance that enabled them to monitor and manage the ward and provide information to senior staff in the organisation but these were either not used or understood.

Three charge nurses told us that they did not have enough time or autonomy to manage the wards. They also said that, where they had concerns, they did not feel that they could raise them and that appropriate action would be taken. They gave examples of when they questioned the management about staff being moved around the wards, they were told "staff were there to meet business needs." This was recorded in a complaint we reviewed.

The organisation's risk register did highlight concerns such as ligatures and poorly maintained physical environments, however, no actions were taken by the senior management team to ensure patients' were in receipt of high quality, safe and effective care. Senior managers told us that they did not have the necessary autonomy or permissions from the organisation's board of directors to address these concerns adequately, as financial constraints were placed on them by directors, preventing them from taking sufficiently robust actions.

Leadership, morale and staff engagement

We found the wards to be poorly led. There was no evidence of clear leadership at a local level. Charge nurses were not visible on the wards during the day-to-day provision of care and treatment, they were not always accessible to staff, and they were not proactive in providing support. The culture on the wards was not open and staff did not feel encouraged to bring forward ideas for improving care.

The ward staff we spoke with were not enthusiastic and did not appear engaged with developments on the wards or in the hospital. They told us they did not always feel able to report incidents, raise concerns and make suggestions for improvements. They told us they did not feel listened to by their line manager. Some staff gave us examples of when they had raised concerns about the care of patients' and said this had been received negatively by senior managers and that no changes being made.

All nursing and healthcare staff we spoke with told us that, following significant changes in the service within the recent year, morale in the service was very low. They also felt that although they had confidence in the new hospital director, the service was not moving forward effectively because other senior managers were hindering relationships and effecting possible improvements because of what they perceived as bullying and harassment.

Sickness and absence rates were high and the ability to recruit new staff was proving a difficult issue for the service. However, when we asked the service to provide specific details regarding this they could not, despite repeated requests from inspectors.

At the time of our inspection there were grievance procedures being pursued within the wards, and there were allegations of bullying and harassment. We were unable to determine from the data provided exactly how many.

Inadequate

Are services well-led?

Staff were aware of the whistle blowing process if they needed to use it, but told us they would rather contact other agencies such as CQC because they did not feel listened to by their own organisation and they also believed that their concerns would be ignored.

Ward managers told us that they had only very limited access to leadership training and development within the hospital.

Commitment to quality improvement and innovation

At the time of this inspection we could not identify any evidence to demonstrate the service was committed to quality improvement and innovation.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the provider MUST take to improve

The service MUST ensure that the environment adequately meets the needs of patients by ensuring that action is taken to minimise the risk of harm.

The service MUST ensure that people have appropriate risk assessments in place which reflect patient risks and actions to be taken to reduce the possibility of harm.

The service MUST have effective arrangements in place for the safe management of medication.

The service MUST have appropriate methods in place to analyse incidents and learn lessons when things go wrong.

The service MUST ensure that staff have the necessary skills and experience to ensure the safety of patients. The service must review the way staff are deployed around wards to ensure they are sufficiently staffed.

The service MUST ensure that patients are protected from the risk of abuse or possible harm by ensuring that there is an open and transparent culture within the hospital and the wider organisation to allow and encourage staff and patients to discuss concerns openly without fear of victimisation, bullying or harassment.

The service MUST ensure that patients' physical, social and psychological needs are appropriately assessed and that care is delivered effectively.

The service MUST ensure that patients have discharge plans and that effective inter agency working relationships with partner agencies are being managed appropriately to ensure optimum outcomes for patients.

The service MUST ensure that best practice and guidance is followed in managing and treating physical and mental health conditions.

The service MUST ensure that staff receive adequate training, appraisal and supervision to meet both management requirements and clinical development needs.

The service MUST ensure that patients receive a healthy and nutritious diet.

The service MUST ensure that the Mental Health Act and Code of Practice are complied with and that staff have the necessary training to ensure compliance.

The service MUST ensure the Mental Capacity Act is applied correctly when required and that staff have the necessary training to ensure compliance.

The service MUST ensure that patients are involved in the planning of their care and appropriate arrangements should be made to meet the needs of patients' religious, cultural and other individual needs.

The service MUST ensure that it has effective governance arrangements in place to ensure effective oversight of all risks within the service and to promote high quality, safe, effective and responsive care and to ensure that appropriate actions are taken to mitigate risks and to promote an open and transparent learning culture within the hospital.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) Practical steps had not been taken to prevent the risk of abuse to patients.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (2) (3) (a) (b) (c) (d) (e) (f) Practicable steps were not taken to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be. Patients did not receive appropriate care and treatment that met their needs. Patients and those acting on their behalf were not adequately involved in the planning of care. Assessments did not take into account current legislation and consider relevant nationally recognised evidence based guidance. Assessments did take into account specific issues that are common in certain groups of patients and can result in poor outcomes for them if not addressed. These include diseases or conditions such as continence support needs and diabetes. Patients' preferences were not taken into account, and make provision for, A clear care and/or treatment plan, which includes agreed goals, was not developed and made available to all staff and others involved in providing the care. Where relevant, the plan should include ways in which the person can maintain their independence. Nationally recognised evidence-based guidance when designing, delivering and reviewing care.

This section is primarily information for the provider

Enforcement actions

The views of patients who use the service and those lawfully acting on their behalf was not sought effectively by demonstrating there was action taken in response to any feedback.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (c) (d) (e) (f) (g) (h) (I) Assessments, planning and delivery of care and treatment was not based on risk assessments that balance the needs and safety of patients using the service. Practical steps had not been taken to mitigate risks that were identified which compromised patient safety and well-being. Staff were not suitably qualified, competent and skilled to carry out their roles. The environment was dirty and not free from the risk of infection and where furniture and fixtures were damaged they were not repaired or replaced. There was not proper and safe management of medication. The service did not work collaboratively with other professionals external to the hospital to ensure patients received safe and effective care.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f)

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) (2) (a) (b) Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to meet the needs of patients. Staff did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
	The service did not effectively assess, monitor an improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); The service did not effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The service did not effectively maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

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Yorkshire Ambulance Service NHS Trust

Quality Report

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Wakefield 41 Business Park
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West Yorkshire
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Tel: 0845 124 1241
Website: www.yas.nhs.uk

Date of inspection visit: 13-16 January 2015,19 January 2015,9 February 2015
Date of publication: 21/08/2015

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	**Requires improvement**
Are services at this trust safe?	**Requires improvement**
Are services at this trust effective?	**Requires improvement**
Are services at this trust caring?	**Good**
Are services at this trust responsive?	**Requires improvement**
Are services at this trust well-led?	**Requires improvement**

Letter from the Chief Inspector of Hospitals

Yorkshire Ambulance Service NHS Trust (YAS) was formed on 1 July 2006 when the county's three former services merged. The trust covers North Yorkshire, South Yorkshire, West Yorkshire, Hull and East Yorkshire covering almost 6,000 square miles of varied terrain, from

Summary of findings

isolated moors and dales to urban areas, coastline and inner cities. The trust employs over 4,670 staff and provides 24-hour emergency and healthcare services to a population of more than five million.

The trust provides an accident and emergency (A&E) service to respond to 999 calls, a 111 service for when medical help is needed fast but it is not a 999 emergency, patient transport services (PTS) and Emergency Operation Centres (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART).

Our inspection of the ambulance service took place between 12 to 15 January 2015 with unannounced inspections on 19 January 2015 and 9 February 2015. We carried out this comprehensive inspection as part of the CQC's comprehensive inspection programme.

We inspected four core services:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services
- Resilience Services including the Hazardous Area Response Team:

Overall, the trust was rated as Requires Improvement. Safety, effectiveness, responsive and well-led were rated as requires improvement. Caring was rated as good.

Our key findings were as follows:

- At the time of inspection four out of the six executives were in substantive positions however there had been a recent loss of the Chief Executive and a history of change at executive level within the trust.
- There was below national average performance over Red 1 and 2 targets and an increased number of complaints which did not meet the trusts 25 day response times. The trust reported an increase in activity across all services during this period.
- The trust were in the process of changing the culture in the organisation from performance target driven to one of professional/clinical culture.
- There was a history of poor staff engagement and relationships between senior management and workforce. There was a recent introduction of new rotas and meal breaks which had a further negative impact on relationships.
- We had significant concerns within the HART service about the checking of equipment a large number had passed their expiry dates and assurance processes had not detected this. There were also inconsistencies with checking of breathing apparatus and the processes observed did not follow best practice guidance. We re-visited the HART base two days after the announced inspection and one month later to check that changes had been implemented in response to our concerns.
- Development work had been undertaken to strengthen the assurance and risk management process and these showed improvement, but lacked maturity. Issues were found on inspection, for example; there were security issues at one station and cleanliness of ambulances was an issue across the region, but particularly at the HART unit, which demonstrated a lack of robustness with misleading results giving rise to false assurance.
- The trust had major difficulties in recruiting staff; national shortages of paramedics contributed to the trust's difficulty in recruiting paramedics which impacted on the ability to be responsive and also enable staff to attend training and other activities. The trust was working hard to be more outward facing, working in partnership with commissioners and improving consultation with patients and the public.

We saw several areas of outstanding practice including:

For the trust:

- The trust's 'Restart a Heart' campaign trained 12,000 pupils in 50 schools across Yorkshire.
- The trust supported 1,055 volunteers within the Community First Responder and Volunteer Care service Scheme.
- Green initiatives to reduce carbon in the atmosphere by 1,300 tonnes per year.
- The emergency operations call centre was an accredited Advanced Medical Priority Dispatch System (AMPDS) centre of excellence.

Summary of findings

- Mental health nurses working in the emergency operations centre to give effective support to patients requiring crisis and mental health support. This included standardised protocols and 24 hour access to mental health pathways and crisis team.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- The trust must ensure all ambulances and equipment are appropriately cleaned and infection control procedures are followed.
- The trust must ensure that equipment and medical supplies are checked and are fit for purpose.
- The trust must ensure all staff are up to date with their mandatory training.

In addition the trust should:

- The trust should ensure all staff receive an appraisal and are supported with their professional development. This should include support to maintain the skills and knowledge required for their job role.
- The trust should ensure risk management and incident reporting processes are effectively embedded across all regions and the quality of identifying, reporting and learning from risks is consistent. The trust should also ensure staff are supported and encouraged to report incidents and provide feedback to staff on the outcomes of investigations.
- The trust should ensure all ambulance stations are secure at all times.
- The trust should review the provision and availability of equipment for use with bariatric patients and ensure staff are trained to use the equipment.
- The trust should review the safe management of medication to ensure that there is clear system for the storage and disposal of out of date medication. The trust should also ensure oxygen cylinders are securely stored at all times.
- The trust should ensure records are securely stored at all times.
- The trust should ensure consistent processes are in place for the servicing and maintenance of equipment and vehicle fleet.
- The trust should ensure performance targets in relation to patient journey times and access to booking systems continue to be monitored and improve.
- The trust should ensure there are appropriate interpreting and translation services available for staff to use to meet the needs of people who use services.

In addition, the trust should consider other actions - these are listed at the end of the report.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

Background to Yorkshire Ambulance Service NHS Trust

Yorkshire Ambulance Service NHS Trust (YAS) was formed on 1 July 2006 when the county's three former services merged. The trust covers North Yorkshire, South Yorkshire, West Yorkshire, Hull and East Yorkshire covering almost 6,000 square miles of varied terrain, from isolated moors and dales to urban areas, coastline and inner cities. The trust employs over 4,670 staff and provides 24-hour emergency and healthcare services to a population of more than five million. YAS is the only NHS trust that covers the whole of Yorkshire and Humber.

The trust provided an accident and emergency (A&E) service to respond to 999 calls, patient transport services (PTS) and Emergency operation centres (EOC) where 999 calls were received clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART). The trust also provided an NHS 111 core service for when medical help is needed fast but it is not a 999 emergency. This core service was not inspected as part of this inspection and will be inspected separately.

In 2013-14 the trust's A&E service responded to 795,750 urgent and emergency calls and received through the EOC 2.2 million 999 and NHS 111 calls per year, which averages at 2,180 calls per day. Within PTS in 2013-14 the service made around 886,312 journeys transporting patients across Yorkshire and neighbouring counties each year.

The trust covers a population of approximately five million people and ethnic diversity ranged from 1.9% to 18.2% of the population. Within West Yorkshire, South Yorkshire and the Kingston upon Hull area, the life expectancy for both men and women was lower than the England average, whereas in North Yorkshire the life expectancy was higher than the England average for both men and women.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers

Head of Hospital Inspections: Julie Walton, Care Quality Commission

A team of 51 people included CQC inspectors, inspection managers, national professional advisor, pharmacy inspectors, inspection planners and a variety of specialists. The team of specialists comprised of paramedics, urgent care practitioners, operational managers, call handlers and experts by experience that had experience of using services.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services

Summary of findings

• Resilience Team including the Hazardous Area Response Team

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the ambulance service. These included the clinical commissioning Groups (CCG's), the Trust Development Authority, NHS England, and the local Healthwatch's.

We held focus groups and drop-in sessions with a range of staff in the service and spoke with staff individually as requested. We talked with patients and staff from a range of acute services who used the service provided by the ambulance trust. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

We carried out the announced inspection visit from 13–15 January 2015 and undertook unannounced inspections on 19 January 2015 and 9 February 2015.

What people who use the trust's services say

Friends and Family Test

In October 2014 95% of patients who responded to the friends and family test would recommend the service to a friend or family member.

Hear and Treat Survey 2013-2014

The 2013/14 Hear and Treat Survey contacted adult callers who had received telephone triage and advice when calling 999 in December 2013. The survey consisted of 25 questions relating to the call handler, clinical adviser, outcome and overall impression of the service provided. The trust performed, on average, the same as other ambulance trusts for 16 questions, and better than other trusts for nine questions. This meant overall the trust was the best performing trust in this survey.

Patient surveys

The patient survey for the EOC in October 2014 showed 87.3% of patients felt the ambulance call taker listened carefully and 86.7% of call takers were reassuring.

For PTS the trust patient experience survey for August 2014 showed 100% of patients said they had been treated with dignity and respect within each of the regions.

The trust's patient experience survey for August 2014 also showed between 66% – 80% of patients across the four regions would be 'extremely likely' or 'likely' to recommend PTS to family and friends if they required transport to hospital.

A&E Patient Survey

In the Yorkshire Ambulance Service - A&E Service User Experience Survey Report for April 2014 to November 2014 for the question 'I understood my care and treatment' the trust has scored 95%. For the same time period 92% would recommend the service to a family member or friend.

Patients views during the inspection

During the inspection, we spoke with a number of patients across all services. Patients also contacted CQC by telephone and wrote to us before and during our inspection. The comments we received were mainly positive about their experiences of care. The main concerns raised with us were in relation to delays in transport for patients using PTS.

Facts and data about this trust

The population the trust serves includes:

- South Yorkshire
- North Yorkshire
- Hull & East Yorkshire
- West Yorkshire

Yorkshire Ambulance Service NHS Trust also provides a 111 service to:

- Bassetlaw
- North Lincolnshire.

Summary of findings

Activity

- In 2013-14 the trust's A&E service responded to 795,750 urgent and emergency calls.
- The total number of calls for 999 and NHS 111 handled by the trust was 2.2 million calls per year which averaged at 2,180 calls per day.
- Within PTS in 2013-14 the service made around 886,312 journeys transporting patients across Yorkshire and neighbouring counties each year.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? A Trust Board paper from the Audit Committee (8 January 2015) identified one of the key risks reported was regarding the adverse impact on clinical outcomes and operational performance due to inability to deliver the A&E workforce plan and associated recruitment and training requirements. It stated this remained a key risk to delivery and further work was on-going in early 2015 to update the plan. Within the trust's Quality Accounts 2014 it stated an internal review found a need to better match resources to current and future demand profile, particularly for evenings and weekends. In March 2014 the trust introduced new rotas and rest break arrangements and revised some of the practice policies. The five year workforce plan was reviewed and educational provision identified to include; a student paramedic programme; advanced practitioners programme; emergency care programme; and a range of professional development courses, for example, sepsis, EOL and domestic abuse. We had significant concerns within the resilience service specifically the HART team about the checking of equipment, a large number had passed their expiry dates and assurance processes had not detected this. There were also inconsistencies with checking of breathing apparatus and the processes observed did not follow best practice guidance. An external audit report of the HART service produced in November 2014 highlighted areas for improvement in relation to equipment including checking of equipment. It was recommended that equipment should be checked on a regular basis to ensure all of the necessary equipment is on board the vehicles in case of an emergency call-out. However at the time of our inspection these improvements had not been implemented. In addition there was equipment that had not been appropriately charged so would not be ready for use. The command vehicle had been connected to the electricity supply however when the vehicle was started the backup generator was running which suggested all systems were not fully charged. Therefore the vehicle would not be ready to dispatch if required and there had been confusion as to how the vehicle should be connected to the electrical supply. The Automated External Defibrillator on the vehicle showed it was not ready for use and had not been suitably charged.	**Requires improvement** 

Summary of findings

The HART team at the Leeds location had six breathing apparatus (BA) sets and these should have been checked at the start of every shift. We were informed that the number of BA sets checked was dependent on the number of HART paramedics on duty and a minimum of four BA sets should be checked per shift. We noted that on one vehicle, two of the four sets had not been checked that day; one set had been checked the day before and the other set two days before.

These concerns were escalated to Executive Director of Operations, for the trust to address. We re-visited the HART base two days after the announced inspection and one month later to check that changes had been implemented in response to our concerns. We found the management team had implemented a range of measures to ensure systems were in place for the checking of equipment. We saw processes had been improved for ensuring breathing apparatus was checked at the beginning of every shift and gas cylinders were stored separately including a having a separate rack for Oxygen, Entonox and empties. The inventory list for all vehicles had also been revised and was easier to follow and audit against.

The HART team was part of the National Ambulance Resilience Unit (NARU) which was established in each ambulance trust to help strengthen national resilience and improve patient outcomes in a variety of challenging pre-hospital environments. Each HART team had to provide assurance 24 hours a day seven days a week they are prepared and able to respond. However during our inspection we found this was not the case.

Concerns regarding equipment, stock management and assurance processes were also identified within the urgent and emergency care service with out of date stock found in ambulances and at ambulance stations.

During the visit the inspection team were able to walk into one ambulance station without being challenged or noticed. We found the station to be unsecure and the inspection team were able to gain open access to the station and to the ambulances in the parking bay.

There was a lead person in the role of Director of Infection Prevention and Control (DIPC), who was supported by one Infection Prevention nurse. The DIPC and nurse were also supported by an Associate Director of Risk and Safety and members of the Risk and Safety Team. Any infection issues were discussed at the incident review group, which had representatives from clinicians, the 111 service, human resources, legal and representatives from operations.

Summary of findings

Monthly audits for infection control took place however during the inspection there were variable standards of cleanliness, infection control and hygiene across the areas visited. This was particularly relevant for ambulances in the HART/ resilience team and the urgent and emergency care services. Vehicle cleaning was rated as a high risk on the corporate risk register, control measures had been put in place and this had reduced the risk to moderate. Due to findings in these services the trust could not rely on the effectiveness of the internal audit reports, particularly over cleanliness, and could not be assured that the control measures had reduced the risk.

Observations during the inspection showed some staff wore wrist watches. The trust's infection prevention and control policy dated 12 February 2014 stated that any watch worn had to be waterproof and washable which was in line with what staff reported. However the trust policy did not contain guidance on how often wrist watches should be decontaminated or cleaned. This was not in line with current best practice, which considers that bare below the elbows means that all staff in contact with patients could effectively decontaminate their hands and wrists between each episode of patient care or contact, which is not possible to do properly when wearing cuffs, watches and/or jewellery.

The NHS Safety Thermometer is not relevant in some areas, such as ambulance Trusts, but we asked about the processes for harm measurement and reporting. We found the Trust produced a monthly safety thermometer briefing and included the number of harm-free days and incidents relating to the patient transport service (PTS) and Accident and Emergency (A&E) service. Within PTS services we saw information on the safety thermometer for January 2015 which indicated two of the reported falls were being investigated due to the severity of the fall. One of the falls had not been reported and had been brought to the trust's attention via a complaint. There was information on the safety thermometer sheet which reminded staff to report incidents as soon as possible.

The trust had developed a policy for duty of candour and being open. The policy statement stated that "All staff including volunteers, working for YAS are required to be open with patients. It is an essential part of us achieving a culture of safe care, identifying lessons which need to be learned." The trust had a log with current cases which were seen at the inspection.

For full details, see the location report for the inspection of this provider.

Summary of findings

Are services at this trust effective?

Requires improvement

The trust used national evidenced-based guidelines to prioritise and categorise emergency calls based on the clinical needs of patients. The emergency operations call centre was an accredited Advanced Medical Priority Dispatch System (AMPDS) centre of excellence.

The trust had Mental Health Nurses working in the emergency operations centre to give effective support to patients requiring crisis and mental health support. This included standardised protocols and 24 hour access to mental health pathways and crisis team.

There were a number of alternative urgent care pathways in line with the recommendations of the Urgent Care Review 2013 by Sir Bruce Keogh. It was recommended that by treating patients at the scene and reducing conveyance rates the ambulance service would contribute to alleviating some of the pressures in emergency departments and offer a better service to patients. These had been developed through partnership working with other providers and included direct referral to specialist teams such a respiratory teams.

The 2013/14 Hear and Treat Survey contacted adult callers who had received telephone triage and advice when calling 999 in December 2013. The survey consisted of 25 questions relating to the call handler, clinical adviser, outcome and overall impression of the service provided. The trust performed, on average, the same as other ambulance trusts for 16 questions, and better than other trusts for nine questions. This meant overall the trust was the best performing trust in this survey.

The trust was better than expected for the number of stroke positive patients who received the appropriate care bundle. A stroke positive patient was identified as showing FAST symptoms. In August 2014 57.3% of patients arrived at a stoke unit within 60 minutes, below the England rate of 60.4%. For ST segment elevation myocardial infarction (STEMI), which is a type of heart attack, the trust was the best performing trust for patients receiving an appropriate care bundle at 85%.

The trust was one of the worse performing ambulance trusts at 23% for patients who had had a cardiac arrest returning to spontaneous circulation (ROSC) at the time of arrival at hospital. That is, reviving a patient when their heart had stopped. The highest performing trust was 40%. The trust was the second highest performing trust for the overall cardiac survival rate for patients who have a cardiac arrest survival to discharge. The trust performed similar to expected for the proportion of patients who received treatment in hospital within 150 minutes.

Summary of findings

In 2013-14 the trust had a mixed performance against the England average for Red1 calls but over the year performed better than the England average, particularly between July and November. In the first two quarters of 2014-15 the trust had performed worse than the England average, rarely getting over 70% of Red 1 calls responded to within 8 minutes. In 2013-14 the trust performed slightly better than the England average, for response times to Red 2 calls, only performing worse in quarter four. In the first two quarters of 2014-15 the trust started worse than England averages, however had started to match the England average at the end of quarter 2 with response rate of 70%. For all category A calls resulting in the arrival of an ambulance at the scene of the incident within 19 minutes the trust performed better than the England average and did not breach the 95% target during 2013-14. The trust had also performed better than England average and did not breach the 95% target during the first six months of 2014-15.

Within the EOC business plan December 2014 it stated the call pick up time was above the standard of 95% in 5 seconds with the year to date position being 95.3%.

Within PTS services during April to October 2014, there were 662,888 actual patient journeys against a planned number of 663,148 journeys. The thresholds for compliance against each key performance indicator were different for each CCG dependent on historic performance, activity profiling targets and historic funding streams. As a consequence compliance in one area was not equitable with performance in another. Trust data by region for patients arriving on time for their appointment during quarter two (July-September 2014) showed: East Yorkshire 74.9% (target 77%), North Yorkshire 77.3% (target 82%) South Yorkshire 86.4% (target 90%) and West Yorkshire 85.1% (target 82%). There were 92.8% of patients who were collected within 120 minutes (on the day and at short notice journeys) against a target of 93.8%.

Performance indicators for renal patients showed targets were not being met for inward arrival times and outward collections within 60 minutes of ready time.

For full details, see the location report for the inspection of this provider.

Are services at this trust caring?

Good

Patients were treated with compassion, dignity and respect by ambulance staff. Staff explained treatment and care options in a way that patients could understand; they explained and involved patients in decisions. Patients were supported to manage their own

Summary of findings

health by using non-emergency services when it was appropriate to do so. Patients, their relatives and others received emotional support when experiencing distressing events, including when someone had died.

Patients and hospital staff spoke positively about the quality of staff. We observed crews on PTS vehicles assist patients and explained procedures to them on accessing the vehicle and during their journey. Crews ensured patients were safely escorted to the hospital department or their home and made comfortable.

For full details, see the location report for the inspection of this provider.

Are services at this trust responsive?

Requires improvement

The trust had five specific vehicles which had an enhanced range of equipment available for patients considered to be bariatric or obese. These had been introduced as an improvement beyond the basic capability of the existing fleet. However staff told us these ambulances were not always able to respond in a timely way for emergencies and described incidents where the patient's dignity had to be balanced with the need for emergency care.In 2013/14, the trust had 14.6% of all Red 1 calls in England and 9.1% of all Red 2 Calls in England. The trust had been dealing with a steady number of calls since 2012; in April to September 2014, the trust had 15% of Red 1 calls and 9.3% of Red 2 calls in England.

For the PTS service patients and hospital staff in North, East and West Yorkshire told us they had difficulty in getting through to the control centre to book or cancel appointments. One patient said they had waited 45 minutes to book a journey another said they had tried to make a booking by phone on the 0300 number many times but could not obtain an answer; instead they had contacted the hospital who made the appointment for them. PTS call data up to October 2014 confirmed the target of 80% of calls being answered within 30 seconds was not being met.

PTS for renal dialysis patients did not always meet prescribed response time targets in line with The National Institute for Health and Care Excellence (NICE) quality standard 15: Patient Transport (March 2011). The guidance stated that patients with chronic kidney disease receiving haemodialysis or training for home therapies should have transport within 30 minutes of their clinical treatment. Records for patients receiving dialysis in York showed that over a six month period, 21 patients had waited more than 60 minutes after their treatment had finished and seven had waited more than two hours. This impacted on waiting times and hospital staff who sometimes had to stay later than their contracted hours to accommodate patients. Targets for renal arrival times were not

Summary of findings

being met effectively. Records for York renal dialysis unit showed between 21 August 2014 and 5 January 2015 five patients arrived earlier than the 60 minute standard and 15 patients had arrived late for their dialysis with the greatest delay being two hours after the appointment time. This was also the case for West Yorkshire and Hull area renal patients; targets were not being met for inward arrival times and outward collections within 60 minutes of ready time.

There were examples of Resilience planning and suitable on-going assessments of service demand and pro-active planning. If HART staff were attending an operational job, they were promptly relieved to attend a Resilience call-out if necessary. Due to the issues regarding stock and equipment there was concern that the responsiveness of the Resilience function, including HART, had been compromised. This, potentially, could have had a negative impact on being able to provide a swift response to Resilience / HART related call-outs.

The trust was the first ambulance trust to receive “Working to become dementia friendly” recognition by the Dementia Action Alliance.

The trust used the four C’s as measures for quality; these were complaints, concerns, comments and compliments. Staff were encouraged to resolve complaints informally where possible, but if there were trust-wide issues then these would be escalated to investigation. Complaints were audited monthly using a criterion based on the Patient Association guidance and also information from a peer ambulance service. The latter enabled a comparison of results across two trusts.

There had been an increasing number of complaints which had not been responded to within the trust’s 25 day target. The trust was achieving the timescales in 60% of cases. At the time of the inspection, there was a back-log in operations of around two months, which equated to about eight cases. The trust had revised the policy, changing the target response time to reflect the complexity of the complaint.

Themes from complaints for the PTS service were generally twofold, delays in picking patients up following appointments and delays in picking up at home. The themes for the EOC were generally around the coding of calls and the timing of response. An audit of calls had been undertaken to highlight any cases that needed escalating to the incident review group.

For full details, see the location report for the inspection of this provider.

Summary of findings

Are services at this trust well-led?

Requires improvement

The trust had a mission statement and a trust strategy. The trust strategy was based on four themes with one mission; 'Saving lives, caring for you'. The trust was facing challenges due to the number of interim posts in the senior management team. The trust's previous Chief Executive had recently resigned, which left only the Chair and three substantive members of the executive team, other posts were on an interim basis only.

The trust governance arrangements comprised of two leadership groups, the Trust Board and the Trust Executive Group, with a range of committee and subgroup structures between and beneath these. The latest version of the Board Assurance Framework was agreed in October 2014 and further updated in December 2014. The strategic objectives on the BAF were underpinned by the risk registers and used to support objectives for the business planning cycle and the annual governance report. Risks to meeting performance targets included attending red calls were considered high. When we visited the resilience team, including the HART service, we found that there were governance failings to ensure that the equipment, including lifesaving equipment and consumables were safe to use, with in-date products and appropriately charged.

Staff reported across the trust that promotion to management had traditionally been through the ranks, with performance targets the main driver rather than quality. It was clear through interviewing the executive team, senior managers and professionals working within the trust that there was an ambition to move to a professional, clinical culture. Before, during and after the inspection staff side representatives raised concerns about safety and performance at the trust.

Vision and strategy

- The trust had a mission statement and a trust vision "Providing world-class care for the local communities we serve". The trust had developed a set of values and behaviours based on an acronym WE CARE which stood for Working together for patients, Everyone counts, Commitment to quality of care, Always compassionate, Respect and dignity and Enhancing and improving lives.
- The trust strategy was based on four themes with one mission; 'Saving lives, caring for you'. The four themes to achieve the mission statement were, "Right care, right place, first time; Right skills for patients; Exceeding expectations and spending public money wisely, and; Engaging and involving communities and staff in change.

Summary of findings

- The trust strategic objectives were delivered through the trust's five year Integrated Business Plan, which was underpinned by a two year Operating Plan which covered 2014-2016. This was also underpinned by directorate and departmental plans to support this.

Governance, risk management and quality measurement

- Yorkshire Ambulance Service covered the whole of Yorkshire and some of north Lincolnshire. It provided services across South Yorkshire, Leeds and Wakefield, Hull and East Riding, Bradford, Calderdale and Kirklees, North Yorkshire and Craven, with emergency operation centres based at Wakefield and York. The trust provided services to 16 acute NHS trusts and seven mental health trusts.
- The trust governance arrangements comprised of two leadership groups, the Trust Board and the Trust Executive Group, with a range of committee and subgroup structures between and beneath these.
- There were five main committees reporting to the Trust Board, which consisted of the audit committee, the finance and investment committee, the quality committee, the remuneration and terms of service committee, and the charitable funds committee.
- Working to the Trust Executive team were five groups, the performance review group, the cost improvement management group, the trust management group, the foundation trust development group and the transformation group (this covered the urgent care, estates/ hub and spoke, organisational development and leadership aspects for the trust).
- A range of subgroups and committees were delegated specific operational and delivery work and included a workforce group, clinical governance group (the patient safety group, the incident review group and the medicines management group reported into the clinical governance group), risk assurance group (also contained the information governance group), health and safety committee and an estates, fleet and equipment group.
- There were arrangements in place across the operational delivery of the trust and were arranged into three groups which specialised in their service area; a patient transport management group; accident and emergency operations management group, and; the NHS 111 management group.
- Working to the operational delivery groups were locality management groups who were responsible for the daily local operational management and reporting.

Summary of findings

- Changes in appointment and recruitment to key posts was on-going, some of which played a role in the mitigation of risk. For example, a Trust Board paper from the Audit Committee (8 January 2015) provided the quality committee risk assurance report. One of the key risks reported was that of the adverse clinical outcomes due to failure of reusable medical devices and equipment. A reduction in risk was stated as "contingent" on the recruitment of a new head of medical devices, at the time of the inspection this post had not been recruited to.
- The trust had a Board Assurance Framework (BAF) and a corporate risk register in place, subject to a quarterly cycle of peer review through the risk assurance group, the trust executive group and Board committees. This was used to prioritise risks that the trust should review through the quality committee, with a report of the outcome to provide to the audit committee.
- The latest version of the Board Assurance Framework was agreed in October 2014 and further updated in December 2014. The risk statements on the BAF were underpinned by the risk registers and the information was used to support risk management of the delivery of the trust's corporate objectives and the annual governance report.
- The main risks on the register were with regard to the lack of staff to provide a paramedic service within the north and south of Yorkshire areas; meeting regulatory requirements regarding health and safety checks and the cleaning of vehicles and; the inability to maintain a cleaning regime for the ambulances. In addition, risks to meeting performance targets included attending red calls were considered high.
- When we visited the resilience team, including the HART service, we found that there were governance failings to ensure that the equipment, including lifesaving equipment and consumables were safe to use, with in-date products and appropriately charged. The vehicles used for a regional response also were unclean - both the exterior and interior of the vehicles. This matter was raised with the trust at the time of the inspection, which acknowledged the failings and took immediate actions to make the service safe and ready to respond.
- There had been audits undertaken within the HART service, as referenced on the risk register and these had not identified the deficiencies above and so no actions had been taken to address the failings.
- The trust had assessed and identified prior to the inspection the following seven areas as key challenges:

Summary of findings

- Clinical supervision, embedding a professional culture and consistent implementation of clinical supervisors across operational areas.
- Meeting increased red demand with wider system pressures such as hospital turnaround times.
- Staff engagement - there were geographical issues and shift patterns across the trust, with a strong unionised culture.
- Management and leadership capacity and capability there had been a number of interim executives, historic deficit in middle to senior management capability, and variation in quality and performance management across localities.
- Support functions such as Fleet and Estates teams, not always well-aligned to needs of front-line staff.
- Complaint Response times - there was an increased number over 25 day target for response.
- Commissioner engagement and strategic direction - the trust had to manage and work with a complex arrangement of CCG's and a lack of coherent commissioner and trust view of future regional strategy. The trust was commissioned by 23 clinical commissioning groups.

- The feedback from the lead commissioner reported that there was a much more positive working relationship developing between the trust and the commissioning bodies.
- We reviewed the trusts corporate risk register and found the trust did not have robust governance processes to manage risks in a timely and effective way. We found the pertinent risks from the risk register showed the trust had been aware of the issues for a number of years and had failed to put sufficient actions in place to minimise the risks. The trust acknowledged that there was further improvement needed to embed the processes across the trust.
- The trust reported there was a national shortage of paramedics and subsequently had significant difficulties in recruiting staff, particularly paramedics, which impacted on the ability to be responsive and also enable staff to attend training and other activities. There were concerns over places not being taken up on paramedic courses leaving shortages in the future and also that funding would not roll over into the next year. This had been on the risk register since May 2013.
- The trust told us at the time of inspection they had significantly expanded opportunities for technicians to become paramedics and that places available were under-subscribed with the trust actively encouraging uptake. However some staff within the trust told us they did not feel the organisation supported them to train to become paramedics.

- New operational rotas increased vacancies for band 5 paramedics which left the trust unable to fill planned core operations staff shifts, with the appropriate skill mix and this impacted on red response calls. There were 23 vacancies and this was identified as a red risk on register from February 2014.
- The risk of A&E vehicle cleaning not being compliant was identified particularly in North and East Yorkshire. The actions recorded identified there was weekly monitoring, IPC audits, 141 inspections to monitor the compliance. It was identified there was a lack of availability of crew to clean within timescales, A&E vehicle checks not being done as required by clinical supervisors and three cleaner vacancies. This was identified as a red risk and had been on register since July 2012. Throughout our inspections we found there were continued concerns with the cleanliness of vehicles. Despite the risk being identified since July 2012 the trust had not managed to put an effective system in place to ensure vehicles were appropriately cleaned. Failure to complete vehicle deep cleaning procedures within the timeframe was also highlighted as an amber risk on register and had been on since September 2013.
- Concerns highlighted on the risk register in relation to health safety identified the H&S policy did not cover all areas expected such as DSE, risk assessment processes, working at height, CoSHH, arrangements in place to cover PPE selection and use, equipment, manual handling etc. Despite control measures being identified at the time of inspection this risk remained on the risk register with the same risk score though the risk had been reduced to amber.
- There was a lack of robust governance systems and processes to identify and mitigate risk within the trust.

Fit and Proper Person Requirement.

- The trust had developed a policy for the Fit and Proper Person Requirement. The policy stated the fitness of directors would be reviewed on a regular basis to ensure they remain fit for the role. This would be annually for existing directors as part of their appraisal and as part of recruitment for new Directors.

Leadership of the trust

- At the time of inspection four out of the six executives were in substantive positions however there had been a recent loss of the Chief Executive and a history of change at executive level within the trust.
- The chair had been in post for approximately four and a half years and the non-executive directors had been in post throughout this period.

- A trust board paper from the Audit Committee (8 January 2015) provided the quality committee risk assurance report. One of the key risks reported was regarding the adverse impact on clinical outcomes due to the failure to embed the clinical leadership framework into the organisation. The update reported that although there was some positive progress further work was continuing to develop and monitor an agreed dashboard.
- Key to the development and future sustainability of the trust was the Transformation Programme, at the time of the inspection the priorities within the programme were identified and further work to finalise the specific deliverables for 2015-16 was in progress. There was executive director lead, associate director lead as part of a wider portfolio and head of service transformation. The trust was planning to recruit to a newly created associate director of service transformation role which had been agreed to further strengthen the programme management arrangements.
- Leadership capability, low staff engagement and the workforce not being fully aligned to the business requirements was acknowledged by the trust as a challenge.
- The trust was preparing for Foundation Trust status and was at the pre-application stage. As part of the preparation for FT status, there has been a recruitment drive for the YAS Forum - a shadow panel of representatives, public and staff to prepare for the future configuration should FT status be approved. We saw agendas, minutes and attended a forum meeting in public on 13 January 2015.
- There was a varied picture from the ambulance crews about how visible the leadership team at board level were. Some had met the interim chief executive officer (CEO) but the majority of staff told us they had not seen or met other members of the board. One crew reported that the CEO had spent time with them on shift, which they appreciated and found valuable. Staff we spoke with generally felt the trust senior management teams were remote and simply issued commands.

Culture within the trust

- Staff reported across the trust that promotion to management had traditionally been through the ranks, with performance targets the main driver rather than quality.
- It was clear through interviewing the executive team, senior managers and professionals working within the trust that there is an ambition to move to a professional, clinical culture. Staff reported that they were proud to do their job but were under

intense pressure to meet targets, and that they were left feeling exhausted. Clinical leaders were introducing training and raising awareness wherever there were opportunities to engage with staff to create a professional base culture.

- An equality analysis of the trust's values based recruitment had been completed. The trust was working with NHS England's equality team to further embed the Equality Diversity System 2; the framework for this was already in place.
- The trust was undertaking a cultural audit to identify engagement issues and staff expectations of leaders and managers at team and departmental level. The cultural barometer provided a platform for the development of a new behavioural framework.
- Before, during and after the inspection staff representatives raised concerns about safety and performance at the trust. Staff side representatives reported that their members had strategic concerns over the PTS service, A&E service and health & safety issues in the trust. Staff members felt there had been too much change at senior management level and turnover of interim executives, with at least four directors of operations posts in a short space of time. Staff reported that they could not remember a stable team leadership since 2006. There was confidence expressed in local senior management.
- Issues raised included the lack of clinical staff, retaining staff, communication difficulties, which were in the main email-based with little time to read. Staff members were reporting health problems, particularly over musculoskeletal problems and work related stress.
- The trust reported they had introduced a number of measures to address musculoskeletal problems and work related stress. There had been a replacement of equipment bags which had been an improvement in 2014. There was a further roll out of new carry chairs as an on-going programme to introduce equipment which mitigated the risk. The trust had implemented a data flagging process to highlight potential dangers and allow staff to stand off and there was work on introducing a dynamic risk assessment.

Public and staff engagement

- The Trust Board met in public every two months. The trust was undertaking the Friends and Family Test (FFT) and patient surveys but they were aware that they needed to reach more patients; the response rate was about 1%. The trust was working on improving patient engagement with the See and Treat patients, which had to have the FFT in place by April 2015 and this was also aligned to a CQUIN target.

Summary of findings

- The trust reported there was a monthly postal patient survey run for all service lines, which have a much higher response rate than the newly introduced national FFT model. The trust won a national award in 2013/14 for their patient experience programme.
- The trust was developing a staff engagement strategy for 2014/15. In the NHS Staff survey for 2014 only 43% of staff responded. The percentage of staff in the trust that felt that they make a difference was 88% compared to the national average of 89%. The trust scored the same as the national average of 76% of staff feeling satisfied with the quality of work and patient care they are able to deliver.
- The trust had launched a staff suggestion scheme in May 2013 called “Bright ideas” which 264 ideas had been submitted.
- Staff sickness absence 2013/14 was above trust target. The Ambulance Service average for the month of March 2014 was 6.3%; the Sickness Absence for the trust was reported as 6.7%. In February 2014 a new absence management policy had been agreed.

The trust had a new partnership with an external company for the provision of occupational health support for staff in the trust. The trust’s employee wellbeing strategy was under development.

Innovation, improvement and sustainability

- There was uncertainty over income generation and the sustainability of some services within the trust. Arrangements were in place to hold a joint quality and financial meeting twice a year, to go through the quality impact assessment process, with a non-executive director as chair.
- Key to the trust’s success to achieve its strategic aims and future development was the transformation programme. This involved the redesign of services to provide a hub and spoke arrangement, call centre integration, intelligent ambulance service, PTS transformation, urgent and emergency care delivery model.
- The trust consistently performed well at 95.50% against the Red 19 national target in reaching patients within 20 minutes.
- The trust were looking at the sustainability of the PTS service. Fleet replacement was a challenge and capital options were being explored.
- The trust was working on building the internal capacity for robust incident investigation and aimed to embed this in the

risk management arrangements at all levels of the organisation. In addition, the trust was implementing the new risk assessment process, including the “dynamic risk assessment” as part of the health and safety strategy arrangements.

- For security, the trust had developed a five year plan, with lock down procedures in place and included the completion of a self-review tool and audit with NHS Protect with the introduction of the new NHS security standards.
- The Emergency Operations Centre has achieved AMPDS Centre of Excellence accreditation and a member of staff had won the international ‘EMD of the Year’ award in 2014.
- The HART team led on the development of the national Urban Search and Rescue capability and is at the forefront of introducing extended skills to these specialist clinicians. YAS is the only ambulance Trust to fulfil the requirements of the MERIT model which was being adapted to fulfil the new guidance for mass casualty.

Overview of ratings

Our ratings for Yorkshire Ambulance Service

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Patient transport services (PTS)	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Emergency operations centre (EOC)	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Resilience	Inadequate	Not rated	Not rated	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Yorkshire Ambulance Service NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Outstanding practice and areas for improvement

Outstanding practice

- The trust's 'Restart a Heart' campaign trained 12,000 pupils in 50 schools across Yorkshire.
- The trust supported 1,055 volunteers within the Community First Responder and Volunteer Care service Scheme.
- Green initiatives to reduce carbon in the atmosphere by 1,300 tonnes per year.
- The emergency operations call centre was an accredited Advanced Medical Priority Dispatch System (AMPDS) centre of excellence.
- Mental health nurses working in the emergency operations centre to give effective support to patients requiring crisis and mental health support. This included standardised protocols and 24 hour access to mental health pathways and crisis team.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

Importantly, the trust must:

- The trust must ensure all ambulances and equipment are appropriately cleaned and infection control procedures are followed.
- The trust must ensure that equipment and medical supplies are checked and are fit for purpose.
- The trust must ensure all staff are up to date with their mandatory training.

In addition the trust should:

- The trust should ensure all staff receive an appraisal and are supported with their professional development. This should include support to maintain the skills and knowledge required for their job role.
- The trust should ensure risk management and incident reporting processes are effectively embedded across all regions and the quality of identifying, reporting and learning from risks is consistent. The trust should also ensure staff are supported and encouraged to report incidents and provide feedback to staff on the outcomes of investigations.
- The trust should ensure all ambulance stations are secure at all times.
- The trust should review the provision and availability of equipment for use with bariatric patients and ensure staff are trained to use the equipment.
- The trust should review the safe management of medication to ensure that there is clear system for the storage and disposal of out of date medication. The trust should also ensure oxygen cylinders are securely stored at all times.
- The trust should ensure records are securely stored at all times.
- The trust should ensure consistent processes are in place for the servicing and maintenance of equipment and vehicle fleet.
- The trust should ensure performance targets in relation to patient journey times and access to booking systems continue to be monitored and improve.
- The trust should ensure there are appropriate interpreting and translation services available for staff to use to meet the needs of people who use services

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment HSCA 2008 (Regulated Activities) Regulations 2014. Regulation 12(2)(h): Assessing the risk of, and preventing, detecting and controlling the spread of infections. We found that the trust did not always have the facilities, systems and arrangements in place to protect service users from the risk of exposure to a health care associated infection. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must ensure all ambulances and equipment are appropriately cleaned and infection control procedures are followed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17 Good governance We found the trust did not have robust governance processes to manage risks in a timely and effective way. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must ensure that equipment and medical supplies are checked and are fit for purpose.

This section is primarily information for the provider

Requirement notices

The trust should ensure risk management processes were effectively embedded across all regions and the quality of identifying, reporting and learning from risks was consistent.

The trust should ensure there is an effective system for reporting incidents and providing feedback to staff on the outcomes of investigations.

The trust should ensure records are securely stored at all times.

The trust should ensure consistent processes are in place for the servicing and maintenance of equipment and vehicle fleet.

The trust should ensure records are securely stored at all times.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18 We found that the Trust did not always protect patients from unsafe or inappropriate care as not all staff had received mandatory training and had an appraisal. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must ensure all staff are up to date with their mandatory training. The trust should ensure all staff receive an appraisal and are supported with their professional development. This should include support to maintain the skills and knowledge required for their job role.

Yorkshire Ambulance Service NHS Trust

Quality Summit

18 August 2015

Overview

The purpose of the Quality Summit is to develop a plan of action and recommendations based on the inspection team's findings as set out in the inspection report. This plan is developed by partners from within the health economy and the local authority.

The Quality Summit considered:

- The findings of the inspection
- Whether the high level action plan proposed by the provider to improve quality is adequate and whether additional steps should be taken
- Whether support should be made available to the Trust from other stakeholders to help them improve.

The recommendations for action will be captured in a high level action plan(s) by the provider. Further work will be required by the Trust and its partners following the Quality Summit to develop the detail beneath the high level actions before moving onto implementation. This will be completed within 28 days of the Quality Summit. Action plans are owned by the Trust and the CQC will expect to be consulted on the adequacy of the action plan before it is agreed. The Trust Development Authority (TDA) will hold the Trust to account for the delivery of the action plan.

Introduction

The CQC provided an overview of the inspection process and the outcome. The considerable delay from inspection to publication was acknowledged (seven months). It was suggested this was primarily due to 'process issues'. There was a sense of frustration from the Trust at the delay in publicising the inspection report.

The CQC set the inspection process and the outcomes within the context of the revised inspection model indicating that so far only two organisations had been rated outstanding, few rated inadequate with most in the middle, highlighting that the bar had been set high. In terms of the Trust it was suggested they "are only a short walk away from being good". It was acknowledged that the Trust had made progress since the inspection and that it was important to focus on the positives. It was suggested that the momentum of improvement would require the continued support of the wider health economy.

Presentation of inspection team key findings

The CQC provided a summary presentation of the report's findings. (Inspection report previously circulated) including an overview of ratings. It was emphasised that the only area rated inadequate was resilience.

CQC ratings for Yorkshire Ambulance Service

	Safe	Effective	Caring	Responsive	Well –led	Overall
Emergency and urgent care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires Improvement
Patient transport services (PTS)	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Emergency operations centre (EOC)	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Resilience	Inadequate	Not rated	Not rated	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Overall Trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Outstanding practice and areas for improvement

The CQC summarised the outstanding practice and areas for improvement (see inspection report previously circulated).

There were no specific questions arising from the presentation.

Trust presentation – response to inspection findings

The focus of this session provided an overview of the Trust, key challenges and the response to the inspection findings.

The Trust began by providing a positive context to their presentation by outlining the following initiatives:

- Successful introduction of NHS 111 service
- Integrated patient pathways – end of life care, mental health, Vanguard bid, community paramedics
- Clinical Quality Strategy – improved patient outcomes – e.g. cardiac arrest
- Accreditation for EOC and business continuity
- Patient experience award winners
- Valued based recruitment
- Delivering financial plan and cost improvements
- Positive community and staff engagement
- Strengthening of Corporate Governance

It was emphasised that prior to the inspection there was a number of known challenges including meeting the increased 'Red' demand – major logistical and workforce transformation; management and leadership capacity and capability; the embedding of a professional culture; staff engagement and communication; commissioner engagement and strategic direction; and the scale of transformation.

The next part of the presentation focused on action following the CQC inspection with particular emphasis on the 'must do' outcomes.

Cleaning and Infection Prevention and Control

The Trust indicated that they had introduced a weekly review of deep clean and increased IPC audits. The Trust had clarified local management and staff responsibilities for standards at station premises and had also increased staffing cover for the cleaning team.

A new initiative 'Make Ready' vehicle preparation would be introduced in Leeds in September 2015. The Make Ready system provides specialist teams of staff who are employed to clean, restock and maintain vehicles which means that staff, who routinely undertake these tasks, can spend more time treating patients. Under the make ready system vehicles are regularly deep-cleaned and swabbed for the

presence of micro-organisms including MRSA and CDiff. Each vehicle is fully stocked to a standardised specification with equipment checked and serviced regularly. To reduce vehicle breakdowns, on-site vehicle maintenance experts will be on-hand to undertake routine maintenance.

The Trust have reinforced the bare below elbows policy with a Trust-wide campaign planned for autumn and implementing fob watches for staff.

Equipment and Medical Supplies

The Trust had taken immediate action on the HART issues raised in the inspection report, together with an immediate review of consumables. In addition, out of date stock processes had been strengthened at station level and health and safety risk assessments of all premises had been undertaken.

Mandatory Training

The development of 2015/16 training plan to ensure delivery meets compliance requirements had been completed. The Trust had increased management monitoring of compliance which currently stood at 92% overall. New processes had been introduced to ensure staff don't 'slip through the net' of mandatory training and a full review of Trust training needs analysis was to be completed by October 2015 to drive the future training plan.

Action following the CQC inspection – What the Trust should do

The inspection report had highlighted a number of 'should do' actions including emphasis on personal development and staff appraisal. The Trust indicated that they were maintaining focus on PDR completion – current Trust compliance stood at 77%. Additional courses were being rolled out to ensure all appraisers have received appropriate training.

The Trust should ensure that all staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. It was indicated that the Trust would maintain e-learning and paper-based workbook delivery and that 92% of staff had now completed this. Training would also be included in the face-to-face clinical refresher course from October.

The Trust should ensure all ambulance stations are secure at all times. Immediate action had been taken during the inspection visit in relation to specific locations and the importance of station security had been reinforced, including an updated security risk assessment for all premises.

The Trust should ensure records are securely stored at all times. The Trust had implemented a records management action plan with a key focus on medical records.

The Trust should ensure risk management and incident reporting processes are effectively embedded across all regions and the quality of identifying, reporting and learning from risks is consistent. The Trust had introduced revised inspections for

improvement process together with increased executive scrutiny of risks and updated training. Improved call answering on 24/7 Datix line had been introduced and the Trust had implemented the Freedom to Speak Up recommendations. There had also been a lessons learned bulletin for staff and consultation to inform feedback.

The Trust should ensure there are appropriate translation services available for staff to meet the needs of people who use services. The Trust had updated the standard operating procedure, with improved contract monitoring and reporting through the Clinical Governance Group.

The Trust should review the provision and availability of equipment for use with bariatric patients and that staff are trained to use equipment. The Trust indicated that they had reviewed the utilisation procedures for bariatric vehicles.

The Trust should review the safe management of medication to ensure that there is a clear system for the storage and disposal of out of date medication. The Trust adhered to the Standard Operating Procedure for the safe disposal of medicines and a review of oxygen storage facilities had been undertaken.

The Trust should ensure consistent processes are in place for the service and maintenance of equipment and vehicle fleet. The standard equipment list had been reviewed and re-issued. A Vehicle Preparation Programme would be introduced – first site live in December and a hub and spoke/make ready strategy would commence with a pilot in Leeds in September. The Trust had purchased 110 new PTS vehicles in 2015.

The Trust should ensure performance targets in relation to patient journey times and access to booking systems continue to be monitored and improve. The Trust had increased PTS call centre staff which had resulted in improved response times. Improved scheduling had resulted in better service efficiency. The Trust had implemented SMS messaging and calls to patients and was working with commissioners on PTS service development. The variance in performance of Patient Transport Services across different areas was noted and that a regional review of PTS was underway. It was also noted that improvement work in relation to patient transport services for renal patients extended across the service.

The final part of the presentation focused on broader action to support the Trust's longer-term goals which included an executive director and associate director/senior management portfolio review; the service transformation programme – major work programmes in A&E, estates and fleet; together with Patient Transport Services. There was a planned increase in the clinical workforce with a revised recruitment and training plan. There was a renewed focus on staff engagement and communication together with improved trade union relationships, including a framework agreement and recognition rights, to include Unite, RCN and GMB, who had previously been derecognised or not recognised for collective bargaining purposes. There was continued engagement with commissioners on the joint urgent and emergency care strategy.

There were no specific questions at this stage.

Development of next steps plan – to agree key actions to issues identified in quality report

This session was chaired by the Trust Development Authority (TDA) and focused on agreeing a high level action plan in response to the findings of the inspection.

It was reported that many areas of the report had been acted upon since the inspection but there was more to be done. It was suggested and agreed that the back bone of the action plan would focus on the 'must do' requirements. The TDA were confident of delivery within timescales. The TDA acknowledged that YAS was different to an acute trust, and that some of the actions would require different approaches. The Trust employed 4,700 staff across a diverse and geographical area which presented particular problems in relation to infection control, for example, when trying to implement and monitor a Trust wide policy.

It was suggested (Cllr Rhodes) that the action plan should have a sharp focus on strengthening Board assurance and independent audit, to ensure better more effective monitoring of performance. Some of the issues identified in the report in relation to patient safety were at the level of basic care and it was concerning that the Trust had not picked up and acted upon these prior to the inspection.

There was a suggestion (from the Chair of the Trust) that the inspection placed little emphasis on the extent and scale of the problem facing the Trust, particularly with regard to demand pressures, recruitment and mandatory training. Resource issues needed to be recognised, particularly in relation to training where staff had to be withdrawn from front line service and that commissioners needed to recognise this and invest in staff cover, as appropriate. Commissioners responded by saying that it was the responsibility of the Trust to ensure the provision of a high quality service and to fulfil the requirements of mandatory training. The Commissioners recognised the workforce challenges together with increased demand and suggested that the Trust could consider a different offer in relation to training. There was a need to revisit planning assumptions and the commissioning strategy was looking towards transformational care. Alternative providers could be considered for the delivery of training.

External support – agree key areas which external support may be required to enable improvements and implementation of action plan

The TDA were providing support to the Trust specifically in relation to governance, risk management and quality measurement. This was also being facilitated through peer support in relation to medical devices and medicines management. It was suggested that Mid Yorkshire Hospitals NHS Trust had undertaken some useful work in relation training on the Mental Capacity Act and would be able to offer support. All stakeholders will provide support and challenge together with wider system support.

Next Steps

The timescale for the development of a detailed action plan in relation to the 'must do' requirements is 28 days from the date of the Quality Summit. The development of the 'should do' improvement plan is 6 weeks. The action plan(s) will be shared with all stakeholders present at the Quality Summit. The inspection report will be published on the 21 August and should remain confidential until that time. Media statements will be agreed between the CQC, YAS and the TDA for release on the 21 August. The TDA will hold the Trust to account for the delivery of the Action Plan. Wider stakeholders will be kept informed of progress and delivery.

Summary

There is clearly an issue in relation to the effectiveness of a Quality Summit so late after the initial inspection and this to some extent muted discussion on the development of an action plan where many areas identified in the report had been addressed. A satisfactory explanation as to why the publication of the report had been delayed was not provided other than to say that it was the result of 'process issues' The Trust were clearly frustrated at the delay in publicising the report.

I spoke with commissioners and the Trust after the Quality Summit regarding on-going monitoring arrangements of the Action Plan and it was agreed that Wakefield Overview and Scrutiny would arrange appropriate meetings with invitations to Y&H scrutiny Chairs and support officers to attend, as agreed.

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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 (Adult Social Services, Public Health, NHS)

Date: 8 September 2015

Subject: Inquiry into Primary Care

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 present a range of information relating to the Scrutiny Board's inquiry around Primary Care and to identify further details/ information required as part of the inquiry.

2 Summary of main issues

2.1 At the Board's meeting in June 2015, the Scrutiny Board identified 'Primary Care' as a specific scrutiny inquiry area for the current municipal year (2015/2016). It was further agreed in July 2015 that the inquiry was likely to consider issues around access to primary care (including GPs and dentists); future plans for primary care; workforce planning; some aspects of health inequalities.

2.2 In the previous municipal year (2014/15) the former Scrutiny Board received details from NHS England associated with the commissioning of Primary Care in Leeds. This was reported to the Health and Wellbeing Board in October 2014 and the former Scrutiny Board in November 2014. For completeness, these details are appended to this report and representatives from NHS England have been invited to attend the meeting to provide any updated information and assist the Board in its deliberations.

2.3 It was agreed that a significant part of the focus around the future plans for primary care should take into account the City's ambitions to build significant levels of new housing/ homes and its potential impact around the availability and accessibility of primary care across the City. As part of this, the Scrutiny Board is being presented with details associated with the East Leeds Extension and East Leeds Orbital Road –

reported to the Scrutiny Board (City Development) at its meeting in July 2015 and appended to this report.

2.4 Appropriate representatives from City Development have been invited to attend the meeting to assist the Board in its deliberations, along with representatives from Leeds South and East Clinical Commissioning Group and Public Health.

Future meetings

2.5 As detailed on the Scrutiny Board's work schedule, it is proposed to have further 'evidence gathering' sessions in relation to primary care. In order to help inform these sessions, members of the Scrutiny Board might usefully identify and agree further information and analysis that the Board should consider.

3. Recommendations

3.1 That the Scrutiny Board considers the report and the detail presented at the meeting, and:

(a) Determines any specific matters to include in its report on Primary Care.
(b) Identify any further information and analysis that the Board should specifically consider as part of its inquiry.
(c) Determine any further scrutiny activity and/or actions, as appropriate.

4. Background papers[1]

4.1 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.

HEALTH AND WELLBEING BOARD

22ND OCTOBER 2014

SUPPLEMENTARY DOCUMENTS –

AGENDA ITEM 9 COMMISSIONING PRIMARY CARE SERVICES IN LEEDS 2014-16

A revised appendix to the report is attached. Please note the amendments in respect of the table included within para 3.2 “Improving Patient Experience and Access” (page 4 of the appendix)

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Leeds Health & Well-being Board

Commissioning Primary Care Services in Leeds – 2014-2016

October 2014

Introduction

This paper sets out the commissioning approach and plans for primary care services in Leeds over the two years from 2014-2016. There are four sections based on the four contractor groups:

A. General practice
B. Dental services
C. Community pharmacy
D. Community optometry

A. General Practice

1. Approach

This paper has been produced collaboratively by the four NHS organisations with commissioning responsibilities for General Practice in Leeds: NHS England, NHS Leeds North CCG, NHS Leeds South and East CCG, and NHS Leeds West CCG. It sets out the national Strategic Ambition for general practice, the local challenges and the commissioning response for the next two years.

2. NHS England Strategic Ambition for General Practice

In summer 2013, NHS England launched a Call to Action: *Improving general practice.* The purpose of this consultation was to support action to transform services in local communities and to stimulate debate as to how we can best support the development of primary care to improve outcomes and tackle inequalities.

Out of the Call to Action, NHS England has set out an ambition for primary care:

We want to ensure that everyone in England gets access to the same high quality services.

a. **Proactive, coordinated care**: anticipating rather than reacting to need and being accountable for overseeing your care, particularly if you have a long term condition.

b. **Holistic, person-centred care**: addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.

c. **Fast, responsive access to care:** giving you confidence that you will get the right support at the right time, including much greater use of telephone, email and video consultations.

d. **Health-promoting care**: keeping you healthy and ensuring timely diagnosis of illness, engaging differently with communities to improve health outcomes and reduce inequalities.

e. **Consistently high quality care**: reducing unwarranted variations in effectiveness, patient experience and safety.

In order to support delivery of our ambitions, we believe that primary and community providers will need to operate **at greater scale and in greater collaboration** with one another, and with patients, carers and local communities.

Importantly, this does not necessarily have to involve a change in organisational form, but the organisations and individuals within those organisations across primary and community care will need to organise themselves together in larger groupings, in formal ways, supported by investment and management capacity.

Our approach is that there should be **no national blueprint** for how this is done but that change should be locally led and over the next two years, NHS England will deliver a series of commissioning workstreams that enable change:

	Description	**Deliverables**
Service Models	A description of the key service components required to deliver against our five ambitions, along with the implications for providers (primary care at scale).	Practical resources to support local strategy development, including: • Service component descriptions, by ambition • An explanation of the strategic choices providers will face • Practical examples and case studies in all areas. (This will also draw on learning from the Prime Minister's Challenge Fund)
Standards for out of hospital care	National standards for any out of hospital care providers that reflect our five ambitions and can be applied to the range of potential providers of the future.	A small number of measurable national standards for out of hospital care, to be incorporated into the contracts for all primary care providers. (It is anticipated that the majority of standards and associated goals for these services would be set locally.)
Co-commissioning	The nationally agreed arrangements for enabling CCGs to drive transformation across primary and community care, and supporting tools.	The options and governance arrangements for co-commissioning of GP practice. Contract forms to support greater formal collaboration across primary, community and secondary care providers. The options and governance arrangements for pooled budgets in 2015/16.
National Contracts	Ensuring that the vision for primary care at scale is appropriately reflected in the national contracts for GPs, dentists, pharmacy and optometrists.	A single negotiating remit for all national primary contracts for 2016/17, which reflects the vision and ambitions for primary care.
Workforce	Ensuring that the future primary care workforce is designed and developed in a way that supports primary care at scale and the new models of care.	Immediate work on returners, retention, international recruitment and GP remediation to increase the number of available GPs. A review into the future primary care workforce, including options for new roles and different skill mix.

3. Local Challenges & Commissioning Plans

Alongside the national work, NHS England in West Yorkshire and the three CCGs in Leeds have continued to work on improving the standards of general practice and developing integrated models of care. There are five principle challenges facing general practice in Leeds. These are the need to:

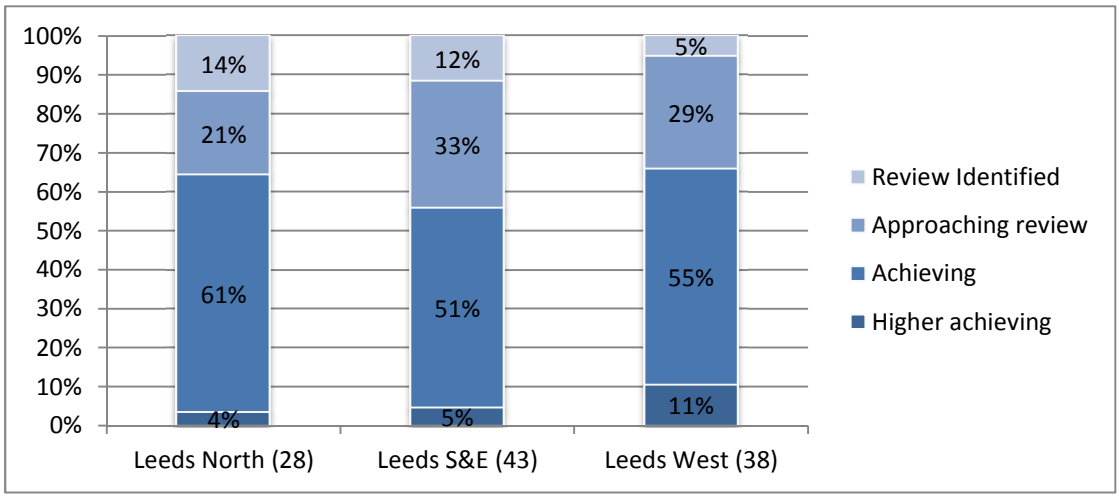
1. sustain and improve the quality of service provision for patients
2. improve patient experience, particularly in relation to access to services
3. develop and drive integrated care out of hospital
4. develop a sustainable workforce for now and the future
5. ensure value for money

3.1 Quality Improvement

(*Supports delivery of Leeds Health & Well-being Strategy – Outcome 3 – People will enjoy the best possible quality of life*)

In summer 2013, NHS England developed and published a Quality Assurance Framework for General Practice. This was the first time that service and outcome data on every general practice in England was brought together and published in a way that allowed commissioners, providers and the public to review and compare the performance of every practice. The Framework assesses practices against more than 30 indicators and establishes whether they are a statistical outlier against their expected performance.

For practices in the Leeds CCGs, the current (August 2014) position is:



For practices in the North and West, this compares favourably to the rest of England where, on average, 39% practices are approaching review or have a need for a review identified. For the South, the assurance framework does identify that 45% of practices are approaching review or have a need for a review identified.

Against this background, NHS England and the CCGs have put in place a number of initiatives to improve the quality of services for patients:

Organisation	Commissioning Approach for 2014-16
All	• Agreed MoU on quality improvement setting out roles and responsibilities. • Improvement plans developed with individual practices of concern.
Leeds North	• Practice level profiles developed for all practices. Profiles encompass key themes from Assurance Framework, JSNA practice profiles and other intelligence. Profiles used to support quality improvement plans for practices with "review identified" and to information action at practice, locality and CCG level. • Specific quality interventions in place across localities include diabetes care in Chapeltown, improving CVD prescribing, city-wide antibiotic / anti-microbial initiative.
Leeds South & East	• Quarterly quality visits to practices. • Specific interventions in place such as action to improve bowel screening uptake and patient safety reporting.
Leeds West	• 10 Locality development sessions per year with quality focus • Quarterly visits to practices. • Practice MOT distributed quarterly to benchmark practices across a number of local indicators and activity data. • Specific interventions in place linked to JSNA, to improve respiratory care, CVD, cancer and alcohol misuse.

3.2 Improving Patient Experience and Access

(Supports delivery of the Leeds Health & Well-being Strategy – outcome 2: people will live full and independent lives, outcome 3: people will enjoy the best quality of life, and outcome 4: people will be involved in decisions made about them)

The latest GP survey results (July 2014) show that patients in Leeds:

	Satisfaction with the quality of consultation (seven questions)			Satisfaction with overall care (two questions)			Satisfaction with access (three questions)		
	2013 - June %	2014 - July %		2013 - June %	2014 - July %		2013 - June %	2014 - July %	
NHS LEEDS NORTH	90.13	90.54	↑	86.25	85.90	↓	84.43	81.10	↓
NHS LEEDS SOUTH & EAST	89.07	89.17	↑	81.40	80.55	↓	80.20	77.57	↓
NHS LEEDS WEST	90.33	90.33	↑	84.65	83.65	↓	83.07	79.90	↓
WEST YORKS	89.63	89.74	↑	83.50	82.35	↓	82.03	77.80	↓
ENGLAND	89.76	89.96	↑	84.00	85.00	↑	83.57	82.70	↓
NORTH OF ENGLAND	90.71	90.59	↓	84.85	83.25	↓	83.83	79.10	↓

In common with patients across West Yorkshire and England, satisfaction with the quality of the actual clinical consultation remains high and is improving but the overall experience is deteriorating due, primarily, to dissatisfaction with access to services (getting through on the telephone, convenience of appointment and availability of appointments).

Against this background, NHS England and the CCGs have put in place a number of initiatives to improve patient experience and access:

Organisation	Commissioning Approach for 2014-16
All	• NHS England enhanced service for patient engagement • NHS England enhanced service for extended access • NHS England funding for system resilience in primary care. Leeds initiatives led by the CCGs include extended hours over bank holidays, additional clinics for children to avoid ED attendances, direct booking from ED to GP, and improved transport to hospital for potential GP admissions to facilitate early assessment and same day discharge. • Prime Minister's Challenge Fund – piloting new approaches to access for patients. First wave commenced July 2014. Second wave to be announced autumn 2014. • Introduction of Friends & Family Test in general practice at end 2014.
Leeds North	• Roll-out of Year of Care: to better inform and engage patients with long term conditions in their care. • Locality based approach to sharing bets practice in relation to primary care access and training with non-clinical staff to improve patient experience. • Commissioning practices to trial new approaches including pre-diabetes support group, practice champions and well-being co-ordinator posts to improve access and experience. • CCG co-ordinated Patient Reference Group bringing together representatives from across the CCG to inform commissioning.
Leeds South & East	• Roll-out of Year of Care: to better inform and engage patients with long term conditions in their care • Implementation of "yellow card" scheme to allow GPs to record soft intelligence on patient experience of services. • Practice development programme utilising service improvement and LEAN methodology to improve capacity and ways of working.
Leeds West	• Development of a Local extended access scheme (from 2014) to test out improving access across 5-days and 7-days, open to all 38 practices. Outcomes focussing on quality of consultation as well as access to appointments. • Roll-out of Year of Care: to better inform and engage patients with long term conditions in their care. • Introduction of Care Co-ordinators working between practices and community teams to pro-actively manage patients. • Roll-out of Productive General Practice programme to improve productivity and engagement with patients. • Patient comment boxes distributed to all practices to collect patient feedback throughout the year.

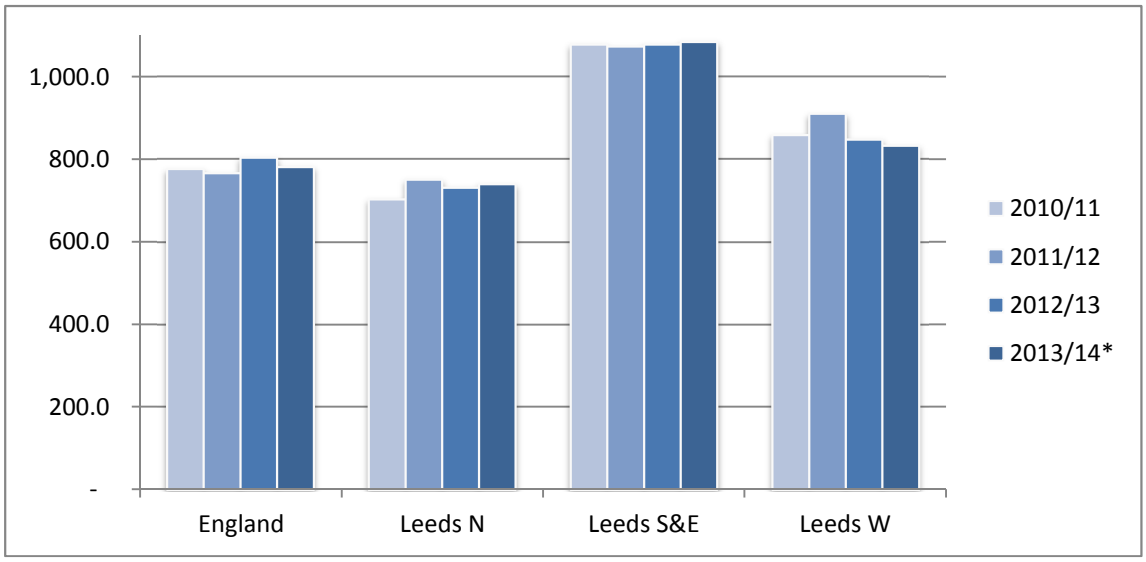
3.3 Develop and drive integrated care out of hospital

(Supports delivery of the Leeds Health & Well-being Strategy – outcome 2: people will live full and independent lives)

Benchmarking data on the three Leeds CCGs indicates that utilisation of secondary care in the north and west of the city is lower than the England average, but higher in the south and east of the city:

Per 1000 population (2013/14)	Leeds North	Leeds West	Leeds South and East	England
G&A emergency admissions	7.65	7.7	9.6	8.52
OP attendances	25.26	24.51	27.59	25.66

For conditions amenable to care outside of hospital, in 2013/14 (*provisional data), there were ca 2500 admissions to hospital where ambulatory care might have been a possible alternative:



Against this background, NHS England and the CCGs have put in place a number of initiatives to improve integrated care out of hospital (note: these initiatives focus solely on work in general practice. There is a much wider commissioning plan for integrated care involving acute, community and voluntary sector providers):

Organisation	Commissioning Approach for 2014-16
All	• NHS England enhanced service to deliver proactive care for the most vulnerable patients in each practice • NHS England enhanced services for dementia care, and alcohol related risk reduction. • Development of standards for out of hospital care to provide commissioner assurance and benchmarking of provision
Leeds North	• Clinical pharmacist working with practices and care homes to undertake medicine reviews for older people. Plan to roll out to patients with a learning disability and vulnerable patients at home. • Working with Otley and Wetherby localities to commission additional capacity to improve support for older people and those with complex

	needs. • Extension to pro-active care scheme and commissioning of additional system resilience initiatives over winter. • Locality-specific schemes relating to alcohol, diabetes and third-sector.
Leeds South & East	• Enhanced support to care home residents and providers • Extension to pro-active care scheme linked to plans for winter • Medication review scheme for most complex patients • COPD scheme to improve prevention, diagnosis, management, admissions avoidance and end of life care
Leeds West	• Year of Care scheme to improve patient engagement in planning and delivery of their care • Development of care co-ordinators to support pro-active care • Clinical pharmacists in care homes to review medications, minimise harm and reduce waste • Extending access to general practice to ensure patients have earlier access to primary care services. • Review of enhanced (medical) care to care homes.

3.4 Develop a Sustainable Workforce

(Supports delivery of the Leeds Health & Well-being Strategy – outcome 3: people will enjoy the best possible quality of life, and outcome 5: people will live in healthy and sustainable communities)

CCG Name	GP Providers	Registered population	GPs per 100,000 population
AIREDALE, WHARFEDALE AND CRAVEN	91	156,100	58
BRADFORD DISTRICTS	202	331,364	61
CALDERDALE	101	211,979	47
LEEDS NORTH	107	202,948	53
BRADFORD CITY	59	117,384	50
GREATER HUDDERSFIELD	130	239,437	54
LEEDS WEST	183	356,860	51
LEEDS SOUTH AND EAST	146	261,359	56
NORTH KIRKLEES	90	186,075	48
WAKEFIELD	201	355,373	56
AREA TOTAL	**1307**	**2,418,879**	**54**
REGIONAL TOTAL	**7,258**	**15,718,338**	**46**
NATIONAL TOTAL	**24,083**	**55,704,177**	**43**

Benchmarking data shows that the number of GPs per 100,000 population in Leeds is well above the figures for the north of England and England overall.

However, we know that more and more GPs are choosing to work part-time and that there are a significant number of GPs approaching retirement. In 2014/15, insufficient GP trainees were recruited to Yorkshire & Humber due to lack of interest from newly-qualified doctors.

In addition, there are pressures in practice nursing arising from an ageing workforce profile and difficulties with recruitment, and a need to consider the workforce requirements for new “at scale” / integrated care models.

Against this background, NHS England and the CCGs have put in place a number of initiatives to understand and improve the workforce position in general practice:

Organisation	Commissioning Approach for 2014-16
All	• Work with Health Education England to complete GP Workforce survey for 2014. • West Yorkshire Quality Improvement Network focus on workforce • Clinical fellowship posts to work alongside clinical leaders • TARGET programme of clinical training in practice • Development of city-wide Practice Nurse Conference and local practice nurse forums.
Leeds North	• Nurse leadership programme commenced in 2014 • Practice manager action learning sets, practice manager forum and training needs analysis supported by CCG. • GP Portfolio Leads development programme.
Leeds South & East	• Action Learning Sets for practice managers • Vocational training scheme for newly-qualified nurses (or nurses moving from secondary care) • Mentorship scheme for practice nurses • E-learning package for clinical skills
Leeds West	• Practice manager development programme • Undergraduate and post-graduate nursing scheme started in 2014 • Leadership course for nurse members – a bespoke leadership opportunity led by a performance coach. • Development of HCA apprenticeships. • Skills audit undertaken to inform future training provision.

3.5 Ensure value for money

There are two city-wide initiatives which will help drive value for money in the commissioning and contracting of GP services:

(i) Equitable funding review

General practice is predominantly funded through one of two national contracts: GMS and PMS. In common with practices across West Yorkshire, PMS practices in Leeds receive more funding than GMS practices. In some cases, this is due to the delivery of additional services but in other cases there is less clarity about what the additional funding delivers.

NHS England has commenced a funding review of PMS practices with the aim of ensuring that by 2018 there is an equitable approach to their core funding when compared to GMS practices.

	Funding per head 2014/15 (national value for GMS and mean value per CCG for PMS)	Range of funding per head in PMS practices
Core GMS Funding	£73.56	
Leeds North (12 PMS practices)	£73.69	£72.56 - £90.70

Leeds South & East (21 PMS practices)	£76.84	£68.16 - £114.67
Leeds West (24 PMS practices	£75.40	£70.32 - £101.04

This may result in core funding to individual practices being increased or decreased (depending on whether they are above or below the national level of core funding for GMS practices). In the circumstance where income is decreased then the practice will receive three years' of transitional relief.

Any funding released from this funding review will be reinvested in general practice in the CCG of origin.

(ii) Co-commissioning

In June 2014, NHS England announced that interested CCGs could choose to participate in the co-commissioning of general practice. The aim is to more closely align the commissioning of the national contract (NHS England's responsibility) with the CCGs' existing responsibility for quality of care and their local plans for integrated out of hospital care.

The three CCGs in Leeds have expressed an interest in co-commissioning from April 2015 and are exploring the opportunity of working together in one city-wide approach with NHS England.

The guidance from NHS England will be published in November 2014 with a view to having joint commissioning arrangements in place from April 2015. The legal framework to support formal joint commissioning arrangements between CCGs and with NHS England was published on 1 October 2014.

The ambition is that there will be opportunities to devolve and pool budgets for primary care to drive integration of general medical services with wider community care.

Alison Knowles – Commissioning Director, NHS England (West Yorkshire)

Gina Davey – Head of Primary Care – Leeds North CCG

Debbie McCartney – Senior Locality Manager – Leeds South & East CCG

Kirsty Turner – Head of Primary Care Transformation – Leeds West CCG.

Section B - Commissioning NHS Dental Services

1. Commissioning Responsibilities

Since the Health & Social Care Act 2013, there has been a tri-partite arrangement for oral health and dental services: Public Health England are responsible for oral health needs assessment, local

councils are responsible for oral health improvement for their residents and NHS England is responsible for commissioning NHS dental services (primary care, community and hospital).

2. **Adult Oral Health in Leeds**

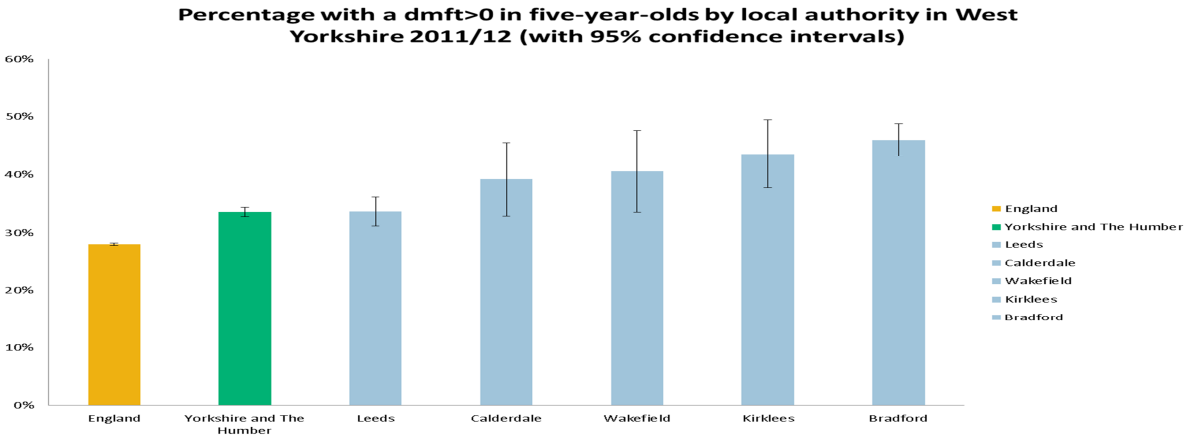
The most recent data available on adults is from the National Adult Dental Survey 2009 which provides analysis at a Yorkshire and Humber level and a postal questionnaire of Yorkshire and Humber adults in 2008 which provides Leeds level data.

The national data (2009) shows that the oral health of adults has been improving and the adult postal questionnaire (2008) shows that adults in Leeds report oral health on a par with people across Yorkshire and Humber:

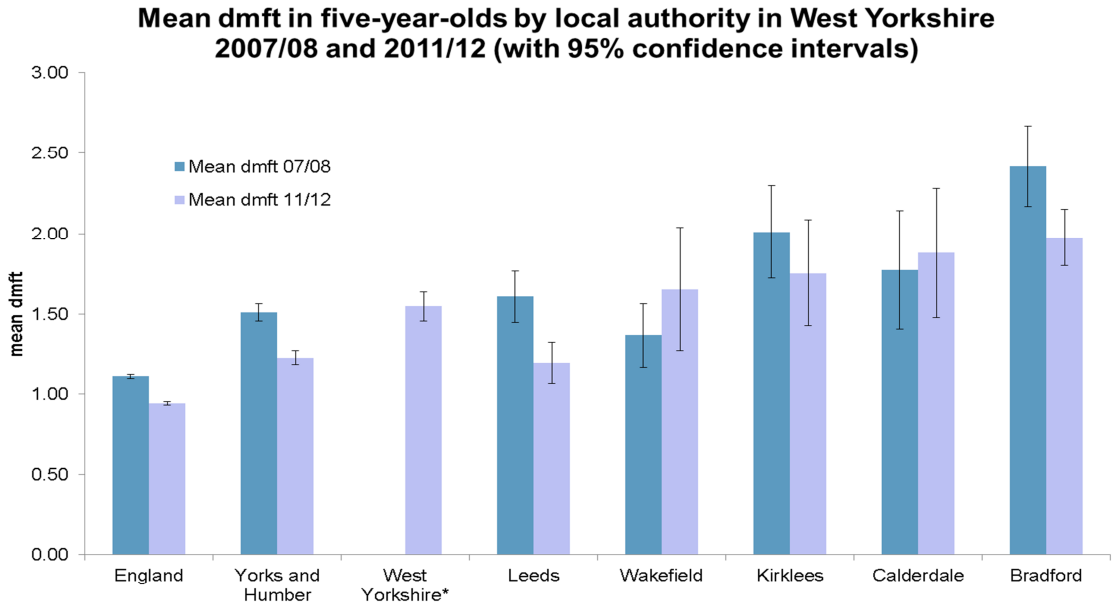
	Leeds	Yorks & Humber
If you went to the dentist tomorrow would you need treatment?	25.6%	25.4%
How would you rate your oral health? (% poor)	24.2%	25.3%

3. Children's Oral Health in Leeds

34% of 5-year old children in Leeds have a dmft score >0 (number of teeth decayed, missing or filled) which is the lowest in Yorkshire and Humber but still higher than the proportion in England overall which is 28%:



In the four years between 2007/2008 and 2011/12, the mean dmft score for 5 year old children in Leeds improved significantly. It is significantly better than the score for children living in other local authorities in West Yorkshire but still above the England score:



Source: PHE National Dental Epidemiology Programme for England.
Chart produced by PHE Knowledge and Intelligence Team Northern and Yorkshire

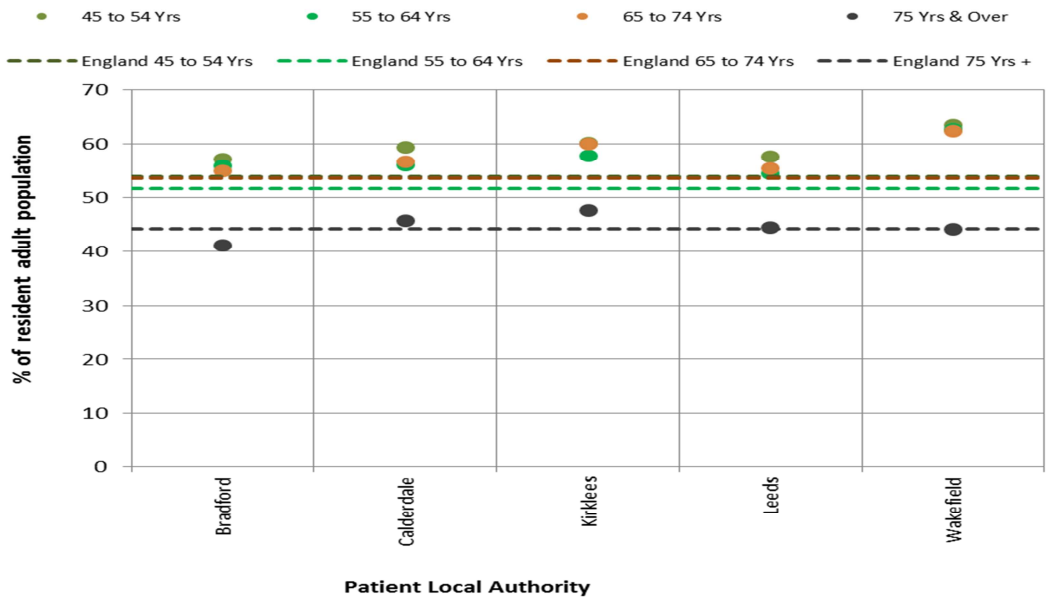
4. Service Structure in Leeds

The NHS spends £45.9 million on dental services in Leeds. The majority of patients attending LTHT are from the Leeds area but the more specialised services area also accessed by patients from across West and North Yorkshire.

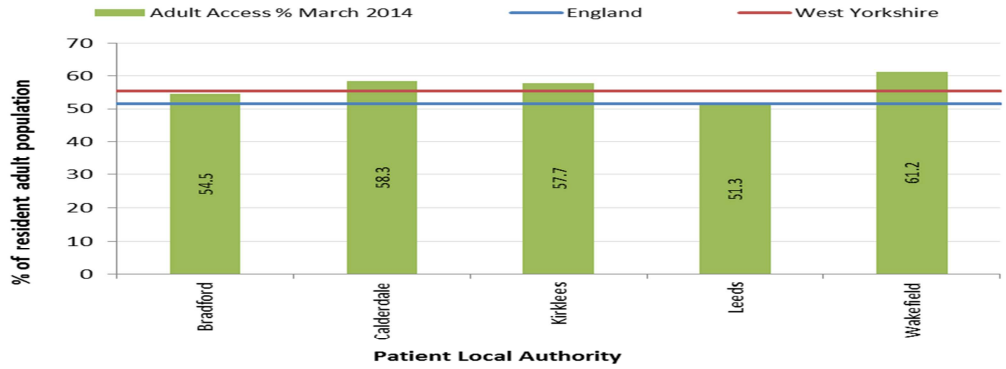
Sector	Provider	Scope	Value
Hospital	LTHT	Secondary care dental, oral surgery and maxillo-facial surgery	£8.2million
Community	LCH	Dental care for children and adults with special needs, and sedation service (including general anaesthetic)	£2.6million
Primary care	101 practices	1.27million UDAs to provide assessment and treatment.	£34.3million
Urgent care service	LCH	Urgent care, 365 days / year	£0.8million
Total Spend			£45.9million

5. Access to Primary Care Dental Services

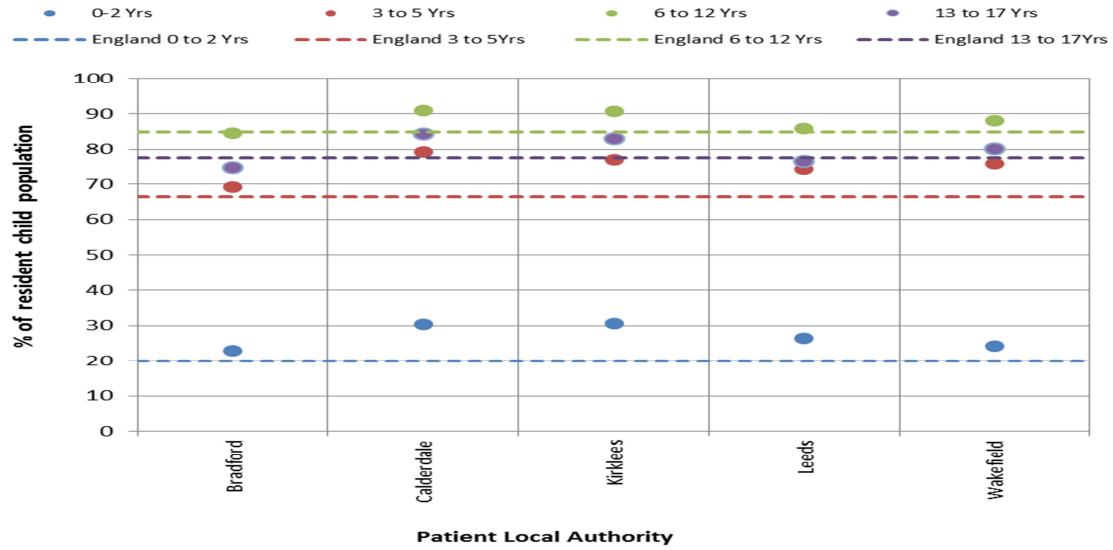
For adults, the access rates in Leeds are at or above the average for England in all age bands:



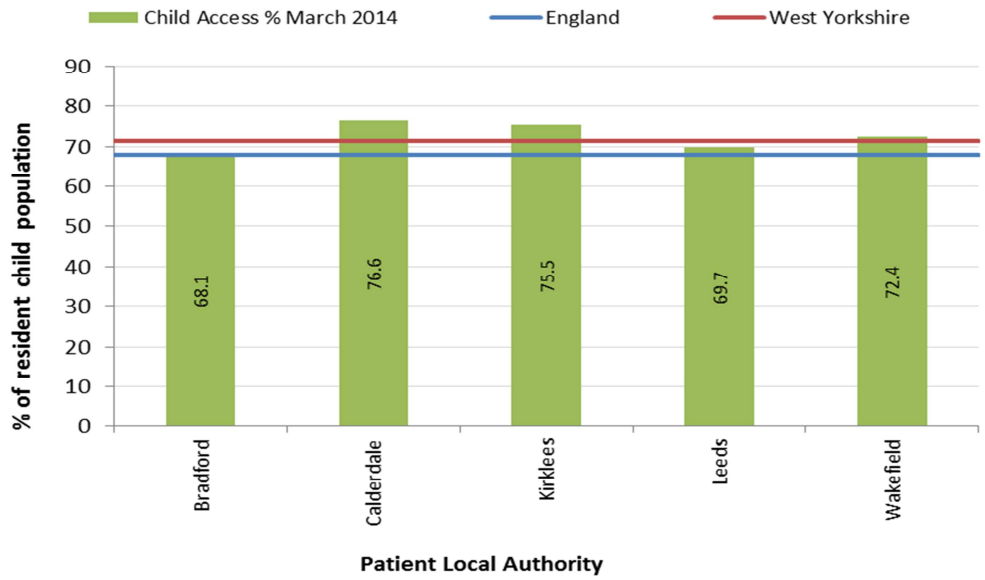
And 51.3% of adults have accessed a dentist within the last two years. This is the lowest access rate in West Yorkshire:



For children, access rates by age are good with particularly high rates in the under 5 age groups:



And 69.7% of children have seen a NHS dentist in the last two years, in line with the rate across England:



For urgent care, very few patients in Leeds attend A&E with dental needs but about 1 in 7 calls to 111 relate to dental health. This is consistent across Yorkshire & Humber.

11% of the commissioned activity in primary care is used to deliver urgent access for local patients but if a primary care dentist is not available to the patient then they are able to access the dedicated urgent care dental service provided through LCD and LCH. LCD provide a triage service supporting 111 and are able to book direct into slots at the LCH dental access centres.

6. **Quality of Primary Care**

NHS England introduced a Quality Assurance Framework for primary dental services in summer 2013. This is the first time that the quality of primary care dental services has been assessed consistently on a quarterly basis.

The quarterly results are reviewed by the Dental Commissioning Team working with clinical dental advisors. Concerns are either addressed through a quality visit to an individual practice or through contractual improvement notices, if warranted.

There are no significant concerns with dental practices in the Leeds area. The high level results from the Assurance Framework are:

Quality indicators	Leeds N	Leeds S & E	Leeds W	Leeds	W Yorks	England	
Radiograph Rate per 100FP17s	19	15.5	17.7	17.3	19.4	20.1	A low rate could indicate non-compliance with FGDP (UK) Good Practice Guidelines – "Selection Criteria for Dental Radiography".

Endodontic Treatment per 100FP17s	1.8	1	1.2	1.3	1.3	1.5	Low levels of endodontic treatment could indicate a number of factors but possibly a greater preference to extract rather than root fill or a high level of root treatments being provided under private contract.
Fluoride Varnish Rate per 100FP17s	34.2	41.7	38.1	38.3	42.9	30.6	A low level of fluoride varnish applications would suggest that treatment is not being offered according to "Delivering Better Oral Health"
Children Re-attending within 3 Months	8	7.4	7.7	7.7	8.5	7.9	In general, a patient who has completed a course of treatment that renders him or her "dentally fit" should not need to see a dentist again within the next three months. A high rate would indicate that further treatment has been provided outside the recall interval but could include urgent treatment etc.
Adults Re-attending within 3 Months	17.4	15.3	17.3	16.6	16	15.7	

7. Patient Satisfaction

There are no current measures of patient satisfaction in primary care dental services. NHS England is introducing the Friends & Family Test to primary care dentistry from April 2015.

Dental patient views on access are measured twice-yearly via the national GP Satisfaction Survey conducted by IPSOS Mori. Response rates to the dental questions in the survey are poor but for this area, the last survey showed satisfaction with access:

Tried to get appointment	**Number who reported trying**	**% successful**
In last 3 months	5216	92.9%
In last 6 months	8487	93.7%
In last 12 months	10802	92.7%
In last 2 years	12082	90.5%

These overall figures do mask differences in different populations and there is evidence that some groups of patients are disadvantaged by current access arrangements.

<u>% of patients successful in getting appointment</u>:

White	91.9%
Other ethnicity	83.8%

Working	91.0%
Retired	94.7%
Other	86.3%

Having seen the dentist before (ie existing patient)	95.4%
Having not seen the dentist before (ie new patient)	62.0%

The national access survey results are based on patients who report having tried to see a dentist recently. The survey also establishes the reasons why patients report not trying to see an NHS dentist are complex and include preferring to access private care and not requiring treatment which together account for ca 30% of patients:

Reason	**% of patients who did not try to get an appointment (n = 5284)**
Did not need to see a dentist	19.8%
No natural teeth	10.9%
Don't like going to the dentist	5.9%
On waiting list	1.6%
See a private dentist	34.3%
Didn't think they could get a NHS dentist	14.0%
Too expensive	3.5%
Other	10.1%

8. **Two Year Plan for Dental Services in West Yorkshire**

NHS England (West Yorkshire) has established a clinical network to steer the planning and commissioning of dental services across the area. The Local Dental Network is chaired by a primary care practitioner from Leeds and has representation from hospital services, community services, Public Health England and the Local Dental Committees. Healthwatch have opted to participate in individual pieces of work rather than have a place on the over-arching network.

In April 2014, the LDN working with NHS England established two-year plan for dental services in West Yorkshire. This sets out six priorities:

1. Moving to increasingly planned care with a reduction in the need for urgent care and a focus on continuity of care;
2. Reducing inequity in access;
3. Improving patient and public access to information about dental services and oral health;
4. Building capacity in primary and community-based services to ensure care is delivered at an appropriate level for every patient;
5. Commissioning care using the national pathways and based on consistent outcomes, quality standards and price irrespective of the place of delivery;
6. Working with Health Education England to ensure the support and development of a workforce which is able to deliver the new model of care.

The financial position within the NHS means that there will not be additional investment in dental services in the two year period. As such we need to ensure that we drive value for money in all sectors of the service.

In the first year, progress has been made on:

(i) Completing an oral health needs assessment for Yorkshire & Humber. This will be published in October 2015.

(ii) Establishing a clinical review of the model for urgent dental care services to reduce reliance on stand-alone provision and set the foundations for the new primary care dental contract which will re-establish a registered list for dental patients in primary care. The review will report in early 2015;

(iii) Reinvesting the funding released from annual primary care contract reviews (July 2014) into the areas of highest need as identified by Public Health England. This funding will be reinvested from October 2014;

(iv) Working with existing providers to review the service specification for community dental services for 2015/16 to establish a core and consistent service across the five providers and to release resources for improved access for frail elderly and bariatric patients;

(v) Introducing a new approach to coding and counting secondary care dental activity to standardise the approach across providers and release funding for investment in primary care.

(vi) Commissioning a dental advice line for West Yorkshire to improve public information about NHS dental services.

(vii) Planning for a central booking service for all secondary care activity. As a first step in 2014/15, all NHS dentists in West Yorkshire have been linked to NHSNet to facilitate electronic transfer of patient and diagnostic data.

Section C - Community Pharmacy Services

As at September 2014, there are 191 pharmacies across the Leeds area, with a good spread across the district and at least 1 pharmacy in every postcode region.

There are also 6 GP practices which are authorised to dispense prescription items directly to patients in rural areas: this covers places such as Bramham, Scholes and Collingham to ensure that patients living in rural areas also have access to services.

Across West Yorkshire during 2013/14 there was a total spend on pharmaceutical services commissioned by NHS England of £80million of which £27 million is spent in the Leeds area alone. This funds core services such as dispensing of prescriptions and disposal of patient waste/returned medications, as well as additional activities such as Medicines Use Reviews to enhance the use of medications.

In addition, the local authority commissions public health services from pharmacies and the CCGs commission some enhanced pharmacy services (such as minor ailment service) across Leeds.

NHS England (West Yorkshire) has established a Local Pharmacy Network to provide clinical input into the planning and commissioning of pharmacy services. The Network is chaired by a local

community pharmacist from the Leeds area and has representatives from across primary, community and secondary care in West Yorkshire. The LPN has established the following priorities:

1. Urgent & emergency care – promotion of Pharmacy First scheme to support general practice out of hours. Learning from Prime Minister's Challenge Fund pilot in Wakefield to establish opportunity for direct booking into pharmacy as an alternative to GP appointment.
2. Integrated care – rolling out Summary Care Record to community pharmacies to promote pro-active care of patients with long term conditions. West Yorkshire is one of three national pilot areas for this.
3. Patient Safety – building on medicine optimisation programme to increase effectiveness of prescribing and reduce medicine wastage.
4. Workforce – identifying opportunities for pharmacists to work in wider primary care settings – given the excess numbers of students that are currently being trained.

Section D - Community Optometry Services

As at September 2014, there are 91 shop based contracts across the Leeds area, with a further 67 contracts to allow sight tests in eligible patient's homes.

Across West Yorkshire during 2013/14, the total spend on core NHS optometry services (excluding community and secondary care which are commissioned by the CCGs) was £24.8million of which £8.2million was spend in the Leeds area.

The NHS-funded service is governed by nationally set eligibility criteria and covers sight tests and vouchers issued against glasses for children, those over 60 and also a range of people who may be on low incomes or receive specific benefits.

NHS England does not have the responsibility to commission enhanced optometry services and this function now sits with the local Clinical Commissioning Groups. A Local Eye Health Network has been established by NHS England to bring together Eye Health specialists and commissioners from across West Yorkshire. This met for the first time in early September 2014.

Alison Knowles
Commissioning Director
NHS England (West Yorkshire)
October 2014

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Report author: Adam Brannen
Oliver Priestley

Tel: 24 75387

Report of Director of City Development

Report to City Development Scrutiny Board

Date: 22nd July 2015

Subject: East Leeds Extension and East Leeds Orbital Road

Are specific electoral Wards affected? If relevant, name(s) of Ward(s): Crossgates & Whinmoor Harewood	☒ 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 East Leeds Extension (ELE) is an area of 225ha allocated for development of new housing in the Local Development Framework through the 2006 Unitary Development Plan. It has potential to deliver around 5,000 new homes and make a significant contribution to the delivery of the city's housing growth target of 66,000 (net) new homes by 2028.

2. Development in the ELE requires major new transport infrastructure to be brought forward, particularly the construction of a new East Leeds Orbital Road (ELOR) that will connect the existing Outer Ring Road at Red Hall to the J46 of the M1 at Thorpe Park.

3. The Council is taking a leading role on the co-ordination of the programme to deliver ELOR and to enable the scale of development it is anticipated to support.

4. The former Housing & Regeneration Scrutiny Board has received reports on ELE and ELOR at a series of meetings since January 2014. This report seeks to provide the new City Development Scrutiny Board with a briefing on the activities within the overall programme and an update on its current position. It is not exhaustive, but intended to bring new Board members 'up to speed' with a large programme of work that will drive forward a very significant part of the city's growth ambition in the coming years.

Recommendations

Scrutiny Board is asked to note the report and advise on any matters it wishes to receive further details and the frequency of any further updates.

1 Purpose of this report

1.1 This report provides Scrutiny Board with a briefing on the East Leeds Extension and East Leeds Orbital Road.

2 Background information

2.2 The Local Development Framework Core Strategy, adopted in November 2014, sets out the broad spatial and land use planning framework for the district up to 2028. Central to its preparation is the desire to plan for the people and places of Leeds in a sustainable way and to meet the needs of anticipated population growth through the allocation of land for 66,000 net new dwellings over the plan period.

2.3 The Core Strategy sets out a range of principles to support this, which include the need to link this growth to the creation of sustainable neighbourhoods and to work in partnership to facilitate delivery. It also sets out the need to develop brownfield and regeneration sites as part of the overall approach to housing growth.

2.4 The East Leeds Extension (ELE) was identified in the Unitary Development Plan (UDP) Review in 2006, as a major area to the east of Leeds (225 hectares/560 acres) to meet demand for housing in the later phases of the plan's life. It was envisaged that the development would incorporate housing, employment, ancillary and green space uses and would only come forward if it could be demonstrated as sustainable.

2.5 The UDP also allocates 63.8 hectares (157 acres) of land for employment uses, as a key business park, at Austhorpe (Thorpe Park).

2.6 In June 2011 Executive Board agreed the principle of releasing Phase 2 and 3 UDP housing allocations in order to make up the shortfall of housing land in Leeds, following a series of planning appeals on greenfield sites. As a result it is now envisaged that 5-7,000 new homes could be built in this part of Leeds (including other adjacent housing allocations and permissions) over the coming years. This would make a significant contribution to the growth targets set out in the Core Strategy, alongside efforts to bring forward brownfield sites for development.

2.7 The ELE is the single largest opportunity in the city to deliver new high quality residential neighbourhoods on allocated green field housing land. It offers a spatial focus for the delivery of the Best City ambition, building in from the very earliest planning stages the aspirations to create a Child Friendly city, meet the needs of older people, enable positive public health outcomes, to deliver attractive and sustainable travel choices and ensure that development is achieved in a way that meets the growth needs of the city whilst complementing and improving the amenity of existing neighbourhoods.

2.8 The process of 'place-making' for the ELE will embrace the planning and delivery of new homes, schools, retail and community facilities, green spaces, sports and leisure facilities, transport and movement infrastructure. It requires co-ordination with a range of development interests across a number of land ownerships and over a period likely to span several years.

2.9 A new East Leeds Orbital Road (ELOR) is required as part of the policy associated with the original ELE UDP allocation, to stretch from the Outer Ring Road at Red Hall round the east side of Leeds to Thorpe Park joining a new Manston Lane Link Road (MLLR) where it would connect into the existing highway infrastructure and link to the M1 motorway. It would effectively become a new 4.3 mile (7km) route to provide the critical highway capacity to support all allocated and approved development in the East Leeds Extension and to relieve congestion on the existing network. It would also enable new public transport connections on the route itself, release capacity on existing networks and support the wider provision of Park and Ride and bus services across East Leeds

2.10 The delivery of ELOR is critical to unlocking the development capacity of the East Leeds Extension and as such has become a focus of strategic planning for the area, with the Council taking a leading role in its delivery including details relating to its cost, funding, scope, phasing in relationship to house building and responsibility for construction.

3 Main issues

Land Ownership & Development Proposals

3.1 The land ownership and interests across the ELE are complex - there are 37 individual parcels of land across 26 different ownerships, with a number of separate options for acquisition registered by developers. The area is best understood as five sections divided by the existing main routes through the area:

Section 1 – A6120 to A58 (Red Hall)
Section 2 – A58 to A64 (Northern Quadrant)
Section 3 – A64 to Barwick Road (Middle Quadrant)
Section 4 – Barwick Road to Leeds-York rail line (Southern Quadrant)
Section 5 – Leeds-York rail line to M1 (Thorpe Park)

3.2 An overview of the ELE and indicative route of the ELOR/MLLR is provided at Appendix 1. The report sets out below the land and development issues in each section.

Section 1 – Red Hall

3.3 At Section 1 of the ELE the Council owns 29 ha of land at Red Hall between the existing Outer Ring Road and the A58 Wetherby Road. Executive Board approved the relocation of Parks and Countryside services from Red Hall in May 2012. Office functions have been relocated to Farnley Hall and work is now underway to plan a replacement nursery at Whinmoor Grange, in accordance with a planning statement approved by Executive Board in October 2012.

3.4 An outline development framework was approved for the Red Hall site by Executive Board in October 2013 as a first stage in considering disposal and development and construction of the ELOR through the site. The land is partly allocated as Business Park in the UDP but has been proposed as wholly residential in the LDF Site Allocations work to date, reflecting national changes in planning policy for business park locations.

Section 2 – Northern Quadrant

3.5 The Northern Quadrant consortium of landowners, submitted an outline planning application in June 2012 for the first phase of residential development on 101 ha, where they propose to build 2,000 houses and associated open spaces with land allocated for a primary school and a local centre. The application also includes details of the route of ELOR through this part of the allocation and related junctions on the A58 and A64.

3.6 The planning application was considered by City Plans Panel in March 2015 and delegated for approval to the Chief Planning Officer, subject to the developers' commitment to deliver a policy-compliant package of planning obligations, including funding of this section of the ELOR. Further discussion is now taking place on the ability of the developer to deliver this package whilst retaining the ability to deliver a viable development.

3.7 The consortium proposes to construct the A58 and A64 ELOR junctions up front to provide access to the site and enable development of the first phases of new homes, but the contribution to the remainder of this section of ELOR would be through a 'roof tax' – staged payments related to the completion of homes on the site.

3.8 It should be noted that there is a single parcel of land that does not currently sit within the consortium's interest, but which will be required to provide for the route of ELOR through the site. This is an owner-occupied property with a business and the Council is currently engaged in negotiations to acquire this land on terms that would be acceptable to the owners, with the costs to be indemnified by the consortium.

Sections 3 & 4 – Middle & Southern Quadrants

3.9 There are currently no proposals or planning applications for development in these quadrants and land ownership is more fragmented. The Council owns 25 ha of land here, the majority in a single parcel on the northern side of the main Leeds-York railway line. Major house builders Persimmon, Taylor Wimpey and Redrow also have significant land holdings or options on land in this section. There are several owner occupied parcels of land and property with whom the Council has engaged about the potential for development, but have not yet committed land to any developer interests.

3.10 The Council intends to bring forward a Development Framework for this part of the ELE, which will set out the overall expectation of quality and scale of housing development and related community infrastructure such as schools and open spaces, along with the mechanisms through which developers will be expected to contribute to the delivery of ELOR. This will provide greater certainty for those smaller landowners who may be seeking to ensure they get a fair return for any land sold.

Section 5 – Thorpe Park

3.11 Outside the ELE, but immediately adjoining at Thorpe Park, Scarborough Developments has a part-implemented planning consent from 1995 for up to 1.8m sq ft of office development with complementary uses, together with a requirement to provide a new park. Approximately 600,000 sq ft has been constructed and occupied.

3.12 In March 2014 Scarborough Developments secured outline planning approval for a revised master plan for Thorpe Park to develop the remainder of the site for a further 1.7m sq ft of mixed retail, leisure and office uses, which could support up to 10,000 new jobs. A further amendment to this master plan was secured in early 2015, to provide for a residential element of 300 new homes. Build out of the Thorpe Park scheme will be subject to conditions that will trigger the provision of a new public park ('Green Park') on land to the west, upon certain uses or amount of floorspace being constructed.

3.13 The developer has obtained detailed planning permission to construct the Manston Lane Link Road (MLLR) and a bridge over the Leeds-York rail line as a dual carriageway. Together with land reserved for future widening, this will provide the route of ELOR through the business park to connect to the M1.

3.14 Scarborough Developments has an agreement with the Council under which the developer can request the construction of a bridge over the railway at its own cost, landing on the Council land to the north. This is facilitated by a further tri-partite Bridge agreement that has been entered into with Network Rail. Relevant Highways Agreements are now also in place and Scarborough anticipates a programme of works that will see completion of the MLLR works in 2017, enabling it to commence implementation of its revised master plan. It is understood that the developer is currently engaging with the retail market to identify and secure core tenants for the scheme.

Other Development Sites

3.15 There is a separate scheme currently on-site at Grimes Dyke, off the A64 adjoining the Northern Quadrant, for 364 new homes delivered by Taylor Wimpey & Persimmon. Though very closely related, development here is not within the ELE and has been permitted without any need for ELOR to be in place or for a financial contribution to its delivery.

3.16 Adjoining the Southern Quadrant at the former Vickers tank factory on Manston Lane in Barnbow, a first phase of development of 151 units is currently underway by Bellway Homes. A hybrid application was submitted by Bellway in May 2014 for 485 further dwellings on the site, 100 of which were in detail, though this has yet to be determined. There is also planning approval for Ben Bailey Homes to develop 256 new homes on the adjoining former Optare factory site. The full development potential of these sites is currently limited to 256 dwellings until the MLLR works are complete and open.

East Leeds Orbital Road

3.17 Given the complexity of land ownerships and development interests, and the different pace at which development proposals were coming forward in separate sections of the ELE, in January 2013 Executive Board approved the principle of the Council taking a leading role in the delivery of the East Leeds Orbital Road and other infrastructure requirements and to formally engage with the landowners about the delivery process for this.

3.18 In March 2013 a feasibility study was commissioned by the Council, at a cost of £150,000, to establish an outline scope for ELOR, a preferred route alignment, indicative cost and potential programme for delivery. This was an objective and up to date highways engineering assessment of the scope of the road, informed by current traffic modelling and development forecasts.

3.19 This work was reported to Executive Board in October 2013 and establishes the need for ELOR to be a dual carriageway at any section along the route of ELOR, to have a design speed of 50mph and to limit junctions to its intersections with existing main routes. The study also provided a suitable highway alignment between the A6120 outer ring road and Manston Lane, based on national and local highways standards and guidance, to tie in with the road infrastructure proposed within the Thorpe Park master plan.

3.20 The feasibility work gave an estimated cost of £74.5m for construction of the preferred route from the outer ring road at Red Hall to the M1, based on 2013 prices and inflation of 3% per annum up to construction date. It includes an ‘optimism bias’ of 45% on top of unit costs – equating to £23m of the estimate – to reflect risks associated with matters that may be unknown at this stage such as site conditions, detailed design, agreed procurement route, phasing or programme.

3.21 The East Leeds Orbital Road (ELOR) is a major investment in infrastructure for the city region. It is ranked as a regional priority for strategic transport investment by the newly formed Combined Authority, which has established a £1bn funding pot to support strategic schemes across the city region. Consequently the West Yorkshire Transport Fund (WYTF) has made a share of monies available to the Council to progress the submission and development of a strategic business case for the continued development of a business case for ELOR.

3.22 The ELOR programme comprises of three separate but related projects – ELOR itself, junction improvement works on the western Outer Ring Road approaches at Park Road, the A61 and King Lane/Stonegate Road and a series of environmental improvements to the Outer Ring Road sections through Cross Gates and Seacroft/Whinmoor that will effectively become bypassed by the new strategic highway.

3.23 The West Yorkshire Combined Authority in managing the Transport Fund appropriately require districts to adhere to a formal 'gateway' process to progress stepped financing of individual projects. Setting up of the assurance framework was a fundamental requirement of the Department for Transport when the fund was established and financial support sought from them.

3.24 A successful application was made to WYCA in January 2014 for a total of £1.3m for project development to progress ELOR to Gateway One submission. This included the back funding of the Council's initial feasibility costs. The Gateway One Business Case was developed and subsequently submitted to WYCA in January 2015 and approved for progression in April.

3.25 WYCA has provisionally allocated £76m towards a total estimated cost of £116.2m for all three elements of the ELOR programme, these costs including inflation and 'optimism bias'. The ELOR element of the project itself accounts for £86m of this, requiring £40m to be secured through third party contributions to the overall cost.

3.26 Third party contributions are currently assumed to be provided by the developers of the ELE, through a 'roof tax' secured through s106 agreements, as has been established in principle at the Northern Quadrant. However other funding routes such as institutional investment may prove to be attractive as a means of managing the costs of cash flow over the life time of the ELE development. Executive Board has requested that once the Northern Quadrant scheme achieves planning approval, it receives a report on the financial implications for the Council of the roof tax.

3.27 The WYCA approval has released a further £3.9m of project development funds to enable detailed stage 2 tasks on the project to be progressed. Work is now been undertaken on detailed environmental surveys and assessments, and preliminary engineering designs. A significant amount of work will now be brought forward to enable planning approval to be sought. A Gateway 2 Business Case will be submitted to WYCA once planning approval is obtained and detailed engineering and procurement documentation drawn up. Approval at that stage will enable procurement to commence. A further gateway approval will enable appointment of contractors and start on site to works.

3.28 The present programme for the ELOR is summarised below. The ongoing programme assumes that the Council, together with the Combined Authority, will continue to lead development of the road scheme. There is no change to the programme previously reported to Members of the Housing & Regeneration Scrutiny Board:

- Sept 2014 – Stage 2 scheme validation
- March 2016 – Stage 3 scheme assessment
- May 2016 – Planning application
- Dec 2016 – Statutory Orders published
- March 2018 – Works start on site
- Early 2020 – Scheme opening

4 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 The East Leeds Regeneration Board continues to hold discussions relating to the matters addressed in this report. The Board has Member representatives from each of the East Leeds wards, each of the Council's political groups, the MPs for Leeds East and Elmet & Rothwell, as well as representatives from the HCA and the Combined Authority.

4.1.2 The progression of the WYCA business case for ELOR to the current stage now requires wide engagement with stakeholders on the emerging project design, provision of information to local residents on the scale and impact of the works and a more concerted exercise to ensure the scheme incorporates local views as far as possible.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 There are no specific EDCI implications arising from this report, as it provides a briefing and update to the Board.

4.3 Council Policies and City Priorities

4.3.1 The ELE and ELOR are included within the allocations and policies of the Unitary Development Plan. The ELE and related policies are carried forward into the Core Strategy as part of the Local Development Framework.

4.3.2 This programme of housing and infrastructure development relates very strongly to the Best Council Plan objective of delivering sustainable and inclusive economic growth and the 'breakthrough project' to deliver housing growth.

4.4 Resources and Value for Money

4.4.1 There are no specific resource implications related to this report, which presents information for discussion by the Scrutiny Board.

4.5 Legal Implications, Access to Information and Call In

4.5.1 There are no specific legal implications related to this report, which presents information for discussion by the Scrutiny Board.

4.6 Risk Management

4.6.1 There are no specific risks related to this report.

5 Conclusions

5.1 The report presents an overview and summary of the Council's activities to bring forward development of around 5,000 new homes in the East Leeds Extension and the work underway to enable funding and construction of the East Leeds Orbital Road in support of this.

5.2 The report is not exhaustive but seeks to bring new Scrutiny Board members 'up to speed' with a large programme of work, the success of which will be important to the city achieving its ambitions for sustainable growth.

6 Recommendations

6.1 Scrutiny Board is asked to note the report and advise on any matters it wishes to receive further details and the frequency of any further updates.

7 Background documents[1]

7.1 None.

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

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Legend

- Red Hall & East Leeds Extension UDP Allocations
- SECTION 1 Red Hall
- SECTION 2 Northern Quadrant
- Grimes Dyke
- SECTION 3 Southern Quadrant
- Former Optare Site
- Former Vickers Site Phase 1
- Former Vickers Site Future Phases
- SECTION 4 Southern Quadrant
- SECTION 5 Thorpe Park
- Green Park
- Indicative route of East Leeds Relief Road
- Indicative route of Manston Lane Link Road

Leeds CITY COUNCIL

EAST LEEDS EXTENSION

PREP BY M. CHRISTIAN
DATE 13/01/2014
OS No SE3637
Scale 1:20,000
PLAN No 11041/BA

Path: G:\PLANS AND PROJECTS\Land Records Plans\11000 - 11099\11041BA East Leeds Relief Road Sections Revised.mxd

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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 (Adult Social Services, Public Health, NHS)

Date: 8 September 2015

Subject: Public Health Budget Update

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

1 Purpose of this report

1.1 The purpose of this report is to introduce a further update from the Director of Public Health regarding the Public Health budget for 2015/16 (i.e. the current year).

2 Summary of main issues

2.1 At the Board's meeting on 23 June 2015, the Director of Public Health and Executive Member for Health, Wellbeing and Adults advised the Scrutiny Board of a recent Treasury announcement that would see Public Health funding reduced by approximately £200M across England for 2015/16 (the current year): Equating to around £3M for Leeds, which was likely to have a significant impact on the Council's 'prevention agenda'.

2.2 At its meeting on 28 July 2015, the Board received a further update from the Director of Public Health advising that a Department of Health consultation was anticipated in the very near future – likely to focus on how the decision to make in-year savings could be implemented.

2.3 On 31 July 2015, the Department of Health launched its consultation '*Local authority public health allocations 2015/16: in-year savings – A consultation*'. The consultation period ran until 28 August 2015 and a copy of the consultation document is attached for information. As expected, the focus of the consultation was around how the total in-year savings should be achieved and distributed across local authority areas.

2.4 The Director of Public Health has been invited to provide an update to the Scrutiny Board, including Leeds' response to the consultation and the anticipated next steps.

3. Recommendations

3.1 That the Scrutiny Board considers the report and the detail presented at the meeting, and determines any future scrutiny actions or activity.

4. Background papers[1]

4.1 None used.

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

Department of Health

Local authority public health allocations 2015/16:

in-year savings

A consultation

July 2015

Title: Local authority public health allocations 2015/16: in-year savings
Author: Public Health policy Strategy Unit (PHPSU) cc:10100
Document Purpose: Consultation
Publication date: 31st July 2015
Target audience: Local Authorities in England
Contact details: **email to: consultation.laphallocations@dh.gsi.gov.uk** Post: Consultation on Local Authority Public Health Allocations Department of Health Public Health Policy and Strategy Unit Room 165 Richmond House 79 Whitehall London SW1A 2NS

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Local authority public health allocations 2015/16:

in-year savings

A consultation

Prepared by the Public Health Policy and Strategy Unit, Department of Health

Contents

Executive summary

As part of wider Government action on deficit reduction, the 2015/16 public health grant to local authorities will be reduced by £200 million. This consultation sets out technical options for implementing the saving and will run for a period of four weeks from 31st July 2015.

The principle question relates to how each LA's contribution to the saving will be calculated. The options include a standard, flat rate of 6.2 per cent applied to all, or a process that differentiates between LAs in different circumstances (allowing for evidence of hardship, for example) applying varied percentages that still total £200 million.

Chapter 1: Introduction

1.1 This consultation document summarises the outstanding policy issues on which we seek views. These issues are set out in Chapter 3. The consultation process is set out at Annex A.

1.2 The need for an economic assessment and an impact assessment of the proposed policy will be looked at after the consultation has finished.

1.3 Questions for consultation are summarised in Annex B. We welcome general comments as well as specific responses to the questions.

1.4 This consultation closes on 28th August 2015. You can contribute to the consultation by responding in two ways:

email to: consultation.laphallocations@dh.gsi.gov.uk

Post:

Consultation on Local Authority Public Health Allocations

Department of Health

Public Health Policy and Strategy Unit

Room 165

Richmond House

79 Whitehall
London
SW1A 2NS

Chapter 2: Background

2.1 Since 2013 local authorities (LAs) in England have had a statutory duty to take the steps that they believe are appropriate to improve the health of their populations. The Department of Health (DH) funds LAs for this with a grant.

2.2 In December 2014 DH announced a 2015/16 public health grant of £2.8 billion, with £430 million to be added to that in October 2015 when responsibility for the commissioning of services for children aged 0-5 transfers to LAs from NHS England – making a total of £3.23 billion. The grant is paid to LAs by PHE in quarterly instalments. The first payment for 2015/16 was made in April 2015.

2.3 DH also identified £5 million to fund a pilot Health Premium Incentive Scheme (HPIS). This was intended to reward LAs that achieve a defined level of progress against two indicators of public health.

2.4 On 4 June the Chancellor of the Exchequer announced a package of savings to be made across government in 2015/16, the current financial year, to reduce public debt. The savings amount to £3 billion and include £200 million from this year's public health grant, to be deducted from the January 2016 instalment.

Scope of the consultation

2.5 The Department wants LAs to have the optimum flexibility in making this saving while at the same time being as supportive as it can. DH intends to continue to make payments due to LAs this year under the HPIS. The Department considered the option of repurposing this money to help mitigate the impact of the grant reduction but does not consider that this would be appropriate. The principle of the HPIS is to reward local progress on key indicators of public health, which DH believes remains important, and the payments it delivers will form an element of LAs' public health funding. This means that LAs will be able to determine how any payments are best used in the context of the grant reduction and their local priorities.

2.6 In reaching its decisions DH will consider carefully the statutory requirements that apply to it, not least the public sector equality duty.

2.7 DH intends the transfer to LAs of responsibility for commissioning 0-5 children's public health services to take place in October as planned. The Regulations mandating the universal aspects of those services will still come into force on 1 October. It will be open to LAs to make savings from the funds that transfer in October as well as from the original April 2015 allocation as long as they comply with these Regulations and the other statutory requirements that apply to them.

2.8 Views on the questions from all will be carefully considered and are equally welcome, particularly in relation to any people sharing a protected characteristic as defined in the Equality Act 2010. Please include in responses any views about ways to minimise possible disruption to services and adverse impacts on public health.

Options

2.9 There are three questions. For one of them DH has expressed its current preferred option in order to help inform the response to this consultation - it will not make any decisions

until it has considered the responses in full. All consultees are welcome to suggest alternative options not mentioned in this document.

Chapter 3. Questions on how to implement public health allocation savings in 2015/16

Question 1

How should DH spread the £200 million saving across the LAs involved?

3.1 DH could, for example:

A. Devise a formula that claims a larger share of the saving from LAs that are significantly above their target allocation.

B. Identify LAs that carried forward unspent reserves into 2015/16 and claim a correspondingly larger share of the savings from them.

C. Reduce every LA's allocation by a standard, flat rate percentage. Nationally the £200 million saving amounts to about 6.2 per cent of the total grant for 2015/16, so that would also be the figure DH applied to individual LAs. Annex C sets out the effect on allocations.

D. Reduce every LA's allocation by a standard percentage unless an authority can show that this would result in particular hardship, taking account of the following criteria:

- inability to deliver savings legally due to binding financial commitments;
- substantial, disproportionate and unavoidable adverse impact on people who share a protected characteristic within the meaning of section 149 of the Equality Act 2010;
- high risk that, because of its impact, the decision would be incompatible with the Secretary of State's duties under the NHS Act 2006 (in particular the duty to have regard to the need to reduce inequalities between people with regard to the benefits they can receive from public health services);
- the availability of funding from public health or general reserves; or
- any other exceptional factors.

3.2 LAs are invited to include any such evidence in responses to this consultation. Should the Department opt to implement option D, it will rely on this evidence in making decisions on its application and will not mount a separate consultation to gather this evidence.

3.3 The total savings required under all options would remain at £200 million - if any LAs are eventually asked to save less than 6.2 per cent it follows that others would be required to save more.

3.4 Subject to the outcome of this consultation, DH's preferred option is C. It is the simplest and most transparent option to implement and would enable the Department to provide LAs quickly with certainty on what would be required of them.

3.5 Option D offers the potential of additional sensitivity to local needs but would be considerably more complex to implement and depends on the provision by LAs of clear evidence to identify confidently a finite number of genuinely exceptional local circumstances.

The need for DH to consider a potentially large number of cases means it would be likely to take significantly longer to provide LAs with clarity on the savings they would be required to make.

Question 2

How can DH, PHE and NHS England help LAs to implement the saving and minimise any possible disruption to services?

3.6 DH welcomes proposals. Only a few aspects of the system architecture are fixed:

- LAs' duties in primary legislation will remain in place.
- It would not be realistic to amend the existing Regulations that require LAs to take particular steps (highlighted in Annex C), or the Regulations that will mandate the universal aspects of commissioning of public health services for children aged 0-5, or any other secondary legislation, in time to influence spending in the current financial year.
- The conditions attached to the grant will stay in place for the rest of 2015/16.

Question 3

How best can DH assess and understand the impact of the saving?

3.7 Again, DH welcomes proposals. To inform its planning for 2016/17 and beyond it is important for the Department to understand the effect of this saving, including its effect on services for children aged 0-5. It is also important to reach that understanding in ways that do not add to LAs' costs. DH could, for example:

- Undertake a national survey of directors of public health and other key stakeholders.
- Commission PHE centre directors to review the local impact and contribute to a national report for DH.
- Work through representative bodies to gather feedback on local impact.

Annex A: The consultation process

Criteria for consultation

This consultation aims to:

- formally consult at a stage where there is scope to influence the outcome;
- consult for a proportionate period
- be clear about the process in the consultation documents, what is being proposed, the scope to influence, and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure effectiveness and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials are guided on how to run an effective consultation exercise and share what they learn from the experience.

Comments on the consultation process itself

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

Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE

e-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.

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

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

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

Summary of responses to the consultation

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at

http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

Annex B: Consultation questions and response form

Question: 1 Do you agree with DH's preferred option (C) for applying the £200 million saving across LAs? If not, which is your preferred option? Please tick your preferred option or describe an alternative : A B C D (see paragraph 3.2)
Question: 2 How can DH, PHE and NHS England help LAs to implement the saving and minimise any possible disruption to services?
Question: 3 How best can DH assess and understand the impact of the saving?

Annex C: Illustrative revised allocations

Indicative impact of a flat 6.2% reduction in each local authority's total 2015/16 public health grant. All figures are £'000s

Local authorities	Total PH allocations excluding 0-5	Children's 0-5 public health allocation (part year)	Total 2015/16 PH allocation	Indicative revised allocation (original minus 6.2%)
Barking and Dagenham	14,213	2,512	16,725	15,688
Barnet	14,335	2,592	16,927	15,878
Barnsley	14,243	2,549	16,792	15,751
Bath and North East Somerset	7,384	1,387	8,771	8,227
Bedford	7,343	1,291	8,634	8,099
Bexley	7,574	1,720	9,294	8,718
Birmingham	80,838	11,210	92,048	86,341
Blackburn with Darwen	13,134	1,880	15,014	14,083
Blackpool	17,946	1,551	19,497	18,288
Bolton	18,790	2,835	21,625	20,284
Bournemouth	8,296	1,818	10,114	9,487
Bracknell Forest	3,049	774	3,823	3,586
Bradford	35,333	6,133	41,466	38,895
Brent	18,848	2,763	21,611	20,271
Brighton and Hove	18,695	2,111	20,806	19,516
Bristol, City of	29,122	3,799	32,921	30,880
Bromley	12,954	1,901	14,855	13,934
Buckinghamshire	17,249	3,061	20,310	19,051
Bury	9,619	1,806	11,425	10,717

Local authorities	Total PH allocations excluding 0-5	Children's 0-5 public health allocation (part year)	Total 2015/16 PH allocation	Indicative revised allocation (original minus 6.2%)
Calderdale	10,679	2,190	12,869	12,071
Cambridgeshire	22,155	3,861	26,016	24,403
Camden	26,368	2,121	28,489	26,723
Central Bedfordshire	10,149	1,902	12,051	11,304
Cheshire East	14,274	2,353	16,627	15,596
Cheshire West and Chester	13,889	2,107	15,996	15,004
City of London	1,698	75	1,773	1,663
Cornwall	20,749	3,673	24,422	22,908
County Durham	45,780	4,894	50,674	47,532
Coventry	19,415	2,807	22,222	20,844
Croydon	18,825	2,748	21,573	20,235
Cumbria	15,594	2,599	18,193	17,065
Darlington	7,184	1,215	8,399	7,878
Derby	15,710	3,094	18,804	17,638
Derbyshire	35,562	5,140	40,702	38,178
Devon	22,060	4,513	26,573	24,925
Doncaster	20,198	3,450	23,648	22,182
Dorset	12,889	2,267	15,156	14,216
Dudley	18,974	2,453	21,427	20,099
Ealing	21,974	2,863	24,837	23,297
East Riding of Yorkshire	9,175	1,536	10,711	10,047
East Sussex	24,067	3,500	27,567	25,858

Local authorities	Total PH allocations excluding 0-5	Children's 0-5 public health allocation (part year)	Total 2015/16 PH allocation	Indicative revised allocation (original minus 6.2%)
Enfield	14,257	2,447	16,704	15,668
Essex	48,192	10,981	59,173	55,504
Gateshead	14,850	1,987	16,837	15,793
Gloucestershire	21,793	3,141	24,934	23,388
Greenwich	19,061	3,574	22,635	21,232
Hackney	29,818	4,009	33,827	31,730
Halton	8,776	1,410	10,186	9,554
Hammersmith and Fulham	20,855	1,996	22,851	21,434
Hampshire	40,363	8,843	49,206	46,155
Haringey	18,189	2,422	20,611	19,333
Harrow	9,146	1,577	10,723	10,058
Hartlepool	8,486	761	9,247	8,674
Havering	9,717	1,372	11,089	10,401
Herefordshire, County of	7,970	1,266	9,236	8,663
Hertfordshire	37,642	8,200	45,842	43,000
Hillingdon	15,709	2,137	17,846	16,740
Hounslow	14,084	1,935	16,019	15,026
Isle of Wight	6,088	1,226	7,314	6,861
Isles of Scilly	73	37	110	103
Islington	25,429	2,092	27,521	25,815
Kensington and Chelsea	21,214	1,342	22,556	21,158
Kent	53,264	11,894	65,158	61,118

Local authorities	Total PH allocations excluding 0-5	Children's 0-5 public health allocation (part year)	Total 2015/16 PH allocation	Indicative revised allocation (original minus 6.2%)
Kingston upon Hull, City of	22,559	2,682	25,241	23,676
Kingston upon Thames	9,302	1,112	10,414	9,768
Kirklees	23,527	3,049	26,576	24,928
Knowsley	16,419	1,593	18,012	16,895
Lambeth	26,437	4,652	31,089	29,161
Lancashire	59,801	9,034	68,835	64,567
Leeds	40,540	4,993	45,533	42,710
Leicester	21,912	4,288	26,200	24,576
Leicestershire	21,930	3,202	25,132	23,574
Lewisham	20,088	3,790	23,878	22,398
Lincolnshire	28,506	4,166	32,672	30,646
Liverpool	41,436	4,845	46,281	43,412
Luton	13,286	2,114	15,400	14,445
Manchester	48,303	5,441	53,744	50,412
Medway	14,280	2,522	16,802	15,760
Merton	9,236	1,476	10,712	10,048
Middlesbrough	16,378	1,398	17,776	16,674
Milton Keynes	8,788	2,079	10,867	10,193
Newcastle upon Tyne	21,301	2,749	24,050	22,559
Newham	26,112	4,644	30,756	28,849
Norfolk	30,590	6,893	37,483	35,159
North East Lincolnshire	9,971	1,299	11,270	10,571

Local authorities	Total PH allocations excluding 0-5	Children's 0-5 public health allocation (part year)	Total 2015/16 PH allocation	Indicative revised allocation (original minus 6.2%)
North Lincolnshire	8,464	1,078	9,542	8,950
North Somerset	7,593	1,636	9,229	8,657
North Tyneside	10,807	1,674	12,481	11,707
North Yorkshire	19,732	2,535	22,267	20,886
Northamptonshire	29,523	5,033	34,556	32,414
Northumberland	13,361	2,547	15,908	14,922
Nottingham	27,839	5,319	33,158	31,102
Nottinghamshire	36,119	5,815	41,934	39,334
Oldham	14,915	2,164	17,079	16,020
Oxfordshire	26,086	4,333	30,419	28,533
Peterborough	9,291	1,563	10,854	10,181
Plymouth	12,276	2,575	14,851	13,930
Poole	6,057	1,287	7,344	6,889
Portsmouth	16,178	2,013	18,191	17,063
Reading	8,212	1,446	9,658	9,059
Redbridge	11,411	2,112	13,523	12,685
Redcar and Cleveland	10,917	1,117	12,034	11,288
Richmond upon Thames	7,891	1,334	9,225	8,653
Rochdale	14,777	2,299	17,076	16,017
Rotherham	14,176	2,150	16,326	15,314
Rutland	1,080	195	1,275	1,196
Salford	18,777	2,444	21,221	19,905
Sandwell	21,805	3,175	24,980	23,431

Local authorities	Total PH allocations excluding 0-5	Children's 0-5 public health allocation (part year)	Total 2015/16 PH allocation	Indicative revised allocation (original minus 6.2%)
Sefton	19,952	2,216	22,168	20,794
Sheffield	30,748	3,724	34,472	32,335
Shropshire	9,843	1,474	11,317	10,615
Slough	5,487	1,546	7,033	6,597
Solihull	9,644	1,407	11,051	10,366
Somerset	15,513	3,843	19,356	18,156
South Gloucestershire	7,345	1,655	9,000	8,442
South Tyneside	12,917	1,392	14,309	13,422
Southampton	15,049	2,103	17,152	16,089
Southend-on-Sea	8,060	1,355	9,415	8,831
Southwark	22,946	3,464	26,410	24,773
St. Helens	13,099	1,582	14,681	13,771
Staffordshire	33,313	5,330	38,643	36,247
Stockport	13,189	2,426	15,615	14,647
Stockton-on-Tees	13,067	1,403	14,470	13,573
Stoke-on-Trent	20,242	1,811	22,053	20,686
Suffolk	25,742	4,206	29,948	28,091
Sunderland	21,036	2,750	23,786	22,311
Surrey	28,977	6,528	35,505	33,304
Sutton	8,619	1,280	9,899	9,285
Swindon	8,558	1,472	10,030	9,408
Tameside	13,463	1,771	15,234	14,289
Telford and Wrekin	10,913	1,572	12,485	11,711

Local authorities	Total PH allocations excluding 0-5	Children's 0-5 public health allocation (part year)	Total 2015/16 PH allocation	Indicative revised allocation (original minus 6.2%)
Thurrock	8,631	1,956	10,587	9,931
Torbay	7,396	1,494	8,890	8,339
Tower Hamlets	32,261	3,855	36,116	33,877
Trafford	10,829	1,642	12,471	11,698
Wakefield	21,105	3,267	24,372	22,861
Walsall	15,827	2,146	17,973	16,859
Waltham Forest	12,277	2,908	15,185	14,244
Wandsworth	25,431	2,871	28,302	26,547
Warrington	10,439	1,467	11,906	11,168
Warwickshire	19,477	3,326	22,803	21,389
West Berkshire	4,819	919	5,738	5,382
West Sussex	27,445	5,582	33,027	30,979
Westminster	31,235	2,242	33,477	31,401
Wigan	23,665	2,761	26,426	24,788
Wiltshire	14,587	2,584	17,171	16,106
Windsor and Maidenhead	3,511	957	4,468	4,191
Wirral	28,164	2,522	30,686	28,783
Wokingham	4,223	930	5,153	4,834
Wolverhampton	19,296	2,198	21,494	20,161
Worcestershire	26,528	3,342	29,870	28,018
York	7,305	916	8,221	7,711
England	2,801,471	429,763	3,231,234	3,030,897

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 8 September 2015

Subject: Work Schedule (September)

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 progress and development of the Scrutiny Board's work schedule for the current municipal year.

2 Summary of main issues

2.1 The Board's outline work schedule, which reflects discussions at the Board's previous meetings, is attached at Appendix 1. It is important to retain sufficient flexibility in the Board's work programme in order to react to any specific matters that may arise during the course of the year; therefore the work schedule may be subject to change throughout the municipal year and should be considered to be indicative rather than definitive.

2.2 In order to deliver the work schedule, it is likely that the Board will need to take a flexible approach and may need to undertake some activities outside the formal schedule of meetings. Adopting a flexible approach may also require additional formal meetings of the Scrutiny Board.

Working Groups

2.3 At its meeting in June 2015, the Scrutiny Board re-established the Health Service Developments Working Group, which will primarily be focused on considering proposed changes and developments of local health services. As detailed at Appendix 1, it is also proposed to consider the following areas of scrutiny activity through this working group:

- Work around co-commissioning (including specialised commissioning); and,
- Any future proposals around the provision of Children's Epilepsy Surgery Services.

2.4 It is proposed to hold regular meetings of the working group meetings. These are currently scheduled to be bi-monthly, but a flexible approach may be required. Precise meeting dates are subject to confirmation and any reports or recommendations from the working group will be provided to the Scrutiny Board.

3. Recommendations

3.1 Members are asked to:

a) Note the content of this report and its attachments.
b) Identify any specific matters to be incorporated into the work schedule for the remainder of the current municipal year.
c) Prioritise any competing demands where necessary and agree the future work schedule for the Scrutiny Board.

4. Background papers[1]

4.1 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.

APPENDIX 1

SCRUTINY BOARD (ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	Sept.	Oct.	Nov.	Dec.	Jan.
Integrated Health & Social Care Teams		Terms of Reference	Visits	Evidence session	
Air Quality		Evidence session 1	Evidence session 2		
Primary Care	Evidence session 1		Evidence session 2		Evidence session 3
* Access to GPs/ dentists					
* Workforce planning					
* Future plans for primary care					
* Some aspects of health inequalities					
Cancer Wait Times	Scope Review		Service commissioners & provider reports (inc. performance)		Scrutiny Board report/ statement for agreement

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	Sept.	Oct.	Nov.	Dec.	Jan.
Involvement of 3rd Sector	Scope Review			Service commissioners & provider reports	
Co-commissioning - specialised commissioning		Update to HSDWG		Update to HSDWG	
Integrated performance reports				To be determined	
CQC Inspection outcome	Standing item YAS - outcome Waterloo Manor - outcome	Standing item LCH - outcome LYPFT - progress LTHT - progress	Standing item	Standing item LCH - progress	Standing item
Care Act Implementation		Progress report from Dir ASC			

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	Sept.	Oct.	Nov.	Dec.	Jan.
Adult Safeguarding - Annual Report				To be determined	
Health Protection Board		Report from DPH			
Director of Public Health - Annual Report		Report from DPH			
Quality Accounts - monitoring / development			Joint working group with HWL (proposed)		
CAMHS & TaMHS		Follow-up report. Content & timing to be determined			Follow-up report. Content & timing to be determined
Future provision of homecare		Progress report from Dir ASC			

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	Sept.	Oct.	Nov.	Dec.	Jan.
Children's Epilepsy		Update to HSDWG		Update to HSDWG	
Maternity Strategy					
Children's Oral Health Plan					
Budget performance/ proposals				Director Reports: ASC & PH	
Public Health Budget Reduction				Future activity to be determined	
Health Service Developments		W/G meeting		W/G meeting	

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	Feb.	March	April
Integrated Health & Social Care Teams		Scrutiny Board report / statement for agreement	
Air Quality	Scrutiny Board report / statement for agreement		Scrutiny Board report / statement for agreement
Primary Care			Scrutiny Board report / statement
* Access to GPs/ dentists			for agreement
* Workforce planning			
* Future plans for primary care			
* Some aspects of health inequalities			
Cancer Wait Times			

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	Feb.	March	April
Involvement of 3rd Sector	Scrutiny Board report / statement for agreement		
Co-commissioning - specialised commissioning	Update to HSDWG		Update to HSDWG
Integrated performance reports			
CQC Inspection outcome	Standing item	Standing item LCH & LYPFT - progress	Standing item
Care Act Implementation		Progress report from Dir ASC	

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	Feb.	March	April
Adult Safeguarding - Annual Report			
Health Protection Board			
Director of Public Health - Annual Report			
Quality Accounts - monitoring / development			Joint working group with HWL (proposed)
CAMHS & TaMHS			Follow-up report. Content & timing to be determined
Future provision of homecare		Progress report from Dir ASC	

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	Feb.	March	April
Children's Epilepsy	Update to HSDWG		Update to HSDWG
Maternity Strategy			CCG progress report
Children's Oral Health Plan			DPH progress report
Budget performance/ proposals			
Public Health Budget Reduction			
Health Service Developments	W/G meeting		W/G meeting