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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, 24th January, 2017 at 1.30 pm

(A pre-meeting will take place for ALL Members of the Board at 1.00 p.m.)

MEMBERSHIP

Councillors

C Anderson	Adel and Wharfedale;
J Chapman	Weetwood;
M Dobson	Garforth and Swillington;
B Flynn	Adel and Wharfedale;
P Gruen (Chair)	Cross Gates and Whinmoor;
A Hussain	Gipton and Harehills;
J Pryor	Headingley;
B Selby	Killingbeck and Seacroft;
A Smart	Armley;
P Truswell	Middleton Park;
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

Principal Scrutiny Adviser:
Steven Courtney
Tel: 24 74707

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the 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 - 20 DECEMBER 2016** To confirm as a correct record, the minutes of the meeting held on 20 December 2016.	1 - 8
7			**MINUTES OF EXECUTIVE BOARD - 14 DECEMBER 2016** To receive for information purposes the draft minutes of the Executive Board meeting held on 14 December 2016.	9 - 26
8			**CHAIR'S UPDATE** To receive an update from the Chair on scrutiny activity since the previous Board meeting, not specifically included elsewhere on this agenda.	27 - 34

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**CARE QUALITY COMMISSION (CQC) - INSPECTION OUTCOMES** To receive a report from the Head of Governance and Scrutiny Support providing the Board with details of recently reported Care Quality Commission inspection outcomes for health and social care providers across Leeds.	35 - 60
10			**DELIVERING THE BETTER LIVES STRATEGY IN LEEDS PROGRAMME - PHASE 3 UPDATE** To receive a report from the Head of Governance and Scrutiny Support introducing a briefing note to provide an update on delivering the Better Lives Strategy in Leeds Programme – Phase 3.	61 - 66
11			**LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST - UPDATE** To consider a report from the Head of Governance and Scrutiny Support introducing a report from the Chief Executive on key issues in relation to Leeds and York Partnership NHS Foundation Trust.	67 - 72
12			**LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST - CARE QUALITY COMMISSION INSPECTION REPORT AND ACTION PLAN** To receive a report from the Head of Governance and Scrutiny Support introducing the Care Quality Commission inspection report and recommendations for Leeds and York Partnership NHS Foundation Trust and the associated Trust action plan.	73 - 192

Item No	Ward/Equal Opportunities	Item Not Open		Page No
13			**GENERAL PRACTICE FORWARD VIEW** To receive a report from the Head of Governance and Scrutiny Support introducing the General Practice Forward View for Leeds and to consider how this relates to the Boards inquiry into Primary Care.	193 - 242
14			**THE 'ONE VOICE' PROJECT** To receive and consider a report from the Head of Governance and Scrutiny Support introducing details around the local Clinical Commissioning Group's 'One Voice' project.	243 - 244
15			**PROPOSED CLOSURE OF THE BLOOD DONOR CENTRE IN SEACROFT** To receive and consider a report from the Head of Governance and Scrutiny Support regarding the proposed closure of the Blood Donor Centre in Seacroft.	245 - 250
16			**WORK SCHEDULE (JANUARY 2017)** To consider the Scrutiny Board's work schedule for the remainder of the 2016/17 municipal year.	251 - 270
17			**DATE AND TIME OF NEXT MEETING** Tuesday, 21 February 2017 at 11:00am (10:30am pre-meeting for members of the Scrutiny Board only).	

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.	

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

TUESDAY, 20TH DECEMBER, 2016

PRESENT: Councillor P Gruen in the Chair

Councillors C Anderson, J Chapman,
C Dobson, B Flynn, A Hussain, J Pryor,
B Selby, A Smart, P Truswell and S Varley

Co-opted Member: Dr J Beal (Healthwatch Leeds)

96 Late Items

The following late and supplementary information was submitted to the Board:

- Agenda item 12 – High Court Judgement (July 2013)
- Agenda item 13 – Letter submitted by Leeds Local Medical Committee Limited dated 16 November 2016
- Agenda item 14 – Report submitted by Director of Public Health regarding 'Request to enter into interim contracts with existing Third Sector, GP and Pharmacy providers of Public Health services in accordance with Contracts Procedure Rules 8.1, 8.2, 9.1 and 9.2'.

97 Declaration of Disclosable Pecuniary Interests

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

- Councillor B Selby advised that a family member was employed within the local NHS.

The above Board Member remained present for the duration of the meeting.

98 Apologies for Absence and Notification of Substitutes

An apology for absence was submitted by Councillor M Dobson.

Notification had been received that Councillor C Dobson was substituting for Councillor M Dobson.

99 Minutes - 22 November 2016

RESOLVED – That the minutes of the meeting held on 22 November 2016 be approved as a correct record.

100 Minutes of Health and Wellbeing Board - 24 November 2016

RESOLVED – That the minutes of the Health and Wellbeing Board meeting held on 24 November 2016, be noted.

101 Minutes of Executive Board - 16 November 2016

RESOLVED – That the minutes of the Executive Board meeting held on 16 November 2016, be noted.

102 Chair's Update - December 2016

The Chair provided a verbal update on recent scrutiny activity that had not been specifically included elsewhere on the agenda.

Meeting with Councillor Rebecca Charlwood (6 December 2016)

- Leeds approach to commissioning / decommissioning
- West Yorkshire STP
- Yeadon Extra Care.

Quality Summit – Leeds and York Partnership NHS Foundation Trust (8 December 2016)

- LYPFT CQC inspection report – action plan due to be considered in January 2017.

Working Group meetings:

- LTHT estates strategy / development of the LGI – 9 December 2016
- Budget discussion – 15 December 2016.

Leeds Medical Committee Meeting (16 December 2016)

- West Yorkshire STP
- The potential coming together of CCGs
- The General Practice Forward View Delivery Plan
- CCGs development of 2 year operational plans
- Other Leeds Medical Committee issues.

NHS Blood & Transplant

- Press coverage of proposals to close blood donor centre in Seacroft (27 January 2017). Currently seeking more details from NHS Blood and Transplant. The Board requested further information regarding future plans to develop the site.
- Concern about lack of consultation on the proposals. The Board discussed highlighting its concerns to the Independent Reconfiguration Panel.

Better Lives Briefing

- A request that the briefing note submitted by the Director of Adult Social Services regarding Phase 3 of the Better Lives Strategy be forwarded to all Board Members. The Board also discussed being provided with a more detailed update on development of the Strategy at the January Board meeting.

RESOLVED –

(a) That the Chair's update be noted.
(b) That the Board highlights its concerns regarding proposals to close the blood donor centre in Seacroft to the Independent Reconfiguration Panel.
(c) That the briefing note regarding Phase 3 of the Better Lives Strategy be forwarded to all Board Members.
(d) That the Board receives a more detailed update on development of the Better Lives Strategy at the January Board meeting.

103 Care Quality Commission (CQC) - Inspection Outcomes

The Head of Governance Services submitted a report which presented the outcomes of recently reported Care Quality Commission (CQC) inspection reports in relation to Health and Social Care organisations within the Leeds boundary.

The following were in attendance:

- Councillor Rebecca Charlwood – Executive Member for Health Wellbeing and Adults
- Mick Ward – Chief Officer (Commissioning), Adult Social Care.

The key areas of discussion were:

- A suggestion that the Board undertook more detailed work in relation to social care provision, particularly focussing on available resources and future plans. The Board was advised about a review of independent care homes and joint work with CCGs and the independent sector focussed on improving the quality of homecare provision.
- Potential involvement by the Board regarding the Better Lives Strategy refresh.
- Confirmation about the commissioning framework in relation to residential care.
- An update on Donisthorpe Hall following its recent 'requires improvement' rating. The Board was advised that it was awaiting a judgement by the CQC to determine whether any further action was required. The Board requested that a further update be provided to a future Board meeting.

RESOLVED –

(a) That the inspection outcomes for health and social care providers across Leeds, and the information discussed at the meeting, be noted.
(b) That the Board receives a further update regarding Donisthorpe Hall at a future Board meeting.

104 Scrutiny Board Inquiries - recommendation tracking

The Head of Governance and Scrutiny Support submitted a report which introduced progress updates against the Scrutiny Board recommendations identified in the recent inquiries into Bereavement and Cancer Waiting Times in Leeds.

The following information was appended to the report:

- Summary of desired outcomes and recommendations
- Leeds Teaching Hospitals NHS Trust (LTHT) – Response to Leeds City Council Scrutiny Board and update on bereavement services within LTHT.

The following were in attendance:

- David Berridge – Deputy Chief Medical Officer, Leeds Teaching Hospitals NHS Trust
- Ian Wilson – Associate Medical Director (Risk Management), Leeds Teaching Hospitals NHS Trust
- Krystina Kozlowska – Head of Patient Experience, Leeds Teaching Hospitals NHS Trust
- Mark Hibbert – Bereavement Services Manager, Leeds Teaching Hospitals NHS Trust.

The Board was advised that following publication of the agenda, LTHT had requested to provide a comprehensive update regarding Cancer Waiting Times to the January Board meeting. It was noted that the Chair had agreed to this request.

The key areas of discussion were:

- Development of the out of hours' service, particularly in terms of supporting the cultural needs of families.
- Improvements to bereavement training and induction for staff.
- An update on information / data collection and analysis that had resulted in significant improvements to body release times.
- The role of the Coroner in relation to invasive / non-invasive post mortems.

RESOLVED –

(a) That the progress update in relation to the Scrutiny Board inquiry into Bereavement, be noted.

(b) That further discussions with the Coroner's office be progressed to consider the potential for routinely offering families the option for non-invasive post mortems.

105 Provision of Pre-Exposure Prophylaxis - update

The Head of Governance and Scrutiny Support submitted a report which updated the Board on NHS England's announcement to fund an extension to the national HIV prevention programme led by Public Health England.

The following information was appended to the report:

- NHS England briefing note dated 4 December 2016 – 'NHS England announces major extension of national HIV prevention programme with Public Health England and funding for ten new specialised treatments'

The following were in attendance:

- Councillor Rebecca Charlwood – Executive Member for Health Wellbeing and Adults
- Dr Ian Cameron – Director of Public Health
- Sharon Foster – Sexual Health Lead, Public Health.

RESOLVED – That the update on NHS England's announcement to fund an extension to the national HIV prevention programme led by Public Health England, be noted.

(Councillor S Varley left the meeting at 3.00pm during the consideration of this item.)

106 Draft West Yorkshire and Harrogate Sustainability and Transformation Plan: The Leeds Plan

The Head of Governance and Scrutiny Support submitted a report which introduced the draft West Yorkshire and Harrogate Sustainability and Transformation Plan (STP), with a particular emphasis on the 'Leeds Plan' – one of 6 place-placed plans that support the overall draft STP.

The following information was appended to the report:

- Draft minutes of West Yorkshire Joint Health Overview and Scrutiny Committee held on 18 November 2016
- West Yorkshire and Harrogate Sustainability and Transformation Plan (STP) – Draft proposals (October 2016).

The following were in attendance:

- Matt Ward – Chief Operating Officer (NHS Leeds South and East CCG).

The key areas of discussion were:

- An update on development of health and care programmes.
- Concern about a lack of engagement on the STP. It was suggested that relevant representatives be invited to attend the January Board meeting to provide a detailed update on engagement activity.
- The need for greater investment in preventative work.

RESOLVED –

(a) That the update on the draft West Yorkshire and Harrogate Sustainability and Transformation Plan (STP), be noted.
(b) That the Board formulates a formal response to development of the STP with a particular emphasis on development of a Leeds plan and cross cutting initiatives.
(c) That NHS representatives be invited to attend the January Board meeting to provide a detailed update on engagement activity.

(Councillor A Hussain left the meeting at 3.50pm during the consideration of this item.)

107 The award of interim contracts to existing third sector, GP and pharmacy providers of public health services

The Head of Governance and Scrutiny Support submitted a report which introduced details of the proposed award of interim contracts to existing third sector, GP and pharmacy providers of public health services.

The following were in attendance:

- Dr Ian Cameron – Director of Public Health
- Sharon Foster – Sexual Health Lead, Public Health.

RESOLVED – That the update on the proposed award of interim contracts to existing third sector, GP and pharmacy providers of public health services, be noted.

108 Work Schedule (December 2016)

The Head of Governance Services submitted a report which invited Members to consider the Board's work schedule for the 2016/17 municipal year.

January Board meeting

- Cancer Waiting Times;
- CQC inspection reports and associated action plans;
- Discussion with CCGs regarding operational plans;
- Development of draft West Yorkshire STP;
- Update on recent working group meetings.

February Board meeting

- Update on Men's Health;
- Quality of homecare provision;
- Quality accounts, including development of partnership approach involving Healthwatch Leeds.

RESOLVED – That subject to any on-going discussions and scheduling decisions, the Board's outline work schedule be approved.

109 Date and Time of Next Meeting

Tuesday, 24 January 2017 at 1.30pm (pre-meeting for all Board Members at 1.00pm)

(The meeting concluded at 4.00pm.)

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EXECUTIVE BOARD

WEDNESDAY, 14TH DECEMBER, 2016

PRESENT: Councillor J Blake in the Chair

Councillors R Charlwood, D Coupar, S Golton, J Lewis, R Lewis, L Mulherin, M Rafique and L Yeadon

SUBSTITUTE MEMBER: Councillor B Anderson

APOLOGIES: Councillor A Carter

110 Substitute Member

Under the provisions of Executive and Decision Making Procedure Rule 3.1.6, Councillor B Anderson was invited to attend the meeting on behalf of Councillor A Carter, who had submitted his apologies for absence from the meeting.

111 Exempt Information - Possible Exclusion of the Press and Public

RESOLVED – That, in accordance with Regulation 4 of The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, the public be excluded from the meeting during consideration of the following parts of the agenda designated as exempt on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the public were present there would be disclosure to them of exempt information so designated as follows:-

(a) Appendix 2 to the report entitled, 'Supporting the Delivery of Housing Mix: Outcome of Marketing of Council Owned Sites', referred to in Minute No. 122 is designated as exempt from publication in accordance with paragraph 10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that it relates to the financial or business affairs of a particular person, and of the Council. This information is not publicly available from the statutory registers of information kept in respect of certain companies and charities. It is considered that since this information was obtained through the inviting of best and final offers for the property/land then it is not in the public interest to disclose this information at this point in time as this could lead to random competing bids which would undermine this method of inviting bids and affect the integrity of disposing of property/land by this process.

It is also considered that the release of such information would or would be likely to prejudice the Council's commercial interests in relation to other similar transactions in that prospective purchasers of other similar properties would have access to information about the nature and level of offers which may prove acceptable to the Council. It

is considered that whilst there may be a public interest in disclosure, much of this information will be publicly available from the Land Registry following completion of this transaction and consequently the public interest in maintaining the exemption outweighs the public interest in disclosing this information at this point in time.

(b) Appendix 1 to the report entitled, 'Design and Cost Report for the Acquisition of a Property for the Council's Investment Portfolio', referred to in Minute No. 123 is designated as exempt from publication in accordance with paragraph 10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that it contains information relating to the financial or business affairs of a particular organisation and of the Council. The property has been offered to the Council to acquire on a one to one basis off the market, rather than being put to the open market. It is considered that the public interest in maintaining the content of the appendix as exempt outweighs the public interest in disclosing the information due to the impact that disclosing the information would have upon the Council and third parties.

112 Declaration of Disclosable Pecuniary Interests

There were no declarations of interest made at the meeting.

113 Minutes

RESOLVED - That the minutes of the previous meeting held on 16th November 2016 be approved as a correct record.

HEALTH, WELLBEING AND ADULTS

114 Time to Shine Project

Further to Minute No. 102, 16th December 2015, the Director of Adult Social Services and the Director of Public Health submitted a joint report providing details on the 'Time to Shine' project and the progress which had been made in tackling social isolation and loneliness in Leeds. The report also described the work which had been undertaken since the previous update report and the impact that it has had so far.

In considering this item, the Board received a presentation entitled, 'Time to Shine: Leeds Community Connect: The Asset Based Community Development (ABCD) Approach' and viewed a short film entitled, 'Loneliness and Me'. As part of this presentation, the Board also received further information from Bill Rollinson, Chair of Leeds Older People's Forum; Sharon Middling, of Community Connect at Rural Action Yorkshire and Jude Woods of Sage at Yorkshire MESMAC on the role that their respective organisations, as delivery partners, were playing in tackling social isolation and loneliness in Leeds as part of the Time to Shine programme.

Responding to a Member's enquiry, the Board received further information on the actions being taken to monitor and evaluate the outcomes from the schemes involved in the programme, and how that data was being utilised for

the purposes of future provision. Officers undertook to provide the Member in question with further information, if required.

Emphasis was also placed on the importance of Community Committees' continued involvement in this field at a local level, whilst also noting some examples of such involvement, as detailed within the submitted report.

Members also discussed the potential for widening the scope of the Asset Based Community Development (ABCD) approach, and considered how such innovative approaches could become more established. Officers also provided further information on the extent to which the funding received for the Time to Shine programme had attracted further investment into this area of work.

In conclusion, the Chair thanked those present, together with all those involved in the programme for the valuable work they undertook. The Chair also highlighted the huge potential of the programme and emphasised how tacking social isolation and loneliness continued to be a key priority for the Council.

RESOLVED –

(a) That the submitted report, together with the presentations and film, updating the Board on the progress of the project, be noted;

(b) That the progress made in the development and delivery of the 'Time to Shine' project, be welcomed;

(c) That the positive impact that the work on tackling loneliness and social isolation will have, together with the contribution it will make towards the breakthrough project 'Making Leeds the Best City to Grow Old In', be recognised;

(d) That the excellent work of the Leeds Older People's Forum in leading the project be commended;

(e) That it be noted that the lead officers responsible for ensuring updates are brought are the Consultant in Public Health (Older People) and the Interim Chief Officer Commissioning, Adult Social Care;

(f) That the added value and impact that this area of work has had in local communities be noted.

EMPLOYMENT, SKILLS AND OPPORTUNITY

115 West Yorkshire Area Based Review of Post 16 Education and Training

The Director of Children's Services submitted a report providing the background to the national framework and process of Area Based Reviews for Post 16 education and training. In addition, the report also presented information on the recommendations arising from the West Yorkshire Area

Based Review, with particular reference to the recommendations that relate to Leeds based providers.

In considering the report, Members noted the limited scope of the review which had taken place, and highlighted the need to continue the collaborative working at a local level in order to further develop a place based approach towards post 16 education and training, with the aim of ensuring that such provision was as effective as possible.

RESOLVED –That the outcome of the West Yorkshire Area Based Review of Post 16 education and training be noted.

RESOURCES AND STRATEGY

116 Financial Health Monitoring 2016/17 - Month 7

The Deputy Chief Executive submitted a report setting out the Council's projected financial health position for 2016/17 as at month 7 of the financial year. The report also reviewed the position of the budget and highlighted any potential risks and variations after 7 months of the year.

RESOLVED –That the Council's projected financial position for 2016/17, at month 7 of the financial year, as detailed within the submitted report, be noted.

117 Safeguarding in Taxi & Private Hire Licensing - 12 month review of progress to December 2016

Further to Minute No. 109, 16th December 2015, the Assistant Chief Executive (Citizens and Communities) submitted a report outlining the progress which had been made in respect of safeguarding policies and improvements in the area of Taxi and Private Hire Licensing, and highlighted how this service was contributing towards public safety generally.

The Board received an update upon the work which continued to be undertaken at a West Yorkshire level in order to improve safeguarding arrangements in the field of taxi and private hire licensing. Also, responding to a Member's specific enquiry, the Board received further information on the actions being taken to work collaboratively with Local Authorities outside of the West Yorkshire boundary on such matters, and the progress which had been made as a result.

Members were provided with assurances around the consistency of approach taken in respect of driver checking processes, whilst the Board was also provided with further information and assurances on the actions which had been taken since the submission of the last update report in order to ensure that improved mechanisms had been put in place around Police disclosure of information.

In conclusion, the Board noted that the issue of safeguarding, together with ensuring the highest standards in terms of licensing remained a key priority of the Council, with emphasis being placed upon the robust and cross-party

approach which was taken by the Licensing Committee in dealing with such matters.

RESOLVED – That the direction which the relevant officers and Members of Licensing Committee have taken, be noted and endorsed, together with the progress which has been made towards beneficial safety improvements for safeguarding in the area of Taxi and Private Hire Licensing.

118 Health, Safety and Wellbeing Performance and Assurance Report

The Deputy Chief Executive submitted a report which provided a review on the Council's performance throughout 2015/16 with regard to health, safety and wellbeing matters. In addition, the report detailed the improvements that had been made during this period and also highlighted priorities, together with any potential future challenges.

Emphasis was placed upon the importance of this area of work, whilst Members noted a number of key priorities for the coming year.

RESOLVED – That the contents of the submitted report be noted, with the recognition that a sensible approach towards the management of health and safety risk will continue to be applied.

119 Vision for Leisure and Wellbeing Centres 2016

The Director of City Development submitted a report outlining the current challenges faced in terms of investment in leisure centres and proposed a revised "Vision for Leisure and Wellbeing Centres" for 2016 onwards, which together with an accompanying set of proposals, aimed to take the service forward by meeting wider Council outcomes, meeting austerity challenges whilst also responding to future demands.

In presenting the report, the Executive Member for Resources and Strategy proposed the establishment of a cross-party working group in order to ensure that moving forward all political groups were involved in the development of the vision.

Members welcomed the proposals detailed, and discussed the nature of the fitness market, and the future role that the Council could play in that market.

In conclusion, the Chair took the opportunity to pay tribute to the City of Leeds Diving Club based at the Council's John Charles Centre for Sport, highlighting the extraordinary sporting success and recognition that the club had brought to the city.

RESOLVED –

(a) That a long term vision to secure a network of high quality, affordable, accessible and financially sustainable leisure and wellbeing centres (in particular public swimming pools) for the benefit of all the people of Leeds, be endorsed;

(b) That the principles for determining the location of leisure and wellbeing centres be agreed, as follows:-
(a) on a main arterial route;
(b) in a town or district centre; and
(c) co-located and in partnerships with schools, health services, day centres, libraries or other complementary community facilities;

(c) That the Director of City Development be requested to bring forward detailed proposals in 2017 for two new Wellbeing Centres to be built: one in Inner East Leeds and one in Rothwell, and that approval be given for the provision of £100k to be made within the Capital Programme in order to support the feasibility studies to this end;

(d) That approval be given for the hours of operation at Kippax Leisure Centre to be reduced to approximately 58 hours, to commence from April 1st 2017, and that the Director of City Development be requested to bring forward a feasibility report into the re-provision of a swimming pool within the catchment area.

(e) That the realising of the capital receipt from the sale of the existing Kippax Leisure Centre be approved, and that approval also be given to bringing forward new investment proposals in line with the overall strategy, as set out within the submitted report;

(f) That the need to support continued prioritised investment in the other existing leisure centres, in order to maximise income and usage, as set out within section 4 of the submitted report, be noted;

(g) That approval be given to extend the existing capital provision for sport maintenance of £500k per annum for a further 3 years from 2017/18;

(h) That a cross-party working group be established in order to ensure that moving forward all political groups are involved in the development of the vision.

120 Best Council Plan Refresh for 2017/18 - Initial Proposals

The Deputy Chief Executive submitted a report which set out an approach for the refresh of the Best Council Plan, which was aligned to the Initial Budget Proposals for 2017/18.

Members welcomed the proposed refresh of the Plan, together with the proposal to incorporate into this process any findings from the planned refresh of the Commission on the Future of Local Government.

RESOLVED – That the following be approved:-

(a) Engagement with Scrutiny Boards on the emerging Best Council Plan, in accordance with the Budget & Policy Framework Procedure Rules;

(b) That the revision of the longer-term contextual narrative section of the Best Council Plan be brought forward to next year as part of the 2018/19 refresh;

(c) The approach, as set out in the submitted report, to update the annual section of the Best Council Plan for 2017/18 which balances continuity of the Best City (Strong Economy and Compassionate City) / Best Council (Efficient and Enterprising Organisation) vision and ambitions with further refinement of the Council's priorities;

(d) That the Deputy Chief Executive will be responsible for developing the Best Council Plan for 2017/18 for its consideration by this Board and Full Council alongside the supporting 2017/18 Budget.

REGENERATION, TRANSPORT AND PLANNING

121 Transport Conversation update and Leeds Public Transport Investment Programme

The Director of City Development submitted a report which set out the strategic case and emerging proposals for the Leeds Public Transport Investment Programme. The report also provided an update on the progress in taking forward the city's longer term transport strategy which would be developed next year, including a clear ambition to consider again the case for mass transit provision in order to meet the future needs of the city. Furthermore, the report also set out the results so far from the 'Transport Conversation' and showed how this process had guided the approach for scheme selection within the Leeds Public Transport Investment Programme.

Given the significant nature of this matter, it was requested that consideration be given to a period of time being designated at full Council in order to provide Political Group Leaders with an opportunity to discuss key issues arising from the Transport Conversation and the Leeds Public Transport Investment Programme. In response, it was undertaken that liaison would take place with Political Group Leaders in order to discuss this matter further.

Responding to a Member's enquiry, the Board discussed the actions and approach to be taken with bus operators in the city with a view to ensuring that improved service provision was achieved in Leeds.

Members discussed how the proposals, amongst other things, aimed to significantly improve air quality and reduce carbon emissions, whilst also reducing congestion.

The Board received further information on the associated wide ranging consultation and communications process which had taken place to date in terms of getting to the current position regarding the Leeds Public Transport Investment Programme, with the restricted timescales associated with this process being noted. Assurances were also provided in respect of the inclusive consultation exercise which would continue as part of the Transport

Conversation, which would play a key role in developing a long term transport strategy for the city, and which would help to maintain and develop strong relationships with partners, which would be key to the successful delivery of the strategy.

RESOLVED –

(a) That the programme of schemes to be included in the Leeds Public Transport Investment Programme (as detailed within the submitted report), which will utilise the £173.5m of Department for Transport funding and bring in significant complementary private sector investment, be agreed;

(b) That the submission of an Outline Strategic Case to the Department for Transport for spending the £173.5m allocated to Leeds, be approved;

(c) That the feedback from the 'Transport Conversation' and how this has shaped the proposed Leeds Public Transport Investment Programme, be noted;

(d) That approval be given for officers to return to Executive Board in Autumn 2017 with a further update on the 'Transport Conversation' and the draft 20 year Transport Strategy, including commentary on the progress on development of mass rapid transit options;

(e) That approval be given for £8.8m of Leeds City Council capital monies earmarked for NGT to be included in this programme, excluding an allowance for NGT funding which is committed to the Clay Pit Lane junction scheme;

(f) That approval be given for the monies identified in resolution (e) (above) be made available immediately in order to commence work on the preliminary designs of some of the schemes identified in resolution (a) (above);

(g) That approval be given for negotiations to continue with bus operators, developers and partners in order to leverage significant additional financial investments to support the Leeds Public Transport Investment Programme;

(h) That it be noted that the Chief Officer Highways and Transportation is responsible for the delivery of the programme.

(Under the provisions of Council Procedure Rule 16.5, Councillor Golton required it to be recorded that he abstained from voting on the decisions referred to within this minute. Also, in relation to such matters, as Councillor B Anderson was in attendance as a non-voting Member, he drew the Board's attention to the fact that if he were able to, he would abstain from voting on the decisions referred to within this minute)

122 Supporting the delivery of housing mix: Outcome of marketing of Council owned sites

The Director of City Development submitted a report presenting the outcomes from a marketing exercise undertaken in respect of five Council owned sites. The report detailed the range of offers received, invited the Board to consider those offers and made recommendations in respect of progressing the matter.

Members welcomed the proposals detailed within the submitted report, including those to help deliver extra care housing. Also, responding to a Member's comment, it was undertaken that consideration would be given to alternative ways in which brownfield sites could potentially be marketed in the future.

Following consideration of Appendix 2 to the submitted report, designated as exempt from publication under the provisions of Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting, it was

RESOLVED –

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

(b) That the recommended offers, as contained within exempt appendix 2 to the submitted report, be approved;

(c) That the Director of City Development, in consultation with the Executive Member for Regeneration, Transport and Planning, be requested to progress the scheme proposals and the disposal of the Council sites, as set out within the submitted report;

(d) That a further report be submitted to the Executive Board outlining the Council's strategy to facilitate and support the delivery of housing with care.

123 Design and Cost Report for Acquisition of a Property for the Council's Investment Portfolio

The Director of City Development and the Deputy Chief Executive submitted a joint report which sought approval for the purchase of an investment property that had been offered to the Council which would generate additional income in order to support the revenue requirements of the Council, as set out in the Initial Budget Strategy.

Following consideration of Appendix 1 to the submitted report, designated as exempt from publication under the provisions of Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting, it was

RESOLVED –

(a) That the acquisition of the property, on the terms outlined within exempt appendix 1 to the submitted report, be approved;

(b) That the injection into the Capital Programme of the sums detailed within exempt appendix 1 be approved, with the 'authority to spend' such sums also being approved;

(c) That the Director of City Development, under the scheme of delegation, be authorised to approve any changes to the recommended terms which may be necessary prior to completion, and that the Director of City Development also be authorised to complete the acquisition;

(d) That the submitted report, together with the resolutions above, be designated as exempt from the Call In process for those reasons as set out in paragraph 4.5.3 of the submitted report (detailed below).

(The Council's Executive and Decision Making Procedure Rules state that a decision may be declared as being exempt from Call In by the decision taker if it is considered that any delay would seriously prejudice the Council's, or the public's interests. In line with resolution (d) above, the resolutions contained within this minute were exempted from the Call In process, given that the terms provisionally agreed for the property (detailed in the exempt appendix to the submitted report) have been concluded on the basis that contracts are exchanged before the end of December 2016. In addition, this particular property was put to the Council very recently. Should the Council seek to delay the consideration of the acquisition to next year it is likely that the seller will offer the property to other parties. Also should the sale not complete within the above timescale, then the Council would be at risk of the sale and the purchase price being re-opened for negotiation in open competition with other parties)

124 Renewing Planning Applications for City Centre Commuter Car Parks

The Director of City Development submitted a report presenting a proposed approach towards dealing with those planning applications which may be expected to be received by the Council in order to extend the temporary planning permissions which had been given in 2012 for 12 cleared sites in the city centre to be used for commuter car parking provision, contrary to planning policy. The report noted that the temporary permissions were due to come to an end in 2017, and as such, the report also sought endorsement of this approach as a material consideration for determining the renewal planning applications.

In noting that the expectation was for these sites to be gradually developed, Members discussed the process by which the overall level of city centre car parking provision would be managed in the longer term.

RESOLVED – That approval be given to the following approach, as set out below, as a material consideration in the determination of any renewal planning applications for the 12 temporary City Centre commuter car parks approved in 2012:-

i. Subject to the full range of planning considerations appropriate for each site, renewals of consent on the sites previously granted temporary

planning permission will be favourably considered in principle for a further period of up to 5 years from April 2017;

ii. In each case there will be an expectation that developers will continue to bring forward the sites for development as soon as possible and that as a result car parking will remain a temporary and diminishing use of the site;

iii. Each consent will include conditions and/or be subject to a S106 agreement to set out a phased programme of reducing long stay commuter spaces as improvements in public transport come forward and in light of landowner's own development plans during the life of the extended permission;

iv. The Council will reserve the right to take enforcement action if appropriate phasing reductions are not met, and to refuse to grant further renewals in due course if it considers that development is not progressing as expected.

CHILDREN AND FAMILIES

125 Regionalisation of Adoption

The Director of Children's Services submitted a report providing information on the progress made in respect of the regionalisation of adoption services and which sought a formal decision regarding the arrangements for the delegation of the adoption service to a Regional Adoption Agency (RAA).

RESOLVED –

(a) That the arrangements for the new Regional Adoption Agency, as detailed within the submitted report, be endorsed, and that, contingent upon all the other partner authorities also agreeing these recommendations, the following be agreed:-

(i) With effect from 10th January 2017:

- Formally appoint the West Yorkshire Adoption Joint Committee ('the Joint Committee');
- Approve and delegate to the Joint Committee the functions, as set out in the Terms of Reference document, as detailed at Appendix 1C to the submitted report;
- Approve the Constitution and Procedure Rules of the Joint Committee, as detailed at Appendices 1A and 1B to the submitted report;

(ii) Formally agree that Leeds City Council hosts the West Yorkshire Adoption Agency that is a shared service and that the name of the Agency is 'One Adoption West Yorkshire';

(iii) Authorise the Director of Children's Services to progress this matter with the other local authorities in order to implement the Regional Adoption Agency;

(b) That the following be noted:-

(i) That the Leader will appoint the Executive Member for Children and Families as a principal Elected Member to the Joint Committee, and the Deputy Executive Members for Children and Families as substitutes;

(ii) The principles of the partnership agreement, as set out in Section 4.5 of the submitted report, together with the process for setting the budget, as set out in section 3.21 of the submitted report. It also be noted that the Director of Children's Services has the authority to approve the Regional Adoption Agency funding formula, terms and signature of the partnership agreement through their existing delegated powers;

(iii) That the Joint Committee will be invited to delegate responsibility to the Director of Children's Services for adoption services including:
- the recruitment and approval of potential adopters;
- identification of potential matches between children and adopters;
- provision of adoption panels; and
- provision of adoption support services to adopters, adoptees, birth families and relevant professionals;

(iv) The transfer of staff via TUPE from other Local Authorities into the employment of Leeds City Council to work within the RAA;

(v) The creation of an organisational unit within Leeds City Council for the West Yorkshire Adoption Agency. The lead officer for this will be the Director of Children's Services (DCS) and the unit will sit within Children's Services;

(c) That it be noted that the submitted report discusses further work required regarding non agency adoption and support for special guardians, and therefore, agreement be provided that the DCS can make further arrangements for extending the breadth of the delegation to this aspect of the function following agreement by the management board and the Joint Committee, as the project develops.

126 Outcome of Statutory Notices on proposals to increase primary learning places in Hunslet, Kirkstall and Gipton & Harehills

The Director of Children's Services submitted a report detailing proposals brought forward in order to meet the Local Authority's duty to ensure sufficiency of school places. Specifically, this report was divided into sections in order to describe the outcome of each of the statutory notices published in respect of proposals to expand: Hunslet St Mary's Church of England (Voluntary Aided) Primary School; Beecroft (Community) Primary School and Hovingham (Community) Primary School. The report sought final decisions on each of those proposals.

RESOLVED –

(a) That the proposal to expand Hunslet St Mary's Church of England (Voluntary Aided) Primary School by increasing its capacity from 210 pupils to 315 pupils, which would increase the admission number from 30 to 45, with effect from September 2017, be approved;

(b) That the proposal to expand Beecroft (Community) Primary School by increasing its capacity from 210 pupils to 315 pupils, which would increase the admission number from 30 to 45, with effect from September 2017, be approved;

(c) That the proposal to expand Hovingham (Community) Primary School by increasing its capacity from 420 pupils to 630 pupils, which would increase the admission number from 60 to 90, with effect from September 2017, be approved;

(d) That it be noted that the responsible officer for the implementation of such matters is the Head of Learning Systems.

127 Learning Places Programme - Capital Programme Update

Further to Minute No. 9, 22nd June 2016, the Director of Children's Services, the Deputy Chief Executive and the Director of City Development submitted a joint report presenting an update on the three year strategy for the provision of sufficient school places in the city. The report also provided an update on the progress of those projects currently forming part of the Learning Places Programme and the Social, Emotional & Mental Health (SEMH) Programme; and sought approval for further authority to spend, and also to reset the capital risk fund.

In presenting the report, the Executive Member for Children and Families highlighted the overall deficit in funding which existed in this area.

RESOLVED –

(a) That 'Authority to Spend' on the Learning Places Programme for the ten schemes, as detailed within the submitted report, at a total value of £40.5m, be approved;

(b) That approval be given for the balance of the programme capital risk fund to be reset from £4.068m to £6.7m, in order to facilitate effective risk management at programme level, whilst approval also be given for the 'Authority to Spend' on the increase of £2.632m;

(c) That it be noted that Children's Services Projects in 2014 onwards and called off through YORbuild have supported 69 new and existing apprentices and 92 people into employment;

(d) That the projected funding deficit which currently stands at £84.6m, based on Education Funding Agency rates, be noted, with Members

also noting that this is likely to increase due to a number of factors, as set out within the submitted report;

(e) That it be noted that in the current reporting period there has been one request to access the programme capital risk fund for Hovingham Primary School, totalling £287,868, which was approved in accordance with the Executive Board governance arrangements;

(f) That it be noted that any savings made from applications on the programme capital risk fund are returned to the risk fund in order to support continued management of programme risks;

(g) That it be noted that the Head of Learning Systems is responsible for capacity and sufficiency planning of school places and delivery of the Bulge Cohort programme, and that the Chief Officer, Projects, Programmes & Procurement Unit (PPPU) is responsible for the delivery of permanent Learning Places expansion projects once the viability and scope has been agreed between the Schools and Children's Services.

COMMUNITIES

128 Consultation outcomes on Local Council Tax Support scheme 2017/18

Further to Minute No. 16, 22nd June 2016, the Assistant Chief Executive (Citizens and Communities) submitted a report providing the Board with information to recommend a local Council Tax Support Scheme for adoption by Full Council by 31st January 2017, which looked to reflect both the consultation feedback received together with the budget position facing the Council. In addition, the report also set out a series of scheme options which had been considered as part of the process to develop a recommended scheme.

The Board thanked the Scrutiny Board (Citizens and Communities) for the comprehensive and valued work which it had undertaken as part of the review into the Council Tax Support Scheme.

RESOLVED –

(a) That in considering the work of the Scrutiny Board (Citizens and Communities):

(i) the support of the Scrutiny Board (Citizens and Communities) to the proposed new changes to the Council Tax Support scheme, as presented as part of its review, be acknowledged;

(ii) agreement be given to undertake a further review of the new Council Tax Support Scheme during the summer of 2018, when the number of Universal Credit claimants is expected to be more significant in Leeds and the Council will be in a good position to gauge the extent to which the new scheme is achieving its overall aim;

(iii) agreement be given to explore other potential scheme saving options when undertaking a wider review of the new Council Tax Support scheme during 2018.

(b) That in considering recommendation 3 of the Scrutiny Board Inquiry Report (as detailed at Appendix D to the submitted report), and in noting the comments of the Assistant Chief Executive (Citizens and Communities) in paragraphs 3.14 to 3.18 of the submitted report, approval be given not to support the removal of protections for all customers on 1 April 2017;

(c) That in taking into account the consultation process undertaken, including the work of the Scrutiny Board (Citizens and Communities), and in light of the above resolutions, approval be given for the Board to recommend to Full Council the adoption of a new Local Council Tax Support Scheme that:

a) Replaces the current Council Tax Support scheme with a Council Tax Support that is aligned with Universal credit, as set out in appendix B to the submitted report;

b) Moves customers onto the new scheme when they are due to transfer to Universal Credit and maintains the current scheme in the meantime;

c) Replaces the scheme of automatic protections with a discretionary hardship scheme with the exception of customers in receipt of Armed Forces Compensation Payments;

d) Moves eligible customers off the scheme of automatic protections when they are due to transfer to Universal Credit;

e) Delegates the design and value of the discretionary hardship scheme to the Assistant Chief Executive (Citizens and Communities) with a requirement that the hardship scheme is taken to Scrutiny Board;

f) Aligns the treatment of changes in Council Tax Support with the treatment of changes in Housing Benefit; and

g) Delegates the development of an operational policy for the treatment of fluctuating income to the Assistant Chief Executive (Citizens and Communities).

(d) That if Full Council supports the adoption of the proposed scheme, the decision will be implemented by the Assistant Chief Executive (Citizens and Communities) and will take effect from 1st April 2017, with implementation commencing as part of the 2017/18 annual billing process in order for the new scheme to be effective from 1st April 2017.

ENVIRONMENT AND SUSTAINABILITY

129 Cutting Carbon Breakthrough Project Annual Report

Further to Minute No. 109, 16th November 2016, the Director of Environment and Housing submitted a report outlining future carbon reduction priorities, strategy and targets for the period up to 2030. In addition, the report also presented information on the creation of the university-led Leeds Committee on Climate Change (LCCC), outlined the progress which the Council had made in reducing carbon emissions through the schemes in the Cutting Carbon Breakthrough Project and provided some insight into the progress made across the city as a whole. Furthermore, the report presented the updated Affordable Warmth Strategy 2017-30 for the purposes of adoption.

Responding to a Member's enquiry, the Board received further information on the range of actions that the Council was taking as part of the Cutting Carbon Breakthrough Project, with the leading role it played in this field being highlighted.

Members also highlighted the importance of collaborative, cross-party working in this area and emphasised the importance of effective communications processes to accompany the delivery of those initiatives which formed part of this breakthrough project.

RESOLVED –

(a) That the Board continue to support the delivery of the carbon reduction schemes within Cutting Carbon and Improving Air Quality Breakthrough Project, and that the progress made to date in this area, be noted;

(b) That approval be given to supplement the city's Climate Change Strategy with an interim target to reduce citywide CO2 emissions by 60% by 2030 from a 2005 baseline;

(c) That the creation of the university-led Leeds Committee on Climate Change be supported, with the Council working with the LCCC and partners in order to advise on how the city's carbon reduction targets can be achieved;

(d) That the updated Affordable Warmth Strategy 2017-30, as appended to the submitted report, be adopted;

(e) That it be noted that all of the resolutions (above) will be delivered from 2017 onwards by the Sustainable Energy & Climate Change team, led by the Executive Programme Manager, within the Projects, Programmes & Procurement Unit.

ECONOMY AND CULTURE

130 Initial Budget Proposals for 2017/18

The Deputy Chief Executive submitted a report which sought the Board's agreement to the Council's initial budget proposals for 2017/18, as detailed within the submitted paper. The report sought approval for those proposals to be submitted to Scrutiny and also used as a basis for wider consultation with stakeholders.

In presenting the submitted report, the Chair highlighted the scale of the financial challenge which the Council continued to face. It was noted that whilst the 2017/18 Local Government Finance Settlement was still to be received, the Board received an update on a Government announcement regarding proposals to enable local authorities to increase the 'Adult Social Care precept' from 2% to 3%, and it was noted that all such matters, when confirmed, would be taken into consideration when developing the final budget proposals, which were scheduled to be submitted to Executive Board and Council in February 2017, following the associated consultation exercise.

RESOLVED – That the initial budget proposals, as set out within the submitted report, be agreed, and that approval be given for the proposals to be submitted to scrutiny and also used as a basis for wider consultation with stakeholders.

(In accordance with the Council's Budget and Policy Framework Procedure Rules, decisions as to the Council's budget are reserved to full Council. As such, the resolution above is not subject to call in, as the budget is a matter that will ultimately be determined by full Council, and the submitted report is in compliance with the relevant Procedure Rules as to the publication of initial budget proposals two months prior to adoption).

(Under the provisions of Council Procedure Rule 16.5, Councillor Golton required it to be recorded that he abstained from voting on the decisions referred to within this minute)

DATE OF PUBLICATION: FRIDAY, 16TH DECEMBER 2016

LAST DATE FOR CALL IN OF ELIGIBLE DECISIONS: 5.00 P.M. ON FRIDAY, 23RD DECEMBER 2016

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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: 24 January 2017

Subject: Chairs Update – January 2017

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 provide an opportunity to formally outline some of the areas of work and activity of the Chair and other members of the Scrutiny Board since the last meeting.

2 Main issues

2.1 Invariably, scrutiny activity can often take place outside of the formal monthly Scrutiny Board meetings. Such activity may involve a variety of activities and can involve specific activity and actions of the Chair and/or other members of the Scrutiny Board.

2.2 In 2015/16, the Chair of the Scrutiny Board established a system whereby the Scrutiny Board was formally advised of scrutiny activity between the monthly meeting cycles. This method of reporting / updating the Scrutiny Board has continued during the current municipal year, 2016/17.

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

2.4 The Chair and Principal Scrutiny Adviser will provide a verbal update of recent activity at the meeting, as required.

Air Quality

2.5 At the previous Scrutiny Board meeting in December 2016, there was brief discussion around progress of the 'Air Quality' inquiry, being undertaken by Scrutiny Board (Environment and Housing), with co-opted members from other Scrutiny Boards, including Scrutiny Board (Adult Social Services, Public Health, NHS). It was agreed that a fuller update be provided at a future meeting. To assist, minutes from the Scrutiny Board (Environment and Housing) meeting held on 8 December 2016 are appended to this report. Minute 59 specifically refers to the matter of Air Quality.

2.6 There will be the opportunity for members to consider any specific issues, as necessary.

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.

SCRUTINY BOARD (ENVIRONMENT AND HOUSING)

THURSDAY, 8TH DECEMBER, 2016

PRESENT: Councillor G Wilkinson in the Chair

Councillors A Blackburn, K Bruce, D Collins, A Gabriel, A Garthwaite, P Grahame, A Khan, A Lamb, M Lyons and K Ritchie

53 Appointment of Chair

Having been unable to attend the Board's November meeting, Councillor P Grahame wished to express her disappointment that Councillor J Procter had resigned as Chair of the Board, following his recent appointment as a Member of the European Parliament (MEP).

RESOLVED – That Councillor G Wilkinson be appointed Chair for the duration of the December Board meeting.

54 Late Items

There were no late items.

55 Declaration of Disclosable Pecuniary Interests

There were no disclosable pecuniary interests declared to the meeting.

56 Apologies for Absence and Notification of Substitutes

Apologies for absence were submitted by Councillors J Bentley and J Procter.

Notification had been received that Councillor A Lamb was to substitute for Councillor J Procter.

57 Minutes - 24 November 2016

RESOLVED – That the minutes of the meeting held on 24 November 2016 be approved as a correct record.

58 Matters arising from the minutes

Minute No. 51 – Work Schedule

The Board was advised that the working group meeting of the Strategy and Resources Scrutiny Board in relation to the Best Council Plan had been moved to Monday, 16 January 2017 at 9.30 am. It was reported that Councillor A Blackburn had agreed to attend the working group meeting.

Councillor A Garthwaite had submitted her apologies. Any other Board Members interested in attending were advised to contact Angela Brogden, Principal Scrutiny Adviser.

59 Scrutiny Inquiry into improving air quality in Leeds - session 2

The Head of Governance and Scrutiny Support submitted a report which presented information in relation to session 2 of the Board's inquiry into improving air quality in Leeds.

The following were in attendance:

- Councillor Lucinda Yeadon, Executive Member for Environment and Sustainability
- Councillor Rebecca Charlwood, Executive Member for Health, Wellbeing and Adults
- Councillor Denise Ragan, Scrutiny Board Member (City Development)
- Neil Evans, Director of Environment and Housing
- Polly Cook, Executive Programme Manager, Strategy and Resources
- Andrew Hall, Head of Transportation
- Kevin McGready, Advanced Health Improvement Specialist
- Dr Judith Y T Wang, Associate Professor in Transport Engineering – Resilient Transportation, University of Leeds
- Jane Astrid Devane, Shire Oak Primary School.

The key areas of discussion were:

- Utilising the Council's website to help raise awareness and share information – the Board acknowledged that the Council's website would act as an information hub, including signposting to other relevant webpages.
- State of the City workshop - a suggestion was made that the presentation provided at the recent State of the City workshop meeting regarding air quality be publicised on the Council's website.
- Other consultation and engagement initiatives – the Board acknowledged the range of existing and proposed initiatives targeted at key stakeholder groups which had been categorised as businesses, residents and schools (parents and children).
- Engaging with local schools – the Board discussed the importance of working with children and parents in terms of exploring alternative greener options for travelling to school and welcomed the input of Dr Wang from the University of Leeds in this regard.
- 'Green Week' pilot initiative - particular reference was made to the pilot initiative undertaken with Shire Oak Primary School in Headingley, which had a particular focus on Air Quality. The Board welcomed the attendance of the Headteacher of Shire Oak Primary School who highlighted the key outcomes arising from this initiative and also shared her views on expanding this work to other schools.
- The importance of joined up working involving planning and highways – concerns were raised about the impact of poor air quality, particularly

in relation to planned development close to main roads. As such, the Board emphasised the importance of a joined up approach involving planning and highways and agreed to explore this further as part of its ongoing inquiry.

- Instigating behaviour change towards more sustainable transport modes – it was recognised that more information was needed to help inform members of the public about the environmental benefits of electric and hybrid cars. Particular reference was also made to the Council's efforts in working with bus companies and taxi and private hire licensing surrounding more sustainable transport modes. However, it was noted that the Board's next inquiry session would be focusing on transport related matters in more detail.
- Working closely with Small and Medium Enterprises – it was acknowledged that further work was needed to engage with local small and medium sized businesses. Linked to this, the Board was informed that the local Chamber of Commerce had been unable to send a representative to attend today's meeting, but welcomed the opportunity to submit views in writing and also attend future inquiry sessions.
- Industry pollution data - a request was made for the Board to receive further information regarding the impacts of local industry pollution.

RESOLVED –

(a) That the above issues raised as part of session 2 of the Board's inquiry into improving air quality in Leeds, be noted.
(b) That the requests for information be provided.

(Councillor A Khan joined the meeting at 10.50am during the consideration of this item.)

(Councillor D Collins left the meeting at 11.30am at the conclusion of this item.)

60 Peckfield Landfill Site - Update

The Head of Governance and Scrutiny Support submitted a report which presented a general update and written response from the Environment Agency in relation to Peckfield Landfill Site.

The following were in attendance:

- Councillor James Lewis, Ward Member for Kippax and Methley
- Louise White, Minerals & Waste Team Leader, City Development
- Christine Boothroyd, Local resident and member of the Peckfield Liaison Committee.

The key areas of discussion were:

- The Board noted the written response of the Area Environment Manager (West Yorkshire) at the Environment Agency as well as acknowledging the meeting held between her and the Scrutiny Board Chair on 24th November. In Councillor Procter's absence, the Principal Scrutiny Adviser gave a brief overview of the issues raised during this meeting, with particular reference made to the existing demands placed upon the Environment Agency resources available across the district.
- Concerns were still raised that the Environment Agency had declined an invitation to attend today's meeting. Whilst the Board acknowledged the willingness of the Area Environment Manager (West Yorkshire) to also meet with the new Scrutiny Board Chair, it was felt that this should be extended to the full Scrutiny Board. As such, the Board requested that the new Scrutiny Board Chair continues to liaise with the Environment Agency to stress the importance of their attendance and to make arrangements for them to meet with the full Scrutiny Board.
- The Board discussed the role of the Peckfield Liaison Committee and it was suggested that Board Members may also wish to attend and observe a future meeting of this Committee.
- The Board noted that local residents had now sought the assistance of the local MP to escalate this matter and were also seeking support to declare the current situation as a statutory nuisance under the Environment Protection Act 1990 with a proposal to seek a reduction in council tax for the residents of Micklefield and Peckfield.
- The Board continued to discuss the role of the Council and the Environment Agency, particularly in terms of holding the operator to account. Linked to this, the Board discussed the distinctions between the role of the Environment Agency and the Council's Environmental Action Teams.
- The Minerals & Waste Team Leader provided an update from a planning perspective and highlighted the operator's intention to submit a S73 Variation of Condition planning application aimed at addressing existing phasing and access issues on site. The Board discussed potential submission deadlines and noted that this was likely to be February/March 2017.
- Particular clarification was sought regarding the operator's environmental management system. It was suggested that the Environment Agency be asked to provide further details regarding this.

RESOLVED –

(a) That the written response provided by the Environment Agency, be noted.
(b) That the progress update provided by the Council's Minerals & Waste Planning Team, be noted.
(c) That the above requests for information be provided.
(d) That the new Scrutiny Board Chair continues to liaise with the Environment Agency to stress the importance of their attendance and to make arrangements for them to meet with the full Scrutiny Board.

(Councillor A Khan left the meeting at 12.20pm during the consideration of this item.)

61 Work Schedule

The Head of Governance Services and Scrutiny Support submitted a report which invited Members to consider the Board's work schedule for the 2016/17 municipal year.

The Board was advised that the January meeting was themed around housing and was to include an update on Tenant Scrutiny Board. It was noted that the Board would also be considering the initial 2017/18 budget proposals during its January meeting.

RESOLVED – That subject to any on-going discussions and scheduling decisions, the Board's outline work schedule be approved.

62 Date and Time of Next Meeting

Thursday, 19 January 2017 at 10.00am (Pre-meeting for all Board Members at 9.30am)

(The meeting concluded at 12.40pm)

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of the Head of Governance and Scrutiny Support

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

Date: 24 January 2017

Subject: Care Quality Commission (CQC) – 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 across the City, the purpose of this report is provide an overview of recently reported CQC inspection outcomes for health and social care providers across Leeds.

2.3 During the previous municipal year (2015/16), a system of routinely presenting and reporting CQC inspection outcomes to the Scrutiny Board was established. The processes involved continue to be developed and refined in order to help the Scrutiny Board maintain an overview of quality across local health and social care service providers.

CQC Inspection reports

2.4 Appendix 1 provides a summary of the inspection outcomes across Leeds published since 1 April 2016. Most recent outcomes, not previously presented to the Scrutiny Board, are highlighted for ease of reference.

2.5 It should be noted that the purpose of this report is only to provide a summary of inspection outcomes across health and social care providers in Leeds. As such, full inspection reports are not routinely provided as part of this report: However, these are available from the CQC website. Links to individual inspection reports are highlighted in Appendix 1.

2.6 It should also be noted the details presented in Appendix 1 are a statement of fact and CQC representatives are not routinely invited to attend the Scrutiny Board. Should members of the Scrutiny Board have any specific matters they wish to raise directly with the CQC, these will have to be dealt with outside of the meeting and/or at a future Scrutiny Board.

3. Recommendations

3.1 That the Scrutiny Board considers the details presented in this report and its appendices; 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.

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
01-Apr-16	Danial Yorath House	Residential Care Home	http://www.cqc.org.uk/directory/1-134123755	Garforth & Swillington	Good
01-Apr-16	Woodhouse Cottage	Residential Care Home	http://www.cqc.org.uk/directory/1-130890690	Ardsley & Robin Hood	Good
05-Apr-16	Tealbeck House	Residential Care Home	http://www.cqc.org.uk/location/1-126242199	Otley & Yeadon	Requires improvement
07-Apr-16	Woodview Extra Care Housing	Homecare agency	http://www.cqc.org.uk/directory/1-283352948	Cross Gates & Whinmoor	Good
08-Apr-16	Moorfield House Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-304652901	Moortown	Requires improvement
08-Apr-16	Outreach Office	Homecare agency	http://www.cqc.org.uk/directory/1-224415641	Headingley	Good
12-Apr-16	The Sycamores Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-127096576	Gipton & Harehills	Good
13-Apr-16	Airedale Residential Home	Residential Care Home	http://www.cqc.org.uk/directory/1-128272457	Pudsey	Good

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
13-Apr-16	Cordant Care - Leeds	Homecare agency	http://www.cqc.org.uk/directory/1-2170495605	City & Hunslet	Good
15-Apr-16	Lofthouse Grange and Lodge	Residential Care Home	http://www.cqc.org.uk/directory/1-123817278	Ardsley & Robin Hood	Good
21-Apr-16	Hillcrest Residential Home	Residential Care Home	http://www.cqc.org.uk/directory/1-516775598	Armley	Good
22-Apr-16	Copper Hill Residential and Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-127503516	City & Hunslet	Requires improvement
26-Apr-16	Grove Park Care Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-2013878639	Chapel Allerton	Requires improvement
27-Apr-16	Creative Support - Hampton Crescent	Homecare agency	http://www.cqc.org.uk/directory/1-1072972554	Burmantofts & Richmond Hill	Good
27-Apr-16	Headingley Hall Care Home	Residential Care Home	http://www.cqc.org.uk/directory/1-119664818	Headingley	Requires improvement
29-Apr-16	Primrose Court	Residential Care Home	http://www.cqc.org.uk/directory/1-126242712	Guiseley & Rawdon	Good

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
30-Apr-16	Springfield House Retirement Home	Residential Care Home	http://www.cqc.org.uk/directory/1-118805299	Morely North	Requires improvement
05-May-16	Carr Croft Care Home	Residential Care Home	http://www.cqc.org.uk/directory/1-146208801	Moortown	Good
06-May-16	Wetherby Manor	Nursing Care Home	http://www.cqc.org.uk/directory/1-663231663	Wetherby	Good
14-May-16	The Green	Residential Care Home	http://www.cqc.org.uk/directory/1-136455703	Killingbeck & Seacroft	Good
14-May-16	Real Life Options - Yorkshire	Homecare agency	http://www.cqc.org.uk/directory/1-2159639674	Beeston & Holbeck	Requires improvement
01-Jun-16	Gledhow Lodge	Residential Care Home	http://www.cqc.org.uk/directory/1-108939262	Roundhay	Good
02-Jun-16	Mears Care Limited	Homecare agency	http://www.cqc.org.uk/directory/1-2229506609	City & Hunslet	Requires improvement
04-Jun-16	Farfield Drive	Residential Care Home	http://www.cqc.org.uk/directory/1-2064565003	Calverley & Farsley	Good

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
04-Jun-16	Raynel Drive	Residential Care Home	http://www.cqc.org.uk/directory/1-2064564806	Weetwood	Good
10-Jun-16	Colton Lodges Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-127503501	Temple Newsam	Requires improvement
10-Jun-16	Park Avenue Care Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-128272617	Roundhay	Requires improvement
10-Jun-16	Rievaulx House Care Centre	Residential Care Home	http://www.cqc.org.uk/directory/1-123208495	Farnley & Wortley	Good
10-Jun-16	Victoria Court	Homecare agency	http://www.cqc.org.uk/directory/1-793208891	Headingley	Good
11-Jun-16	Cross Heath Drive	Residential Care Home	http://www.cqc.org.uk/directory/1-2064542599	Beeston & Holbeck	Good
11-Jun-16	Mount St Joseph – Leeds	Nursing Care Home	http://www.cqc.org.uk/directory/1-131623876	Headingley	Good
14-Jun-16	Simon Marks Court	Residential Care Home	http://www.cqc.org.uk/directory/1-126242079	Farnley & Wortley	Good

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
14-Jun-16	Claremont Care Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-122224585	Calverley & Farsley	Requires improvement
16-Jun-16	The Gables Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-120249107	Pudsey	Inadequate
16-Jun-16	Bluebird Care (Leeds North)	Homecare agency	http://www.cqc.org.uk/directory/1-280404914	Horsforth	Good
21-Jun-16	St Armands Court	Residential Care Home	http://www.cqc.org.uk/directory/1-111148838	Garforth & Swillington	Good
21-Jun-16	Green Acres Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-2259160271	Burmantofts & Richmond Hill	Requires improvement
21-Jun-16	Adel Grange Residential Home	Residential Care Home	http://www.cqc.org.uk/directory/1-110993039	Adel & Wharfedale	Requires improvement
21-Jun-16	Parkside Residential Home	Residential Care Home	http://www.cqc.org.uk/directory/1-109780793	Roundhay	Requires improvement
22-Jun-16	Oak Tree Lodge	Residential Care Home	http://www.cqc.org.uk/directory/1-1477142369	Gipton & Harehills	Requires improvement

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
22-Jun-16	Ashcroft House - Leeds	Residential Care Home	http://www.cqc.org.uk/directory/1-109574569	Adel & Wharfedale	Requires improvement
24-Jun-16	Seacroft Grange Care Village	Nursing Care Home	http://www.cqc.org.uk/directory/1-990605516	Killingbeck & Seacroft	Requires improvement
24-Jun-16	Bremner House	Nursing Care Home	http://www.cqc.org.uk/directory/1-128584398	Armley	Requires improvement
25-Jun-16	The Spinney Residential Home	Residential Care Home	http://www.cqc.org.uk/directory/1-112270555	Armley	Good
25-Jun-16	UBU - 67 Elland Road	Residential Care Home	http://www.cqc.org.uk/directory/1-142626153	Morely North	Good
25-Jun-16	Harewood Court Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-155030449	Chapel Allerton	Requires improvement
28-Jun-16	Mineral Cottage Residential Home Limited	Residential Care Home	http://www.cqc.org.uk/directory/1-229359398	Farnley & Wortley	Good
01-Jul-16	AJ Social Care Recruitment Limited - 4225 Park Approach	Homecare agency	http://www.cqc.org.uk/directory/1-115002084	Temple Newsam	Good

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
01-Jul-16	Elmwood Care Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-128272518	Roundhay	Requires improvement
06-Jul-16	Southlands Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-119664848	Roundhay	Requires improvement
07-Jul-16	Hillside	Homecare agency	http://www.cqc.org.uk/directory/1-2267851709	Beeston & Holbeck	Good
07-Jul-16	Comfort Call - Leeds	Homecare agency	http://www.cqc.org.uk/directory/1-1626371041	Morely North	Requires improvement
07-Jul-16	Community Integrated Care, Leeds Regional Office	Homecare agency	http://www.cqc.org.uk/directory/1-1857243215	Kirkstall	Requires improvement
08-Jul-16	Kirkside House	Residential Care Home	http://www.cqc.org.uk/directory/1-156503084	Kirkstall	Good
08-Jul-16	Middlecross	Residential Care Home	http://www.cqc.org.uk/directory/1-136455602	Armley	Good
08-Jul-16	Gledhow	Nursing Care Home	http://www.cqc.org.uk/directory/1-312270514	Roundhay	Good

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
09-Jul-16	Wetherby Home Care Limited	Homecare agency	http://www.cqc.org.uk/directory/1-1551243664	Wetherby	Good
16-Jul-16	Corinthian House	Nursing Care Home	http://www.cqc.org.uk/directory/1-1494575220	Farnley & Wortley	Requires improvement
16-Jul-16	Holmfield Court	Residential Care Home	http://www.cqc.org.uk/directory/1-120101275	Roundhay	Requires improvement
16-Jul-16	SignHealth Constance Way	Homecare agency	http://www.cqc.org.uk/directory/1-118140768	Hyde Park & Woodhouse	Requires improvement
19-Jul-16	Shadwell Medical Centre	General Practice	http://www.cqc.org.uk/directory/1-582111403	Alwoodley	Requires improvement
20-Jul-16	Kestrel House	Homecare agency	http://www.cqc.org.uk/directory/1-137500639	City & Hunslet	Good
20-Jul-16	Morley Manor Residential Home	Residential Care Home	http://www.cqc.org.uk/directory/1-111200339	Morely South	Requires improvement
22-Jul-16	Sue Ryder - Wheatfields Hospice	Hospice	http://www.cqc.org.uk/directory/1-136414799	Headingley	Requires improvement

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
26-Jul-16	27 Ledston Avenue	Rehabilitation - Residential Care	http://www.cqc.org.uk/directory/1-296741513	Garforth & Swillington	Good
26-Jul-16	Vive UK Social Care Limited	Residential Care Home	http://www.cqc.org.uk/directory/1-122175223	City & Hunslet	Requires improvement
27-Jul-16	Dr R D Gilmore and Partners	General Practice	http://www.cqc.org.uk/directory/1-542490411	Bramley & Stanningley	Good
29-Jul-16	Dr CA Hicks & Dr JJ McPeake	General Practice	http://www.cqc.org.uk/directory/1-552591165	Morely South	Good
30-Jul-16	Positive People Recruitment Limited	Homecare agency	http://www.cqc.org.uk/directory/1-1914211820	Farnley & Wortley	Requires improvement
02-Aug-16	Kirkstall Lane Medical Centre	General Practice	http://www.cqc.org.uk/directory/1-552846870	Headingley	Outstanding
05-Aug-16	Helping Hands North	Homecare agency	http://www.cqc.org.uk/directory/1-451430539	Garforth & Swillington	Requires improvement
05-Aug-16	Meadowbrook Manor	Residential Care Home	http://www.cqc.org.uk/directory/1-112578091	Garforth & Swillington	Requires improvement

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
09-Aug-16	Aspire	Community based mental health services	http://www.cqc.org.uk/directory/1-256804055	Gipton & Harehills	Requires improvement
09-Aug-16	Prestige First Call	Homecare agency	http://www.cqc.org.uk/directory/1-1321423984	Temple Newsam	Requires improvement
10-Aug-16	Paisley Lodge	Residential Care Home	http://www.cqc.org.uk/directory/1-2583919829	Armley	Requires improvement
10-Aug-16	Acacia Court	Residential Care Home	http://www.cqc.org.uk/directory/1-123208600	Pudsey	Good
16-Aug-16	Dr A Khan and K Muneer	General Practice	http://www.cqc.org.uk/directory/1-533299035	City & Hunslet	Good
16-Aug-16	West Yorkshire	Community Services - nursing / homecare agency	http://www.cqc.org.uk/directory/1-154214570	Beeston & Holbeck	Requires improvement
16-Aug-16	The Roundhay Road Surgery	General Practice	http://www.cqc.org.uk/directory/1-541883559	Gipton & Harehills	Good

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
17-Aug-16	Newton Surgery	General Practice	http://www.cqc.org.uk/directory/1-552754314	Chapel Allerton	Good
18-Aug-16	Assisi Place	Homecare agency	http://www.cqc.org.uk/directory/1-397672324	City & Hunslet	Good
19-Aug-16	Elderly Care Services	Homecare agency	http://www.cqc.org.uk/directory/1-415123704	City & Hunslet	Inadequate
24-Aug-16	Rutland Lodge Medical Practice	General Practice	http://www.cqc.org.uk/directory/1-549768513	Chapel Allerton	Good
25-Aug-16	Waterloo Manor Independent Hospital	Hospital - Mental Health	http://www.cqc.org.uk/directory/1-156620871	Garforth & Swillington	Good
30-Aug-16	Drs Ross, Mason, Champaneri, Mason, Hardaker & Limaye	General Practice	http://www.cqc.org.uk/directory/1-549674372	Pudsey	Good
02-Sep-16	Sevacare - Leeds	Homecare agency	http://www.cqc.org.uk/directory/1-2544811890	Weetwood	Requires improvement
03-Sep-16	Local Care Force	Homecare agency	http://www.cqc.org.uk/directory/1-330021774	City & Hunslet	Good

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
06-Sep-16	The Wilf Ward Family Trust Domiciliary Care Leeds and Wakefield	Homecare agency	http://www.cqc.org.uk/directory/1-939874319	Garforth & Swillington	Good
07-Sep-16	Pulse - Leeds	Community Services - nursing / homecare agency	http://www.cqc.org.uk/directory/1-303216298	City & Hunslet	Good
07-Sep-16	Valeo Domiciliary Care Service	Homecare agency	http://www.cqc.org.uk/directory/1-576931725	Beeston & Holbeck	Good
08-Sep-16	Leeds Federated Housing Association	Homecare agency	http://www.cqc.org.uk/directory/1-131663345	Hyde Park & Woodhouse	Good
09-Sep-16	Owlett Hall	Nursing Care Home	http://www.cqc.org.uk/directory/1-141599363	Morely North	Inadequate
09-Sep-16	Manorfield House	Residential Care Home	http://www.cqc.org.uk/directory/1-136455588	Horsforth	Good
09-Sep-16	Reflections Community Support	Homecare agency	http://www.cqc.org.uk/directory/1-973343971	Guiseley & Rawdon	Requires improvement

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
09-Sep-16	The Medical Centre	General Practice	http://www.cqc.org.uk/directory/1-573811790	Killingbeck & Seacroft	Good
09-Sep-16	The Medical Centre	General Practice	http://www.cqc.org.uk/directory/1-573811763	Burmantofts & Richmond Hill	Good
10-Sep-16	New Mabgate Centre	Homecare agency	http://www.cqc.org.uk/directory/1-341088808	Armley	Good
12-Sep-16	Gibson Lane Practice	General Practice	http://www.cqc.org.uk/directory/1-570699732	Kippax & Methly	Good
13-Sep-16	Martin House	Hospice	http://www.cqc.org.uk/directory/1-101635211	Wetherby	Good
14-Sep-16	Manston Surgery	General Practice	http://www.cqc.org.uk/directory/1-2116560070	Cross Gates & Whinmoor	Good
17-Sep-16	Rest Assured Homecare Services	Homecare agency	http://www.cqc.org.uk/directory/1-164355808	Otley & Yeadon	Requires improvement
22-Sep-16	Avanta Care Ltd	Homecare agency	http://www.cqc.org.uk/directory/1-1586299768	Horsforth	Good

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
23-Sep-16	Craven Road Medical Practice	General Practice	http://www.cqc.org.uk/directory/1-547429698	Hyde Park & Woodhouse	Good
23-Sep-16	Dr RI Addlestone, Dr N Mourmouris, Dr GE Orme, Dr AM Sixsmith and Dr PK Smith	General Practice	http://www.cqc.org.uk/directory/1-552575041	Armley	Good
27-Sep-16	Armley Medical Centre	General Practice	http://www.cqc.org.uk/directory/1-554538861	Armley	Good
27-Sep-16	Chapel Allerton Hospital	Acute Hospital Trust	http://www.cqc.org.uk/directory/RR819	Chapel Allerton	Good
27-Sep-16	Leeds General Infirmary	Acute Hospital Trust	http://www.cqc.org.uk/directory/RR801	Leeds City Centre	Requires improvement
27-Sep-16	Leeds Teaching Hospitals NHS Trust	Acute Hospital Trust	http://www.cqc.org.uk/directory/RR8	Leeds City Centre	Good
27-Sep-16	St James's University Hospital	Acute Hospital Trust	http://www.cqc.org.uk/directory/RR813	Gipton & Harehills	Requires improvement

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
27-Sep-16	Wharfedale Hospital	Acute Hospital Trust	http://www.cqc.org.uk/directory/RR807	Otley & Yeadon	Good
28-Sep-16	Chapeltown Family Surgery	General Practice	http://www.cqc.org.uk/directory/1-544269716	Chapel Allerton	Good
28-Sep-16	Manor House Residential Home	Residential Care Home	http://www.cqc.org.uk/location/1-126691746	Farnley & Wortley	Requires improvement
28-Sep-16	Woodhouse Medical Practice	General Practice	http://www.cqc.org.uk/directory/1-559425153	Hyde Park & Woodhouse	Good
29-Sep-16	BPAS - Leeds	Clinic	http://www.cqc.org.uk/location/1-129168570	City & Hunslet	Not formally rated
29-Sep-16	Woodhouse Hall	Residential Care Home	http://www.cqc.org.uk/location/1-130890705	Ardsley & Robin Hood	Requires improvement
01-Oct-16	St Gemma's Hospice - Leeds	Hospice	http://www.cqc.org.uk/location/1-109728988	Moortown	Outstanding
04-Oct-16	Otley Dental Care	Dentist	http://www.cqc.org.uk/directory/1-194252044	Otley & Yeadon	Not formally rated

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
07-Oct-16	Dr F Gupta's Practice	General Practice	http://www.cqc.org.uk/directory/1-559493188	Morley North	Good
07-Oct-16	Fieldhead Surgery	General Practice	http://www.cqc.org.uk/directory/1-547501963	Horsforth	Good
10-Oct-16	Leeds Student Medical Practice	General Practice	http://www.cqc.org.uk/directory/1-541964802	Hyde Park & Woodhouse	Outstanding
12-Oct-16	Moorleigh Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-120251458	Kippax & Methly	Requires improvement
15-Oct-16	Affinity Trust - Domiciliary Care Agency - North	Homecare agency	http://www.cqc.org.uk/directory/1-120590481	Beeston & Holbeck	Good
15-Oct-16	Allied Healthcare Leeds	Homecare agency	http://www.cqc.org.uk/directory/1-557596500	Cross Gates & Whinmoor	Requires improvement
18-Oct-16	Rani Care C.I.C.	Homecare agency	http://www.cqc.org.uk/directory/1-780475340	Roundhay	Good
18-Oct-16	Roche Caring Solutions	Homecare agency	http://www.cqc.org.uk/directory/1-119643355	Beeston & Holbeck	Requires improvement

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
19-Oct-16	Manor Square Dental Practice	Dentist	http://www.cqc.org.uk/directory/1-211556350	Otley & Yeadon	Not formally rated
20-Oct-16	East Park Medical Centre	General Practice	http://www.cqc.org.uk/directory/1-557761878	Burmantofts & Richmond Hill	Inadequate
20-Oct-16	High Ash Dental Practice	Dentist	http://www.cqc.org.uk/directory/1-188934266	Harewood	Not formally rated
22-Oct-16	Ashlands	Nursing Care Home	http://www.cqc.org.uk/directory/1-119643340	Kippax & Methly	Inadequate
25-Oct-16	Springfield Home Care Services Limited	Homecare agency	http://www.cqc.org.uk/location/1-156230692	Garforth & Swillington	Requires improvement
26-Oct-16	Donisthorpe Hall	Residential Care Home	http://www.cqc.org.uk/location/1-114958058	Moortown	Inadequate
28-Oct-16	Ghyll Royd Nursing Home	Nursing Care Home	http://www.cqc.org.uk/location/1-113524085	Guiseley & Rawdon	Requires improvement
29-Oct-16	Caring Hearts and Hands	Homecare agency	http://www.cqc.org.uk/location/1-422009787	Horsforth	Requires improvement

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29-Oct-16	Express Healthcare UK Limited Domiciliary Care Agency	Homecare agency	http://www.cqc.org.uk/location/1-1172120629	Gipton & Harehills	Requires improvement
29-Oct-16	Southlands Care Home	Nursing Care Home	http://www.cqc.org.uk/location/1-119664848	Roundhay	Requires improvement
29-Oct-16	Southlands Nursing Home	Nursing Home	http://www.cqc.org.uk/location/1-119664848	Roundhay	Requires improvement
02-Nov-16	Hillfoot Surgery	General Practice	http://www.cqc.org.uk/location/1-547843143	Calverley & Farsley	Good
03-Nov-16	Cedars Care Home	Residential Care Home	http://www.cqc.org.uk/location/1-120284958	Kippax & Methly	Good
03-Nov-16	Radis Community Care (Leeds)	Homecare agency	http://www.cqc.org.uk/location/1-403115252	Morley South	Requires improvement
04-Nov-16	Lee Beck Mount	Residential Care Home	http://www.cqc.org.uk/location/1-123610238	Ardsley & Robin Hood	Requires improvement

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
10-Nov-16	All Seasons	Homecare agency	http://www.cqc.org.uk/location/1-820131546	Garforth & Swillington	Requires improvement
10-Nov-16	United Response - 2a St Alban's Close	Residential Care Home	http://www.cqc.org.uk/location/1-123018728	Burmantofts & Richmond Hill	Good
12-Nov-16	Mears Homecare Limited - Leeds DCA	Homecare agency	http://www.cqc.org.uk/location/1-140963566	Burmantofts & Richmond Hill	Good
14-Nov-16	Dr ASA Robinson and Partners	General Practice	http://www.cqc.org.uk/location/1-672024224	Farnley & Wortley	Good
14-Nov-16	Quarry House Dental Practice	Dentist	http://www.cqc.org.uk/location/1-2562120781	City & Hunslet	Not formally rated
15-Nov-16	Leigh View Medical Practice	General Practice	http://www.cqc.org.uk/directory/1-575614656	Ardsley & Robin Hood	Good
15-Nov-16	The Dekeyser Group Practice	General Practice	http://www.cqc.org.uk/directory/1-542888227	Morley South	Good
18-Nov-16	Leeds and York Partnership NHS Foundation Trust	Acute Hospital Trust	http://www.cqc.org.uk/directory/RGD	Garforth & Swillington	Requires improvement

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Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
18-Nov-16	St Mary's Hospital	Acute Hospital Trust	http://www.cqc.org.uk/directory/RGD17	Armley	Requires improvement
23-Nov-16	Morley Health Centre Surgery	General Practice	http://www.cqc.org.uk/location/1-2410728461	Morley South	Good
23-Nov-16	Woodleigh Care	Homecare agency	http://www.cqc.org.uk/location/1-527967595	Guiseley & Rawdon	Good
24-Nov-16	The Gables Surgery	General Practice	http://www.cqc.org.uk/location/1-584836167	Pudsey	Good
30-Nov-16	St Anne's Community Services - Croft House	Residential Care Home	http://www.cqc.org.uk/location/1-121773394	Horsforth	Good
30-Nov-16	Chelwood Dental Practice	Dentist	http://www.cqc.org.uk/location/1-219653761	Moortown	Not formally rated
30-Nov-16	High Field Surgery	General Practice	http://www.cqc.org.uk/location/1-545322613	Adel & Wharfedale	Good
01-Dec-16	Mydentist - Windsor Court	Dentist	http://www.cqc.org.uk/location/1-206165219	Morley South	Not formally rated

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
02-Dec-16	The Gables Nursing Home	Nursing Home	http://www.cqc.org.uk/location/1-120249107	Pudsey	Requires improvement
02-Dec-16	Teeth	Dentist	http://www.cqc.org.uk/location/1-211331028	Roundhay	Not formally rated
03-Dec-16	Hillside House	Residential Care Home	http://www.cqc.org.uk/location/1-2242192562	Headingley	Good
03-Dec-16	Carlton House	Residential Care Home	http://www.cqc.org.uk/location/1-130890582	Ardsley & Robin Hood	Good
05-Dec-16	Windsor House Group Practice	General Practice	http://www.cqc.org.uk/directory/1-539000049	Morley South	Good
07-Dec-16	Dovetail Care Limited	Residential Care Home	http://www.cqc.org.uk/directory/1-114550846	Horsforth	Requires improvement
13-Dec-16	Robin Lane Health and Wellbeing Centre	General Practice	http://www.cqc.org.uk/directory/1-594189072	Pudsey	Outstanding
14-Dec-16	West Lodge Surgery	General Practice	http://www.cqc.org.uk/directory/1-547256701	Calverley & Farsley	Good

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
14-Dec-16	Olive Lodge	Residential Care Home	http://www.cqc.org.uk/directory/1-140482438	Horsforth	Good
14-Dec-16	St Lukes Care Home	Nursing Home	http://www.cqc.org.uk/directory/1-116738422	Calverley & Farsley	Requires improvement
20-Dec-16	Marie Stopes International Leeds Centre	Clinic	http://www.cqc.org.uk/location/1-130902791	Chapel Allerton	Not formally rated
20-Dec-16	Nova Healthcare	Clinic	http://www.cqc.org.uk/location/1-764278383	Gipton & Harehills	Good
20-Dec-16	York Street Health Practice	General Practice	http://www.cqc.org.uk/location/RY663	City & Hunslet	Outstanding
28-Dec-16	Vesper Road Surgery	General Practice	http://www.cqc.org.uk/location/1-567968305	Kirkstall	Good
28-Dec-16	Hyde Park Surgery	General Practice	http://www.cqc.org.uk/location/1-565596983	Hyde Park & Woodhouse	Good
30-Dec-16	Astha Limited- Leeds	Homecare agency	http://www.cqc.org.uk/location/1-1554674153	Chapel Allerton	Requires improvement

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
30-Dec-16	Manor House Residential Home	Residential Care Home	http://www.cqc.org.uk/location/1-126691746	Farnley & Wortley	Requires improvement
04-Jan-17	Oaklands Residential Homes	Residential Care Home	http://www.cqc.org.uk/location/1-1963864878	Kippax & Methly	Good
06-Jan-17	Atkinson Court Care Home	Nursing Home	http://www.cqc.org.uk/location/1-126476576	Burmantofts & Richmond Hill	Requires improvement
06-Jan-17	Dental Care Direct-Lexicon House	Dentist	http://www.cqc.org.uk/location/1-1788701883	Chapel Allerton	Not formally rated

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of the Head of Scrutiny and Member Development

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

Date: 24 January 2017

Subject: Delivering the Better Lives Strategy in Leeds Programme - Phase 3 update

Are specific electoral Wards affected? If relevant, name(s) of Ward(s): Hyde Park and Woodhouse	☐ 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

1.0 Purpose

1.1 The purpose of this report is to introduce an update from the Director of Adult Social Services in relation to the delivering the Better Lives Strategy in Leeds Programme - Phase 3.

2.0 Background

2.1 Discussions around Phase 3 of the Better Lives Strategy in Leeds Programme have continued during the course of the current municipal year, including a 'call-in' meeting in October 2016.

2.2 Following the outcome of the Call-In meeting, at its meeting on 19 October 2016, Executive Board agreed the following in relation to the 'Better Lives Programme: Phase Three: Next Steps and Progress Report:

a) *That the Scrutiny Board's recommendations, as detailed at 3.2.1 to 3.2.6 of the submitted report, be accepted, noting the additional comments in relation to The Green, as per resolution (b) below;*
b) *That the original decisions taken by the Executive Board on 21st September 2016, be re-affirmed, subject to The Green being retained until there can be a seamless transition to the new facility;*
c) *Whilst the decision is to close The Green as a long term residential care service, it will remain open until there is a transition to a new function/ facility. The Board notes The Green will be retained as a community asset and that discussions will continue with the NHS about future use of the facility. A*

progress report, including an update on discussions with the NHS, will be brought back to the Executive Board. This update report to also provide information about how the seamless transition would work, with any associated timescales;

d) That it be noted and highlighted that the input of the Scrutiny Board is appreciated, and that it also be noted that the Scrutiny Board will be kept informed in order to enable it to monitor the progress made against any decisions taken.

2.3 Appended to this report is a briefing note from the Director iof Adult Social Services in order to provide an update on progress, in line with the Executive Board's decision.

2.4 Appropriate representatives from Adult Social Care will be in attendance to discuss the update provided and address any questions raised by the Scrutiny Board.

3.0 Recommendations

3.1 The Scrutiny Board is asked to consider the update provided and agree any further actions, as appropriate.

4.0 Background Papers

None[1]

[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.

The purpose of this briefing note is to update Scrutiny Board in relation to the Council's Better Lives strategy and specifically regarding the *Better Lives Programme: Phase 3 Residential & Day Services – Next Steps and Progress report,* at which Executive Board approved;

- The closure of The Green (Killingbeck & Seacroft ward) as a long term residential care home. It has a provisional closure date of July 2017 but this is subject to contractual agreement for intermediate care services being confirmed. This would fulfil the commitment to retain it as a local community asset.
- The decommissioning of the long term residential care services provided at Middlecross care home (Armley ward) with anticipated closure Mid-April 2017 and Siegen Manor care home (Morley South ward) with anticipated closure in May 2017.
- The decommissioning of the day services provided at Middlecross, with an anticipated closure Mid-April 2017, Siegen Manor, Mid-April 2017, The Green, July 2017, Springfield (Beeston & Holbeck ward), January 2017, and Radcliffe Lane (Pudsey ward), March 2017.
- The remodelling of Wykebeck Valley day centre (Gipton & Harehills ward) to become a complex needs centre for the east of the city. This will include reinvestment of £0.111m of the planned savings to ensure Wykebeck can offer an enhanced service.
- All other recommendations in the September Executive Board report including noting the closure of Manorfield House residential care home (Horsforth ward), with anticipated closure in December 2016.

Communication of Decision

All staff, residents, service users and their families and carers have been informed in writing of the decision taken by Executive Board, and face to face meetings held with staff, and with residents and their families/carers where requested.

To reflect the high level programme plan as per the September Executive Board report (copy attached to this report for reference), the months of anticipated closure were included, also reiterating that the Assessment and Transfer team will work at a pace that is as comfortable as possible, nothing will happen suddenly or unexpectedly, and residents / service users and their families / carers will be supported to make informed choices, so that people are supported to move to a suitable alternative home or day centre where their needs can be fully met. In addition:

- The person being cared for will still receive at least equal quality of care as currently provided.
- They will not be financially worse off as a result of these changes.
- We will support the person being cared for and their family/carer to find an alternative service provider that will meet their needs.
- The person being cared for and their family/carer will receive as much help as they need at every step.

Senior Managers, HR Business Partners and Trade Union representatives are working with staff members individually to seek opportunities that are right for them. Senior Managers supported by HR are working with Trade Union representatives to ensure that staff are fully consulted and supported throughout the process and their aim is to identify potential redeployment opportunities for staff within the service and across the Council. For those staff interested in accessing the Early Leavers Initiative, consideration will be given to such requests. It is hoped this work will significantly minimise the risks to staff in terms of compulsory redundancies.

We have received positive feedback from a family member about the process (the names have been changed to protect the identity of the service user):

"I just wanted you all to know that I have just taken a call from Mr C, son of a resident.He wanted me to know and to pass on his comments of how extremely happy he has been with his whole experience of moving his mother from Manorfields to her new placement. He says he cannot compliment her social worker enough. She has done everything she said she would: she has kept him fully informed of what will happen next, and she has put in a lot of time not only to his mother, but to his mother's sister and himself.

He says he came into this process with preconceived negative views of social workers and what they do and he has been proved totally and utterly wrong, He says he could not fault the social worker and her work and commitment to getting everything just right for the family".
Pat Gledhill: Team Manager – Assessment and TransitionTeam

The Green Residential care home

As detailed in the letters to staff, residents and their families / carers there is written agreement in principle from the NHS Commissioners to fund Adult Social Care to provide an intermediate care / recovery service from The Green. An update meeting was held with families on 14 December to inform them of this development. When confirmation has been received, a transition plan will be produced and taken to Executive Board that will enact the closure process once approved. Confirmation is expected in January 2017. We will hold further face to face meetings with families once more is known.

A provisional closure date of July 2017 for The Green as a long term residential care facility has been given based on the timeline set by NHS commissioners for when they would want to see the new intermediate service go live, which would be Autumn 2017.

As committed to at September 2016 Executive Board meeting an update on The Green is to be provided at February 2017 Executive Board.

Closure of Manorfield House Care Home

The Assessment & Transfer team have been working closely with staff, 9 residents and their families/carers at Manorfield House. Residents have been able to move with their friends whenever they have expressed a wish to do this. 7 residents have moved to alternative homes, two residents died prior to any move (one following hospital admission). Follow up reviews for residents including their families/carers will take place three months and twelve months following their moves.

Of the16 staff working at Manorfield House, 9 have moved to roles in other council residential care homes, 2 have moved to roles at Cardinal Court Extra Care Housing, and 5 have left the Council through the Council's Early Leavers Initiative.

The care home was formally transferred into void management on the 19th December 2016 and now forms part of the Housing Care Futures programme.

Assessment & Transitions started at Springfield day centre

Assessments and visits to potential alternative day support services are currently underway for the 21 people attending Springfield day centre. Again, service users have been able to move with their friends when they have expressed a wish to do this. It is expected that the centre will close as anticipated by the end of January 2017. Expected outcomes for service users are detailed below, although it should be noted that this may vary depending on their and their family's preferences.

New service identified	Number of people
Trinity Network (Neighbourhood Network)	6
Farnley Elderly Action (Neighbourhood Network)	2
Morley Elderly Action (Neighbourhood Network)	1

Holt Park Active	3
Laurel Bank (ASC Dementia day service)	2
Shared Lives	1
Outcomes still to be confirmed	6

Consultations with staff and Trade Unions are ongoing to determine alternative work opportunities or ELI options.

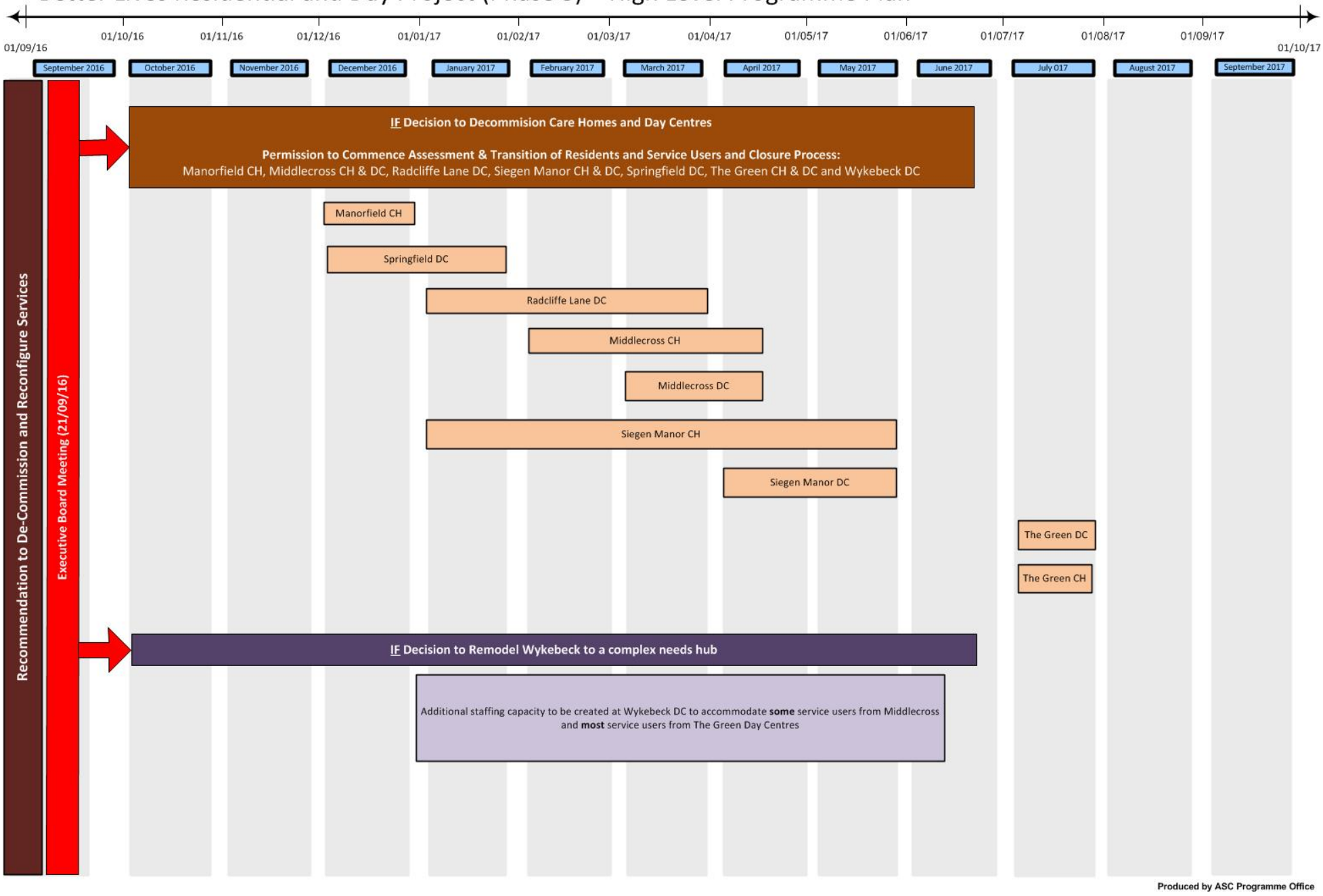
The Springfield site is being considered by the Alzheimer's Society as a potential base for their younger dementia service currently based in Armley.

Assessment & Transitions at other closing care homes and day centre

Some service users and their families/carers have chosen to take steps to start the process of finding another care home, day service or short break service and have requested an allocated social worker. As such, transition meetings to sensitively manage the moves to new homes and day centres are also underway at Siegen Manor residential home & day centre, Middlecross residential home & day centre and Radcliffe Lane day centre.

Cath Roff
Director Adult Social Services
10th January 2017

Better Lives Residential and Day Project (Phase 3) – High Level Programme Plan



Report author: Steven Courtney
Tel: (0113) 247 4707

Report of Head of Governance and Scrutiny Support

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

Date: 24 January 2017

Subject: Leeds and York Partnership NHS Foundation Trust – update

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

Summary of main issues

1. The purpose of this report is to introduce a general update on key issues and progress update from Leeds and York Partnership NHS Foundation Trust. The latest Chief Executive's report prepared to be presented to the Trust Board is appended to this report.

2. Appropriate senior representatives have been invited to the meeting to discuss the details of the report and address questions from members of the Scrutiny Board.

Recommendations

3. That the Scrutiny Board considers the details presented and agrees any specific scrutiny actions or activity that may be appropriate.

Background documents[1]

4. 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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Leeds and York Partnership NHS
NHS Foundation Trust

Chief Executive Report – January 2017

The following paper is intended to provide the scrutiny committee with an update on key matters for Leeds and York Partnership NHS trust. The Trust is a specialist provider of mental health and learning disability services to people across Leeds, York and for some of our specialist service regionally and nationally.

CQC inspection

The trust has a comprehensive CQC inspection in July 2016 and received the findings late 2016. Overall the Trust has been rated as requires improvement however there were a number of notable areas of improvement from the previous inspection. 78% of our services were rated as good or outstanding.

The chair of scrutiny joined us at the Quality Summit on the 8th December following which we submitted our action plan to the CQC.

The Director of Quality and Nursing is the executive lead for CQC on our Trust board and has provided a separate paper to today's scrutiny committee on our actions and progress.

We are committed to addressing the recommendations in a timely manner such that we progress to a good rating within the next 12 months.

Trust strategy

Our trust board is in the process of finalising our Trust strategy for the next 5 years. We will present it to our council of governors in February and then formally approve it at our public board in March 2017. The new trust strategy has been built on a significant amount of engagement work with our staff, stakeholders and governors. Form this we developed a new set of values and behaviours which are important for setting the right culture in our organisation to deliver outstanding patient care and staff experience.

Finance update

We are currently on track to meet our financial control total for this year as set by NHSI – which is to deliver a £3.1 million surplus. Meeting our control total is important as it means we get around £1 million released back to us from NHS England. It also means we retain a healthy risk rating from our regulator, NHS Improvement and puts us in a stronger position when we bid for additional transformation monies in the coming months.

For 2017/18, we've accepted a control total of a £3.7 million surplus, which again includes £1 million contribution from NHS England. This is a challenging requirement which we have

only agreed to on the basis that we think we can deliver some non- recurrent savings, above the 2% cost improvements we have to make each year.

Our underlying position is break-even – basically every pound of income we get we plan to spend - so we have rejected the surplus control total for 2018/19. Any surpluses we generate create cash for us to improve services, but this is cash we can only spend once so it will mainly be set aside for our infrastructure i.e. estate and information assets.

Staffing pressures and temporary ward closure at Clifton House, York.

Like many NHS and social care organisations recruitment is an ongoing challenge. We faced a particular issue in our forensic cervices in York late 2016 which led to the board supporting the decision to temporarily close one ward in the short term. Our priority was to maintain safe staffing and safe patient care which we have done. Recruitment is now underway to support the reopening of the ward as soon as possible.

Leeds Mental Health Flow – rapid improvement process

Colleagues in the Leeds Care Group have been leading a piece of work to improve patient experience, reduce out of area treatments and save £1.5 million for the local health system.

The Leeds Mental Health Flow aims to deliver radical, system-wide, sustainable change to improve quality of care for patients, improve patient experience and improve the system that supports this.

They held a four day "rapid improvement event" in September 2016 with around 40 clinicians, health workers and managers from across the Leeds health and social care system. The following work streams were established following this first event:

1. Community Mental Health Team criteria
2. Safety Culture
3. Purposeful interventions
4. Variation of Length of Stay

A full report on the outcomes of the first event can be found on our website.

At the 60 day review event in November, latest data on adult admissions, occupied bed days, lengths of stay and out of area treatments was looking really positive. Although it is still too early to draw any definitive conclusions, it looks like out of area placements and bed occupancy levels have improved since we started in September. We are now using one less bed per day which is great news.

Contracts for 2017-2019

We are set to sign the two year contract with NHSE and Leeds commissioners within the next week or so. Leeds commissioners have committed to non-recurrent investment for liaison and memory support workers. NHSE have invested in an additional 2 perinatal

mental health beds which are now open and therefore enable us to provide a greater service to new mums.

We submitted our two year operational plan on 23rd December as required by NHSI. We are still awaiting and expecting feedback on our final submission in the coming weeks

Transformation bids

The trust and partners are submitting a bid to NHSE for additional monies to expand our mental health liaison service which is provided within LTHT. It is an invaluable service that brings benefits for patients who present in the acute trust. If successful this would see up to £500,000 additional investment this next financial year. However it is only one year of funding so we are planning with our commissioners how this can be continued in subsequent years to maintain such a valuable service.

West Yorkshire and Harrogate STP

The Trust is a member of the STP and the implications of this are twofold.

We are part of an alliance with Bradford district Care Trust and SWYFT as the three lead providers of mental health and learning disability services in West Yorkshire. We came together to do joint work as part of the acute an urgent care vanguard which has resulted in significant service developments regarding crisis services, street triage, crisis cafes and putting mental health nurses in police control rooms. We are now looking to build on this to see where we can have greater impact on the quality and consistency of care provision across west Yorkshire. Areas we are looking at include CAMHS provision, access to specialist rehab to reduce the number of people that have to go out of area and where we can share supporting functions such as IT/training etc.

More locally we have been working with LCH and primary and social care on the neighbourhood teams projects to develop more integrated services that are tailored to the needs of local populations. This work will continue from the current pilots e.g. in Armley to share the learning across the wider Leeds footprint. We are also working with our commissioners and LCH to look at how we can provide a more integrated pathway of access to mental health support that encompasses primary care, IAPT and community mental health teams.

In our Learning disability services we have just completed a review of our community LD offer and are now looking at how we can improve this to meet the changing needs of our services users and communities. We are also members' of the transforming care programme board which is responsible for ensuring there is a plan in place to enable people who have been in specialist placements out of area to come back to Leeds. We need a clear strategic plan for this that supports the current service users in placements but that also serves to reduce the need for people with a learning disability to go into specialist placements which can be disconnected from families and local communities.

Board level recruitment

We welcome our new Medical Director, Dr Claire Kenwood, to the Trust on the 1st March. Dr Kenwood joins us from Cumbria Partnership NHS Foundation Trust, where she is currently Associate Medical Director for Quality and a Consultant psychiatrist in the field of rehabilitation. She is also a Non-Executive Director for Advancing Quality Alliance (AQuA), with particular interests in mental health recovery, service and quality improvement.

We have now advertised for a substantive Chief Operating Officer and on the 20th January the Trust Governors will be interviewing candidates for our new Trust Chair.

Frank Griffiths is retiring from his post on the 31st March after 7 years of outstanding contribution and leadership for our organisation.

Reasons to be Proud

Congratulations to Caroline Foster, specialist dietitian in our Rehab and Recovery Service, who was highly commended at this year's Yorkshire Evening Post 'Best of Health' Awards in December. Caroline was nominated by a service user in the Mental Health Worker of the Year category, which celebrates those who go the extra mile to help people facing the most difficult times of their lives.

In December we started offering a new out-of-hours Liaison Psychiatry Service for patients at Leeds General Infirmary and St James's University Hospital. The out-of-hours Specialist Practitioner Service offers mental health advice and assessment, and provides a single point of contact for Leeds Teaching Hospitals Trust. Great work getting this off the ground!

Our specialist service for deaf children and young people was given the highest possible rating of outstanding by the Care Quality Commission in their reports published in November 2016. Inspectors were impressed by the range of therapies and treatments delivered by the service and praised team members for tailoring their work to meet the specific communication needs of families. They described staff as "passionate and enthusiastic" and noted that the feedback from young people and carers who used the service, and from partners who work with the team, was "universally positive".

Dr Sara Munro
Chief Executive
January 2017

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: (0113) 247 4707

Report of Head of Governance and Scrutiny Support

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

Date: 24 January 2017

Subject: Leeds and York Partnership NHS Foundation Trust – Care Quality Commission Inspection Report and Action Plan

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

Summary of main issues

1. The purpose of this report is present the Care Quality Commission (CQC) inspection outcome report published in November 2016, in relation to Leeds and York Partnership NHS Foundation Trust, alongside the associated response and action plan from the Trust.

2. Appended to this report are the following documents:
   - The CQC Inspection report (published 18 November 2016);
   - A summary note from Leeds and York Partnership NHS Foundation Trust;
   - A summary of 'must do' regulatory requirements;
   - A summary of the Trust's service areas, rated against each inspection domain; and,
   - A summary action plan for 'must do' and 'should do' recommendations.

3. Appropriate senior representatives from the Trust have been invited to the meeting, alongside CQC representatives, to discuss the details of the information provided and address questions from members of the Scrutiny Board.

Recommendations

4. That the Scrutiny Board considers the details presented and agrees any specific scrutiny actions or activity that may be appropriate.

Background documents[1]

[1] The background documents listed in this section are available to download from the Council's website,

5. None.

Leeds and York Partnership NHS Foundation Trust

Quality Report

2150 Century Way,
Thorpe Park, Leeds,
West Yorkshire
LS15 8ZB
Tel: 0113 305 5000
Website: www.leedspft.nhs.uk

Date of inspection visit: 11 July – 15 July 2016
Date of publication: 18/11/2016

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	The Becklin Centre The Newsam Centre	RGDBL RGD03
Wards for older people with mental health problems	The Mount	RGD04
Long stay/rehabilitation wards for working age adults	Asket Centre The Newsam Centre	RGD10 RGD03
Forensic/Inpatient secure wards	Clifton House The Newsam Centre	RGDT5 RGD03
Wards for people with learning disabilities or autism	St Mary's Hospital Parkside Lodge	RGD05 RGDPL
Wards for children and young people with mental health problems	Mill Lodge	RGDY1
Mental health crisis services and health based places of safety	Trust Headquarters The Becklin Centre	RGD01 RGDBL
Integrated Community based mental health services for adults of working age and for older people	Trust Headquarters	RGD01
Community mental health services for people with learning disabilities or autism	Trust Headquarters	RGD01

Summary of findings

Specialist community mental health services for children and young people	Trust Headquarters	RGD01
Supported Living Service	St Mary's Hospital	RGD05
Yorkshire Centre for Psychological Medicine	Leeds General Infirmary	RGD08

This report describes our judgement of the quality of care at this provider. 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 people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

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

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of findings

Overall summary

We rated Leeds and York Partnership NHS Foundation Trust overall as Requires Improvement because:

- The trust did not have robust governance arrangements in place in relation to staff training, supervision and appraisal, medication management and audit, application of the Mental Capacity Act, systems and guidance to support the application of the Mental Health Act, the delivery of seclusion, restraint and rapid tranquilisation in line with the trust policy, accurate and contemporaneous records, the timely reporting of incidents, the crisis assessment unit's service provision, policies and procedures being sufficiently embedded. The trust did not have a systematic approach in place with regard to the documentation required to assure themselves, or the Care Quality Commission, that the directors met the fit and proper person requirement, regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- Systems and guidance were either not in place, not sufficiently embedded, or not operated effectively to ensure the delivery of safe and quality care. Incidents were not reported to the National Reporting and Learning System in a timely way and systems were not robust enough to ensure that incidents were reported to the trust from some services, including the supported living service and the forensic and secure inpatient services. The trust did not always meet its own targets or those agreed with the commissioners, for example the clustering targets. The trust did not return the data requested by the Care Quality Commission during the inspection in a timely way. Records were not always accurate and contemporaneous and did not always include all decisions about patient's care and treatment within their care record.
- The provider failed to ensure that all people receiving a service were protected from potential harm because the emergency equipment and medication checks were not sufficiently robust on some wards, including the inpatient wards for older adults and the long stay and rehabilitation wards, where items were out of date or missing and equipment like blood glucose testing meters were not being recalibrated. The trust compliance was low for training courses including essential life support, intermediate life support, and safeguarding children level two and three. The low compliance with essential and immediate life support meant that the service could not guarantee that all staff could respond to patients in a medical emergency.
- We had concerns about the management of medicines in some settings. Medicines across the trust were not being stored at the correct temperatures to remain effective. Staff in many of the clinical areas throughout the trust were not monitoring ambient room temperatures and where they were, temperatures were exceeding the room temperature recommended by the World Health Organisation guidelines. Staff in clinical areas were either not recording the fridge temperatures or not always taking action when temperature readings were outside of the required range. The internal audit systems were not always sufficiently robust to identify missed doses or other medication issues and errors in some services.
- The trust did not ensure that staff received appropriate training, supervision and appraisal. The trust had not met its target of 90% compliance for appraisals and some services had low compliance. The trust compliance for clinical supervision was low across the trust except for the mental health services for children and young people.
- Compliance in the mandatory level two Mental Health Act community and inpatient level two training was low and five teams or services had below 75% compliance in the Mental Capacity Act training, including Deprivation of Liberty Safeguards. The application of the Mental Capacity Act in some services was not in line with the trust policy or the Act and the trust did not always ensure that patients who did not have the capacity to consent to their care and treatment were detained using the appropriate legal authority such as by Deprivation of Liberty Safeguards. The systems and guidance in place did not fully support, or ensure, the application

of the Mental Health Act across the trust and the code of practice was not sufficiently embedded across all the services or detailed in the trust policies.

- Not all ward environments were safe or clean. There were concerns in relation to the trusts management of mixed sex environments and maintaining the patients' dignity and privacy at three of the inpatient services we visited including the Yorkshire Centre for Psychological Medicine, Two Woodland Square and the crisis assessment unit. We did not accept that the Yorkshire Centre for Psychological Medicine met the requirements of the Department of Health guidance on same sex accommodation (2010), or the Mental Health Act code of practice at the time of the inspection. The provider had outstanding actions on the trust's reducing restrictive interventions action plan and the use of seclusion; restraint and rapid tranquilisation were not always completed in line with the trust policy. In the community services systems were not in place in all services to manage risk effectively. This was in relation to supporting patients whilst they were on the waiting lists to access the service, managing the premises, and employing sufficient lone working systems to protect staff and patients. Also, there were delays above 20 weeks for patients to access some psychological therapies identified in the integrated community services for working age adults and older adults with mental health problems.

However:

- The community services that supported deaf and hearing impaired children and young people, as well as children and young people with mental health problems whose family had hearing impairments, was rated as an outstanding service.
- The trust was committed to improving and developing its services, using information from the local population and through working in partnership with the commissioners, other statutory, third-sector and voluntary organisations. Patient involvement appeared to be embedded in the trust's approach to shaping its services and informing care and treatment. It had a well-established service user network and involved patients in research projects, delivering training and recruitment.
- The trust had implemented a new recruitment strategy in 2016 and had implemented a number of measures to attract new staff to work in the trust. It had successfully recruited newly qualified and experienced staff through its recruitment events and its work with the universities, using values based recruitment. Whilst there continued to be regular use of bank and agency staff across the trust, the staff used were either substantive staff who worked extra shifts, or staff who worked regularly in particular areas but who chose not to take substantive posts to ensure the continuity of care for patients. Staff were respectful, caring and compassionate towards patients, relatives and carers and mindful of the best way to communicate with patients in order to support them.

  The trust did not own all the premises it delivered care or treatment from. It had identified this as one of its strategic risks and was committed to improving working arrangements with its private finance initiative partners and NHS Property Services Ltd, to improve response times for maintenance and repairs and the overall management of its estate. The trust had completed a significant amount of work in relation to the identification and removal or mitigation of ligature risks across all its wards and services. They had robust systems in place to assess, report and communicate any ligature risks, supported by the trust's ligature risk procedure.
- In the majority of services and teams, comprehensive assessments were completed using recognised assessment tools, care plans were holistic and person centred, risk was assessed and addressed. Staff produced different versions of care plans in accessible formats, for example in the community services for deaf children and adolescents and the community services for learning disabilities or autism. Care and treatment was delivered by a multidisciplinary team and was reviewed regularly. Patients told us that they were involved in their care and most of the patients spoken to during the inspection told us they could have a copy of the care plan if they wanted one.
- A range of information was available to patients in accessible and appropriate formats for the patients in the wards or services. The trust had a robust and

Summary of findings

effective complaints process and almost all the wards and services we visited during our inspection demonstrated a positive culture of reporting complaints and learning from complaints. Patients knew how to complain if they wanted to and were supported to do so.

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated Leeds and York Partnership NHS Foundation Trust as requires improvement for safe because:

- The emergency equipment and medication checks were not sufficiently robust on some wards, including the long stay and rehabilitation wards, where items were out of date or missing. Equipment like blood glucose testing meters were not being recalibrated.
- The trust could not provide assurance that medicines were being stored at the correct temperatures to remain effective. Staff in many of the clinical areas throughout the trust were not monitoring ambient room temperatures and where they were, temperatures were exceeding the room temperature recommended by the World Health Organisation guidelines. Staff in clinical areas were either not recording the fridge temperatures or not always taking action when temperature readings were outside of the required range.
- The trust compliance was low for mandatory training courses including essential life support, moving and handling advanced, food safety level two, fire level three, intermediate life support, safeguarding children level two and three. This placed patients at risk of receiving care that was unsafe. The low compliance with essential and immediate life support meant that the service could not guarantee that all staff could respond to patients in a medical emergency.
- The ligature cutters were not readily available for all staff in an emergency on the inpatient wards for people with learning disabilities or autism and the crisis service were kept in the locked medication room or clinic room.
- The wards for patients with learning disabilities or autism' including the respite services and the psychiatric intensive care unit, were not clean and maintenance issues had not been attended to. Infection control principles in these services were poor and compliance in a number of services across the trust for the mandatory infection control training was below 75%.
- There were concerns in relation to the trusts management of mixed sex environments and maintaining the patients' dignity and privacy at three of the inpatient services we visited including the Yorkshire Centre for Psychological Medicine, Two Woodland Square and the crisis assessment unit. We did not

accept that the Yorkshire Centre for Psychological Medicine met the requirements of the Department of Health guidance on same sex accommodation (2010), or the Mental Health Act code of practice at the time of the inspection.

- Concerns were identified in the seclusion facilities, the high dependency rooms and de-escalation rooms at the Newsam Centre, Mill Lodge and Parkside Lodge. Issues were identified with the local working protocols to support staff in their decisions to seclude patients and the rooms themselves did not fully meet the requirements of the Mental Health code of practice.
- Actions on the reducing restrictive interventions action plan remained outstanding. As such, restraint incidents, including prone restraint, remained high and the staff were not always operating within the trust policy. Staff on Parkside Lodge told us that they always used prone restraint to give medication via an injection when a patient refused it, which was not in line with the trust rapid tranquilisation policy.
- Blanket restrictions were identified in some inpatient services including the observation procedures on the acute wards and psychological intensive care unit and the routine searches following unescorted leave on the forensic and secure wards. A blanket restriction is a rule that applies to all patients on a ward and restricts their freedom regardless of individual risk assessments.
- Caseloads were high in the integrated community services for older age adults and working age adults with mental health problems and teams did not actively manage the risk for patients waiting to access the service. They relied on information from referring services, patients, relatives or carers to inform them of any escalating risk.
- In the community services for adults with mental health problems the lone working procedure could not always guarantee the safety of the staff.
- The timely reporting of incidents to the National Reporting and Learning System and the commissioners remained a risk for the trust and we identified that reporting incidents was a concern in both the supported living service and the forensic and secure inpatient services.

However:

- The trust was committed to improving its estates and response times and the management of its estate was included in its strategic objectives.

Summary of findings

- The trust had completed a significant amount of work in relation to the identification and removal or mitigation of ligature risks across many of its wards and services. They had robust systems in place to assess report and communicate any ligature risks, supported by the trust's ligature risk procedure. Wards had completed ligature risk and environmental audits and identified ligature points. Risk assessments were in place to mitigate these risks.
- Almost all wards and community services had either fixed call points or access to personal alarms to summon assistance in an emergency. Where alarms were not in place, the needs for these were mitigated.
- The senior executives and non-executive directors recognised staffing as one of the key risks for the organisation. The trust had implemented a successful recruitment strategy in 2016 to attract candidates and raise the profile of the organisation, including both experienced staff and newly qualified staff. The trust's recruitment plan targeted the roles and services where there was the highest number of vacancies. The trust also had a safer staffing task and finish group to lead on all issues related to safer staffing and dashboard including safer staffing figures was available at ward level.
- Whilst the use of bank and agency staff was high across the trust, bank staff were either substantive staff who worked extra shifts or staff who worked regularly in particular areas but who chose not to take substantive posts. This ensured a continuity of care for the patients.
- All wards and services reported good access to consultant psychiatrists, specialist doctors and junior doctors as required meeting the patients' needs in a timely way.
- Risk assessments were in place in all services and reviewed regularly at all services except the respite services.
- Although there was low compliance with safeguarding children training, staff were clear about the procedures to follow for both adult and child safeguarding and knew how to access safeguarding guidance.

Are services effective?

We rated Leeds and York Partnership NHS Foundation Trust as requires improvement for effective because:

Requires improvement

Summary of findings

- Care records in the respite services at Woodland Square for patients with a learning disability or autism had not been reviewed for significant periods and did not always identify the patients' needs whilst at the services. The care plans at these services did not always contain health action plans.
- Patient records were not always accurate and contemporaneous and did not include all decisions about patient's' care and treatment within their care record. The use of paper records as well as electronic records could cause confusion for the wider teams accessing the system, as the most up to date information may not be held in the central electronic record.
- The inpatient wards for older people with mental health problems did not use any standardised occupational therapy tools to measure interventions and outcomes. Staff in the crisis assessment unit were unclear of the National Institute of Health and Care Excellence guidance that would apply to the service.
- The internal audit systems were not always sufficiently robust to identify missed doses or other medication issues and errors were identified in the supported living service, on the inpatients wards for older people with mental health problems and the inpatient wards for patients with learning disabilities or autism.
- There were no robust systems in place to ensure that the physical health monitoring for antipsychotic medication was completed. There was a lack of clarity regarding who should take responsibility for ensuring that these physical health checks were completed.
- The trust average clinical supervision rate as of the 30 June 2016 was 70% and was below 50% in some services, including the Yorkshire Centre for Psychological Medicine, Parkside Lodge and Three Woodland Square and the inpatient wards for older adults with mental health problems.
- The appraisal rate for the trust as of the 30 June 2016 was 82% and did not meet the trust target of 90%.
- Compliance in the mandatory level two Mental Health Act community and inpatient level two training for the trust were also below 75%. Five teams or services had below 75% compliance in the Mental Capacity Act training, including Deprivation of Liberty Safeguards.
- We found that second opinion appointed doctors were not requested in a timely manner in some cases when the three

month rule was approaching. This means other authority, such as treatment in an emergency, needed to be used. Section 62 authorises treatment in an emergency and was used widely throughout the trust.

- We found some issues with the documenting of section 132 rights, including on the wards for older people and in the crisis and health based place of safety.
- We found delays in identifying errors with detention documents, despite the systems to receive and check Mental Health Act documentation and the internal audits to identify errors that were in place. This could result in patients being deprived of their liberty without the legal authority.
- Patients in the respite services for patients with learning disabilities and autism did not have capacity to consent to their respite care and treatment and were subject to continuous supervision and control and were not allowed to leave. The services had carried out capacity assessments but had not made applications for Deprivation of Liberty Safeguards. These safeguards are a lawful requirement to ensure the service upholds the human rights of patients. Staff on the acute wards and the wards for older people with mental health problems, were unclear about their responsibilities under the Mental Capacity Act and were not adhering to the trust policy.

However:

- In the majority of services and teams, comprehensive assessments were completed using recognised assessment tools and care plans were holistic and person-centred and were reviewed regularly.
- Staff followed guidelines from the National Institute of Health and Care and Excellence when providing care and treatment, including for prescribed medication and psychosocial interventions.
- There was a comprehensive audit programme across the trust and in the teams and services we inspected and the trust pharmacy team completed a number of medicines related audits to assess quality and to assist in the identification of areas for improvement.
- All teams consisted of a wide range of disciplines, included consultant psychiatrists and junior doctors, nurses and health

support workers, occupational therapists and regular input from pharmacy. Other professionals were engaged as required. Regular team meetings took place in all teams and services and all members of the multidisciplinary teams attended these.

- There were good examples of integrated partnership working and local partnership arrangements between the trust and other agencies, as well as between internal trust services.
- Staff and patients told us there was good access to independent mental health advocates.

Are services caring?

Good

We rated Leeds and York Partnership NHS Foundation Trust as good for caring because:

- Staff were respectful, caring and compassionate towards patients, relatives and carers. Patients, relatives and carers told us that staff were kind, visible and approachable.
- Staff were mindful of the best way to communicate with patients in order to support them. Communication was appropriate to the patients' level of understanding or appropriate to their age.
- We observed examples on the wards and during home visits where staff maintained patients' dignity, privacy and confidentiality. The trust scored higher than the England average on the patient led assessment of the care environment for privacy, dignity and well-being.
- Patients were orientated to all wards and services and were involved in decisions around their treatment and care. Where patients were unable to attend multidisciplinary meetings directly, their views and opinions were communicated in other ways.
- Patients told us that they were involved in their care plans and most of the patients we spoke with during the inspection told us they could have a copy of the care plan if they wanted one. Staff produced different versions of care plans in accessible formats, for example in the community services for deaf children and adolescents and the community services for learning disabilities or autism.
- We observed good examples of patient involvement in the service. Patients were involved in the central recruitment of staff and volunteers had been recruited in the intensive community services and the community services for working

age adults and older age adults with mental health to support and engage patients. A patient in the Leeds Autism Diagnostic Service was involved in the training videos to explain their experiences of living with autism.

- Staff supported patients to use advocacy services and the wards and services we inspected had established good links with adult advocacy services.
- Patients were able to feedback on the majority of wards through weekly community or forum meetings on the inpatient wards. Whilst staff, patients, relatives and carers all found collecting and providing feedback more of a challenge in the community services, there were some proactive initiatives to gain feedback in these services, including the use of electronic devices to gather patient experiences.

However:

- We heard patients detained with Ministry of Justice restrictions referred to in an appropriate way.
- On the inpatient wards for children and adolescents with mental health problems, the advocacy services offered by the trust were not specifically for children and adolescents.
- There were no patient meetings at the respite services for people with learning disabilities or autism. This meant that opportunities for patients to feedback about their stay were limited.

Are services responsive to people's needs?

Good

We rated Leeds and York Partnership NHS Foundation Trust as good for responsive because:

- The trust used information about the local population when planning and delivering services through working in partnership with the commissioners, other statutory, third-sector and voluntary organisations. These stakeholders told us that the trust was 'aspirational' and 'forward thinking' with regard to new ways of working to deliver care and treatment.
- Bed occupancy and high numbers of out of area placements for the trust had been identified as strategic risks by the trust and the trust had implemented a bed management improvement plan, including a number of initiatives like piloting the proactive purposeful admissions to inpatient care model. At the time of the inspection, the trust had nine patients placed out of area.

Summary of findings

- The trust worked proactively and in partnership with other organisations and community services at all levels to reduce the number of patients delayed in being discharged and the number of days that patients are delayed by.
- Information on the wards and services, other local services, patients' rights, access to advocacy, medicines and treatment and how to complain was observed in almost all services. The information was in appropriate and accessible formats, for example in child friendly formats in the mental health services for children and young people and in easy read formats in the services for people with learning disabilities or autism.
- Patients were able to personalise their bedrooms on the wards and in the respite services and were encouraged to do so. They had access to lockable storage.
- Patients on the wards were able to make phone calls in private.
- Patient's individual needs and preferences were central to the planning and delivery of treatment and care at the trust. Staff respected and provided support to meet the diverse needs of their patients including those related to disability, ethnicity, faith and sexual orientation. Staff in all the services we inspected were respectful of people's cultural and spiritual needs.
- Since the last CQC inspection in 2014, the trust committed to improving its response to the complaints it received. There was a robust and effective complaints process. Almost all the wards and services we visited during our inspection demonstrated a positive culture of reporting complaints and learning from complaints and had local arrangements to discuss these in their team meetings.

However:

- There were delays for patients in the community services for working age adults and older adults with mental health problem to access some psychological therapies. Patients waited for up to 20 weeks to receive psychological therapy from a psychologist.
- Parkside Lodge, the inpatient ward for people with learning disabilities and autism, had reduced bed occupancy due to staffing concerns and so a bed was not always available for the local population. There was no bed management strategy and the bed management procedure was at the early stages of discussions.

Summary of findings

- There was a lack of clarity of the current service provision in the crisis assessment unit at the time of the inspection. Patients were admitted who required treatment and not extended assessments, which the unit was not currently equipped for. Staff in the unit and in other trust wide services were unclear of the role of the crisis assessment unit, including the referral criteria.
- The crisis assessment service was not regularly meeting the four hour target for response times for crisis assessments.
- The Section 136 suite for children and young people was formerly the service's Section 136 suite for adults. Although the suite was designated for children and adolescents, we did not note any specific adaptations to make it a child-centred environment.
- Staff and carers raised concerns that patients at 2 Woodland Square were unable to attend activities that were not pre-planned and part of the patient's normal routine prior to attending the respite service. They told us that this was due to staffing levels, the lack of a mini-bus driver, and the lack of access to specially adapted transport. The trust told us that activities were available for all patients and that appropriate transport could be arranged
- Access to the outside space and the outside environment itself was a concern at The Mount and the Becklin Centre. Not all the wards at these sites had direct access to the gardens and outside areas and patients were unable to access these unescorted. The paths in the garden at The Mount where the wards for older adults with mental health problems were situated were gravel and therefore not ideal for patients with limited mobility and those who needed to use mobility aids. Patients were smoking in the hospital grounds and wards at the Becklin Centre. This put staff and patients at risk of the effects of passive smoking.
- There was limited choice on the inpatient wards for children and young people with mental health problems for patients' dietary requirements relating to their culture or religion, or to meet their preferences for food. Patients on these wards and the forensic wards told us that they did not like the food.

Are services well-led?

We rated Leeds and York Partnership NHS Foundation Trust as requires improvement for well-led because:

Requires improvement

Summary of findings

- The trust did not have robust governance arrangements in place in relation to staff training, supervision and appraisal, medication management and audit, application of the Mental Capacity Act, systems and guidance to support the application of the Mental Health Act, the delivery of seclusion, restraint and rapid tranquilisation in line with the trust policy, accurate and contemporaneous records, the timely reporting of incidents, the crisis assessment unit's service provision, policies and procedures being sufficiently embedded.
- Staff in some services and teams reported that senior managers were not always visible; including staff in the supported living service, the inpatients wards for older people and the respite services for people with learning disabilities or autism reported that this was not the case. Also, at the time of the inspection, the non-executive directors or the board of governors did not gain additional assurance from visiting the services discussed at board level.
- Senior managers told us that quality improvement methodology was not always applied consistently.
- The trust was unable to provide data requested during the inspection in a timely way and some of the data we received conflicted with previous data provided, and with the views of some clinical teams.
- The trust did not always meet its own targets and those agreed with the local commissioners, for example their own appraisal target and the required clustering targets agreed with commissioners.
- The trust did not have a systematic approach in place with regard to the documentation required to assure themselves, or the Care Quality Commission, that the directors met the fit and proper person requirement, regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- The trust had not updated all the polices following the updating of the Mental Health Act code of practice and there was no overall plan detailing how the trust was implementing the changes to the code. Senior management did not have a good understanding of which policies required updating or which one's had been reviewed and updated. This meant it was difficult for staff to know if their practice was in line with the revised code of practice and as such patients' rights may not be upheld.

However:

Summary of findings

- The trust had adapted their recruitment process to include values based recruitment and recently adapted the appraisal process to include the behavioural aspects that demonstrate the trust values. Most staff were aware of the trust's vision and values.
- The trust complied with the duty on public bodies to publish equality objectives. The objectives were developed collaboratively with the community and other stakeholders and priority actions were identified. The trust recognised that the experience of black minority ethnic staff members was an important challenge and had introduced a Workforce Race Equality Standard Ideas and Implementation Group and worked with the Yorkshire and Humber Equality and Diversity Leads Network to work collectively on priority areas for action and to share best practice.
- The trust worked proactively to address sickness and had introduced additional sources of support for the most common reasons for absence.
- The trust held an annual nursing conference, which offered development and networking opportunities for nursing staff across the trust. Staff achievements, linked to trust values were recognised through a monthly 'STAR' awards and an annual awards celebration.
- The trust was committed to working with people who use services to inform treatment and care and shape their services. It had a well-established service user network and involved patients in research projects.
- The trust participated in national audits and national quality improvement programmes in some of its services, including accreditation schemes and peer review. It was committed to research and the development of care and treatment and also worked in collaboration with the local universities to develop its workforce and to create training courses.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Phil Confue, Chief Executive of Cornwall Partnership NHS Foundation Trust

Head of Hospital Inspection: Nicholas Smith, Care Quality Commission

Team Leaders: Kate Gorse-Brightmore, Inspection Manager, mental health services, Care Quality Commission

The team included CQC inspectors and a variety of specialists: experts by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting, consultant psychiatrists, Mental Health Act reviewers, social workers, pharmacists, registered nurses (general, mental health and learning disability nurses), psychologists, occupational therapists and senior managers.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of 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?

Before the inspection visit the inspection team:

- Requested information from the trust and reviewed the information we received.
- Asked a range of other organisations for information including Monitor, NHS England, clinical commissioning groups, Healthwatch, Health Education England, Royal College of Psychiatrists, other professional bodies and user and carer groups.
- Sought feedback from patients and carers through attending 14 detained patient and carer groups and meetings.
- Received information from patients, carers and other groups through our website.

During the announced inspection visit from the 11 July to 15 July 2016 the inspection team:

- Visited 41 wards, teams and clinics.
- Spoke with 166 patients and 72 relatives and carers who were using the service.
- Collected feedback from 107 patients, carers and staff using comment cards.
- Spoke with more than 44 ward and team managers, modern matrons, community clinical managers or service managers.
- Spoke with more than 293 staff, including doctors, nurses, health support workers, consultant psychiatrists, dieticians, speech and language therapists, teachers, junior doctors, physiotherapists, psychologists, psychotherapists, occupational therapists, occupational assistants, student nurses, social workers, care co-ordinators, pharmacists and a pharmacist technician, independent mental health act advocates, administrators, administration support workers, healthy living workers and activity co-ordinators.
- Attended more than 19 focus groups attended by staff.
- Interviewed over 40 senior staff and board members.
- Attended and observed over 57 hand-over meetings, multidisciplinary meetings and reviews.
- Joined care professionals for 40 home visits, clinic appointments and observations.
- Looked at over 217 care and treatment records of patients.

Summary of findings

- Carried out a specific check of the medication management across a sample of wards and teams, including 141 medication charts and records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Requested and analysed further information from the trust to clarify what was found during the site visits.
- Observed a board meeting.

Information about the provider

Leeds Partnerships NHS Foundation Trust was awarded NHS foundation trust status on 1 August 2007. It merged with the mental health and learning disability services from NHS North Yorkshire and York on 1 February 2012, becoming Leeds and York Partnership NHS Foundation Trust.

As of 1 October 2015 the trust continue to provide specialist mental health and learning disability services in Leeds However, following a re-tender exercise the trust now only provide the specialist services in York, including forensic services and inpatient wards for children and young people with mental health problems. The remaining mental health and learning disability services in York are now delivered by Tees, Esk and Wear Valley NHS Foundation Trust.

The trust works closely with related organisations to provide effective, accessible and modern mental health and learning disability services.

The trust provides the following core service:

- Acute wards for adults of working age and psychiatric intensive care units.
- Long stay/rehabilitation mental health wards for working age adults.
- Forensic inpatient/secure wards.
- Wards for older people with mental health problems.
- Wards for people with learning disabilities or autism.
- Wards for children and young people with mental health problems.
- Mental health crisis services and health-based places of safety.
- Specialist community mental health services for children and young people.
- Community-based mental health services integrated for older people and adults of working age.
- Community mental health services for people with learning disabilities or autism.

In addition the trust also provides supported living services, eating disorder services, perinatal services, gender identity services and psychology and psychotherapy services. The trust delivers holistic care for people with complex medically unexplained symptoms and physical - psychological comorbidities at its Yorkshire Centre for Psychological Medicine. It also provides substance misuse services as part of the consortium Forward Leeds.

The trust delivers services from 39 locations and has 424 beds and has a turnover of £167 million. It employs a total of 2,547 substantive staff in both clinical and non-clinical support services. It also employs 465 bank staff.

As of the 1 June 2016, the trust had 10 active locations registered with the CQC, serving mental health and learning disability needs. These locations in Leeds include the Asket Centre, Parkside Lodge, St Mary's Hospital, The Becklin Centre, The Mount, The Newsam Centre, Trust Headquarters and the Yorkshire Centre for Psychological Medicine (previously known as Ward 40). The locations in York include Clifton House and Mill Lodge.

The trust had a comprehensive inspection between 30 September and 2 October 2014 where it was rated as 'requires improvement' overall. In this inspection, four of the five domains were deemed as 'requires improvement'. These were safe, effective, responsive and well led with caring rated as good. We issued 21 compliance actions in the inspection against seven locations. The provider took steps to respond to these actions. However, as of the 27 June 2016, there were still a number of actions that were only partially complete, including the trust achieving its own target for mandatory training and appraisal, the relocation of the Yorkshire Centre for Psychological Medicine and the final agreement of the contract with local clinical commissioning group to ensure that patients in the low secure setting have timely access to a GP.

Leeds and York Partnership NHS Foundation Trust has had 17 Mental Health Act reviewer visits between 1 June 2015 and 1June 2016, of which all were unannounced. The main issues highlighted were in the 'purpose, respect

Summary of findings

participation, least restrictive' category. This had 16 issues and equated to 33% of the total concerns. This category included concerns that the care plans were not completed in collaboration with the patient and did not reflect the patients' goals or views and patients were unsure of their rights and these were not been repeated on a regular basis. Concerns were highlighted in the 'leave of absence domain' with eight issues highlighted. This was 16% of the total concerns. Three quarters of the issues in this domain attributed to section 17 leave forms not being completed to evidence of the patient and relevant others had been given a copy of their form. Ward one at the Becklin Centre (the acute ward) and ward one at the Newsam Centre (psychiatric intensive care unit) had the most issues in a single visit, with five each.

What people who use the provider's services say

We received 107 comments cards during the inspection, of which 28 were positive and 15 were negative. The positive comments from patients we received included feedback that staff were nice, kind, helpful and go that extra mile. Patients felt that they were treated with dignity and respect. They said that service was good and the environment was safe. Patients also said that the food was good. Negative feedback on the comment cards included patients feeling too restricted, that medication was not always available and that patients were smoking on the wards.

We spoke with over 166 patients and 72 relatives and carers. On the whole feedback was positive from patients, relatives and carers.

Patients told us that the treatment and care they received was good and that they felt safe in the services and on the inpatient wards. They told us that they felt involved in the decisions about their care and treatment and their recovery, including any changes. Patients told us that they were aware of their care plan and were offered copies. Most patients thought the food was good. Patients knew how to complain and would feel comfortable approaching staff to do so.

Patients, relatives and carers told us that staff were supportive and empathic. They said that staff were approachable and kind and treated them with dignity and respect. They said that staff took the time to listen to them and were calm in a crisis or a difficult situation. Patients told us that staff were flexible in their approach, considered their opinions, thoughts and feelings and aimed to support them in the best way that suited them.

Carers were generally complimentary about the staff and the wards and services. They said that wards and teams worked closely to support families as well as patients. They told us that staff included them in decisions about their care and treatment. Patients and carers told us they could contact the team or ward and speak to staff promptly. Some carers confirmed that they were involved in the patient treatment decisions and care plans, received copies of care plans, as well as any information requested. Relatives and carers said that they felt their family member was safe and received high quality care. They also felt that they were supported with and involved in, their family member's discharge from treatment.

There was some negative feedback from patient and carers, which was specific to individual services, relating to food, staffing at night, involvement in leave decisions and transport for patients to activities.

Good practice

- The Leeds autism diagnostic service completed assessments and diagnosis for some patients in additional languages. Where patients' spoken language was not English the teams had completed assessments in the language spoken by the patient. Staff had completed assessments in Shona and Persian to accommodate the needs of patients as an alternative to using interpreter services.

Summary of findings

- The Yorkshire Centre for Psychological Medicine won a trust award for improving health and improving lives in 2015. The service was a very good example of how positive outcomes can be achieved using the bio-psychosocial model.
- The rehabilitation and long stay inpatient wards for people with mental health problems had introduced individual digital tablets to patients. The tablets contained an 'I' motif and allowed patients to take more control over their care through a platform that enabled communication with their clinician. This was launched in January 2016 and each patient could keep the tablet they used. They could also use it for the internet as Wi-Fi was available. This meant the patient could keep in touch with their friends and family.
- A Person Centred Recovery course has been developed in collaboration with Leeds Beckett University. Clinicians from the service deliver this training. It is open and free of charge to employees of the trust and their partner organisations. Patients are helping deliver this training.
- Staff were able to access a personal health budget to manage the health of the inpatients on the rehabilitation and long stay wards for people with mental health problems. This is a pilot and involvement is agreed as part of the multidisciplinary team. As an example, a patient with self-esteem issues due to their appearance was able to access this money to get some dentistry work done to their teeth.
- The rehabilitation and long stay inpatient services for people with mental health problems was involved in a Photo Elicitation Research Project. Once a participant has been assessed and accepted in to the research group, they were encouraged to take photographs to help them express their experience of being a patient. The aim of the research was to improve the understanding of the experience of the patient
- The culture within the community mental health services for deaf children and young people was to deliver research-based practice to young people and their families. The teams used their meetings to reflect on their practice in ways that fed into service development. Team members spoke of feeling valued and being proud to work within the specialist service that had a culture that encouraged all staff to work together and further develop expertise.
- Team members in the community mental health services for deaf children and young people consistently tailored interventions to meet the communication needs of young people and their families. This meant the development of bespoke care tools for individual sessions. Service information contained quick response codes (machine-readable codes consisting of an array of black and white squares, used for storing information) that allowed documents to be scanned into smartphones enabling access to British sign language.
- The community mental health service for children and young people were embedded in the deaf communities it served with links that were both professional and social. This had broken down barriers and reduced stigma for deaf users of the child and adolescent mental health teams. Supervision and support were available to and accessed by all staff in these services, including the freelance interpreters who worked with the teams.
- The forensic and secure services for people with mental health problems at Clifton House engaged in a peer review of its services, which was published in Royal College of Psychiatrists Quality Network for Forensic Mental Health services in March 2016. They also undertook a clinical service review of Rose ward and had implemented an action plan to improve its services for women with personality disorder.
- The trust had implemented a pilot project using the 'purposeful admissions to inpatient care' model on the acute wards for adults with mental health problems. This meant that staff regularly monitored the patient journey. The 'purposeful admissions to inpatient care' reduced the time staff needed to spend in the multidisciplinary process therefore freeing up time to spend with patients.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the governance systems are established to assess, monitor, and improve the quality and safety of the service, and manage risk, operate effectively and are embedded in the service.
- The provider must ensure that the systems and processes in place with regard to the documentation that confirms that the directors meet the fit and proper person requirement, regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014, provides assurance to themselves and the Care Quality Commission.
- The provider must ensure all its services comply with the Department of Health guidance on same sex accommodation and the code of practice.
- The provider must ensure that incidents are identified and reported in teams and services across the trust and that the systems are in place to enable them to do so.
- The provider must ensure that they respond to requests for information from the Care Quality Commission and report all incidents to the national reporting and monitoring systems, in a timely way.
- The provider must ensure that records are accurate and contemporaneous, including all decisions about patient's care and treatment within their care record.
- The provider must ensure that the emergency equipment and medication checks are sufficiently robust to ensure that equipment for providing care and treatment is safe for use and are in sufficient quantities to ensure the safety of service users and meet their needs.
- The provider must ensure that they monitor fridge and ambient room temperatures and ensure that medicines are stored at the correct temperatures to remain effective.
- The provider must ensure that physical health monitoring of antipsychotic medication is completed in line with the National Institute of Health and Care Excellence guidelines and clarify responsibilities.
- The provider must ensure that all staff have sufficient training, supervision and appraisal to enable them to carry out their role.
- The provider must ensure internal medication audit systems are sufficiently robust.
- The provider must ensure staff have a good understanding of the Mental Capacity Act and their responsibilities under the Act and those patients are detained using the appropriate legal authority such as by Deprivation of Liberty Safeguards.
- The provider must ensure that the systems and guidance in place supports the application of the Mental Health Act and ensures that the code of practice is sufficiently embedded across all the services and detailed in the trust policies.

Action the provider SHOULD take to improve

- The provider should ensure that the outstanding actions on the trust's reducing restrictive interventions action plan are addressed and that the use of seclusion, restraint and rapid tranquilisation are in line with the trust policy.
- The provider should ensure that they continue to build on the existing work completed to continue to reduce bed occupancies and out of area placements.
- The provider should ensure that patients have a choice of meals that meet their dietary requirements and take into account cultural and individual preferences.
- The provider should ensure that patients have access to advocacy that is relevant to their specific requirements.
- The provider should ensure that the community services have systems in place to manage risk effectively with regard to supporting patients whilst they are on the waiting list, managing the premises, and employing sufficient lone working systems to protect staff and patients.
- The provider should ensure all patients receive psychological therapies in a timely manner and within national guidelines.

Summary of findings

- The provider should ensure that all inpatient wards are clean and that ligature cutters are easily accessible in an emergency.
- The trust should consider privacy and dignity with regards to gender of patient in all its services including the section 136 suite and crisis assessment unit, and the respite services.

Leeds and York Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983.We use our findings as a determiner in reaching an overall judgement about the Provider.

- The trust compliance for the mandatory training in the Mental Health Act level level one and two overall was 76%. At service level training compliance ranged and ranged from 41% in wards for older people to 89% in specialist community deaf child and adolescent mental health service. However, staff generally understood their responsibilities under the Mental Health Act and how it related to their service.
- The trust had a central Mental Health Act legislation team based at the Beklin Centre who provided support for Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards to the wards and community. The team supported training, detention documentation and advice.
- The revised Mental health Act code of practice came into effect in April 2015.The trust had not updated all of its polices in relation to the updated Mental Health Act code of practice and there was no overall plan detailing how the trust was implementing the changes to the code.
- Consent to treatment under the Mental Health Act was generally well documented in the patients' records except for some inpatient wards where capacity to consent to treatment assessments and treatment certificates were not fully completed. This meant that the patients' capacity and consent to treatment and was not clear and treatment may be given without the appropriate consent.
- Second opinion appointed doctors were not requested in a timely manner in some cases when the three month rule was approaching. The trust had not implemented a system to monitor the use of section 62 authorisation.
- Rights under the Mental Health Act were explained to patients on admission and revisited when required at regular intervals. There were also information leaflets available in easy read and other languages, which staff used. We found some gaps in the documenting of this process.
- We saw evidence that patients had access to appeals against their detention.
- Staff and patients told us there was good access to independent mental health advocates and patients were able to refer themselves or be referred by staff.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Compliance for the mandatory training on the Mental Capacity Act and Deprivation of Liberty Safeguards was 76%. We had concerns that five teams or services had below 75% compliance in the Mental Capacity Act training, including Deprivation of Liberty Safeguards, including the wards for older adults with a mental

health problem which had a compliance of 43% for this training. Staff understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards and their use in practice was variable in the core services..

- The trust had a central mental health legislation office which staff contacted for advice and guidance in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards. However, advice from the office was not always followed by clinical staff and the office found it difficult to address this with senior management.
- The trust had a Mental Capacity Act 2005 protocol which had recently been updated to include procedural changes in the trust and described recording of capacity and best interest decisions. We found little evidence that capacity assessments and best interest decisions were being completed in most of the core services, or evidence of attempts to support people to make a specific decision for themselves before they were assumed to lack the mental capacity to make it, which meant we could not ensure the Act was being used correctly.
- The trust had a Deprivation of Liberty Safeguards protocol which was due to be reviewed in June 2016. The protocol gave details of deprivation of liberty, how to apply for an authorisation and how this was managed in the trust. However, some patients were subject to continuous supervision and control and were not allowed to leave but had no authorisation for detention in place.
- Both Mental Capacity Act and Deprivation of liberty protocols had audit requirements
- The trust information for Deprivation of Liberty Safeguards applications showed they had made 13 Deprivation of Liberty Safeguards applications between 1 October 2015 and 31 March 2016.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We rated Leeds and York Partnership NHS Foundation Trust as requires improvement for safe because:

- The emergency equipment and medication checks were not sufficiently robust on some wards, including the long stay and rehabilitation wards, where items were out of date or missing. Equipment like blood glucose testing meters were not being recalibrated.
- The trust could not provide assurance that medicines were being stored at the correct temperatures to remain effective. Staff in many of the clinical areas throughout the trust were not monitoring ambient room temperatures and where they were, temperatures were exceeding the room temperature recommended by the World Health Organisation guidelines. Staff in clinical areas were either not recording the fridge temperatures or not always taking action when temperature readings were outside of the required range.
- The trust compliance was low for mandatory training courses including essential life support, moving and handling advanced, food safety level two, fire level three, intermediate life support, safeguarding children level two and three. This placed patients at risk of receiving care that was unsafe. The low compliance with essential and immediate life support meant that the service could not guarantee that all staff could respond to patients in a medical emergency.
- The ligature cutters were not readily available for all staff in an emergency on the inpatient wards for people with learning disabilities or autism and the crisis service were kept in the locked medication room or clinic room.
- The wards for patients with learning disabilities or autism' including the respite services and the psychiatric intensive care unit, were not clean and maintenance issues had not been attended to. Infection control principles in these services were poor and compliance in a number of services across the trust for the mandatory infection control training was below 75%.
- There were concerns in relation to the trusts management of mixed sex environments and maintaining the patients' dignity and privacy at three of the inpatient services we visited including the Yorkshire Centre for Psychological Medicine, Two Woodland Square and the crisis assessment unit. We did not accept that the Yorkshire Centre for Psychological Medicine met the requirements of the Department of Health guidance on same sex accommodation (2010), or the Mental Health Act code of practice at the time of the inspection.
- Concerns were identified in the seclusion facilities, the high dependency rooms and de-escalation rooms at the Newsam Centre, Mill Lodge and Parkside Lodge. Issues were identified with the local working protocols to support staff in their decisions to seclude patients and the rooms themselves did not fully meet the requirements of the Mental Health code of practice.
- Actions on the reducing restrictive interventions action plan remained outstanding. As such, restraint incidents, including prone restraint, remained high and the staff were not always operating within the trust policy. Staff on Parkside Lodge told us that they always used prone restraint to give medication via an injection when a patient refused it, which was not in line with the trust rapid tranquilisation policy.
- Blanket restrictions were identified in some inpatient services including the observation procedures on the acute wards and psychological intensive care unit and the routine searches following unescorted leave

on the forensic and secure wards. A blanket restriction is a rule that applies to all patients on a ward and restricts their freedom regardless of individual risk assessments.

- Caseloads were high in the integrated community services for older age adults and working age adults with mental health problems and teams did not actively manage the risk for patients waiting to access the service. They relied on information from referring services, patients, relatives or carers to inform them of any escalating risk.
- In the community services for adults with mental health problems the lone working procedure could not always guarantee the safety of the staff.
- The timely reporting of incidents to the National Reporting and Learning System and the commissioners remained a risk for the trust and we identified that reporting incidents was a concern in both the supported living service and the forensic and secure inpatient services.

However:

- The trust was committed to improving its estates and response times and the management of its estate was included in its strategic objectives.
- The trust had completed a significant amount of work in relation to the identification and removal or mitigation of ligature risks across many of its wards and services. They had robust systems in place to assess report and communicate any ligature risks, supported by the trust's ligature risk procedure. Wards had completed ligature risk and environmental audits and identified ligature points. Risk assessments were in place to mitigate these risks.
- Almost all wards and community services had either fixed call points or access to personal alarms to summon assistance in an emergency. Where alarms were not in place, the needs for these were mitigated.
- The senior executives and non-executive directors recognised staffing as one of the key risks for the organisation. The trust had implemented a successful recruitment strategy in 2016 to attract candidates and raise the profile of the organisation, including both experienced staff and newly qualified staff. The trust's recruitment plan targeted the roles and services where there was the highest number of vacancies. The trust also had a safer staffing task and finish group to lead on all issues related to safer staffing and dashboard including safer staffing figures was available at ward level.
- Whilst the use of bank and agency staff was high across the trust, bank staff were either substantive staff who worked extra shifts or staff who worked regularly in particular areas but who chose not to take substantive posts. This ensured a continuity of care for the patients.
- All wards and services reported good access to consultant psychiatrists, specialist doctors and junior doctors as required meeting the patients' needs in a timely way.
- Risk assessments were in place in all services and reviewed regularly at all services except the respite services.
- Although there was low compliance with safeguarding children training, staff were clear about the procedures to follow for both adult and child safeguarding and knew how to access safeguarding guidance.

Our findings

Safe and clean care environments

The trust addressed the management of its estate in its strategic objectives that underpin the trust's overall strategy 2013 to 2018. The trust acknowledged several risks with regard to its estate, including the provision of services from premises that it did not directly own which resulted in delays in responses to maintenance requests or environmental changes. The trust was working to resolve these or identify a more efficient way forward, including formal partnerships working with its private finance initiative partners, improved working arrangements with NHS Property Services Ltd. An Estates Strategy Steering group reviewed all the processes linked to reactive and

planned maintenance, including ligature assessment process and change request processes. The trust had undertaken 12 environmental projects in the last 18 months. We observed the trust's estates action plans, as well as meeting minutes that demonstrated the trust's commitment and insistence with its private finance partners and NHS property services to improve its estates and response times.

Following the 2014 CQC inspection, the trust reviewed its approach to the management of ligature risks and over the past 18 months had developed a new procedure through joint work between Care Services, the Risk Management team and the Estates and Facilities team. All clinical environments had completed ligature risk assessments in accordance with the trust's procedure and standards. The oversight of the ligature risk assessment process was led by the matrons and clinical service managers, supported by a monthly operational trust-wide clinical environments group. The clinical environments group reported to the estates strategy steering group.

A significant amount of work had been undertaken across the clinical areas and a number of larger refurbishment programmes were ongoing. The trust told us that they had also significantly focussed on ensuring that the identified local risks had mitigating action and were known to the clinical teams within each clinical area through the use of the risk register process and local team communication systems.

As such, ligature risk and environmental audits were in place and in date on all wards we visited. All wards had identified ligature points and risk assessments were in place to mitigate these risks. Where ligature risks remained, these were identified on the trust risk register. A ligature point is a place where a patient intent on self-harming might tie something to in an attempt to strangle them self. However, we were concerned that there were ligature risks in both communal bathrooms at Parkside Lodge and no viewing point for staff. This meant that staff would need to remain in the bathroom while patients were using it, or that staff would need to keep the door open. This presented an issue with privacy and dignity for patients. Also at Woodside Square, Parkside Lodge and the crisis service, the ligature cutters were kept in the locked medication room or clinic room and so were not readily available to all staff in an emergency.

The Patient Led Assessment of the Care Environment (PLACE) 2015 score for Leeds and York Partnership NHS Foundation Trust is 97%. This figure is 2% above the national. The Mount scored the highest for cleanliness with 100%. Three locations scored below the national average including Asket House (now included in the Asket Centre), Clifton House and the Becklin Centre. The Becklin Centre scored the lowest of all the trust locations with 92% for cleanliness.

Most of the wards and services we visited were clean and well maintained. We observed health and safety checks and action identified to correct any issues identified. Where some furnishings were tired, the trust, for example at the Newsam Centre, the Yorkshire Centre for Psychological Medicine and in some of the community services. The trust confirmed that they were currently completing a programme of refurbishment. The majority of wards and services adhered to infection control principles including hand washing, maintaining cleaning schedules and records and having personal protective equipment readily available.

However, we had concerns around the cleanliness of the psychiatric intensive care unit at the Newsam Centre, where the flooring on the corridors was unclean even despite the cleaning contractors having cleaned the floors on the morning of our inspection. Some toilets required further cleaning and there were areas of staining that had been present for some time. Bathroom tiles were stained, as were some of the shower curtains.

There were also concerns around the cleanliness of the wards for patients with learning disabilities or autism. At Parkside Lodge, some of the ward areas were not clean. In the female communal bathroom, the flooring was stained and the shower hose was dirty. In bedroom three on the male corridor, the window frame on the door was broken and staff had held it together with medical tape. At Three Woodland Square the ward was not safe because infection control practices were poor. There was mould on the base of the shower in the communal bathroom and the shower curtain was dirty. The bathroom light did not have a long enough pull string and staff had tied a plastic balloon rod to it. The manager had reported these problems to the estates department but the service had not dealt with them. The staff replaced the shower curtain during our visit. We saw that decoration throughout both sides of the ward was tired, as was the furniture. Similarly at Two

Woodland Square, staff kept coats and lockers in the communal patient bathroom. We found three mattresses stored in the bathroom. Staff told us that this was because the building did not have enough storage space. When things are not stored correctly, it increases the chance of the spread of infection. This risk was high for this patient group due to their complex health needs. The trust completed an infection control audit in May 2016 and there were outstanding issues from this audit on our visit. Staff told us that they completed a deep clean of every bedroom after each patient left, however cleaning records were not available to confirm this. Infection control training was mandatory and compliance was variable across wards and service. For example, compliance was below 75% in the crisis assessment unit and the intensive community service, Three Woodland Square, as well as the Yorkshire Centre for Psychological Medicine and the supported living service.

The trust had a number of wards that had mixed sex accommodation. We had some concerns in relation to the trusts management of mixed sex environments and maintaining the patients' dignity and privacy at three of the inpatient services we visited including the Yorkshire Centre for Psychological Medicine, Two Woodland Square and the crisis assessment unit. The Yorkshire Centre for Psychological Medicine provided mixed sex accommodation for seven females and one male on the day of the inspection. Bedrooms for males and females were not en suite and situated on either side of a long corridor. Patients did not have segregated bathroom facilities and would have to pass through areas occupied by the opposite sex to reach their bathroom facilities. We were told that, following discussions with the local Clinical Commissioning Group and an internal review in May 2016, instructions were developed to manage the bathroom requirements and to ensure that there were always staff in the vicinity to offer added protection. Nevertheless, and contrary to the trust's own assessment, we do not accept that such arrangements meet the requirements of the Department of Health guidance on same sex accommodation (2010), or the Mental Health Act code of practice. At Two Woodside Square the male and female bedrooms were on the same corridor, there was a mixed sex communal bathroom and the service did not have a female only lounge. In addition, during our feedback to the trust we raised concerns that the crisis assessment unit was not fully compliant with this guidance or the code of practice as on two of the occasions we visited the crisis assessment unit we noticed that the door separating the male and female sections of the unit was left open. Staff told us this was for ease of access and so male patients could access the staff in the nurse's office. However it meant that there was potential for male patients to be in the female section of the corridor as female patients accessed the toilet and shower facilities. The trust responded and showed us a local operating procedure that demonstrated the door being shut was the normal operating procedure, with this being open when only patients of the same sex were on the ward. The trust operating procedure did not match what was happening locally in the service, which was the opposite. The section 136 suite did not have bathrooms designated specifically male and female and patients had to walk past bedrooms to access bathrooms.

The trust did not have seclusion facilities on all the inpatient wards that we visited. Of the seclusion facilities we observed, we identified a concern for the forensic services at the Newsam Centre. The seclusion room for female patients was situated on a male ward and there was no local protocol in place to support staff in making decisions around secluding female patients to ensure their dignity was maintained whilst escorting them to this seclusion room.

We also identified a number of concerns with the seclusion room at the Newsam Centre for the forensic wards. The patients could not see a clock and as a result may not be orientated to time, the intercom functioned but with significant interference that made communication difficult. The de-escalation room was adjacent to seclusion and they could not be in use at the same time. Similarly, there was no clock in the high dependency room used at Mill Lodge, the inpatient service for children and young people with mental health problems, as required by the Mental Health Code of Practice.

Parkside Lodge, an inpatient ward for patients with a learning disability or autism, had a seclusion room that the trust had re-fitted following concerns raised at our previous visits. This seclusion room did not meet all seclusion guidance from the Mental Health Act Code of Practice. The door was not wide enough to bring a patient safely into the room in restraint holds, which increased the risk of injury to staff and patients. The room had a communication system, but this was not two-way. Staff could speak to patients

through the system, but patients could not reply. The room had no natural light and no access to fresh air. There was also a de-escalation room at Parkside Lodge, which staff used with patients as a less restrictive environment than seclusion when they needed to spend time away from the ward. The room was sparse and was not a therapeutic environment for patients, as it did not contain activities or relaxation equipment. Staff told us that this was because patients could use the equipment for self-harm, but this was not individually risk assessed for patients. The only item in the room was a plastic couch and it looked like a second seclusion room. There was a glass panel in the door and the room was in the middle of the corridor between the male and female bedrooms so other patients could see in the de-escalation room.

All wards and community services had emergency alarm provision: either fixed service alarms, access to personal alarms, or both. Where alarms were not in place, the need for these were mitigated, except at two Woodside Square where there were no alarms and the service had not considered the use of the alarm in a medical emergency. This may have been beneficial to the patient group whom the service supports.

The clinic rooms we observed were fully equipped locked clinic rooms which contained a medicines fridge, resuscitation equipment, emergency drugs and a 'grab bag'. A grab bag is a small, accessible bag which contains emergency equipment for first aid. The acute ward areas had access to oxygen cylinders and we saw that there were 'flammable' signs on doors where oxygen was stored. Some clinic rooms did not have an examination couch and these services used the patient's rooms, like the crisis assessment unit.

Emergency equipment and medication was checked regularly to ensure that they were fit for use and in sufficient supply. These checks were not sufficiently robust on the long stay rehabilitation service, the wards for older people with mental health problems, where there was out of date items like oxygen and dressings, half full oxygen cylinders, missing items that either had not been identified, or identified but no action taken and equipment like blood pressure monitors that had not been recalibrated since September 2015. We also found some areas were not calibrating the blood glucose testing meters and that some of the control solution to do this was out of date. This meant that the trust could not provide assurance of accurate results when conducting blood glucose tests for diabetic patients. However, we did not identify any patients that this could have affected during this inspection.

Safe staffing

The executive directors and the non-executive directors that we spoke to during the inspection all stated staffing as one of the key risks for the organisation. This included both staffing levels, as well as the skills staff required to deliver the models of care. The senior managers spoke with clarity about the staffing issues and where they were most prevalent, the rationale for these issues and the trust response to them.

The trust had implemented a new recruitment strategy in 2016. It focussed on three areas: to improve the trust recruitment process, to improve the trust profile to attract candidates using social media and other recruitment platforms and for the trust to develop partnerships with universities, colleges and other partners. Initially the recruitment plan supported by the executive team targeted the areas where there were the greatest number of vacancies, including band 5 and 6 nurses and band 3 health support workers. Using NHS job sites and social media, the trust held two recruitment events in January and April this year, using an assessment centre approach. The trust had worked in partnership with the local universities to recruit newly qualified nurses. At the time of the inspection the trust had recruited 143 clinical staff, including 105 qualified nurses and 38 health support workers. The trust recruited the nurses in volume and then allocated the nurses and health assistants to the wards and services were the demand at the time was the greatest, rather than recruiting to specific services. The trust had additional recruitment events planned and have been using real life stories and media to support their recruitment campaign. In an attempt to retain staff the trust had introduced enhanced preceptorship and talent management programmes to support front-line staff and to attract new staff. In this way the strategy was successful at recruiting new staff during a period where nationally recruitment of qualified nurses is challenging. Some of the staff criticisms regarding this recruitment were that the trust had only held recruitment events in Leeds and not in York so nurses and health support workers local to these York services may not have the same opportunities to attend the events. Also, managers in some of the local

services felt that they had no input on the staff that were being recruited to their services and were concerned that some of the staff recruited did not have the enthusiasm or the skills for the specific specialisms required on certain wards.

Full details about the trust staffing levels were reported to the public meetings of the trust Board of Directors and also made it accessible to the public via NHS Choices as required nationally. The trust also displayed planned and actual staffing levels on each ward at the start of every shift. The Director of Nursing completed the nationally required six month staffing review. This review was due for completion in July 2016. The trust had also developed weekly dashboards for staffing, with the aim of triangulating patient safety data to understand the impact of staffing on patient safety and experience in the future. The trust also had a safer staffing task and finish group to lead on all issues related to safer staffing. This was led by the Assistant Director of Nursing with the Director of Nursing, with support from the workforce planning and operational managers and the Professor of Mental Health Nursing from the University of Leeds. Current trust staffing levels had been agreed with the Director of Nursing and wards had been budgeted to staff to these level, with guidance in place for wards which sets shift patterns and minimum staffing levels for these shifts. However, the task and finish group identified six pilot areas to test and trial changes to staffing ratios and levels to determine their effectiveness and had developed a tool which is being used to scrutinise use of local staffing against defined criteria and measures. These measures include skill mix, newly qualified mix, bank and agency hours, vacancy factor and budgets. Further work is on-going to refine this tool, with the trust contributing to the wider Yorkshire and Humber safer staffing work stream for mental health. These measures were routinely reported to the Trust Board, as well as detailed exception reports for each of the inpatient wards against planned and actual staffing. As part of the inspection, we attended a board of directors meeting and observed this exception reporting. The Director of Nursing presented the findings, including whether the wards met the safer staffing requirements and how this was mitigated. For example, concerns were reported on the acute inpatient female wards at the Becklin Centre and the learning disability acute assessment and treatment wards at Parkside Lodge. This reporting allowed the trust to identify where the staff were required to be deployed following the recruitment events and so eight staff for example were being employed in stages to Parkside Lodge.

As of the 30 June 2016, he trust employed 2,546 substantive staff. This included 842 whole time equivalent qualified nurses and 661 whole time equivalent health support workers. At the time of the inspection, the trust also employed 67 consultant psychiatrists, 119 doctors, 175 allied health professionals, 25 pharmacists, 21 psychotherapists and 76 psychologists.

The total number of substantive staff leavers between the 1 April 2016 and the 30 June 2016 was 69, which was 3% of the workforce. The total number of vacancies overall in the trust, excluding seconded staff, was 9%. The number of whole time equivalent vacancies for qualified nurses was 145 and the number of whole time equivalent nursing assistants was 78. The forensic and secure inpatient wards had the highest qualified nurse vacancy rate for the trust of 20% and have a nursing assistant vacancy rate above the trust average of 6%. The acute wards and psychiatric intensive care unit had the highest qualified nurse vacancy rate with 17% and adult social care had the highest nursing assistant vacancy rate of 46%.

The permanent staff sickness rate was 5%.

The trust calculated the use of bank and agency staff use, including those staff used that was in excess of the budgeted establishment. Bank and agency staff were used to cover vacancies, sickness and other leave, increased levels of acuity and for increased engagement and observation. The number of shifts filled by bank and agency staff in the last three months was 2,780. Two hundred and twenty-four shifts were not covered in the same time period. Adult social care services had the highest total number of shifts filled by bank or agency staff to cover sickness, absence or vacancies with 2170. They also had the highest number of shifts not filled with 138. The forensic and secure inpatient wards had the second highest total number of shifts filled by bank and agency with 1582. They also had the second highest number of shifts not filled by bank and agency staff with 120.

The trust acknowledged that they used bank and agency staff on a regular basis. They told us that many bank staff were either substantive staff who worked extra shifts or staff who worked regularly in particular areas but who

chose not to take substantive posts. This was corroborated by the trust's analysis of bank and agency staff that the use of staff who work less than an average of 15 hours per week over a three-month period did not go above 10% for any inpatient ward. However, there were some comments from patients on the inpatient wards for children and young people with a mental health problem that they were not always familiar with the staff who were covering the shifts at night. Also, during the focus group at the same service, it was noted that the staff were not familiar with the needs of one of the patients who required additional support.

In response to the high use of bank and agency staff, the trust had recently employed a lead nurse with the responsibility for ensuring that bank and agency staff received the same levels of support and supervision as substantive staff. Bank staff were also expected to have completed appropriate compulsory training. Both bank and agency staff received a local induction in the areas in which they worked. This included information on local working practices.

There was adequate medical cover across the trust, despite some vacancies identified. All wards and services reported good access to consultant psychiatrists, specialist doctors and junior doctors as required meeting the patients' needs in a timely way.

The trust had difficulties in recruiting pharmacists at band 7 and band 8a levels. In response the trust had created split band 7 posts with the local Clinical Commissioning Group to try to help with this. The Chief Pharmacist chaired a collaborative work force group, which included staff from the local acute trusts and the local Clinical Commissioning Groups. They were in the process of developing a proposal to ensure long-term sustainability of pharmacists by offering a three-year rotational programme for band 6 and band 7 pharmacists.

In the community services for people with learning disabilities or autism, the average caseload across the three community learning disability teams was 18. The average caseload for the service as a whole in the period January to June 2016 in the intensive community service was 25 patients and at the time of the inspection staff felt that this was manageable.

However, in the integrated community services for older age adults and working age adults with mental health problems, we saw caseloads were high across all the teams. They ranged from 40 to 50 patients per care coordinator. National guidance from the Department of Health in 2002 suggested that average caseload size for community mental health teams should be around 30 to 35 patients per care coordinator. High caseloads were identified on the local risk register.

Management did not use a weighting tool to manage caseloads in any of the community services that we inspected; instead, the clinical leads and team managers had oversight and distributed the caseloads accordingly. Caseloads were regularly reviewed through supervision. A caseload weighting tool is a tool used to review caseloads and look at complexity of cases against amount of cases on staff caseloads.

However, information provided by the trust stated from July 2016 that allied health professionals would be piloting a caseload weighting tool across community learning disability services for six months.

The mandatory training compliance target for the trust was 90% but the trust mandatory training compliance across the trust at the time of the inspection was 80%. Mandatory training compliance was a concern at the previous inspection in 2014 and the trust continued to be unable to meet their training compliance target at this inspection. In addition, there appeared to be confusion regarding the timescales for the trust to meet the trust's compliance target of 90%. Three senior managers reported different timescales ranging from the end of July 2016, to December 2016, to April 2017.

The trust compliance was below 75% for training courses on essential life support, moving and handling advanced, food safety level two, fire level three, intermediate life support, safeguarding children level two and three, mental health act community and inpatient and duty of candour. This placed patients at risk of receiving care that was unsafe and the low compliance with essential and immediate life support meant that the service could not guarantee that all staff could respond to patients in a medical emergency.

The trust compliance was 90% and above for training in fire safety level one, equality and diversity, health and safety, safeguarding children level one, food safety level one, information governance, personal safety theory, safeguarding adults, as well as for the trust induction.

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Low compliance in mandatory training, including essential and intermediate life support, was a concern in number of individual wards and services, including the wards for people with learning disabilities or autism, the crisis services, the forensic services and the Yorkshire Centre for Psychological Medicine. For example, at the Yorkshire Centre for Psychological Medicine, the compliance with essential life support, intermediate life support, infection control, clinical, moving and handling, safeguarding children and duty of candour training was all below 75%. Staff on the ward dealt with percutaneous endoscopic gastrostomy (feeding a patient using a tube), wound care and the use of hoists on a regular basis so it was essential that staff remained up to date with these skills to provide safe care and treatment.

Staff received a monthly email from the trust notifying them that a particular element of mandatory training needed updating. They were responsible for booking their own training using an online programme. We checked the availability of training courses for both Leeds and York on the training dashboard and found there was sufficient availability for staff to access mandatory courses in both geographical areas.

Assessing and managing risk to patients and staff

We looked at the quality of individual risk assessments across the wards and teams we inspected. We reviewed 217 records during the inspection. These identified and addressed risk in most of the care and treatment records that we reviewed. The trust used two recognised risk assessments; the functional analysis of the care environments risk profile and a gate assessment. However, there were concerns at two and three Woodland Square that risk assessments, as well as the fire evacuation plans at two Woodland Square, were not being reviewed regularly for people with learning disabilities or autism. Some risk assessments had not been reviewed in under six months, whilst other risk assessments and the fire evacuation plans had not been reviewed since 2013 and 2014.

We saw good use of crisis planning in the community services, except in the community services for patients with learning disabilities or autism, where the use of crisis plans was more variable. All staff provided patients with a crisis card in case of an emergency, which contained emergency contact numbers for support.

In the community teams where there were waiting lists, teams were reliant on the referring service's ongoing monitoring of the patient risk, or on the self-report form patients, relatives or carers. Teams discussed the waiting lists on an ongoing basis as a multidisciplinary team and made regular contact by letter to patients on waiting lists. Where there had been an increase or sudden change in the presenting risk of a patient on the waiting list, the teams responded positively offering support, guidance or appointments.

Recognised tools for areas such as nutrition and pressure care were not used when they were required in the supported living service. In comparison, the Yorkshire Centre for Psychological Medicine and the wards for older people with mental health problems were vigilant to the additional risks these patients presented, for example, developing pressure ulcers and falls. The ward had pathways into tissue viability, endoscopy, stoma care and other physical health services, which they could access locally when required.

There had been no episodes of long-term segregation recorded across the trust between 1 January 2016 and 30 June 2016. In this time period, there were 88 incidents of seclusion recorded. Fifty of these seclusion incidents were recorded on the acute wards and psychiatric intensive care unit which had the highest number of seclusion incidents. This service that recorded the second highest use of seclusion was the forensic and secure wards, which recorded 18 incidents of seclusion.

On the inpatient wards for children and young people with mental health problems, there was confusion amongst staff regarding the use of seclusion. Staff were not clear on whether seclusion was used or not, or what constituted seclusion, where patients were transferred to the high dependency unit following long periods of restraint and were prevented from leaving the room. There was also confusion about the procedure following a patient being transferred to the high dependency unit and seclusion being used. The manager informed us that they used some documentation from the trust seclusion policy but did not carry out medical reviews. We asked the trust for the number of seclusion episodes from 1 March 2016 to 30 June 2016 and they informed us that there were 10 occasions when a patient was secluded. Staff were unable to provide us with any clear seclusion records as specified

in the trust policy. This meant that when restrictions placed on a patient that resulted in seclusion, not all of the safeguards required by the Code of Practice and the trust policy were put in place.

In the forensic and secure services, two of the eight seclusion records were reviewed on Rose ward. Both records were not compliant with the Mental Health Act Code of Practice. There were no seclusion care plans in place and the nursing reviews did not record a picture of the patients' presentation consistent with the medical reviews. Some observation sheets were missing in one record.

There were 808 uses of restraint on 254 different patients between 1 January 2016 and 30 June 2016. One hundred and thirty-four of those interventions resulted in the use of prone restraint. In addition 69 of the prone restraints resulted in rapid tranquilisation. When medicines were administered for rapid tranquilisation, we saw that staff attempted physical health monitoring after the dose was given. The Care Quality Commission defines prone restraint as 'holding chest down whether face down or to the side'. Rapid tranquilisation is defined by the National Institute for Health and Care Excellence as when 'when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them to reduce any risk to themselves or others and allow them to receive the medical care that they need.' National Institute for Health and Care Excellence guidance states that staff should only use prone restraint when it is unavoidable. This is because of the risk to patients of coming to harm due to the compression of the chest used in this technique.

The highest number of restraints was recorded for the acute wards and the psychiatric intensive care unit in this time period. Three hundred and nine restraints were recorded on 130 patients, 82 were recorded as prone and 43 of those prone restraints resulted in rapid tranquilisation. This second highest use of restraint was recorded on the wards for patients with learning disabilities and autism which recorded 213 restraints on 14 patients. Ten were in the prone position and two resulted in rapid tranquilisation. This was followed by the wards for older people with mental health problems which recorded 148 restraints on 50 patients. Eight were in the prone position and five resulted in rapid tranquilisation.

Staff on Parkside Lodge told us that they always used prone restraint to give medication via an injection when a patient refused this. The trust rapid tranquilisation policy (May 2015) did not state that rapid tranquilisation should be given in prone restraint. Staff could use other techniques for rapid tranquilisation. Therefore, staff were working outside of the trust policy.

The trust was working towards reducing the use of restraint, particularly prone restraint, as recommended by the Department of Health Guidance: Positive and Proactive Care: reducing the need for restrictive interventions (2014). We observed the trust's action plan for its reducing restrictive interventions programme (2014 to 2016), minutes from the reducing restrictive interventions working group and details of 'safe ward' development day. All inpatient services worked towards using the safe ward interventions and each ward had their own development plan to update quarterly. The trust had a managing challenging behaviour policy as a guide for staff. Ninety percent of trust staff had completed personal safety theory training and over 75% were compliant in the low and high-level physical interventions training with breakaway techniques. We observed the preventing and managing violence and aggression training and noted that central to this training was recognising changes in patients' behaviour that may indicate an escalation in behaviour, followed by the use of de-escalation techniques, before the use of any restrictive interventions. In the reducing restrictive interventions action plan, completing the post incident review in 72 hours, consulting with patients for their experience on their restraint and the Board of Directors and Senior Management Executive Team making the decision on the type of restrictive interventions that were to be used going forward in line with national guidance and were documented in the trust's policy, were all still outstanding despite some progress being made. As such, restraint incidents, including prone restraint, remained high, prone restraint was still prominent in the trust's training package to manage challenging behaviour and the staff were not always operating within the trust policy.

There was an observation and engagement of people policy in place. Observation levels on almost all wards were dependent on the risk the patient presented and would be more frequent where they had been assessed as high risk.

The trust had a policy for searching of patients. Staff did not routinely search patients on most of the wards we

visited. They carried out searches when they felt it to be necessary due to risk to self or others. Staff obtained consent from the patient and conducted the search in line with the Mental Health Act code of practice.

Blanket restrictions were identified in some inpatient services, including the observation procedures on the acute wards and psychological intensive care unit and the routine searches following unescorted leave on the forensic and secure wards. A blanket restriction is a rule that applies to all patients on a ward and restricts their freedom, regardless of individual risk assessments.

We saw adequate signage on the doors advising informal patients that they were free to leave the unit at will, or leaflets on patients' rights and responsibilities, in line with the Mental Health Act Code of Practice, except at Parkside Lodge where a patient did not have their right to leave the ward clearly explained to them.

Good personal safety protocols were in place in the community services for patients with a learning disability or autism and the specialist community services for children and young people with a mental health problem. However, in the community services for adults with mental health problems, the lone working procedure could not always guarantee the safety of the staff.

The trust contributed at both Board and operational levels of the Leeds Safeguarding Children's Board and were fully engaged in the Leeds Domestic Violence Hub and the operational steering group.

Adult safeguarding training and child safeguarding training, level one, two and three, was mandatory for the trust. Adult safeguarding training compliance was 90% and child safeguarding training level one had a 92% compliance rate. Compliance for these two courses met the trust mandatory training target of 90%. However, child safeguarding training level two and three were below the trust compliance target of 90% and below 75%, with a compliance rate of 51% and 66% respectively for those staff eligible to complete it.

Although there was low compliance with safeguarding children training, staff said they were clear about the procedures to follow for both adult and child safeguarding and knew how to access safeguarding guidance. All said they would report any concerns directly to a manager in the first instance. Incident reports showed that staff had consulted with the trust safeguarding team, including the named child and adult safeguarding nurses and made safeguarding referrals where they believed potential or actual abuse had occurred. This was demonstrated in the ten safeguarding cases that we reviewed during the inspection. We observed evidence of staff liaising with social care co-ordinators in the community and attendance at multidisciplinary meetings with the local authority.

However, at Two Woodlands Square, the respite service for patients with a learning disability or autism, we saw evidence in two patient files of staff completing body maps on admission after finding bruising on a patient. Staff had written about these in daily notes but had not taken advice or recorded that they had made or discussed safeguarding referrals in these cases.

Staff working in the adult services, were expected to discuss child and safeguarding within clinical and management supervision. Named nurses facilitated safeguarding supervision in the mental health services for children and young people, the perinatal services and the substance misuse services. Assurance was provided to the Trust Safeguarding Committee, though the trust did not collect discreet data on safeguarding supervision at the time of the inspection. An adult and child safeguarding policy and procedure was available to staff on the staff intranet to guide and support staff in their work. The safeguarding children policy had been recently ratified on the 1July 2016 prior to the inspection. Staff communications on safeguarding via the intranet, the safeguarding bulletin and attendance by the trust safeguarding team at team meetings provided additional guidance for staff.

The Chair of the Leeds Safeguarding children's Board completed an audit in 2014 and was assured that the whole trust accepted and shared responsibility for safeguarding children, or that it was integrated into part of everyday mainstream practice for all practitioners. Since that visit the trust had developed and promoted the Leeds 'Think Family, Work Family' approach to safeguarding. This ensures that practitioners that work with adults adopt a holistic approach and consider wider issues for the family that may affect the health and well-being of other vulnerable members of the family. 'Think Family, Work Family' was included in the trust's level three safeguarding children training, though compliance was low despite the audit being completed in 2014. The trust was also developing a new Safeguarding Supervision Policy in line with the Leeds Safeguarding Children's Board minimum

standards, requiring eligible staff to participate in separate safeguarding supervision every 3 months. This was still in draft format, despite the audit being completed in 2014, with the plan to launch the policy and the monitoring arrangements at the October 2016 trust safeguarding conference. The child safeguarding records we reviewed confirmed that concerns were identified in a range of adult services, including the substance misuse services, the community services for adults of working age with mental health problems, as well as the memory services.

The trust visitors' procedure included guidance about how staff should manage situations of children visiting the wards to maintain safety as not all wards and services had a child-friendly visiting room. The trust safeguarding team was due to complete an audit on the provision of visiting rooms appropriate for children across the trust.

There were three pharmacy dispensaries in the trust. Medicines were delivered to all trust sites by courier. The pharmacy dispensary service was extended in April 2016 to provide cover on weekends and bank holidays. Out of hours, staff could access emergency drug cupboards and an on call pharmacist. The trust was in the process of identifying a building that was big enough to enable the merging of the two Leeds-based pharmacy dispensaries. The current facilities were not deemed fit for purpose and are mentioned on the trust risk register.

Medicines were stored securely across the trust. However, the trust could not provide assurance that medicines were being stored at the correct temperatures to remain effective. Whilst staff in some clinical areas recorded medicines fridge temperatures, staff did not always take action when temperature readings were outside of the required range. One ward fridge had numerous readings of 11 degrees centigrade and staff had not taken any action. On other wards, fridges were broken, were not monitored or had missed temperature readings. Pharmacy staff did not always check to ensure that ward fridge temperatures were being monitored properly. In addition to this, we found that the temperatures of the fridge in one of the pharmacy dispensaries had not been monitored since the 17th February 2016.

Staff in many of the clinical areas throughout the trust were not monitoring ambient room temperatures where medicines were stored to ensure that the temperature remained below 25 degrees centigrade in line with the trust's policy. Medications stored at room temperature should not exceed this limit as recommended in the World Health Organisation guidelines for the storage of essential medications. There were no thermometers in most of the clinical areas and where they were introduced during the inspection, for example in the crisis unit at the Becklin centre, the temperature recorded 29 degrees centigrade. Therefore, the trust could not provide assurance that medicines that needed to be stored at room temperature were being stored below 25 degrees centigrade.

These issues were brought to the attention of the immediate attention chief pharmacist during the inspection. A trust wide action plan was implemented during the inspection.

Staff handled pharmaceutical waste appropriately throughout the trust.

Controlled drugs were stored securely and managed appropriately across the trust. All the controlled drug cupboards that we saw complied with legal requirements. The controlled drug accountable officer (who was also the Chief Pharmacist) sent regular reports of controlled drugs related incidents to the controlled drug local intelligence network.

The trust had recently implemented electronic prescribing in some areas using the MedChart clinical system. We saw that all prescriptions (both paper and electronic) included patient identifiable data and information on allergies. In some areas, photographs were included with the prescription charts to aid the identification of patients. On the inpatient ward for children and young people with mental health problems; all prescription charts included the weight of the patient. Where appropriate, the documentation regarding legal authority to administer medicines to individual patients (for example, T2 and T3 forms) was readily available.

The paper prescription charts had a section at the back relating to medicines for minor ailments (e.g. paracetamol tablets, gaviscon advance liquid, senna tablets). We saw that prescribers and pharmacists were very good at ensuring that this section was crossed off if these medicines were not suitable for individual patients.

Pharmacists usually screened prescription charts on the ward. If nurses needed a medicine when the pharmacist

was not on the ward, the prescription charts were sent via secure nhs.net email to the pharmacy department. If the prescription was electronic, the pharmacists were able to screen them by logging into the MedChart system remotely.

We saw that Clozapine was managed appropriately throughout the trust. The trust had outpatient clozapine clinics twice a week that were run by members of the pharmacy team. Staff used these clinics as an opportunity to gather information on side effects being experienced as well as the smoking status of the patients.

This trust no longer used patient group directions (PGDs). However, staff within the occupational health department work under a patient group directive written by a neighbouring trust to administer influenza vaccines to trust staff during flu season. The governance of the patient group directive was managed by the trust that produced it.

Previously, there were patient group directive used in the crisis team. The trust employed doctors and nurse prescribers within the crisis team so that medicines could be prescribed in the traditional way if needed.

Whilst the trust was starting to implement a system for supporting patients to self-administer their medicines, we saw that this system was not robust. Pharmacy staff were involved in monitoring and assessing patients; however, the information that they gathered was kept in the pharmacy department and not on the wards. This meant that not all members of the multidisciplinary team could access it.

The trust had a clear process for managing medicines alerts. Information was sent via the trust communication system, ensuring that all members of staff were informed of any action required.

Pharmacists and pharmacy technicians conducted medicines reconciliation for each patient admitted to a ward. (Medicines reconciliation is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, or GP). Pharmacy staff used smart cards to access GP held 'Summary Care Records'. This meant that pharmacy staff could provide quality advice about medicines use.

We saw that nurses on some wards were able to dispense small amounts of medicines for patients going on short-term leave. The process required two nurses to check the medicines before giving them to the patients. This was used when pharmacy staff were not present on the ward. The majority of short-term leave was planned and the pharmacy department usually supplied the medicines. On the inpatient unit for children and young people, the Consultant wrote FP10 prescriptions for a patient who was going on leave at short notice. This enabled the family to go to a local community pharmacy and get the medicines dispensed immediately.

Medicines information was sent to GPs and community pharmacies on discharge. The trust had identified that some of the discharge information being sent was ambiguous. To rectify this, the trust had pharmacy staff based in five GP practices. They had access to the trust information technology systems so that they could deal with any medicines queries.

Track record on safety

We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning System and to the Strategic Executive Information System and serious incidents reported by staff to the trust's own incident reporting system. These three sources were not directly comparable because they used different definitions of severity and type and not all incidents were reported to all sources. For example, the National Reporting and Learning System does not collect information about staff incidents, health and safety incidents or security incidents.

Providers are encouraged to report all patient safety incidents of any severity to the National Reporting and Learning System at least once a month. The trust was an outlying reporter to the National Reporting and Learning System. The most recent report covering 1 April 2015 to 30 September 2015 identified that Leeds and York Partnership NHS Foundation Trust, reported 50% of incidents more than 71 days after the incident occurred this is outside the average rate, which is 27 days.

For the period 1 June 2015 and 31 May 2016, 4,929 incidents were recorded by the National Reporting and Learning System for the trust. Of these incident, 68% were recorded as resulting in no harm, 29% recorded as resulting in low harm, 2% recorded as resulting in moderate harm, 0.4% recorded as resulted in death and less than 0.1% resulted in severe harm. The National Reporting and

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Learning System considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture. Patient accident was the most reported incident to the National Reporting and Learning System, accounting for over a quarter of all the incidents reported, with a total of 1,408 patient accidents reported. This was followed by 22% of incidents reported by the trust relating to self-harming behaviour and 20% relating to disruptive and aggressive behaviour (including patient to patient).

Trusts are required to report serious incidents to the Strategic Executive Information System. These include never events which are serious patient safety incidents that are wholly preventable. The trust reported 49 serious incidents between 1 March 2015 and 29 February 2016 to the Strategic Executive Information System and requested that one incident be de-logged as a serious incident. Thirty of these incidents occurred in the adult community mental health teams, with just over two-thirds, attributed to apparent, actual or suspected self-inflicted harm. There were no 'never events' recorded in this time frame. However, the performance framework data submitted by the trust, identified a 'never event' occurring in March 2016. The 'never event' related to an attempted suicide on one of the acute inpatient wards, where a collapsible rail had failed to collapse.

The trust also records serious incidents. Between 1 March 2015 and 23 February 2016 the trust recorded 48 incidents. This was the same for the number of incidents recorded on the Strategic Executive Information System which recorded accounting for the serious incident that the trust asked to be de-logged. Thirty-five of the trust serious incidents were categorised as incidents that were unexpected or avoidable death or severe harm of one or more patients. Of the 13 remaining serious incidents, nine were in relation to a fall, two in relation to an information governance breach and one in relation to property damage by a service user and one in relation to the Mental Health Act.

The overall number of deaths for the trust decreased between 2014 and 2016, from 274 to 241. However the unexpected deaths doubled in 2014 to 2015 in comparison to 2013 to 2014. Of the 163 unexpected deaths reported in the last three years, 121 were investigated by the trust with 89 categorised as a serious incidents requiring investigation. Eighty-four were recorded on the Strategic Executive Information System. Mental health community services for adults had the most unexpected deaths in the three year period between 2013 and 2016 with 86 unexpected deaths. The trust provided data to confirm that they had investigated 74% of unexpected deaths. Eight unexpected deaths were not investigated by the trust including four in the community services for older adults with mental health problems, three in the specialist community mental health services for children and young people and one on the inpatient wards for people with a learning disability or autism.

The NHS Safety Thermometer measures a monthly snapshot of four areas of harm including falls and pressure ulcers. In the period April 2015 to April 2016, the safety thermometer data showed that the trust reported eight new pressure ulcers. Two pressure ulcers were reported in both June 2015 and July 2015, with a prevalence rate of 0.6% and 0.7%. This was the highest number of pressure ulcers reported in a month. Again in the period between April 2015 and April 2016, the trust reported 28 falls with harm. The highest monthly numbers reported were five each in May 2015 and August 2015, with prevalence rates of 1% and 2% respectively. In this same period, the trust did not report any new catheter and urinary tract infection cases.

Some of the responses to questions in the NHS Staff Survey 2015 provided circumstantial evidence about the culture of safety and incident reporting. The trust was higher than the national average for mental health trusts with regard to the responses to the survey for staff reporting that they had witnessed potentially harmful errors, near misses or incidents in the last month. Thirty per cent of staff reported this, compared to 26% nationally. The trust was one percent lower than the national average for staff actually reporting these near misses, errors and incidents, with 90% of staff reporting this in the survey. Staff's confidence and security in reporting unsafe clinical practice was lower than the national average for mental health trusts.

In the NHS Staff Survey 2015, 26% of staff said they experienced physical violence from patients, relatives or the public in the last 12 months, which is five percentage points higher than the national average of 21% for mental health trusts. Thirty-two percent had experienced harassment, bullying or abuse from patients, relatives and the public in the last 12 months, which is the same as the national average for mental health trusts.

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Are services safe?

Reporting incidents and learning from when things go wrong

A web based reporting system was used for reporting incidents called Datix. The trust used the incident reporting system to record incidents, accidents and near misses and had been using this system since April 2015. Prior to this, incident reports were made using handwritten forms. Staff across the trust had a good understanding about the types of incidents they should report and the incident reporting procedure.

As part of our inspection we reviewed information relating to incidents reported. We found that a range of different types of incidents were reported and the incidents were reported appropriately. Some of the types of incidents reported included safeguarding concerns, patient deaths, accidents, information governance issues and medication errors.

All medicines errors were reported on the Datix incident reporting system and reviewed by the trust Medicines Safety Officer. Staff that we spoke with had an awareness of how to report medicines incidents.

All deaths were reported as an incident on the Datix system and were reviewed by the Mortality Review Group weekly to confirm whether a full fact find report was required. The Mortality Review Group was started in June 2016 in response to an external independent review of deaths of people with learning disabilities or mental health problems at the Southern Health NHS Trust by Dr Mazar. A full fact find report was not currently completed for expected deaths. However, the trust was changing its process so that a full fact find report was completed for every death of patients in contact with their services, or recently discharged. The trust had a weekly mortality and fact find review meeting to agree the levels of investigation required.

Staff recorded all hands-on interventions as an incident. They recorded all these incidents in detail and completed body maps to note any injuries from restraint. The restrictive interventions working group, which reported to the Mental Health Legislation Group, reviewed all incidents of restraint and identified any learning. They confirmed that they then may work with staff on an individual basis, or certain teams and services, but would cascade relevant learning trust-wide via the intranet.

Where a death was identified as a serious incident, the trust followed the same process as it would for all serious incidents. The death was reported on the Strategic Executive Information System and to the National Reporting and Learning System. An investigator was allocated from outside of the service where the incident occurred. Independent external investigators were appointed for the most serious incidents. The Risk Management Team oversaw the management of the investigations. A draft investigation report was discussed by the Care Group Risk Forum and recommendations and actions were developed. Relevant staff members were involved throughout. We were told that immediate learning may be shared in advance of the final report where changes to practice were needed without delay.

The report was presented to Trust Incident Review Group. This Trust Incident Review Group was chaired by the Medical Director and membership included the clinical directors and professional leaders. Recommendations were agreed at this meeting and actions finalised. The Trust Incident Review Group considered whether findings were root causes, contributory factors or incidental findings; and recorded them as such, agreeing the required oversight to completion. The investigator or appropriate member of staff would meet with the family, to discuss the report and any findings.

Reports were fed back into care groups via the clinical governance forums. The treatment incident review group minutes were shared with Care Group Risk Forums and the Quality Committee.

All action plans were implemented by the team where the incident occurred, governed by care group clinical governance forums. Trends and themes arising from actions were analysed and shared through the 'Learning to Improve' process. For cross-care group learning, the trust also circulated Lessons Learned communications, as well as through the Clinical Team Managers' Forums and Consultants' Committees. The Board of Directors and the Governors received reports on the serious incidents and the lessons learnt. The trust submitted completed reports to commissioners and other relevant external bodies.

The timely reporting of incidents was identified as a risk factor for the trust and the commissioners raised concerns about the timeliness of these incidents, including suicides and falls, being investigated and information being fed back to them. The trust told us that they had accumulated a significant backlog of paper incident forms awaiting input to the electronic system from 2013 due to a gap in

administrative support, exacerbated by the resource impact of implementing the new electronic system. The trust had made some recent changes prior to the inspection to improve the timeliness of their reporting, the completion of their investigations and the feedback to staff and commissioners. They were also in the process of recruiting two dedicated Root Cause Analysis investigators to join the Risk Management Team, to improve capacity and consistency in investigation management. They were also investing in a new training package for investigators and for members of the Trust Incident Review Group to support them in critiquing investigations and providing feedback.

During the inspection we attended a Trust Incident Review Group meeting, a Mortality Review meeting, the trust Board of directors meeting and reviewed trust-wide incidents reports and investigations, including the 'never event' that occurred in March 2016. We observed timely investigations and comprehensive records. The meetings we attended were robust with appropriate, discussion, challenge, recommendations and actions.

Staff confirmed in almost all services that information regarding best practice and lessons learnt following investigations of incidents was shared with teams. Teams received feedback about incidents internal and external of the service through team meetings, handovers and emails sent out to staff. Staff told us that incidents were discussed in their supervision. Staff told us that changes to practice have been put in place following investigations of incidents. Reports from incidents including lessons learnt were available on the trust intranet. Staff told us that they received a formal de-brief following incidents from their manager and were supported by their colleagues. However, staff did not show an understanding of lessons learned specifically from medicines incidents or how feedback was relayed to members of staff who had reported incidents.

We had concerns about the reporting of incidents at the supported living services, as well as the learning from incidents. The electronic reporting system had not been implemented in this service, despite being implemented across the other trust services and teams. This meant the house managers and operations manager no longer received feedback from the provider on trends in accidents and incidents. This meant issues could be missed because the data was not being routinely analysed and people therefore may not receive changes in support which may have been required to minimise the risk of the issue reoccurring. Following the inspection they told us a formal plan had been devised for this to happen in 2016.

The provider is legally responsible to report all safeguarding concerns to the National Reporting and Learning Monitoring System. However, at this same service, we looked at the data held locally and cross referenced this to the NHS report of all incidences reported. We found that five incidences were not reported. The provider immediately looked at how this had happened and changed the system in place to ensure this did not happen again. The operations manager told us once the Datix system is introduced, reporting errors will not happen.

In addition, staff in the forensic and secure inpatient services did not always follow the trust procedures for investigating incidents and complete the investigations in the timescales required. When a patient went absent without leave from the service the service completed its initial fact find six days after the incident, rather than within 12 hours as per the policy.

Duty of Candour

In November 2014, the Care Quality Commission introduced Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation requires the trust to be open and transparent with people who use services and other 'relevant persons' in relation to their care or treatment, specifically when things go wrong. This specifically includes suspected or actual reportable harm incidents that resulted in moderate or severe harm.

The Board of Directors received training on the requirements of the duty of candour through a board workshop in November 2014. The Quality Committee, a sub-committee of the board, had the oversight of the implementation of the duty of candour regulation and we observed information discussed at the board in April and July 2015.

The trust had developed a procedure to guide staff in their duties in relation to duty of candour and also updated their electronic management system to include prompts for staff regarding duty of candour and if it was appropriate.

We observed a duty of candour presentation for staff during their induction and a page specific to this on the

trust intranet. Training on duty of candour was classified as mandatory in June 2016. At the time of the inspection the trust compliance rate was 42%, with an expected compliance rate of 90% by the end of March 2017.

Staff worked with a culture of openness and transparency and knew their responsibilities when things went wrong. We reviewed case records where there had been a notifiable event to check that staff had been open and honest in their approach to patients, relatives and carers. All incidents were discussed at the Trust Incident Review Group, including their appropriateness for duty of candour. We found that the trust was meeting its duty of candour responsibilities.

Anticipation and planning of risk

The Board of Directors had identified the strategic risks that may adversely affect trust business. The trust's board assurance framework identified the trust's principle risks for each of its five strategic objectives. Risks identified included failing to meet deadlines for implementing systems, impacts of funding and tendering on delivering care, cyber-attacks, workforce vacancies and capability, defective detentions and risk with the providing services from premises that are not in direct ownership of the trust. The board assurance framework we observed included information on how the trust were mitigating these risks, how they were assured these controls were effective and highlighted any gaps and further action required.

Requires improvement

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

We rated Leeds and York Partnership NHS Foundation Trust as requires improvement for effective because:

- Care records in the respite services at Woodland Square for patients with a learning disability or autism had not been reviewed for significant periods and did not always identify the patients' needs whilst at the services. The care plans at these services did not always contain health action plans.
- Patient records were not always accurate and contemporaneous and did not include all decisions about patient's' care and treatment within their care record. The use of paper records as well as electronic records could cause confusion for the wider teams accessing the system, as the most up to date information may not be held in the central electronic record.
- The inpatient wards for older people with mental health problems did not use any standardised occupational therapy tools to measure interventions and outcomes. Staff in the crisis assessment unit were unclear of the National Institute of Health and Care Excellence guidance that would apply to the service.
- The internal audit systems were not always sufficiently robust to identify missed doses or other medication issues and errors were identified in the supported living service, on the inpatients wards for older people with mental health problems and the inpatient wards for patients with learning disabilities or autism.
- There were no robust systems in place to ensure that the physical health monitoring for antipsychotic medication was completed. There was a lack of clarity regarding who should take responsibility for ensuring that these physical health checks were completed.
- The trust average clinical supervision rate as of the 30 June 2016 was 70% and was below 50% in some services, including the Yorkshire Centre for Psychological Medicine, Parkside Lodge and Three Woodland Square and the inpatient wards for older adults with mental health problems.
- The appraisal rate for the trust as of the 30 June 2016 was 82% and did not meet the trust target of 90%.
- Compliance in the mandatory level two Mental Health Act community and inpatient level two training for the trust were also below 75%. Five teams or services had below 75% compliance in the Mental Capacity Act training, including Deprivation of Liberty Safeguards.
- We found that second opinion appointed doctors were not requested in a timely manner in some cases when the three month rule was approaching. This means other authority, such as treatment in an emergency, needed to be used. Section 62 authorises treatment in an emergency and was used widely throughout the trust.
- We found some issues with the documenting of section 132 rights, including on the wards for older people and in the crisis and health based place of safety.
- We found delays in identifying errors with detention documents, despite the systems to receive and check Mental Health Act documentation and the internal audits to identify errors that were in place. This could result in patients being deprived of their liberty without the legal authority.
- Patients in the respite services for patients with learning disabilities and autism did not have capacity to consent to their respite care and treatment and were subject to continuous supervision and control and were not allowed to leave. The services had carried out capacity assessments but had not made applications for Deprivation of Liberty Safeguards.

Requires improvement

Are services effective?

These safeguards are a lawful requirement to ensure the service upholds the human rights of patients. Staff on the acute wards and the wards for older people with mental health problems, were unclear about their responsibilities under the Mental Capacity Act and were not adhering to the trust policy.

However:

- In the majority of services and teams, comprehensive assessments were completed using recognised assessment tools and care plans were holistic and person centred and were reviewed regularly.
- Staff followed guidelines from the National Institute of Health and Care and Excellence when providing care and treatment, including for prescribed medication and psychosocial interventions.
- There was a comprehensive audit programme across the trust and in the teams and services we inspected and the trust pharmacy team completed a number of medicines related audits to assess quality and to assist in the identification of areas for improvement.
- All teams consisted of a wide range of disciplines, included consultant psychiatrists and junior doctors, nurses and health support workers, occupational therapists and regular input from pharmacy. Other professionals were engaged as required. Regular team meetings took place in all teams and services and all members of the multidisciplinary teams attended these.
- There were good examples of integrated partnership working and local partnership arrangements between the trust and other agencies, as well as between internal trust services.
- Staff and patients told us there was good access to independent mental health advocates.

Our findings

Assessment of needs and planning of care

We reviewed 217 care records. Generally, comprehensive assessments were completed, using recognised assessment tools. The care records we reviewed were individually tailored to each patient's needs and showed the patients' involvement in completing and agreeing the care plan. Information in the assessments and care plans covered a range of areas including mobility, nutrition, activities, health needs and support with any challenging behaviour. They were holistic, recovery orientated and included patients' views. However, not all records were sufficiently detailed, for example on the inpatient wards for older adults with mental health problems, a number of patients' nutritional needs were being monitored by way of food and fluid intake charts and not all records were fully completed in relation to what patients had consumed.

We observed good practice, for example in the inpatient services for patients with a learning disability or autism at Two Woodland Square, where care plans were person-centred and included the likes and dislikes of the patient. Each patient had brief communication guides in place, showing how they communicated with staff. However, whilst we found that care plans were regularly reviewed and updated in the majority of teams and services, in this same respite service, we identified concerns that the nurses did not document when they updated care plans, so it was unclear whether the care plan contained the most recent information. For example, a patient had an administration care plan for an emergency epilepsy rescue medication written in January 2010. Also, during the inspection we saw that staff had written in patient care plans that they liked to go to bed between 6.00pm and 7.00pm. We questioned this, because this was not person centred. One patient told us that they did not like respite, because they had to go to bed before the day shift left and went to bed much later at home. The carer of another patient told us that their relative did not like the early night time routine. After we raised this concern on our first visit, we re-visited the ward at night one week later, practices had changed and staff had amended care plans to include a more person centred description of each patient's preferred night time routine. Both patients were up in the lounge at the time of our night time visit.

In addition at Three Woodland Square, whilst all the patients had care plans present, the service had not always written these and took them from the community team's electronic system. This meant that the care plans were not specific to the respite service and not updated after each respite stay. Also, less than half of the care records we reviewed at this service contained health action plans. A health action plan should be in place for all learning

disabled adults. It is a personal plan about what a patient needs to stay healthy. It lists any help people may need and is a record of all information about a patient's health needs. Similarly, at Parkside Lodge only one of the four patient records reviewed contained a health action plan.

The majority of patients' records were stored securely on an electronic system. This electronic system contained all the records and information from the multidisciplinary teams, for example psychology, occupational therapy and speech and language therapists. Hand written records, for example the medical notes, were typed up by the administration teams and scanned on to the electronic system.

The electronic system could be accessed by all members of the multidisciplinary team, including the social workers and so was readily available when required. However, agency staff were unable to access or input on to the electronic recording system. Services had systems in place to ensure that these staff had access to the current patient information, including through handovers and printed care plans. The ward managers or nurses would input information onto the system for agency workers, or the agency workers would write paper notes which would be scanned on to the system. For those services where agency workers wrote paper notes that were later scanned on, like on the inpatient wards for older people with mental health problems, this meant that notes on the system were not contemporaneous.

Staff in a number of services told us that navigation around the system could be difficult as information was not always stored in the same part of the record. Pharmacy staff admitted that they too found it difficult to access information relating to physical health monitoring using the clinical system. The trust had a formulary available to staff via the intranet.

Some teams used paper record as well as the electronic records, for example the respite services, as well as the community services for people with learning disabilities or autism and adults with mental health problems. These paper files were stored securely in most cases, except at the respite services the cabinet containing these paper records was not locked and the door was wedged open to the nurse's office containing these files during our inspection.

The use of paper records as well as electronic records could cause confusion for the wider teams accessing the system, as the most up to date information may not be held in the central electronic record. For example, in the community services for adults with mental health problems, information was recorded on paper in addition to the electronic system. This meant that some teams may not have real time access to the information that had been recorded on the paper patient records. This included crisis teams and inpatient wards that may need information to deliver care outside of operating hours. The chief information officer recognised that it was a challenge for staff not working on site to access and update electronic records, including providing remote access and that the PARIS electronic system was a challenge in itself. The interim Chief Executive Officer confirmed that they were aware of these challenges and as a trust they were considering the way forward with regard to the patient information systems.

The electronic record system was a challenge for the specialist community services for deaf children and young people with mental health problems so these services either kept electronic and paper records, or just paper records. The documents within the electronic system were adult and hearing based and so not necessarily appropriate for these services.

Best practice in treatment and care

The Clinical Audit and Effectiveness Team coordinated the implementation of the National Institute of Health and Care Excellence guidance throughout the trust. The effective care committee ensured that the guidance was relevant to the trust and following dissemination through the trust's governance structures, the committee ensured that the appropriate action had been taken. Compliance declarations were sent to the commissioners, including any action plans, for National Institute of Health and Care Excellence guidance implemented. For example, to ensure that access across the trust to psychological therapies and family therapies was compliant with the National Institute of Health and Care Excellence guidance, action had been taken to integrate the psychological therapies with the community mental health services. Psychological therapies were available to all patients.

The care plans we reviewed referenced current guidance from the National Institute of Health and Care Excellence except at Two Woodland Square where staff had included

outdated guidance in care plans, for example, a patient had gastrostomy guidelines in their file, which professionals had written in in 2003 and 2004 and the same patient had dietician guidelines from 2005 in their file. This put patients at risk because new staff, who did not know the patient, might follow outdated care plans with misleading guidance.

Patients were offered a choice of prescribed medication and regular medication reviews were carried out with the support of the trust pharmacist. Staff were aware of the requirement for physical health monitoring in patients taking high dose antipsychotics, however, there were no robust systems in place to ensure that this monitoring was completed. There was a lack of clarity regarding who should take responsibility for ensuring that physical health checks were completed. This meant that local GPs sometimes refused to monitor physical health in patients known to the trust. National Institute of Health and Care Excellence guidance states that for some medicines, clinical responsibility remains with the Consultant Psychiatrist and this has been the source of debate regarding who should take responsibility for physical health monitoring.

Smoking cessation therapy was offered to patients throughout the trust.

Within all teams and services, there were good procedures in place to monitor the physical health of patients and to ensure that patients' physical health needs were being met. Staff updated adult modified early warning scores and baseline physical health observations. The Modified Early Warning Score is a tool used to record consistently blood pressure, heart rate, temperature, respirations and oxygen saturations. A physical health screening tool which staff completed with patients, included information about alcohol consumption, substance misuse, smoking and nutrition. Monitoring of physical health throughout a patients stay was evident. Patients' weights were recorded. There was also evidence of ongoing health monitoring during treatment, except on the crisis assessment unit. Staff worked with other health professionals such as tissue viability nurses and physiotherapists to help patients with their health needs and in particular with the acute trusts and the primary care GPs.

Recognised models, tools and interventions were used by the occupational therapy teams, for example the model of human occupation and the associated screening tool.

However, no recognised standardised occupational therapy tools were being used to measure interventions and outcomes for patients on the inpatient wards for older people with mental health problems.

Staff in the memory service routinely used tools specifically aligned to the dementia pathway to inform patients about their recovery. This included the Addenbrooke's Cognitive Examination tool for memory testing, Assessment of Motor and Process Skills and the Pool Activity Level tool for assessing patients' function and abilities.

We had a concern that the service manager in the crisis assessment unit told us that the service was unable to find any guidance from the National Institute for Health and Care Excellence that would apply to the service. Guidance that would apply to the service would include such areas as best practice in medication and assessment and referral in a crisis.

In the specialist community service for deaf children and young people with mental health problems, members of the team were involved in developing national quality standards for working with deaf children for the National Institute for Health and Care excellence. Care pathways, 'working with deaf parents' and 'self-harm' were being submitted to the National Institute for Health and Care Excellence from the service.

Staff used various rating scales to assess and record severity and outcomes. These included the health of the nation outcome scale, which covers a wide range of health and social domains, psychiatric symptoms, physical health, functioning, relationships and housing. In the children's and young people's mental health services, the trust used health of the nation outcome scales specifically for children and adolescents.

Across the teams and services we inspected, staff also used the shortened version of the Warwick-Edinburgh Mental Well-being scale, the Liverpool University Neuroleptic Side Effect Rating Scale, the Goal Attainment Scale, the Beck's Depression Inventory and the Clinician Outcomes in Routine Evaluation assessment.

The trust pharmacy team completed a number of medicines related audits to assess quality and to assist in the identification of areas for improvement. These included audits of:

- < >

Rapid tranquilisation as (part of POMH-UK audits)

- High dose antipsychotics audit (as part of POMH –UK audits)
- Medicines reconciliation
- Antibiotic use
- Drug chart audits (which included missed doses – have asked if there is a critical drugs list in the trust)
- Dispensing errors
- Medicines storage

However, the medication audits completed at individual team and ward level were varied. We saw that there were some missed doses on the paper prescription charts. The MedChart system made it difficult to review missed doses of medicines. The internal audit systems were not always sufficiently robust to identify missed doses or other medication issues. At The Mount on wards one and four for older adults with mental health problems, we identified missed doses and nursing staff did not understand the impact that a missed dose of a medicine for Parkinson's disease could have on a patient. Missed doses of medication were also identified on the inpatient wards for children and young people with mental health problems at Mill Lodge. Similarly in the supported living service the internal medication audit systems had not identified issues that we found during the inspection around the storage and administration of medicines. On the inpatient wards for patients with learning disabilities or autism, during the inspection, we found four drugs errors at Two Woodlands Square and two errors at Parkside Lodge during the inspection relating to medication administration. On theses wards, staff told us that they did not do medication audits and so they had not picked up these errors, despite the trust stating that weekly medication audits took place. Medication errors were also identified in the respite services for patients with learning disabilities or autism.

There was a comprehensive audit programme across the trust and in the teams and services we inspected; though the staff who were not involved in these audits were not always aware of them. A robust clinical audit procedure provided guidance for staff participating in clinical audit and all clinical audits were supported and monitored by the Clinical Audit and Effectiveness Team. We observed an overview of the audit action plans, which included 49 audits and detailed the progress made. Audit subjects included improving information systems, adherence the National Institute of Health and Care Excellence guidance and to other national standards, medication administration, Mental Health Act application, incident reporting and lessons learnt and creative ways to improve pathways in the trust.

The trust participated in the National Audit of Schizophrenia and the National Audit of Psychological Therapies.

Skilled staff to deliver care

All teams consisted of a wide range of disciplines, included consultant psychiatrists and junior doctors, nurses and health support workers, occupational therapists and regular input from pharmacy. Other professionals were engaged as required, for example social workers, housing officers, speech and language therapists, dieticians, physiotherapists and specialist doctors. Other staff members important to the operation of the wards although not involved in direct care included the administration workers, receptionists, housekeeping and domestic staff.

The managers and staff we spoke with told us they had regular supervision. This included managerial and clinical supervision. The trust's supervision policy required that all full-time clinical staff undertook clinical supervision for a minimum of an hour every two months. However, the trust average clinical supervision rate as of the 30 June 2016 was 70%. The services that had the highest compliance for clinical supervision were the mental health services for children and young people. The specialist community services for deaf children and young people had 83% compliance rate and the inpatient wards for children and young people had a compliance rate of 82%. The only other services that had a compliance rate over 75% for clinical supervision were the community services for adults with mental health problems and the community services for people with learning disabilities or autism. Clinical supervision compliance was below 50% in some services, including the Yorkshire Centre for Psychological Medicine, Parkside Lodge and Three Woodland Square and the inpatient wards for older adults with mental health problems.

Staff also received an annual appraisal. The appraisal rate for the trust as of the 30 June 2016 was 82%. The trust target for appraisals was 90%. Improving the appraisal rate and achieving the trust target was an outstanding action

from the previous inspection in 2014. The trust did not meet their own target for the percentage of appraisals completed across the trust. Though most teams and services did not meet the 90% compliance rate for appraisals, the compliance was generally high and above 75%. There were a few exceptions including Parkside Lodge, the crisis assessment unit and intensive community service, all of which were below 60%. In the NHS staff survey 2015, 87% of staff in the trust reported that they had completed an appraisal. The national average for similar organisations was 89%.

All staff received a trust induction, including training and local working instructions. Induction training met with the Care Certificate standards for care. Staff had access to their own training record on the electronic training system that the trust used. This was called the 'I Learn' system where staff could see their own training compliance and available training courses. In addition, on the Yorkshire Centre for Psychological Medicine, there was a specific four-month ward preceptorship package, which all staff completed. This prepared them for working with patients who had complex mental and physical health conditions.

During trust induction, pharmacy staff were used to deliver medicines management sessions; however, this had stopped happening due to changes in the induction programme schedule. This meant that junior doctors did not receive any teaching sessions from the pharmacy team on induction.

There was an e-learning package aimed at junior doctors, however it was not specific to mental health. An education and training pharmacist within the trust had offered to develop a module specific to mental health to assist with this.

We were told that student nurses shadowed pharmacy technicians for half a day to gain some understanding of medicines management.

Pharmacy staff completed competency checks before they were allowed to do final checks on dispensed medicines.

Mandatory training compliance for the trust was 80% which was below the trust compliance target of 90%. Outside of this mandatory training, staff could undertake various specialist training courses appropriate to their role.

The trust had a Medicines Safety Officer who was also the Lead Pharmacist for Medicine Risk Management, Community & Gender Identity. This pharmacist was also a prescriber and the only person in the country who has a specialist practice in gender identity.

Regular team meetings took place in all teams and services and all members of the multidisciplinary teams attended these.

According to the General Medical Council, as of the 22 July 2016, 113 doctors at the trust had been revalidated. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the General Medical Council. However, only 101 doctors revalidated had connections to the trust. This meant that revalidation rates for the trust were more than 100%. The reasons for this provided by the trust were that this data included all revalidation recommendations made since the introduction of medical revalidation, as well as for doctors who had since retired or left the trust.

We observed 20 personnel records of staff with different professional roles. All the records we reviewed held the information required in line with the trust's reference procedure. These records demonstrated that the trust had completed the necessary checks to ensure that the staff they had employed were of good character and had the appropriate qualifications, skills, experience and competency to fulfil their role and the sufficient health to complete their role with necessary adjustments.

The trust was committed to addressing poor performance. At the time of the inspection, there was an improvement plan at the forensic services in York to address concerns with staff attitude and performance. The trust had a personal performance policy which set out what the trust expected from staff and what the staff could expect from the trust. There was a procedure to manage poor staff performance and disciplinary issues. Team managers were able to access support from the trust's human resources team when required. During the inspection, we observed five disciplinary records, including two dismissals, two final written and a first written warning. The records demonstrated a fair process including a thorough

investigation, involvement of the human resources team, evidence that additional support was offered for example from occupational health and evidence of union involvement from Staff Side.

Multidisciplinary and inter-agency team work

The results of the NHS staff survey 2015 showed that the trust scored 3.74 for effective team working. This was slightly worse than the average score for other mental health trusts of 3.82.

We observed effective multidisciplinary working. Staff held regular multidisciplinary meetings on both the inpatient wards and in the community services where staff considered all aspects of the patient's care and new patient referrals. Multidisciplinary meetings included a discussion about risk, treatment, discharge, detention and the mental capacity of each patient. The multidisciplinary team invited other professionals such as social workers and advocates to these meeting where appropriate.

Patients were invited to participate in the multidisciplinary meetings, or teams ensured that patient's views were included in these meetings. For example on the inpatient wards for older aged adults with mental health problems, on the inpatient wards for children and young people with mental health problems and the inpatient wards for people with learning disabilities or autism, patients were given the opportunity beforehand to contribute their views in a format appropriate to the individual.

Staff told us that they felt supported to make decisions about patients care and treatment within these meetings.

We observed handovers between shifts in the inpatient areas and observed each patient being discussed in turn to ensure the nurses and the health support workers on the new shift were aware of the treatment requirements and status of each patient.

There were good examples of integrated partnership working between the trust and other agencies. For example, mental health crisis triage teams had two nurses to work within the police control centre based in Leeds to support them in identifying the most appropriate course of action for people with mental health problems. Also, the Yorkshire Centre for Psychological Medicine operated from within the Leeds Teaching Hospital Trust and therefore had to be mindful of local working practices as well as their own trust policies. The staff had built effective working relationships with the hospital where the service was based. In addition, the memory support worker was employed by the Alzheimer's society and worked together with the memory service team to offer support and advice to patients and carers after they received a diagnosis. Also a consultant geriatrician from the acute trust held weekly reviews on the inpatient wards for older adults with mental health problems and accepted referrals for patients who required support with their physical health

The service had good working relationships with other internal trust services, for example the crisis teams and pharmacy support, despite some staff describing local working issues. For example the intensive support team did not always have a clear understanding of the crisis assessment unit criteria and there were complaints that the crisis teams did not always fully explain to patients, relatives and carers about the inpatient service they were being referred to.

The inpatient wards and services had good relationships with the external professionals, agencies and services. This included GP surgeries, the police, adult social care, child safeguarding, schools, colleges, befriending services and other voluntary organisations.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Training in the Mental Health Act was mandatory for all staff and the trust had set a target for 90% to be achieved by July 2016. The 90% target had not been achieved trustwide or in any of the services. The trust compliance for the mandatory training in the Mental Health Act level two was 62% for the inpatient setting and 63% for community setting, the overall trust compliance was 76% combined for level one and level two. At service level training compliance ranged from 41% in wards for older people to 89% in specialist community deaf child and adolescent mental health service. However, in most services staff understood their responsibilities under the Mental Health Act and how it related to their service.

The Mental health Act code of practice came into effect in April 2015.The trust had not updated all of its polices in relation to the updated Mental Health Act code of practice and there was no overall plan detailing how the trust was implementing the changes to the code. Some polices had been updated such as search of service users effective 8 July 2016; procedure for use of seclusion and long term

segregation effective 8 July 2016. Some other policies were in draft form and others required amendments to be compliant with the code. Senior management did not have a good understanding of which policies required updating or which one's had been reviewed and updated. This meant it was difficult for staff to know if their practice was in line with the revised code of practice and as such, patients' rights may not be upheld.

The seclusion policy had been updated three days before the inspection and It was further updated during the inspection. In the child and adolescent mental health services ward staff did not have a clear understanding of what constituted seclusion or the procedures they needed to follow to ensure patients were protected by the safeguards of the Mental Health Act code of practice. In Parkside Lodge staff had not followed the guidance in the code of practice while patients were in seclusion.

The doors to many of the wards we visited were locked. On Parkside Lodge however, there was no information displayed to inform patients of the process to enable them to leave the ward. This was especially important for informal patients. Some wards had arrangements in place for informal patients to leave the ward. At the Becklin Centre and two wards at The Mount informal patients were assessed to have a swipe card to leave the ward. On another older person's wards there were keypads next to the door with the number to open the door clearly displayed.

Consent to treatment under the Mental Health Act was generally well documented in patient records. However, in long stay rehabilitation mental health wards capacity and consent to treatment assessments were only in three of the ten patient records we looked at. In acute & psychiatric intensive care units we found the electronic prescribing system did not always accurately reflect the most up to date authorisation certificate. On ward three at the Becklin Centre we saw eight patients had more than one authorisation certificate. In learning disability inpatient wards staff had assessed and recorded capacity to consent to medication but had not revisited the capacity assessment three months after the start of treatment. This meant that the patients capacity and consent to treatment and was not clear and treatment may be given without the appropriate consent.

Second opinion appointed doctors provide a safeguard after three months of treatment for patients who lacked capacity to consent to treatment or those who refused treatment. We found that second opinion appointed doctors were not requested in a timely manner. This means other authority, such as treatment in an emergency, needed to be used. Section 62 authorises treatment in an emergency if these reviewed more timely there would be no need to use section 62. The Mental Health Act code of practice states this should be monitored but the trust had not implemented a system to monitor the use of section 62 authorisation.

Section 132 rights were explained to patients on admission and revisited when required at regular intervals, information leaflets were available in easy read and other languages. In learning disability inpatient wards staff used easy read versions with patients who had learning disabilities. In child and adolescent mental health services we saw an example of a recently detained patient with limited understanding having their rights explained three times in one day. Staff also gave written information to the patient and their relative or carer. We found some issues with the documenting of this process. In wards for older people we looked at four patient's records specifically in relation to their rights. Two of these records showed gaps despite a lack of patients' understanding. In one case, the gap was over three months. In crisis and health based place of safety a recent audit indicated that staff were not routinely documenting this in care notes.

We saw evidence that patients had access to appeals against their detention.

The trust had a central Mental Health Act legislation team based at the Beklin Centre who provided support to the wards and community. The team supported training, detention documentation and advice in relation to Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards. The trust had improved systems to support the process of receiving and checking Mental Health Act documentation and the trust was able to provide data regarding errors and internal audits. However, we found there were delays in identifying errors with detention documents which could result in patients being deprived of their liberty without the legal authority. Between January and June 2016, 36 detention files were audited and errors were identified on seven of these. These related to the

completion and the content of the detention papers including insufficient reasons recorded for detention, nearest relative not being consulted and administration errors such as a missing address.

Section 17 leave was authorised on a standard form. These forms were generally completed in a clear and concise way across the trust with the exception of older people's wards where old forms were not clearly cancelled. On wards one and two some patients had more than one form still in date and staff were not clear which was in use, this could lead to confusion.

Staff and patients told us there was good access to independent mental health advocates. Patients were able to refer themselves and we saw posters on wards with contact details. Staff would also refer patients should they prefer it. In forensic wards advocates visited the wards on a weekly basis. In wards for older people staff told us they referred all detained patients to the service and the advocate visited the wards on a regular basis.

Good practice in applying the Mental Capacity Act

Compliance for training on the Mental Capacity Act and Deprivation of Liberty Safeguards was 76%. This training was identified as mandatory training in February 2015 and the training schedule was implemented in July 2015. The trust assured us that the compliance for Mental Health Act and the Mental Capacity Act would meet the trust compliance target of 90% by July 2016. We had concerns that five teams or services had below 75% compliance in the Mental Capacity Act training, including Deprivation of Liberty Safeguards. Four of these services had compliance above 70% including the long stay and rehabilitation wards, the forensic and secure wards, the acute wards and psychiatric intensive care unit and the community services for adults of working age with a mental health problem. However, the wards for older adults with a mental health problem had a compliance of 43% for this training. Staff understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards and their use in practice was variable in the core services. On the acute wards staff were not clear about their responsibilities under the Mental Capacity Act. Capacity assessments were only carried out by consultants.

The trust had a Mental Capacity Act 2005 protocol which had recently been updated to include procedural changes in the trust. The protocol described how to carry out an assessment of capacity, a best interest decision and how to record these on the trust's patient electronic record system either in the records or using a specific form. Recording forms were also available on the trust's intranet for staff to download. We found little evidence of capacity assessments and best interests decisions being completed in most of the core services. On the inpatient wards for older adults with mental health problems, staff were not completing Mental Capacity Act capacity assessments as required by trust policy, which meant we could not ensure the Act was being used correctly.

The trust had a Deprivation of liberty safeguards protocol which was reviewed in June 2016. A revised policy was awaiting review by the Mental Health Legisltation operational steering group and subsequent ratification by the policies and procedures group. However, the protocol gave details of deprivation of liberty, how to apply for an authorisation and how this was managed in the trust. Deprivation of Liberty Safeguards were not well understood or used in some of the core services. Patients at 2 and 3 Woodland Square lacked capacity to consent to their respite care and treatment. They were subject to continuous supervision and control and were not allowed to leave. The service had carried out capacity assessments but had not made applications for Deprivation of Liberty Safeguards. These patients had also been identified by the mental health legislation office as being deprived of their liberty. We were informed that the clinical team were awaiting advice from the local authority before taking action. There was no process in place to deal with this type of conflict in the trust guidance or protocol. These safeguards are a lawful requirement to ensure the service upholds the human rights of patients. The mental health legislation office kept a detailed central record of all Deprivation of Liberty Safeguards assessment outcomes.

Where capacity was impaired, we did not find that capacity to consent was constantly assessed. We saw evidence of decision specific assessments in the care records but these were usually completed by medical staff, other disciples of staff, such as nursing, looked to medical staff to carryout capacity assessments. We did not see attempts to support people to make a specific decision for themselves before they were assumed to lack the mental capacity to make it.

We saw evidence of best interests being made for people but these were not always accompanied by a capacity assessment.

Requires improvement

Are services effective?

Staff understand and where appropriate work within the Mental Capacity Act definition of restraint.

The trust had a central mental health legislation office which could be contacted for advice and guidance in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards and staff knew how to contact this office. However, advice from the office was not always followed by clinical staff and the office found it difficult to address this with senior management.

Both Mental Capacity Act and Deprivation of liberty protocols had audit requirements However, we could not find any evidence that addressed these audit requirements. The trust had recently carried out an audit into clinician knowledge of the Mental Capacity Act, clinical audit number 12, which showed more than 70% of the staff self-reported that they were confident in their knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards. However, 45 % of staff were not familiar with policy, procedure or processes for the Deprivation of liberty safeguards.

The trust provided information around the Deprivation of Liberty Safeguards applications they have made between 1 October 2015 and 31 March 2016.There were 13 Deprivation of liberty safeguards applications made with the majority in mental health wards for older people by ward 1 and ward 3 with 4 applications each.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

We rated Leeds and York Partnership NHS Foundation Trust as good for caring because:

- Staff were respectful, caring and compassionate towards patients, relatives and carers. Patients, relatives and carers told us that staff were kind, visible and approachable.
- Staff were mindful of the best way to communicate with patients in order to support them. Communication was appropriate to the patients' level of understanding or appropriate to their age.
- We observed examples on the wards and during home visits where staff maintained patients' dignity, privacy and confidentiality. The trust scored higher than the England average on the patient led assessment of the care environment for privacy, dignity and well-being.
- Patients were orientated to all wards and services and were involved in decisions around their treatment and care. Where patients were unable to attend multidisciplinary meetings directly their views and opinions were communicated in other ways.
- Patients told us that they were involved in their care plans and most of the patients we spoke with during the inspection told us they could have a copy of the care plan if they wanted one. Staff produced different versions of care plans in accessible formats, for example in the community services for deaf children and adolescents and the community services for learning disabilities or autism.
- We observed good examples of patient involvement in the service. Patients were involved in the central recruitment of staff and volunteers had been recruited in the intensive community services and the community services for working age adults and older age adults with mental health to support and engage patients. A patient in the Leeds Autism Diagnostic Service was involved in the training videos to explain their experiences of living with autism.
- Staff supported patients to use advocacy services and the wards and services we inspected had established good links with adult advocacy services.
- Patients were able to feedback on the majority of wards through weekly community or forum meetings on the inpatient wards. Whilst staff, patients, relatives and carers all found collecting and providing feedback more of a challenge in the community services, there were some proactive initiatives to gain feedback in these services, including the use of electronic devices to gather patient experiences.

However:

- We heard patients detained with Ministry of Justice restrictions referred to in an appropriate way.
- On the inpatient wards for children and adolescents with mental health problems, the advocacy services offered by the trust were not specifically for children and adolescents.
- There were no patient meetings at the respite services for people with learning disabilities or autism. This meant that opportunities for patients to feedback about their stay were limited.

Our findings

Kindness, dignity, respect and support

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used; giving them the opportunity to feedback on their experiences of care and treatment. The trust scored below the England average for recommending the trust as a place to receive care for each of the six months October 2015 to March 2016. Eighty-one percent of patients would recommend the trust as a place

to receive care. This was below the national average of 87%. Patients who would not recommend the trust as a place to receive care was comparable to the national response for other trusts.

Patient led assessments of the care environment or PLACE assessments are self-assessments undertaken by NHS and private/ independent health care providers. At least 50% of the assessors are members of the public known as patient assessors. PLACE assessments focus on different aspects of the environment in which care is provided and non-clinical services. In relation to privacy, dignity and wellbeing, the 2015 PLACE score for the trust was 91%, which was above the England average of 86%. The Newsam Centre scored the highest on the PLACE assessment for privacy, dignity and well-being with 95%. The Asket Centre, the Mount and the Becklin Centre all scored above 90%. However, five locations scored below the England average, including Parkside Lodge, one of the wards we inspected for people with a learning disability or autism.

As part of the inspection, we spent time observing staff interactions with patients. We found that staff were respectful, caring and compassionate towards patients, relatives and carers. Staff worked in a flexible, person centred way. Person centred means maintaining the individual's choices, preferences and wishes so that people receive the support they want and how they like it. We noted that staff identified the best way to communicate with patients in order to support them. Communication was appropriate to the patients' level of understanding or appropriate to their age.

However, during the inspection on the forensic wards at Clifton House, we heard a patient referred to in an inappropriate way. They were referred to as a "prisoner". The patient was not present at this time. We discussed our concerns with the senior ward staff and we were assured that this would be addressed.

Staff maintained patients' dignity, privacy and confidentiality and we observed examples on the wards and during home visits. For example, on the acute wards and the wards for people with learning disabilities or autism, we observed patients supported to a private space to discuss their concerns. In the community services for adults of working age and older age adults, we observed staff taking steps to protect patients' confidentiality by taking off their identification badges before seeing a patient in the community.

Almost all the patients, relatives and carers we spoke to confirmed that they were happy with the care and treatment delivered by the wards and services in the trust. They spoke highly of the support they received. They told us that staff were kind and caring, visible and approachable. Patients told us that they felt safe.

The staff Friends and Family Test was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their service as a place to receive care and whether they would recommend their service as a place of work. Sixty percent of staff would recommend the trust as a place to receive care. This was below the England average of 79%. Nationally 7% of staff would not recommend the trust they work for as a place to receive care. In comparison, 13% of staff working in the trust would not recommend it as a place to receive care. The trust also had a 3.4% lower staff response rate than the England average from 1 July to 31 September 2015, with only 8% of staff responding.

The trust scored slightly below the average for mental health trusts in the NHS staff survey 2015 for the staff satisfaction in the quality of their work and the treatment delivered at the trust. The trust scored 3.82 and the average was 3.84. Eighty-nine percent of staff agreed in the survey that their role made a difference to patients, which was the same as the national average.

The trust scored about the same as other mental health trusts in the Care Quality Commission survey in all ten questions asked, including questions about the workers in the trust and changes in who the patients see for their care, the organisation, planning and review of the care received, treatments and crisis care, other areas of their life and their overall views and experiences of the trust.

The involvement of people in the care they receive

On admission to all the wards we inspected, staff gave patients a tour of the ward and provided them with a welcome or admission pack, which contained information about the service.

On all the wards and in all the services we visited, we observed that patients were involved in decisions around their treatment and care. Where they could not attend multidisciplinary meetings directly, their views and opinions were communicated in other ways. For example in the inpatient wards for children and young people with

mental health problems at Mill Lodge, patients completed a form to record their thoughts, their progress and their wishes. Members of the multidisciplinary team discussed these in the meetings and we saw that the patient's named nurse provided feedback to the patient following this. On the inpatient wards for people with learning disabilities and autism, staff gave patients easy-read forms to complete to feed into their multidisciplinary team meeting and ensure the meeting listened to their view.

The friends and family test data collected between January and March 2016 provided by the trust, considered the views of 215 patients, relatives or carers. This data showed that patients felt safe, able to achieve their goals, listened to and that they were part of care planning. However, they reported that they had not all received a copy of their care plan.

Patients told us that they were involved in their care plans and most of the patients spoken to during the inspection told us they could have a copy of the care plan if they wanted one. We observed holistic, person centred care plans, including patient involvement in all care plans. However, in the community services for people with learning disabilities or autism, we found variable information about patient involvement in care planning, despite the patients' positive feedback about their involvement in their care plan. Of the 25 electronic patient records reviewed, we found that according to the patient electronic recording system that 11 of these patients had not received a copy of their care plan and five patients' care plans did not refer to the patients' views.

Staff supported patients to use advocacy services and the wards and services we inspected had established good links with advocacy services. Services invited the advocacy services to meetings like community meetings, multidisciplinary meetings and care programme approach meetings. Specific mental health advocacy was available through the British society for mental health and deafness in the community services for deaf children and young people who had mental health problems. However, the advocacy service used by the trust in the inpatient wards for children and young people with mental health problems was not specifically for children and adolescents.

We observed appropriate involvement of relatives and carers during the inspection and in the records reviewed. Relatives and carers supporting patients in the community services and respite services for people with learning disabilities all confirmed that the staff actively involved them in the patient's treatment and care. This was the same in the inpatient wards and community services for children and young people with mental health problems where relatives and carers were involved in the multidisciplinary meeting and at the Yorkshire Centre for Psychological Medicine where patients could choose the level of relative and carer involvement they would prefer. However, one family member on the acute wards and psychiatric intensive care unit told us staff did not take into account their concerns about their relative's care.

Patients were involved in the central recruitment of staff. The trust included patients, carers and stakeholder partners in 'community panels' to support the recruitment assessment centre activities for qualified nursing roles and health support worker roles below band seven, as well as for interviews for staff grades band seven and above.

The South, South East community mental health locality had recruited five volunteers who had previously used the service. They worked in the reception area meeting and greeting guests. One of the volunteers told us how important this role was for them and how it had empowered them to work and develop their confidence.

Patients were able to feedback on the service through weekly community or forum meetings on the inpatient wards. However, there were no patient meetings on the inpatient wards for people with learning disabilities or autism, except at Parkside Lodge which had recently started a patient involvement group. Staff said that this was because of the nature of respite, being a constant change of patients. However, that meant that opportunities for patients to feedback about their stay were limited.

Staff, patients, relatives and carers all found collecting and providing feedback more of a challenge in the community services. Relatives said it was a challenge to provide regular informal feedback, for example in the community services for people with a learning disability or autism and staff said that there was often a low response rate to feedback requests, for example in the crisis services.

However, there were some examples of proactive initiatives to gain feedback in these services, including the introduction of the on-line survey in addition to the family and friends feedback cards. An iPad project had been specifically designed that allowed service users to feedback on their experience. This was being utilised in the

Good

Are services caring?

community services for children and young people. The memory service routinely collected feedback about the cognitive stimulation group they offered to patients and used this feedback to improve their interventions.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

We rated Leeds and York Partnership NHS Foundation Trust as good for responsive because:

- The trust used information about the local population when planning and delivering services through working in partnership with the commissioners, other statutory, third-sector and voluntary organisations. These stakeholders told us that the trust was 'aspirational' and 'forward thinking' with regard to new ways of working to deliver care and treatment.
- Bed occupancy and high numbers of out of area placements for the trust had been identified as strategic risks by the trust and the trust had implemented a bed management improvement plan, including a number of initiatives like piloting the proactive purposeful admissions to inpatient care model. At the time of the inspection, the trust had nine patients placed out of area.
- The trust worked proactively and in partnership with other organisations and community services at all levels to reduce the number of patients delayed in being discharged and the number of days that patients are delayed by.
- Information on the wards and services, other local services, patients' rights, access to advocacy, medicines and treatment and how to complain was observed in almost all services. The information was in appropriate and accessible formats, for example in child friendly formats in the mental health services for children and young people and in easy read formats in the services for people with learning disabilities or autism.
- Patients were able to personalise their bedrooms on the wards and in the respite services and were encouraged to do so. They had access to lockable storage.
- Patients on the wards were able to make phone calls in private.
- Patient's individual needs and preferences were central to the planning and delivery of treatment and care at the trust. Staff respected and provided support to meet the diverse needs of their patients including those related to disability, ethnicity, faith and sexual orientation. Staff in all the services we inspected were respectful of people's cultural and spiritual needs.
- Since the last CQC inspection in 2014, the trust committed to improving its response to the complaints it received. There was a robust and effective complaints process. Almost all the wards and services we visited during our inspection demonstrated a positive culture of reporting complaints and learning from complaints and had local arrangements to discuss these in their team meetings.

However:

- There were delays for patients in the community services for working age adults and older adults with mental health problem to access some psychological therapies. Patients waited for up to 20 weeks to receive psychological therapy from a psychologist.
- Parkside Lodge, the inpatient ward for people with learning disabilities and autism, had reduced bed occupancy due to staffing concerns and so a bed was not always available for the local population. There was no bed management strategy and the bed management procedure was at the early stages of discussions.
- There was a lack of clarity of the current service provision in the crisis assessment unit at the time of the inspection. Patients were admitted who required treatment and not extended assessments, which the

Good

Are services responsive to people's needs?

unit was not currently equipped for. Staff in the unit and in other trust wide services were unclear of the role of the crisis assessment unit, including the referral criteria.

- The Section 136 suite for children and young people was formerly the service's Section 136 suite for adults. Although the suite was designated for children and adolescents, we did not note any specific adaptations to make it a child-centred environment.
- Staff and carers raised concerns that patients at 2 Woodland Square were unable to attend activities that were not pre-planned and part of the patient's normal routine prior to attending the respite service. They told us that this was due to staffing levels, the lack of a mini-bus driver, and the lack of access to specially adapted transport. The trust told us that activities were available for all patients and that appropriate transport could be arranged.
- Access to the outside space and the outside environment itself was a concern at The Mount and the Becklin Centre. Not all the wards at these sites had direct access to the gardens and outside areas and patients were unable to access these unescorted. The paths in the garden at The Mount where the wards for older adults with mental health problems were situated were gravel and therefore not ideal for patients with limited mobility and those who needed to use mobility aids. Patients were smoking in the hospital grounds and wards at the Becklin Centre. This put staff and patients at risk of the effects of passive smoking.
- There was limited choice on the inpatient wards for children and young people with mental health problems for patients' dietary requirements relating to their culture or religion, or to meet their preferences for food. Patients on these wards and the forensic wards told us that they did not like the food.

Our findings

Service planning

The trust used information about the local population when planning and delivering services. NHS England requires every area to produce a sustainability and transformation plan as part of the NHS Five Year Forward View. The trust were involved in the development of the Leeds and West Yorkshire sustainability and transformation plans, which included adult social care organisations and the acute trusts. The trust was also actively involved in the development of the West Yorkshire sustainability and transformation plan and the urgent and emergency care vanguard.

The trust told us that they had good working relationships with commissioners and other stakeholders, including third sector organisations. The trust had introduced a procurement framework to allow them to sub contract to voluntary and third sector organisations. The third sector organisations we contacted informed us that the trust was forward thinking and that they had good relationships with the trust and staff at all levels. The commissioners told us that the trust were aspirational and ambitious with regard to new ways of working. However, there were concerns regarding the trust's ability to manage and deliver on these projects and meet the targets set.

Access and discharge

In the community services, the trust overall had a mean referral to assessment of 52 days and a mean assessment to onset of treatment of 25 days. Referral time to treatment standards have been introduced for mental health trusts for a number of services. Prior to their introduction mental health services were exempt from the NHS constitution. The trust had a number of locally monitored access targets for key services as part of our contracts with commissioners. The trust measured time from referral to assessment and from assessment to treatment using activities recorded on the trust clinical information system. This measurement assumes that treatment does not begin at assessment whereas for many services there is the opportunity to begin delivery of a National Institute of Health and Care Excellence compliant treatment at the first contact with the patient.

The trust had identified eight services that breached the 18 week referral to treatment standard, including the rationale for this and taken appropriate action. For example, the trust had recently restructured the delivery of

psychological therapies and integrated this into the community services, in order to reduce the waits to psychological services in general, making it more accessible, in particular access to family therapy.

The trust was flagged as a risk for its bed occupancy ratio, looking at the average daily number of available and occupied consultant-led beds open overnight, as well as the number of detained patients allocated to a location compared with the number of available beds.

The trust had 424 beds in total and at the time of the inspection, the trust had 409 beds in operation due to refurbishment of a ward for older age adults with mental health problems at The Mount. The trust commissioned an independent report on bed capacity. The organisation that completed the review found that the trust was working at optimal bed capacity.

The trust provided details of their bed occupancy rates for 28 wards between 1 October 2015 and 31 March 2016. The average bed occupancy rate was 88% across all wards. Eighteen out of 28 wards for the trust had bed occupancies of 85% and above. The Royal College of Psychiatrists state that the optimal bed occupancy is 85% as this allows patients to be admitted to a ward that is local to them in a timely way. It also allows patients to leave the ward and return to the same ward following a period of leave. The highest bed occupancy rate was ward four at the Becklin Centre, the acute wards for adults of working age, with a bed occupancy rate of 99.9%. Wards three and five Woodland Square had the lowest bed occupancy with 24%.

The acute wards for adults of working age and psychiatric intensive care units had the highest bed occupancy with 98%. The lowest bed occupancy recorded was for the inpatient wards for patients with learning disabilities or autism with 48%. Bed occupancy was 48% at Parkside Lodge, 73% at two Woodland Square and 23% at three Woodland Square. The ward manager explained that bed occupancy was low at Parkside Lodge because they did not accept admissions if the ward was not safe due to staffing or the patient case-mix. This meant patients in the local area could not be admitted if this was required, regardless of the low bed-occupancy and the patient would be transferred out of area or admission to the ward would be delayed.

Between the 1 April 2015 and 31 March 2016, the average length of stay across all wards for discharged patients was 212 days. In the same time-frame, the average length of stay across all wards for current patients was 285. The forensic and secure inpatient wards had the highest 'average length of stay for patients discharged in the last 12 months with 498 days. This was followed by the long stay and rehabilitation wards for adults with mental health issues which had an average length of stay of 362 days for patients discharged in the last 12 months. As of the 13 April 2016, the average length of stay for current patients was the highest in these same two inpatient services. The long stay and rehabilitation inpatient wards had the longest average length of stay with 777 days, followed by the forensic services with an average length of stay for current patients of 570 days.

In the 12 months prior to March 2016, 127 patients had recived care in out of area placements. Ninty-six were patients using acute wards for adults of working age and the psychiatric intensive care unit, 24 for the long stay and rehabilitation mental health wards for adults of working age, five for wards for older people with mental health problems and, two for wards for people with learning disabilities or autism, in the 12 months prior to March 2016. Patients placed out of area, predominantly went to services in North Yorkshire, County Durham and Cheshire. However, about a fifth of patients were placed in services as far away as Nottinghamshire, Hertfordshire and London. The trust had the financial and clinical responsibility for the out of area placements. The commissioners had concerns that the trust did not have sufficient case managers to deal with the out of area placements. However, at the time of the inspection, there were nine patients being cared for in an out of area placement and we observed the Board of Governors reviewing the numbers of out of area placements at the meeting we attended.

The Quarterly Mental Health Community Teams Activity return collects data on the number of patients on a Care Programme Approach followed up within seven days following discharge from psychiatric inpatient care. Between January 2016 and March 2016, the trust achieved 96% for the number of patients on a Care Programme Approach who were followed up within seven days after discharge. This was above their target of 95% required by Monitor but 1% below the England average.

Between the 1 October 2015 and the 31 March 2016, the trust reported 129 readmissions within 90 days across 28 wards. The wards with the highest number of readmissions,

was the crisis assessment unit with 35 readmissions within 90 days. This was followed by the two acute wards for adults of working age at the Becklin Centre, ward five and ward four, with 22 and 15 readmissions within 90 days, respectively. The significant majority of readmissions within 90 days occurred on the acute wards for adults of working age and psychiatric intensive care units, with 66. This was 51% of all readmissions within 90 days.

From 1 October 2015 to 31 March 2016, there were three delayed discharges across three wards. Ward one at the Becklin Centre had one patient who was delayed for a total of 153 days and ward three at the Becklin Centre had another patient whose discharge had been delayed for 62 days. Both these wards are the acute wards for the adults of working age. The third delayed discharge reported by the trust was on ward four at the Mount, the wards for older adults with mental health problems, where a patient was delayed for a total of 43 days. The average delay across the three wards (in terms of days) for delayed discharges was 86 days. The reasons the trust provided for these three delayed discharges was that two people were waiting for residential care and one person waiting for accommodation.

The trust complies with the national guidance to determine numbers of service users whose transfer of care from hospital has been delayed. The guidance states that for a transfer to be delayed a multidisciplinary team decision that the service user is clinically fit for discharge must been recorded and it must be safe to discharge the service user.

Between May 2015 and April 2016, the total number of delayed transfers was 38. The trust's total number of delayed patients transferring peaked in May 2015, July 2015 and then April 2016, but remained at a relatively steady level in other months. The number that was the responsibility of social care was higher than the number that was the responsibility of NHS in every month. The number of delayed days in this time period was 1,131 days.

Between May 2015 and April 2016, the main reason for the delayed transfers for patients for ten months of that year was that patients were waiting for a residential home placement. Forty-seven percent of delayed transfers were due to patients waiting for a residential home placement and totalled 526 delayed days, 26% were due to patients waiting for a nursing home placement or availability which totalled 297 delayed days and 18% were due to housing issues that totalled 235 delayed days.

All admissions to the acute admission wards were gate kept by the crisis assessment service to ensure that the service user's needs could not be met by alternatives to hospital admission. Admissions to the psychiatric intensive care unit were gate kept by that team to ensure that the patients' needs could not be met in a less restrictive environment. The crisis assessment unit was a specialist unit within the crisis assessment service providing extended mental health assessments for people over the age of 18 years old for a period of up to 72 hours. This six-bedded unit opened in 2015. Since opening the unit had accepted around 250 admissions and has reduced admissions to acute inpatients by up to 4 admissions per week. In the period January 2016 to June 2016, 46% of patients referred to the crisis assessment service waited more than four hours for an assessment, 14% of patients were seen within four to eight hours, 5% of patients were seen within eight-twelve hours, 11% of patients were seen within 12-24 hours, and 16% of patients were seen after 24 hours.

Bed management was one of the strategic risks identified by the trust and a bed management improvement plan was in place. However, staff we spoke to were concerned that there was no bed management strategy, particularly with the concerns regarding the out of area placements. Also, the West Yorkshire sustainability and transformation plan includes a reduction in out of area placements by 50% by 2021. There were also concerns that there was no bed management policy. The trust confirmed that the bed management procedure was is in very early stages and was due to go to the bed management group for completion at the end of July before going through the trust governance processes for ratification.

The trust has a bed bureau team which included the capacity manager, four administration staff and a recently appointed housing support co-ordinator. The capacity manager worked across both care groups and was accountable to the chief operating officer. The team monitored admissions and discharges to ensure that beds were available to patients as soon as possible. They were proactive in following up out of area placements and searching for accommodation and social care placements. The housing support coordinator worked with patients to access options for housing at discharge, for example support patients through the bidding process and provides additional expertise.

Good

Are services responsive to people's needs?

All wards used purposeful inpatient admission boards to help plan discharge as soon after admission as possible. The boards highlighted actions to be taken to facilitate discharge and provide a structured and visible way of monitoring that these actions take place at the right time. There was a 'purposeful admissions to inpatient care' model being piloted on the acute wards for adults of working age, where staff regularly monitored the patient journey as a multidisciplinary team.

The trust had increased its joint working between the trust and partners from adult social care, the local commissioning groups and third sector organisations to work together to facilitate timely discharge and the provision of increased wrap-around support in the community, rather than admissions to residential settings or nursing homes.

We had concerns that the crisis assessment unit which provided a safe space for its purpose of undertaking extended assessments of adults experiencing acute and complex mental health crises which required a period of assessment of up to 72 hours, was also being used for other purposes for which it was not fit for purpose. Whilst the trust acknowledged that the crisis assessment unit had the provision to accept patients waiting for admission to acute wards to maintain their safety, we had concerns that there was a lack of clarity of the current service provision at the time of the inspection and that staff were unclear of the role of the crisis assessment unit.

The crisis assessment unit had, in some cases, admitted people who required treatment and not extended assessments. This was not the stated purpose of the unit and it was therefore not equipped for treatment interventions, including meaningful activities. The unit had admitted older people over the age of 65 including one with a diagnosis of dementia. However, because the unit was not designed for treatment, it did not meet the Department of Health's (2015) guidance 'dementia friendly health and social care environments'. We asked the service to clarify 'short term treatment in a safe space' and were told that the patients had been admitted for clozapine titration in one case and to manage the effects of electro-convulsive therapy in another.

We found that the additional roles the crisis assessment unit was undertaking had created a lack of clarity about the purpose of the unit both within the crisis assessment service and in other services within the trust. Staff in the intensive community service told us that they were not sure of the criteria for admitting people to the crisis assessment unit and provided examples of incidents where they had attempted referrals to the unit for people they believed matched the criteria to be told that the person was not acceptable for admission. The unit was opened in recognition of a gap in provision for the crisis assessment service to be able to undertake assessments over a longer time period, to fully assess risk and in so doing to reduce unnecessary admissions. However, the beds within the crisis assessment unit had become part of the overall system for bed management

Team meeting minutes from April 2016 indicated that the service adopted new referral criteria, which had significantly decreased the number of patients requiring unit-based treatment. However, the service manager was clear that the service did not have a set referral criteria. We asked the service to provide referral criteria but the service was unable to provide this.

The facilities promote recovery, comfort, dignity and confidentiality

Medicines information leaflets were available in different languages via the Choice and medication website, accessible via the trust intranet. Staff also had access to medicines information in formats that were suitable for patients living with learning disabilities and pharmacy staff attended a number of patient groups to provide information about medicines. They also attended carers meetings to them with medicines knowledge.

Information on the ward or community service, other local services, patients' rights, access to advocacy and how to complain was observed in almost all services. This information included information for detained patients under the Mental Health Act regarding appeals and tribunals and also information in the community services for patients subject to community treatment orders. The information was in appropriate and accessible formats, for example in child friendly formats in the mental health services for children and young people and in easy read formats in the services for people with learning disabilities or autism.

However, it was noted in the older people's service, the contact information for detained patients about their right to complain to the Care Quality Commission included an incorrect address. These were replaced with posters

displaying the correct address during out inspection. Also, there was no information on how to complain in an easy read format in the inpatient services for people with a learning disability or autism. In the east-north-east team, one of the community services for people with learning disabilities or autism, information about advocacy services and how to access them was not on display. We fed this back during our visit and the manager assured us they would address this immediately

The inpatient wards for people with mental health problems and learning disabilities or autism, had a range of rooms and equipment to deliver treatment and care to patients and to support their rehabilitation and recovery of patients. However, there were concerns identified on some wards, notably around sufficient space for visiting, examination and for meals and with access to outside space.

There was insufficient space at the Yorkshire Centre for Psychological Medicine, Two Woodland Square and the crisis assessment service to have a clinic room or an examination bed in order to deliver care and treatment and also to facilitate private visits that were not in the patients' rooms.

The Yorkshire Centre for Psychological Medicine did not have sufficient room in the clinic for an examination bed, or sufficient space on the ward for visits and the patient lounges doubled up as the activity rooms. This meant that patients were unable to use these rooms to relax when activities were in progress. Similarly, the wards for patients with learning disabilities and autism did not have a specific activity room. Two Woodland's Square did not have sufficient space in the clinic room for an examination bed and the design of the service did not meet the needs of the patient group. Boxes of medical equipment such as continence products and wipes were stored in patient bedrooms and on corridors. The ward only had one storage room, which also meant that patients were unable to bring all of their specialist equipment when they stayed. At both two and three Woodland Square, visitors would need to meet with patients in bedrooms or communal lounges, which did not promote privacy and dignity.

Ward one at The Mount for older age adults with mental health problems had direct access to the outside space with a garden and seating areas. However, patients from the other three wards did not have direct access to the garden as these wards were on the floors above, though staff were able to escort patients from these wards to use the garden. Also, the paths in the garden were gravel and therefore not ideal for patients with limited mobility and those who needed to use mobility aids. The modern matron said they hoped to address this in future as they had realised it did not promote safety. Similarly, patients on the acute and psychiatric intensive care unit wards had access to outside space. However, patients on the wards on the first and second floors of the Becklin Centre needed staff to escort them as there was no direct access from the wards. Patients on the inpatient wards for learning disabilities or autism had access to a garden but they could only use this with support due to ligature risks.

We found additional concerns regarding the environment of the crisis assessment service operated from a newly refurbished area within the Becklin centre which included the Section 136 suites for adults and for children and the crisis assessment unit. The service had one clinic room for both suites and the crisis assessment unit.

The Section 136 suite did not have a separate interview room for patients. There were no facilities for access to private outside space, other than the unenclosed hospital grounds. There were no facilities for access to quiet areas other than patient bedrooms and no facilities for patients to make a phone call in private.

The locked door between the female section of the corridor and the Section 136 suite had a glass panel which was approximately two thirds obscured with an opaque film. Staff told us that the panel was not fully obscured so that staff on the crisis assessment unit could see into the Section 136 suite when they were responding to incidents. However, it also meant that patients in the crisis assessment unit could potentially see and hear patients on the Section 136 suite as they were being admitted in a state of crisis. This impacted on the privacy and dignity of patients in the Section 136 suite. We raised this with the trust and on our return visit the service had added an additional screen to the door which, whilst reducing the vision through the panel further, had still left a gap through which people could see into the Section 136 suite.

The Section 136 suite for children and young people was formerly the services Section 136 suite for adults. Although the suite was designated for children and adolescents, we did not note any specific adaptations to make it a child-centred environment.

Good

Are services responsive to people's needs?

Patients on the inpatient wards had access to hot and cold drinks either from the patient kitchen or from jugs in the lounge areas, with fruit and snacks available throughout the day and night. However, staff locked kitchens at Three Woodland Square and Parkside Lodge which meant patients could not access the kitchen to make food and drinks without staff support. The kitchen at Two Woodland Square was open, however staff supervised patients at all times when in the kitchen.

Patients were able to personalise their bedrooms and were encouraged to bring photographs or belongings from home. There was lockable storage for patients to store their belongings securely. Patients were able to access payphones, portable phones on the ward or use their own mobile phones. There were some restrictions on internet access to maintain privacy and dignity, for example on the crisis wards patients were not able to use the camera function on their mobile phones. However, on the forensic wards, patients were not allowed to use smart mobile phones on the ward at all.

Activities including therapeutic, occupational, social and educational groups were delivered in all wards and services, including at weekends, appropriate to the patients' needs. Patients at two Woodland Square continued with their lives as they did when they were at home, so patients continued to attend school, college and day centres. Staff and carers raised concerns that patients at 2 Woodland Square were unable to attend activities that were not pre-planned and part of the patient's normal routine prior to attending the respite service. They told us that this was due to staffing levels, the lack of a mini-bus driver, and the lack of access to specially adapted transport. The trust told us that activities were available for all patients and that appropriate transport could be arranged.

The community services for people with mental health problems and for learning disabilities or autism, all had interview rooms with adequate soundproofing and blinds on the windows for privacy. Whilst most teams told us that there was sufficient space to complete assessments and interventions, some staff in the south-south-east community services for people with learning disabilities or autism told us that there was not enough interview rooms as facilities at Aire Court as these were shared with other teams that were based there.

Patient's individual needs and preferences were central to the planning and delivery of treatment and care at the trust. Staff respected and provided support to meet the diverse needs of their patients including those related to disability, ethnicity, faith and sexual orientation.

There were good examples of how the services considered the patients individual needs in the delivery of the service. For example, the Leeds autism diagnostic service had arranged the test of the fire alarm at Aire Court to take place between outside of their clinic opening hours. This had been requested in order to avoid unnecessary distress for patients attending clinic that may be hypersensitive to noise. Also, the crisis assessment service did not exclude people on the basis that they had used alcohol or drugs, in line with the crisis concordat. Data from the service indicated that a police station had been used as a place of safety for intoxicated people only twice from January 2015 to May 2016 whereas the Section 136 suite had been the place of assessment for 22 intoxicated people.

All wards and community services were accessible for patients, relatives and carers with mobility issues or disabilities, with accessible bathroom facilities appropriate to the type of service. In the community services, venues for appointments were considered carefully before booking both in terms of geographical and physical accessibility. The inpatient wards for older adults with mental health problems had adjustable profile beds on the wards for people with organic illnesses, like dementia and as required on the other wards for people with functional mental illness, like depression.

Almost all inpatient services were able to meet patients' individual dietary requirements for health and culture, requesting specialist diets for patients who needed them. This included meals for patients who required vegan, vegetarian or coeliac diets as well as kosher or halal meat if required. Patients who prepared their own food could plan for and buy any particular food that met their own dietary requirements. Patients and carers confirmed this and we observed healthy meal choices marked on the menus. However, the meal provider on the inpatient wards for children and young people with mental health problems could not sufficiently cater for a patient's cultural needs or preferences for food. Staff locally sourced food for one

Meeting the needs of all people who use the service

patient who was vegan, as their supplier could not meet this need. Additionally, a patient with dietary requirement relating to their religious groups had very limited choice in their menu.

The trust were in the process of implementing the statutory Accessible Information Standard to ensure that people accessing services who have a disability, impairment or sensory loss are provided with information that is accessible, easy to understand and meets any defined support needs. Information leaflets were available in different languages on request. All wards and services were able to access interpreters for other languages including sign language.

In the community services for children and young people with mental health problems who were deaf, skilled interpreters were available to work with young people using British sign language supported the therapeutic work offered by the team. Where a family spoke a different language to ensure communication was clear sessions had taken place using both language and signed interpretation. A range of leaflets about this service had QR codes that could be scanned on smartphones enabling access to information using British sign language. Communication with young people and their families included using plain English in letters, pictorial representations and video letters as required, for example pictures of the staff on the appointment letters.

The intensive community service told us that they were having difficulties procuring leaflets in languages other than English. Staff offered different explanations for this with some suggesting it was a trust wide issue, whilst others stated that it was related to the uncertainty surrounding the future of the service. During the inspection, we did not find difficulties in other areas accessing leaflets in other languages.

Staff in all the services we inspected were respectful of people's cultural and spiritual needs. Staff supported patients to practice their faith. For example, in the inpatient settings where there was no multi-faith room, patients were encouraged to pray in their bedroom, or staff arranged for the chaplain or different faith representatives to visit. In the Yorkshire Centre for Psychological Medicine, patients were able to attend the chapel in the infirmary. Where patients had authorised leave, were an inpatient on an informal basis, or attended community mental health services, patients were supported to attend local spiritual and religious support.

Listening to and learning from concerns and complaints

Since the last CQC inspection in 2014, the trust committed to improving its response to the complaints it received. The complaints and patient advice and liaison service, has more than doubled in size and the Head of Patient Experience and Engagement is now involved with the complaints team. The complaints team have worked hard to build relationships with the local advocacy services and to deliver training to the wider trust teams and demonstrate their accessibility. The Head of Patient Experience and Engagement informed us that over 120 people had attended complaints training in the last 12 months. The training advocates local resolution and contacting an investigator in the complaints team at the earliest convenience to support with the complaint process. The patient advice and liaison team visited the wards in Leeds and York on specified days of the week to maintain their visibility to staff, patient and carers and to encourage people to approach them if they have any concerns. We observed the patient advice and liaison team offer a compassionate and supportive approach towards patients during the inspection.

The trust received 199 complaints in the 12 months between the 1 April 2015 and 29 March 2016. Almost half of those complaints were either upheld or partially upheld, with 40 complaints upheld and 56 partially upheld. In the same 12 month period, just one complaint received in the acute wards and psychiatric intensive care unit has been referred to the Ombudsman.. The services that received the most complaints were the community based mental health services for adults of working age, which received 51 complaints between 1 April 2015 and 29 March 2016; a quarter of the total complaints. The long stay and rehabilitation wards received the lowest number of complaints for the trust, with just one received in this time period. For the month of May 2016, the trust received 13 formal complaints.

Five complaints records were reviewed. All five records demonstrated the comprehensive approach by the trust towards the complaints it received and the robust systems in place. The records indicated that all the complainants

were reassured that they had the right to complain and that they were made aware of the support available to them. All records demonstrated that people had been advised that their complaint would not compromise their care, or the care of their family. People were able to communicate their concern in a medium and time that suited them, including by email, letter or through the web-site. The Complaint's Manager confirmed that any complaints that were not clear would be followed up when the complaint was received to clarify the information and the resolution that was being sought. All five complaints reviewed demonstrated that complaints were acknowledged within the three day initial response time, with almost all being acknowledged the same day the complaint was received. We saw evidence that all those who complained were offered additional support, for example from advocacy and other relevant support groups. The complaint's team discussed with all those who complained, their preferred method of communication, including face-to-face meetings, as well as the timescales for the complaint to be dealt with. Where the complaint could not be resolved in the 30 day timescale detailed in the trust complaint's procedure, we saw evidence that the complainant was updated regularly regarding the delay, the reason for this and the proposed updated timescale. The complaints team circulated a weekly complaints tracker to the Care Groups, providing a summary of open complaints, with timeframes for completion.

There was a clear audit trail for all complaints, with the investigation report stored on the electronic recording system and all the communication regarding the complaint stored securely on the trust shared drive. All five investigations we observed were very detailed. They included detail about the complaints and the context, risk assessments and evidence including medical notes, interviews with patients and staff and statements. Three of the complaints were escalated to board level. For all the complaints we reviewed, a final letter was observed, which were detailed and thorough and signed by either the Chief Executive Officer or other appropriate staff member, like a consultant psychiatrist. Of the five complaints we reviewed, three were not upheld and two were partially upheld, with one of the complainants being offered compensation.

The trust routinely requested complainants' feedback. Previously they had enclosed a feedback questionnaire and prepaid envelope with each response letter. However, the 13% response rate between April 2015 and March 2016 was low. The complaint's manager and Head of Patient Experience and Engagement told us that they were attempting new methods to collect feedback, including telephone calls and emails.

The trust demonstrated a commitment to learning from complaints. Themes from complaints were fed in to the Care Group Clinical Governance Councils for local action, through a monthly CLIP (Complaints, Litigation, Incidents and PALS) report. To support organisational learning the trust completed thematic analysis of actions identified in response to complaints and claims in addition to serious incidents, safeguarding and Mental Health Act monitoring visits. On a 6-monthly basis this information is reported to the Care Services Strategic Management Group, for agreement of three priority issues for focused action. These priorities are reviewed by the Quality Committee for assurance that action is completed. Complaints information was also reviewed at the monthly or bi-monthly trust Board meetings. We observed compliments, complaints and claims information being presented by the Director of Nursing at the Board meeting we attended as part of the inspection and discussed by the executive and non-executive directors, including key themes, learning and proposed action, including training. The trust had also developed a quarterly review panel to involve service users in quality assessing complaints responses, with any learning from these reviews being fed into the complaints training sessions.

The trust took appropriate action where learning had been identified. For example, the trust had identified the attitude of staff as the most common complaint, with the predominant reason for these complaints being upheld highlighted as communication. The trust responded through commissioning the National Performance Advisory Group to deliver a workshop entitled 'Putting the Patient First – Communication and Customer Care'. A Complaints Management Training Package, including perception and communication, patient experience and basic customer service had been developed and Customer Service training for front-line support staff had been rolled out.

Other examples of service changes as a consequence of learning from complaints included a link established for admin staff to update clinical records where a relative had died in order to ensure deceased people would not be contacted, a community mental health team had

Good

Are services responsive to people's needs?

established meeting with GPs to improve relationships with people accessing services and a change in catering arrangements. in response to an issue about access to vegan food

Almost all the wards and services we visited during our inspection demonstrated a positive culture of reporting complaints and learning from complaints and had local arrangements to discuss these in their team meetings. Feedback from formal investigation of complaints was inconsistent only on the forensic and secure wards. This meant improvement in practice or service delivery on these wards were limited.

Requires improvement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

We rated Leeds and York Partnership NHS Foundation Trust as requires improvement for well-led because:

- The trust did not have robust governance arrangements in place in relation to staff training, supervision and appraisal, medication management and audit, application of the Mental Capacity Act, systems and guidance to support the application of the Mental Health Act, the delivery of seclusion, restraint and rapid tranquilisation in line with the trust policy, accurate and contemporaneous records, the timely reporting of incidents, the crisis assessment unit's service provision, policies and procedures being sufficiently embedded.
- Staff in some services and teams reported that senior managers were not always visible; including staff in the supported living service, the inpatients wards for older people and the respite services for people with learning disabilities or autism reported that this was not the case. Also, at the time of the inspection, the non-executive directors or the board of governors did not gain additional assurance from visiting the services discussed at board level.
- Senior managers told us that quality improvement methodology was not always applied consistently.
- The trust was unable to provide data requested during the inspection in a timely way and some of the data we received conflicted with previous data provided, and with the views of some clinical teams.
- The trust did not always meet its own targets and those agreed with the local commissioners, for example their own appraisal target and the required clustering targets agreed with commissioners.
- The trust did not have a systematic approach in place with regard to the documentation required to assure themselves, or the Care Quality Commission, that the directors met the fit and proper person requirement, regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- The trust had not updated all the polices following the updating of the Mental Health Act code of practice and there was no overall plan detailing how the trust was implementing the changes to the code. Senior management did not have a good understanding of which policies required updating or which one's had been reviewed and updated. This meant it was difficult for staff to know if their practice was in line with the revised code of practice and as such patients' rights may not be upheld.

However:

- The trust had adapted their recruitment process to include values based recruitment and recently adapted the appraisal process to include the behavioural aspects that demonstrate the trust values. Most staff were aware of the trust's vision and values.
- The trust complied with the duty on public bodies to publish equality objectives. The objectives were developed collaboratively with the community and other stakeholders and priority actions were identified. The trust recognised that the experience of black minority ethnic staff members was an important challenge and had introduced a Workforce Race Equality Standard Ideas and Implementation Group and worked with the Yorkshire and Humber Equality and Diversity Leads Network to work collectively on priority areas for action and to share best practice.
- The trust worked proactively to address sickness and had introduced additional sources of support for the most common reasons for absence.
- The trust held an annual nursing conference, which offered development and networking opportunities

Requires improvement

Are services well-led?

for nursing staff across the trust. Staff achievements, linked to trust values were recognised through a monthly 'STAR' awards and an annual awards celebration.

- The trust was committed to working with people who use services to inform treatment and care and shape their services. It had a well-established service user network and involved patients in research projects.
- The trust participated in national audits and national quality improvement programmes in some of its services, including accreditation schemes and peer review. It was committed to research and the development of care and treatment and also worked in collaboration with the local universities to develop its workforce and to create training courses.

Our findings

Vision, values and strategy

The trust's purpose and strategy, 2013 to 2018, "improving health, improving lives" detailed the three strategic goals that the trust aims to achieve for the people who use it services and their relatives and carers. These three strategic goals include:

- People achieve their goals for improving health and improving lives
- People experience safe care
- People have a positive experience of their care and support

The strategy had five strategic objectives which describe how the trust will achieve its strategic goals, as well as the outcome measure used to demonstrate the trust's progress towards both its objectives and its goals. The strategic objectives focus on quality and outcomes, partnerships, workforce, efficiency and sustainability and governance and compliance. An operational plan for 2016 to 2017 set out the trust wide priorities for the coming year for each of these strategic objectives, including the challenges at service level and board level, the local commissioner requirements and the improvement and development objectives. The trust is currently involved in working with other commissioners and providers in Leeds to implement the NHS five year forward view and agree the local sustainability and transformation plan to meet the needs of the local population. This sustainability and transformation plan will supplement the trust's current operational plan.

The leadership team regularly monitored and reviewed its progress on delivering the strategy through attendance at the relevant committees in the trust governance structures and the monthly or bimonthly board of directors meetings. As part of the inspection, we attended a board of directors meeting and observed discussions relevant to the trust strategy and operational plan, including efficiency, quality and performance.

The values that underpinned the trust's approach and identified in the 2013 strategy and trust's priorities in the operational plan 2016-2017, were those identified in the NHS constitution, derived from extensive engagement with staff, patients and the public. These values included:

- Respect and dignity
- Commitment to quality of care
- Working together
- Improving lives
- Compassion
- Everyone counts

The trust had adapted their recruitment process to include values based recruitment and recently adapted the appraisal process to include the behavioural aspects that demonstrate the trust values. The trust values were displayed in the services that we visited. Whilst some of the staff we spoke to in all the trust services we inspected were able to demonstrate the trust values in their discussions and their behaviours, others told us that they were unclear about the trust vision and strategy. Also, staff in the forensic services at Clifton House did not demonstrate respect and dignity in their descriptions of the people who used their services. Staff in the crisis assessment service and the intensive community service did not know the trust vision and values.

At the time of the inspection the trust was undertaking a strategy refresh for 2016 to 2021 including staff, service users and other key stakeholders. This included working with the board of governors at the staff to identify the vision and values that were important to them. These were due to be agreed at the board and circulated to staff for their final input at the end of July 2016. This piece of work included a

programme of listening events led by the Chief Executive in March 2016 and the use of crowdsourcing digital platform to gain the trust stakeholder opinions, video and trust internet in order to increase stakeholder involvement.

Good governance

The trust board of directors were accountable for the running of the trust and had oversight of governance and quality issues through the four sub committees, including the quality committee, the mental health legislation committee, the audit committee and the finance and business committee. The remuneration committee and the nominations committee are also sub committees to the board of governors and part of the corporate governance structure. They oversee the recruitment and motivation of the senior executive team and the non-executive directors respectively.

The trust board of directors included a chief executive and five executive directors who were responsible for strategic leadership. A chairman and six non-executive directors also make up part of the board. They were not employed by the trust and their role was to provide advice and challenge to the executives. Non-executive directors were appointed to the sub-committees appropriate to their skills and experience.

The elected and appointed governors had a role in holding the non-executive directors to account for the performance of the board of directors. During the inspection we spoke with representatives from the board of governors and the non-executive directors, who spoke with clarity about their role, including examples where they had requested information and challenged decisions. In the board of directors meeting, we observed there was challenge from the non-executive directors regarding the out of area placements and suggestions offered.

A governance framework was in place within the trust which had a clear reporting structure for ward-to-board assurance. Professional leaders and matrons had each had particular focus on safety and quality and worked closely with their teams. They provided assurance through local leadership forums, local governance forums and clinical improvement forums. Quality and safety was discussed at these meetings and learning was shared and any risks identified.

These local leadership forums were represented on Care Group clinical governance and risk forums. Arrangements of these clinical governance and risk forums varied in order to align with the individual structures within the trust's two Care Groups but were well-established. The two Care Groups included the Leeds Group which included the crisis assessment services, rehabilitation and long stay, acute and older adults inpatient wards for people with mental health problems and the Specialist Services and Learning Disabilities Care Group, which included the forensic and secure services, the learning disability services and the child and adolescent mental health services.

The Medicines Safety Officer was a member of the clinical governance and risk forum. Medicines incidents were discussed there. Additionally, the Medicines Safety Officer produced a six monthly report with recommendations and this was sent to the trust board.

The Care Group clinical governance and risk forums were the key link between local and organisational clinical governance arrangements and fed into the Care Group Clinical Governance Councils chaired by clinical directors. These clinical directors were members of the Effective Care Committee and also the CQC Fundamental Standards Group which both reported to the trust's Quality Committee, a sub-Committee to the Board of Directors. In this way the Care Group Clinical Governance Councils were the link between the Care Groups and the organisational assurance mechanisms. The Medicines Optimisation Group also reported to the Effective Care Committee and the Chief Pharmacist attended this meeting.

The role of the Quality Committee was to ensure clear accountability for the quality of care throughout the trust, including the systems and processes for escalating and resolving quality issues and escalating to the board of directors where appropriate. The trust incident review group, the safeguarding committee, the health and safety committee and the medical revalidation and appraisals group, also reported into the Quality Committee.

The Board of Directors received assurance from its other sub-committees, including the:

- Mental Health Act Legislation Committee which reviewed the trust's compliance with all aspects of mental health legislation, including the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards.

- Audit Committee which ensured that the financial reporting, compliance, risk management and internal controls were appropriately applied and were, reliable and robust.
- Finance and Business Committee which oversaw the trust's financial planning, the estates strategy and the information technology strategies.

The executive directors confirmed that they gained additional assurance through spending time visiting the services and shadowing staff. The frequency was dependent on the role, for example the Chief Executive told us she visited the services weekly, where as the Chief Operating Officer confirmed that the majority of her work was spent within services. Staff told us that they knew the Chief Executive and received communication from them in the chief executive's blog. Whilst some staff reported that senior managers were visible in the services, others including staff in the supported living service, the inpatients wards for older people and the respite services for people with learning disabilities or autism reported that this was not the case.

The non-executive directors did not regularly visit the trust's services and this was not routine. The non-executive directors told us that it had happened on occasion and the Chief Executive told us that the non-executive directors visiting the wards and services had recently commenced. This position was the same for representatives on the board of governors. Therefore, at the time of the inspection, the non-executive directors or the board of governors did not gain additional assurance from visiting the services discussed at board level.

Both the strategy and the operational plan reflected the trust's financial position. The trust was committed to a number of financial efficiencies in 2016 to 2017, including workforce efficiencies, an estates review and improved procurement of services. This reflected the trust's commitment to achieve a surplus requirement of 2.1 million pounds in 2016/17. We attended a board meeting on the 23 June May 2016. We reviewed minutes from this meeting. The trust currently had a financial sustainability risk rating of 3. The trust identified that the current surplus at month two of the financial year was £67k behind the planned position. This was attributed to unfunded out of area placements and unidentified cost improvement plans. The Finance Officer identified a number of actions in the financial presentation to the Board in order to achieve the required surplus. This included negotiating funds with the Leeds Clinical Commissioning Groups and accelerating planned cost improvement schemes. The Chief Finance Officer and the Director of Nursing stated that quality impact assessments were completed to ensure that quality was not lost where there was a reduction in financial contribution. However, senior managers told that this improvement methodology was not always applied consistently.

In addition, despite these governance structures being in place, there were concerns identified across the trust with regard to key elements of the trust's governance, including:

- Low compliance for some essential mandatory training and training not meeting the trust targets. The senior managers were not clear on the timescales of the trust's trajectory to meet the 90% compliance for mandatory training.
- Compliance for clinical supervision was low and the trust had not yet implemented separate quarterly safeguarding supervision, despite the Leeds Safeguarding Children's Board identifying this as a requirement in 2014.
- Appraisal rates still that had not reached the trust target of 90%.
- Issues with regard to the storage of medication, the monitoring of antipsychotic medication, the systems to support the self-administration of medicines and the effectiveness of the medication audits.
- The application of the Metal Capacity Act in some services was not in line with the trust policy or the Act. This included the assessment and recording of capacity in some services and the use of the appropriate legal authority such as the Deprivation of Liberty Safeguards for all patients who lack the capacity to consent to their care and treatment.
- The systems and guidance in place did not fully support, or ensure, the application of the Mental Health Act across the trust. For example policies were not in line with the code of practice, section 132 rights were not always documented, second opinion appointed doctors were not always contacted in the appropriate timescales and audits did not always pick up the detention errors in a timely manner. There were also blanket restrictions in place in some services.

Requires improvement

Are services well-led?

- The use of seclusion, restraint and rapid tranquilisation was not always in line with the trust policy. Seclusion rooms were not always in line with the requirement of the code of practice. Actions were also still outstanding on the trust's reducing restrictive interventions action plan. Therefore restraints remained high, including the use of prone restraint and prone restraint was still prominent in the trust's training package for managing challenging behaviour.
- Systems were not in place to report incidents in a timely manner and were not in place in some services.
- Not all patient records of care and treatment contained decisions about the patients' care and treatment, or were accurate and contemporaneous. Not all staff, and teams and services, had access to the electronic recording and incident systems, or used both paper and electronic records.
- Policies and procedures across the trust to support staff were either not embedded or not in place, for example the bed management procedure and there was a lack of clarity around the crisis assessment unit's service provision.

The Care Quality Commission requested data as part of the comprehensive inspection. The trust was unable to provide this in a timely way and some of the data we received was conflicting with previous data and information told to us by teams. In total, 411 additional data requests were sent to the trust between the dates of 16 June 2016 to 29 July 2016. As per the agreed process, these requests were asked to be returned within 48 hours except for where an extended timescale was identified by CQC. Where a request was sent after 17:00 by the Care Quality Commission to the trust, the following working day was recorded as the date it was sent. The trust returned 223 data requests, 61%, outside of this timescale (48 hours / two working days). The longest time taken for a data request to be completed was 17 days. During the inspection, the Head of Inspection had to contact the trust on several occasions to raise his concerns about the return of the data requests. The length of time taken was in part attributed to the fact that all the information supplied to the Care Quality Commission had to be overseen by the Director of Nursing before being sent.

The trust used key performance indicators to gauge the performance of each ward. Ward managers could access the trust dashboard to monitor team performance against key performance indicators that were relevant to the service. Across the trust, these included staff training compliance, staff absence, physical healthcare, supervision rates, restrictive practice, and length of stay on the ward or in the service, new patient admissions, time from referral to assessment, discharge, bed availability and occupancy. Not all the ward managers or staff we spoke to understood what key performance indicators were for their team or service. The crisis assessment unit did not have targets to measure and benchmark performance or to identify areas of concern. Also, the crisis assessment service did not collect data on the transportation used to for people brought to the section 136 suites.

The trust did not always meet the required commitment to quality and innovation targets or the targets agreed by commissioners, for example in March 2016, the trust failed to meet its clustering commitment to quality and innovation target and a financial penalty was applied by the commissioners. Also the trust did not meet its targets for the number of registered mental health nurses trained in autism, or the timely communication with GPs. The trust had agreed action plans in place to meet these. The commissioners commented that they had concerns regarding the trust's ability to and manage and deliver on the agreed projects and meet the targets set, for example nurses had not been recruited into the primary care pilot as agreed. The commissioners were also concerned regarding the lack of clinical representation at board level generally and at strategic meetings. It was felt that the Director of Nursing had a large portfolio to manage. The trust had recognised the need for a full-time medical director post.

Each ward had a risk register, the ward managers were able to input items on the risk register. The modern matron was able to put items onto the trust risk register following discussion with senior managers. The risks were each rated in relation to their severity and were subject to regular review. There was action documented as to what current control measures were in place to mitigate each risk.

As of the 15 March 2016, the trust identified nine strategic risks. Deteriorating financial standing, delivering from premises not owned by the trust, vacancies in care services, bed occupancy by patients fit for discharge and defective detentions were all identified as extreme risks for

the trust. We had concerns that the Board did not have oversight of the risks that were on the register below the strategic risk register, or the removal of these risks from the register.

Fit and proper persons test

The Fit and Proper Persons Requirement (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014) ensures that directors of NHS providers are fit and proper to carry out this important role.

The trust's fit and proper person requirements for directors procedure, ratified on the 17 December 2015 by the quality committee, confirmed that their procedure applied to executive and non-executive directors, including those who were permanent and interim posts. The trust and their procedure confirmed that the word 'director' where used included all individuals within this definition. The author, the head of corporate governance, acting as the trust board secretary, was responsible for disseminating the policy to the target audience identified in the procedure, including the human resources team and the board members.

The trust carried out enhanced checks without barred list checks for all its non-executive directors and executive directors in accordance with the law and the Care Quality Commission guidance.

We reviewed the personnel files of six executive directors on the board and seven non-executive directors, which included the Chair. Although, the personnel files we reviewed contained some evidence of the documentation to confirm the trust's compliance with the regulation, it was difficult for the trust to provide us with the complete information at our initial request on the 11 July 2016. On the 14 July 2016, there still remained some information that was outstanding. The trust has since told is that this was due to the fact that some of this evidence had to be drawn together from sources outside of the corporate governance office.

For example, as of the 14 July 2016, the information relating to the occupational health checks for one of the executive directors was still outstanding and one of the executive directors confirmed during the inspection week that they were still in the process of completing this report. Also, the disclosure and barring checks for a non-executive board member and an executive board member were still being processed, though the certificate numbers were available. Information since provided by the trust confirmed that one of these two non-executive director's certificate was held-up due to the Disclosure and Barring Service requesting further evidence and information about the role of the non-executive director. As of the 14 July 2016, the qualification certificates for one of the executive directors was also still outstanding and provided by the trust on the 15 July. The personnel file for the Chair was not available until the final day of the inspection week. The trust told us that this was due to a file corruption during the data transfer to the secure inpection team's portal. Also, the information we received had wrong dates recorded, for example they were dated December 2016, rather than 18 December 2015.

As such, the trust did not have a systematic approach in place with regard to the documentation required to assure themselves, or the Care Quality Commission, that the directors met the fit and proper person requirement, regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Finally, the information received from the trust regarding these directors did not contain any detail concerning the managerial supervision received, the mandatory training undertaken, or the annual appraisals undertaken. However, the non-executive directors confirmed that they were provided with support to complete the role, including internal and external training courses, and an annual appraisal including 360-degree feedback.

Senior managers acknowledged the issues identified by the Care Quality Commission around providing complete documentation to evidence the fit and proper person checks completed by the trust. They acknowledged that improvements could be made in this area.

Equality and Diversity

The Trust complied with the duty on public bodies to publish equality objectives. The objectives were developed collaboratively with the community and other stakeholders and priority actions identified. The Equality and Inclusion Group reviewed the development and progress of equality priorities and were actively involved in the delivery of priority actions. This included the co-ordination of the engagement work, in line with the Equality Delivery System and the implementation of an annual work plan and reporting against the Trust Equality objectives. The trust had an equality, diversity and human rights procedure. The procedure was approved and ratified on the 8 July 2016 by

the Employment Policies and Procedures Group. This agenda was overseen by the Director of Workforce. Equality and Diversity training in the trust was mandatory and compliance across the trust was 95%.

The trust used the NHS Equality Delivery System framework as a performance and quality assurance mechanism to review and improve their performance for service users, communities and staff in respect to all characteristics protected by the Equality Act 2010. The annual 2015 assessment was undertaken with stakeholders and local interest groups to monitor the trust's progress for people with protected characteristics, against the four goals within the framework. The four goals include better health outcomes for all, improved patient access and experience, empowered, engaged and well supported staff and inclusive leadership at all levels. The 2015 assessment for the trust focussed on two of these four goals: improved patient access and experience and inclusive leadership. Out of the seven outcome grades, two were graded as 'developing' and the rest as 'achieving.'

In response to the outcome of this assessment against the Equality Delivery System framework, the trust identified four priority areas for 2015/16. These priority areas included collecting and analysing demographic data for the formal complaints received by the trust and identifying equality themes or trends. None were identified from the data collection over a six month period with a 41% response rate. The trust also made a commitment to improving the access and support for deaf and hard of hearing communities through staff development and improved technologies. Improved pathways of care for people with cognitive impairment and dementia was identified as an additional priority and was addressed through a dementia care training framework, including a three-day Cornerstones of Dementia Care course for 30 clinical staff, Dementia Friends information sessions to over 100 staff and E-learning dementia programmes accessed by 125 staff. Finally, the trust delivered six development sessions to 60 staff focusing on the specific needs of lesbian, gay and bisexual communities, refugees and asylum seekers and deaf and hard of hearing communities, in order to support staff to work in culturally competent ways.

To further support the trusts commitment to the implementation of the NHS Equality Delivery System framework, the trust had also committed to data collection, analysis and the identification of improvement actions in relation to the Workforce Race Equality Standard. The Workforce Race Equality Standard was introduced across the NHS from April 2015 to ensure that employees from black minority ethnic backgrounds have equal access to career opportunities and receive fair treatment within the workplace. The Census 2011 data showed that the black minority ethnic populations that the trust serves for Leeds is 17% and 13% for York. In line with the requirements of the Workforce Race Equality Standard, an initial baseline report was produced in July 2015. This was followed by the Workforce Race Equality Standard report providing the details of the trust performance in 2015/16. The nine indicators were based on the data collected between the 1 April 2015 and 31 March 2016, the staff survey information from 2015 and the Board composition. The total number of staff employed at the date of the 2016 Workforce Race Equality Standard was 2582 and the proportion of black minority ethnic staff employed was 15%, which was in line with the population the trust serves. All staff had reported their ethnicity.

In response to the findings of this Workforce Race Equality Standard report, the trust identified its priorities and actions for 2016/17 in order to improve their performance. Examples of outcomes and actions taken included:

- White staff appointed from shortlisting was 1.4 times greater compared to staff from a black minority ethnic background. The trust action to this included resolution through their recruitment strategy and having a revised centralised assessment centre, using values based recruitment.
- The prevalence of black minority and ethnic bank staff entering the formal disciplinary process was 4 times higher than for white staff in the staff bank. The trust completed a thematic analysis of the data to identify potential themes in relation to reasons for entering the disciplinary process and analysis by professional group and job role, as well as comprehensive bank staff improvement project for the support and development structures for bank staff.
- The Board members from a black minority ethnic community was 8%. This was lower than the black minority ethnic workforce of 15%. The trust action to improve the current under-representation included ensuring this is taken into account when recruiting and appointing new Non-Executive Directors and when

renewing terms of office. Actions also included ensuring that there was a central focus on supporting equality of opportunity, succession planning and associated criteria for appointments to the all Board positions.

Other outcomes where concerns were raised included increased bullying and harassment and lower career progression for black minority ethnic communities in comparison to white people. The trust addressed this through their current strategy development work, the development of a behavioural framework through this trust-wide engagement and consultation, and the introduction of values based recruitment and a values-based appraisal system.

However, in the NHS staff survey 2015, 87% of staff felt that the trust provided equal opportunities for career progression or promotion. This was better than the national average in comparison to other similar mental health trusts, which was 84%.

A number of the responses to the Workforce Race Equality Standard were still in their infancy, including the behavioural framework and the equality, diversity and human rights policy. The Director of Workforce acknowledged that work on these priorities was ongoing as the rationale for the outcomes of some of these indicators were still unclear, for example the conversion rate for black minority ethnic applicants being lower than white applicants and black minority ethnic staff feeling more likely to be bullied than white staff. Not all the staff we spoke to had a clear understanding on the actions taken in response to the outcomes from these Workforce Race Equality Standard indicators. However, the trust recognised that the experience of black minority ethnic staff members was an important challenge. Therefore the trust had introduced a Workforce Race Equality Standard Ideas and Implementation Group. This was led by a cross section of black minority ethnic staff with support from the Chief Executive and the Director of Workforce Development. The trust was also working with the Yorkshire and Humber Equality and Diversity Leads Network to work collectively on priority areas for action and to share best practice.

The trust completed a service evaluation of the patients' experience from a black minority and ethnic community of the psychology and psychotherapy services. This was called "Hear me out." It was a service user research project to identify barriers in access to these services for patients from these communities. Areas identified for development that were taken forward within the team included closer working with specialist outside agencies.

Leadership and culture

The Trust has conducted organisational wide local surveys two ways over the past 12 months: the delivery of an agreed programme of senior manager engagement in March 2016 and the staff friends and family test.

The programme of senior management engagement was designed to enable the staff voice to be heard and also for real change to be realised on the key recurring issues that were important to staff. The programme included the delivery of listening events with the interim Chief Executive Officer supported by an online engagement campaign utilising crowdsourcing, the analysis of the staff feedback by an external partner and key actions identified in areas including staff health and wellbeing, managing performance and appraisals, better recruitment, improving information technology systems, improving the physical environment and supporting and valuing individuals and teams and retaining people.

The staff Friends and Family Test, was conducted quarterly and the results were analysed by Quality Health. Narrative comments were analysed internally and key themes identified. Staff Friends and Family Test results were communicated quarterly to staff via the trust-wide email bulletin and also posted on the 'Your Voice Counts' pages of the trust intranet and on the external trust website.

The NHS staff survey 2015 overall outcome for overall staff engagement was below the national average for mental health trusts, as was staff motivation at work, staff feeling able to contribute towards improvements at work, staff satisfaction with their level of responsibility and involvement, effective team working and recognition and value of staff by managers and the organisation. In the same survey the percentage of staff who would recommend the trust as a place to work was 46%. This was 16% below the England average of 62% in comparison to other mental health services.

The trust was also below average for similar mental health services for the outcome off the NHS staff survey 2015 for the support staff received from their immediate managers and for the quality of their appraisals and the mandatory training, learning or development they received. The trust

was the same as the national average for the percentage of appraisals completed. The trust was also below the national average for staff reporting that they felt pressured in the last three months to attend work whilst feeling unwell. However, staff reporting suffering from work-related stress in the last 12 months was the same as the national average.

On the NHS staff survey 2015, staff reporting that they had experienced physical violence from other staff in the last 12 months was 3%, which was the same as the national average for other mental health trusts. The percentage of staff experiencing physical violence form patients, relatives and carers reported was above the national average. However, staff reporting abuse, harassment or violence from other staff recently and in the last 12 months, was below the national average in comparison to other similar mental health services.

There were no bullying and harassment cases at the time of our inspection. Staff were aware of the trust's whistle-blowing process and of the 'freedom to speak up guardian.' There were three whistleblowing enquiries raised to the Care Quality Commission between 1 January 2015 and 21 June 2016. However, the staff we spoke to stated they would feel comfortable in speaking in person to their manager if they had concerns, or were able to raise concerns via the trusts intranet. During the inspection, the staff we spoke to told us that they felt able to do this without fear of victimisation or recrimination. Whilst some staff still raised concerns about their involvement in the previous transformation plans for the trust over four years ago, staff and teams were generally positive with regard to their current involvement in the development of the service they worked in and the trust as a whole.

Despite the staff NHS survey outcome 2015, morale appeared positive overall in the teams and services. All the staff we spoke to spoke highly of their work colleagues and the support they received from all the members of the multidisciplinary team. However, staff acknowledged that there had been challenges prior to the inspection which at times had been stressful. For example the change of management on the forensic and secure services, the recent high caseloads and the proposed redesign in the community services for adults and older people with mental health problems, the recent staff investigations as a result of staff concerns raised at Parkside Lodge and the temporary merge of the inpatient wards for older adults with mental health problems during redesign of the wards at the Mount.

The turnover for all substantive staff in the 12 months prior to the 31 March 2016 was 10%. The trust vacancy rate was 9% excluding seconded staff. During the inspection we reviewed the trust's last five grievances. These followed the trust's procedure. We also reviewed 15 exit interviews. One third identified the reason for leaving as promotion, in comparison to just under a third highlighting lack of opportunities or a better reward package as the reason for leaving. The trust told us that they had assessed their reward packages and were competitive with other similar sized organisations. Staff were provided with opportunities for leadership training at ward management level.

The Trust held an annual nursing conference, which offered development and networking opportunities for nursing staff across the trust. Staff achievements, linked to trust values were recognised through a monthly 'STAR' awards and an annual awards celebration.

The trust sickness rate was 5%, similar to the national average. The trust had identified musculoskeletal concerns and mental health and stress, as the top two reasons for absence. In response, the trust had a full-time physiotherapist who staff could directly refer to. In supporting staff with mental health and stress, the trust had developed a managing stress toolkit and had plans to implement a first day absence occupational health intervention. The trust were also using the Health and Safety Executive stress risk questionnaire with staff to identify work-related issues and to support managers to address these as appropriate. Where there had been long-term sickness for staff in the teams or services, for example in the long stay and rehabilitation services for adults with mental health problems, we saw evidence of managers being proactive to support these individuals, including requesting support from occupational health.

Engagement with the public and with people who use services

The trust had over 1700 members which it consulted with in order to shape the future of its services to meet the needs of the trust's local communities with mental health and learning disability needs. The members received regular information about the trust, including a quarterly

magazine. Members were eligible to stand as a governor on the trust's Council of Governors and vote for other members to become governors. In this way, people with experience of the services were actively engaged in the planning and delivery of the services and also, as a governor, holding the trust to account. A number of governors on the Council of Governors had service user and/or carer experience.

The trust gained feedback from people who use their services through formal methods including the Patient Related Experience Methods, the Friends and Family Tests, NHS Choices and Patient Opinion and National Service User Surveys.

However, the response rate from patients on the friends and family test fluctuated between 0.1% and 0.3% from October 2015 to February 2015. This was low in comparison to the national average for responses. However, in March 2016 the trust responded by separating the patient related experience measures from the friends and family test and redesigning the postcard response. This resulted in a significant increase in responses to 36, which was three times more responses received in comparison to the 11 received in February 2016. In June 2016, the trust had 71 responses.

In addition, the trust had a well-established service user network. The network had monthly meetings and was led by the trust's recovery and social inclusion team. We observed minutes and a plan for the upcoming service user meetings and observed this as a space for people to give their views within a peer-supported environment and that senior managers were committed to attending. The staff we spoke to from the recovery and social inclusion team were passionate about their role and spoke of their creative ideas to involve the trust's service users in the different services. An Involvement Leads Network involving nominated individuals from each service area, facilitators and service user representatives to review policy and best practice to co-produce clinical services. Service users were also supported to attend the Board of Director's meetings to give direct feedback to the Board and their own experience of the trust. The trust were involving service users in their recruitment activities. The trust had a carers development manager who was responsible for increasing the level of carer involvement throughout the trust.

Seven clinical audits were completed in the trust involving collecting data on the experience of service users and carers. On completion of the audit, their feedback would be used to directly inform service changes. For example an audit was completed to compare the Leeds Autism Diagnostic Service compliance against the National Institute of Health and Care Excellence. Whilst compliance was good, actions included improving risk assessments and ensuring the purpose and process of the autism assessment is explained to the service user.

At ward and service level, people who use services and their carers and relatives were able to feedback into the service through comments boxes, their local community meetings and Patient Advice and Liaison meetings.

Quality improvement, innovation and sustainability

The trust participated in national clinical audits, including the National Audit of Schizophrenia, the National Audit of Psychological Therapies, Prescribing Observatory for Mental Health – UK audits and the national mental health commissioning for quality and innovation indicators for cardiometabolic screening. We observed the trust's action plans for each of these following the outcome of these audits.

The trust participated in national quality improvement programmes, including accreditation schemes and peer review. The trust provided documentation to confirm this, including actions identified where appropriate. The trust was:

- accredited as excellent in March 2016 with the Electro Convulsive Therapy Accreditation Service
- accredited in April 2016 with the Memory Service National Accreditation Programme following approval from the Royal College of Psychiatrists' Combined Committee
- accredited for four years with the Psychiatric Liaison Accreditation Network in March 2016.

In addition:

- Mill Lodge inpatient child and adolescent mental health service in York was registered with the Quality Network for Inpatient Child and Adolescent Mental Health Services. However, this service was yet to be accredited.
- The forensic and secure inpatient services at both the Newsam Centre and Clifton House were members of the Quality Network for Forensic Mental Health Services. Both services had been reviewed in the last six months.

Requires improvement

Are services well-led?

- The Yorkshire and Humber mother and baby unit was accredited in July 2014 with the Quality Network for Perinatal Mental Health Services for three years.
- The Yorkshire Centre for Eating Disorders was accredited in September 2015by the Quality Network for Eating Disorders.

The trust did not participate in the Accreditation for Inpatient Mental Health Service schemes at the time of the inspection.

The trust was committed to research and development. The trust recruited 842 participants into 27 nationally funded research projects. Research projects were completed in both child and adolescent mental health and the general psychiatric population.

The trust had worked in collaboration with the local universities to develop its workforce and to create training courses, for example the Person Centred Recovery course delivered by clinicians, with the support of patients, on the long stay and rehabilitation wards.

A number of pilot projects and initiatives were being undertaken across the trust at the time of the inspection to develop the workforce, improve practice and the patient experience. This included projects in the forensic services and on the acute wards, as well the publication of the arts and minds network 'creative pathways' guide to support staff in promote recovery and well-being in the services.

The trust had introduced current technology, including the provision of electronic tablet devices, to increase patient engagement and gather patient feedback to develop its services.

The trust completed an annual membership campaign to raise awareness of mental health and learning disabilities, reduce stigma and to signpost people to both trust and external support services. The 2015 campaign focussed on men's mental health and well-being, whilst the 2016 campaign, "This is me!" focussed on identity, labels and sense of self and how this impacts on a persons' mental health and well-being.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met** The governance systems established to assess, monitor, and improve the quality and safety of the service, and manage risk, did not operate effectively and were not embedded in the service. The trust did not have a systematic approach in place with regard to the documentation required to assure themselves, or the Care Quality Commission, that the directors met the fit and proper person requirement, regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Incidents were not reported to the National Reporting and Learning System in a timely way. Incidents were not reported in both the supported living service and the forensic and secure inpatient services and the systems were not in place in all services to ensure incidents were reported and reported in a timely way. Systems were either not in place or sufficiently robust to ensure that records were accurate and contemporaneous, including all decisions about patient's care and treatment within their care record.

This section is primarily information for the provider

Requirement notices

The internal audit systems were not always sufficiently robust to identify missed doses or other medication issues and errors in some services.

The application of the Metal Capacity Act in some services was not in line with the trust policy or the Act.

The systems and guidance in place did not fully support, or ensure, the application of the Mental Health Act across the trust and the updated code of practice was not sufficiently embedded across all the services or detailed in the trust policies.

The trust did not return the data requested by the CQC during the inspection in a timely way.

This is a breach of regulation 17(2)(a) (b) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The trust compliance was low for training courses on essential life support, moving and handling advanced, food safety level two, fire level three, intermediate life support, safeguarding children level two and three. The low compliance with essential and immediate life support meant that the service could not guarantee that all staff could respond to patients in a medical emergency. Compliance in the mandatory level two Mental Health Act community and inpatient level two training and the duty of candour, for the trust were also below 75%. Five teams or services had below 75% compliance in the Mental Capacity Act training, including Deprivation of Liberty Safeguards.

This section is primarily information for the provider

Requirement notices

The trust had not met its target of 90% compliance for appraisals and some services had low compliance.

The trust compliance for clinical supervision was low across the trust, except for the mental health services for children and young people.

This is a breach of regulation 18 (2) (a)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met:

The emergency equipment and medication checks were not sufficiently robust on some wards, including the inpatient wards for older adults and the long stay and rehabilitation wards, where items were out of date or missing and equipment like blood glucose testing meters were not being recalibrated.

Medicines across the trust were not being stored at the correct temperatures to remain effective. Staff in many of the clinical areas throughout the trust were not monitoring ambient room temperatures and where they were, temperatures were exceeding the room temperature recommended by the World Health Organisation guidelines. Staff in clinical areas were either not recording the fridge temperatures or not always taking action when temperature readings were outside of the required range.

There was no physical health monitoring of antipsychotic medication and staff in the community services were unclear who was responsible for physical health monitoring.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 12 (2) (e) (f) (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met:** The Yorkshire Centre for Psychological Medicine did not comply with the Department of Health guidance same sex accommodation (2010), or the code of practice, at the time of the inspection. This was a breach of regulation 10 (2) (a) and (c)

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.

Update on the CQC visit to LYPFT 11-15th July 2016

Background

LYPFT received a comprehensive visit from the CQC between 11th and 15th July 2016. The final report was received in November 2016 with the action plan having to be submitted by 16th December 2016. A Quality Summit was held on 8th December 2016 where the CQC presented the findings of their report and the Trust were able to give a response. NHS Improvement then facilitated discussion between all the stakeholders present as to how to support the Trust moving forward.

Key Findings

The Trust was rated as "Requires Improvement" with the individual domains that the CQC uses to assess services rated as below.

Five key questions	Ratings at Trust level
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well led?	Requires improvement
Overall Trust Rating	**Requires Improvement**

Appendix 2 shows how each individual service rated in the inspection against each domain..

The Trust received twenty Regulatory requirements against six Regulations for the provider as a whole and against individual services. Appendix 1 has these listed.

In summary the trust was required to :

Review the statement of purpose for the Crisis Assessment Unit (Regulation 9)

Meet single sex requirements on the Yorkshire Centre for Psychological Medicine (Regulation 10)

Ensure care plans were updated and medicines managed safely (Regulation 12)

Review the seclusion and search policies (Regulation 13)

Improve Governance and reporting procedures (Regulation 17)

Improve compliance rates with training and appraisals amongst staff (Regulation 18)

Actions already completed

The Trust was already aware of many of the issues highlighted and work was already in progress to address the issues. Since the visit the following actions have already been completed:

1. Electronic prescribing has been rolled out across the Trust which ensures safer recording of medicines administration.
2. Reporting of patient safety incidents to the national Reporting and learning System are now completed in seventeen days which is above the national average.
3. A system has been introduced to monitor the reading of patient rights who are detained to ensure best practice.

Internal Governance

An action plan (attached) was submitted to the CQC in December 2016. The action plan contains the “Must do” actions and the “Should do” actions required by the CQC. The “Must do” actions incorporate the Regulatory requirements and so these are not included in the action plan. They are listed in Appendix 1.

The Trust’s CQC Fundamental Standards Group (CQCFSG) will monitor the progress against the action plan through a bespoke electronic tracker that has been developed. This will allow the monitoring of completed actions which will all have had to be signed off by the relevant service governance committee. Actions will not be allowed to be signed off unless specific evidence is provided. The CQC FSG will seek assurance on completion of actions and report to the Board on progress.

Next steps

The Trust is also keen to go beyond meeting CQC requirements and so is developing a Quality Strategy to define what Good should look like. Engagement with key stakeholders is taking place through January, February and March to seek views on what should be in such a strategy and how this should be measured.

Conclusion

The Scrutiny Committee is asked to note the rating applied to the Trust of Requires Improvement. The Committee is also asked to note all the great work that has been recognised in the reports. The Committee is also asked to note the progress made against the action plan so far. Continued progress will be monitored by the CQCFSG and any further reports will come to the Committee as requested.

Mark Gallacher

Interim Head of Performance and Quality, January 2017

APPENDIX 1

Services	Crisis Service	Acute wards	Wards for older people	YCPM	LD wards	Forensics	CAMHS	SSLS	Provider
Detail of service	**Crisis Assessment Unit and Intensive Community services**	**Becklin centre ward 4 and PICU at Newsam Centre**	**The Mount**	**Yorkshire Centre for Psychological Medicine at the LGI site of LTHT**	**Parkside Lodge and Woodland Square at St. Mary's Hospital**	**Clifton House in York and wards 2&3 at the Newsam Centre**	**Tier 4 Child and Adolescent in-patient service at Mill Lodge in York**	**Specialist Supported Living Services based at St. Mary's Hospital**	**The Trust as a whole**
Required actions.									
Regulation 9: Person-centred care	Unit not being used for stated purpose of providing services of up to 72 hours.								
Regulation 10: Dignity and respect				Bedrooms not en-suite					YCPM did not comply with DH guidance for same sex accommodation
Regulation 12: Safe Care and Treatment					Patient care plans at 2 Woodlands did not show that staff had updated them.			There was not safe and proper management of medicines.	Emergency equipment and medication checks not robust on some wards. Medicines were not being stored at the correct temperatures. There was no physical health monitoring of antipsychotic medication. Staff in community services unclear who was responsible for physical health monitoring.

APPENDIX 1

Services	Crisis Service	Acute wards	Wards for older people	YCPM	LD wards	Forensics	CAMHS	SSLS	Provider
Detail of service	Crisis Assessment Unit and Intensive Community services	Becklin centre ward 4 and PICU at Newsam Centre	The Mount	Yorkshire Centre for Psychological Medicine at the LGI site of LTHT	Parkside Lodge and Woodland Square at St. Mary's Hospital	Clifton House in York and wards 2&3 at the Newsam Centre	Tier 4 Child and Adolescent in-patient service at Mill Lodge in York	Specialist Supported Living Services based at St. Mary's Hospital	The Trust as a whole
Regulation 13: Safeguarding service users from abuse and improper treatment					The trust had not made Deprivation of Liberty Safeguards applications for patients at 2 and 3 Woodland Square.	Blanket restrictions were in place for routine searching following periods of leave	Staff did not have a full understanding of what constituted seclusion and the procedures to follow		
Regulation 17: Good governance	Service not fully completing section 136 detention documentation. Service did not routinely share all data with other agencies. CAS and intensive community service were not able to share relevant information with the Care Quality Commission in		The provider did not always maintain an accurate and contemporaneous record of each patient.					The system for reporting safeguarding concerns did not ensure all incidences were recorded robustly.	1.Governance systems to assess, monitor, and improve quality did not operate effectively 2.Trust did not have a systematic approach in place to assure themselves, that the directors met the fit and proper person requirement, 3. Incidents were not reported to the National Reporting and Learning

Services	Crisis Service	Acute wards	Wards for older people	YCPM	LD wards	Forensics	CAMHS	SSLS	Provider
Detail of service	Crisis Assessment Unit and Intensive Community services	Becklin centre ward 4 and PICU at Newsam Centre	The Mount	Yorkshire Centre for Psychological Medicine at the LGI site of LTHT	Parkside Lodge and Woodland Square at St. Mary's Hospital	Clifton House in York and wards 2&3 at the Newsam Centre	Tier 4 Child and Adolescent in-patient service at Mill Lodge in York	Specialist Supported Living Services based at St. Mary's Hospital	The Trust as a whole
	a timely manner.								System in a timely way. 4. Incidents were not reported in both the supported living service and the forensic and secure inpatient services in a timely way 5. Systems were either not in place or sufficiently robust to ensure that records were accurate and contemporaneous. 6. Internal audit systems were not always sufficiently robust to identify missed doses of medication 7. The application of the Metal Capacity Act in some services was not in line with the trust

Services	Crisis Service	Acute wards	Wards for older people	YCPM	LD wards	Forensics	CAMHS	SSLS	Provider
Detail of service	**Crisis Assessment Unit and Intensive Community services**	**Becklin centre ward 4 and PICU at Newsam Centre**	**The Mount**	**Yorkshire Centre for Psychological Medicine at the LGI site of LTHT**	**Parkside Lodge and Woodland Square at St. Mary's Hospital**	**Clifton House in York and wards 2&3 at the Newsam Centre**	**Tier 4 Child and Adolescent in-patient service at Mill Lodge in York**	**Specialist Supported Living Services based at St. Mary's Hospital**	**The Trust as a whole**
									policy or the Act. 8. Systems and guidance did not fully support the application of the Mental Health Act across the trust 9. Trust did not return data requested by the CQC during the inspection in a timely way.
Regulation 18: 2014 Staffing	Staff in the crisis assessment service and the intensive community service did not receive an annual appraisal.	The trust did not ensure that staff were up to date with their mandatory training	Not all staff had received appropriate training, supervision and appraisal	Compliance with mandatory training was low	The service did not offer staff regular supervision and annual appraisal.	Staff members were adequately trained in: Clinical risk Immediate life support Mental Health Act			Trust had not met its target of 90% compliance for appraisals. Trust compliance for clinical supervision was low across the trust.

Appendix 2
Core service ratings

#	Core Service	Commissioner of service	Safe	Caring	Effective	Responsive	Well-led		Overall Rating
1	Community based services for older people	Leeds CCGs							
2	Community Services for people with learning disabilities or autism	Leeds CCGs							
3	Wards for people with learning disabilities or autism	Leeds CCGs							
4	Acute Wards for Adults of working age and PICU	Leeds CCGs							
5	Mental Health Crisis Services and Health Based Place of Safety	Leeds CCGs							
6	Community Services for working age adults	Leeds CCGs							
7	Long stay rehabilitation wards for working age adults	Leeds CCGs		☆		☆	☆		☆
8	Deaf CAMHs	NHS England							
9	CAMHs inpatient ward	NHS England							
10	Wards for older people with mental health problems	Leeds CCGs							
11	Forensic Inpatient/Secure Wards	NHS England							
12	Yorkshire Centre for Psychological Medicine	Leeds CCGs and case by case							
13	Specialised Supported Living Service	Leeds City Council							

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Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Safe	Must Do	The provider must ensure that the mandatory training compliance is in line with the trust target.	We will consolidate our recording and reporting of clinical supervision, appraisal and compulsory training into a single electronic system (iLearn) by end of March 2017.	At Board level, compliance will continue to be reported in the monthly Integrated Quality Report, and monitored via reports to the Quality Committee.		30/06/17	Susan Tyler/Lynn Parkinson
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Safe	Must Do	The provider must ensure that the mandatory training compliance is in line with the trust target.	Managers will receive a single integrated report (on a weekly basis) showing compliance against clinical supervision, appraisal and compulsory training targets	Across Care Services, Integrated compliance reports will be monitored each month via the Care Group Management Team and through individual supervision with team / ward managers and professional leads.		30/06/17	Susan Tyler/Lynn Parkinson
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Safe	Must Do	The provider must ensure that the mandatory training compliance is in line with the trust target.	Compulsory training – we will implement a system of 'block' compulsory training events which maximise the opportunity for attendance by clinical staff to build on the current overall compliance rate we currently have of 88%			30/06/17	Susan Tyler/Lynn Parkinson
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Safe	Must Do	The provider must ensure that the mandatory training compliance is in line with the trust target.	Care Services (supported by the HR business partners) will ensure – within both Care Groups – that a clear process is in place for the monthly monitoring of performance in relation to appraisal, supervision and compulsory training, via the Care Group management and governance meetings.			30/06/17	Susan Tyler/Lynn Parkinson
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Safe	Must Do	The provider must ensure that the mandatory training compliance is in line with the trust target.	We will also establish a Compulsory training Task & Finish group to review the delivery and compliance of each aspect of our compulsory training programme that is achieving below 85%. This group will agree and implement specific plans to increase compliance against each specific training that is underperforming, and will agree trajectories for each service area to maintain or achieve an 85% compliance by the end of June 2017.			30/06/17	Susan Tyler/Lynn Parkinson
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Effective	Should Do	The provider should ensure that e-prescribing information matches the authorised Mental Health Act medication documentation.	We have identified the professional group responsible for recording Section 58 data on the electronic prescribing system.	The process will ensure compliance with section 58 requirements. Audit report		30/04/17	Anthony Deery

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Effective	Should Do	The provider should ensure that e-prescribing information matches the authorised Mental Health Act medication documentation.	Implemented the process as above.			30/04/17	Anthony Deery
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Effective	Should Do	The provider should ensure that e-prescribing information matches the authorised Mental Health Act medication documentation.	We will undertake a compliance audit to determine if the new process is effective	Audit report		30/04/17	Anthony Deery
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Safe	Should Do	The provider should ensure that all acute and psychiatric intensive care unit wards at the Newsam Centre are clean.	Re-examine joint terms of reference for joint cleanliness group.	Revised schedules and specification will be implemented.		31/03/17	Dawn Hanwell
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Safe	Should Do	The provider should ensure that all acute and psychiatric intensive care unit wards at the Newsam Centre are clean.	Redefine and respecify cleanliness standards			31/03/17	Dawn Hanwell
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Safe	Should Do	The provider should continue to refurbish wards and where possible remove ligature risks.	Programme of refurbishment in place to specifically address outstanding ligature issues	The programme of work will be completed and evidence that all identified ligature risks have been appropriately addressed.		30/09/17	Dawn Hanwell
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Safe	Should Do	The provider should ensure that all staff have a good understanding of the trusts policies and procedures in relation to patient observation levels	The Clinical Improvement Forum will ensure that there is a process in place to remind staff of their responsibility to familiarise themselves with all trust policies.	Staff will have a good working knowledge of policies and procedures and their application to practice.Minutes of Acute Inpatient Service and PICU Clinical Improvement Forum		28/02/17	Alison Kenyon

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Safe	Should Do	The provider should ensure that all staff have a good understanding of the trusts policies and procedures in relation to patient observation levels	Staff will be reminded of their responsibility to familiarise themselves with policies.			28/02/17	Alison Kenyon
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Safe	Should Do	The provider should ensure staff monitor medicine fridge temperatures daily. Where temperatures are outside recommended levels action should be taken to rectify them.	Standard Operating Procedure (SOP) describing in detail the process for monitoring temperatures in clinic rooms and medication fridges has been produced and ratified at the Policy and Procedures Group, distributed to all ward managers and matrons for implementation and uploaded onto staffnet.			31/12/16	Elaine Weston
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Safe	Should Do	The provider should ensure staff monitor medicine fridge temperatures daily. Where temperatures are outside recommended levels action should be taken to rectify them.	New recording charts have been employed on every ward /dept with medication. Pharmacy staff to check weekly that monitoring is taking place by nursing staff and that all breaches are reported through the datix system.			31/12/16	Elaine Weston
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Effective	Should Do	The provider should ensure staff have a good understanding of the Mental Capacity Act and their responsibilities under the Act.	MCA/DOLS level 2 training is mandatory for professionally qualified staff (AC's and section 12 approved Dr's are exempt). We are currently at 82% compliance for this training. Regular dates for training are available for the next six months.	This will ensure patients' rights are safeguarded in accordance with the respective legislation.		31/03/17	Anthony Deery
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Effective	Should Do	The provider should ensure staff have a good understanding of the Mental Capacity Act and their responsibilities under the Act.	To increase knowledge and support around the use of the MCA and DOLS we are training 'MCA Champions'. These will be identified individuals in clinical areas who will receive more in-depth training, delivered in partnership with adult social care, and will offer advice and support to their clinical area.	This will be evidenced via clinical audit.		31/03/17	Anthony Deery
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Effective	Should Do	The provider should ensure staff have a good understanding of the Mental Capacity Act and their responsibilities under the Act.	We are also producing a practical guide to the use of the MCA and DOLS in clinical areas. This will assist staff in identifying when someone may be deprived of their liberty and how to authorise this, assessments of capacity, consultation and best interest decisions.	Monthly audits of detention documentation and processes are in place.		31/03/17	Anthony Deery

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
	Acute Wards for adults of working age and psychiatric intensive care units	Effective	Should Do	The provider should ensure staff have a good understanding of the Mental Capacity Act and their responsibilities under the Act.	The MHA Legislation Department will continue to provide support and advice around all matters relating to MCA/DOLS, including attending best interest meetings and supporting assessment of capacity.	Yearly audit cycle of documentation relating to the detention of patients within the trust		31/03/17	Anthony Deery
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Effective	Should Do	The provider should ensure notices with regard to the rights of informal patients to leave the wards are displayed on all wards	Interim notices placed on wards	Notices are displayed and staff are able to articulate patients rights.		31/01/17	Anthony Deery
	Acute Wards for adults of working age and psychiatric intensive care units	Effective	Should Do	The provider should ensure notices with regard to the rights of informal patients to leave the wards are displayed on all wards	Trustwide notices to be agreed in the Mental Health Legislation Group. Communications department to produce and distribute the leaflets	Audit to check if notices displayed in all areas.		30/04/17	Anthony Deery
Leeds	Acute Wards for adults of working age and psychiatric intensive care units	Well led	Should Do	The provider should ensure that the managers have a good understanding of the key performance indicators used to ensure that a safe and high quality service is delivered on these wards.	Quality Performance Framework agreed for all clinical areas.	Performance Indicators in place		30/06/17	Alison Kenyon
S&LD	Child and Adolescent mental health wards	Safe	Must Do	The trust must ensure staff have a full understanding of what constitutes seclusion and that they follow the follow the Mental Health Act code of practice when this occurs.		Any use of seclusion will be monitored via the newly established Trust Seclusion Monitoring Group, which is overseen by (and provides a report to) the Mental Health Legislation Operational Group		30/06/17	Anthony Deery
leeds	Acute Wards for adults of working age and psychiatric intensive care units	Well led	Should Do	The provider should ensure that the managers have a good understanding of the key performance indicators used to ensure that a safe and high quality service is delivered on these wards.	Clinical Improvement Forums to monitor achievement of KPIs.	Evidence of managers using indicators to demonstrate quality of services.		30/06/17	Alison Kenyon

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
leeds	Acute Wards for adults of working age and psychiatric intensive care units	Well led	Should Do	The provider should ensure that the managers have a good understanding of the key performance indicators used to ensure that a safe and high quality service is delivered on these wards.	System of performance reviews of clinical areas to be developed and implemented			30/06/17	Alison Kenyon
LD&SS	Child and Adolescent mental health wards	Safe	Should Do	The trust should ensure that medications are stored within the required temperature range.	Standard Operating Procedure (SOP) describing in detail the process for monitoring temperatures in clinic rooms and medication fridges has been produced and ratified at the Policy and Procedures Group, distributed to all ward managers and matrons for implementation and uploaded onto staffnet	This will ensure the cold chain is maintained and no destabilisation effect on the medicines stored.Reduction in datix reports around missed monitoring of fridge/ clinic room temperatures or/and aberrant temperature reporting.		31/12/16	Elaine Weston
LD&SS	Child and Adolescent mental health wards	Safe	Should Do	The trust should ensure that medications are stored within the required temperature range.	New recording charts have been employed on every ward /dept with medication.			31/12/16	Elaine Weston
LD&SS	Child and Adolescent mental health wards	Safe	Should Do	The trust should ensure that medications are stored within the required temperature range.	Pharmacy staff to check weekly that monitoring is taking place by nursing staff and that all breaches are reported through the datix system.			31/12/16	Elaine Weston
LD&SS	Child and Adolescent mental health wards	Safe	Should Do	The trust should ensure that the medicines audit procedures identify all missed signatures on the prescription charts	The implementation of Electronic prescribing Trustwide eradicates the issue of non recorded 'missed doses' as the system demands a reason for a dose not being given.	The EPMA reports of numbers of missed doses should decline.		31/12/16	Elaine Weston
LD&SS	Child and Adolescent mental health wards	Safe	Should Do	The trust should ensure that the medicines audit procedures identify all missed signatures on the prescription charts	The Medication Safety Committee will determine the frequency of audit of medication charts via EPMA re 'missed doses' and other medication issues and formulate an action plan on the results.	An increase in overall datix reporting re medication errors /incidents should occur.		31/12/16	Elaine Weston
LD&SS	Child and Adolescent mental health wards	Safe	Should Do	The trust should ensure that the medicines audit procedures identify all missed signatures on the prescription charts	All datix regarding medication are reviewed by the Medicines Safety Committee to identify trends and implement necessary training or action to avoid repetition.	Datix reports regarding medication are reviewed regularly by Meds Safety Committee, identifying trends and implementing necessary training or action to avoid repetition.		31/12/16	Elaine Weston

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
LD&SS	Child and Adolescent mental health wards	Safe	Should Do	The trust should ensure that the medicines audit procedures identify all missed signatures on the prescription charts	6 monthly medication error report is produced that goes to the Medicines Optimisation Group and Effective care.	The 6 monthly report gives recommendations to the Trust for improvement		31/12/16	Elaine Weston
LD&SS	Child and Adolescent mental health wards	Safe	Should Do	The trust should ensure that the medicines audit procedures identify all missed signatures on the prescription charts	The Nurse leads need to encourage reporting of errors involving medication onto Datix	The Medicines Safety Committee to be the guardians of the drug chart audit reporting of the EPMA system		31/12/16	Elaine Weston
LD&SS	Child and Adolescent mental health wards	Responsive	Should Do	The trust should ensure the unit provide meals to meet a patient's dietary requirements taking into account cultural and individual preferences.	A meeting took place in September 2016 between the Clinical Team Manager at Mill Lodge, the unit dietitian and the Facilities Department catering manager. A new menu was to be developed a new menu with direct input from the service users and clinical staff together.	Patients will be able to select nutritious meals suitable to their cultural preferences.This system of joint development and review will continue with a formal review in 6 months. Any interim issues will be raised directly with the Trust's Catering Manager.		30/06/17	Anthony Deery
LD&SS	Child and Adolescent mental health wards	Caring	Should Do	The trust should ensure patients have access to advocacy specifically for young people.	The existing two advocacy providers for services in Leeds and York did not have CAMHS specialist advocacy services	Specific advocacy services for young people are available		31/07/17	Andy Weir
LD&SS	Child and Adolescent mental health wards	Caring	Should Do	The trust should ensure patients have access to advocacy specifically for young people.	CAMHS Service Manager to review current provision of advocacy,			31/07/17	Andy Weir
LD&SS	Child and Adolescent mental health wards	Safe	Should Do	The trust should ensure that patients are informed of the staff members due on a night time shift.	Mill Lodge Ward Manager to ensure system of communicating staff on duty for next 24 hours is in place and maintained	Evidence of written system / procedure in place. Young people able to identify staff on duty.		31/01/17	Andy Weir
Leeds	Community based mental health services for older people	Safe	Should Do	The service should continue to work towards reducing staff caseloads so they align to recommended good practice guidelines.	Memory Services will continue to transfer the monitoring of the anti dementia drugs back to GPS/primary care	Reduced numbers on caseloads of all professionals. Professionals will work within recommended practice guidelines.		30/06/17	Alison Keynon
Leeds	Community based mental health services for older people	Safe	Should Do	The service should continue to work towards reducing staff caseloads so they align to recommended good practice guidelines.	YPDT will undergo an evaluation of the present model of care provision and any recommendations identified with be implemented	Relevant papers re the model review and evidence of implementation of any recommendations		30/06/17	Alison Kenyon
Leeds	Community based mental health services for older people	Safe	Should Do	The service should continue to work towards reducing staff caseloads so they align to recommended good practice guidelines.	The new model for older people's community services will be implemented.	Implementation plan for OPS service		30/06/17	Alison Kenyon

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Leeds	Community based mental health services for older people	Safe	Should Do	The service should continue to work towards reducing staff caseloads so they align to recommended good practice guidelines.	Caseloads will be reviewed in line with the new service criteria.	Caseload reports on number of patients		30/06/17	Alison Kenyon
Leeds	Community based mental health services for older people	Safe	Should Do	The service should ensure that the lone working procedure protects staff safety throughout the day	Lone working practices will be reviewed and use of technology to support this will be considered.	Revised lone working procedures will be produced. Evidence of the technology to be utilised will be supplied.		30/01/17	Anthony Deery
Leeds	Community based mental health services for older people	Safe	Should Do	The service should ensure the East, North East team have a system in place to manage premises effectively for the safety of staff and patients.	A full review of all premises is being carried out as part of the estates strategy.	Once completed this will provide recommendations for future and suitability of premises and how they are managed effectively.		30/04/17	Dawn Hanwell
Leeds	Community based mental health services for older people	Safe	Should Do	The service should ensure the East, North East team have a system in place to manage premises effectively for the safety of staff and patients.	Concerns from report relate to the entrance door to the north wing.	A new external door has been arranged to be fitted. Work to be completed by mid-December 2016.		30/04/17	Dawn Hanwell
Leeds	Community based mental health services for older people	Responsive	Should Do	The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Undertake a capacity and demand analysis of the community services.	Patients will receive appropriate psychological therapies in a timely manner.New pathway developed		31/03/17	Alison Kenyon
Leeds	Community based mental health services for older people	Responsive	Should Do	The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Redesign of the management of referrals and scheduling of patients.	Additional temporary staff in post		31/03/17	Alison Kenyon
Leeds	Community based mental health services for older people	Responsive	Should Do	The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Recruit temporary posts to support a waiting list initiative.	This action will provide information to target the training strategy (completed survey)		31/03/17	Alison Kenyon
Leeds	Community based mental health services for older people	Responsive	Should Do	The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Conduct a training needs analysis to appraise team based psychological skills	Multidisciplinary staff will be trained to undertake lower level psychological interventions within a stepped care framework.		31/03/17	Alison Kenyon
Leeds	Community based mental health services for older people	Responsive	Should Do	The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Undertake training to develop appropriate team based psychological skills	(training strategy to be produced)		31/03/17	Alison Kenyon

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Leeds	Community based mental health services for older people	Responsive	Should Do	The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Utilise a formulation based approach that emphasises team based psychological skills.			31/03/17	Alison Kenyon
Leeds	Community based mental health services for older people	Responsive	Should Do	The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Restructure psychological governance of CMHT based psychological activity	When considering referrals for psychological intervention the 5P framework will be used to encourage a stepped approach to intervention.(Formulation documented in Paris notes) The psychology staff will oversee/supervise smaller groups of mdt staff to ensure closer and better quality governance of team based psychological activity		31/03/17	Alison Kenyon
Leeds	Community based mental health services for older people	Effective	Should Do	The service should ensure that physical health monitoring and recording is consistent across all teams	A continuous improvement event will be held to identify the relevant staff who will be clear on their responsibilities regarding physical health monitoring, what is to be monitored, who will carry out that monitoring and how that information will be shared with colleagues in Primary care.	Results of national CQUIN audit 2017-18.Demonstrate compliance through reports to the Board in line with Single Oversight Framework requirements.		30/04/17	Anthony Deery
Leeds	Community based mental health services for older people	Effective	Should Do	The service should ensure that physical health monitoring and recording is consistent across all teams	Review the terms of reference for the Trust wide Physical health care steering group to ensure coverage of the monitoring and implementation requirements.			30/04/17	Anthony Deery
Leeds	Community based mental health services for older people	Effective	Should Do	The service should ensure that all mandatory training, appraisal, and supervision compliance meets the trust targets.	We will consolidate our recording and reporting of clinical supervision, appraisal and compulsory training into a single electronic system (iLearn) by end of March 2017	The action will ensure that staff have requisite clinical skills for their area of area of practice.		30/06/17	Susan Tyler/Lynn Parkinson
Leeds	Community Based Services for Working Age Adults	Safe	Should Do	The service should continue to work towards reducing staff caseloads so they align to recommended good practice guidelines.	To introduce the new CMHT criteria in all three localities.	Improved clarity can support transfer to primary care as well as signposting to appropriate services		31/12/16	Alison Kenyon
Leeds	Community Based Services for Working Age Adults	Safe	Should Do	The service should continue to work towards reducing staff caseloads so they align to recommended good practice guidelines.	To introduce a standardised method of caseload management.	Using an evidence based caseload management tool will support caseload management		31/03/17	Alison Kenyon

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Leeds	Community Based Services for Working Age Adults	Safe	Should Do	The service should continue to work towards reducing staff caseloads so they align to recommended good practice guidelines.	To continue work of RIE around purposeful interventions	Identifying and delivering good practice guidelines		Ongoing	Alison Kenyon
Leeds	Community Based Services for Working Age Adults	Safe	Should Do	The service should continue to work towards reducing staff caseloads so they align to recommended good practice guidelines.	Ongoing development of primary care mental health liaison roles and primary care pilots in each of the localities	supporting services users in primary care along with the transitions from secondary to primary care (including clusters 4 and below).		Ongoing	Alison Kenyon
Leeds	Community Based Services for Working Age Adults	Safe	Should Do	The service should ensure that the lone working procedure protects staff safety throughout the day	Lone working practices will be reviewed and use of technology to support this will be considered.	Revised lone working procedures will be produced..Evidence of the technology to be utilised will be supplied		31/01/17	Anthony Deery
Leeds	Community Based Services for Working Age Adults	Responsive	Should Do	The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Undertake a capacity and demand analysis of the community services	Provide information to identify required resources to meet demand		31/03/17	Alison Kenyon
Leeds	Community Based Services for Working Age Adults	Responsive	Should Do	The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Redesign of the management of referrals and scheduling of patients	New pathway developed		31/03/17	Alison Kenyon
Leeds	Community Based Services for Working Age Adults	Responsive	Should Do	The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Recruit temporary posts to support a waiting list initiative	Additional temporary staff in post		31/03/17	Alison Kenyon
Leeds	Community Based Services for Working Age Adults	Responsive	Should Do	The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Conduct a training needs analysis to appraise team based psychological skills	This action will provide information to target the training strategy (completed survey)		31/03/17	Alison Kenyon
Leeds	Community Based Services for Working Age Adults	Responsive	Should Do	The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Undertake training to develop appropriate team based psychological skills	Multi disciplinary staff will be trained to undertake lower level psychological interventions within a stepped care framework. (training strategy to be produced).		31/03/17	Alison Kenyon
Leeds	Community Based Services for Working Age Adults	Responsive	Should Do	The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Utilise a formulation based approach that emphasises team based psychological skills	When considering referrals for psychological intervention the 5P framework will be used to encourage a stepped approach to intervention. (Formulation documented in Paris notes).		31/03/17	Alison Kenyon
Leeds	Community Based Services for Working Age Adults	Responsive	Should Do	The service should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Restructure psychological governance of CMHT based psychological activity	The psychology staff will oversee/supervise smaller groups of MDT staff to ensure closer and better quality governance of team based psychological activity (structure to be discussed in the Clinical Improvement Forum).		31/03/17	Alison Kenyon

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Leeds	Community Based Services for Working Age Adults	Effective	Should Do	The service should ensure that physical health monitoring and recording is consistent across all teams	A continuous improvement event will be held to identify the relevant staff who will be clear on their responsibilities regarding physical health monitoring, what is to be monitored, who will carry out that monitoring and how that information will be shared with colleagues in Primary care.	Results of national CQUIN audit 2017-18.Demonstrate compliance through reports to the Board in line with Single Oversight Framework requirements. This will ensure that all patients on anti-psychotic medication will have their physical health needs assessed and responded to appropriately.		31/03/17	Anthony Deery
Leeds	Community Based Services for Working Age Adults	Effective	Should Do	The service should ensure that physical health monitoring and recording is consistent across all teams	Review the terms of reference for the Trust wide Physical health care steering group to ensure coverage of the monitoring and implementation requirements.			31/03/17	Anthony Deery
Leeds	Community Based Services for Working Age Adults	Effective	Should Do	The service should ensure that all mandatory training, appraisal and supervision compliance meets the trust targets	Compulsory Training and we will consolidate our recording and reporting of clinical supervision, appraisal and compulsory training into a single electronic system (iLearn) by end of March 2017	The action will ensure that staff have requisite clinical skills for their area of area of practice.			
Leeds	Community Based Services for Working Age Adults	Effective	Should Do	The service should ensure that all mandatory training, appraisal and supervision compliance meets the trust targets	Managers will then receive a single integrated report (on a weekly basis) showing compliance against clinical supervision, appraisal and compulsory training targets	The action will ensure that staff have requisite clinical skills for their area of area of practice.		30/06/17	Susan Tyler/Lynn Parkinson
Leeds	Community Based Services for Working Age Adults	Effective	Should Do	The service should ensure that all mandatory training, appraisal and supervision compliance meets the trust targets	Supervision – we will initially pilot and then fully implement a new standard process for the recording of clinical supervision				
Leeds	Community Based Services for Working Age Adults	Effective	Should Do	The service should ensure that all mandatory training, appraisal and supervision compliance meets the trust targets	Compulsory training – we will implement a system of ‘block’ compulsory training events which maximise the opportunity for attendance by clinical staff to build on the current overall compliance rate we currently have of 88%				

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
leeds	Community Based Services for Working Age Adults	Effective	Should Do	The service should ensure that all mandatory training, appraisal and supervision compliance meets the trust targets	We will also establish a Compulsory training Task & Finish group to review the delivery and compliance of each aspect of our compulsory training programme that is achieving below 85%. This group will agree and implement specific plans to increase compliance against each specific training that is underperforming, and will agree trajectories for each service area to maintain or achieve an 85% compliance by the end of June 2017.				
leeds	Community Based Services for Working Age Adults	Effective	Should Do	The service should ensure that all mandatory training, appraisal and supervision compliance meets the trust targets	Appraisal – all team managers will develop local plans to achieve or maintain compliance with an 85% target				
Leeds	Community Based Services for Working Age Adults	Effective	Should Do	The service should ensure that all mandatory training, appraisal and supervision compliance meets the trust targets	Care Services (supported by the HR business partners) will ensure – within both Care Groups – that a clear process is in place for the monthly monitoring of performance in relation to appraisal, supervision and compulsory training, via the Care Group management and governance meetings.				
Leeds	Community Based Services for Working Age Adults	Safe	Should Do	The service should ensure the East, North East team have a system in place to manage premises effectively for the safety of staff and patients.	A full review of all premises is being carried out as part of the estates strategy.	Once completed this will provide recommendations for future and suitability of premises.		30/04/17	Dawn Hanwell
LD&SS	Community Mental Health services for people with learning disabilities and autism	Effective	Should Do	The provider should ensure that patient recording systems are used consistently by all staff and information on electronic patient record systems is accurate and contemporaneous	Review of documentation & recording systems to be implemented as part of the Community LD review implementation, led by operational manager	Ensure contemporaneous records thereby reducing the risk of error and improving patient safety		31/12/17	Andy Weir
LD&SS	Community Mental Health services for people with learning disabilities and autism	Effective	Should Do	The provider should ensure that patient recording systems are used consistently by all staff and information on electronic patient record systems is accurate and contemporaneous	Local operating procedure (linked to Trust policy) to be developed and implemented	Evidence of review and new procedure ensuring consistency across the community LD services. Audit process in place to demonstrate checks		31/12/17	Andy Weir

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
LD&SS	Community Mental Health services for people with learning disabilities and autism	Effective	Should Do	The provider should ensure that all non-medical staff are appraised.	We will consolidate our recording and reporting of appraisal into a single electronic system (iLearn) by end of March 2017	Staff will feel well supported and their development needs addressed.			
Leeds	Mental health crisis services and health-based places of safety	Responsive	Must Do	The trust must ensure that the crisis assessment unit is used according to its statement of purpose to provide services for patients experiencing acute and complex mental health crises that require a period of assessment of up to 72 hours.	A review of the utilisation and purpose of the CAU will be undertaken with any resultant changes being approved and agreed within the Care Group and Trust Governance structure	At a service and care group level the utilisation of the CAU will be monitored at the CAS Clinical Improvement Forum and Care Group Clinical Governance Council as part of the wider evaluation report of the service.		30-Jun-17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Responsive	Must Do	The trust must ensure that the crisis assessment unit is used according to its statement of purpose to provide services for patients experiencing acute and complex mental health crises that require a period of assessment of up to 72 hours.	A revised statement of purpose and service specification will be developed if necessary.	Exceptions will be reported to the Care Services Strategic Management Forum.		30-Jun-17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Responsive	Must Do	The trust must ensure that the crisis assessment unit is used according to its statement of purpose to provide services for patients experiencing acute and complex mental health crises that require a period of assessment of up to 72 hours.	A communication and engagement process will be undertaken with stakeholders to share the revised purpose including staff within the service			30-Jun-17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Responsive	Must Do	The trust must ensure that the crisis assessment unit is used according to its statement of purpose to provide services for patients experiencing acute and complex mental health crises that require a period of assessment of up to 72 hours.	Utilisation of the CAU will be monitored through the CAS Clinical Improvement Forum.			30-Jun-17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Well led	Must Do	The trust must routinely collect and share data with other agencies to monitor compliance with all aspects of the crisis care concordat.	A crisis performance monitoring report will be shared and discussed at the Section 136 Interagency meeting with appropriate actions taken to improve performance.	A repeat audit of Section 136 documentation will be undertaken to ensure the required improvements have been made.		30/06/17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Well led	Must Do	The trust must routinely collect and share data with other agencies to monitor compliance with all aspects of the crisis care concordat.	Areas of concern and exception reports will be made to the CAS Clinical Improvement forum.	The minutes of the interagency meeting and the Chairs report from the clinical improvement forum will be received by the Care Group Clinical Governance Council		30/06/17	Alison Kenyon

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Leeds	Mental health crisis services and health-based places of safety	Well led	Must Do	The trust must routinely collect and share data with other agencies to monitor compliance with all aspects of the crisis care concordat.	A review of the Trust Business Intelligence and Information sharing systems will be undertaken.			30/06/17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Effective	Must Do	The trust must improve compliance with section 136 documentation standards.	The Trust previously completed a clinical audit (ref 256) that produced an action plan to improve compliance with the documentation standards	A repeat audit of Section 136 documentation will be undertaken to ensure the required improvements have been made.		30/06/17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Effective	Must Do	The trust must improve compliance with section 136 documentation standards.	The team will continue to implement the actions. Areas of concern and exception reports will be made to the CAS Clinical Improvement Forum	The minutes of the interagency meeting and the Chairs report from the clinical improvement forum will be received by the Care Group Clinical Governance Council		30/06/17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Well led	Must Do	The trust must ensure that the crisis assessment service and the intensive community service has effective governance systems in place to share information in a timely manner.	A review of the Trust Business Intelligence and Information sharing systems will be undertaken.	Readily accessible information held locally and centrally. Improved data quality reports.		30/04/17	Anthony Deery/Bill Fawcett
Leeds	Mental health crisis services and health-based places of safety	Effective	Must Do	The trust must improve compliance with annual appraisal targets	consolidate our recording and reporting of clinical supervision, appraisal and compulsory training into a single electronic system (iLearn) by end of March 2017	At Board level, compliance will continue to be reported in the monthly Integrated Quality Report, and monitored via reports to the Quality Committee.		30/03/17	Lynn Parkinson
Leeds	Mental health crisis services and health-based places of safety	Effective	Must Do	The trust must improve compliance with annual appraisal targets	Managers will then receive a single integrated report (on a weekly basis) showing compliance against clinical supervision, appraisal and compulsory training targets	Across Care Services, Integrated compliance reports will be monitored each month via the Care Group Management Team and through individual supervision with team / ward managers and professional leads		30/06/17	Lynn Parkinson
Leeds	Mental health crisis services and health-based places of safety	Effective	Must Do	The trust must improve compliance with annual appraisal targets	Compulsory training – we will implement a system of ‘block’ compulsory training events which maximise the opportunity for attendance by clinical staff to build on the current overall compliance rate we currently have of 88%			30/06/17	Lynn Parkinson

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Leeds	Mental health crisis services and health-based places of safety	Effective	Must Do	The trust must improve compliance with annual appraisal targets	We will also establish a Compulsory training Task & Finish group to review the delivery and compliance of each aspect of our compulsory training programme that is achieving below 85%. This group will agree and implement specific plans to increase compliance against each specific training that is underperforming, and will agree trajectories for each service area to maintain or achieve an 85% compliance by the end of June 2017.			30/06/17	Lynn Parkinson
Leeds	Mental health crisis services and health-based places of safety	Effective	Must Do	The trust must improve compliance with annual appraisal targets	Appraisal – all team managers will develop local plans to achieve or maintain compliance with an 85% target.			30/06/17	Lynn Parkinson
Leeds	Mental health crisis services and health-based places of safety	Effective	Must Do	The trust must improve compliance with annual appraisal targets	Care Services (supported by the HR business partners) will ensure – within both Care Groups – that a clear process is in place for the monthly monitoring of performance in relation to appraisal, supervision and compulsory training, via the Care Group management and governance meetings.			30/06/17	Lynn Parkinson
Leeds	Mental health crisis services and health-based places of safety	Effective	Must Do	The trust must improve compliance rates with mandatory training, including essential and immediate life support training.	consolidate our recording and reporting of clinical supervision, appraisal and compulsory training into a single electronic system (iLearn) by end of March 2017	At Board level, compliance will continue to be reported in the monthly Integrated Quality Report, and monitored via reports to the Quality Committee.		30/03/17	Susan Tyler/Lynn Parkinson
Leeds	Mental health crisis services and health-based places of safety	Effective	Must Do	The trust must improve compliance rates with mandatory training, including essential and immediate life support training.	Managers will then receive a single integrated report (on a weekly basis) showing compliance against clinical supervision, appraisal and compulsory training targets	Across Care Services, Integrated compliance reports will be monitored each month via the Care Group Management Team and through individual supervision with team / ward managers and professional leads.		30/06/17	Susan Tyler/Lynn Parkinson
Leeds	Mental health crisis services and health-based places of safety	Effective	Must Do	The trust must improve compliance rates with mandatory training, including essential and immediate life support training.	Compulsory training – we will implement a system of ‘block’ compulsory training events which maximise the opportunity for attendance by clinical staff to build on the current overall compliance rate we currently have of 88%			30/06/17	Susan Tyler/Lynn Parkinson

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Leeds	Mental health crisis services and health-based places of safety	Effective	Must Do	The trust must improve compliance rates with mandatory training, including essential and immediate life support training.	We will also establish a Compulsory training Task & Finish group to review the delivery and compliance of each aspect of our compulsory training programme that is achieving below 85%. This group will agree and implement specific plans to increase compliance against each specific training that is underperforming, and will agree trajectories for each service area to maintain or achieve an 85% compliance by the end of June 2017.			30/06/17	Susan Tyler/Lynn Parkinson
Leeds	Mental health crisis services and health-based places of safety	Responsive	Should Do	The trust should ensure that the privacy and dignity of patients admitted to the section 136 suite is maintained	Incorporate additional guidance in 136 interagency guidelines to manage the mixed sex environment. This to be signed off in the 136 interagency meeting and CAS Clinical Improvement Forum.	To ensure that the privacy and dignity of patients in the 136 suite are maintained. Datix reports. Minutes of the 136 interagency meeting. CAS Clinical Improvement Forum.		31/03/17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Responsive	Should Do	The trust should ensure that the privacy and dignity of patients admitted to the section 136 suite is maintained	to review as part of the Trust Wide mixed sex accommodation review	Minutes of Trust wide mixed sex accommodation review.		31/03/17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Responsive	Should Do	The trust should ensure that the privacy and dignity of patients admitted to the section 136 suite is maintained	Disseminate updated guidelines to all staff via team meetings.			31/03/17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Responsive	Should Do	The trust should ensure that the privacy and dignity of patients admitted to the section 136 suite is maintained	Monitor any incidents in the 136 interagency meeting.			31/03/17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Safe	Should Do	The trust should consider privacy and dignity with regards to gender of patient in the section 136 suite and crisis assessment unit.	Incorporate additional guidance in 136 interagency guidelines to manage the mixed sex environment. This to be signed off in the 136 interagency meeting and CAS Clinical Improvement Forum.	No breaches reported regarding privacy and dignity. High levels of patient satisfaction. Minutes of 136 interagency meeting CAS Clinical improvement forum		31/01/17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Safe	Should Do	The trust should consider privacy and dignity with regards to gender of patient in the section 136 suite and crisis assessment unit.	Disseminate updated guidelines to all staff via team meetings.			31/01/17	Alison Kenyon

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Leeds	Mental health crisis services and health-based places of safety	Safe	Should Do	The trust should consider privacy and dignity with regards to gender of patient in the section 136 suite and crisis assessment unit.	Monitor any incidents in the 136 interagency meeting.			31/01/17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Safe	Should Do	The trust should consider privacy and dignity with regards to gender of patient in the section 136 suite and crisis assessment unit.	To ensure datix is completed regarding any incidents relating to the recommendation.			31/01/17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Safe	Should Do	The trust should consider privacy and dignity with regards to gender of patient in the section 136 suite and crisis assessment unit.	To ensure vistamatic doors are installed.			31/01/17	Alison Kenyon
Leeds	Mental health crisis services and health-based places of safety	Effective	Should Do	The trust should ensure that staff in the crisis assessment service have timely access to records of patients admitted to the section 136 suite for children and adolescents.	To scope out what is required with regard to an information system perspective to meet this recommendation	Staff have access to records and are able to plan appropriate care.		31/03/17	Alison Kenyon/Bill Fawcett
Leeds	Mental health crisis services and health-based places of safety	Effective	Should Do	The trust should ensure that staff in the crisis assessment service have timely access to records of patients admitted to the section 136 suite for children and adolescents.	To review current process of requesting access to clinical information on children and adolescents currently under the care of CAMHS services and consider any additions to make this more timely			31/03/17	Alison Kenyon/Bill Fawcett
Leeds	Mental health crisis services and health-based places of safety	Effective	Should Do	The trust should ensure that staff in the crisis assessment service have timely access to records of patients admitted to the section 136 suite for children and adolescents.	To ensure that an incident report is completed when this lack of information has had a direct consequence on the clinical care of that service user.			31/03/17	Alison Kenyon/Bill Fawcett
Leeds	Mental health crisis services and health-based places of safety	Responsive	Should Do	The trust should improve compliance with response time targets for referral to assessment in the crisis assessment service	At present there are no targets for access to crisis services, however the Trust are committed to delivering timely access to all services and are preparing to meet any access targets that arise through the implementation of the single oversight framework and the requirements of our commissioners	That performance targets are met once they have been established.		31/03/17	Alison Kenyon/Bill Fawcett
Leeds	Mental health crisis services and health-based places of safety	Responsive	Should Do	The trust should improve compliance with response time targets for referral to assessment in the crisis assessment service	Develop a quality performance framework and mechanisms to review this for Crisis Services	Framework developed.		Ongoing	Alison Kenyon/Bill Fawcett

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Leeds	Mental health crisis services and health-based places of safety	Responsive	Should Do	The trust should improve compliance with response time targets for referral to assessment in the crisis assessment service	Work with commissioners to coproduce any future requirements for access targets.	To offer ore information in relation to response times to determine what is required strategically and operationally to improve.		31/03/17	Alison Kenyon/Bill Fawcett
Leeds	Mental health crisis services and health-based places of safety	Safe	Should Do	The trust should ensure that clinic room temperatures are within those stated in the trust's medicines code.	Standard Operating Procedure (SOP) describing in detail the process for monitoring temperatures in clinic rooms and medication fridges has been produced and ratified at the Policy and Procedures Group, distributed to all ward managers and matrons for implementation and uploaded onto staffnet. New recording charts have been employed on every ward /dept with medication. Pharmacy staff to check weekly that monitoring is taking place by nursing staff, and any breeches are reported via the datix system	Reduction in datix reports around missed monitoring of fridge/ clinic room temperatures or/and aberrant temperature reporting		31/12/16	Elaine Weston
Leeds	Mental health crisis services and health-based places of safety	Effective	Must Do	The trust must improve compliance rates with mandatory training, including essential and immediate life support training.	Appraisal – all team managers will develop local plans to achieve or maintain compliance with an 85% target			30/06/17	Susan Tyler/Lynn Parkinson
Leeds	Mental health crisis services and health-based places of safety	Effective	Must Do	The trust must improve compliance rates with mandatory training, including essential and immediate life support training.	Care Services (supported by the HR business partners) will ensure – within both Care Groups – that a clear process is in place for the monthly monitoring of performance in relation to appraisal, supervision and compulsory training, via the Care Group management and governance meetings.			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Wards for people with learning disabilities or autism	Safe	Must Do	The trust must ensure that all patients who lack capacity to consent to their care and treatment are cared for using the appropriate legal authority such as by Deprivation of Liberty safeguards.		This will ensure patients' rights are safeguarded in accordance with the respective legislation.This will be evidenced via clinical audit.Monthly audits of detention documentation and processes are in place. Yearly audit cycle of documentation relating to the detention of patients within the trust		03/03/17	Anthony Deery

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
SS&LD	Wards for people with learning disabilities or autism	Safe	Must Do	The trust must ensure that all patients who lack capacity to consent to their care and treatment are cared for using the appropriate legal authority such as by Deprivation of Liberty safeguards.	Care Services (supported by the HR business partners) will ensure – within both Care Groups – that a clear process is in place for the monthly monitoring of performance in relation to appraisal, supervision and compulsory training, via the Care Group management and governance meetings.			03/03/17	Anthony Deery
SS&LD	Wards for people with learning disabilities or autism	Safe	Must Do	The trust must ensure that all patients who lack capacity to consent to their care and treatment are cared for using the appropriate legal authority such as by Deprivation of Liberty safeguards.	We are also producing a practical guide to the use of the MCA and DOLS in clinical areas. This will assist staff in identifying when someone may be deprived of their liberty and how to authorise this, assessments of capacity, consultation and best interest decisions. The legislation department will continue to provide support and advice around all matters relating to MCA/DOLS, including attending best interest meetings and supporting assessment of capacity.			03/03/17	Anthony Deery
SS&LD	Wards for people with learning disabilities or autism	Effective	Must Do	The trust must ensure that staff complete mandatory training, and that the service offers appraisal and supervision regularly and in line with trust policy	We will consolidate our recording and reporting of clinical supervision, appraisal and compulsory training into a single electronic system (iLearn) by end of March 2017	The action will ensure that staff have requisite clinical skills for their area of area of practice.		30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Wards for people with learning disabilities or autism	Effective	Must Do	The trust must ensure that staff complete mandatory training, and that the service offers appraisal and supervision regularly and in line with trust policy	Managers will then receive a single integrated report (on a weekly basis) showing compliance against clinical supervision, appraisal and compulsory training targets			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Wards for people with learning disabilities or autism	Effective	Must Do	The trust must ensure that staff complete mandatory training, and that the service offers appraisal and supervision regularly and in line with trust policy	Supervision – we will initially pilot and then fully implement a new standard process for the recording of clinical supervision			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Wards for people with learning disabilities or autism	Effective	Must Do	The trust must ensure that staff complete mandatory training, and that the service offers appraisal and supervision regularly and in line with trust policy	Compulsory training – we will implement a system of 'block' compulsory training events which maximise the opportunity for attendance by clinical staff to build on the current overall compliance rate we currently have of 88%			30/06/17	Susan Tyler/Lynn Parkinson

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
SS&LD	Wards for people with learning disabilities or autism	Effective	Must Do	The trust must ensure that staff complete mandatory training, and that the service offers appraisal and supervision regularly and in line with trust policy	We will also establish a Compulsory training Task & Finish group to review the delivery and compliance of each aspect of our compulsory training programme that is achieving below 85%. This group will agree and implement specific plans to increase compliance against each specific training that is underperforming, and will agree trajectories for each service area to maintain or achieve an 85% compliance by the end of June 2017.			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Wards for people with learning disabilities or autism	Effective	Must Do	The trust must ensure that staff complete mandatory training, and that the service offers appraisal and supervision regularly and in line with trust policy	Appraisal – all team managers will develop local plans to achieve or maintain compliance with an 85% target			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Wards for people with learning disabilities or autism	Effective	Must Do	The trust must ensure that staff complete mandatory training, and that the service offers appraisal and supervision regularly and in line with trust policy	Care Services (supported by the HR business partners) will ensure – within both Care Groups – that a clear process is in place for the monthly monitoring of performance in relation to appraisal, supervision and compulsory training, via the Care Group management and governance meetings.			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Wards for people with learning disabilities or autism	Safe	Must Do	The trust must ensure that staff update patient care plans and evacuation plans at 2 Woodland Square and that they contain relevant guidance and link with risk assessments.	The Ward Manager will work with the nursing team to ensure that all care plans are up to date, linked to risk assessments and include an up to date patient evacuation plan	Evidence of regular audit of care plans and relevant actions completed – this will be formally reported by the Matron to the LD Clinical Governance group.		30/04/17	Andy Weir
SS&LD	Wards for people with learning disabilities or autism	Safe	Should Do	The trust should ensure that infection control practices improve that the trust repairs risks identified by staff in a timely manner at 2 and 3 Woodland Square. Including the removal of mattresses and staff belongings from the patient shower room and the sky light repair.	Monthly report on outstanding actions / repairs to be submitted by the Matron to the Clinical Environments Group. Ward Manager to ensure immediate actions taken (completed)	Evidence of identification and tracking of any outstanding / unresolved issues		Monthly	Andy Weir

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
SS&LD	Wards for people with learning disabilities or autism	Safe	Should Do	The trust should ensure that staff monitor and record the temperatures of clinic rooms.	Standard Operating Procedure (SOP) describing in detail the process for monitoring temperatures in clinic rooms and medication fridges has been produced awaiting ratification at the Policy and Procedures Group. New recording charts have been employed on every ward /dept with medication. Pharmacy staff to check weekly that monitoring is taking place by nursing staff and that any breaches are recorded on the datix system	Reduction in datix reports around missed monitoring of fridge/ clinic room temperatures or/and aberrant temperature reporting		31/12/16	Elaine Weston
SS&LD	Wards for people with learning disabilities or autism	Safe	Should Do	The trust should ensure staff carry out thorough medication and equipment audits to reduce risk of errors occurring or going undetected, in line with trust policy.	The implementation of Electronic prescribing Trustwide eradicates the issue of non recorded 'missed doses' as the system demands a reason for a dose not being given.	The EMPA reports of numbers of missed doses should decline.		31/01/17	Elaine Weston
SS&LD	Wards for people with learning disabilities or autism	Safe	Should Do	The trust should ensure staff carry out thorough medication and equipment audits to reduce risk of errors occurring or going undetected, in line with trust policy.	The Medication Safety Committee will determine the frequency of audit of medication charts via EPMA re 'missed doses' and other medication issues and formulate an action plan on the results.	An increase in overall datix reporting re medication errors /incidents should occur.		31/01/17	Elaine Weston
SS&LD	Wards for people with learning disabilities or autism	Safe	Should Do	The trust should ensure staff carry out thorough medication and equipment audits to reduce risk of errors occurring or going undetected, in line with trust policy.	All datix regarding medication are reviewed by the Medicines Safety Committee to identify trends and implement necessary training or action to avoid repetition. 6 monthly medication error report is produced that goes to the Medicines Optimisation Group and Effective care.	Datix reports regarding medication are reviewed regularly by Meds Safety Committee, identifying trends and implementing necessary training or action to avoid repetition.		31/01/17	Elaine Weston
SS&LD	Wards for people with learning disabilities or autism	Safe	Should Do	The trust should ensure staff carry out thorough medication and equipment audits to reduce risk of errors occurring or going undetected, in line with trust policy.	The Nurse leads need to encourage reporting of errors involving medication onto Datix	The 6 monthly report gives recommendations to the Trust for improvement. The Medicines Safety Committee to be the guardians of the drug chart audit reporting of the EPMA system.		31/01/17	Elaine Weston
SS&LD	Wards for people with learning disabilities or autism	Safe	Should Do	The provider should ensure that patients at 2, Woodlands Square are cared for with dignity and respect, due to the sharing of same sex accommodation and communal bathrooms.	The Matron will ensure that a local operating procedure is in place to effectively manage the issues of shared accommodation / privacy & dignity, supported by staff training	Staff will be aware of the correct procedures to follow and will implement these		28/02/17	Andy Weir
SS&LD	Wards for people with learning disabilities or autism	Safe	Should Do	The provider should ensure that it adheres to guidance in the Mental Health Act (Code of Practice) at Parkside Lodge	All policies and procedures are compliant with the updated Code of Practice. We have a schedule of review for all procedures relating to the MHA to ensure they are fit for purpose and support the application of the act.				

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
SS&LD	Wards for people with learning disabilities or autism	Safe	Should Do	The provider should ensure that it adheres to guidance in the Mental Health Act (Code of Practice) at Parkside Lodge	Changes to the Code of Practice have been incorporated in the MHA mandatory training. Changes will be reiterated in a bulletin to be sent to all clinical staff and a document will be available on MH legislation staff net page which clearly highlights the changes to the code.				
SS&LD	Wards for people with learning disabilities or autism	Responsive	Should Do	The provider should ensure that patients at 2 Woodland Square can access activities and that the staff and the people who use the services are aware that appropriately adapted transport can be facilitated where required.	Staff will have a good working knowledge of the MHA and CoP and their application to practice. Monthly audits of detention documentation and processes are in place.Yearly audit cycle of documentation relating to the detention of patients within the trust.	Evidence of available activities and individualised care planning related to this (links to care plan reviews & audit above)		30/04/17	Andy Weir
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The trust should improve compliance rates with mandatory training, including essential and immediate life support training, in line with their own targets.	We will consolidate our recording and reporting of clinical supervision, appraisal and compulsory training into a single electronic system (iLearn) by end of March 2017	this will ensure staff have the requisite clinical skills for their area of practice		30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The trust should improve compliance rates with mandatory training, including essential and immediate life support training, in line with their own targets.	Managers will then receive a single integrated report (on a weekly basis) showing compliance against clinical supervision, appraisal and compulsory training targets			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The trust should improve compliance rates with mandatory training, including essential and immediate life support training, in line with their own targets.	Supervision – we will initially pilot and then fully implement a new standard process for the recording of clinical supervision.			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The trust should improve compliance rates with mandatory training, including essential and immediate life support training, in line with their own targets.	Compulsory training – we will implement a system of 'block' compulsory training events which maximise the opportunity for attendance by clinical staff to build on the current overall compliance rate we currently have of 88%.			30/06/17	Susan Tyler/Lynn Parkinson

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The trust should improve compliance rates with mandatory training, including essential and immediate life support training, in line with their own targets.	We will also establish a Compulsory training Task & Finish group to review the delivery and compliance of each aspect of our compulsory training programme that is achieving below 85%. This group will agree and implement specific plans to increase compliance against each specific training that is underperforming, and will agree trajectories for each service area to maintain or achieve an 85% compliance by the end of June 2017.			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The trust should improve compliance rates with mandatory training, including essential and immediate life support training, in line with their own targets.	Appraisal – all team managers will develop local plans to achieve or maintain compliance with an 85% target.			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The trust should improve compliance rates with mandatory training, including essential and immediate life support training, in line with their own targets.	Care Services (supported by the HR business partners) will ensure – within both Care Groups – that a clear process is in place for the monthly monitoring of performance in relation to appraisal, supervision and compulsory training, via the Care Group management and governance meetings.			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The trust should ensure that capacity assessments for treatment for detained patients are recorded in their file.	MCA/DOLS level 2 training is mandatory for professionally qualified staff (AC's and section 12 approved Dr's are exempt). We are currently at 82% compliance for this training. Regular dates for training are available for the next six months.To increase knowledge and support around the use of the MCA and DOLS we are training 'MCA Champions'. These will be identified individuals in clinical areas who will receive more in-depth training, delivered in partnership with adult social care, and will offer advice and support to their clinical area.	This will ensure that the patients are treated in accordance with their rights under the Mental Capacity Act. Monthly audits of detention documentation and processes are in place.Yearly audit cycle of documentation relating to the detention of patients within the trust		31/03/17	Anthony Deery

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The trust should ensure that capacity assessments for treatment for detained patients are recorded in their file.	We are also producing a practical guide to the use of the MCA and DOLS in clinical areas. This will assist staff in identifying when someone may be deprived of their liberty and how to authorise this, assessments of capacity, consultation and best interest decisions. The legislation department will continue to provide support and advice around all matters relating to MCA/DOLS, including attending best interest meetings and supporting assessment of capacity.			31/03/17	Anthony Deery
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The managers should continue their positive approach to clinical and managerial supervision in line with trust policy	We will consolidate our recording and reporting of clinical supervision, appraisal and compulsory training into a single electronic system (iLearn) by end of March 2017	this will ensure staff have the requisite clinical skills for their area of practice		30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The managers should continue their positive approach to clinical and managerial supervision in line with trust policy	Managers will then receive a single integrated report (on a weekly basis) showing compliance against clinical supervision, appraisal and compulsory training targets			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The managers should continue their positive approach to clinical and managerial supervision in line with trust policy	Supervision – we will initially pilot and then fully implement a new standard process for the recording of clinical supervision.			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The managers should continue their positive approach to clinical and managerial supervision in line with trust policy	Compulsory training – we will implement a system of 'block' compulsory training events which maximise the opportunity for attendance by clinical staff to build on the current overall compliance rate we currently have of 88%.			30/06/17	Susan Tyler/Lynn Parkinson

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The managers should continue their positive approach to clinical and managerial supervision in line with trust policy	We will also establish a Compulsory training Task & Finish group to review the delivery and compliance of each aspect of our compulsory training programme that is achieving below 85%. This group will agree and implement specific plans to increase compliance against each specific training that is underperforming, and will agree trajectories for each service area to maintain or achieve an 85% compliance by the end of June 2017.			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The managers should continue their positive approach to clinical and managerial supervision in line with trust policy	Appraisal – all team managers will develop local plans to achieve or maintain compliance with an 85% target.			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Long stay/rehabilitation mental health wards for working adults	Effective	Should Do	The managers should continue their positive approach to clinical and managerial supervision in line with trust policy	Care Services (supported by the HR business partners) will ensure – within both Care Groups – that a clear process is in place for the monthly monitoring of performance in relation to appraisal, supervision and compulsory training, via the Care Group management and governance meetings.			30/06/17	Susan Tyler/Lynn Parkinson
SS&LD	Long stay/rehabilitation mental health wards for working adults	Safe	Should Do	The trust should ensure that oxygen cylinders are regularly checked and replaced when used.	Audit all grab bags to ensure medicines and equipment is in date, commenced 12.12.16, expected completion date 23.12.16 to compile responses.	Emergency situations can be responded to safely.For emergency equipment and medicines ;Reduction in datix reports around missed monitoring of fridge/ clinic room temperatures or/and aberrant temperature reporting.Assurance that equipment in grab bags are in date via review timetable. All out of date equipment / medication found to be reported on datix		31/12/16	Elaine Weston

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
SS&LD	National Deaf CAMHS	safe	Should Do	The specialist deaf child and adolescent mental health north team members had an inconsistency in their access to the electronic systems used by the Leeds and York Partnership Foundation Trust. This meant the team recording systems were different for the three service areas. For information technology systems to work effectively across Manchester and Newcastle access issues to systems through the firewalls for separate health trusts, need to be reconciled.	Trustwide reminders already sent out via comms, with checklist for nursing staff to check grab bags. In addition senior nurses need to cascade the reminder to nursing staff for implementation. This includes oxygen cylinders.	Assurance that equipment in grab bags are in date via review timetable. All out of date equipment / medication found to be reported on datix		30/06/17	Bill Fawcett
LD&SS	National Deaf CAMHS	Safe	Should Do	Risk and care plans were not consistently available electronically. Whilst in part this was due to staff access to the electronic notes system and the need to develop additional or improved technology to support documentation using sign language or pictures, staff also identified there was need to work more towards consistent recording of practice.		Evidence of written standards / processes and system of audit to demonstrate compliance		31/07/17	Andy Weir
Leeds	Wards for older people with mental health problems	Safe	Must Do	The provider must ensure that where staff identify patients as requiring specific monitoring, records should be detailed and accurate so they can be used to inform any treatment decisions in a safe and meaningful way.	Care Services (supported by the HR business partners) will ensure – within both Care Groups – that a clear process is in place for the monthly monitoring of performance in relation to appraisal, supervision and compulsory training, via the Care Group management and governance meetings.	A records and compliance audit will be undertaken to ensure the required improvements have been made.		30/04/17	Anthony Deery
Leeds	Wards for older people with mental health problems	Safe	Must Do	The provider must ensure that records of care and treatment provided to patients are accurate and contemporaneous. All decisions about patient's care and treatment should be contained within their appropriate care records.	Education programme for staff on all aspects of record keeping. Responding to the findings from clinical record audits together with the inclusion of Clinical supervision in the Trust iLearn system, as an additional mechanism to reinforce good record keeping, will collectively ensure clinical staff are meeting this requirement	A records and compliance audit will be undertaken to ensure the required improvements have been made.		30/04/17	Anthony Deery

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Leeds	Wards for older people with mental health problems	Effective	Must Do	The provider must ensure all relevant staff have received appropriate training in the Mental Capacity Act and the Mental Health Act. Staff must receive clinical and managerial supervision at the necessary frequency and in accordance with trust targets.	MCA/DOLS level 2 training is mandatory for professionally qualified staff (AC's and section 12 approved Dr's are exempt). We are currently at 82% compliance for this training. Regular dates for training are available for the next six months.To increase knowledge and support around the use of the MCA and DOLS we are training 'MCA Champions'. These will be identified individuals in clinical areas who will receive more in-depth training, delivered in partnership with adult social care, and will offer advice and support to their clinical area.	This will ensure patients' rights are safeguarded in accordance with the respective legislation.This will be evidenced via clinical audit.Monthly audits of detention documentation and processes are in place.		30/06/17	Susan Tyler/Lynn Parkinson
Leeds	Wards for older people with mental health problems	Effective	Must Do	The provider must ensure all relevant staff have received appropriate training in the Mental Capacity Act and the Mental Health Act. Staff must receive clinical and managerial supervision at the necessary frequency and in accordance with trust targets.	We are also producing a practical guide to the use of the MCA and DOLS in clinical areas. This will assist staff in identifying when someone may be deprived of their liberty and how to authorise this, assessments of capacity, consultation and best interest decisions.			30/06/17	Susan Tyler/Lynn Parkinson
Leeds	Wards for older people with mental health problems	Effective	Must Do	The provider must ensure all relevant staff have received appropriate training in the Mental Capacity Act and the Mental Health Act. Staff must receive clinical and managerial supervision at the necessary frequency and in accordance with trust targets.	The legislation department will continue to provide support and advice around all matters relating to MCA/DOLS, including attending best interest meetings and supporting assessment of capacity.			30/06/17	Susan Tyler/Lynn Parkinson
Leeds	Wards for older people with mental health problems	Effective	Should Do	The provider should ensure that all staff supporting and interacting with patients have opportunity to acquire training in the mental and physical health conditions of the patients they support.	The service will conduct a training needs analysis in relation to the Mental and Physical Health needs of patients.	Results of training needs analysis		31/03/17	Alison Kenyon
Leeds	Wards for older people with mental health problems	Effective	Should Do	The provider should ensure that all staff supporting and interacting with patients have opportunity to acquire training in the mental and physical health conditions of the patients they support.	Develop a training plan with LTHT	Timetable of physical health training		31/03/17	Alison Kenyon

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Leeds	Wards for older people with mental health problems	Effective	Should Do	The provider should ensure that all staff supporting and interacting with patients have opportunity to acquire training in the mental and physical health conditions of the patients they support.	Commencement of RAMMPS training			30/04/17	Alison Kenyon
Leeds	Wards for older people with mental health problems	Effective	Should Do	The provider should ensure necessary staff assess and record patient capacity in accordance with trust policy and the provisions of the Mental Capacity Act 2005	MCA/DOLS level 2 training is mandatory for professionally qualified staff (AC's and section 12 approved Dr's are exempt). We are currently at 82% compliance for this training. Regular dates for training are available for the next six months.To increase knowledge and support around the use of the MCA and DOLS we are training 'MCA Champions'. These will be identified individuals in clinical areas who will receive more	This will ensure patients' rights are safeguarded in accordance with the respective legislation.This will be evidenced via clinical audit. Monthly audits of detention documentation and processes are in place. Yearly audit cycle of documentation relating to the detention of patients within the trust		31/03/17	Anthony Deery
Leeds	Wards for older people with mental health problems	Effective	Should Do	The provider should ensure necessary staff assess and record patient capacity in accordance with trust policy and the provisions of the Mental Capacity Act 2005	We are also producing a practical guide to the use of the MCA and DOLS in clinical areas. This will assist staff in identifying when someone may be deprived of their liberty and how to authorise this, assessments of capacity, consultation and best interest decisions. The legislation department will continue to provide support and advice around all matters relating to MCA/DOLS, including attending best interest meetings and supporting assessment			31/03/17	Anthony Deery
Leeds	Wards for older people with mental health problems	Effective	Should Do	The provider should review how they can ensure results from clinical audits are used to drive improvement across the service.	Action plans and lessons learnt from all audits carried out reported at the Clinical Improvement Forum. Roll out of audit programme improvements to be fed back in all staff meetings within the service	Improved performance demonstrated through reaudit.		30/04/17	Alison Kenyon
Leeds	Wards for older people with mental health problems	Safe	Should Do	The provider should ensure that staff identify shortfalls or concerns in relation to medicines management and storage and act upon these in a timely manner and take necessary action.	Pharmacy department to carry out a programme of education for staff.	Reduction in reporting of datix of medicine management issues.		28/02/17	Alison Kenyon
Leeds	Wards for older people with mental health problems	Safe	Should Do	The provider should ensure that staff identify shortfalls or concerns in relation to medicines management and storage and act upon these in a timely manner and take necessary action.	Compliance checks to be carried out during quarterly matron walkabout.	Record of attendance and matron walkabout records		28/02/17	Alison Kenyon
Leeds	Wards for older people with mental health problems	Safe	Should Do	The provider should ensure notices with regard to the rights of informal patients to leave the wards are displayed on all wards	Interim notices placed on wards	Notices are displayed and staff are able to articulate patients' rights.		31/01/17	Anthony Deery

Directorate	Report/Service	Domain	Category	Findings	Action	How action will address the issue raised- evidence provided	Governance Committee	Due Date	Director/AD/CD
Trust	Leeds and York Partnership NHS Foundation Trust Provider report	Well led	Must Do	The provider must ensure that the governance systems are established to assess, monitor, and improve the quality and safety of the service, and manage risk, operate effectively and are embedded in the service.		Creating a timely, responsive and well governed review process, fully supported by clinical groups will ensure timely reporting, , notification, investigation, review and improvement to clinical and non-clinical services in line with national timescales overseen and scrutinised by Clinical Commissioning Groups and part of Care Quality Commission inspection processes.		30/04/2017	Anthony Deery

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Governance and Scrutiny Support

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

Date: 24 January 2017

Subject: General Practice Forward View

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 the General Practice Forward View for Leeds, recently developed by local Clinical Commissioning Groups (CCGs) and submitted to NHS England.

2 Main issues

2.1 During the previous municipal year (2015/16), the Scrutiny Board received and considered a range of evidence associated with the planning and provision of Primary Care across the City. Some of the specific issues considered and identified during the course of the inquiry included:

- Planning for the future demand for primary care services – particularly in relation to the planned housing growth across the City.
- Transfer of commissioning responsibility from NHS England to local CCGs and development of primary care strategies.
- GP closures and transfers of patients.
- Development and operation of Primary Care Committees.
- Access to services and provision of extended hours.
- The role of pharmacy services in the provision of primary care.
- The impact of proposed budget reductions for pharmacy services.
- The development and operation of integrated health and social care teams.

2.2 In order to further inform the development of these areas and any associated recommendations / follow-up actions, it seems appropriate and timely that the Scrutiny Board formally considers the Forward View for General Practice, developed

by local CCGs and submitted to NHS England. Details presented to Leeds South and East CCG in December 2016 are appended to this report.

2.3 Suitable representatives from Leeds CCGs have been invited to summarise the attached details and address questions from the Scrutiny Board.

3. Recommendations

3.1 Members are asked to consider the information provided in relation to the scrutiny inquiry around primary care, and identify how this may inform the development of a formal report, associated recommendations and any further scrutiny activity.

4. Background papers[1]

None used

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

APPENDIX B

NHS
Leeds South and East
Clinical Commissioning Group

Agenda Item: PCCC16/61	**FOI Exempt:** No

NHS Leeds South and East CCG Primary Care Commissioning Committee

Date of meeting: 22 December 2016

Title: General Practice Forward View Development Plan

Lead Governing Body Member: Andy Harris – Clinical Chief Officer	Category of Paper	Tick as appropriate
Report Author: Gaynor Connor – Associate Director of Primary Care and New Models of Care	Discussion and Approval	✓
Reviewed by EMT: 14 December 2016	Information	
Reviewed by Committee/Date: N/A	Discussion	
Checked by Finance: N/A		
Approved by Lead Primary Care Commissioning Committee member: Yes		

Strategic Aims – that this report relates to	
1. To improve the health of the whole population and reduce inequalities in our communities.	✓
2. To secure continuous improvement in the quality and safety of all services commissioned for our population	✓
3. To ensure that patient, public and carer voices are at the centre of our healthcare services from planning to delivery	✓
4. To deliver continuous improvement in health and social care systems within available resources	✓
5. To develop and maintain a healthy organisation to underpin the effective delivery of our strategy	✓

Assurance Framework - to which risks on the GBAF does this report relate?

Risk 7

EXECUTIVE SUMMARY:

This paper provides members of the Primary Care Commissioning Committee with a copy of the GP Forward View Development Plan (GPFVDP) which will be submitted to NHS England along with the CCG's Operational Plan and West Yorkshire Sustainability and Transformation Plan, on the 23 December 2016, subject to sign off by the Governing Body.

The GPFVDP is being presented to the Primary Care Commissioning Committees of the three Leeds CCGs, and to the Leeds South and East CCG Governing Body, for approval and sign-off in advance of submission to NHS England.

NHS Leeds South and East CCG (LSECCG) are working in partnership with NHS Leeds North CCG and NHS Leeds West CCG to develop a single GPFVDP for Leeds. The GPFVDP supports the delivery of the Leeds Plan and West Yorkshire and Harrogate Sustainability and Transformation Plan (WYSTP).

Members of the Primary Care Commissioning Committee are asked to note that the interrelationship between the GPFVDP, Operational Plan and Leeds Plan means that the GPFVDP may be subject to some minor changes in advance of submission.

It is proposed that the NHS Leeds South and East CCG Primary Care Commissioning Committee endorse the attached version of the GPFVDP and recommend its approval to the Governing Body.

NEXT STEPS:

Following endorsement and approval of the GPFV from the PCCCs of the three Leeds CCGs, highlight reports on the progress and delivery will be reported to the PCCCs on a quarterly basis.

The risk associated with delivering the GPFV will be assessed and described in the primary care risk registers of each CCG and, in LSE CCG, reported to the Audit and Governance Committee.

Primary care commissioning leads from the three Leeds CCGs will work together to lead the implementation and monitoring of the GPFV Delivery Plan.

A workshop focussed on delivering the GPFV will bring together the executive management team and clinical commissioning forum members in January 2017.

RECOMMENDATION:

The Primary Care Commissioning Committee is asked to:

(a) **Endorse** the draft Leeds General Practice Forward View Delivery Plan;
(b) **Recommend** its approval to the Governing Body on 22 December 2016.

Corporate Impact Assessment: Insert commentary or refer to body of report or N\A	
Statutory/Legal/Regulatory/Contractual	✓
Financial	N/A
Communication and Involvement	N/A
Workforce	N/A
Equality	N/A
Environmental	N/A

Approval of the Leeds General Practice Forward View Delivery Plan

1. Background

The General Practice Forward View (GPFV) was published in May 2016. The GPFV sets out a national blueprint and a series of directives relating to the transformation and sustainability of general practice between 2016 and 2020. Nationally, all CCGs are required to submit a GP Forward View Delivery Plan (GPFVDP) by the 23 December 2016 describing how the GPFV will be delivered locally.

NHS Leeds South and East CCG (LSECCG) are working in partnership with NHS Leeds North CCG and NHS Leeds West CCG to develop a single GPFVDP for Leeds. The GPFVDP supports the delivery of the Leeds Plan and West Yorkshire and Harrogate Sustainability and Transformation Plan (WYSTP).

Within LSECCG, the primary care engagement team has retained oversight of the operational development of the GPFVDP.

2. Engagement and feedback on the GPFV Delivery Plan

At the LSECCG Primary Care Commissioning Committee (PCCC) in November 2016, the PCCC noted and supported the approach to the development of a citywide GPFVDP including the proposed approach to seek and gain feedback on the draft GPFVDP from key stakeholders.

The draft GPFVDP has been shared with a broad range of local (on behalf of each of the three CCGs) and city-wide stakeholders for comment and feedback including:

- LSECCG Member Practices
- LSECCG Council of Members
- LSECCG Patient Assurance Group
- Members of LSECCG PCCC
- LSECCG colleagues in commissioning; finance; communications
- The Leeds Local Medical Committee (LMC)
- Adult and Children's Social Care Commissioners
- Public Health
- Local Councillors and Local Councillor Health Champions.
- NHS England

The content of the draft GPFVDP has been presented and discussed at the November 2016 LSECCG members meeting and LSECCG Council of Members; the LMC STP Conference in November 2016 and as part of the Healthwatch Primary Care workshop held in early December 2016.

Key themes that have emerged through the engagement phase include:

- Strong support for developing the GPFVDP as a citywide plan;
- Recognition that the way the ambitions are delivered may need to vary in relation to different population needs;
- Recognition of the differential risk in delivering the ambitions in each CCG;
- Recognition of the risk associated with the LSE primary care quality improvement schemes being non-recurrently funded and the potential lack of availability of future recurrent funds;
- Recognition of the work already underway across the city to sustain and transform general practice in the context of increased integration and collaboration;
- The need to place greater emphasis on the 'Leeds Conversation', more explicit recognition that the way in which patients will use primary care services in the future will change and the need to engage with patient about these changes eg the fact that in future patients may increasingly see a wider health and care professionals better placed to meet their needs than a GP;
- More explicit reference to parity of esteem and reference to mental as well as physical health;
- More explicit reference to children and young people;
- The need to provide an explicit resourcing trajectory to demonstrate investment and input to support delivery of the plan based on local plus nationally available funding.

An earlier draft version of the GPFVDP was submitted to NHS England. Specific feedback was given alongside generic feedback at a workshop with NHS England in December 2016. Primary care commissioning leads from the three Leeds CCGs have worked together to review comments and feedback received and incorporate these into the final draft version of the GPFV being presented to PCCC.

3. Endorsement and Approval

LSECCG is required to submit the GPFVDP, along with the CCG's Operational Plan and West Yorkshire Sustainability and Transformation Plan, on the 23 of December 2016.

The GPFVDP is being presented to the PCCCs of the three Leeds CCGs for approval and sign-off in advance of submission.

The interrelationship between the GPFVDP, Operational Plan and Leeds Plan means that the GPFVDP may be subject to some minor changes in advance of submission.

It is proposed that the LSECCG PCCC endorse the attached version of the GPFVDP and recommend its approval to the Governing Body.

Following endorsement and approval of the GPFV from the PCCCs of the three Leeds CCGs, highlight reports on the progress and delivery will be reported to the PCCCs on a quarterly basis.

4. Recommendations

Members of the PCCC are asked to:

- **Endorse** the draft Leeds General Practice Forward View Delivery Plan;

- **Recommend** its approval to the LSECCG Governing Body.

5. Next Steps

Following endorsement and approval of the GPFV from the PCCCs of the three Leeds CCGs, highlight reports on the progress and delivery will be reported to the PCCCs on a quarterly basis.

Primary care commissioning leads from the three Leeds CCGs will work together to lead the implementation and monitoring of the GPFV Delivery Plan.

The risk associated with delivering the GPFV will be assessed and described in the primary care risk registers of each CCG and, in LSE CCG, reported to the Audit and Governance Committee.

A workshop focussed on delivering the GPFV will bring together the executive management team and clinical commissioning forum members in January 2017.

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GENERAL PRACTICE FORWARD VIEW

APRIL 2016

Delivering the GP Forward View in Leeds

DRAFT v0.22
7 December 2016

NHS Leeds North Clinical Commissioning Group
NHS Leeds South and East Clinical Commissioning Group
NHS Leeds West Clinical Commissioning Group

Delivering the GP Forward View

Contents:

1. Introduction

Welcome to our General Practice Forward View (GPFV) delivery plan for Leeds. Our starting point is a recognition that a good standard of primary care is already being delivered across large parts of the city. We recognise the unique strength of general practice in providing continuity of care for patients through the registered list and that the public relies on primary care services for the health and wellbeing of themselves and their family.

We recognise this as one of the great strengths of the NHS – "**if general practice fails, the NHS fails"**.

In the current environment of increased demand and finite resources, patients and professionals need to think creatively about how and why services are delivered and used in order to sustain and transform high quality general practice.

Our plan is set in the context of the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP) and the Leeds Plan (figures 1 and 2) both of which set out the vital role that general practice will play in achieving sustainability across the whole health and social care system. Put bluntly – unless we are able to transform the way in which primary and community services are commissioned and provided, we will not deliver the STP or Leeds Plan.

This GPFV delivery plan describes the steps we will take, in partnership, with the 105 general practices across Leeds, to build on the many existing approaches to collaboration and service integration - using the GP registered list as the cornerstone to ensure:

- Patients will have an increasingly improved experience of using GP services;
- Patients will be increasingly involved in managing their own care and experience better health and wellbeing outcomes;
- The 'Leeds pound' invested in general practice will be used to better effect for maximum impact and gain;
- The overarching aim of system change to support people to stay in their own homes, families or community and that people will only spend time in hospital or residential care when needed;
- The move to a system-wide population health management approach that secures collaborative and integrated ways of working though new models of care based around general practice;
- Staff working within general practice will feel supported and confident with the vision of where general practice is going and how it will feel in the future.

We have recognised the challenges and risks in responding to this ambitious agenda and have committed to work collectively in Leeds to bring about the transformation of general practice through workforce development; reducing the workload; environmental and technological improvements in infrastructure; redesigning care including population health accountability; using available investment and aligning system incentives.

We have articulated the work required to achieve our ambition through six ambitions for general practice described in detail in the following slide.

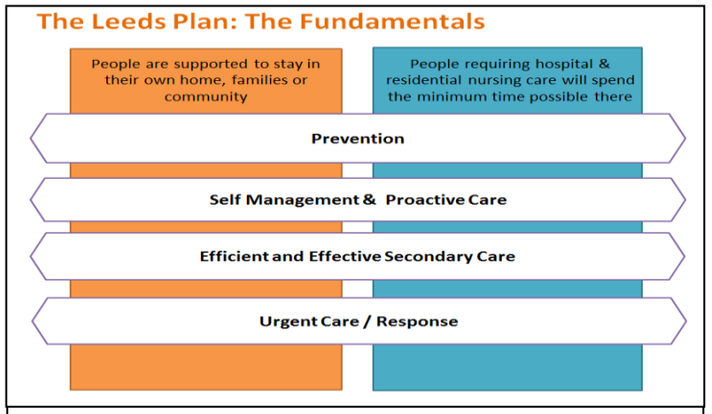
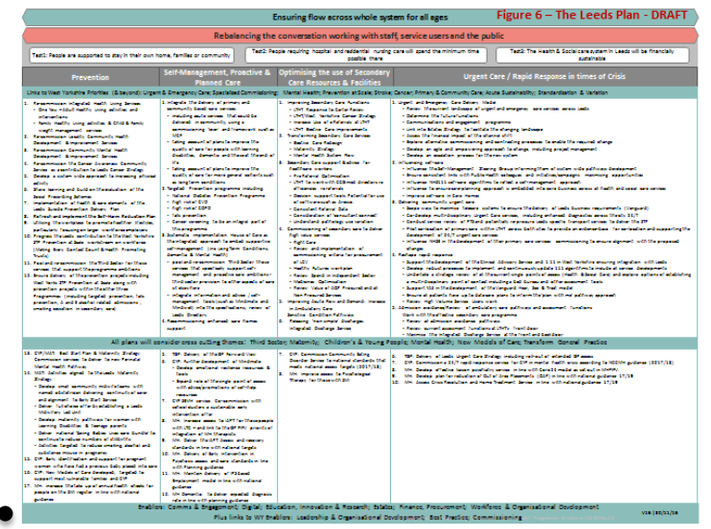


Figure 1 – Tests and cross-cutting programmes within the Leeds Plan

Figure 2 – Annotated Leeds Plan on Page to demonstrate links to GPFV Delivery Plan



The primary care transformation initiatives and models of care described within the GPFV delivery plan underpin the delivery of the Leeds Plan.

2. Vision for general practice

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Our **Six Ambitions** for general practice by 2020/2021 across Leeds are to:

1. Ensure there is a motivated, engaged, integrated and healthy **workforce** with the right skills, behaviours and training, available in the right numbers.

2. Ensure all patients registered with a GP in Leeds:
- understand how, when and are able, to **access** routine and urgent primary medical care when needed; and
- are **empowered to manage their own conditions** to live fulfilling lives in their community.

3. Fully use and prioritise our collective **estates and technology** resources we have available to improve the quality of primary medical care and New Models of Care experienced and delivered by patients and professionals.

4. **Free up more time** in general practice to plan and deliver better care for patients and professionals by streamlining workload in primary care and between different care providers.

5. **Redesign the way care is delivered** by progressing a whole system model which focusses on a 'place-based' approach where everybody has a part to play, both citizens and services together.

6. Increase the **investment and resourcing** into general practice and primary care through maximising funding opportunities

Underpinning principles

The three Leeds CCGs will work, with one commissioning voice, to achieve these ambitions by:

- Working with patients, practices and partners to be a constant listener and to ensure implementing our ambitions responds to local needs.
- Working with commissioning partners and key local providers to align local contracts and incentives to deliver the priority health and wellbeing outcomes for populations in Leeds.
- Improving the quality and efficiency of general practice through greater working 'at scale'.
- Supporting general practice to establish their 'Provider Voice' across the city as a key provider of New Models of Care.
- Fully using our delegated commissioning responsibilities to align system incentives and use new contract forms to commission for improved health outcomes for patients registered with a Leeds GP.
- Ensuring commissioning intentions and decisions support the wider shift to a population health management approach .

3. What will be different when we achieve the ambitions set out in the GP Forward View (GPFV) Delivery Plan?

In the context of increased demand and finite resources, patients and professionals need to think creatively about how and why services are delivered and used in order to sustain and transform high quality general practice.

We have described what will be different from the perspectives of patients (in blue) and practices (in purple) when we deliver the full ambition described in the plan.

This summary should be read in conjunction with the detail of the GPFV delivery plan itself which outlines how these ambitions and key objectives will be achieved.

Ambition 1
Ensure there is a motivated, engaged, integrated and healthy w**orkforce** with the right skills, behaviours and training, available in the right numbers.

By 2020/21 patients will:
- Be supported to see the most appropriate professional to meet their needs
- See a greater range of health and care professionals within the practice
- Take an active part in managing their health and wellbeing through collaborative care planning

By 2020/21, practices will:
- Have access to trained staff to support patients to navigate the health and care system more effectively
- Be part of a wider team of professionals including mental health workers and clinical pharmacists working across groups of practices
- Be confident in the ability to recruit, retain and train new members of the team

Ambition 2
Ensure all patients registered with a GP in Leeds:
- understand how, when and are able to **access** routine and urgent primary medical care when needed; and
- are **empowered to manage their own conditions** to live fulfilling lives in their community.

By 2020/21 patients will:
- Have access to routine and urgent appointments 7 days a week
- Be confident to know when and where to access care
- Be supported to access a greater range of services and wider support through other routes such as digitally and virtually

By 2020/21 practices will:
- See a reduction in demand for care that could be more appropriately delivered by other providers such as community pharmacy
- Deliver a higher proportion of care through digitally enabled solutions
- Be working 'at-scale' and collaboratively with other providers to deliver extended access to routine and urgent appointments 7 days a week

Ambition 3
Fully use and prioritise our collective **estates and technology** resources to improve the quality of primary medical care and New Models of Care experienced and delivered by patients and professionals.

By 2020/21 patients will:
- Be aided to use a range of different digital skills and solutions to meet their needs
- Receive care from primary and community premises which support their wellbeing, relieves stress and aids recovery
- Be able to have more choice of locations from which to access care depending on their need

By 2020/21 practices will:
- Be able to use effective and efficient technology and digital working which supports clinician to clinician and patient to clinician interfaces
- Be able to use premises in a more flexible way
- Have premises which are utilised more effectively and are fit for purpose

Ambition 4
Free up more time within general practice to plan and deliver better care for patients and professionals by streamlining workload within practices and between different care providers.

By 2020/21, patients will:
- Be confident in being able to manage minor self limiting illnesses themselves, obtaining advice from other health professionals such as pharmacists or through other initiatives such as NHS111
- Avoid the morning 'on the day' rush for appointments through effective appointment capacity
- Have an improved overall experience of general practice

By 2020/21 practices will:
- Have been supported to review workload and will see a reduction in bureaucracy and reporting
- Experience improved communication between providers, preventing the need for re-referrals and chasing up tasks etc.
- See better managed demand and will experience a better work/life balance

Ambition 5
Redesign the way care is delivered, by progressing a whole system model which focusses on a 'place-based' approach where everybody has a part to play, both citizens and services together.

By 2020/21 patients will:
- Access a broader range of health and wellbeing services out of hospital in their community
- Be empowered to make decisions to stay well and improve their physical and mental health
- Be confident that the professionals caring for them have the right information to support them, reducing the need for repeat assessment

By 2020/21 practices will:
- Have more time for GPs to provide expert medical advice to support patients with the most complex needs
- Working more collaboratively to share resources , increase resilience and provide patients with access to a wider range of options
- Part of a wider team of health and care professionals working together to meet the needs of the local population

Engagement with patients, member practices and wider stakeholders on how we "what will be different" will be undertaken to ensure that priorities are appropriately reflected and the language is consistent with other plans in the city.

4. Collaborative working between general practices in Leeds

GENERAL PRACTICE FORWARD VIEW APRIL 2016

In Leeds, 105 individual general practices provide primary medical care services and wider primary care for the population of Leeds. These 105 general practices are diverse in size, shape and form. The list size of general practices in Leeds varies between 1,040 and 37,000 with a (median) average list size of 6,844. As individual businesses with an individual contract, there is significant variation in the way in which services are delivered to registered populations of patients. The population of Leeds is also extremely diverse and so **the ability of general practice to respond and deliver care in relation to the specific needs of different population groups is a key strength of general practice.**

As demonstrated by the outcomes of the recent Care Quality Commission (CQC) visits , **the vast majority of the 105 general practices in Leeds are providing good, and in some cases outstanding, care to patients registered with general practices** in Leeds benchmarking above average in relation to the domains assessed by CQC. However, the range and quality of services, patient experience and sustainability of care delivered to patients across general practices in Leeds can vary significantly. The ambitions described in this GPFV delivery plan aim to reduce this variation through quality improvement support and through greater collaboration between general practices.

Another key strength, unique to general practice, is to continuity of care provided to patients through the registered list. Going forward we recognise that that this unique strength of general practice must be retained within the context of greater collaboration and care redesign. General practices in Leeds are increasingly working together in collaboration to design and deliver services which respond to the needs of their populations. The drivers, structure and form of these collaborations vary between the 'formal' federation across 30 GP practices across NHS Leeds South and East CCG, the provider network in NHS Leeds West CCG and Memorandum of Understanding (MOUs) between locality grouping of GPs in NHS Leeds North CCG. The commonality across these different structural arrangements is that they enable general practices to:

- work together to identify, plan and respond to a specific need e.g. providing extended hours through hub working in NHS Leeds West CCG
- work collaboratively and with other providers to design and deliver innovative, bottom-up models of care to the needs of a defined population, such as delivering multi-provider diabetes and mental health wrap-around services for patients living in the Chapeltown locality of NHS Leeds North CCG
- share core functions to increase the efficiency and effectiveness of 'back-office' functions and care provided to improve the sustainability and resilience of general practice and improve care for patients, for example the work undertaken by the GP federation in NHS Leeds South and East CCG to support quality improvement with local GPs.

Alongside commissioning general practices to deliver primary medical care at individual practice level, going forward the Leeds CCGs will increasingly:

- work with GPs and other providers to commission services 'at scale' for populations of 30-80,000 patients
- commission services through hub and spoke models of delivery which are aligned to general practice
- consider the future sustainability of practices required to meet the need of patient populations when making decisions around the provision of general practices services across the city.

Strong collaborative working is essential for the future sustainability of general practice as the key provider of care in its own right, as well as being the foundation to develop New Models of Care (NMoC). The role of general practice in supporting and enabling emerging models of accountable care, and a wider move towards a population health management approach across the city, is described in greater detail in Section 5 Care Redesign.

Section 5. Ambition 1: Supporting and growing the workforce

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Ensure there is a **motivated, engaged, integrated and healthy workforce** with the right skills, behaviours and training, available in the right number

Introduction and overview

Leeds will be a vibrant and attractive place to work, offering flexibility and innovative employment opportunities within an integrated workforce which supports a transformed primary care service.

Our members are passionate about general practice and its place within the health care system and wish to promote it with health care professionals, emphasising the importance of the role of ***general practitioner (GP)*** in the community. Leeds has a lot to offer our future GPs and we plan to expedite and target the recruitment of additional GPs, focussing on areas where recruitment is currently proving a challenge.

It is well documented that there is a need to look at **alternative workforce models** to support the sustainability of general practice given the recruitment and retention challenge that is facing us. We have several sites across Leeds testing new workforce models and we are working with our Local Medical Committee (LMC) colleagues to highlight positive case studies and identify practices who are keen to develop further.

We are **committed to working together as a city on workforce** to ensure a collective review and equity across the whole Leeds system so that workforce models reflect population need and support a reduction in health inequalities. A primary care workforce sub-group has already been established as part of the 'Leeds Plan' programme structure to ensure an appropriate focus on primary care workforce which is not isolated from the wider health and social care workforce. The group will be accountable for delivering the immediate milestones of: 1) establishing an accurate baseline of general practice workforce including gaps : 2) supporting an increase in the number of (additional) clinical pharmacists in practice (30% = 10) through engaging in the clinical pharmacist scheme: 3) implementing new care navigator / medical assistant roles in general practice following 1st cohort of training.

At a recent engagement event 71% of practice representatives (lead clinicians and managers) surveyed said that they were considering alternative workforce models, with 43% looking at working across a groups of general practices demonstrating the current transformational appetite within general practice.

Leeds has made significant progress with regard to workforce models and currently has learning to share in the following areas:

- NHS England clinical pharmacist pilot
- Practice employed pharmacists
- Direct employment of mental health workers
- Physio First and other models
- Clinical care co-ordinators
- Practice nursing preceptorship
- HCA apprenticeships
- Physician associate placements (Y1)
- Role emerging placements for occupational therapists (REPOT)
- Learning disability nurses providing routine health checks in GP
- Hub and cross-site working in the evenings and at weekends
- Inclusion health – inc paediatric asthma programme and Gypsy and Traveller health
- Introduction of the Collaborative Care and Support Planning (previously known as 'Year of Care') – GP team approach to managing long term conditions
- Care home nurses and enhanced care home teams of AHPs, incorporating the Calderdale Framework to risk assess role merging and role blending)

Supporting and growing the primary care workforce underpins the delivery of the Leeds Plan and forms part of the wider Leeds workforce strategy.

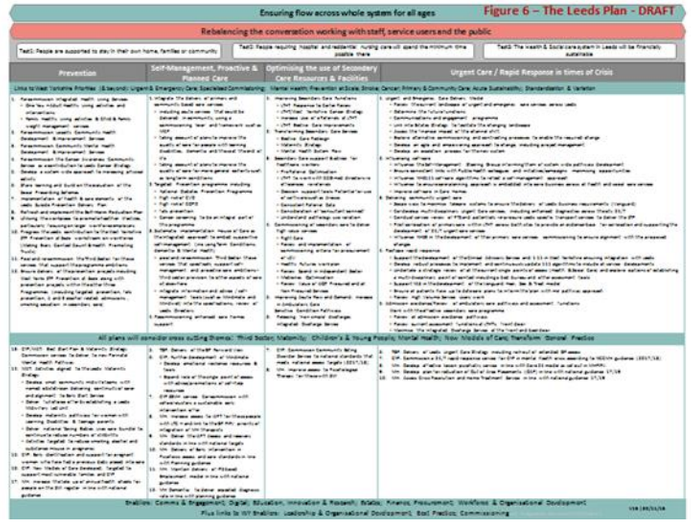


Figure 6 – The Leeds Plan - DRAFT

Ambition 1: Supporting and growing the workforce

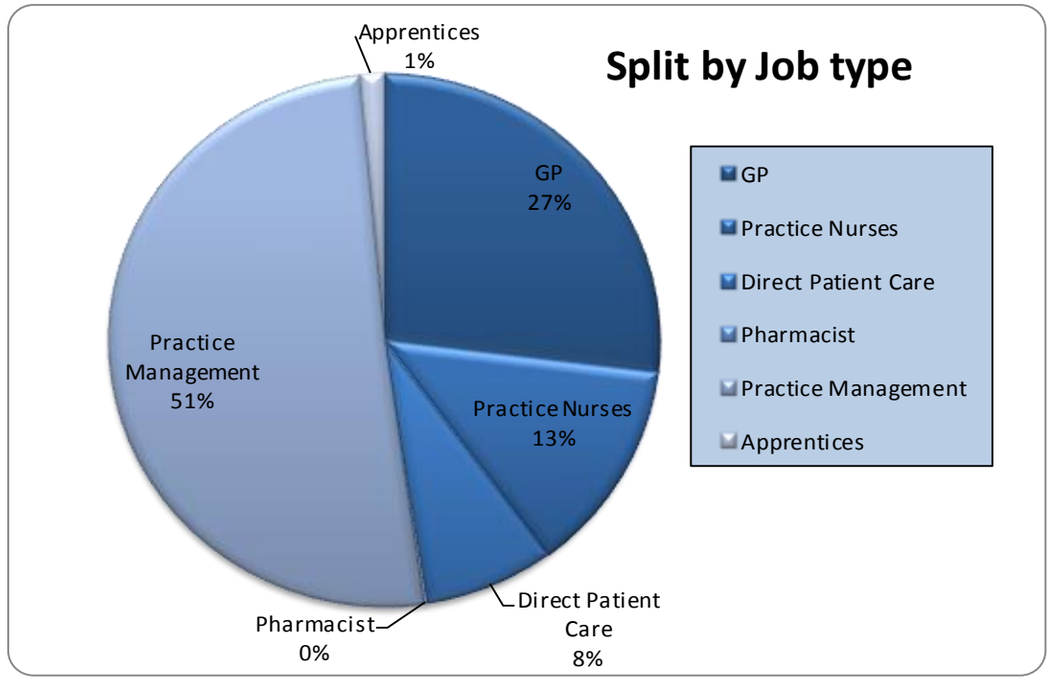
GENERAL PRACTICE FORWARD VIEW APRIL 2016

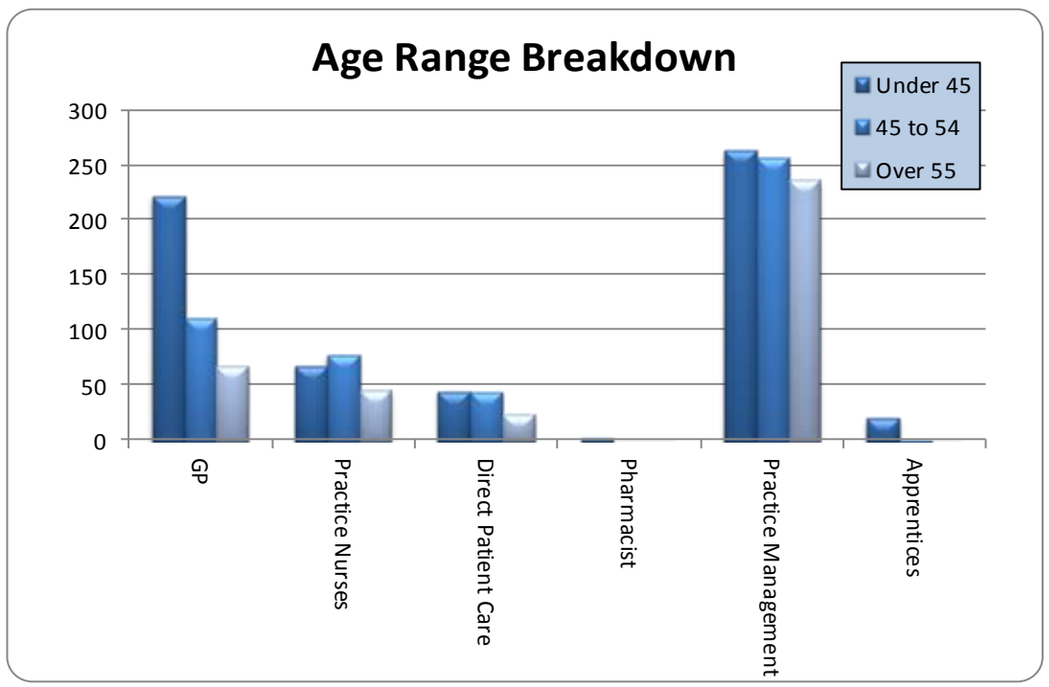
Figure 3 - Combined Leeds CCGs - Job Type Summary

Source - NHS Health Education

	Full Time Equivilant (FTE)	Male			Female		
		Under 45	45 to 54	Over 55	Under 45	45 to 54	Over 55
GP	400.93	93.60	58.11	44.84	128.38	52.78	23.22
Practice Nurses	192.96	1.00	4.00	1.00	67.86	74.00	45.10
Direct Patient Care	113.79	4.46	0	0	40.85	43.66	24.42
Pharmacist	3.41	0.21	0	0	3.20	0	0
Practice Management	756.35	28.72	15.02	8.65	234.46	242.10	227.40
Apprentices	21.92	2.60	0	0	18.15	1.17	0
Total	**1,489.36**	**130.59**	**77.53**	**54.49**	**492.90**	**413.71**	**320.14**

80 of 105 Practice Reporting





Ambition 1: Supporting and growing the workforce

City wide position

GENERAL PRACTICE FORWARD VIEW APRIL 2016

One of the key priorities for Leeds as a system is establishing an accurate baseline of the primary care workforce so that we can identify gaps and priorities at individual practice level and across localities. The data we currently hold only represents 75% of general practices in the city. In order to offer further help and support we need a complete picture of the current challenge, gaps and risks facing practices. As CCGs we have worked closely with Health Education England (HEE) and LMC colleagues to raise awareness on the importance of submitting workforce data so that it enables proactive planning in terms of recruitment and identifying hot spots as well as commissioning future training places.

The information provided from practices (figure 3) identifies a number of key risks – several practices are already highlighting problems recruiting new GPs with a number also highlighting multiple leavers over the next three years leading to concerns regarding sustainability. One of the key actions is to manage these risks and use available resources and programmes, such as the general practice resilience programme, to look at alternative recruitment options or innovative solutions.

The average list size per GP FTE for Leeds is currently at 2004. Whilst we recognise this is a traditional way of measuring demand, looking at this at a practice level highlights variation in practices, particularly where recruitment difficulties are already starting to have an impact.

Current workforce information (figure 3) shows that we have a current workforce gap of 50 GPs which represents a 12% gap in overall GP numbers. This would represent what is needed to fulfil some of the unmet needs but fails to address what is required for general practice to perform at its highest level. We would need to exceed this amount to truly bring general practice into the 21st century.

The Leeds fair share of the 5,000 additional doctors (committed to in the GPFV) equates to 74 doctors, however we know the population is expected to rise over the next five years due to the number of new housing developments. Leeds also continues to thrive as a city and other external factors such as Leeds University being awarded 'University of the Year' may further attract additional students to Leeds. We need to attract new doctors to general practice by showcasing the good work undertaken in primary care by encouraging additional practices to become training practices.

The Leeds fair share of the additional 1,000 physician associates committed in the GPFV is 15. We need to continue to model workforce numbers based on the availability of other staffing groups and use tools such as the HEEYH WRaPT tool (a planning tool to enable us to help model workforce for population groups).

By 2020/21 patients will:

- **Be supported to see the most appropriate professional to meet their needs**
- **See a greater range of health and care professionals within the practice**
- **Take an active part in managing their health and wellbeing through collaborative care planning**

By 2020/21, practices will:

- **Have access to trained staff to support patients to navigate the health and care system more effectively**
- **Be part of a wider team of professionals including mental health workers and clinical pharmacists working across groups of practices**
- **Be confident in the ability to recruit, retain and train new members of the team**

Ambition 1: Supporting and growing the workforce

City wide position continued…

GENERAL PRACTICE FORWARD VIEW APRIL 2016

As a city we already have some experience of clinical pharmacists in practice. Initial feedback from practices is that this is already having a positive effect on workload. We are committed to taking the opportunity of being an early adopter site for the clinical pharmacist scheme where we estimate having an additional 25 pharmacists across the city.

There is a growing appetite amongst primary care to embrace new roles and we have some positive examples across the city of mental health workers working in an integrated way with general practice to reflect the population needs. A number of practices have already expressed an interest in being early implementers for this role as we prioritise its expansion across Leeds, working collaboratively with our mental health commissioning colleagues to ensure alignment with the overall strategy.

We have identified that we have a moderate risk regarding GPs aged 55 and over who may be looking to retire in the next few years and to some degree a greater risk of practice nurses and practice management (which includes our administrative and clerical colleagues). A number of initiatives are in development to help support greater resilience in our workforce, including:

- Career seminars for those close to retirement, with a view to looking at options for supporting colleagues to stay in practice
- Developing alternative workforce models including employing physician associates and pharmacists
- Greater collaboration with other independent contractors such as community pharmacy with the Pharmacy First scheme which helps support patients to self-manage and a possible alternative to general practice
- Application to HEE on behalf of Leeds re: nursing associate role test site lead partner LTHT (successful application to start in Dec 2016 - trainee nurse associates to be placed in primary care as part of the programme which includes placements across secondary care, community, mental and care homes
- Implementing the general practice nurse scheme, delivered in partnership with HEE, across 16 practices in Leeds.

A key element of supporting and growing the workforce is adopting an integrated approach to staff training and developing clinical and non-clinical groups. Over the next few months we will work as a city, and with partners, to understand key issues and gaps relating to training provision particularly how we use our collective resources to maximise training opportunities across organisational boundaries. This is particularly relevant in areas of training where there has been a reduction in nationally funded training places, such as practice nurse training. Going forward, a key enabler is the cross-organisational development of a business case to establish a Leeds Health and Care Academy which would provide a system wide resource for health and social care staff.

Ambition 1: Supporting and growing the workforce

City wide approach

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Current position	2016-17	2017-18	2018-19/ 2020-21
Pilots established within specific localities: clinical pharmacists : Physio First and mental health therapists All Leeds CCGs have pre-registration pharmacists doing part of their year's training in CCGs. Citywide workforce group established with key stakeholders with a specific focus on primary care workforce. Harmonising pan-Leeds workforce underway (redeployment and mandatory training). Joint CCG / LMC communication to encourage accurate recording of workforce data to truly understand baseline position. Development of the Leeds Workforce Plan, incorporating values based recruitment at every level. Leeds Institute for Quality Healthcare LIQH) development proposal being implemented across the Leeds CCGs. Including patient leaders as part of our extended team to ensure patient experience is embedded into everything we do. Working with HEIs & FEIs to inform curriculum re-design / refreshment, promoting community inclusivity and parity of esteem (physical and mental health). Scoping opportunity to work more closely with providers (esp LCH – including WE hubs, shared training opportunities). Participating in citywide collaborative recruitment events / careers fairs. Primary Care Workforce Development Group set up. Leeds Workforce Transformation Group set up.	Joint LMC / CCG workshop to take place in January 2017 to discuss workforce sustainability. Developing a core 'workforce' offer for practices taking into account the needs of the population Testing locality developments for shared staff, back office functions, urgent and routine access, home visits. Promote leadership at every level – including LIQH and induction training packages delivered through TARGET. Implement GPN Ready scheme and support new to role GPNs. Underpin training with RCGP competence assurance framework at practice level. CCG support for the successful nursing associate pilot Increase number of apprenticeships at business admin and health care assistant levels including vocational qualifications for progression into nursing - general practice to support placements for the nursing associate roles. Expand and integrate the pilots established in localities with CCG based teams - clinical pharmacists , including advanced level pharmacists , community and practice nurses collaborations Develop foundation AHP and pharmacists roles in CCGs to develop the skills required for working in primary care and GP practices. Support development of business case for proposed Leeds Health and Care Academy Ensure Cavendish Care Certificate obtained by all non-registered patient-facing clinicians.	Pilots within specific localities: evaluated and rolled out: Physio First; mental health therapists. Scaling up locality developments for shared staff, back office functions, urgent and routine access, home visits across all practices. Staff roles including health care assistants, practice nurses and advanced nurse practitioners – improve consistency and benchmarking for learning beyond registration as well as induction, preceptorship and refresher/update training. Wider integration of health and social care. Also promote parity of esteem between mental and physical health Advanced Training Practices Network – support LSMP, expand number of spoke practices, increase placement capacity to 20% of practices offering undergraduate nursing placements. by 2017 Develop new mentors and sign-off mentors n localities to support pre-registration nurses and GP mentors to support non-medical prescribing and the development of the clinical pharmacist role Develop recruitment and retention initiatives to support growth in the workforce. Include recruitment days, develop career portfolios Evaluate the outcomes of the pilots established within localities: with CCG based teams: clinical pharmacists; community and practice nurse collaborations Further roll out of the ANPs and ACPs including pharmacists roles in CCGs to develop the skills required for working in primary care and GP practices, including post graduate diplomas and non-medical prescribing. Improve IT literacy across all teams so technology can underpin improvements in administrative and consulting behaviour - best use of data; include single care record and online services (e.g. non-complex LTC review). Develop skill mixing in practice nursing and advanced nurse practitioners. Develop collaborative working between general practice and community nursing.	Actively promote healthcare careers, including recruitment days established to support practices and groups of practices in recruiting Leavers destination surveys analysed and action plan to address. Include support for those to stay in or return to work Continued roll out of schemes such as Physio First, mental health workers, ACPs and clinical pharmacists Continued development of apprenticeship schemes, Develop AHPs / ACPs including pharmacist roles in CCGs to develop the skills required for working in primary care and GP practices, including post graduate diplomas and non-medical prescribing. Continued increase in Advanced Training Practices Network, with an aspiration of 30% of practices offering undergraduate placements by 2019 Reduce dependence on temporary staffing Shift administrative burden from clinicians to administrative staff to free-up direct contact time; train and support care navigators at front desk

Additional support requirements: Local NHSE Transformation Team to provide dedicated Leeds-level capacity to lead project management and coordination of current schemes and support the Leeds PC workforce group. Support to include bid development for accessing additional monies. National support to address gap in access to practice nurse training.

Ambition 2: Improving access to general practice

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Ensure all patients registered with a GP in Leeds understand how, and are able to, access routine and urgent primary medical care services when needed, are **empowered** to manage their own conditions and live fulfilling lives in their community

Introduction and context

We know, from what patients have told us, that the majority of patients in Leeds find getting an appointment with a general practice in Leeds fairly or very easy. Headlines from the GP Patient Survey in July 2016 demonstrate that 72% of patients find it very easy or fairly easy to access the GP practice via telephone and 74% of patients have a very good or fairly good experience of making an appointment. We want to build on these results to provide even better access to routine and urgent primary care from general practice and wider primary care services alongside a greater focus on supporting and empowering patients to better manage their own conditions.

While figures suggest that the majority of patients registered with a general practice in Leeds are able to easily access their general practice, we know that for other patients, this is not the case. Our patients have told us that improving access to general practice services during routine hours and for some population groups (such as those with complex needs), and continuity of seeing the same health professional, are key priorities. We know from GPs that the demand for 'routine' in-hours appointments is increasing and placing significant pressures on general practice. At the same time, the GP Patient Survey highlights that the majority of patients surveyed want additional extended hours appointments;71% of patients would like additional appointments after 6.30pm and 74% of patients would like additional appointments on Saturdays. The challenge and opportunity for the Leeds CGGs is how we balance these local priorities alongside a national directive and increasing patient expectations to establish seven day access to primary care by 2020/21.

In 2014, NHS Leeds West CCG was successfully appointed as a GP Access Fund site to test a new model of extended seven day access to GP for registered patients. This opportunity has enabled improved access to general practice for the 350,000 patients registered with a Leeds West CCG GP, and has also generated key learning and insight to be applied across the city as the CCGs work together to improve access to routine and urgent primary medical care services for the whole population of Leeds.

The CCGs have three, interrelated opportunities as we work together to improve access to routine and urgent p the whole population of Leeds:

1) Providing greater support to empower patients to better manage their own conditions
2) The Leeds urgent care system redesign, currently being developed as part of the Leeds Urgent Care Strategy
3) The huge opportunity to increase the role of technology in providing and supporting digital access to GP for patients

Urgent care forms one of the four redesign programmes in the Leeds Plan.

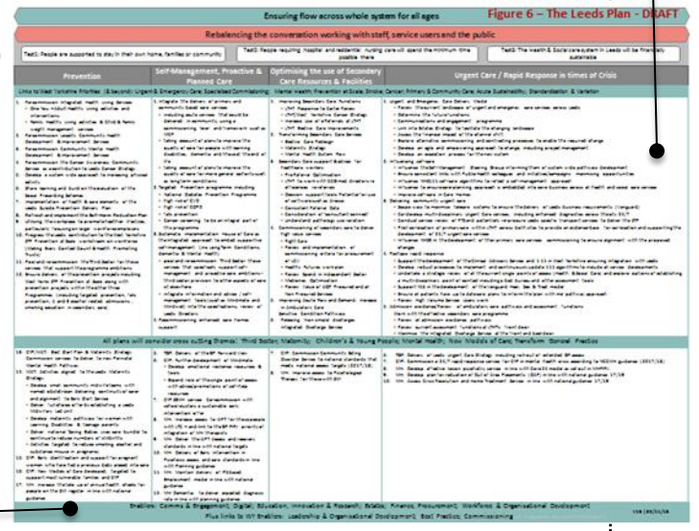


Figure 6 – The Leeds Plan - DRAFT

Developing digital capacity and infrastructure underpins the delivery of the Leeds Plan and forms part of the wider Leeds workforce strategy.

Ambition 2: Improving access to general practice

GENERAL PRACTICE FORWARD VIEW APRIL 2016

City wide approach

Supporting and empowering patients to manage their own conditions and live fulfilling lives in their community

We recognise that supporting and empowering patients to better manage their health, wellbeing and conditions is central to improved access to general practice as well as the wider transformation of health and care services. To enable this we are working as a city on the 'Leeds Conversation' a consistent approach across all health and care providers to frame all interactions between patients and services in the context of the contribution, assets and responsibilities of the patient (see Figure 8). In general practice, this is being supported through health coaching and self-management programmes such as Collaborative Care and Support Planning (previously known as 'Year of Care') approaches, and self-care campaigns. We want patients to feel confident to directly identify and access a range of services, including community pharmacy and services provided through the third sector, to meet their care and support needs.

We have developed information points such as Mindwell and Mindmate to enable patients to directly access self-help and services to support their mental health and wellbeing and commissioned social prescribing to further enable and empower patients to directly access the support and services they need. This programme of behaviour change will be further strengthened by rolling out the Leeds Medicine Communication Charter, a unique approach co-produced with patients, to support patients to get the most of their medicines through different conversations with health professionals resulting in better clinical outcomes and experience, improved patient empowerment and reduced demand for services. Supporting patients to be more activated in the management of their own health, wellbeing and care is a key component of population health management described further in Section 5 Ambition 5.

By 2020/21 patients will:
- **Have access to routine and urgent appointments 7 days a week.**
- **Be confident to know when and where to access care**
- **Be supported to access a greater range of services and wider support through other routes ,such as digital and virtual**

Leeds Urgent Care Strategy and The Leeds Plan

Our approach to improving access to routine and urgent primary medical care forms a key component part of Leeds Urgent Care Strategy, (which in itself forms one of the four work programmes in the Leeds Plan). The Leeds Urgent Care Strategy provides an opportunity for commissioners and providers to work together to take a whole-system approach to redesigning urgent care services, including general practice to address the **key challenges across the Leeds system.** These include: **1)** Variation in access for patients registered with different general practices within different CCGs; **2**) Given the finite capacity of the GP workforce across Leeds - already under significant pressure to meet levels of demand for routine appointments - the need to develop alternative workforce models to deliver urgent and routine primary care; **3)** The need to simplify what is currently a very complex urgent care system ; **4)** High levels of A&E use in early evening by families with young children and from patients living within deprived Leeds **5)** High rates of elderly admissions.

In redesigning services to address these challenges, we will better understand and respond to the unmet needs of **specific population groups** in Leeds. These include **1)** new migrant populations with low understanding of local services; **2)** young families with social and emotional support needs **3)** additional language needs within some migrant groups which require more face to face translation and care navigation **4)** Growing elderly and multiple LTC population with limited assessment / near patient testing in the community **5)** Limited digital literacy across a number of population groups with limited uptake of virtual access in working adult population.

By 2020/21 practices will:
- **See a reduction in demand for care that could be more appropriately delivered by other providers such as community pharmacy.**
- **Deliver a higher proportion of care through digitally enabled solutions**
- **Be working 'at scale' and collaboratively with other providers to deliver extended access to routine and urgent appointments 7 days a week**

Increase the role of technology in providing and supporting digital access to GP for patients

Technology, such as patient online services, provides a huge opportunity to support self care, provide direct digital access to GP and free up capacity in general practice for face-face care for groups who need this most. The opportunity for improvement is demonstrated in the most recent GP Survey results below:

- 35% of patients have awareness of online appointment booking
- 30% of patients have awareness of online repeat prescription ordering
- 6% of patients have awareness of online access to medical records
- 49% have no awareness of online services

A focus on increasing technology, digital access and digital literacy will be a key focus for the CCGs in Leeds over the next five years (see Section 5 Ambition 3 for wider context re technology development

Ambition 2: Improving access to general practice

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Current position

NHS Leeds North CCG

- Practice Reference Group + '3 Things ' feedback: Improve in-hours access, continuity of care for key population groups and provide some extended hours pm and Saturday am;
- Successful system resilience scheme delivered between 8 practices and Local Care Direct since 2014. Provides enhanced access to GP appointments for all Leeds patients during system pressure. Ability and agility to flex capacity to meet demand;
- 84% of population have access to extended hours via national enhanced service.
- Member engagement feedback: future models should be hub-based, technology driven, multidisciplinary and flex to population need.

NHS Leeds West CCG

- Successful 2nd Wave GP Access Fund site delivering 7 day access to services since Oct. 14 (local and national investment);
- Hubs established in a number of localities with high patient satisfaction and attendance;
- Locality groups established to provide infrastructure for population based approaches; 12 hour enhanced access Mon-Fri in 34/37 practices. Weekend access hubs serve approx. 50% of population;
- 83% satisfaction with opening hours.

NHS Leeds South and East CCG

- Clinical pharmacy pilot providing direct patient care;
- Establish 4 collaborative hubs 37/42 practices (10,000 patients not covered);
- Improved access through additional roles within PC team provide in hours capacity, 1 hub providing additional extended opening;
- NMoC pilots established in Beeston and Cross Gates creating multidisciplinary teams
- Discussions with members regarding OOH/UC provision to inform commissioning intentions;
- 84% of the population have access to extended hours.

2016-17

Continue to support initiatives that improve access to GP and primary care whilst planning a citywide future model of care for extended primary care access as part of the developing Leeds Urgent Care Strategy. Future care model to reflect local and national learning, patient insight and member feedback.

In-year initiatives to improve access:

- Ongoing provision of CCG access schemes;
- Ongoing support to practices to achieve online service target of 15-20% by 16/17;
- To look at peer review and ways to address variation in quality – link to Right Care;
- Capacity and demand audits aligned to Primary Care Web Tool extended access data + newly developed tool;
- Continued local commissioning of community pharmacy to deliver Pharmacy First, and Prescriptions Urgent Request Medicines service (PURM);
- Deliver Phase 1 care navigator training to support signposting to effective services;
- Finalise citywide approach to 'Leeds Conversation';
- Launch of Leeds Medicine's Communication Charter.

Development and investment in future model

- Develop and test local delivery of extended access 'in' and OOHs through hub working across the city via West Yorks Vangurd (WYV) Accelerator funding;
- Test direct booking of in-hours GP-appointments from 111 through WYV to support quality triage process;
- Analysis of existing capacity, population and activity flow data to inform design of wider model for extended PC access as part of UC strategy;
- Finalise primary care estates strategy to support future hub working including evening and weekend access;
- Design models of extended access that better meet specific populations needs (families with young children; working age adults, elderly / those living with multiple LTCs; and deprived localities with lower uptake of planned and preventative services);
- Establish and support new technologies via (ETTF cohort 1) – GP mobile devices, telephony hub and Increasing digital literacy for patients;
- Seek national support to address liability issues associated with delivering extended hours.

2017-18

Further improve the quality of in-hours access, initial roll-out of extended access hub and spoke working and scope the integrated pathways across GP and Dentists, Optometrists and Pharmacists . A strong focus on signposting and communication WITH Leeds citizens will be a priority.

In-year initiatives to improve access

- Implement clear (digital) communication resources to support patients to self care and navigate wider health and care system for routine and urgent care needs;
- Training and roll-out Leeds Conversation approach with patients and providers;
- CCG investment to enable partial delivery of extended access 'at-scale' (LNCCG & LSECCG to utilise minimum of £1.50 p/h of GPFV baseline requirement, LWCCG investing £6p/h as a Challenge Fund site);
- Develop hub and spoke working to provide a form of extended access for 50% of the Leeds GP registered population;
- Spread learning from ETTF projects to increase digital literacy of patients (achieve GP online target of 30%);
- Test paediatric 'hot clinic' to respond to primary urgent care for a priority population;
- Locally develop core in-hours standards to further improve quality of in-hours access to GP (explore 15m appointment);
- Roll-out stage 2 navigator training to other staff groups
- Further support collaborative working between practices to support even more efficiency service delivery;
- Support development of non-GP workforce to support delivery of extended access.

Development and investment in future model

- Confirm and agree model for GP extended access in the context of urgent care and OOHs review including the West Yorkshire Accelerator funding. Will reflect needs of different population groups. Understand re-procurement requirements in the context of wider potential MCP developments timeframe;
- Scope requirement for wrap around and support services e.g. diagnostics, transport and near patient testing;
- Engage with dentists, optometrists and pharmacists and their associated local committees around wider integrated working;
- Work with NHSE/ WYCP re pharmacy contracting to include minor ailments, Pharmacy First and developing community

2018-19 / 2020-21

Deliver extended access by working across the city 'at-scale' through an integrated hub and spoke delivery model. Improved access will be designed to meet specific populations needs.

Key in year work areas

- **18/19** – Use £3.34 p/h to increase population coverage of extended access in LNCCG & LSECCG via hub and spoke working;
- **19/20** – Use £6 p/h to deliver extended access to 100% of Leeds population as per national specification through hub and spoke working and in partnership with other urgent care providers including GP OOHs. Transparently describe procurement approach as part of future urgent care procurement process.

- Working at scale will enable different access offers to meet specific populations needs.
- Digital literacy – online services use, 40% in 18/19, 50% in 19/20);
- Early implementation of test models of urgent care responses for different population groups e.g. same day assessment / diagnostics for frail elderly / LTCs populations and community aligned support solutions to address language and system navigation needs within migrated populations;
- Leeds Conversation is fully embedded across all patient groups and service providers.

Additional support requirements: Local NHSE Transformation Team to provide dedicated Leeds-level capacity to lead project management and coordination of Leeds approach to extended access (Business Intelligence, population need modelling and service-redesign capacity and capability).

Ambition 3: Transforming estates and technology

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Develop and fully use our **collective estate and technology** resources to improve the quality of care delivered and the experiences of patients and professionals

Introduction and context

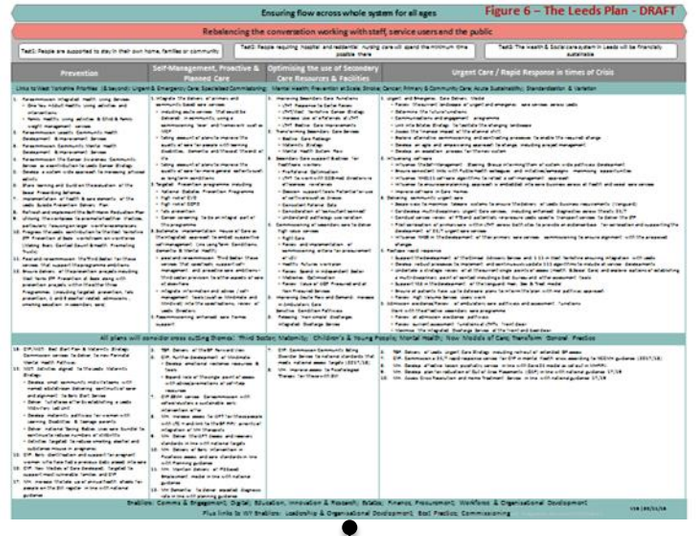
In June 2015, CCGs were asked to lead the development of local estates strategies supported by advisors from NHS Property Services. A Framework for Commissioners was produced which outlined the process required and the timescales for the work to be undertaken. This process included the formation of Strategic Estates Forums (SEF). Within Leeds this is the Strategic Estates Group which includes representation from key commissioner and provider organisations across the city. Estates strategies were to be completed initially by December 2015.

In September 2015, local health and care systems were asked to produce Local Digital Roadmaps (LDRs) by 30 June 2016, setting out how they will achieve the ambition of 'paper-free at the point of care' by 2020.

In October 2015, CCGs were invited to put forward proposals to the Estates and Technology Transformation Fund (ETTF) for future estates and technology investment, in line with their local estates and digital plans. 26 proposals were received, reviewed, prioritised and submitted as part of the national 'Stage One' process by 30 June 2016.

A draft Primary Care Estates Strategy for Leeds has recently been completed. This strategy highlights the current location and condition of general practice premises across Leeds as well as the outcomes of a number of building surveys undertaken within practices. There is enormous variation across Leeds in the quality of premises from which general practices operate and we are aware that this has a direct relationship on the quality and range of care received by patients and on the working lives of professionals.

The result of surveys undertaken as part of the primary dare estates strategy along with local practice knowledge and intelligence, regarding future housing and local infrastructure developments, provides the rationale within the estates strategy for recommendations relating to the future investment and development of general practice estate. It underpins a strategic aim to develop a built environment fit for the future in delivering our ambition of sustainable and transformed primary care as a key aspect of whole system change.



Developing improved estates, digital capacity and infrastructure underpins the delivery of the Leeds Plan and forms part of the wider Leeds workforce strategy.

Ambition 3: Transforming estates and technology

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Develop and fully use our **collective estate and technology** resources to improve the quality of care delivered and the experiences of patients and professionals

The vision for the primary care estate is that it should move towards even more purpose-built, flexible, multi use, premises which are adaptable to changes in services, capacity or demand. Premises should continue to support a culture of teaching and learning both for healthcare professionals and patients. Estate is one of the biggest financial risks both from an investment, funding and ongoing maintenance perspective. Consolidating estates and 'sweating the assets' creates opportunities through developing integrated, multi-occupancy premises which include a range of providers and services, but with sufficient room for future growth/expansion. Premises development should be planned on a hub and spoke model to allow for additional services to be delivered across a whole neighbourhood.

By 2020/21 practices will:
- **Be able to use effective and efficient technology and digital working which supports clinician to clinician and patient to clinician interfaces.**
- **Be able to use premises in a more flexible way**
- **Have premises which are used more effectively and are fit for purpose**

Through the Leeds primary care estates strategy, proactive estate and infrastructure plans will be drawn up so that premises should be well managed and link whole health and social care systems. This approach will include greater partnership working with strategic landlords and others to ensure the total estate is considered. Consistent policies will be developed in relation to rent reviews, including premises reimbursements, as well as agreeing strategic decisions relating to ownership, leases and agreeing any future disposal options for estate.

Infrastructure and technology should support patients to be involved in managing their own health and wellbeing and decisions about their care through information, advice and engagement. We know that new technologies provide huge opportunities to enable patients to access services, advice and their own records digitally but that different levels of digital literacy and appetite exist across different population groups. Promoting and supporting digital access across receptive population groups will free up face to face access for patients who most need this.

By 2020 /21patients will:
- **Be aided to use a range of different digital skills and solutions to meet their needs**
- **Receive care from primary and community premises which support their wellbeing, relieve stress and aids recovery**
- **Be able to have more choice of locations from which to access care depending on their need**

We also recognise the importance and value of digital technologies in enabling greater integration and more flexible delivery of care across different service providers. This includes greater access to shared digital records, the development of near patient testing, the use of mobile devices as well as telephone and digital based solutions that enable improve real time communication between professional to deliver better and more efficient care for patients. The role of technology in delivering more efficient and effective care between patients and professionals is a key component of our wider approach to population health management

Investment in estate and technology is needed, not just to improve existing facilities and the quality of primary medical care received by patients, but to increase the sustainability and transformation of general practice.

The investment and development of flexible primary care estates and technology solutions underpin the delivery of the GP Forward View, New Models of Care and the aspiration of the city to establish a population health management approach.

Primary care estates - Citywide approach

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Current position	2016-17	2017-18	2018-21
105 general practices occupying 127 premises ranging from rural branch surgeries, to large single practices in fully maintained buildings. 5,506 new homes each year for next 5 years focussed around city centre and inner area = 27,530 x 2.3 new patients per dwelling = 63,319 new patients in the next 5 years. Established Leeds Strategic Estates Plan covering all local health, social care and local authority stakeholders. 10 x LIFT buildings developed from 2004-2010. Space utilisation surveys show many buildings under used, and some such as LIFT significantly so. 54% of primary care buildings fail to meet minimum NHS standards for physical condition, 15% for functional suitability and space utilisation and 58% for statutory compliance status. Significant issues with backlog maintenance on a large number of practices. (£1.5m 2016 6 facet surveys). Numerous opportunities to consolidate primary care estate and co-location with other health and social care partners.	Primary care estates property appraisals to be completed, analysed and action planned. Estates workshops with representatives of key stakeholder groups. Workshops review the current collective stakeholder estate in each neighbourhood and identify any initial opportunities for collaborative estates development. Complete primary care estate strategy as part of wider health and social care estates strategy. Agreed NHS provider estates strategies updated and factored in to the citywide Estates Transformational Plan. Draft development and investment pipeline of potential estates schemes based on strategy and list of issues identified. Implement successful schemes from the Estates and Technology Transformation Fund. Leeds LIFT/PFI contract review to be completed. Citywide policy on approach to rent reviews, decision making around premises reimbursements agreed. Partnership working arrangements with key organisations establish to support a cohesive approach to estates of the future	Project workstream implemented for estates transformation , business cases from development and investment plan to be drafted. Improvements in the primary care estates through the One Public Estate programme. Scope 'utilities' technology to reduce estate costs Agreed future citywide transformational Primary Care Estates Development, Investment and Divestment Plan. Map citywide training capacity and other multifunctional space such as meeting rooms etc. Leeds LIFT contract: implement recommendations for actions to realise financial savings opportunities. Leeds PFI contract: implement recommendations for actions to realise financial savings opportunities. Citywide approach to estates ownership, lease agreements and future disposal of primary care estate.	Leeds LIFT building space use improved to 65% and above. Centralised shared training facility to be established – estates solution provided. Centralised CCG/LCC back office and head office accommodation estates solution agreed and delivered for health and social care partners. Integrated strategic estates and development lan developed including redesign for Leeds general Infirmary. Submission of Phase 4 One public estate bid to include primary care.

Additional support requirements – developing primary care estate is currently dependent on the successful funding of applications submitted through the ETTF from the Leeds CCGs. Specialist support required around estates development and support for practices to look a estates issues across their neighbourhoods.

Primary care estates – CCG specific actions

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Current position	2016-17	2017-18	2018-21
NHS Leeds North CCG 34 buildings ranging from small converted premises to large multipurpose sites. 53% of primary care buildings fail to meet minimum NHS standards for physical condition, 18% for functional suitability and space utilisation and 56% for statutory compliance status. 5 practices flagged as high risk.	**ETTF:** CCG supported submission for 11 bids, 7 premises schemes and 4 IT schemes including one citywide IT scheme. Implementation of ETTF scheme for extension of Westgate Surgery to be completed by 2016-17. Project initiation of St Martins House development in in Chapeltown.	ETTF: Project initiation of remaining premises schemes to be completed by 2019. Scope potential hub locations to align with proposed extended access schemes and urgent care strategy. Develop and implement action plan to address priorities identified in Primary Care Estates Strategy Implement successful Phase 2 ETTF schemes.	Establish integrated community hubs aligned with the urgent care strategy and MCP models of working.
NHS Leeds South and East CCG 45 buildings ranging from small converted premises to large multipurpose sites. 52% of primary care buildings fail to meet minimum NHS standards for physical condition, 18% for functional suitability and space utilisation and 58% for statutory compliance status. 11 practices flagged as high risk.	**ETTF**: CCG supported submission for 11 bids, 10 practice bids (2 IT) , one IT CCG bid. Review of primary care estates within defined areas- LS8/9 and Garforth will be completed by 2016/17- inform future estates needs and support sustainability of PC. Potential resubmission to ETTF portal based on review/ in line with estates strategy.	Implementation of successful ETTF schemes and develop evaluation plan for ETTF Continue phased assessment of primary care across geographical areas within CCG/ shared boundaries with other CCGs- to aid understanding of estates and IT, to support development of collaboration and integration, and primary care working at scale to deliver extended access Development and implementation of action plan to address priorities identified in Primary Care Estates Strategy	Ongoing evaluation of premises development in 2017/18 to understand further need and possible further submission to ETTF.
NHS Leeds West CCG 48 buildings ranging from small converted premises to large multipurpose sites. 56% of primary care buildings fail to meet minimum NHS standards for physical condition, 9% for functional suitability and space utilisation and 58% for statutory compliance status. 2 practices flagged as high risk.	**ETTF**: Progression of 5 successful premises development schemes supported through first stage Management of locality workshops to explore potential estate for future planning/community hubs. Completion of 6 facet surveys and Leeds West Primary Care Estates Strategy .	Development of action plan to address priorities identified in Primary Care Estates Strategy . Action plan to include assurance that minimum standards for practice premises attained. Implementation of successful ETTF schemes and develop evaluation plan for ETTF. Coordinate future planning of estate needs working with locality hubs.	Evaluation of premises development in 2017/18 to identify further need.

Primary care technology - Citywide approach

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Current position	2016-17	2017-18
Leeds Digital Roadmap (LDR) and the Leeds Plan outlines the case for improving and maximising technology. Leeds Care Record in use across multiple providers e.g. secondary care, mental health, community and social care includes medications, allergies and adverse reactions. All GP practices signed up. Currently 15% of patients have signed up to access online services. Less than 1% has access to detailed coded record (DCRA). Only 54 practices enabled DCRA. Current use of Electronic-Referral Systems across Leeds average 60% (national QP target 80% by Sept 2017). Current use of electronic discharge advice notices from secondary to primary care 84%. 90% of GP practices EPS2 compliant. Only 6% using repeat dispensing. All practices using common Electronic Palliative Care Coordination System (EPaCCS) template. All practices have at least 3 PCs capable of supporting Skype-like consultations.	Scope further development and opportunity with the Leeds Care Record (LCR); develop clinical specialist advice and increased use particularly in community pharmacy and A&E. Evaluate patients currently using patient online, who, where and how used. Increase uptake to 20% (national target 10%). Support digital literacy skills for patients and staff increasing percentage who have all five basic digital skills. 10% of patients registered for online services to be actively using them. DCRA to be offered to all patients on 2% high risk group. Add 'flag' for other providers. Provide tools to supported self-care e.g. telehealth, online questionnaires. Public Wi-Fi access in all GP practices. Consistent approach to practice website design and links to other services. Implement technology to support hub and spoke and collaborative working to support delivery of extended hours and seven day working eg shared records and call handling. Implement e-consultation - email, instant chat and video consultations with patients. 90% digital referrals. 95% of GP practices EPS2 compliant. 80% of repeat scripts to be done via EPS2. 10% via repeat dispensing. Increase uptake of EPACCS across GP practices with more patients having palliative care plans in place. Roll-out electronic out-patient letters from secondary care to primary care. Scope digital support for care homes through remote access to clinical records or shared education and training opportunities.	Roll out further use of the LCR focussed on care navigation and patient records which can be accessed on the move . Linked to new Health Information Exchange. Increased uptake of Patient Online from 20% to 25% (national target 20%). Enable availability of clinical correspondence. 20% of patients registered for online services to be actively using them. Undertake benefits analysis of the practice PODs and measure the impact on practice workload. Test and further develop the e-consultation offer to patients. Scope impact of digital Lloyd-George notes (e-LGS) to free up space from paper records. Move towards one infrastructure footprint and service for the city including voice, data, email, collaboration tools etc. Scoping 'utilities' technology to reduce costs of estates. 100% of practices using EPS2. 80% of all scripts via EPS2 incl acute. Increase repeat dispensing to 15%. Introduce SNOMED DM+D - a universal identifying coding system which is used by the Dictionary of Medicines and Devices (dm+d). Implement unified communication systems such as instant messaging, voice and video in primary care.

Additional support requirements –accelerating digital capability is dependent on the successful funding of applications submitted through the ETTF from the Leeds CCGs. Accelerating digital literacy across Leeds will be underpinned by the Leeds CCCGs receiving national monies to further support uptake of GP online as committed in the GPFV. Additional support from NHS Digital on maximising and implementing new technology.

Primary care technology – CCG specific actions

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Current position	2016-17	2017-18	2018-21
NHS Leeds North CCG Investment in introduction of Surgery PODs via PCIF .	Implement the Digital Literacy Programme. Develop the Health Information Exchange to link with the GP clinical system and Leeds Care Record. Pilot for integrated nurse triage unit and call handling across multiple practices. Roll-out Wi-Fi to facilitate use of new technologies in Practices.	Evaluate Digital Literacy programme to share best practice and commission citywide. Linked Health Information Exchange with wider developments on Leeds Care Record to support population health management. Additional locality triage units linked to urgent care and new models of care strategy.	Implementation of hub and spoke working around back office, call handling and urgent care across all localities.
NHS Leeds South and East CCG 2015/16 Direct investment by CCG to support roll out of Wi-Fi in practices – supported by PCTF monies. Direct investment by CCG to support roll out of mobile working.	39/42 practices have access to Wi-Fi. By end of 2016/17 39 practices (52 sites) will have the ability to support mobile technology to support safe high quality care. ETTF: CCG supported submission for 2 IT practice bids, one IT CCG bid. LCR: encourage practice use through shared messages and development of case studies. Other clinical system and tools (EPACCS) to enhance pt care and clinical practice.	Support the implementation of city wide IT (tokens) bid during 2017-2019- facilitated learning/ standards of approach. Share learning from health pods and impact on access and workload to PC services. Explore opportunities from Vanguard sites and the evaluation to understand impact for PC. Continue phased assessment of primary care across geographical areas within CCG/ shared boundaries with other CCGs to aid understanding of estates and IT, to support collaboration and integration, and primary care working at scale to deliver extended access.	Explore options for patient held technology and integration with clinical records
NHS Leeds West CCG Establish baseline assessment of all current estate and technology requirements within the CCG.	Progress successful technology scheme to enable mobile working supported through first stage of ETTF. Wi-Fi Installation in all practices to facilitate use of new technologies. Skype Telehealth Kit installed in all practices to support virtual means of access and multi-disciplinary working Develop a standard practice website to include appropriate signposting to services Continued support to practices for access to Leeds Care Record.	Implement successful ETTF schemes. Develop evaluation plan for ETTF schemes. Work to support practices and localities through the network to: • test and increase use of video kit to improve patient care • maximise the potential of practice websites in signposting patients to self-care, obtain advice from pharmacy first and connecting to voluntary sector through social prescribing. Expand the Leeds Care Record.	Evaluate premises development in 2017/18 to identify further need

Ambition 4: Better workload management

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Reduce practice burdens and help release time with the management of demand, diversion of unnecessary work and an overall reduction in bureaucracy

Introduction and context

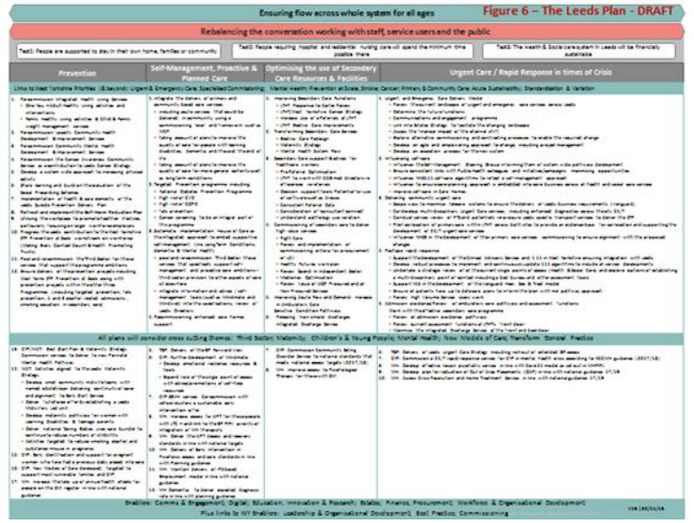
The three Leeds CCGs have successfully supported member practices in managing their workload through significant historic investment in quality improvement programmes such as the General Practice Improvement Programme (GPIP), Productive General Practice, in addition to establishing and supporting the bespoke Leeds Institute for Quality Improvement.

A key component of quality improvement is the ability to accurately assess capacity and demand and support practices to make small changes to manage appointment systems. As a national GP Access Fund site, NHS Leeds West CCG is an early implementer of a systematic approach to capacity and demand. The understanding and learning from this will be shared across the city as we launch the approach in 2017, providing dedicated support to practices. The plan will be to initially work with those practices that have currently identified specific capacity issues. We will also look at a structured approach to reducing missed appointments, focused on those practices that are indicating this is a particular issue for them and their patient population.

A standardised quality dashboard has been produced across the city which will further support how we transparently work with practices to identify and share good examples of quality improvement as well as where additional support may be required in relation to specific citywide quality themes or at specific practice level. The 'One Voice' work has emphasised the importance of primary care development support and commitment to use our collective resource to support practices on the basis of need as required.

Leeds has made significant progress in implementing a number of the national expectations relating to the NHS Standard Contract. A full review of the recommendations arising from the GPC Urgent Prescription for General Practice has been undertaken with our LMC colleagues which aims to reduce the impact on general practice. A system is established, through Leeds Provider Query to allow practices to flag where there are compliance issues and these will continue to be monitored and fed back to our local providers to continue to support the appropriate workload management in general practice.

Initiatives planned to improve the efficiency and effectiveness of the interface between within primary care and general practice will support this strand of the Leeds Plan.



Ambition 4: Better workload management

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Reduce practice burdens and help release time with the management of demand, diversion of unnecessary work and an overall reduction in bureaucracy

We are working with NHS England colleagues in identifying those **practices that may benefit from the GP resilience programme**. 13 practices (and one locality) have been identified by CCGs and practices to date, in addition to at least 11 practices (or localities) receiving vulnerable practices funding. This demonstrates some of the challenges being faced by our practices and our focus will be on sustaining services for the population. Recognising the importance of the general practice registered list in providing continuity of care, we also know that by supporting increasing collaboration between practices, we will continue to identify schemes which may allow the resources to be managed at scale across a wider footprint.

The CCGs and the LMC have agreed to work together to continue to identify areas of good practice and share case studies to ensure continuous improvement and spread of initiatives across the city, particularly encouraging practices to share initiatives that have impacted upon their workload. All three CCGs have **successful social prescribing models** in place which is already starting to show an impact on supporting GP workload.

A high level review against the **10 high impact changes** has been undertaken (see figure 4) and a commitment has been made to share good practice, learning and ideas for development, particularly regarding productive work flows, in a coordinated way across the city. An identified lead for each 'high impact' area has been identified who will help to monitor and push for progress through the citywide collaborative.

Effective workload management also sits alongside the workforce chapter in identifying opportunities for other health and care professionals to work as part of an integrated team to help support a more appropriate workload depending on the needs of the population and the skills available within the practice team. A positive example of this is the integration of mental health workers in primary care reflecting the **key role of general practice is holistically supporting the mental and physical health and wellbeing needs of patients.**

A **GP wellbeing action plan** for 2016-18 has been developed across the city which aims to focus on a number of initiatives to support GP resilience including coaching and mindfulness . Feedback from GPs who have participated in the initial Mindfulness course has been extremely positive.

By 2020/21, patients will:

- **Be confident in being able to manage minor self limiting illnesses themselves, obtaining advice from other health professionals such as pharmacists or through other initiatives such as NHS111**
- **Avoid the morning 'on the day' rush for appointments through effective appointment capacity**
- **Have an improved overall experience of general practice**

By 2020/21 practices will:

- **Have been supported to review workload and will see a reduction in bureaucracy and reporting**
- **Experience improved communication between providers, preventing the need for re-referrals and chasing up tasks etc.**
- **See better managed demand and will experience a better work/life balance**

Ambition 4: Better workload management

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Figure 4 - City wide assessment of progress against delivery of 10 high impact changes and links to the ambitions outlined in the GPFV delivery plan.

		Workforce	Access	Estates & Technology	Workload	Redesign
Active signposting	• Increase in use of online services • Procure new website to actively signpost • Leeds Directory • Commitment to work across the city to commission training for admin and clerical staff	✓	✓	✓	✓	✓
Personal productivity	• Coaching support for GPs • Review of TARGET session to support personal productivity • Mindfulness sessions	✓			✓	
New consultation types	• All CCGs testing new consultation types – need to consolidate efforts to reduce duplication of 'testing', share good practice • Evaluation of e-consultations underway in Leeds West as part of GPAF – funding in 2017/18 for online consultations • Various models underway – need to share learning		✓	✓	✓	
Partnership working	• Good links with CPWY – Pharmacy First • All CCGs progressing 'primary care, provided at scale' either through networks, federation, MOUs or scoping options • Prototypes established in each CCG for "New Models of Care"	✓	✓		✓	✓
Reduce missed appointments	• Support for MJOG • 'Forgotten Something' campaign • Structured approach to DNA's to be launched in 2017		✓	✓	✓	
Develop the team	• LSECCG & LNCCG part of clinical pharmacist scheme – learning to be shared • Citywide approach to workforce – pilot new roles, PA, physio /MSK in house services • LNCCG in-house diabetes led nursing management and recruitment & retention for new GPs (Chapeltown HATCH Initiative	✓				✓
Productive work flows	• All CCGs funded support packages through either Productive General Practice or General Practice Improvement Programme. • Focus on capacity and demand processes – systematic approach planned for 2017				✓	✓
Social prescribing	• All CCGs have social prescribing initiatives in place • Leeds Directory to help signpost to other services in the community	✓	✓		✓	✓
Support self care	• Leeds part of National Diabetes Prevention Programme, established collaborative care and support Planning (YOC) approach, health coaching • Procure Healthy Living Services • Pharmacy First	✓	✓		✓	✓
Develop Quality Improvement (QI) Expertise	• Review TARGET – proposal to include LIQH within TARGET to develop QI expertise locally • Productive General Practice and general practice improvement programme offered to all Leeds practices • Focus on information for improvement – standardised quality dashboard	✓			✓	✓

Ambition 4: Better workload management

City-wide approach

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Current position	2016-17	2017-18	2018-21
Baseline assessment against the 10 high impact areas undertaken. Leeds identified and will continue to monitor and share good practice through the citywide primary care collaborative. NHS Leeds West CCG trialling new software to measure demand through GP Access Fund. Expression of Interest submitted to the releasing time to care programme submitted – assessing scope of programme and benefits in light of previous investment. Local training and support offered to receptionists to encourage uptake of online services to support workload management (further sessions to be arranged). Support roll out of electronic repeat prescribing. 54% practices participated in either GPIP or PGP. Use Leeds Provider Query email to understand non-compliance of acute providers against the NHS Standard Contract. Identify 1st wave priorities for GP resilience .	Leeds Institute for Quality Healthcare to offer quality improvement course to GP staff teams. Review 3 CCG engagement schemes and align where possible Collaborative Care and Support Planning consultations (previously known as 'Year of Care') scaling and targets Develop a quality strategy for general practice, capturing the positive work already in place across Leeds. Promote a culture of quality improvement amongst practices. Develop a standard quality dashboard to support workload management and identify areas of support for practices. Practice manager representation from CCGs to scope an active signposting and correspondence training offer for GP reception staff with health coaching and social prescribing models– to roll out training across the city by Jan / February 2017. Systematic approach to demand and capacity to be offered across the city. Embedding quality improvement methodologies. Continued to audit DNAs and utilise the 'Forgot Something' campaign. Development and testing of 'Mindwell' – citywide information portal to improve mental health information access, self-help and direct referral to IAPT – will divert a proportion of patients from GP direct to MH services. Continue sharing case studies and best practice across Leeds through practice manager sessions, TARGET, CCG bulletins and using the LMC Viewpoint. Engage the sessional GP workforce. Work with communication and engagement colleagues to undertake campaign for supported self management (Pharmacy First etc.)	Scope a web solution for a common front end access point to deliver: active signposting, self-management and triage (as per West Wakefield and Leeds West model). CCGs continuing to support the delivery of 10 high impact changes across GP at scale over 17/18 and 18/19. Engagement with community pharmacy colleagues to scope joint approaches to support workload management. Scope citywide social prescribing service based on pilot evaluations. Continue to increase online services through active promotion. Evaluate impact of Collaborative Care and Support Planning (previously known as 'Year of Care') Programme. City wide approach to communications and engagement to support self care through Pharmacy First and 111. Roll out Mindwell and increase awareness of the portal. Wave 2 investment (Dec 17) in more psychological therapy linked employment advisors to support those with LTCs. Develop standard templates and processes to support practices' management of housing / PLP forms etc. Share standardised protocols for reception staff to manage clinical correspondences. Further offer care navigation training with a focus on asset mapping local community resources /self-care options / pharmacy first as a route for helping navigate patients. Continue sharing of case studies and best practice across Leeds.	Further offer care navigation training with a focus on supporting patients to access new posts and functions within the general practice team and wider multidisciplinary team. Continue sharing case studies and best practice across Leeds. Continue to increase online services through active promotion.

Additional support requirements – support to be provided by the transformation Team to secure funding for bespoke resources to support quality improvement methodologies in Leeds in recognition of the significant local investment in general practice quality programmes; support to align national and local enhanced services and local schemes to reduce bureaucracy and share best practice case studies from across the Region

Ambition 5: Redesign care delivery

Progress to a whole system model which focusses on a 'place-based' approach where everybody has a part to play, both citizens and services together

Introduction and background

The ambition to redesign the way primary care is delivered is at the heart of ensuring the sustainability and transformation of both general practice and the wider health and care system. We know that **general practice's understanding of local population needs alongside the continuity of care enabled through the registered list are strengths that we will value and retain going forward**. Building from the general practice registered list provides a firm foundation for care to be delivered differently – in a more collaborative and integrated way - bringing together different providers of health and social care across the city. **This chapter outlines the central role of general practice and general practitioners in driving forward change that will support and enable the wider system transformation described within the West Yorkshire and Harrogate Sustainability and Transformation Plan (WYSTP) and the underpinning Leeds Plan.**

Leeds is recognised nationally as being ahead of the curve in relation to current levels of integration between service providers within the city. Over the last two years the Leeds CCGs have guided and supported general practices to develop new ways of working in line with the New Models of Care (NMoC) approach described in the Five Year Forward View. Across Leeds, general practices are working with community, acute and third sector providers to develop and deliver NMoC which respond to the needs of priority populations within a given locality. Joint leadership teams are being developed and supported to enable provider joint working. The aim of this approach is to **support the consideration of the use of collective resources and expertise, including the social assets of patients and communities, to deliver increasingly better outcomes for local populations.** The benefits of working in a more collaborative way includes the better use of finite system resources such as workforce and estates. We believe this will lead to improved outcomes and increased satisfaction for patients and in improvements to the working lives of front line staff through better working relationships. Supported through facilitation and resource from CCGs, the following examples illustrate how general practices are working collaboratively and with other providers to develop NMoC.

Armley Test Bed

A 'Community Wellbeing Leadership Team' has been established in the Armley locality. Membership is local leaders drawn from general practice,(representing five practices in the area) LCH, LYPFT, adult social care, the Armley One Stop Centre and the local voluntary sector. The key aims are to improve relationships, develop local leadership and promote integration. The overall aim of the group is to improve the aspirations of people in Armley. The group have identified priorities around mental health, self care and delivery of care using coaching approaches. Self-led projects are underway including setting up a 'self-care' whole system MDT to support the Adult Social Care Strengths Based Social Care innovation site in partnership with New Wortley Community Centre. The group also want to roll out coaching training to all front line clinical and non clinical staff so that all people in the area will receive a consistent response when accessing all services.

Beeston & Crossgates Test Bed

In the Beeston and Cross Gates localities of LSECCG a new model of care project is developing that aims to provide proactive, integrated, patient centred care for people with multiple LTCs including CVD or COPD. A new multidisciplinary team in in place in both localities comprising of GP, geriatrician, matron, therapist and health advisors, with provision for mental health and pharmacist input once the level of need has been identified. The model will focus on developing wellbeing plans in partnership with participants along with resilience plans that support better self-management of conditions, coordinate resources more effectively and use community assets to better effect. The team are working with small groups(approx. 600/locality) from the identified cohort to develop the model in line with participant needs, ensuring citizen feedback is integral to the service design and development.

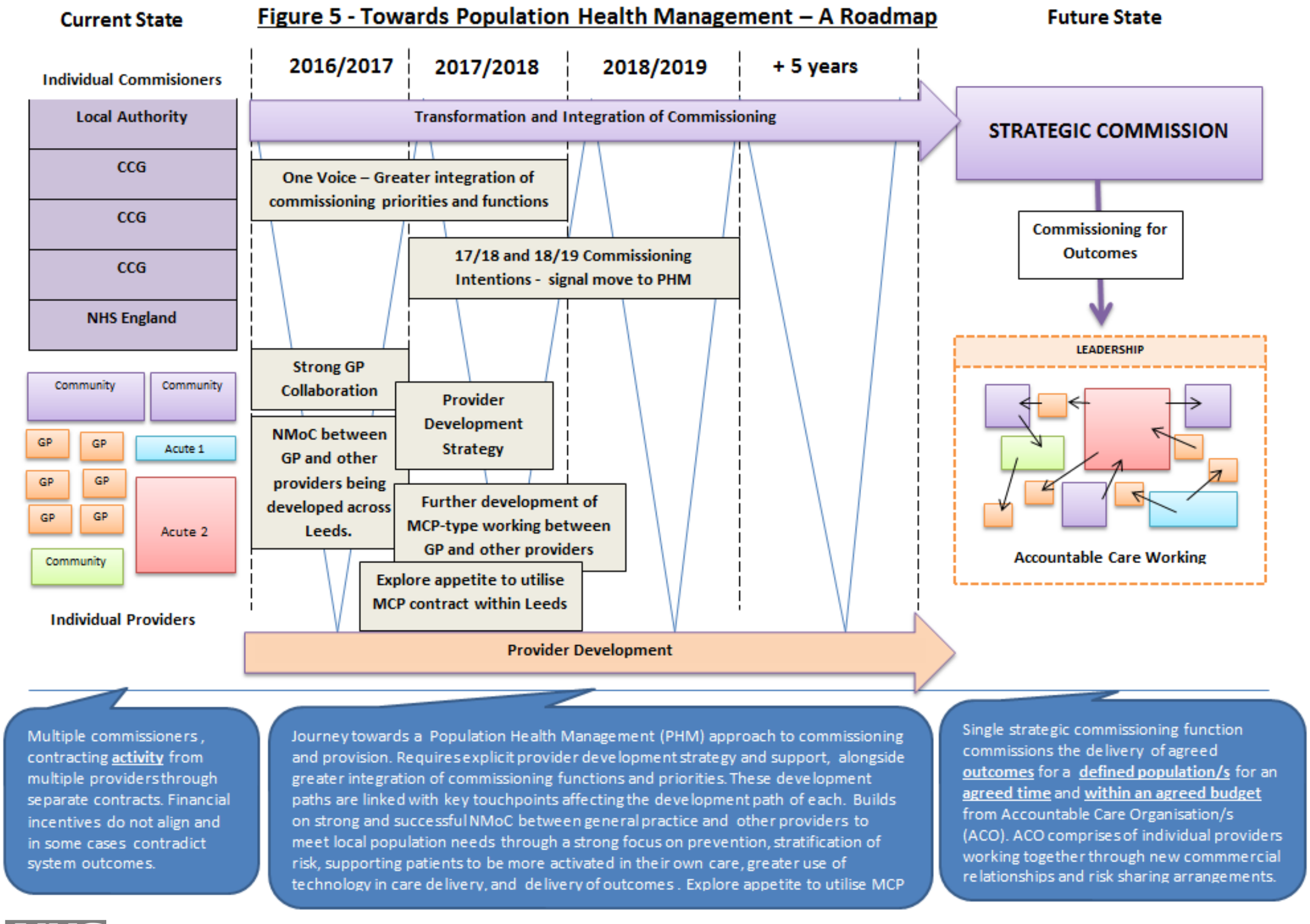
Chapeltown Test Bed

In the Chapeltown locality of LNCCG, practices have established a Memorandum of Understanding (MOU) to strengthen their ability to work together, to develop and deliver services and approaches for one of the most deprived populations in Leeds. Working alongside community providers, GPs in the locality have established a new local diabetes service. With a jointly appointed nurse specialist, the service is seeing more complex patients in the practices and upskilling the practice workforce. With mental health and third sector providers and alongside the social prescribing service 'Connect-well' the locality has also established a mental health wraparound service for local patients as an early implementer of the citywide MH Framework for Leeds. In addition, the locality has established HATCH (Health and Social Care Talent In Chapeltown and Harehills), which aims to strengthen and make more resilient the workforce in Chapeltown and make the locality a national 'go-to' destination for primary care workforce .

Working with providers, the CCGs in Leeds have described an ambition to move to a population health management (PHM) approach to commissioning for improved outcomes for the population of Leeds. The establishment and learning from the NMoC described are one of a number of key steps towards a PHM approach which include the move towards more strategic commissioning, providers working together in a more 'accountable care' way, and the alignment of contracts and incentives to support this way of working. Another step is to understand and explore the appetite and benefits of testing Multi Specialty Care Provider (MCP) contract within the city. Figure 5 outlines and describes a roadmap to PHM and some of the key steps on this journey.

Figure 5 – Approach to population Health Management (PHM)

GENERAL PRACTICE FORWARD VIEW APRIL 2016



Ambition 5:Redesign care delivery

GENERAL PRACTICE FORWARD VIEW APRIL 2016

The role of general practice in supporting delivery of the Leeds Plan and Sustainability and Transformation Plan

The Leeds Plan (Figure 6) describes the system changes required to achieve a sustainable and transformed health and care system and supports the delivery of the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP). The Leeds Plan describes four work programmes which will achieve the three overarching tests of the plan; 1) People will be supported to stay in their own homes, family or community 2) People requiring hospital and residential nursing care will spend the minimum time possible there 3) The health and social care system in Leeds will be financially sustainable.

GP redesign is at the heart of supporting and enabling this change.

There are three areas of focus within the care redesign of general practice that contribute towards the wider system change to support delivery of the STP and the Leeds Plan.

By 2020/21 patients will:
- **Access a broader range of health and wellbeing services out of hospital in their community**
- **Be empowered to make decisions to stay well and improve their physical and mental health**
- **Be confident that the professionals caring for them have the right information to support them, reducing the need for repeat assessment**

1. **Redesign general practice to be sustainable** - As outlined in the preceding sections of this GPFV delivery plan, this includes the redesign of workforce, access, workload and estates and technology to increase the sustainability and transformation of general practice as the key provider of primary care for the population of Leeds . The 10 high impact actions to release GP capacity is the key starting block for sustainability and GPs being able to work at the top of their license within integrated services.

2. **Redesign the delivery of general practice services through collaborative working 'at-scale' –** By working collaboratively to share some workforce, back-office, estates and service delivery models, general practice will be more efficient, sustainable and resilient. Working together 'at-scale' across population groups of approximately 30-80,000 will shape the formation of hub and spoke working to deliver a range of GP services and enable wider alignment to support provider integration.

3. **Redesign and integrate the wider health and care system, of which the general practice registered list is the cornerstone** - This is the focus of the Leeds Plan, which consolidates four work programmes . Aligning this plan to other strategies around urgent care, pharmacy, mental health, children and families and carers is key.

By 2020 /21 practices will:
- **Have more time for GPs to provide expert medical advice to support patients with the most complex needs.**
- **Working more collaboratively to share resources , increase resilience and provide patients with access to a wider range of options.**
- **Part of a wider team of health and care professionals working together to meet the needs of the local population**

Delivering redesign across the three levels outlined above is predicated on fully accessing the funding and resources committed in the GPFV as well as realigning existing resources, including finance and workforce, between existing provider boundaries.

Figure 6 – The Leeds Plan - DRAFT

Ensuring flow across whole system for all ages

Rebalancing the conversation working with staff, service users and the public

Test1: People are supported to stay in their own home, families or community

Test2: People requiring hospital and residential nursing care will spend the minimum time possible there

Test3: The Health & Social care system in Leeds will be financially sustainable

Prevention	Self-Management, Proactive & Planned Care	Optimising the use of Secondary Care Resources & Facilities	Urgent Care / Rapid Response in times of Crisis

Links to West Yorkshire Priorities (& beyond): Urgent & Emergency Care; Specialised Commissioning; Mental Health; Prevention at Scale; Stroke; Cancer; Primary & Community Care; Acute Sustainability; Standardisation & Variation

Prevention

1. Re-commission Integrated Health Living Services:
   - One You – Adult Healthy Living activities and interventions
   - Family Healthy Living activities & Child & Family weight management services
2. Re-commission Locality Community Health Development & Improvement Services
3. Re-commission Community Mental Health Development & Improvement Services
4. Re-commission the Cancer Awareness Community Service as a contribution to Leeds Cancer Strategy
5. Develop a system wide approach to increasing physical activity
6. Share learning and build on the evaluation of the Social Prescribing Schemes
7. Implementation of health & care elements of the Leeds Suicide Prevention Delivery Plan
8. **Refresh and implement the Self-Harm Reduction Plan**
9. Utilising the workplace to promote healthier lifestyles, particularly focusing on larger workforce employers
10. Progress the Leeds contribution to the West Yorkshire STP Prevention at Scale workstream on workforce (Making Every Contact Count & Health Promoting Trusts)
11. Pool and re-commission the Third Sector for those services that support the programme ambitions
12. Ensure delivery of the prevention projects including West Yorks STP Prevention at Scale along with prevention projects within the other three Programmes: (including targeted prevention, falls prevention, A and E alcohol related admissions , smoking cessation in secondary care)

Self-Management, Proactive & Planned Care

1. Integrate the delivery of primary and community based care services:
   - including acute services that could be delivered in community, using a commissioning 'lever' and framework such as MCP
   - taking account of plans to improve the quality of care for people with learning disabilities, dementia and those at the end of life
   - taking account of plans to improve the quality of care for more general cohorts such as long term conditions
2. Targeted Prevention programme including:
   - National Diabetes Prevention Programme
   - high risk of CVD
   - high risk of COPD
   - falls prevention
   - Cancer screening to be an integral part of this programme.
3. Systematic implementation House of Care as the integrated approach to embed supportive self-management (inc Long Term Conditions, dementia & Mental Health)
   - pool and re-commission Third Sector those services that specifically support self-management and proactive care ambitions - third sector provision to other aspects of care sit elsewhere
   - integrate information and advice / self-management tools (such as Mindmate and Mindwell) into the specifications; review of Leeds Directory
4. Recommissioning enhanced care homes support

Optimising the use of Secondary Care Resources & Facilities

1. Improving Secondary Care Functions
   - LTHT Response to Carter Review
   - LTHT/West Yorkshire Cancer Strategy
   - Increase Use of e Referrals at LTHT
   - LTHT Elective Care Improvements
2. Transforming Secondary Care Services
   - Elective Care Redesign
   - Maternity Strategy
   - Mental Health System Flow
3. Secondary Care support & advice for healthcare workers
   - Pre Referral Optimisation
   - LTHT to work with CCG med directors re efficiencies re referrals
   - Decision support tools. Potential for use of software such as Arezzo.
   - Consistent Referral Data
   - Consideration of 'consultant connect'
   - Understand pathology use variation
4. Commissioning of secondary care to deliver high value services
   - Right Care
   - Review and implementation of commissioning criteria for procurement of LCV
   - Healthy Futures work plan
   - Review Spend in Independent Sector
   - Medicines Optimisation
   - Review Value of AQP Procured and all Non Procured Services
5. Improving Acute Flow and Demand: Increase in Ambulatory Care
   Sensitive Condition Pathways
6. Releasing 'non simple' discharges: Integrated Discharge Service

Urgent Care / Rapid Response in times of Crisis

1. Urgent and Emergency Care Delivery Model
   - Review the current landscape of urgent and emergency care services across Leeds
   - Determine the future functions
   - Communications and engagement programme
   - Link into Estates Strategy to facilitate the changing landscape
   - Assess the financial impact of the channel shift
   - Explore alternative commissioning and contracting processes to enable the required change
   - Develop an agile and empowering approach to change, including project management
   - Develop an escalation process for the new system
2. Influencing self-care
   - Influence the Self-Management Steering Group informing them of system wide pathways development
   - Ensure consistent links with Public Health colleagues and initiatives/campaigns maximising opportunities
   - Influence NHS111 self-care algorithms to reflect a self-management approach
   - Influence to ensure care-planning approach is embedded into core business across all health and social care services
   - Improve self-care in Care Homes
3. Delivering community urgent care
   - Scope ways to maximise telecare systems to ensure the delivery of Leeds business requirements (Vanguard)
   - Co-develop multi-disciplinary Urgent Care services, including enhanced diagnostics across the city 24/7
   - Conduct service review of PTS and potentially re-procure Leeds specific transport services to deliver the STP
   - Pilot co-location of primary care within LTHT across both sites to provide an evidence-base for co-location and supporting the development of 24/7 urgent care services
   - Influence NHSE in the development of their primary care services commissioning to ensure alignment with the proposed changes
4. Reshape rapid response
   - Support the development of the Clinical Advisory Service and 1 11 in West Yorkshire ensuring integration with Leeds
   - Develop robust processes to implement and continuously update 111 algorithms to include all service developments
   - Undertake a strategic review of all the current single points of access (Health & Social Care) and explore options of establishing a multi-disciplinary point of contact including a bed bureau and other assessment tools
   - Support YAS in the development of the Vanguard Hear, See & Treat model
   - Ensure all patients have up to date care plans to inform the 'plan with me' pathway approach
   - Review High Volume Service Users work
5. Admission avoidance/Review of ambulatory care pathways and assessment functions
   Work with the effective secondary care programme
   - Review all admission avoidance pathways
   - Review current assessment functions at LTHT's front door
   - Maximise the Integrated Discharge Service at the front and back door

All plans will consider cross cutting themes: Third Sector; Maternity; Children's & Young People; Mental Health; New Models of Care; Transform General Practice

Prevention

13. CYP/MAT: Best Start Plan & Maternity Strategy: Commission services to deliver to new Perinatal Mental Health Pathway
14. MAT: Activities aligned to the Leeds Maternity Strategy:
    - Develop small community midwife teams with named obstetrician delivering continuity of carer and alignment to Early Start Service
    - Deliver full choice offer by establishing a Leeds Midwifery Led Unit
    - Develop maternity pathways for women with Learning Disabilities & teenage parents
    - Deliver national 'Saving Babies Lives care bundle' to continue to reduce numbers of stillbirths
    - Activities targeted to reduce smoking, alcohol and substance misuse in pregnancy
15. CYP: Early identification and support for pregnant women who have had a previous baby placed into care
16. CYP: New Models of Care developed, targeted to support most vulnerable families and CYP
17. MH: increase the take up of annual health checks for people on the SMI register in line with national guidance

Self-Management, Proactive & Planned Care

5. TGP: Delivery of the GP Forward View
6. CYP: Further development of Mindmate:
   - Develop emotional resilience resources & tools
   - Expand role of the single point of access with advice/promotions of self-help resources
7. CYP SEMH service: Co-commission with school clusters a sustainable early intervention offer
8. MH: Increase access to IAPT for those people with LTC – and link to the GP FYFV priority of integration of MH therapists
9. MH: Deliver the IAPT Access and recovery standards in line with national targets
10. MH: Delivery of Early Intervention in Psychosis access and care standards in line with Planning guidance
11. MH: Maintain delivery of IPS based Employment model in line with national guidance
12. MH Dementia: to deliver expected diagnosis rate in line with planning guidance

Optimising the use of Secondary Care Resources & Facilities

7. CYP: Commission Community Eating Disorder Service to national standards that meets national access targets (2017/18)
8. MH: Improve access to Psychological Therapy for those with SMI

Urgent Care / Rapid Response in times of Crisis

6. TGP: Delivery of Leeds Urgent Care Strategy including roll-out of extended GP access
7. CYP: Commission a 24/7 rapid response service for CYP in mental health crisis according to NCCMH guidance (2017/18)
8. MH: Develop effective liaison psychiatry service in line with Core 24 model as set out in MHFYFV.
9. MH: Develop plan for reduction of Out of Area Placements (OAP) in line with national guidance 17/19
10. MH: Assess Crisis Resolution and Home Treatment Service in line with national guidance 17/19

Enablers: Comms & Engagement; Digital; Education, Innovation & Research; Estates; Finance, Procurement; Workforce & Organisational Development

Plus links to WY Enablers: Leadership & Organisational Development; Best Practice; Commissioning

Ambition 5: Redesign care delivery

GENERAL PRACTICE FORWARD VIEW APRIL 2016

The layers of redesign

1. Redesign general practice to be sustainable

The initial focus of redesign is to support GP sustainability.

Building on the delivery of the previous four sections of this plan, general practice will be supported to work through and adopt the changes in the 10 high impact actions which will release capacity within general practice. The focus of the 10 high impact areas is likely to vary across the city depending upon local population and practice needs. For example, focussing on the high impact action on social prescribing may be a higher priority in areas of deprivation where there is a high need to support the wider social needs. The capacity created will support greater redesign and integration of the wider health and care system, notably this will free GPs time to work more at the 'top of their licence' and support the management of complex patients who have multiple needs. This would see GPs having more dedicated capacity to support system flow, for example, supporting the discharge process by actively supporting patients out of secondary care and aligning the management of care home and 'housebound' patients. This capacity will also support better in hours access to care. Figure 7 below demonstrates the future focus of GP capacity within the integrated health and care system and management of patients with complex and multiple needs.

2. Redesign the delivery of general practice services through collaborative working 'at-scale'

The second area of focus is to support GP collaboration, through this we can deliver a foot print for hub working on which the next layer of redesign can be based. The assumption here is that collaborative and hub working is used to support delivery of services and functions where this makes sense and that this builds on, as opposed to replaces, the registered list and care that is more appropriately delivered at individual practice level.

We know there are existing high levels of public satisfaction with general practice, however, due to the workload pressure in general practice, some patients have reported difficulty accessing services. As described at Ambition 2, the GPFV has committed extra national money to extend access to core primary care medical services to be delivered through collaborative working in hubs. This will encourage and support general practices to work at scale. Working at scale supports the STP and Leeds Plan place based approach to care and the ability to integrate general practice and community services through hub working. It is envisaged that hubs in Leeds will cover localities consisting of population footprints of approximately 30-80,000.

There will be two phases to developing hub working. The first will be to support general practice collaboration to work more collectively to deliver extended access, the second phase will be to align more community health, mental health and third sector services around hub working. We envisage future hubs will offer a skilled mixed team with some specialist services to meet local populations needs. As an example, we will explore how hub working could enable delivery of specialist paediatric care via hot clinics to meet existing needs for same day early evening access to care for unwell children.

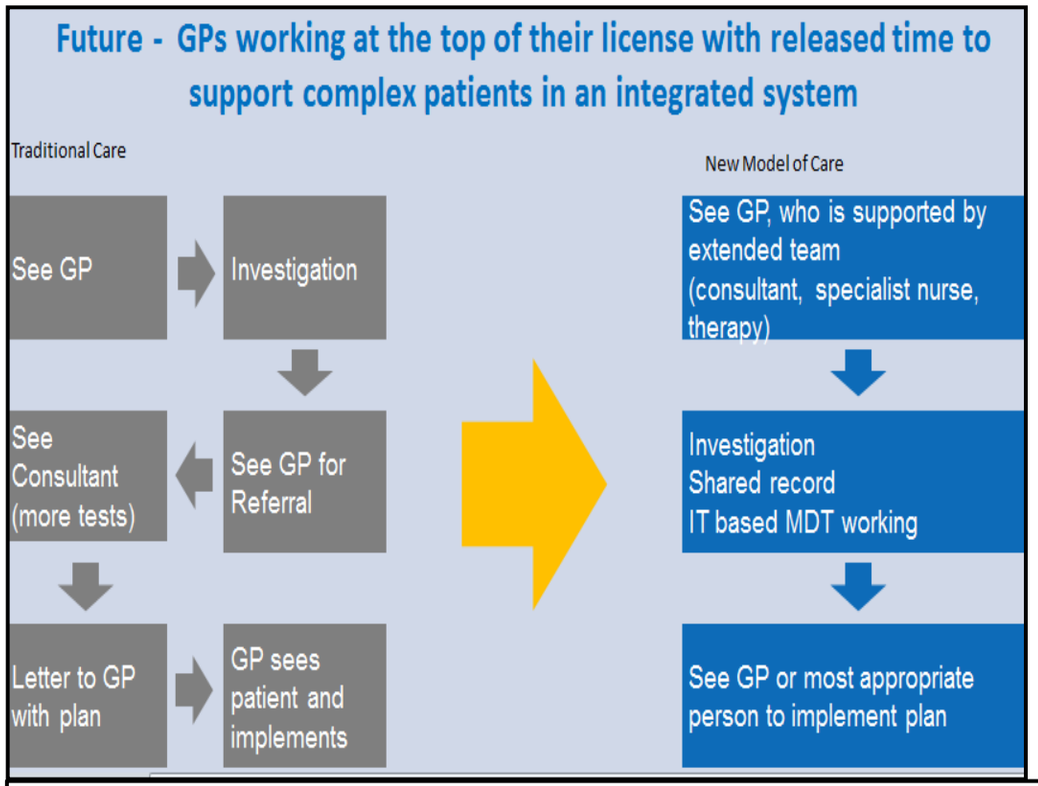


Figure 7 – Future focus of GP capacity within integrated health and care system

Ambition 5: Redesign care delivery

GENERAL PRACTICE FORWARD VIEW

The layers of redesign

3. Redesign and integrate the wider health and care system, of which the GP list is the cornerstone

The third focus of redesign is to align and integrate primary care, including general practice, with pharmacy, community health, mental health, children's and maternity services and third sector providers around geographical neighbourhoods, localities or hubs. Working together in this way helps to build relationships as providers come together to consider and plan the delivery of their services in response to local needs.

This system redesign and renewed focus will support the achievement of the four key Leeds Plan work programmes as well as the 'Leeds Conversation' each of which are described in further detail below.

Prevention work programme

Integrating health and social care including third sector providers will bring a renewed focus on promoting health and wellbeing and preventing ill-health across the city. General practices in Leeds are already commissioned by CCGs and Leeds City Council to deliver activities aimed at promoting health and wellbeing and preventing people from becoming ill e.g. delivery of NHS Health Checks, and commissioning screening champions within the most deprived practices in the city. The Leeds Plan prevention programme consolidates and builds on the work already being undertaken and places specific emphasis on targeting resources to support the city's most deprived populations addressing the inequalities gap and improving the health of the poorest fastest. A much stronger focus on prevention and the use of new technology to support this is a key component of a future population health management approach.

Proactive care and self-management work programme

For some time, general practice in Leeds, has been changing the way support is offered to patients to self-manage. A significant programme is already under way to roll out the collaborative care and support planning (previously know as Year of care). This approach enables patients to set their own goals, and skills staff to provide health coaching and will be adopted and used as a fundamental model of interaction with patients throughout the integrated teams . A self-management approach to care through the use of decision support, asset based approaches and common signposting will be fundamental in care redesign. Care redesign for general practice will also involve ensuring patients are informed and clear about their medications (through the launch of a Leeds Medicines Charter), receptionists are skilled and trained to signpost and ensure patients are seeing the right professional first time and patients expectations about this are managed well. Proactive ,rather than reactive, care will be delivered through more integrated care models, with proactive care and case management targeted at patients with more complex needs e.g. those living in care homes or with multiple long term conditions. Care delivered in a range of settings will be enabled by a greater use of technology and the increasing participation of patients as they take more control of their own health. These are both key features of a future population health management approach.

Optimising the use of secondary care resources and facilities work programme

GPs and secondary care consultants will be supported to maximise their clinical capacity in order to work more jointly to support patient care in the community. GPs will be freed to work at the 'top of their license' and support the management of more clinically complex patients. The programme will explore ways of working that ensures patients are only in hospital for as long as clinically needed with GPs playing a role in proactively support their care back into primary care. The programme also aims to increase the capacity for diagnostic and rapid assessment of patients across primary and secondary care.

Urgent Care /Rapid Response in times of crisis work programme

It is well recognised that the majority of urgent care is delivered in general practice. The programme will explore how the primary care contribution has maximum impact across the urgent care system by reshaping the 'crisis response' including extending access to general practice across the city. Changing the way that same day urgent care need is responded to across the system will be a key part of the required transformation for future sustainability. See Ambition 2 for further information.

Ambition 5: Redesign care delivery

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Enabler to redesign –the Leeds Conversation

The Leeds Conversation – an enabler to system sustainability

The Leeds Conversation will 'activate' patients to be owners and partners in their own care and using this system is fundamental to supporting prevention and self-management. Leeds will create a 'one team' approach to care delivery. This will support person centred care, empower staff to do the right things and remove duplication in care. Developing the Leeds Conversation between patients, the public and professionals and which all providers will support, will help us have transparent conversations WITH people about the services we are delivering and people's role in their own care.

This approach is crucial to support a culture change in both staff and the public and help with the shift towards scaled prevention, self-management and system sustainability and is central to the future approach of population health management.

The Leeds Conversation features in a number of strategies and plans that set out the delivery of improved outcomes for populations and across care pathways. These include urgent care; mental health; children and maternity services; and Carers.

Longer term system redesign

A longer term, 10 year redesign of current approaches to commissioning and provision with a move towards population health management (Figure 5) will move the strategic commissioning of outcomes for defined populations within an agreed budget within an agreed timeframe for new ways of working to deliver accountable care, supported by aligned incentives and contractual levers across the system.

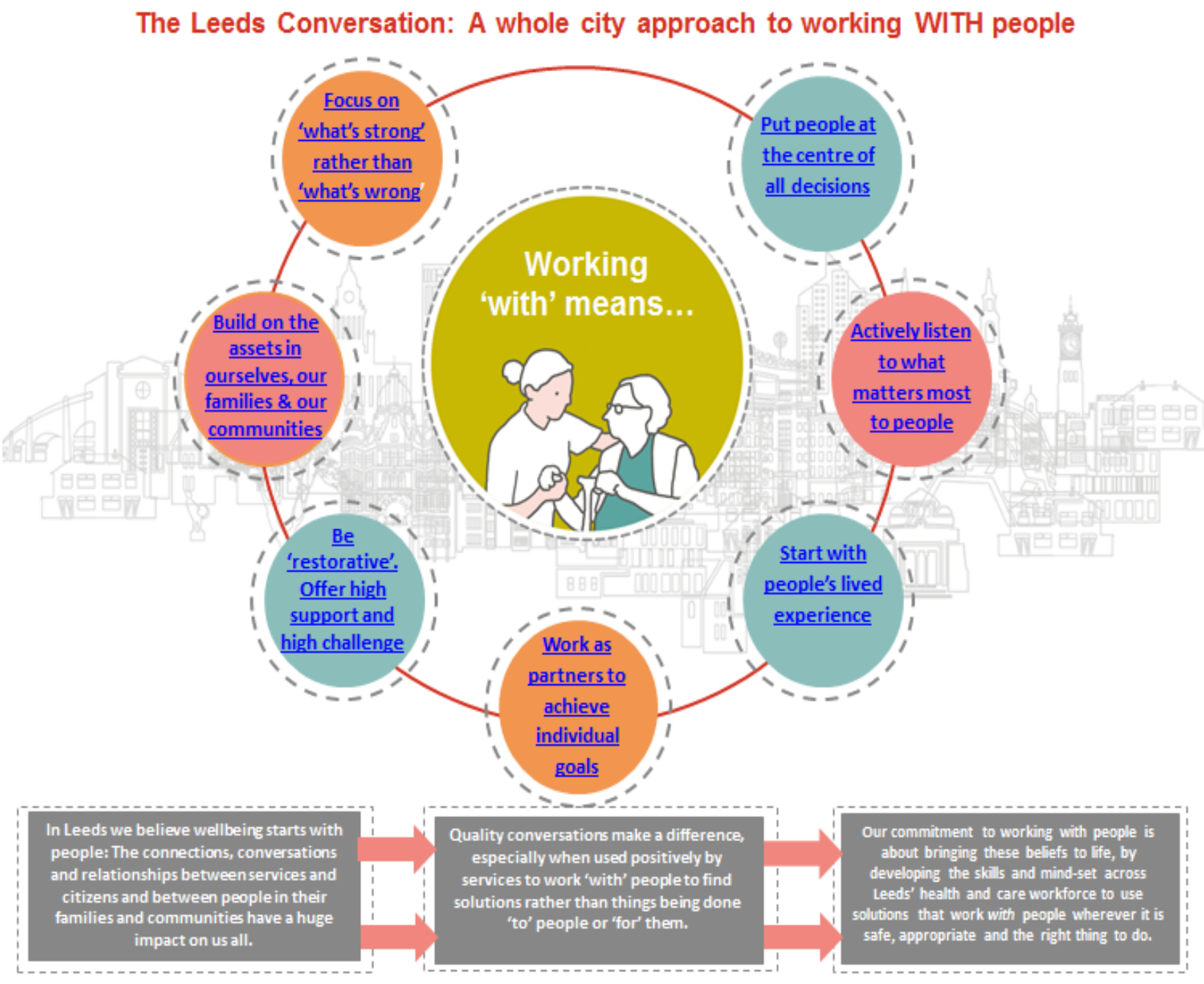


Figure 8 – The Leeds Conversation and its key component parts

Ambition 5. Redesign care delivery

Citywide delivery approach:

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Current position	2016-17	2017-18	2018-21
Core GP redesign and hub working • CCG commissioned engagement schemes moving general practice towards more prevention, supported self-management, managing populations and working jointly together. • GPs are at the heart of NMoC test projects for segments of the population or a via a placed based approach. • General practice 'at scale' through federations, networks or across local agreements to support hub working. • CCGs taken on level 3 delegated commissioning of core GP contract in April 2016. **Wider system redesign** • 13 neighbourhood teams based around the GP registered list. • Leeds Plan developed with identified work streams. • Leeds Care Record supports sharing of appropriate health and social care information across providers. • Quality improvement methodology across providers (LIQH courses) • Developing the PHM approach. • Developing a 'one team' approach to service provision. • Concept of a social contract signed up to.	***The focus in 2016-17 is to understand where opportunities exist to support collaboration between practice and integration with other providers*** **Key in year work areas** **Core GP redesign and hub working** • Scoping the opportunities and learning from elsewhere around GP contract changes with QOF/ES. • Review CCG commissioned GP engagement schemes to support alignment of resources towards system wide priority populations in 2017-19. To focus care to be proactive and on secondary prevention. • Support and develop patient participation groups (PPGs) to be active in their role as part of the whole system redesign and support development of the 'Leeds Conversation'. • Consolidate any core NMoC learning into commissioning planning for 2017-19. • Continue to skill GP staff to deliver collaborative and care support planning towards supported self-management. • Continue to support and facilitate collaborative working through federation, networks or alignment to have a strong GP provider voice. • Facilitate collaboration to hub working to support access. **GP as part of wider system redesign** • The city is developing a population health management (PHM) approach as a framework for the future health and care system. • Further develop and agree segmented priority populations. • Deliver a further quality improvement programme to support joint working and learning to address variation in care. • Facilitate providers to align in NMoC development to create the 'one team' approach. • Develop the 'Leeds Conversation' through a social contract between providers and citizens for the city.	***The focus in 2017-18 will be to align community providers to deliver joint population outcomes. To develop an MCP model for Leeds and scope where general practice sits within this model*** **Key in year work areas** **Core GP redesign and hub working** • Continue to support and develop PPGs and virtual PPGs. • Scope service changes that GP could deliver in the Leeds Plan (supported by expanded access to GP, community pathways, point of care testing). • GP to continue to be part of NMoC test projects and develop more supported self-management. • Implement a joined/ coordinated Leeds GP engagement scheme. • To scale collaborative and care support planning. • To further roll out extended access via hub working and scope alignment of other services **GP as part of wider system redesign** • Ensure general practice is part of MCP model conversations, scoping and development. • Continue developing and testing the PHM approach. • Test population budgets. • Build clear expectations around NMoC and PHM joint working into all CCG provider contracts. • Support integrated nursing approach for practice and community nursing teams through empowering front line staff to make change. • Embed the 'Leeds Conversation' through a social contract between providers and citizens for the city • Use the social contract as a tool to support culture change and shared vision for the workforce. • Develop models / plans for community care hubs which integrate urgent care, 111, rapid assessments, diagnostics and extended GP access. • Scale health coaching skills roll out across health and care staff to support self-management.	***The focus between 2018-21 will be on full MCP model working and aligning contract outcomes to deliver integrated care*** **Key in year work area** **Core GP redesign and hub working** • Scale NMoC learning. • Support clinical leadership with better data sources. • Develop improved GP access to specialist opinion (physical and mental health). • Deliver extended access supported by skilled mixed teams as part of hub working. **GP as part of wider system redesign** • To use the PHM approach for managing more priority populations / place based care. • Roll out / go live on some population budgets. • Review and further develop the 'Leeds Conversation' through a social contract between providers and citizens for the city. • Commission community care hubs which integrated urgent care, 111, rapid assessments, diagnostics and align to extended GP access. • Alliance or integrated MCP contract in place.

Additional support requirements – transformation team to support the alignment of the STP and GPFV delivery plans and support the Leeds Conversation movement and provide regional and national support for local communications and engagement to manage patient expectations with any service changes

Ambition 6: Investment and resourcing of General Practice and Primary Care

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Delivering our ambition is predicated on fully accessing the funding and resources committed in the GPFV as well as realigning existing resources, including finance and workforce, between existing provider boundaries across Leeds. The table below outlines our **investment plan** incorporating **local** and **national** investments to deliver all aspects of the GP Forward View in 2016/17

Ambition	NHS Leeds North CCG	NHS Leeds South and East CCG	NHS Leeds West CCG
1. Supporting and Growing the Workforce			
a) Clinical pharmacists (local investment)	£305,000	£224,000	
b) TARGET (£60K city wide in S+E budget)	£22,500	£60,000	£38,000
c) Supporting and growing workforce clinical navigator training national allocation	£18,000	£24,000	£32,000
d) Health & wellbeing FD	£2,667	£2,667	£2,667
2. Improving Access to General Practice			
a) Improving quality schemes (CCG engagement that supports patients through increased access & self care)	£1,872,000	£5,183,344	£5,760,840
b) Extended access enhanced service (£1.90) Per patient	£326,147	£522,200	£701,488
c) Improving Access to general Practice			£2,215,223
3. Transforming Estates and Technology			
a) WIFI	£126,000		
b) Infection control audits	£2,833	£3,750	£4,000
c) Surgery pods	£144,000		
d) GP IT (based on registered capitation split)	£543,086	£695,150	£934,107
4. Better Workload Management			
a) Secondary care requested bloods	£34,000	£45,000	£60,000
b) Vulnerable practices 16.17	£32,000	£40,200	£15,000
c) Fair share of national GP resilience funding	£59,106	£76,269	£102,246
d) CCG Social prescribing	£666,667	£460,000	£278,833
5. Redesign of Care Delivery			
a) Enhanced provision to care homes	£229,000	£446,000	£475,000
b) Prevention and health inqualities	£200,000	£489,000	
c) New care models support	£710,000	£800,000	£429,000
6. Core Contract			
a) Delegated Primary Medical Services	£24,813,853	£35,107,800	£40,728,512
b) Core Contract Uplift	£768,000	£1,043,000	£1,089,842
c) PMS Premium	£128,000	£227,000	£387,158
Total Primary Care Resource	**£31,002,859**	**£45,449,380**	**£53,253,916**

Ambition 6: Investment and resourcing of General Practice and Primary Care

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Delivering our ambition is predicated on fully accessing the funding and resources committed in the GPFV as well as realigning existing resources, including finance and workforce, between existing provider boundaries across Leeds. The table below outlines our **investment plan** incorporating **local** and **national** investments to deliver all aspects of the GP Forward View in 2017/18 is**:**

The local **investment plan** to deliver all aspects of the GP Forward View in 2017/18 is:

Ambition	NHS Leeds North CCG	NHS Leeds South and East CCG	NHS Leeds West CCG
1. Supporting and Growing the Workforce			
a)Clinical pharmacists		£321,000 (+National Funding)	
Fair Share of Clinical pharmacists National funding	£414,101	£532,718	£713,618
b)TARGET £60K city wide in S+E budget	£22,500	£60,000	£38,000
c)Supporting and growing workforce clinical navigator training	£36,692	£47,579	£63,836
d)Practice manager training	£22,176	£28,546	£38,300
2. Improving Access to General Practice			
a)Improving quality schemes (CCG engagement that supports patients through increased access & self care)	£1,872,000	£4,769,626	£1,856,802
b)Extended access enhanced service (1.90) Per patient	£329,408	£525,887	£705,585
c) Improving Access to general Practice			£2,228,162
3. Transforming Estates and Technology			
a)Infection control audits	£2,833	£3,750	£4,000
b)GP IT	£543,086	£695,150	£934,107
c)GP IT Transformation	£250,000	£320,000	£430,000
d)GP Software	£55,443	£71,368	£95,755
4. Better Workload Management			
a)Secondary care requested bloods	£34,000	£45,000	£60,000
b)Fair share of GP resilience	£29,625	£38,134	£51,165
c)Social prescribing CCG	£333,333	£460,000	£488,500
d)Fair share Releasing time to care	£110,883	£142,731	£191,503
5. Redesign of Care Delivery			
a)Enhanced provision to care homes	to be confirmed	£446,000	£475,000
b)Prevention and health inequalities	£100,000	£125,000	
c)New care models support		£800,000	
d) Redesign of care delivery £1.50PP (CCG using this funding differently) Leeds North for access, Leeds S+E for Transformation and Leeds West for Leadership to support new models of care)	£322,536	£413,718	£555,423
6. Core Contract			
a) Delegated Primary Medical Services	£25,581,853	£35,624,913	£41,112,769
b) Core Contract Uplift	£418,739	£1,568,200	£2,271,314
c) PMS Premium	£192,000	£341,000	£616,332
Total Primary Care Resource	**£30,671,208**	**£47,059,320**	**£52,930,170**
		* Future investment pending evaluation of Non Recurrent schemes	

Ambition 6: Investment and resourcing of General Practice and Primary Care

Delivering our ambition is predicated on fully accessing the funding and resources committed in the GPFV as well as realigning existing resources, including finance and workforce, between existing provider boundaries across Leeds. The table below outlines our **investment plan** incorporating **local** and **national** investments to deliver all aspects of the GP Forward View in 2018/19.

The local **investment plan** to deliver all aspects of the GP Forward View in 2018/19 is:

Ambition	NHS Leeds North CCG	NHS Leeds South and East CCG	NHS Leeds West CCG
1. Supporting and Growing the Workforce			
a)Clinical pharmacists		£172,000 (+National Funding)	
Clinical pharmacists National funding	£248,461	£319,631	£418,171
b)TARGET £60K city wide in S+E budget	£22,500	£60,000	£38,000
c)Supporting and growing workforce clinical navigator training	£36,975	£47,566	£63,418
d)Practice manager training	£22,184	£38,230	£28,538
2. Improving Access to General Practice			
a)Improving quality schemes (CCG engagement that supports patients through increased access & self care)	£1,872,000	£1,379,060 (additional investment to be advised*)	£1,866,691
b)Extended access enhanced service (1.90) Per patient	£332,703	£529,527	£709,342
c) Improving Access to general Practice	£723,585	£930,852	£2,240,029
3. Transforming Estates and Technology			
a)Infection control audits	£2,833	£3,750	£4,000
b)GP IT	£543,086	£695,150	£934,107
c)GP IT Transformation			
d)GP Software	£73,949	£95,132	£127,436
4. Better Workload Management			
a)Secondary care requested bloods	£34,000	£45,000	£60,000
b)GP resilience 16.17 17.18 and 18.19	£29,701	£38,208	£51,183
c)Social prescribing CCG	to be confirmed	To be advised*	£506,500
d)Releasing time to care	£110,920	£143,269	£191,148
5. Redesign of Care Delivery			
a)Enhanced provision to care homes		£446,000	£475,000
b)Prevention and health inequalities	£100,000	£125,000	
c)New care models support		To be advised*	
d) Redesign of care delivery £1.50PP (CCG using this funding differently) Leeds North for access, Leeds S+E for Transformation and Leeds West for Leadership to support new models of care)	£322,536	£413,718	£555,423
6. Core Contract			
a) Delegated Primary Medical Services	£26,192,592	£37,193,113	£43,384,083
b) Core Contract Uplift	£421,705	£1,055,360	£1,501,575
c) PMS Premium	£256,000	£454,000	£454,000
Total Primary Care Resource	**£31,345,730**	**£42,633,506**	**£53,608,644**
		* Future investment pending evaluation of Non Recurrent schemes	

Ambition 6: Investment and resourcing general practice and primary care

GENERAL PRACTICE FORWARD VIEW APRIL 2016

The table below summarises the regional and national support required to deliver the Leeds GPFV delivery plan. Each support requirement links to the phased delivery plan for the ambitions outlined in section 5.

Ambition	Areas of regional and national support required
1. Supporting and growing the workforce	• Local NHSE transformation team to provide: ➢ Dedicated Leeds level capacity to lead project management and co-ordination of current schemes. ➢ Project management support to the Leeds primary care workforce group. ➢ Support in bid development for accessing local, regional and national monies. • National support to address gap in access to practice nurse training. • Explore GP resilience funds to support health and wellbeing plans for practice staff (across the region).
2. Improving access to general practice	• Local NHSE transformation team to provide dedicated Leeds level capacity to lead project management and coordination of Leeds approach to extended access (business intelligence and service redesign capacity and capability). • Assumes access to West Yorkshire Vanguard Accelerator funding in 16/17 to pump-prime additional enhanced access • Assumes receipt of nationally available monies to support extended access in 18/19 (£3 per head) and 19/20 (£6 per head).
3. Transforming estates and technology	• Developing primary care estate and accelerating digital capability is dependent on the successful funding of applications submitted through the ETTF from the Leeds CCGs. • Accelerating digital literacy across Leeds will be underpinned by the Leeds CCGs receiving national monies to further support uptake of GP online as committed in the GPFV.
4. Better workload management	• Bespoke resources (over and above Releasing Time to Care Programme) to support quality improvement methodologies within Leeds in recognition of the significant local investment in general practice quality programmes. • Support to align national and local enhanced services and local schemes to reduce bureaucracy. • Sharing best practice case studies from across the region.
5. Redesign care delivery	• Local NHSE transformation team to support the alignment of the STP and GPFV delivery plans and support the social contract movement and provide regional and national support to manage communications and engagement to manage patient expectations with any service changes.

6. Engagement

GENERAL PRACTICE FORWARD VIEW APRIL 2016

Summary of engagement undertaken to date and plans for future engagement

Introduction and context
The initiatives, priorities and ambitions described within the GPFV delivery plan have been developed in response to engagement undertaken and feedback received by the three Leeds CCGs from a range of stakeholders. A summary of areas of engagement with key stakeholders undertaken to date and activities planned for the future is described in the summary table below. Going forward, a full engagement plan to support the design, delivery and evaluation of initiatives taken forward through the GPFV delivery plan will be developed and implemented.

Stakeholder Group	Engagement undertaken and insight gathered to inform content of GPFV Delivery Plan	Principles of engagement in the future: Engagement should underpin activity at every stage, including feedback when changes have been implemented (You said, we did)
Patients and public	• Engagement with patient reference groups or patient participation groups (PPGs) to inform scope and priorities within plan – in particular in relation to emerging models of extended access • 3 Things campaign – has identified a range of local patient and public priorities relating to the workforce, access and technology sections of the GPFV delivery plan. • National GP Patient Survey • Update relating to the development of the citywide GPFV Delivery Plan presented to all 3 Leeds PCCC (public meetings) • Feedback from Patient Assurance Groups.	• We will undertake targeted specific engagement initiatives to inform the implementation of specific initiatives within the GPFV Delivery Plan. We know from feedback that a key focus of engagement will be on developing and communicating new workforce models such as the roles of pharmacists, physiotherapists and care navigators in general practices. Others areas include working with children and families to scope the development and test of paediatric “hot” clinics in the extended access initiative. • Regular updates regarding the overall implementation of the plan through communications to patient reference/participation groups and the virtual patient reference groups and networks. • Future conversations with public and patients regarding how best to positon the concept of the social contract as part of the wider ‘Leeds conversation’ work.
CCG members	• Ongoing and regular workshops with member practices around different elements of the plan as part of formal members meetings, operational working groups and locality meetings. • Work with clinical leads for specific ambitions within the plan to scope and describe plans.	• Specific task and finish groups to progress specific elements of the GPFV delivery plan. • Ongoing updates regarding implementation of GPFV delivery plan at members meetings.

6. Engagement

Summary of engagement (continued)

Stakeholder Group	Engagement undertaken and insight gathered to inform content of GPFV Delivery Plan	Principles of engagement in the future: Engagement should underpin activity at every stage, including feedback when changes have been implemented (You said, we did)
Partners, including CCG workforce	• Work has been undertaken to engage with citywide commissioning teams i.e. teams leading on programmes and initiatives that interface with key elements of the plan, Examples include the citywide urgent care Team, primary care workforce group, citywide informatics team. • LMC – the three CCGs have worked closely with the LMC to understand the implications and commitments made within the GPFV and in relation to the content of the plan going forward. This has included specific LMC meetings and presenting the draft GPFV delivery plan at a recent LMC STP conference in Nov 16.	• Ongoing engagement with key internal partners in the implementation and more detailed scoping of initiatives within the plan.
Local authority and elected members	• Commissioning primary medical care services across the three Leeds CCGs was a specific area of enquiry by the Adult Social Services, Public Health and NHS Scrutiny Committee in 2015/16. Key feedback was received in relation to adopting a citywide approach to commissioning and in particular in relation to extended access. This feedback has been reflected through the development of the citywide GPFV delivery plan. • A draft copy of the GPFV has been shared with adult and children's social services, public health and local councillor health and wellbeing champions for review and feedback.	• Continue to engage with community committees on the GPFV delivery plan and its implementation
CCG Primary Care Commissioning Committees	• Update and briefing provided to PCCCs outlining the proposed approach to the development of the GPFV delivery plan • Final draft of the GPFV delivery plan to be presented to PCCC for approval in December 2016 in advance of final submission 23 December 2016.	• Regular updates and briefings relating to the implementation of the plan – standing item at each meeting.

7. Risks and mitigations

The three Leeds CCGs work together to identify, review and control collective risks relating to the sustainability and transformation of general practices . The level of differential risk and mitigating actions are reported to each of the three Primary Care Commissioning Committees. A summary of the current identified overall risk with specific reference to the implementation of the GP Forward View delivery plan is provided below. This should be read alongside each CCG's wider primary care risk register.

Risk ID	Risk Description	Initial Risk Rating	Controls and Measures in Place	Mitigated Risk Rating
GPFV workforce	There is a risk that general practices in Leeds are unable to recruit and retain workforce within general practice and within partner organisations . This is due to local and national workforce shortages resulting in the inability to provide high quality core primary care services and develop and deliver new models of care.		Leeds CCGs working with members to support a wide variety of workforce development initiatives aimed at improving the recruitment, retention and resilience of general practice workforce. These include: • recruitment programmes, • development programmes, • reviewing skills mix, • new community pharmacy roles, • trial of new physiotherapy roles and initiatives between primary care and community nursing. Workforce challenges and needs are being reviewed as part of the wider strategic workforce work and through the citywide primary care workforce working group.	
GPFV access	There is a risk that CCGs are unable to deliver access to routine and urgent primary care appointments 7 days a week due to lack of available workforce and financial resource and resistance to change, resulting in reduced patient experience, potential pressure on the wider health and care system and non-delivery of a national directive.		Leeds CCGs are working together to: • support a variety of workforce initiatives (see mitigating actions above), • engage with member practice to develop and test new models of care for extended primary care access, • develop the model of extended access as part of the Leeds Urgent Care Strategy to maximise workforce and reduce service duplication • fully utilise nationally available funds to commission new models of extended access • monitor outcomes and impact of schemes on demand management and the wider Health and Social Care system	
GPFV estates and IT	There is a risk that the Leeds CCGs are unable to support the transformation of primary care and new models of care due to the limitations of current primary care estate and technology; resulting in patients experiencing a poor quality of care and practices being unable to deliver improved models of care for patients.		• Practices encouraged to apply for capital funding via the National Estates and Technology Transformation Fund (ETTF) . • Primary care estate is being reviewed as part of the wider citywide strategic estates work to understand the totality of available estate across all providers on a locality by locality basis. • Draft Primary Care Estates Strategy completed for Leeds.	
GPFV workload	There is a risk that the significant workload currently placed on general practice due to increasing demand and reducing capacity will result in the inability of general practices to deliver high quality care for patients, increased pressure of general practice workforce and the inability to transform and re-design general practice.		• CCG investment in quality improvement methodologies. • Supported programme to roll out 10 high impact changes across general practice underway across Leeds – positive feedback received already • Work with LMC to improve workload at interface between general practice and other providers.	

7. Risks and mitigations (continued)

INSPIRING CHANGE
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Risk ID	Risk Description	Initial Risk Rating	Controls and Measures in Place	Mitigated Risk Rating
GPFV redesign of care delivery	There is a risk that engagement and relationships between the Leeds CCGs and member practices will deteriorate due to potentially unpopular decisions that may need to be made in relation to commissioning and contracting general practice services. This may affect the ability of the Leeds CCGs and member practices to work effectively to design and plan the delivery of the transformation of primary care and new models of care		Proactive open and transparent discussions with members utilising existing infrastructure, ensuring clinical engagement is central in the development of all proposals relating to primary care	
GPFV investment	There is a risk to the sustainability of general practice due to funding challenges resulting from the PMS equitable funding review; other contract changes; and non-recurrently funded schemes resulting in the inability of practices to deliver high quality services for their local populations .		• Systematic approach to the utilisation of PMS premium funding and wider investment in general practice. • In year contract review meetings incorporating financial information and intelligence. • Significant local CCG investment in general practice through the commissioning of local quality improvement schemes, subject to affordability. • Application to maximise nationally available resources • Strong relationships between the three CCG primary care and finance teams, supported through citywide Primary Care	
GPFV quality	There is a risk that general practices are unable to deliver high quality services due to workforce, workload, estates and finance challenges; resulting patients experience poor quality and/or unsafe care.		• A citywide general practice quality dashboard has been produced to enable the Leeds CCGs to systematically identify and respond to quality issues and concerns at a CCG and individual practice level • See mitigating actions described in relation to the workload, workforce, finance and estates mitigating actions above.	
GPFV CCG capacity	There is a risk that the Leeds CCGs are unable to fully deliver responsibilities associated with primary care commissioning due to lack of capacity and capability within the primary care commissioning and locality teams resulting in the inability to implement the ambitions described in the GPFV delivery plan for Leeds.		• Through the One Voice work, CCG primary care commissioning and locality teams working together to maximise primary care commissioning capacity and capability across the city • Citywide delivery of GPFV delivery plan and associated monitoring arrangements will identify risks to delivery and the implementation of mitigating actions.	

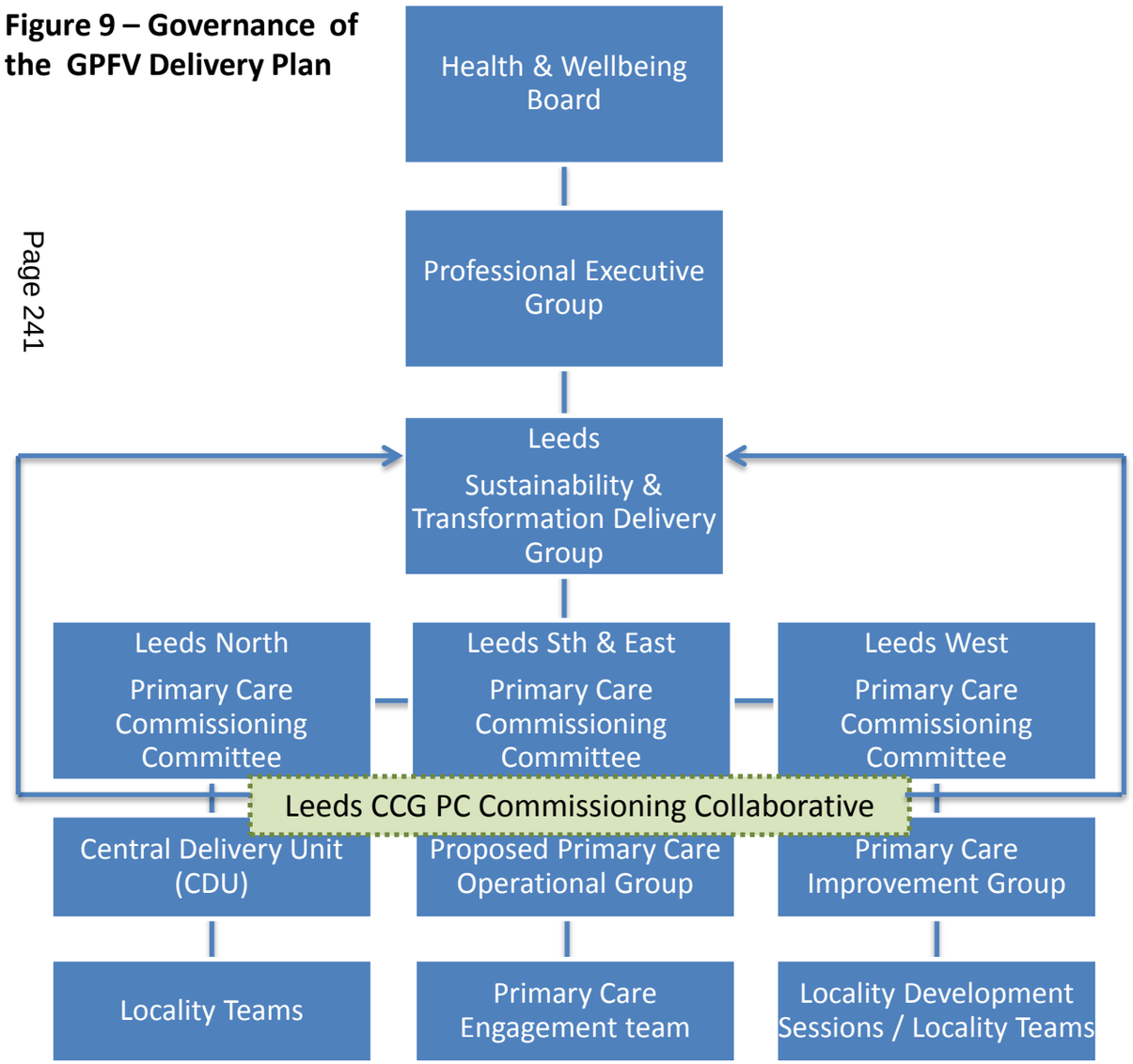
KEY
Red = No effective plan to reduce risk - intervention required
Amber = Plan in place to address risk - significant residual risk
Green = Plan in place to mitigate risk to reasonable level

8. Governance

GENERAL PRACTICE FORWARD VIEW APRIL 2016

The governance arrangements to assure each CCG and NHS England that the plan is being delivered fully and on time

Figure 9 – Governance of the GPFV Delivery Plan



- The GPFV delivery plan will be presented to the Primary Care Commissioning Committees of the three Leeds CCGs in December 2016 for sign off in advance of the plan being submitted on the 23 December 2016.

- Through the Leeds CCG Primary Care Commissioning Collaborative Group, the three Leeds CCGs will continue to work together to implement the GPFV delivery plan through a citywide approach. This will be further strengthened by wider One Commissioning Voice programme being undertaken to align the CCGs' approach to commissioning across the city.

- Each CCG will formally report on the delivery of the GPFV delivery plan to its respective Primary Care Commissioning Committee. As part of the One Commissioning Voice programme, these three statutory committees will become increasingly aligned. The delivery of the component parts of the plan will be led by the three CCG primary care development teams, through the operational groups underpinning the PCCCs (see Figure 9) and working in partnership with appropriate stakeholders.

- Risks in relation to the sustainability of primary care in general and specifically in achieving the ambitions of the GPFV delivery plan, will be assessed, owned and reported through existing CCG governance structures.

- The GPFV delivery plan underpins the wider Leeds Plan. CCG primary care and New Models of Care leads will form part of the delivery teams for each of the four programmes for the Leeds Plan. Within this, there will be a requirement to report and provide assurance on the delivery of the GPFV delivery plan to the Leeds Sustainability and Transformation Plan delivery group.

- Each CCG will work closely with internal patient assurance groups to provide assurance to PCCCs and CCG Boards and Governing Body that the GPFV delivery plan is being implemented with full and appropriate levels of patient engagement and communication.

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Report author: Steven Courtney
Tel: 247 4707

Report of Head of Governance and Scrutiny Support

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

Date: 24 January 2017

Subject: One Voice Project

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 provide an opportunity for the Scrutiny Board to consider Leeds Clinical Commissioning Groups (CCGs) 'One Voice' Project.

2 Main issues

2.1 During the previous municipal year (2015/16), the Scrutiny Board received and considered a range of evidence associated with the planning and provision of Primary Care across the City.

2.2 Part of the discussions included consideration of the transfer of commissioning responsibility from NHS England to local CCGs; the development of primary care strategies and the development and operation of Primary Care Committees. The opportunity to discuss these aspects in more detail is included elsewhere on the agenda.

2.3 However, the extension of primary care commissioning responsibilities represented a further development in the role of local CCGs since formally coming into existence in April 2013, following the abolition of Leeds Primary Care Trust on 31 March 2013.

2.4 More recently, there have been ongoing discussions around closer collaboration between Leeds three CCGs, with some details outlined in a recent national publication. This collaborative project is referred to locally as 'One Voice'.

2.5 Suitable representatives from Leeds CCGs have been invited to attend and discuss the 'One Voice' project in more detail and address questions from the Scrutiny Board.

3. Recommendations

3.1 Members are asked to consider the information provided at the meeting and determine any further scrutiny actions and/or activity.

4. Background papers[1]

None used

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

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Governance and Scrutiny Support

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

Date: 24 January 2017

Subject: The proposed closure of the Blood Donor Centre in Seacroft

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 present further information in relation to the proposed closure of the Blood Donor Centre in Seacroft.

2 Main issues

2.1 At the Scrutiny Board meeting in December 2016, the Board was first advised on the proposed closure of the Blood Donor Centre in Seacroft. Press coverage reported proposals to close blood donor centre in Seacroft on 27 January 2017.

2.2 The Board raised concern regarding the apparent lack of consultation regarding the proposals and was advised that further details were being sought from the provider of the service / facility, NHS Blood and Transplant. Details of the exchange in correspondence between the Chair of the Scrutiny Board and NHS Blood and Transplant are appended to this report.

2.3 Following the meeting in December, the concerns raised by the Board were drawn to the attention of the Independent Reconfiguration Panel. Further discussions are taking place and an update will be provided at the meeting.

2.4 Any further details provided by NHS Blood and Transplant will be presented at the meeting.

3. Recommendations

3.1 Members are asked to consider the information provided at the meeting and determine any further scrutiny actions and/or activity.

4. Background papers[1]

None used

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

Wayne Lawley

Head of Corporate Communications
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Councillor Peter Gruen
Chair, Scrutiny Board
(Adult Social Services, Public Health, NHS)
3rd Floor (East)
Civic Hall
LEEDS
LS1 1UR

Sent via e-mail only

E-Mail address: peter.gruen@leeds.gov.uk
Civic Hall tel: 0113 3950456

Our ref: PJG/SMC
Date: 22 December 2016

Dear Wayne,

Re: Closure of the Leeds Bridle Path Donor Centre in Seacroft

I am writing on behalf of Leeds City Council's Scrutiny Board (Adult Social Services, Public Health, NHS) to express the Board's disappointment and concern regarding the decision to close a NHSBT Blood Donor Centre in Leeds without any involvement or consultation with the Scrutiny Board.

It was not until 19 December 2016 that I first became aware of NHSBT's 'decision' to close the Blood Donor Centre in Seacroft on 27 January 2017. I brought this to the attention of the Scrutiny Board at its meeting on 20 December 2016.

The Scrutiny Board discharges the Council's health scrutiny function and I have enclosed a copy of the Board's terms of reference, for your information. I would specifically draw your attention to the following functions of the Scrutiny Board:

- to review and scrutinise any matter relating to the planning, provision and operation of the health service in its area and to make reports and recommendations on any such matter it has reviewed or scrutinised;
- to comment on, make recommendations about, or report to the Secretary of State in writing about such proposals as are referred to the authority by a relevant NHS body or a relevant health service provider.

Cont./

The Scrutiny Board would view the proposed closure of any local health care facility as a 'substantial variation' of service and therefore subject to a process of formal public consultation and engagement with the Scrutiny Board. While the media article suggests the closure decision follows a review by NHSBT, I am not aware of any formal involvement and engagement with either service users or the Scrutiny Board.

On behalf of the Scrutiny Board I am trying to establish the general level of awareness and/or involvement in NHSBT's decision to close this local facility. As such, I am sharing this letter with key health partners across Leeds.

Meanwhile, I should be grateful if you could provide further details of NHSBT's decision and any service user / public consultation and engagement that has informed the decision.

I look forward to hearing from you in the near future.

Yours sincerely

Councillor Peter Gruen
Chair, Scrutiny Board
(Adult Social Services, Public Health, NHS)

Enc.

cc All Leeds Clinical Commissioning Groups
Leeds Teaching Hospitals NHS Trust
Leeds Community Healthcare NHS Trust
Director of Public Health, Leeds City Council

NHS
Blood and Transplant

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Chair, Scrutiny Board
(Adult Services, Public Health, NHS)
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Email – peter.gruen@leeds.gov.uk

13 January 2017

Dear Councillor Gruen,

Thank you for contacting NHS Blood and Transplant (NHSBT) to request further information regarding our decision to close the blood donation centre at our Leeds Bridle Path site.

We first wrote to Councillor Debra Coupar in May 2016 to make the council aware that we were looking at the long term options for our centres in Leeds and Sheffield.

We followed this with a further letter on 6 September 2016 advising that in addition to reviewing our estate the recent decision by the Department of Health Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO) to collect fewer platelets (a component of blood) by apheresis procedure and the ongoing decline in hospital demand for blood meant that we had taken the decision to propose the closure of the Leeds Bridle Path Blood Donor Centre.

In late September we entered into a period of collective consultation with staff side representatives for those impacted by the proposed change which ran until the end of October. Having fully considered several counter proposals put forward by staff side the decision to go ahead with the closure of the Bridle Path Donor Centre was taken on 4 November 2016. This was then followed by a period of individual consultation with affected staff, as I'm sure you can appreciate it was not appropriate to confirm the decision externally until we had completed this process. However, we apologise that the Council heard of the decision to close the centre before we had sent you an official update.

There are currently two blood donor centres in the city of Leeds that collect both platelets and whole blood. One is located at the NHSBT centre at Bridle Path, while the other donor centre is located in the city centre of Leeds at a leased property (The Headrow). In light of the fact we have two donor centres in such close proximity, it made sense that we reviewed our donor centre provision in the area.

NHSBT is a publicly funded organisation, therefore we have a responsibility to deliver our services as efficiently and as effectively as possible. When the proposal to close Leeds Bridle Path donor centre was formulated, all options to consider what donor centre presence in Leeds was needed were considered. The conclusion reached was that the Leeds Headrow site is best placed to serve the city of Leeds. This is primarily because this site already has a substantially bigger whole blood donor base than Leeds Bridle Path and also has more donor potential due to the higher footfall around the city centre. The Headrow site is also better placed to attract more donors from ethnic minority backgrounds.

It is important to stress that the closure of the Leeds Bridle Path Donor Centre will not affect NHSBT's ability to collect and supply enough blood and blood products to meet the demand of hospitals in Leeds or surrounding areas. In addition there will still be donation centres in Leeds city centre and

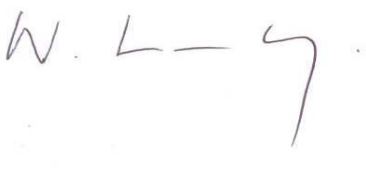
Bradford as well as mobile community sessions, so every donor that wants to give blood will still be able to do so. We very much hope most people will; we appreciate that each and every one of them saves and improves lives every time they come to donate.

As a national organisation, I wish to assure you that we very much value the opinions of local authorities, and the residents they represent. We are committed to ensuring that we are as open as possible when communicating changes to our blood collection programme.
Therefore, as well as communicating any changes to our loyal donors, as an Arms Length Body (ALB) accountable directly to the Department of Health, we also ensure we keep our DH Sponsors updated on our planned changes.

I hope that the information provided here has been helpful in addressing the concerns raised.

Please do not hesitate to contact me if you have any further queries.

Yours sincerely



Wayne Lawley
Head of Corporate Communications

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Governance and Scrutiny Support

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

Date: 24 January 2017

Subject: Work Schedule (January 2017)

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 (2016/17).

2 Summary of main issues

2.1 At the Scrutiny Boards first meeting of the municipal year (2016/17) in June 2016, the Board identified a number of matters for consideration during the course of the year, including:

- Length of hospital stay / delayed discharges, including the role intermediate care services.
- Men's health – following publication of the State of Men's Health in Leeds report.
- CCG updates, particularly in relation to the new role as commissioners of primary care services.
- Specific activity around Adult Safeguarding
- CQC inspection outcomes – including the outcomes from inspections at Leeds Teaching Hospitals NHS Trust (LTHT) and Leeds and York Partnership NHS Foundation Trust (LYPFT).
- Budget monitoring for Adult Social Services and Public Health.
- Focussed work on budgets, e.g. budget pressure likely to impact on the delivery of Child and Adolescent Mental Health Services (CAMHS) and Targeted Mental Health Services (TaMHS) services through the single point of access, including an analysis of referrals into Child and Adolescent Mental Health Services across Leeds.

- The use of Pre-Exposure Prophylaxis (PrEP) in preventing the spread of HIV infection.
- Development of integrated care through joint health and social care teams.

2.2 Following discussions with Leeds Community Healthcare NHS Trust in response to the Board's statement on changes to service locations, the Board also agreed to consider the emerging overview of the use of the built estate across the health and social care sector in Leeds.

2.3 Other specific matters discussed included:

- Scrutiny Board (Environment and Housing) progressing an inquiry regarding Air Quality, with representatives from other relevant Scrutiny Board's invited to take part.
- The West Yorkshire Joint Health Overview and Scrutiny Committee focusing on the West Yorkshire Sustainability and Transformation Plan and the associated implications, specifically around patient flows to acute hospitals.

2.4 A range of other matters have also been considered during the course of the year, including Renal Patient Transport and Children's Epilepsy Surgery Services.

2.5 The Board's outline work schedule for the remainder of the municipal is presented at Appendix 1.

2.6 In order to consider and address matters as they arise during the course of the year, it is important to retain sufficient flexibility in the Board's work. It is also important to recognise that the work schedule presented may be subject to change and should be considered to be indicative rather than precisely definitive.

2.7 In order to deliver the work schedule, the Board has needed to take a flexible approach and undertaken some activities outside the formal schedule of meetings – such as working groups and site visits, where this is deemed appropriate. This flexible approach has also required some additional formal meetings of the Scrutiny Board.

Working Groups

2.8 In December 2016, the Scrutiny Board held two working group meetings – a Health Service Developments Working Group; and a working group to consider the initial 2017/18 budget proposals in relation to Adult Social Services and Public Health.

2.9 A summary of the issues considered and outcome from each working groups will be presented to the Scrutiny Board for consideration.

3. Recommendations

3.1 The Scrutiny Board (Adult Social Services, Public Health, NHS) is asked to:

(a) Consider, comment on and agree any amendments to the work schedule for the remainder of the 2016/17 municipal year.
(b) Consider the details of the working groups presented at the meeting and agree any appropriate actions.

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.

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APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Notes	Jan. 17	Feb. 17
SCRUTINY INQUIRY TOPICS/ AREAS				
Service Quality	*Performance Review*	Nuffield Independent Hospital - CQC inspection schedueld for 8 February 2017	CQC Inspection Reports Summary	CQC Inspection Reports Summary
- LTHT CQC outcome	*Performance Review*			LTHT CQC Inspection Outcome & Action Plan
- LYPFT CQC outcome	*Performance Review*		LYPFT CQC Inspection Outcome & Action Plan	
- LCH CQC outcome	*Performance Review*	Timing to be confirmed. CQC inspection schedueld for 31 January 2017		
Better Lives Strategy	*Performance Review*	Monitor progress on implementation of Phase 3. Development of Phase 4 TBC.	Progress update on implementation of Phase 3	
Budget Monitoring	*Performance Review*	Focus on impact of budget reductuions on patients / service users	Draft response to 2017/18 budget proposals	ASC & PH 2016/17 budget monitoring report
Primary Care	*Scrutiny Inquiry*	Continued focus on Primary Care services in Leeds.	General Practice Forward View Proposals	

APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Notes	Jan. 17	Feb. 17
Integrated Health & Social Care Teams	*Scrutiny Inquiry*	Update report on progress against actions identified in July 2015 TBC.		Progress against actions identified in July 2015.
Third Sector Involvement in Health & Socuial Care in Leeds	*Scrutiny Inquiry*	Progress / updates to be provided as part of the Board's recommendation tracking		
Men's Health	*Scrutiny Inquiry*	Reports from commisioners on changes to commissioning arrangements in light of issues highlighted in the State of Men's Health report.	TBC	TBC
Hospital Discharges	*Scrutiny Inquiry*	Progress delayed. Consider later in the year and/or 2017/18.		TBC
West Yorkshire & Harrogate Sustainability and Transformation Plan	*Performance Review*	Further consideration of the Leeds Plan (as part of the wider WY&H STP) required. Invite CEx to attend SB.		TBC
One Voice Project		Invite CCGs to discuss proposals under the 'One Voice' project and associated implications.	CCGs invited to attend	
PERFORMANCE REVIEW				
Recommendation Tracking	*Performance Review*			Cancer Waiting Times inquiry: progress update

APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Notes	Jan. 17	Feb. 17
NHS provider updates	*Performance Review*	Progressing to include general updates, progress against CQC actions, key performance measures and specific matters identied by the Scrutiny Board.	Leeds & York Partnership NHS Foundation Trust	Leeds Teaching Hospitals NHS Trust
PROPOSED SERVICE CHANGES				
Renal Patient Transport	*Progress Review*	Issues highlighted by Kidney Patients Association in August 2016.		
Children's Epilepsy Surgery Services	*Progress Review*	6-month post implementation update due in October 2017.		

APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Notes	Jan. 17	Feb. 17
Proposed Closure of Blood Donor Centre in Seacroft		Identifed in December 2016. request for more details sent to NHS Blood and Transplant.	Update / progress report	
OTHER MATTERS				
Request for Scrutiny	*Request for Scrutiny*			
	Request for Scrutiny			
Briefings			Update on Air Quality Inquiry	Donisthorpe Hall Update (TBC)
WORKING GROUPS / VISITS	*Working Group*	Confirm arrangements for HSDWG in 2017/18	**St. Gemma's Hospice Visit** (5 Jan. 2017)	
			Quality Accounts - Part 1 (12 Jan. 2017)	

APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Notes	Jan. 17	Feb. 17
CALL-IN				

APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Mar-17	Apr-17	May-17 (TBC)
SCRUTINY INQUIRY TOPICS/ AREAS				
Service Quality	*Performance Review*	CQC Inspection Reports Summary	CQC Inspection Reports Summary	CQC Inspection Reports Summary
- LTHT CQC outcome	*Performance Review*			
- LYPFT CQC outcome	*Performance Review*			
- LCH CQC outcome	*Performance Review*			
Better Lives Strategy	*Performance Review*			
Budget Monitoring	*Performance Review*	ASC & PH 2016/17 budget monitoring report	ASC & PH 2016/17 budget monitoring report	
Primary Care	*Scrutiny Inquiry*	Scrutiny Board report		

APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Mar-17	Apr-17	May-17 (TBC)
Integrated Health & Social Care Teams	*Scrutiny Inquiry*			
Third Sector Involvement in Health & Socuial Care in Leeds	*Scrutiny Inquiry*			
Men's Health	*Scrutiny Inquiry*	TBC	TBC	TBC
Hospital Discharges	*Scrutiny Inquiry*	TBC	TBC	TBC
West Yorkshire & Harrogate Sustainability and Transformation Plan	*Performance Review*	TBC	TBC	TBC
One Voice Project				
PERFORMANCE REVIEW				
Recommendation Tracking	*Performance Review*		Involvement of the Third Sector inquiry: progress update	

APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Mar-17	Apr-17	May-17 (TBC)
NHS provider updates	*Performance Review*	Leeds Community Healthcare NHS Trust		
		Autism Assessment Waiting Times (to include Leeds childrens emotional & mental health wellbeing transformation plan)		
PROPOSED SERVICE CHANGES				
Renal Patient Transport	*Progress Review*	Update / progress report		
Children's Epilepsy Surgery Services	*Progress Review*			

APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Mar-17	Apr-17	May-17 (TBC)
Proposed Closure of Blood Donor Centre in Seacroft				
OTHER MATTERS				
Request for Scrutiny	*Request for Scrutiny*			
	Request for Scrutiny			
Briefings				
WORKING GROUPS / VISITS	*Working Group*	**DIAL House** (TBC)		**Quality Accounts** - Part 2 (3 May 2017)

APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Mar-17	Apr-17	May-17 (TBC)
CALL-IN				

APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Unscheduled / Carry over 2017/18
SCRUTINY INQUIRY TOPICS/ AREAS		
Service Quality	*Performance Review*	
- LTHT CQC outcome	*Performance Review*	
- LYPFT CQC outcome	*Performance Review*	
- LCH CQC outcome	*Performance Review*	
Better Lives Strategy	*Performance Review*	Re-commissioning of Independent Sector Care Homes: Work of Advisory Board
Budget Monitoring	*Performance Review*	
Primary Care	*Scrutiny Inquiry*	

APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Unscheduled / Carry over 2017/18
Integrated Health & Social Care Teams	*Scrutiny Inquiry*	
Third Sector Involvement in Health & Socuial Care in Leeds	*Scrutiny Inquiry*	
Men's Health	*Scrutiny Inquiry*	
Hospital Discharges	*Scrutiny Inquiry*	
West Yorkshire & Harrogate Sustainability and Transformation Plan	*Performance Review*	
One Voice Project		
PERFORMANCE REVIEW		
Recommendation Tracking	*Performance Review*	Follow-up bereavement issues with the Coroner

APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Unscheduled / Carry over 2017/18
NHS provider updates	*Performance Review*	
PROPOSED SERVICE CHANGES		
Renal Patient Transport	*Progress Review*	
Children's Epilepsy Surgery Services	*Progress Review*	

APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Unscheduled / Carry over 2017/18
Proposed Closure of Blood Donor Centre in Seacroft		
OTHER MATTERS		
Request for Scrutiny	*Request for Scrutiny*	
	Request for Scrutiny	
Briefings		
WORKING GROUPS / VISITS	*Working Group*	

APPENDIX 1

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

2016/17 WORK SCHEDULE

Title	Type of Item	Unscheduled / Carry over 2017/18
CALL-IN		

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