Notice of a public meeting of
Health, Housing and Adult Social Care Policy and Scrutiny Committee

To: Councillors Doughty (Chair), Cullwick (Vice-Chair), Richardson, Cannon, Mason, Warters and Pavlovic

Date: Tuesday, 25 July 2017

Time: 5.30 pm

Venue: The Snow Room - Ground Floor, West Offices (G035)

A G E N D A

1. **Declarations of Interest** (Pages 1 - 2)
   At this point in the meeting, Members are asked to declare:

   - any personal interests not included on the Register of Interests
   - any prejudicial interests or
   - any disclosable pecuniary interests

   which they may have in respect of business on this agenda.

2. **Minutes** (Pages 3 - 10)
   To approve and sign the minutes of the meeting held on 20 June 2017.

3. **Public Participation**
   At this point in the meeting, members of the public who have registered their wish to speak regarding an item on the agenda, or an issue within the Committee's remit, can do so. The deadline for registering is **5:00pm** on **Monday 24 July 2017**. To register please contact the Democracy Officer for the meeting.

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4. **End of Year Finance & Performance Report** (Pages 11 - 44)
This report analyses the financial outturn position and performance data for 2016/17 by reference to the service plans and budgets for all of the services falling under the responsibility of the Corporate Director of Health, Housing & Adult Social Care.

5. **Be Independent - End of Year Position** (Pages 45 - 58)
This paper provides an update to Members on the performance of Be Independent for 2017. It advises Members on the key performance areas included within the Council's contract, highlights areas where increased monitoring is required and advises Members of any concerns regarding performance of the organisation.

6. **Report on The Retreat action plan following CQC inspection** (Pages 59 - 126)
This report and its annexes inform the Committee of the recent Care Quality Commission (CQC) inspection of The Retreat in York along with the hospital's quality improvement plans and a summary of the CQC action plan.

7. **Safeguarding Adults at Risk Annual Assurance Report** (Pages 127 - 186)
This report accompanies the York Safeguarding Adult Board Annual Report 2016-2017 and outlines arrangements in place to ensure that City of York Council discharges its responsibilities to protect adults with care and support needs from abuse and neglect, whilst maintaining their independence and well-being.

8. **Introduction to Safer York Partnership** (Pages 187 - 194)
This report provides a comprehensive overview of Safer York Partnership, the statutory community safety partnership (CSP) for the City of York, as the Health, Housing and Adult Social Care Policy and Scrutiny Committee now holds the portfolio for Community Safety.

9. **Community Safety Strategy** (Pages 195 - 218)
This report summarises the Safer York Partnership's Community Safety Strategy 2017-20 including the current trends, emerging priorities and the implications of the strategy.

10. **Work Plan 2017/18** (Pages 219 - 222)
Members are asked to consider the Committee's work plan for the municipal year.

11. **Urgent Business**
Any other business which the Chair considers urgent under the Local Government Act 1972.

Democracy Officer:

Name- Laura Clark
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For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting

- Registering to speak
- Business of the meeting
- Any special arrangements
- Copies of reports

Contact details are set out above

This information can be provided in your own language.

我們也用您們的語言提供這個信息 **(Cantonese)**

এই তথ্য আপনার নিজের ভাষায় দেয়া যেতে পারে। **(Bengali)**

Ta informacja może być dostarczona w twoim własnym języku. **(Polish)**

Bu bilgiyi kendi dilinizde almanız mümkündür. **(Turkish)**

یہ معلومات آپ کی اپنی زبان (بولی) میں بھی مہیا کی جاسکتی ہیں۔ **(Urdu)**

☎ **(01904) 551550**

Agenda Item 1

Health and Adult Social Care Policy and Scrutiny Committee

Agenda item 1: Declarations of Interest.

Please state any amendments you have to your declarations of interest:

Councillor Cannon	Member of Health and Wellbeing Board
Councillor Doughty	Member of York NHS Foundation Teaching Trust
Councillor Mason	Registered Paramedic Owns a private ambulance company with NHS contracts
Councillor Richardson	Niece is a district nurse Ongoing treatment at York Pain Clinic and ongoing treatment for knee operation

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City of York Council	Committee Minutes
Meeting	Health, Housing and Adult Social Care Policy and Scrutiny Committee
Date	20 June 2017
Present	Councillors Doughty (Chair), S Barnes, Richardson, Cannon, Mason and Orrell (Substitute for Councillor Cullwick)
Apologies	Councillors Cullwick and Warters

1. Declarations of Interest

Members were invited to declare at this point in the meeting any personal interests, not included on the Register of Interests, or any prejudicial interests or disclosable pecuniary interests that they might have in the business on the agenda.

Councillor Mason declared that he was a Registered Paramedic, owned a private ambulance company with NHS contracts and was Vice Chair of the North Yorkshire Police and Crime Panel.

2. Minutes

Resolved: That the minutes of the Health and Adult Social Care Policy and Scrutiny Committee held on 31 May 2017 be approved and signed by the Chair as a correct record.

3. Public Participation

It was reported that there had been no registrations to speak under the Council's Public Participation Scheme.

4. Attendance of Executive Member for Housing & Safer Neighbourhoods

The Executive Member for Housing & Safer Neighbourhoods was in attendance to discuss priorities and challenges for the forthcoming year, along with the Corporate Director for Health, Housing and Adult Social Care. The Executive Member highlighted the following:

- A key priority, and challenge, was affordable housing for key workers.
- A CYC housing development company was being considered, with expectation of a paper being presented in September.
- CYC had recently achieved homelessness gold standard, one of only three in the country at this time.
- A new Community Safety Plan was currently being drafted to reflect Safer York Partnership's strategic priorities for the next three years.
- The roll out of Universal Credit in July would be a challenge and may cause some issues. In pilot areas there had been a rise in rent arrears so this would need to be carefully managed.

The Chair commented, for the record, on his concerns around this committee absorbing the Housing & Safer Neighbourhoods portfolio, given the demands of Health and Adult Social Care alone.

In response to questions from Members the Executive Member stated:

- The CYC Housing Development Company was still in the early stages with a business case to be done. It would take a leadership role in providing affordable housing.
- In relation to housing allocation, the budget had been allocated for a new IT system and it was expected this would be in place by 2019.
- Formal consultation on Woolnough House would take place as part of the Older Persons accommodation plan.
- There was recognition that the housing market in York was tough, partly due to its desirability as a place to live. Mixed tenure across the city was an important part of a wide offer to those on lower incomes and key workers.
- In relation to the 'Prevent' agenda the Executive Member agreed that Councillors should never have to submit an FOI for information from CYC. Information circulated by police had included 'anti-fracking' groups as a category. There would be a locally agreed peer review taking place on Prevent in September.
- Substance misuse would be covered under the Community Safety Plan.

- There had been a recent decision session on the Private Sector Assistance Policy and category 1 hazards were now being considered by occupational therapists using increased funding from the Disability Facilities Grant, alongside usual adaptations.
- In terms of Category1 hazards the Executive Member agreed to circulate further details to the committee following the meeting.

The Executive Member went on to give an update to the committee on Fire Safety, with the Head of Building Services in attendance to answer Member questions. He confirmed that as well as the information which had been circulated to members a letter was being sent to residents in all CYC housing as soon as possible. It was stated that:

- CYC's own housing stock had no cladding of the kind which had been used elsewhere.
- Fire Safety Risk Assessments were completed on a cycle, with 350 communal areas to be completed in the 2017/18 municipal year.
- Vulnerable tenants would all have 'personal emergency evacuation plans' in sheltered housing
- Sprinklers were not necessary in York given that we had no tower blocks. Sprinklers were only considered necessary for buildings where higher floors were out of reach for fire service equipment.
- The Executive member for Children, Education and Young People was checking with all schools in relation to fire risk assessments and cladding.

  It was agreed that there would be a further update on this in due course.

  Resolved: That Members note the comments of the Executive Member for Housing & Safer Neighbourhoods.

  Reason: To update the committee on the Executive Member's priorities and challenges for the forthcoming year.

5. Attendance of Executive Member for Health & Adult Social Care

The Executive Member for Health and Adult Social Care was in attendance to discuss priorities and challenges for the forthcoming year, along with the Corporate Director for Health, Housing and Adult Social Care. The Executive Member gave a brief update on the report and highlighted the following priorities:

- Mental Health, in particular the new hospital
- Healthy Child Service
- Work Place Health and the launch of the Yorwellbeing Service
- Older Person's Accommodation Programme

In response to member questions it was stated:

- The Humber, Coast and Vale Sustainability and Transformation Partnership was looking at providing more synergy across provision including 6 locality plans and 3 hospital trusts and the Better Care Fund (BCF) was one of those locality plans. This was linked to supporting a reduction in admissions and delays in discharge and the BCF supports that flow. More broadly this meant more prevention, early help and support within communities.
- Money saved through the decommissioning of the intermediate care hospital had not all been reinvested in supporting people to stay in their homes. This was perhaps something this committee could scrutinise. There was however an awareness that NHS England were under extra pressure to close the CCG's financial gap.
- Non-attendance at training sessions for the third sector had been a significant issue and they had now been asked to make a contribution. However there was an understanding of the impact this may have on small organisations and so, subject to attendance, this could be looked at again.
- In terms of the Mental Health Strategy there was a commitment to co-production with both users and the wider community. Engaging housing in the strategy was significant and involvement of the third sector was also a key factor.

Resolved: That Members note the comments of the Executive Member for Health & Adult Social Care.

Reason: To update the committee on the Executive Member's priorities and challenges for the forthcoming year.

6. Annual Report of Health and Wellbeing Board

Members considered a report presenting the Health, Housing and Adult Social Care Policy and Scrutiny Committee with the 2016/17 Annual Report of the Health and Wellbeing Board (HWBB). The Chair of the HWWB was in attendance to present the report and answer Member questions.

Members thanked the Chair for the work that had been done on this report and its accessibility as a document was commented upon. It was also noted that an 'easy read' version was also being made available around the city and on the website.

Resolved: That Members note the contents of the Health and Wellbeing Board's 2016/17 Annual Report.

Reason: To keep members of the Committee up to date with the work of the Health and Wellbeing Board.

7. Six Monthly Quality Monitoring Report – Residential, Nursing and Homecare Services

Members considered a report detailing the performance by organisations providing a service in York against Care Quality Commission (CQC) standards. The Head of Commissioning (Adult) was in attendance to present the report and answer Member questions.

Officers highlighted York's improved position with one additional 'good' rating as this recent improvement was not included in the figures.

Resolved: That Members note the report.

Reason: To update the committee on the performance and standards of provision across care service in York.

8. Update on Decisions Taken on Smoking Cessation and Their Impact

Members considered a report providing a summary of the uptake of the City of York Council Stop Smoking Service, and successful quit rates, over the time period where Nicotine Replacement Therapy (NRT) and Varenicline have and have not been funded. The Corporate Director of Health, Housing & Adult Social Care was in attendance to present the report and answer Member questions.

He gave a brief background to the report and highlighted areas of concern, in particular that the drop out rate for the service was higher than expected and that prevalence of smoking younger adult women remained the same.

Members were asked to consider public health doing more work to look at other areas in the country where there had been a drop off in uptake of these services and also to note the cost implications of any recommendations to Executive.

During discussion Members expressed concern that there were huge cost implications for additional social care related to smokers over the age of 50. They also highlighted that this issue had been brought to the fore by a motion to council on health inequality in relation to CCG restrictions on surgery. It was strongly felt that this decision needed to be urgently reviewed.

Resolved: That;

I. Members note the information presented in the report
II. The Committee reaffirm an earlier resolution to ask the Executive Member for Health and Adult Social Care to review her decision on the level of support for smokers and in particular the provision of free Nicotine Replacement Therapy for smokers and funding for Varenicline (Champix) stop smoking medication

Reason: So Members can add their input ahead of a decision concerning the future funding of pharmacotherapies for smoking cessation.

9. Clinical Commissioning Group Task Group Scoping Report

Members considered a report introducing proposals for a scrutiny review into the Vale of York Clinical Commissioning Group's (CCG) approach to public and stakeholder engagement on delivering its Operational Plan 2017-19 and its Medium-Term Financial Strategy.

The Chair stated that although Councillor Barnes was soon to be replaced on this committee that he was in favour of him being a member of this task group given his level of expertise on this subject. It was agreed that the task group would include Councillors S Barnes, Culwick and Richardson and that invitations could be extended to co-optees and external bodies.

Resolved: Members agree to undertake a scrutiny review into the CCG's approach to public and stakeholder engagement and the remit detailed in paragraph 8 and appoint a Task Group to carry out this work on the Committee's behalf.

Reason: To work with the CCG to support delivery of its Operational Plan 2017-19 and its Medium-Term Financial Strategy.

10. Work Plan

Members gave consideration to the Committee's work plan for the municipal year.

After discussion it was: -

Resolved: That the work plan be approved.

Reason: To ensure that the Committee has a planned programme of work in place.

11. Urgent Business

Members considered a report detailing progress on plans for a new mental health hospital in York, which had been received after agenda publication and attached as a supplement online. Representatives from the Tees, Esk and Wear Valleys NHS

Foundation Trust were in attendance to present the report and answer Member questions.

In response to questions from Members they stated the following:

- Whilst a community model of care was the ideal, there was still a clear need to deliver hospital based care.
- There was a need to engage with community links on discharge and interventions should be made earlier and closer to home.
- Accessibility was a challenge as they were dealing with such varied needs.
- The trust had worked in collaboration with both universities and going forward wanted research and development to form part of plans to ensure that this was a leading edge facility.
- Historic England were not in opposition to using Bootham Park, however were concerned about the level of harm to the building when there were other viable sites available.
- Part of the modelling was that care remain as local as possible, thus reducing out-of-area placements.

Resolved: That Members note the report.

Reason: To update the committee on progress towards a new mental health hospital in York.

Councillor Doughty, Chair
[The meeting started at 5.30 pm and finished at 8.50 pm].

Health, Housing & Adult Social Care Policy & Scrutiny Committee 25 July 2017

Report of the Corporate Director of Health, Housing & Adult Social Care

2016/17 Finance and Performance Draft Outturn Report – Health, Housing & Adult Social Care

Summary

1. This report analyses the financial outturn position and performance data for 2016/17 by reference to the service plans and budgets for all of the services falling under the responsibility of the Corporate Director of Health, Housing & Adult Social Care.

Financial Analysis

2 A summary of the service plan variations is shown at table 1 below.

Table 1: HHASC Financial Summary 2016/17 – Draft Outturn

2016/17 Quarter 3 Variation £000		2016/17 Final Approved Budget			2016/17 Outturn Variation	
		Gross Spend £000	Income £000	Net Spend £000	£000	%
+167	ASC Prevent	7,157	1,389	5,768	+245	+4.2%
+199	ASC Reduce	9,912	2,802	7,110	-48	-0.7%
-56	ASC Delay	13,316	7,598	5,718	+24	+0.4%
-66	ASC Manage	46,847	14,704	32,143	-45	-0.2%
+244	**Adult Social Care Total**	**77,232**	**26,493**	**50,739**	**+176**	**+0.3%**
+0	Public Health	9,161	8,673	488	-49	-10.0%
+159	Housing and Community Safety	11,932	9,408	2,524	+66	+2.6%
+403	**HHASC General Fund Total**	**98,325**	**44,574**	**53,751**	**+193**	**+0.4**
-127	**Housing Revenue Account Total**	**31,345**	**34,344**	**-2,999**	**-1,276**	**-4.1**

+ indicates increased expenditure or reduced income / **-** indicates reduced expenditure or increased income

3 The following sections provide more details of the significant outturn variations.

Adult Social Care Prevent Budgets (+£245k / +4.2%)

4 Staffing overspent by £43k. This is predominantly due to the Occupational Therapy service (+£33k) as the full year saving from removing a senior practitioner post was only implemented part way through the year.

5 Externally commissioned care contracts overspent by £59k as the needs of individuals accessing these services increased over the year.

6 The directorate did not recover £55k from Be Independent (BI) regarding the support services budget. A £205k budget was transferred when BI spun out; this was acknowledged as being an apportionment of the costs of Finance, HR, IT etc, and work would be done to determine the true cost of the support. This was calculated at £150k but the contract value was not reduced to reflect this revised offer and it was felt inappropriate to pursue as this may have destabilised BI's financial position.

7 The cost of LOLER (Lifting Operations and Lifting Equipment Regulations) 1998 checks have increased by 50% from 2015/16 and has caused a £32k overspend.

Adult Social Care Reduce Budgets (-£49k / -0.7%)

8 There is a £154k pressure within the direct payment budget as more customers than budgeted for took up the option, and recovery of overpayments was not as great as expected.

9 The Small Day Services, a series of council run day support options for customers, is forecast to underspend by £239k due mainly to staffing vacancies.

10 Staffing budgets overspent by £48k, an improvement of £99k from quarter 3. The Hospital Social Work Team overspent by £96k. Two discharge to assess posts were employed over the approved structure in a pilot to assess customers in the most appropriate setting to speed up discharge from hospital and to improve customers' ability to remain independent. There is also a social worker committed to the Integrated Care hub which is being backfilled when the initial intention was to simply move the resource.

11 The Intensive Support Service underspent by £49k, an improvement of £75k from quarter 3. The service expected to recruit to a couple of vacant posts but was unable to fill them by the year end.

12 The Better Care Fund (BCF) contribution from the Vale of York Clinical Commissioning Group (VoYCCG) was expected to be £5.3m but some schemes that were expected to deliver cashable benefits in 2016/17 were delayed in starting, or didn't deliver to the full value expected. This meant the contribution was reduced to £5.0m resulting in a £285k pressure in 2016/17. Work is ongoing to agree the fund for 2017/18.

Adult Social Care Delay Budgets (+£24k / +0.4%)

13 The community support budget for Learning Disability customers overspent by £155k. This was due to having four more customers at a higher than forecast weekly rate (+£374k), but offset by receiving higher than expected Continuing Healthcare (CHC) income for several customers (-£219k).

14 Spend/income on the framework home care contracts was £213k under budget as the department was successful in securing CHC income above expectations, particularly regarding physically and sensory impaired customers.

Adult Social Care Manage Budgets -£45k/ -0.2%)

15 There was a net overspend of £1,360k within external residential placement budgets, mainly as a result of increased older people residential placements (£479k) and delays or decisions not to transfer some learning disability (LD) customers to supported living schemes (£691k). This budget will be realigned alongside the supported living budget in 2017/18 to reflect the customers' decisions.

16 The position has improved since quarter 3 as a customer was being charged for on a spot basis at Lifeways when the placement was covered by the block contract. The LD short stay budgets still overspent by £67k but this has reduced by £190k from quarter 3.

17 The Mental Heath working age residential care customer group overspend has increased markedly since quarter 3 from £124k to £296k. This is due to one customer having a significant backdated increase to their care package and a new customer who was placed in October 2016 but not put on the system and paid until January 2017.

18 Nursing Care budgets underspent in total by £117k. Older People budgets underspent by £56k and Physical & Sensory Impaired customer budgets underspent by £86k due to an increase in CHC income.

19 External Care provision presents a significant challenge in 2017/18 and beyond. Significant savings are expected from these areas and we are under pressure to find capacity for those with dementia in particular as well as Learning Disability customers transitioning from children's

services, for which no growth was received. The improved Better Care Fund (iBCF) may assist with some of these pressures but this may be tempered by the VoYCCG's financial position and other system pressures.

20 The teams have also been very successful in CHC applications over the last year, several of which have been backdated beyond activity in 2016/17. The continued success of application may again be restricted by VoYCCG's strategy of reducing spend in this area over the next four years.

21 Older People's Homes budgets overspent by £159k which has improved slightly from £197k at Quarter 3. The current overspend is mainly in respect of staffing (£280k) where staff to customer ratios were maintained at relatively high levels to ensure a smooth transition for residents whilst the accommodation programme continues. This has partially been offset by over recovery of income (£121k). Use of casual staff continued as some permanent posts were kept vacant in order to allow flexibility within the accommodation programme but this will lessen following the closure of Willow House as permanent staff moved to fill those vacancies.

22 This overspend will be met from the capital receipts generated in 2016/17 by the sale of Oliver House. The 2016/17 Local Government settlement gave councils flexibility to use capital receipts to fund reform of its services, which the Older Persons' Accommodation Programme clearly does. This has been shown as mitigation throughout the 2016/17 reporting framework to members. £150k of receipts will also be used to fund other revenue transitional costs such as securing sites, employing a social worker to ensure customers move homes safely etc.

23 There is an underspend of £721k in LD supported living budgets. This is largely due to increased CHC contributions as a result of the Transforming Care Program, but also due to customers not moving as expected from LD residential placements (see para 15). There has also been a delayed start on some new schemes to ensure successful transition of customers returning to services in York which also contributed to the underspend in this area.

24 The Independent Mental Capacity advocacy budget has underspent by £83k as the volume of best interest assessments and doctors' assessments did not materialise as expected by the year end. The department has also trained in house best interest assessors which has helped avoid more expensive external assessments.

25 The directorate's budget for 2016/17 included a requirement to deliver savings totalling £3m from the on-going work being undertaken on service transformation. To date savings of £2,027k have been identified and implemented, leaving a shortfall of £977k. This is a short term pressure

as plans are in place to deliver the majority of the shortfall from 2017/18 onwards.

26 The council's former £1,023k care act grant was transferred to mainstream funding from 2016/17. £391k is committed against this budget leaving £632k available to contribute towards other directorate pressures.

27 There is a Care Act reserve of £765k that the department has also used to mitigate this year's overspend.

Public Health (-£49k / -10% or -0.53% of gross expenditure budget)

28 Within Public Health there is an underspend on Substance Misuse contracts of £94k following lower than expected claims from pharmacies. The Healthy Child programme underspent by £103k due to one-off transition costs relating to the transfer of the school nurse and health visitor staff from York Hospital. The Integrated Wellness Service underspent following restructuring of the team and from additional grant income (-£50k).

29 In addition there are underspends on staffing in the Public Health Team (-£47k) and on operating expenditure (-£73k). These are offset by an overspend on sexual health contracts of £52k due to higher LARC costs (contraception services) and sexual health service cross charging from outside the York area.

30 As the Public Health Grant is ringfenced it is necessary to carry forward the unspent budgets. The underspend relating to grant funded activities of £243k has been transferred into an earmarked reserve. This will be used to contribute to the expected restructuring costs of the Healthy Child Service and procurement issues in Sexual Health and Substance Misuse in 2017/18. The remaining £49k underspend comes from the council's contribution to public health and fitness activities.

Housing and Community Safety General Fund (+£66 / +2.6%)

31 Overall there is a year end overspend of £66k. The service has funded £60k legal fees relating to a long-standing legal dispute between the council and a housing developer regarding the obligation to pay a commuted sum in lieu of on site affordable housing. The first case has been found in favour of the council however there is a further appeal by the developer surrounding the s106 obligation.

32 There are also a number of other variances including overspends on managing the Travellers' sites (£56k) as well as the residual costs of dealing with flooding at James St Site (+£26k), additional income from managing Housing Association properties (-£34k), some staffing

vacancies within housing (-£45k) and savings across Community Safety (-£41k).

Housing Revenue Account (-£1,276k / -4.1% of gross expenditure budget)

33 The projected outturn position for the Housing Revenue Account for 2016/17 is an overall net underspend of £1,276k. The table below provides more detail on this position.

Activity area	2016/17 Net Budget	Outturn 2016/17	Draft Variance
	£000	£000	£000
Repairs & Maintenance	6,352	6,630	+278
General Management	5,790	4,993	-797
Special Services	2,196	2,057	-139
Other Expenditure	17,059	18,825	-1,766
Dwelling rents	-32,067	-32,234	-167
Non Dwelling Rents	-338	-348	-10
Charges for Services	-904	-975	-70
Other Income	-1,087	-3,223	-2,137
Total	**-2,999**	**-4,275**	**-1,276**

Repairs & Maintenance

34 Repairs and maintenance have overspent by £278k. This is lower than that forecast at quarter 3, partly due to an additional charge of void works to capital. There has been an initial increase in the productivity of the workforce following the introduction of mobile working and improvements in management controls. The service anticipates being able to use this increased capacity to pick up some of the work currently allocated to subcontractors. There has been a reduction in the use of subcontractors of £1.2m in 2016/17, however this needs to reduce further in order for the service to be within budget in 2017/18.

General Management

35 Prudent assumptions were made when the budget was set about the levels of recharges that would be made. Savings have been identified across this area in 2017/18. Recharges will continue to be reviewed and this will feed into the next update of the HRA Business Plan.

Special Services

36 There was an underspend of £139k (6.3%) primarily due to underspends on utility costs arising form voids and sheltered housing.

Other Expenditure

37 Slippage arising from the capital IT and Water Mains programmes will mean that the expected contribution to the capital programme from the revenue budget has been reduced by £393k. Lower than forecast levels of arrears required a reduced contribution to the bad debt provision of £326k).

Dwelling Rents

38 There was additional income from dwelling rents totalling £160k. The original budget did not reflect the 0.9% rent increase for supported housing as this exemption from the 1% decrease had not been announced at the time of budget setting. In addition, delays to the implementation of the high value sales policy have lead to a small increase in rents recovered compared to budget.

Charges for Services

39 Leaseholder charges out-turned £70k higher than budget.

Working Balance

40 The working balance position at 31 March 2017 is £22.6m. This is higher than forecast in the latest business plan (£20.2m) due to the underspend achieved in 2015/16 and 2016/17. The working balance is due to increase to £46m by 2024/25 when the first tranche of debt taken out as part of the self financing settlement is due to be repaid.

41 It is proposed that £220k of the additional level of working balance will fund two initiatives:

- Stock Conditions Surveys £100k
  - Executive (October 2016) agreed to HRA funding stock condition appraisal as part of review of Housing Stock Options
- Building Services Business Change £120k
  - Additional fixed term post over 2 years to support new ways of working within Building Services

Performance Analysis

42 This performance analysis relates to the previously agreed scorecard for Health and Social Care Policy and Scrutiny Committee. It is suggested that there is a separate discussion on the indicators to be included for

future performance updates to ensure appropriate coverage for the scope of the new committee.

Adult Social Care

Residential and nursing admissions

43 Avoiding permanent placements in residential and nursing care homes is a good measure of ensuring of how effective packages of care have been in ensuring that people regain control of their lives quickly. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. It is important that even with lower numbers going into Residential Care, we can balance the system through ensuring that equal or greater numbers are moved on. This means offering alternatives such as Supported Living for people who would otherwise stay in Residential Care for long periods.

44 There were 623 people in long-term residential and nursing care at the end of 2016/17). This is lower than the 632 at the end of 2015/16. During 2016/17 there were 248 admissions of older people (aged 65 or over) to residential and nursing care homes (a rate of 656 per 100,000) and 16 admissions of younger adults (aged 18-64) to residential and nursing care homes (a rate of 11 per 100,000). Both these figures were lower than the corresponding figures for 2015/16 (260 and 22 admissions respectively), indicating more success in efforts to ensure that people live independently.

Adults with learning disabilities and mental health issues

45 There is a strong link between employment and enhanced quality of life. Having a job reduces the risk of being lonely and isolated and has real benefits for a person's health and wellbeing. Being able to live at home, either independently or with friends / family, has also been shown to improve the safety and quality of life for individuals with learning disabilities and mental health issues.

46 Our performance level during 2016/17 (on average, 8.3% of adults with a learning disability were in paid employment), is a slight decrease from that of 2015/16 (9.7% of adults with a learning disability were in paid employment). Additionally, during 2016/17 on average 82.3% of adults with a learning disability were living in their own home or with family, which is a minor decrease from 2015/16 (the corresponding figure was 82.6%). For those with mental health issues, on average 39.2% of this group were living independently, with or without support during 2016/17, an increase from 28.5% of this group in the previous year.

Adult Social Care Survey user results

47 The Adult Social Care User Survey asks, every year, users of adult social care services in the city a number of questions which include how satisfied they are with the services they receive, whether they feel safe and whether they have more social interaction.

48 In the 2016/17 Survey, 50% of those surveyed reported that they had “as much social contact as they would like”. This is an increase from the corresponding figure reported in the 2015/16 Survey (46%). The percentage of those service users reporting that they “felt safe” also increased during 2016/17, to 71%, from 67% in 2015/16. However, the number who said they were “extremely or very satisfied” with their care and support as a result of using services fell to 62% in 2016/17 from 64% in 2015/16, although the proportion who expressed some level of dissatisfaction remains low (3%).

Delayed Transfers of Care

49 This measures the impact of hospital services and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. This indicates the ability of the whole system to ensure appropriate transfer from hospital for the entire adult population. It is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. A delayed transfer of care (DToC) occurs when a patient has been clinically assessed as ready for discharge from hospital, but a care package (from either the NHS or Adult Social Care) is not available.

50 The number of DToC at hospitals attributable to both NHS and social care rose during 2016/17 to 16.85 per 100,000 population from 13.2 per 100,000 population in 2015/16. The number of DToC attributable solely to social care rose also, but at a slower rate: from 6.9 per 100,000 population in 2015/16 to 7.5 per 100,000 population during 2016/17, although the rate actually fell from Q1 onwards following a considerable rise in that quarter.

51 NHS England have advised that the Adult Social Care Outcome Framework measures associated with DToC will change during 2017/18, but have yet to provide information about how they will change.

Public Health

Under 18 conceptions

52 Most teenage pregnancies are unplanned and around half end in an abortion. While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers

bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty.

53 There were 55 under 18 conceptions in York in the year to March 2016 and 11 in the most recent quarter. The latest annual rate is 18.8 conceptions per 1,000 females aged 15-17 in York - lower than regional (23.5) and national (20.4) averages. The latest quarterly rate is 15.2 per 1,000 females aged 15-17 in York - lower than regional (23.7) and national (19.8) averages. The longer term trend shows falling rates in York. In 2015 in York 51.7% of under 18 conceptions lead to abortions – similar to the national average (51.2%) but higher than the regional average (43.4%).

54 Ward level rates are available for the three year aggregated period 2012-2014. The rate in Westfield (43) is significantly higher than the York average (20).

Smoking Status at the time of Delivery

55 Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. The Tobacco Control Plan contained a national ambition to reduce the rate of smoking throughout pregnancy to 11% or less by the end of 2015.

56 The percentage of women who are recorded as smoking at the time of maternity booking is falling in York. The figure was 13.3% in September 2015 and the most recent figure was 10.9% in May 2017. In the year to May 2017, 11% of mothers giving birth in York were smokers at the time of delivery (201 smokers out of 1,832 live deliveries). This is an improvement compared with the May 2016 figure of 11.9%. The rate in York is below the regional average (14.3%) but slightly higher than the national average (10.8%).

57 There is a wide variation in smoking rates at the time of delivery across the City. Rates are over 6 times higher in some areas compared with others.

58 Pregnant smokers are able to access specialist stop smoking support and free Nicotine Replacement Therapy through the Council's stop smoking service. Referral rates into the service are high but there is a relatively high drop out rate. Reductions in smoking rates at the time of delivery appear therefore to be a result of fewer women smoking at the time of booking rather than cessation occurring between booking and delivery.

Smoking Prevalence in the General Population

59 Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. Smoking is a modifiable lifestyle risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population.

60 York has a significantly lower percentage of current smokers (12.6%) compared with regional (17.7%) and national (15.5%) averages. Smoking prevalence in York has fallen from 18.7% in 2013 to the current level of 12.6% in 2016. Smoking prevalence amongst people working in routine and manual occupations in York is also falling. In 2013 the rate was 34.3% and this fell to 26.4% in 2016. Smoking rates amongst people working in routine and manual occupations in York are in line with national (26.5%) and regional averages (28.9%).

61 The specialist stop smoking service in York is now open to self-referrals from the general population (previously it had only been open to pregnant smokers and those with long term health conditions).

Health Visitor Service Delivery Metrics

62 Evidence shows that what happens in pregnancy and the early years in life impacts throughout the course of life. Therefore a healthy start for all our children is vital for individuals, families, communities and ultimately society. The health visiting service leads on the delivery of the Healthy Child Programme (HCP), which was set up to improve the health and wellbeing of children aged 0-5 years. The health visitor service delivery metrics currently cover the antenatal check, new birth visit, the 6-8 week review, the 12-month review and the 2-2½ year assessment.

63 Performance on a number of these metrics has improved steadily over the last two years. The percentage of timely new birth visits is now 78% compared with 89% nationally. The percentage of timely 6-8 week reviews is 77% compared with 84% nationally. The prevalence of breastfeeding at 6-8 weeks has now reached the national average of 44%. The percentage of 2.5 year visits carried out has improved to 42% but this remains below the national average of 75%. The national benchmarking figures should be interpreted with some caution as local authorities self report on performance and may interpret the indicator timescales / guidelines differently.

64 6-8 week breastfeeding rates are not currently broken down into smaller areas of York however we know from Maternity data that breastfeeding initiation rates are lower in some parts of the City.

Childhood Obesity - National Child Measurement Programme (NCMP)

65 There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. Under the NCMP, Local Authorities are required to weigh and measure all children in Reception and Year 6.

66 Provisional data for 2016/17 indicates that there has been no change in the obesity rate in Reception year (8.6%) compared with 2015/16. The most recently published national figure is 9.3% so York continues to have a lower level of obesity amongst reception aged children. The obesity rate in year 6 children in York appears to have increased slightly from 15.1% to 15.9% but this remains significantly lower than the national average of 19.8%

67 Whilst the overall picture for childhood obesity in York is positive, we know that there are inequalities within the City. For Year 6 children, rates are higher for boys and there is a clear inequality 'gradient' i.e. the prevalence of obesity rises as the level of deprivation increases. Obesity rates are higher for children from Black and Asian ethnic groups, for both reception and year 6.

68 The YorWellbeing service is carrying out some work promoting the Daily Mile programme in York schools. An audit of schools is currently being undertaken to see who is already running the initiative with a view to having a co-ordinated promotion of the scheme. In addition a Healthy Lunchbox Guidance Document is being finalised and is to be approved by the head teacher at Westfield before its launch. This area was selected due to its high deprivation. The school highlighted a need for more information around healthy eating for parents. Once implemented, we will look to track the impact of the guidance document before using this working model in other educational establishments.

Chlamydia detection

69 Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. It causes avoidable sexual and reproductive ill-health. The National Chlamydia Screening Programme (NCSP) recommends screening for all sexually active young people under 25 annually or on change of partner. This indicator monitors progress in controlling Chlamydia and delivering accessible, high-volume Chlamydia screening.

70 In 2016 in York a significantly higher proportion of the 15-24 population (22.5%) were screened for Chlamydia compared with regional (19.5%) and national (20.7%) averages. Given the large student population in

York and the pressure on the Sexual Health budget this represents an achievement for the service. The Chlamydia detection rate in York (1,828 cases per 100,000 of population aged 15-24) is similar to the national average of 1,882.

71 The sexual health service in York offers a comprehensive Chlamydia screening provision which follows the National Chlamydia Screening Programme guidelines which are considered best practice. The service has established sexual health services for both Universities and the local FE college, where drop in and appointments are available. The service also has long standing clinics both in the city centre and in Acomb. Free Chlamydia postal kits are available with telephone or face to face triage available and self-sampling kits are available to pick up in a wide range of localities.

Physical Activity

72 Why is this a Key Indicator? People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health.

73 The Active Lives Survey carried out by Sport England shows that in 2015/16 York had: a lower % of people (19.7%) who are physically inactive compared with the national (22%) and regional (24%) averages; a higher % of people who are physically active (67.9%) compared with the national (65.4%) and regional (64%) averages and a higher % of people who have taken part in sport and physical activity at least twice in the last 28 days (82.7%) compared with the national (77.2%) and regional (75%) averages.

74 Whilst the overall figures are clearly positive, we know from national data that some sectors of the population are likely to have lower levels of activity (e.g. females, older people, those with a long term limiting disability and those living in more deprived areas).

75 In York a number of physical activity schemes are aimed at those with a disability or a long term condition.

Health Checks

76 The Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess, raise awareness and support them to manage their risk of cardiovascular disease. A high

take up of NHS Health Check is important to identify early signs of poor health leading to opportunities for early interventions.

77 In 2016/17, 434 checks were offered in York and 93 were carried out. The low numbers were due to the fact that in 2016/17 we made the transition from a GP commissioned service to one provided in house by the YorWellbeing service. To date, about 150 checks have been delivered by the YorWellbeing service and more detailed feedback on the outcomes of these checks will be provided in the 2017/18 quarter one performance report.

Successful Completions from Drug / Alcohol Treatment (without representation)

78 Individuals achieving this outcome demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced alcohol related illnesses and hospital admissions, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health.

79 In the latest 18 month monitoring period to March 2017, 326 people left treatment successfully (without representation within 6 months) out of a total of 1,288 clients in treatment in York. This is a rate of 25.3% which is above the England rate of 21.6%. Broken down by type of substance used, York has a slightly lower rate of completions without re-presentation for alcohol users but a higher rate for Opiate and Non-Opiate users.

80 To promote sustained recovery from substance misuse and to prevent representation to services a number of community initiatives are in place in York including peer support, mutual aid, recovery support and aftercare. The emphasis is on helping people to increase their social capital, build their resilience and develop links with abstinent communities in order that they become less reliant on treatment services.

Corporate Priorities

81 The information included in this report is linked to the council plan priority of “A focus on frontline services to ensure all residents, particularly the least advantaged, can access reliable services and community facilities.”

Implications

82 The financial implications are covered within the main body of the report. There are no other direct implications arising from this report.

Recommendations

83 As this report is for information only there are no specific recommendations.

Reason: To update the committee on the latest financial and performance position for 2016/17.

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Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers

2016/17 Finance and Performance Draft Outturn Report, Executive 29 June 2017

Annexes

Annex A: 2016/17 Outturn Performance Scorecard

Abbreviations

ASC – Adult Social Care
BCF – Better Care Fund
BI – Be Independent
CHC – Continuing Health Care
COPD – Chronic Obstructive Pulmonary Disease
DToC – Delayed Transfer of Care
HCP – Healthy Child Programme
HHASC – Health, Housing and Adult Social Care
HR – Human Resources
HRA – Housing Revenue Account
iBCF – Improved Better Care Fund
IT – Information Technology
LD – Learning Difficulties
LOLER – Lifting Operations and Lifting Equipment Regulation
NCMP – National Child measurement Programme
NCSP – National Chlamydia Screening Service
NHS – National Health Service
VOYCCG – Vale of York Clinical Commissioning Group

Health, Housing & Adult Social Care 2016/2017

ANNEX A

No of Indicators = 82 | Direction of Travel (DoT) shows the trend of how an indicator is performing against its Polarity over time.

Produced by the Strategic Business Intelligence Hub July 2017

				Previous Years			2016/2017						
			Collection Frequency	2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4	Target	Polarity	DOT
Adult Social Care	PVP02	Number of permanent admissions to residential & nursing care homes for older people (65+)	Monthly	241	260	248	70	68	53	57	-	Up is Bad	◀▶ Neutral
	PVP18	Number of customers in long-term residential and nursing care at the month end	Monthly	692	632	623	628	636	610	623	-	Neutral	◀▶ Neutral
	PVP19	Number of permanent admissions to residential & nursing care homes for younger people (18-64)	Monthly	14	22	16	4	2	6	4	-	Up is Bad	◀▶ Neutral
Adult Social Care Outcomes Framework	ASCOF1E	Proportion of adults with a learning disability in paid employment	Monthly	13.70%	9.70%	8.33%	7.12%	7.28%	7.73%	7.62%	10.00%	Up is Good	▼ Red
		Benchmark - National Data	Annual	6.00%	5.80%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	6.60%	6.30%	-	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	9	30	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	4	-	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	1	4	-	-	-	-	-	-		
	ASCOF1G	Proportion of adults with a learning disability who live in their own home or with family	Monthly	91.80%	82.60%	82.26%	84.30%	84.32%	82.44%	79.91%	85.00%	Up is Good	▼ Red
		Benchmark - National Data	Annual	73.30%	75.40%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	81.40%	78.60%	-	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	5	48	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	7	-	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	1	6	-	-	-	-	-	-		

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				2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4			
Adult Social Care Outcomes Framework	ASCOF1H	Proportion of adults in contact with secondary mental health services living independently, with or without support	Annual	55.10%	28.50%	39.21%	20.69%	38.19%	45.83%	52.14%	62.00%	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Annual	59.70%	58.60%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	67.20%	64.70%	-	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	113	144	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	14	15	-	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	13	15	-	-	-	-	-	-		
	ASCOF1I1	Proportion of people who use services who reported that they had as much social contact as they would like	Annual	46.60%	45.80%	50.00%	-	-	-	-	-	Up is Good	▲ Gree
		Benchmark - National Data	Annual	44.80%	45.40%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	45.70%	46.00%	-	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	46	70	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	7	9	-	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	6	10	-	-	-	-	-	-		

Health, Housing & Adult Social Care 2016/2017

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				2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4			
Adult Social Care Outcomes Framework	ASCOF2A1	Long-term support needs met by admission to residential and nursing care homes, per 100,000 population (younger adults) (YTD Cumulative) (New definition for 2015/16)	Monthly	9.9	11.3	11.27	2.25	3.76	8.26	11.27	10.00	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	14.2	13.3	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	11.5	13.9	-	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	50	64	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	5	7	-	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	11	5	-	-	-	-	-	-		
	ASCOF2A2	Long-term support needs met by admission to residential and nursing care homes, per 100,000 population (older people) (YTD Cumulative) (New definition for 2015/16)	Monthly	630.8	683.1	656.1	189	372.6	515.7	669.6	620.00	Up is Bad	◀ ▶ Neutr
		Benchmark - National Data	Annual	668.8	628.2	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	726.9	699.5	-	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	72	92	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	6	7	-	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	8	13	-	-	-	-	-	-		

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				2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4			
Adult Social Care Outcomes Framework	ASCOF2C1	Delayed transfers of care from hospital, per 100,000 population - (YTD Average)	Monthly	11.6	13.2	16.85	17.63	18.02	18.02	16.85	11.00	Up is Bad	▲ Red
		Benchmark - National Data	Annual	11.1	12.1	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	9.6	10.2	-	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	102	103	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	11	12	-	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	11	8	-	-	-	-	-	-		
	ASCOF2C2	Delayed transfers of care from hospital which are attributable to adult social care, per 100,000 population - (YTD Average)	Monthly	6.3	6.9	7.49	9.99	9.31	8.75	7.49	4.00	Up is Bad	▲ Red
		Benchmark - National Data	Annual	3.7	4.7	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	3	3.4	-	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	133	123	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	14	14	-	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	5	12	-	-	-	-	-	-		
	ASCOF3A	Overall satisfaction of people who use services with their care and support	Annual	67.10%	64.00%	62.00%	-	-	-	-	-	Up is Good	▼ Red
		Benchmark - National Data	Annual	64.70%	64.40%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	65.90%	63.80%	-	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	44	82	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	7	10	-	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	5	13	-	-	-	-	-	-		

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			Collection Frequency	2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4	Target	Polarity	DOT
Adult Social Care Outcomes Framework	ASCOF4A	Proportion of people who use services who feel safe	Annual	62.30%	66.90%	71.00%	-	-	-	-	-	Up is Good	▲ Green
		Benchmark - National Data	Annual	68.50%	69.20%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	67.70%	69.90%	-	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	131	101	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	13	13	-	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	16	13	-	-	-	-	-	-		
Alcohol	LAPE03	Alcohol-specific mortality: Males, all ages (per 100,000 population)	Annual	11.3	13.3	-	-	-	-	-	-	Up is Bad	◀▶ Neutr
		Benchmark - National Data	Annual	16.1	15.9	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	17.6	17.1	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	2	4	-	-	-	-	-	-		
	LAPE04	Alcohol-specific mortality: Females, all ages (per 100,000 population)	Annual	7.6	N/A	-	-	-	-	-	-	Up is Bad	◀▶ Neutral
		Benchmark - National Data	Annual	7.4	N/A	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	8.1	N/A	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	5	N/A	-	-	-	-	-	-		
	PHOF95	% of alcohol users in treatment who successfully completed drug treatment (without representation within 6 months)	Quarterly	-	32.81%	-	36.04%	39.32%	37.27%	-	-	Up is Good	◀▶ Neutral
		Benchmark - National Data	Quarterly	-	38.17%	-	38.36%	38.17%	38.33%	-	-		
Building Works	BW06	% of dwellings failing to meet the decent homes standard	Annual	0.04%	0.00%	-	-	-	-	-	-	Up is Bad	▼ Green
	BW06a	No of council homes in York failing to meet the decency standard	Annual	3	0	-	-	-	-	-	-	Up is Bad	▼ Green

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			Collection Frequency	2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4	Target	Polarity	DOT
Building Works	BW09	% of all repairs completed on time - (YTD)	Monthly	88.25%	96.60%	95.24%	92.79%	94.32%	94.55%	95.24%	-	Up is Good	◀ ▶ Neutral
	BW11	% of Repairs completed on first visit (New for 2016/17)	Monthly	-	-	67.46%	68.50%	68.73%	68.46%	67.46%	-	Up is Good	◀ ▶ Neutral
Employment	PHOF40	Gap in employment rate for mental health clients and the overall employment rate	Annual	63.20%	69.30%	-	-	-	-	-	-	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	66.10%	67.20%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	62.70%	64.00%	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	8	15	-	-	-	-	-	-		
Health	EH2	Proportion of population aged 15 to 24 screened for chlamydia	Annual	23.60%	22.30%	22.50%	-	-	-	-	-	Neutral	◀ ▶ Neutr
		Benchmark - National Data	Annual	24.50%	22.50%	20.70%	-	-	-	-	-		
		Benchmark - Regional Data	Annual	24.50%	21.20%	19.50%	-	-	-	-	-		
Homelessness	HOU101	Number of homeless households in temporary accommodation - (Snapshot)	Quarterly	65	56	62	57	72	63	62	56.00	Up is Bad	◀ ▶ Neutral
	HOU102	Number of homeless households with dependent children in temporary accommodation - (Snapshot)	Quarterly	41	30	33	27	36	28	33	40.00	Up is Bad	◀ ▶ Neutral
		Number of children in temporary accommodation (snapshot)	Quarterly	69	46	58	48	63	65	58	-	Up is Bad	◀ ▶ Neutral
	HOU103	Number of households for whom positive action has prevented homelessness - (YTD)	Quarterly	665	630	778	174	362	591	778	-	Up is Good	◀ ▶ Neutral
	HOU105	Number of households accepted as homeless and in priority need - (YTD)	Quarterly	105	91	97	28	53	81	97	-	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Quarterly	54,430	57,760	59,090	15,170	30,100	44,490	59,090	-		
		Benchmark - Regional Data	Quarterly	3,228	3,406	3,649	936	1,831	2,597	3,649	-		
	HOU106	Number of 16-17 year olds accepted as homeless - (YTD)	Quarterly	1	0	0	0	0	0	0	-	Up is Bad	◀ ▶ Neutral
	HOU214	Number of people sleeping rough on a single night - (Snapshot)	Annual	13	18	18	-	-	18	-	12.00	Up is Bad	◀ ▶ Neutral

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			Collection Frequency	2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4	Target	Polarity	DOT
ıelessı	HOU251	Number of applicant households for which decisions were taken - (YTD)	Quarterly	188	163	186	51	95	149	186	-	Neutral	◀ ▶ Neutral
Housing	CAN061	Number of new affordable homes delivered in York	Quarterly	136	109	-	25	3	-	-	-	Up is Good	◀ ▶ Neutral
	CAN200	Number of council homes let by direct exchange - (YTD)	Monthly	153	138	134	36	73	113	134	-	Up is Good	▼ Red
	HOU107	Number of active applicants on North Yorkshire Home Choice who are registered with CYC (Waiting List) - (Snapshot)	Quarterly	1,545	1,612	1,597	1,746	1,653	1,540	1,597	-	Up is Bad	◀ ▶ Neutral
Housing Debt and Arrears	HOU108	Current council tenant arrears as % of annual rent due - (Snapshot)	Quarterly	1.62%	1.62%	2.09%	1.91%	2.13%	2.21%	2.09%	-	Up is Bad	◀ ▶ Neutral
	HOU109	% of rent collected (including current arrears brought forward) - (Snapshot)	Quarterly	97.84%	97.62%	97.26%	92.38%	95.31%	96.47%	97.26%	-	Up is Good	◀ ▶ Neutr
Life Expectancy	PHOF16	Life Expectancy at birth - Female	Annual	83.5	83.4	-	-	-	-	-	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Annual	83.2	83.1	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	82.4	82.3	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	2	2	-	-	-	-	-	-		
	PHOF17	Slope index of inequality in life expectancy at birth - Female - (Three year period)	Annual	5.1	-	-	-	-	-	-	-	Up is Bad	◀ ▶ Neutral
		Regional Rank (Rank out of 15)	Annual	3	-	-	-	-	-	-	-		
	PHOF36	Life Expectancy at birth - Male	Annual	80.1	80.2	-	-	-	-	-	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Annual	79.55	79.5	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	78.7	78.6	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	3	3	-	-	-	-	-	-		

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Life Expectancy	PHOF37	Slope index of inequality in life expectancy at birth - Male - (Three year period)	Annual	6.5	-	-	-	-	-	-	-	Up is Bad	◀ ▶ Neutral
		Regional Rank (Rank out of 15)	Annual	3	-	-	-	-	-	-	-		
Mental Health	CMHD02	IAPT Referrals (18+), per 100,000 population - (VoY CCG)	Quarterly	307.08	468.52	-	-	-	-	-	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Quarterly	838.72	860.6	-	-	-	-	-	-		
		Benchmark - Regional Data	Quarterly	909.29	897.15	-	-	-	-	-	-		
	CMHD03	% of people who have completed IAPT treatment who achieved "reliable improvement" - (VoY CCG)	Quarterly	61.40%	63.64%	-	-	63.64%	-	-	-	Up is Good	◀ ▶ Neutr
		Benchmark - National Data	Quarterly	61.62%	63.70%	-	-	63.70%	-	-	-		
		Benchmark - Regional Data	Quarterly	60.17%	63.11%	-	-	63.11%	-	-	-		
	CMHP15A	Number of bed days in secondary mental health care hospitals, per 100,000 population - (VoY CCG)	Quarterly	8,285.59	4,989.34	-	-	-	-	-	-	Up is Bad	◀ ▶ Neutral
	PHOF32	Suicide rate (per 100,000 population)	Annual	9.94	13.98	-	-	-	-	-	-	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	8.94	10.15	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	9.26	10.72	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	11	14	-	-	-	-	-	-		
	POPPI01	Total population aged 65 and over predicted to have dementia	Annual	2,680	2,717	2,788	-	-	-	-	-	Up is Bad	◀ ▶ Neutral
Mortality	CHP02	Child mortality rate (1-17 years), per 100,000 population	Annual	10.27	9.32	-	-	-	-	-	-	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	11.96	11.87	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	13.28	13.71	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	4	2	-	-	-	-	-	-		

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				2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4			
Mortality	PHOF33	Excess Winter Deaths Index (all ages single year)	Annual	16.84	27.7 (Prov)	-	-	-	-	-	-	Up is Bad	▲ Red
		Benchmark - National Data	Annual	27.67	14.7	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	25.84	15.2	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	-	-	-	-	-	-	-		
	PHOF46	Mortality rate from causes considered preventable (per 100,000 population)	Annual	176.11	169.27	-	-	-	-	-	-	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	185.08	184.46	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	200.23	200.18	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	3	2	-	-	-	-	-	-		
	PHOF49	Under 75 mortality rate from all cardiovascular diseases (per 100,000 population)	Annual	69.41	67.85	-	-	-	-	-	-	Up is Bad	▼ Green
		Benchmark - National Data	Annual	75.72	74.65	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	84.68	83.54	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	2	2	-	-	-	-	-	-		
	PHOF55	Under 75 mortality rate from cancer (per 100,000 population)	Annual	140.02	130.5	-	-	-	-	-	-	Up is Bad	▼ Green
		Benchmark - National Data	Annual	141.51	138.8	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	151.69	148.4	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	3	3	-	-	-	-	-	-		

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				2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4			
Mortality	PHOF61	Under 75 mortality rate from liver disease (per 100,000 population)	Annual	13.58	14.9	-	-	-	-	-	-	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	17.78	18	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	18.13	17.9	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	2	3	-	-	-	-	-	-		
	PHOF66	Under 75 mortality rate from respiratory disease (per 100,000 population)	Annual	31.6	31.2	-	-	-	-	-	-	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	32.62	33.1	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	38.58	38.4	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	4	4	-	-	-	-	-	-		
Obesity	NCMP01	% of reception year children recorded as being obese (single year)	Annual	7.03%	8.59%	-	-	-	-	-	-	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	9.08%	9.31%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	8.83%	9.42%	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	2	-	-	-	-	-	-		
	NCMP02	% of children in Year 6 recorded as being obese (single year)	Annual	14.97%	15.14%	-	-	-	-	-	-	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	19.08%	19.82%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	19.19%	20.29%	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	1	-	-	-	-	-	-		

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			Collection Frequency	2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4	Target	Polarity	DOT
Obesity	PHOF44	% of adults classified as overweight or obese	Annual	56.88%	56.40%	-	-	-	-	-	-	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	64.59%	64.80%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	67.09%	67.40%	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	1	-	-	-	-	-	-		
Physical Activity	PHOF01	% of physically active and inactive adults - active adults	Annual	62.18%	69.83%	-	67.90%	-	-	-	-	Up is Good	◀ ▶
		Benchmark - National Data	Annual	57.04%	57.05%	-	65.40%	-	-	-	-		
		Benchmark - Regional Data	Annual	56.08%	56.35%	-	64.00%	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	2	1	-	-	-	-	-	-		
	PHOF02	% of active and inactive adults - inactive adults	Annual	21.57%	17.54%	-	19.70%	-	-	-	-	Up is Bad	◀ ▶
		Benchmark - National Data	Annual	27.73%	28.65%	-	22.00%	-	-	-	-		
		Benchmark - Regional Data	Annual	29.21%	29.12%	-	24.00%	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	1	-	-	-	-	-	-		
Pregnancy and Maternity	YH13	% of mothers smoking at time of delivery - (Rolling 12 Month)	Monthly	-	12.05%	11.26%	12.13%	12.01%	11.50%	11.26%	-	Up is Bad	▼ Green

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			Collection Frequency	Previous Years			2016/2017				Target	Polarity	DOT
				2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4			
Public Health and Wellbeing	EH1	Chlamydia diagnoses (15-24 year olds), per 100,000 population	Annual	1,682.5	1,462	1,838	-	-	-	-	-	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	2,035.3	1,887	1,882	-	-	-	-	-		
		Benchmark - Regional Data	Annual	2,240.1	2,031.4	2,072	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	13	14	12	-	-	-	-	-		
	HV01	% of births that receive a face to face New Birth Visit (NBV) by a Health Visitor within 14 days	Quarterly	-	74.40%	78.30%	74.32%	70.14%	73.70%	78.30%	-	Up is Good	▲ Green
		Benchmark - National Data	Quarterly	-	87.80%	-	87.60%	88.50%	88.70%	-	-		
		Benchmark - Regional Data	Quarterly	-	86.80%	-	87.40%	85.10%	86.20%	-	-		
	HV02	% of face-to-face NBVs undertaken by a health visitor after 14 days	Quarterly	-	21.70%	12.77%	21.21%	19.64%	17.70%	12.77%	-	Up is Bad	▼ Gree
		Benchmark - National Data	Quarterly	-	9.50%	-	10.00%	9.30%	9.30%	-	-		
		Benchmark - Regional Data	Quarterly	-	10.80%	-	10.70%	12.50%	11.60%	-	-		
	HV03	% of infants who received a 6-8 week review by the time they were 8 weeks	Quarterly	-	70.80%	77.09%	75.22%	78.96%	77.80%	77.09%	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Quarterly	-	82.70%	-	81.60%	81.90%	83.90%	-	-		
		Benchmark - Regional Data	Quarterly	-	86.40%	-	86.10%	86.10%	87.70%	-	-		
	HV04	% of infants being breastfed at 6-8wks	Quarterly	-	30.10%	44.23%	34.03%	36.87%	35.70%	44.23%	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Quarterly	-	43.70%	-	43.87%	44.40%	44.10%	-	-		
		Benchmark - Regional Data	Quarterly	-	36.60%	-	37.96%	-	-	-	-		

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			Collection Frequency	2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4	Target	Polarity	DOT
Public Health and Wellbeing	HV05	% of children who received a 12 month review by the time they turned 12 months	Quarterly	-	16.77%	41.65%	23.98%	21.66%	25.00%	41.65%	-	Up is Good	▲ Green
		Benchmark - National Data	Quarterly	-	73.60%	-	74.30%	75.50%	74.80%	-	-		
		Benchmark - Regional Data	Quarterly	-	82.50%	-	81.10%	81.60%	82.10%	-	-		
	HV06	% of children who received a 12 month review by the time they turned 15 months	Quarterly	-	70.00%	76.92%	68.94%	74.81%	74.50%	76.92%	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Quarterly	-	82.50%	-	82.05%	82.50%	82.70%	-	-		
		Benchmark - Regional Data	Quarterly	-	88.50%	-	89.06%	88.80%	86.80%	-	-		
	HV07	% of children who received a 2-2½ year review	Quarterly	-	11.60%	18.55%	22.39%	23.08%	16.10%	18.55%	-	Up is Good	◀ ▶ Neutr
		Benchmark - National Data	Quarterly	-	74.70%	-	76.27%	78.10%	78.20%	-	-		
		Benchmark - Regional Data	Quarterly	-	81.30%	-	82.74%	82.60%	81.90%	-	-		
	PHOF11	Cumulative % of eligible population aged 40-74 offered an NHS Health Check	Quarterly	38.11%	70.67%	-	71.91%	-	-	-	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Quarterly	37.94%	56.44%	-	61.51%	-	-	-	-		
		Benchmark - Regional Data	Annual	31.33%	49.80%	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Quarterly	4	2	-	-	-	-	-	-		
	PHOF11b	Cumulative % of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	Quarterly	39.35%	37.57%	-	37.47%	-	-	-	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Quarterly	48.93%	48.59%	-	48.37%	-	-	-	-		
		Benchmark - Regional Data	Annual	52.23%	48.80%	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Quarterly	12	12	-	-	-	-	-	-		

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				2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4			
Public Health and Wellbeing	PHOF12	Cumulative % of eligible population aged 40-74 who received an NHS Health Check	Quarterly	14.99%	26.55%	-	26.95%	-	-	-	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Quarterly	18.56%	27.42%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	16.36%	24.30%	-	29.75%	-	-	-	-		
		Regional Rank (Rank out of 15)	Quarterly	7	5	-	-	-	-	-	-		
	PHOF31	% of eligible population aged 40-74 who received an NHS Health Check	Quarterly	7.32%	9.81%	-	-	-	-	-	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Quarterly	9.62%	8.99%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	-	-	-	-	-	-	-	-		
	PHOF79	HIV late diagnosis	Annual	56.30%	68.80%	-	-	-	-	-	-	Up is Bad	▲ Red
		Benchmark - National Data	Annual	42.20%	40.30%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	49.70%	48.20%	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	3	15	-	-	-	-	-	-		
Resident and Corporate Surveys	TAP09	% of panel confident they could find information on support available to help people live independently	Quarterly	NC	NC	65.46%	64.00%	NC	65.46%	NC	-	Up is Good	◀ ▶ Neutral

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			Collection Frequency	2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4	Target	Polarity	DOT
Safeguarding (Young People)	CHP32	Hospital admissions as a result of self harm (10-24 years), per 100,000 population	Annual	552.96	675.2	-	-	-	-	-	-	Up is Bad	◀▶ Neutral
		Benchmark - National Data	Annual	398.8	430.5	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	367.9	384.8	-	-	-	-	-	-		
	PHOF06	Under 18 conceptions (per 1,000 females aged 15-17) (Calendar Year)	Quarterly	15.71	20.41	-	-	-	-	-	-	Up is Bad	▲ Red
		Benchmark - National Data	Quarterly	22.8	20.78	-	-	-	-	-	-		
		Benchmark - Regional Data	Quarterly	26.35	24.31	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	5	-	-	-	-	-	-		
	PHOF27	Under 18 conceptions: conceptions in those aged under 16 (per 1,000 females aged 13-15) (Calendar Year)	Annual	2.13	1.82	-	-	-	-	-	-	Up is Bad	▼ Gree
		Benchmark - National Data	Annual	4.38	3.73	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	5.49	4.45	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	1	-	-	-	-	-	-		
Smoking	NGPP01	Gap in smoking prevalence rate between adult general population and adults in routine and manual occupations	Annual	15.24%	13.19%	-	-	-	-	-	-	Neutral	◀▶ Neutral
		Benchmark - National Data	Annual	10.93%	9.59%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	10.12%	9.58%	-	-	-	-	-	-		
	PHOF10	% of women who smoke at the time of delivery	Quarterly	10.80%	12.06%	-	11.96%	9.70%	10.30%	12.26%	-	Up is Bad	▲ Red
		Benchmark - National Data	Annual	11.38%	10.65%	-	10.21%	10.40%	10.60%	10.79%	-		
		Benchmark - Regional Data	Annual	15.56%	14.53%	-	14.24%	14.20%	14.10%	14.26%	-		
		Regional Rank (Rank out of 15)	Annual	1	4	-	-	-	-	-	-		

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Smoking	PHOF20	% of population smoking (routine and manual workers) (APS)	Annual	32.80%	28.20%	26.40%	-	-	-	-	-	Up is Bad	▼ Green
		Benchmark - National Data	Annual	29.60%	28.10%	26.50%	-	-	-	-	-		
		Benchmark - Regional Data	Annual	32.50%	30.00%	28.90%	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	9	4	4	-	-	-	-	-		
	PHOF45	% of population smoking (APS)	Annual	17.24%	14.63%	12.60%	-	-	-	-	-	Up is Bad	▼ Green
		Benchmark - National Data	Annual	19.86%	18.63%	15.50%	-	-	-	-	-		
		Benchmark - Regional Data	Annual	17.85%	16.93%	17.70%	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	4	2	2	-	-	-	-	-		
Sport	PHYS05	Adults (aged 16+) who have taken part in sport and physical activity at least twice in the last 28 days	Annual	-	82.70%	-	-	-	-	-	-	Up is Good	◀ ▶
		Benchmark - National Data	Annual	-	77.20%	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	-	75.00%	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	-	1	-	-	-	-	-	-		
Substance Misuse	CSB17	Number of mothers recorded by Midwifery Services in regard to alcohol or substance misuse (by Estimated Delivery Date)	Quarterly	26	33	-	13	-	-	-	-	Up is Bad	▲ Red
	PHOF76	% of opiate users in treatment who successfully completed drug treatment (without representation within 6 months)	Quarterly	5.20%	5.50%	-	6.07%	7.97%	8.05%	-	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Quarterly	7.38%	6.80%	-	6.97%	6.58%	6.58%	-	-		
		Benchmark - Regional Data	Quarterly	6.24%	-	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	9	-	-	-	-	-	-	-		

Health, Housing & Adult Social Care 2016/2017

ANNEX A

No of Indicators = 82 | Direction of Travel (DoT) shows the trend of how an indicator is performing against its Polarity over time.

Produced by the Strategic Business Intelligence Hub July 2017

				Previous Years			2016/2017						
			Collection Frequency	2014/2015	2015/2016	2016/2017	Q1	Q2	Q3	Q4	Target	Polarity	DOT
Substance Misuse	PHOF77	% of non-opiate users in treatment who successfully completed drug treatment (without representation within 6 months)	Quarterly	40.10%	31.10%	-	32.51%	37.93%	37.89%	-	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Quarterly	39.19%	37.30%	-	37.17%	36.91%	36.75%	-	-		
		Benchmark - Regional Data	Quarterly	40.19%	-	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	9	-	-	-	-	-	-	-		
Tenant Satisfaction Survey	TSS01	% of tenants satisfied with the way their landlord deals with repairs and maintenance generally	Annual	81.27%	84.56%	80.56%	-	-	-	80.56%	-	Up is Good	◀ ▶ Neutral
		% of tenants dissatisfied with the way their landlord deals with repairs and maintenance generally	Annual	14.43%	13.30%	11.79%	-	-	-	11.79%	-	Up is Bad	▼ Gree

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Health, Housing & Adult Social Care Policy and Scrutiny Committee 25 July 2017

Report of the Head of Commissioning, Adult Social Care

Be Independent – Contract Monitoring Information

Summary

1. This paper provides an update to Members on the performance of Be Independent for 2017. It advises Members on the key performance areas included within the Council's contract, highlights areas where increased monitoring is required and advises Members of any concerns regarding performance of the organisation.

2. The key findings in this report shows improvements in;

- An increase in customer satisfaction with Community Alarm provision
- A small sample of feedback on community provision indicating a positive response from customers
- An increase in strategic outcomes from a customer perspective
- Continued improvement in telephone responses
- An increase in equipment deliveries carried out
- For those that have left the community alarm service, there is a higher proportion where Be Independent has been able to identify the reason for leaving.
- The quantity of private customers is now starting to stabilise rather than reduce.

However there is still:

- A continued reduction in eligible customers
- The service is yet to show increases in private community alarm customers

Background

3. The City of York Council previously provided a community alarm, telecare and equipment service. These services were externalised in 2014 and as a result a Social Enterprise was established which was awarded the contract to manage services for an initial five year period.

The new organisation, Be Independent, is now in its fourth year of operations, in line with other externalised services such as Explore.

4. Following the externalisation of Be Independent and York Explore, an audit of monitoring processes was carried out by Veritau in October 2014. This audit demonstrated that effective processes were in place to monitor the contract for Be Independent with the exception that monitoring data should be reported to this Committee on a half yearly basis.

Be Independent Monitoring Information

Telephone calls

5. The service provides a 24 hour call and response service depending on the package of service they receive. Receiving calls in a timely manner is therefore an essential requirement to providing a good quality service:

Indicator: **Telephone calls answered promptly**	*14/15*	*15/16*	16/17
% calls responded to in under 30 seconds	*94.7%* **Target: 90%**	*95.8%* **Target: 90%**	*96.9%* **Target: 90%**
Total number of telephone calls received	*Average per quarter = 39,434*	*Average per quarter = 35,220*	*Average per quarter = 33,684*

6. There has been a progressive increase in the percentage of calls responded to in 30 seconds. The improvement in response rates is likely to be down to the progressive reduction in the quantity of calls.

7. The reduction of calls has led to capacity which will enable the service to explore new business ideas.

8. Part of the reason for the reduction in calls is down to reduction in community alarm customers and problem solving in utilising telecare initiatives to reduce the quantity of repeated telephone calls.

Community Alarm

9. Most outcomes are recorded through direct views of customers receiving the service and are as follows:

	Outcome	Applicable to	Monitored By
1	Satisfaction with service received	Equipment Loan and telecare	Council consultation, aligns with National Adult Social Care Survey
2	Enhanced quality of life		
3	Increased independence		
4	Improvement in feeling safe		
5	Improved wellbeing		
6	An increase in the number of people who are enabled to remain living in their chosen home		Council consultation
7	A reduction in the number of people requiring admission to hospital, residential or nursing care		Council consultation
	Evidence of efficient hospital discharges facilitated by a responsive Equipment Service		Council consultation/ stakeholder feedback/ case studies
	Evidence that the provision of appropriate equipment can in some cases prevent deterioration of a condition or the complications of additional related health problems		Stakeholder consultation
8	Reduced fear of falls or accidents		Council consultation
	Their Carer/s are more confident and able to look after them safely		Carers Survey
	Their Carer/s have peace of mind knowing that the person they care for is safe in their own home		Carers Survey

10. It was agreed to delay the consultation to May/June 2017 to avoid duplication or customer confusion with the National ASC survey. This took place agreed sample of 10% of customers receiving the telecare survey. There was 97 responses received (38.8%).

11. The results of customer outcomes were as follows:

	Previous survey/s 2014-15	Current Survey 2017
1.Satisfaction with service received	87.5%	90% ⇧
2.Enhanced quality of life	28.5%	29% ⇧
3.Increased independence	63.2	71% ⇧
4.Improvement in feeling safe	80.7%	83% ⇧
5.Improved wellbeing	Previous captured in a different way	30%
6.An increase in the number of people who are enabled to remain living in their chosen home	54.5%	61%. ⇧
7.A reduction in the number of people requiring admission to hospital, residential or nursing care	27.5%	34.0 ⇧
8.Reduced fear of falls or accidents	85.5%	93%. ⇧

12 A full breakdown has been provided in Appendix 1

13 There is a positive increase in all outcomes measured in the same way with the greatest marked increase in independence and requirement to be admitted to hospital or residential care. Scaled up this would indicate 815 customers perceive that the service prevented them from needing to being admitted to hospital or residential care.

<u>Outputs – Community Alarm</u>

Community Alarm Connections	*14/15 at year end*	*15/16 at year end*	*16/17 at year end*
Total number of community alarm customers (across all tiers)	2,769	2,575	2,396
Total number of self funding customers	1,435	1,363	1,324

(across all tiers)			
Total number of eligible customers (across all tiers)	1,334	1,212	1,073
% of eligible community alarm customers	48.2%	47.1%	45%

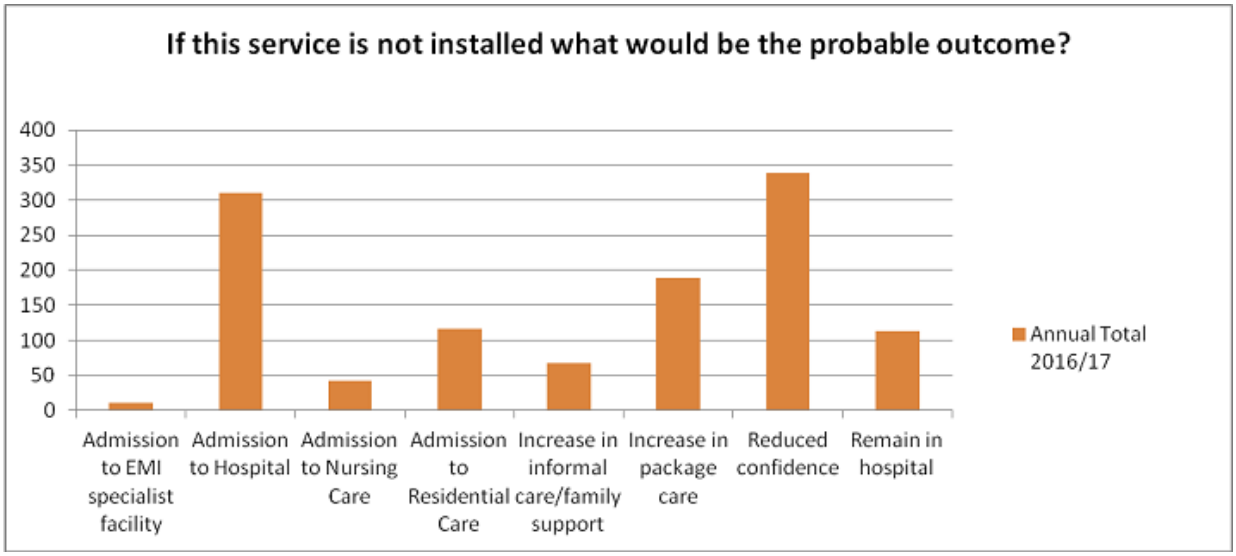
14 This shows a continued decrease in eligible customers, while the quantity of private customers has stabilised. Point 20 of the report shows 707 customers no longer using the service, mainly down to change of circumstances which represents a loss of 29% of the customer base. There needs to therefore be 59 new customers a month just to stand still. The high turnover would suggest the customer base is predominantly those that are just managing to remain independent. There are other lower cost community alarm services that may be better placed to pick up on the lower risk customers (services where a keyholder, eg relative would respond rather than a warden), these would more likely require the service for longer, reducing the turnover.

15 Following the previous report to scrutiny it was agreed to provide the following details on the reasons for activation of alarms:

	Q1	**Q2**	**Q3**	**Q4**	**Number of calls 2016/17**
Fallen	580	566	560	564	2270
No Response	1108	972	1662	1537	5279
Unplugged	204	411	552	362	1529
Anxiety Call	3063	1441	2093	1808	8405
Fire Brigade	14	9	21	15	59
Medical Emergency *Services Alerted - Ambulance, DN, GP*	89	83	84	90	346
Other - False Alarms	4385	3704	4696	4352	17137

17 The previous report also proposed providing details on the perceived outcome if the service was not offered.

18 This information is collected from the Be Independent referral form and is self-identified by the referrer. More than one outcome can be chosen.



19 The table demonstrates that the service is targeting the right customers with the customer referring looking to reduce access to statutory services.

20 It was also agreed to provide details on why a customer has left a service to see if the proportion of reasons classified as "other" could be achieved.

REASONS FOR CUSTOMERS LEAVING THE SERVICE	**Number of customers 2016/17**	**% of total 2016/17**	**Previous report 6 qtrs April '15 to Sept '16**
Customer Death	308	43.6%	*42.1%*
Moved to Sheltered Housing	24	3.4%	*3.7%*
Moved to SHEC	13	1.8%	*1.1%*
Moved to hospice or long-term hospital admission	11	1.6%	*1.7%*
Moved to residential care home or residential with nursing	192	27.2%	*24.4%*
Move in with family, or equivalent	44	6.2%	*5.9%*
Evicted / abandoned tenancy / imprisoned			*0.2%*
Dissatisfied with service	3	0.4%	*0.3%*
Financial reasons	4	0.6%	*1.1%*
Transferred to alternative provider	5	0.7%	*0.3%*
Other (unclassified)	103	14.6%	*19.3%*
TOTAL	707	100%	*100%*

21 Be Independent have provided details of a sample of 31 customers “no longer requiring the service” reported as Other (unclassified) in the table above. After scrutinising records, 4 cases were identified with change of circumstances known to Be Independent which was not reflected in the reported data (data quality issues). In addition, adult social care records showed that 6 further customers had change of circumstances that may not have been made known to Be Independent.

22 Of the remaining 21 customers in the sample, 15 customers were self-funding whilst 6 customers were receiving the service free of charge (approx 70%/30% split). Out of the self-funding group, 6 customers had assessed social care needs or were receiving care services

23 The table shows a decrease in number of “other” departures compared to previous report, indicating improved processes for identifying reasons for leaving service.

24 It would suggest that financial reasons may be one of a number of factors why a self-paying customer may choose to leave the service without disclosing why. Customer satisfaction levels are high which would suggest that few will leave due to the quality of the service.

25 As the service is a “just in case” service, customers may go through a significant period of time where they have not needed to activate the community alarm. It is therefore anticipated that some customers may perceive they do not require it. This may particularly be the case where the referral is from a relative /doctor etc rather than the customer, where the perception in the level of frailty/ vulnerability may be different. As a result we are checking with Be Independent what the proportion of customers that left the service activated their alarm over the last year.

26 <u>Number of Loan Equipment Deliveries</u>

Indicator	*14/15*	*15/16*	*16/17*
Number of Deliveries	*Average per quarter = 4337*	*Average per quarter = 3404*	*Average per quarter = 4653*
Priority 2D (Within 5 working days) - % Deliveries completed on time	93.7%	94.7%	98.5%

	Target: 90%	Target: 90%	Target: 90%

27 The quantity of deliveries has fluctuated based on fluctuations in demand.

28 Deliveries completed within 5 working days are performing strongly, with the indicator values showing continuous improvement in this area.

29 Reporting information generally indicates that the quality of service in respect to outputs for delivery remained good since it was externalised in April 2014. Outcomes are less easy to obtain due to services being one off pieces of work rather than a continued service.

30 As part of the consultation process the responses were gathered for 2016-17. Unfortunately only 7 responses were received with 6 out of 7 being positive and confirmed they would recommend the service to someone else.

When asked what one thing would have made your experience better, the following feedback was provided:

“Bars on the bath made a great difference”

“Words fail me to thank you for the care and attention& loan of your equipment”

“Nothing, my experience was fine”

“Nothing could have made anything any better”

“Nothing - prompt and helpful”

“The lid of the commode bucket is almost impossible to remove - so I will use the lid off the old commode.”

“I only wish I had known of you before I went out and bought equipment needed prior to operation. Your service was excellent. Staff - kind careful and helpful, delivery and collection very efficient”

31 Be Independent are working alongside the OT team to ensure there is good communication and a shared expectation with respect to service delivery.

Implications

Financial

32 Initially, looking at the drop in eligible community alarm customers, this would raise concerns regarding value for money. However with an increase in deliveries and a year on year contract reduction a more balanced Value for Money has been achieved.

33 Although it is not possible to create a clear unit value for comparison, with two very different services within the same contract the cost of weekly community alarm provision and deliveries against the block contract value were compared on a year by year basis. This would give a unit value of £12.89, £13.98 and £13.72 respectively over the last 3 financial years.

34 Improved outcomes, partially around the perception of increased customers having prevented hospital or residential care admission should also be taken into consideration with any value for money considerations.

Equalities

35 There are no direct equality issues associated with this report

Other

36 There are no implications relating to Human Resources, Legal, Crime and Disorder, Information Technology or Property arising from this report.

Risk Management

37 There are at present no risks identified with issues within this report.

Recommendations

38 Members are asked to note the performance of Be Independent.

39 It is recommended that scrutiny reports are now submitted on an annual rather than 6 monthly basis to create monitoring proportionality with other services. However if Councillors agree in principal this will need to be approved by Veritau as this was the auditors requirement for services that have been externalised.

40 That the next scrutiny report to Scrutiny focuses on the business development of the service.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Carl Wain Commissioning Manager Adults Commissioning Team (01904) 554595	**Martin Farran** Corporate Director Health, Housing and Adult Social Care
	Report Approved ✓ **Date** 6 July 2017

Specialist Implications Officer(s)

Wards Affected: **All** ✓

For further information please contact the author of the report

Appendix 1

Community Alarm Survey 2017

Total surveys sent	**250**	**100%**
Total surveys received	**97**	**38.8%**

1. When you first started to receive a service from Be Independent, were you given information to explain what service you could expect?	**Yes**	**No**	N/A	Don't know
	71	3	0	9
	86%	**4%**	**0%**	**11%**

2. Did you get the equipment and alarm services you needed within the timescale you were given?	**Yes**	**No**	N/A
	81	2	0
	98%	**2%**	**0%**

3. Can you tell us what the service has helped you to achieve?		**%**
Has enabled me to remain independent	67	71%
Has enhanced my quality of life	27	29%
Has improved my wellbeing	28	30%
Has enabled me to remain at home	57	61%
Has enabled me to feel safe e.g. through having someone to contact at night	78	83%
It reduces the fear of what will happen if I have a fall	87	93%
It has prevented my admission to a residential or nursing home	22	23%
It has prevented my admission to hospital or a hospice	11	12%
It has prevented an increase to my package of care	16	17%
It has prevented a delayed discharge from hospital for me	11	12%

It has provided reassurance to family and friends, knowing that I can always contact someone i.e. it has prevented family and friends feeling anxious and therefore supported their caring role and increased my independence.	79	84%

4. Can you tell us if the service has helped you in any of the other ways listed below?		**%**
Has it led to other advice being provided to you e.g. how you might reduce the chances of having a fall	17	22%
Has it made you aware of any other services that may be useful to you e.g. the Occupational Therapy service, the aides and equipment service	40	52%
Has it provided reassurance over the phone to you	55	71%
Has it at any time contacted the emergency services for you.	28	36%

5. Are you able to tell us if your family / friend /carer have more peace of mind knowing that you are safe in your own home?	**Yes**	**No**	N/A
	84	1	8
	90%	**1%**	**9%**

6. Are you able to tell us if your family / friend /carer feel more confident and are able to look after you better knowing that you have the Be Independent service in place?	**Yes**	**No**	N/A
	75	1	14
	83%	**1%**	**16%**

7. If you have had a fall or there has been any other reason why Be Independent has had to come out to you quickly, do you feel you had a response in a timely manner?	**Yes**	**No**	N/A
	45	12	4
	73.8%	**19.7%**	**6.6%**

8. Are Be Independent staff always pleasant and helpful?	Yes	No	N/A
	89	1	1
	98%	**1%**	**1%**

9. If you have ever had to make a complaint were you satisfied with the way it was dealt with?	Yes	No	N/A
	14	15	11
	35.0%	**37.5%**	**27.5%**

10. Overall, how satisfied or dissatisfied are you with the services you are receiving from Be Independent?		
I am extremely satisfied	38	**39%**
I am very satisfied	36	**37%**
I am quite satisfied	14	**14%**
I am neither satisfied nor dissatisfied	2	**2%**
I am quite dissatisfied	0	**0%**
I am very dissatisfied	0	**0%**
I am extremely dissatisfied	0	**0%**
no answer	7	**7%**

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Health, Housing & Adult Social Care Policy & Scrutiny Committee

25 July 2017

Report of the Assistant Director – Legal & Governance

The Retreat Inspection Cover Report

Summary

1. This report and its annexes inform the Committee of the recent Care Quality Commission (CQC) inspection of The Retreat in York along with the hospital's quality improvement plans and a summary of the CQC action plan.

Background

2. The Retreat is a charity delivering not-for-profit specialist mental health services. It works closely with the NHS and other service commissioners and providers including the Vale of York Clinical Commissioning Group (CCG) and the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV).

3. The Retreat was established in 1796 and is an independent specialist mental health care hospital for the treatment of up to 98 people with complex mental health needs.

4. The CQC carried out a focused inspection of The Retreat in February 2017 in response to a number of safeguarding concerns that the hospital had raised with the City of York Council and about which it had notified the CQC. As a result of this focused inspection, on a single current unit for older males, the hospital received an 'inadequate' rating.

5. The concerns related primarily to staff delivery of patient personal care, inappropriate moving and handling of patients, and staffing shortages. These concerns also contained reports of bullying within the staff team. The reported incidents had occurred during the period the 11 January 2017 to 3 February 2017 when six patients from George Jepson unit were moved to another unit, the 'Allis' unit , while refurbishment work took place on the George Jepson unit. The Retreat previously closed

Allis unit to inpatients in 2015 as they found it unsuitable for the patient group that resided there. The Retreat had not informed the CQC of their intention to move patients for a six week period. There were no patients on Allis unit when the CQC visited as the provider had closed the unit on 3 February 2017 in response to the safeguarding alerts.

6. Although there were no patients on Allis unit at the time of the inspection, the unit was dirty, damp and cold; there was limited hot water and unsuitable kitchen, toilet and bathing facilities.

7. Following the February 2017 inspection areas for improvement were highlighted along with action The Retreat **must** take to improve:

    - The provider must ensure that care and treatment is provided in a safe way for patients.
    - The provider must ensure that risks to the health and safety of patients receiving the care or treatment are assessed and mitigated.
    - The provider must ensure that all premises are clean and safe with suitable equipment and facilities.
    - The provider must ensure that patient dignity and respect are considered and acted in accordance with at all times.
    - The provider must ensure that all patient documentation is complete and filed appropriately on the George Jepson unit.
    - The provider must ensure that all safeguarding incidents are reported.
    - The provider must ensure that appropriate planning and governance processes are in place; this includes ensuring that environmental and patient risks are identified, captured, managed and communicated with patients, families and staff when making decisions that affect the service.

Options

8. Members can ask to be updated on the progress of actions in The Retreat quality improvement plan, or not.

Analysis

9. There is no analysis included in this report.

Council Plan

10. This report is linked to A Focus on Frontline Services element of the Council Plan, particularly that support services are available to those who need them, that residents are supported to live healthy lives and that residents are protected from harm.

Risks and Implications

11. There are no risks associated with the recommendations in this report. However, there is a risk the Committee would not be fulfilling its responsibility to review and scrutinise an matter relating to the planning, provision and operation of health services within the city if it were not assured that issues raised by the CQC are being addressed.

Recommendations

12. Having read and commented on this report and its annexes Member are asked to request that the Committee is updated on the progress of The Retreat quality improvement plan as and when appropriate.

    Reason: So the Committee is assured that concerns raised by the CQC are being addressed

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Report Approved ✓ **Date** 14/07/2017

Wards Affected: **All** ✓

For further information please contact the author of the report
Annexes

Annex 1 – The Retreat Quality Improvement Plan
Annex 2 – CQC Action Plan Summary
Annex 3 – CQC Quality Report

Abbreviations

CCG – Clinical Commissioning Group
CQC – Care Quality Commission
TEWV – Tees, Esk and Wear Valleys NHS Foundation Trust

ANNEX 1

THE RETREAT: RESPONDING TO FOCUSED INSPECTION FEBRUARY 2017

Our quality improvement plans

The Retreat Community

Compassion Collaboration Community

Becoming one of the most important institutions for the care and treatment of mental health

Contents

Introduction

The Retreat is a charity, delivering not-for-profit specialist mental health services. We work closely with the NHS and other service commissioners and individuals to provide services for people whose mental health gives them and their families cause for concern, from the complex and challenging to the less intensive but equally distressing and anxiety-provoking.

The Retreat was established over 200 years ago by the Tukes, a Quaker family. It was the first place in the world to offer humane, dignified and respectful approaches to the treatment of mental health difficulties. The Wellcome Trust (2017) state[1] "The Retreat in York is historically one of the most important institutions for the care and treatment of mental health patients". We would like to work towards ensuring that our importance is not only historical, but that we remain an important force for innovative, high quality compassionate care for people with mental health issues.

The issue

The CQC carried out a focused inspection on The Retreat in February 2017 in response to a number of safeguarding concerns that we had raised with the City of York Council and about which we had notified the CQC. As a result of that focused inspection, on a single current unit for older males, we received an 'inadequate' rating.

This rating has caused our commissioners and partners to ask us how we are responding to the CQC's concerns. However, we have not had any response from the local community in relation to this.

We welcome the opportunity to discuss our rating with the Scrutiny Board and to outline the actions we are taking to address it.

Our response

We have developed a quality improvement plan in response to the focused CQC inspection and in consideration of the future of The Retreat. This plan is embedded within our new and emerging aspirational strategy for The Retreat's future. The plan is provided in Appendix A. We have mapped the quality improvement plan on to our emerging strategy to show how this work is integral to The Retreat's future.

Appendix B outlines the key indicators we will use to show that we have achieved improvements in quality and the flow chart in Appendix C shows how this work will be

[1] See https://wellcomelibrary.org/collections/digital-collections/mental-healthcare/the-retreat/, accessed 10/5/17

monitored and quality assured. Our strategy is aspirational, it outlines what we will do in order to become the best we can be. It considers what capabilities need to be in place and what management systems need to be instituted. This strategy will address all of the concerns raised by the CQC and moreover that it will enable us to become one of the most important institutions for the care and treatment of mental health in the country. Importantly, it is also founded upon our values, which are set out in Appendix D.

Our current position

In the CQC report[2] from our comprehensive inspection in November 2016 the CQC pointed out a number of strengths:-

- **Involvement** - patients and carers are involved in their care and the running of the service.
- **Staff qualities** - carers and patients said that staff were respectful and polite and that described staff as amazing, and that they felt valued and supported by staff.
- **Approach and ethos** - patients said that staff saw them as people and not as a condition
- **Understanding** - the CQC cited evidence that staff knew patients well and had taken time to understand their needs, wishes and preferences.
- **Safeguarding** - they reported that safeguarding is embedded across the organisation and that we have good links with the local authority.
- **Policy** - they felt that our care and treatment records reflected safeguarding concerns and staff knew and acted in line with our safeguarding policy.

This same report identified some areas for improvement, including:-

- **External communication** – we need to become more outward-facing, developing a wider range of appropriate and proactive partnerships
- **Looking after our staff** – we need to ensure that they have the resources needed to do the job, ensure their safety is taken seriously, address concerns about pay and benefits, support them to feel optimistic about the future, work hard to ensure they have confidence in the Leadership Team, communicate openly, honestly and regularly and create a positive environment. Including staff in the development of the staff survey action plan will help.
- **Systems, processes and infrastructure** – we need a more robust operational framework, across the organisation and within units. We also need a more flexible infrastructure that is fit for the purposes we will require for the future.
- **Service development**- our services are somewhat static and require some investment to ensure we are innovating and modernising. We tend to rely on past successes rather than looking to a rather more challenging future context with less

[2] See http://www.cqc.org.uk/sites/default/files/new_reports/AAAG2726.pdf, accessed 10th May 2017

funding and with funders who are only willing to pay for treatment for the most complex mental health needs.

- **Environment** – we have beautiful grounds and buildings, but we need to have a more flexible environment that can meet modern mental healthcare demands.

The report from the focused inspection in February 2017 reiterated the strengths from the previous report, but pointed out that we also must ensure that:-

- Care and treatment is provided in a safe way for patients.
- Risks to the health and safety of patients receiving the care or treatment are assessed and mitigated.
- All premises are clean and safe with suitable equipment and facilities.
- Patient dignity and respect are considered and acted in accordance with at all times.
- All safeguarding incidents are reported.
- Appropriate planning and governance processes are in place

Our quality improvement plan, in Appendix A, addresses all of these concerns, the indicators we will use to measure the improvement in quality are outlined in Appendix B and the flowchart in Appendix C shows how we will monitor, progress and embed the quality improvement plan.

Appendix A: Quality Improvement Plan

This Plan is responding to the following requirement notice and enforcement action, as detailed in the CQC inspection report of 13th February 2017. It is also in response to the accompanying warning notices - ENF1-3909457876, ENF1-3909457801, ENF1-3672186936. It is part of our emerging strategy and it fits with our ongoing plans for the development of The Retreat.

Requirement notice

The provider did not ensure that each person's privacy must be maintained at all times including when they are asleep, unconscious or lack capacity.

How the regulation was not being met:

One patient on George Jepson unit had been moved to a room that was not personalised and did not offer the patient privacy; there was no privacy film on the door panel or windows. Patient belongings were stored in a basket on the floor in the room.

This was a breach of 10(2)(a).

Enforcement action

The provider did not ensure that systems and processes were established and operated effectively to prevent abuse of patients.

How the regulation was not being met:

Staff did not report safeguarding concerns for patients on Allis unit; this included nurses, support workers, psychologists, dietician, physiotherapy and the chaplain. One member of staff descried the move as a 'done deal' and another told us that they had raised concerns with the manager. This was a breach of 13(2).

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **CQC KLOE Safe:** The provider must ensure that care and treatment is provided in a safe way for patients. **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 3:** Improve the recruitment and retention of staff						
How the regulation was not being met 1: Both units had ligature risks and blind spots. We found that staff could not always see patients on the unit.	**Immediate:** Update the Environmental Risk Policy (HSR 20) to include: • Changes in roles and responsibilities; • Inclusion of a specific Ligature Risk Assessment Form; • Review the current Risk Assessment Form in place for the overall unit environment (including bedrooms).	7th July 2017	In progress	Minimal - mitigate risks through heightened awareness of environmental risk assessment process	Interim Registered Manager/Audit & Information Manager	New version of the Environmental Risk Policy HSR 20 policy & procedures (which includes formats for the assessment of environmental risks).
	Complete all environmental and ligature risk assessments (including bedrooms) on each Unit as per guidance outlined in the policy. This will involve:	31st July 2017	In progress	Minimal - mitigate risks through heightened awareness of environmental risk assessment process	All Unit Managers	MDT minutes. Individual Risk Assessments. Updated Care Plans. Unit Manager checks of Care Plans

	• Ligature audits being completed annually unless there have been changes made to the room. • Risk assessments for patients should be completed regularly particularly on admission and when there is a change in circumstance with their clinical presentation). • Uploading specific patient risks to individual risk management plans on the Care Partner EPR System. • Including Unit wide risk on the Unit Risk Register via the Ulysses System. This leads to identified risks in the environment consequently feeding into individual risk management plans on the Care Partner EPR System and these will be shared with the wider MDT and staff					and Risk Assessments to be included in managers' monthly report.

	team. • Carrying out periodic checks on individual Care Plan and Risk Assessments to monitor that they reflect current unit environmental risks.					
	Longer term: Improve the awareness, embedding and use of Policy HSR 20 and its procedures through the development and implementation of a staff intranet, which will allow the organisation to monitor awareness and understanding of all policies.	31st December 2017	Development of intranet agreed at Leadership Team; plans in progress	Staff awareness, understanding and use of the environmental risk process is being closely monitored, so patient impact should not be negative	IT Consultant/IT Officer Learning & Development Manager	Implementation of an Intranet. Data from intranet quizzes and read audits.
	We are carrying out a site feasibility study to bring about change to the environments to include mitigation of ligature and blind spot risk. Risk areas that remain will be picked up on the unit environmental risk	1st December for feasibility study report Between June 2018 – June 2020 for the work emerging from the feasibility	Expressions of interest for feasibility study received.	Risks mitigated through observations, environmental risk assessments, MDT discussions, care planning and individual risk assessments	Feasibility Study working Group Leadership Team & the Trustee Directors	Feasibility Study report Works plans

	assessments.	study				
How the regulation was not being met 2: We found there to be unsafe and unsuitable staffing levels and skill mix on both units; during the move there was only one qualified nurse allocated to cover both units on a regular basis.	**Immediate:** In March 2017 Unit Managers carried out a review of their safe staffing levels which resulted in adjustments to the agreed establishment figures and budgets. Staffing levels are discussed as a daily agenda item at the morning Unit Managers meeting.	31st March 2017	Review completed & staffing levels being checked at the morning Unit Managers meeting each day	Minimal because patient care will only be impacted if staffing issues cannot be resolved. Even if staffing issues cannot be resolved the skill mix in the shift should minimise patient impact.	All Unit Managers	Actual staffing levels (from HR)
	Database of daily staffing records to be developed	31/8/17	In progress	Minimal	Interim Registered Manager	Database records
	Each morning the Site Co-ordinator will contact each of the Units to identify deficits in daily staffing, as will be stated in revised Site Coordinator Procedure.	Ongoing throughout 2017	Changes to the Site Coordinator Procedure in progress	Minimal	Site Co-Ordinators	Site Coordinator records in handover book
	If staffing levels are identified as low it is the role of the Site Coordinator to support and coordinate additional	Ongoing throughout 2017	Changes to Site Coordinator Procedure in progress	Use of agency staff can have a negative impact on patients – mitigated by this action	Site Co-Ordinators	Site Coordinator Procedure

	staffing. The process is as follows: Step 1 - The Site Coordinator will liaise with the nurse in charge to find resource within the hospital Step 2 - Obtain staffing support from Bank. Step 3 - As a last resort obtain staffing support from agency. This procedure is outlined in the Site Coordinator Procedure.					
	Recruiting a Night Site Coordinator to manage the bank and oversee agency use. This will ensure that staffing is more closely monitored and that use of agency and bank are managed more effectively	30th September 2017	Job advertisement currently in place for a Night Site Coordinator		Interim Registered Manager	Presence of a Night Site Coordinator
	Learning & Development Manager will ensure that Site Co-ordinator training supports the requirements of the Site Co-ordinator procedure	31st August 2017	Changes to Site Co-ordinator training in progress		Learning & Development Manager	Site Co-ordinator training programme contents and training stats
	Longer Term:		Work stream		HR Manager & HR	New Recruitment

	Employer of Choice Work stream implemented to develop a Recruitment and Retention Strategy, which will be accompanied by implementation plans. Where additional staffing is required we will use our Proposal for Changes Template. (See Change Management Policy and Procedure for further information)	31st December 2017	established		Consultant	and Retention strategy Fewer staff leaving More staff recruited
	Employer of Choice Strategy Work stream includes a Rostering Project to improve the efficiency and effectiveness of staffing rotas.	31st May 2018	Work stream established		HR Manager & HR Consultant IT Manager & IT Consultant All Unit Managers	New Rostering system in place
	We're conducting a formal review of Bank and Agency usage. This will inform future planning for staff shortages.	31st October 2017	Review started		Interim Registered Manager Night Site Coordinator HR Consultant & IT Consultant	New process for bank and agency use
	We are implementing a staff intranet to improve	31st December 2017	Development of intranet agreed		Marketing and Communications	Staff intranet to improve

	communication and improve access and embedding of operational policies and procedures		at Leadership Team; plans in progress		Manager	communication and improve access and embedding of operational policies and procedures
How the regulation was not being met 3: Patient risk plans were not all up to date and there were no patient risk assessments relating to the flooring work being completed on the George Jepson unit.	**Immediate:** To ensure that risk assessments are always updated each unit has a log to act as a prompt.	31st August 2017	Some units have this log in place (Acorn), the others are being asked to ensure they are putting it in place. Risk Management Policy and Procedures in process of being reviewed and adjusted.	Impact mitigated by additional monitoring by Unit managers are part of their monthly reporting	All Unit Managers Audit & Information Manager Risk & Quality Officer	Unit managers' monthly report and bi-monthly care plan audits as part of the annual Clinical Audit Programme. Monthly patient records check Management supervision notes
	It is the responsibility of the key worker & associate key worker to update the risk assessment. This will be outlined in our Risk Management Policy and Procedures.	31/8/17	In progress	N/A	All Unit Managers All Key workers & associate key workers	Care Partner records and the Care Plan Audit programme
	To address systemic issues relating to decision making around operational and	Ongoing 2017 (already in	In place and being used	N/A	Leadership Team	Log of decisions made at Leadership Team and Board

	environmental changes we have implemented a Change Management system. A set of guidelines are available to all staff together with a Proposal for Changes template to ensure that all operational/ environmental change proposals are presented in a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our Change Management Policy which outlines the process to be followed when proposing operational or environmental change.	place)				Level for operational & environmental change
	To ensure that we have up to date risk plans when change such as the flooring work on George Jepson is proposed the proposal for change	In place	Process being used	N/A	Unit managers Leadership Team	Examples of proposals for change (George Jepson Phase 2 flooring)

	process must always include relevant risk assessment and patient impact assessments. See Proposal for Change Protocol & guidelines **Longer term:** Embed importance of incorporating relevant risk assessments into all Proposals for Change and subsequent project plans we are improving access to related policies & procedures by implementing a staff intranet.	31st December 2017	Development of intranet agreed at Leadership Team; plans in progress	Negative impact mitigated by additional monitoring by unit managers	Unit managers Leadership team IT Consultant Sales & Marketing Manager	Care Partner records
How the regulation was not being met 4: Not all incidents were reported on the provider's incident management system; this meant the provider could not act on minimising all risks	**Immediate:** We have a robust IT incident reporting system that all staff are trained to use to report all incidents. The Risk & Quality Officer visits all units to ensure they understand the system & how to use it. In addition, the Risk & Quality Officer has a session during the staff	Completed	Reporting system and training in place – updating and ensuring its embedding is ongoing.	N/A	Risk & Quality Officer All staff – incident reporting is everyone's business	Daily incident reports Quarterly analysis of incidents for the Clinical Governance Group.

to patients.	induction programme on incident reporting					
	Longer term: To embed the importance of recording incidents we are improving access to policies by implementing a staff intranet.	3/18 & ongoing	Development of intranet agreed at Leadership Team; plans in progress	Negative impact mitigated by Risk manager and unit managers raising awareness through attending unit business meetings and including it in Management Supervision.	Unit Managers Leadership Team IT consultant Marketing and Communications Manager Learning development manager	Intranet Audit of access to policies and procedures
Regulation 17, (1 2 b c), Good Governance, of the Health and Social Care Act 2008 (regulated activities) Regulations 2014: **Safe:** The provider must ensure that risks to the health and safety of patients receiving the care or treatment are assessed and mitigated. **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes						
How the regulation was not being met 1: Neither unit had an environmental risk register relating to the flooring refurbishment of George Jepson.	**Immediate:** To ensure that environmental risks are registered when bringing about operational and environmental changes we have implemented a Change Management system. A set of guidelines	Completed	Implemented	N/A	Leadership Team	Log of decisions made at Leadership Team and Board Level for operational & environmental change

	are available to all staff together with a Proposal for Changes template to ensure that all operational/ environmental change proposals are presented in a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our new Change Management Policy which outlines the process to be followed when proposing operational or environmental change.					
	Unit managers to familiarise themselves with the Change Management Policy & Procedures	31/8/17	In progress	Minimal	Unit Managers	Part of key policy sign-off
	Longer term: To embed the importance of incorporating	31st March	Development of intranet agreed	Negative impact mitigated by the	Unit Managers	Examples of proposals for

	environmental risks into all proposals for change and subsequent project plans we are implementing a staff intranet.	2018	at Leadership Team; plans in progress	Risk & Quality Officer and Unit Managers raising awareness through attending unit business meetings and including it in Management Supervision.	Leadership Team IT consultant Marketing and Communications Manager	change (George Jepson Phase 2 flooring)

Regulation 17, (1 2 b c), Good Governance, of the Health and Social Care Act 2008 (regulated activities) Regulations 2014: **Safe:** The provider must ensure that all premises are clean and safe with suitable equipment and facilities. **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 3:** Improve the recruitment and retention of staff **The Retreat's Strategic Objective 4:** Develop as a Centre of Excellence in compassionate care						
How the regulation was not being met 1: Although there were no patients on Allis unit at the time of inspection, the unit was dirty, damp and cold;	**Immediate:** We have entered into a voluntary agreement with the CQC not to use the Allis unit unless significance works have been completed and approved by the CQC. We have no intention of using this unit again without CQC	Completed	Completed	N/A	Chief Executive	Letter of voluntary agreement

there was limited hot water and unsuitable kitchen, toilet and bathing facilities.	approval. To ensure that a similar situation will never occur again we have introduced a Change Management system for all operational and environmental changes. A set of guidelines are available to all staff together with a Proposal for Changes template to ensure that all operational/ environmental change proposals are presented in a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our Change Management Policy which outlines the process to be followed when proposing operational or environmental change.	Ongoing (already in place)	In place and being used	N/A	Leadership Team	Log of decisions made at Leadership Team and Board Level for operational & environmental change
How the regulation was not being met	**Immediate:** We undertake monthly					Medication audits

2: There was no clinic room on Allis unit and medicines storage was not in keeping with best practice when we visited.	Medication Audits which include a question about the safe storage of medicines. If that indicates any issues with medicines storage the unit manager will take immediate action in line with recommendations from the Clinical Audit Action Plan. This will not happen again as all operational and environmental changes are now governed by the Change Management Policy.	Completed Completed	Implemented Implemented	N/A N/A	Pharmacist Unit managers Audit & Information Manager Leadership Team	as part of annual Clinical Audit Programme Log of decisions made at Leadership Team and Board Level for operational & environmental change
How the regulation was not being met 3: We did not see, and were told by one nurse that worked on Allis unit, that there was no grab bag on the unit; a grab bag contains items to use in an emergency such as	**Immediate:** All units now have access to grab bags on their unit. The Resuscitation Policy (PC10) states that the Unit Manager is responsible for the weekly auditing of grab bag contents and location using a checklist.	Complete Complete	Implemented Implemented	N/A N/A	Unit managers Reception staff Site Coordinator Unit managers	Presence of grab bags Grab bag audits Grab bag audits

resuscitation equipment or emergency medications. The provider told us that the closest grab bag was on another unit directly below the Allis unit.	**Longer Term:** Weekly Grab Bag check results are part of unit weekly check records.	31st August 2017	In progress	N/A	Unit managers	Unit weekly checks
How the regulation was not being met 4: On George Jepson unit cleaning charts were not available in all patient bedrooms and support staff were not adequately protected when cleaning	**Immediate:** Discuss cleaning requirements with Unit Managers and implement appropriate improvements as per their recommendations **Longer term:** Create & implement a hospital wide cleaning operational plan with Unit Managers. This will involve:- A review of daily checking system and checklist Domestics' Supervisor to check works complete against a checklist. Once complete checklist	31st July 31st October 2017	In progress Identified as part of work stream developments	N/A The immediate actions will mitigate the impact, ensuring that cleanliness and records of cleaning are maintained	Director of Finance, IT & Support Services Director of Finance, IT & Support Services Unit managers Domestic Supervisors	Immediate actions Place audits Completed checklists Reports from unit managers

	should be signed by Supervisor and Unit Manager.					
	Training needs analysis for domestic team and training plans for the team, including:- Defensible documentation Infection control Mental Health Awareness Safeguarding Incident reporting	30th November 2017	In progress	The immediate actions will mitigate the impact, ensuring that cleanliness and records of cleaning are maintained	Learning & Development Manager	Training records
	As part of our Strategy Work streams: we are conducting a review of culture and systems within Domestic services .	31st March 2018 and ongoing	In progress	PLACE and infection control identifies when things go wrong and immediate actions can be put in place.	Director of Finance, IT & Support Services Interim registered manager	PLACE audits Staff survey Cleaning records Central Services Audit Quarterly Clinical Governance Report
Regulation 10 HSCA (RA) Regulations 2014 Dignity and Respect: The provider must ensure that patient dignity and respect are considered and acted in accordance with at all times **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes						

The Retreat's Strategic Objective 3: Improve the recruitment and retention of staff **The Retreat's Strategic Objective 5:** Enable the people who use our services to find meaningful engagement within their communities						
How the regulation was not being met 1: On GJ patients were unable to use the conservatory, quiet room or access the garden.	**Immediate:** Patients now have full access to the conservatory, quiet room and access to the garden.	Complete	Complete	N/A	George Jepson Unit manager Maintenance Lead Porters	Rooms can be viewed - now accessible and usable
How the regulation was not being met 2: On George Jepson unit staff were unable to spend meaningful time engaging with patients as they were responding to other patient needs.	**Immediate:** George Jepson now has a timetabled activity programme in place.	Complete	Complete	Positive impact	George Jepson Unit manager	Briefing sheet outlining what meaningful activity looks like on George Jepson.
	Sharing the Learning: Katherine Allen to share how they record meaningful activity.	30th June 2017	Meetings taking place	Activity already in place so impact negligible	Katherine Allen Unit manager	
	We have a key worker role in place to record individual, meaningful engagement which is fed into the MDT via the OTs.	Complete	Complete, but ongoing		George Jepson Unit manager OTs	MDT notes
	Longer term: George Jepson is taking a	31st December	In progress, but	Negligible because	George Jepson Unit	

	step by step approach to improving record keeping around meaningful activity.	2017	cultural change so will take time	activity taking place	manager	Care plans Activity records Meaningful engagement strategy document
	As part of our Strategy Work streams: We are developing a Meaningful Engagement Strategy.	31st March 2018	Identified as a work stream and OTs working on this already	Negligible because activity taking place	OT Lead	As part of our Strategy Work streams: We are developing a Meaningful Engagement Strategy.
How the regulation was not being met 3: Doors were locked on the units and patients were not risk assessed to be able to leave the units unescorted or without permission. Not all staff had swipe fobs to be able to leave the unit or access to the duty room.	**Immediate:** Unescorted leave to be included on MDT forms and discussed at MDT and then incorporated into the risk assessment. This will be linked to the Restricted Practice Plan. This will occur on all units, not just to GJ unit.	30th June 2017	In progress	Some possible restrictions relating to unescorted leave, but mitigated by individual approach to patient requirements and MH status	Unit managers	MDT form MDT notes Restricted Practice Plan Risk Assessments Section 17 Leave Policy
	Section 17 Leave Policy revised to include risk assessment.	30th June 2017	In progress		MH Law Lead Policy Development & Ratification Group	Section 17 Leave Policy revised to include risk assessment.

	Agency staff have fobs, which are monitored. All fobs are numbered as part of the sign out process.	30th June 2017	Complete	N/A	George Jepson Unit manager	Fob records
	Longer term: An identified person responsible for Security for each unit - responsible for distributing and recalling keys and alarms.	30/9/17	Role already in place on George Jepson unit.	N/A	Unit managers	Security person role description
	George Jepson is replacing mortice locks with fobs.	30th September 2017	In progress	N/A	George Jepson Unit manager Maintenance Lead	Mortice locks no longer in place

Regulation 17, (1 2 b c), Good Governance, of the Health and Social Care Act 2008 (regulated activities) Regulations 2014:

The provider must ensure that all safeguarding incidents are reported

The Retreat's Strategic Objective 1: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly

The Retreat's Strategic Objective 2: Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes

The Retreat's Strategic Objective 3: Improve the recruitment and retention of staff

How the regulation was not being met: The provider did	**Immediate:** All staff trained on safeguarding prior to working on any clinical	Complete	Though complete, it is an ongoing process	N/A	Safeguarding Lead Learning & Development manager	Training records

not ensure that systems and processes were established and operating effectively to prevent abuse of service users. Staff did not report safeguarding concerns for patients on Allis unit	unit, as part of induction, with regular updates.				Social work team	
	Information about how to raise a safeguarding alert is clearly visible on the ward.	Complete	Complete	N/A	Safeguarding Lead	Check units for presence of poster
	All Management Supervisions include a check on safeguarding – reminder on management supervision template	Complete	Reminder on template now; implementation ongoing	Provided this check is in place and used, there should be no impact on patients	All managers	Management supervision template Management supervision records
	We have a robust IT safeguarding reporting system that all staff are trained to use to record all safeguarding concerns and the Risk & Quality Officer visits all units to ensure they understand the system & how to use it. In addition, the Risk & Quality Officer has a session during all staff inductions on incident reporting which also covers reporting safeguarding concerns.	Ongoing	All units visited, but ongoing process	IT system and training already in place, but until it is all completely embedded culturally the unit managers will need to ensure it's checked regularly to ensure all safeguarding concerns are being reported.	Risk & Quality Officer Unit managers All staff (safeguarding is everyone's business)	Training records Safeguarding reports (quarterly for governance and externally for LSB)

	Social Work Team visit all units to ensure they understand roles and responsibilities within safeguarding	Implemented	This is already implemented, but will be an ongoing process, constant updates		Social work Lead All managers All staff	Social work team log
	Robust IT systems in place to report on and identify safeguarding themes.	Completed	Implemented	N/A	Risk & Quality Officer All staff	Quarterly Clinical Governance report
	Service users and carers are also trained / and or provided with information on safeguarding.	Completed	Implemented	Positive impact because they understand safeguarding	Social work team Involvement team with Unit staff	Service users and carers' reporting
	Positive working with the CYC, Director sits on Local Safeguarding Board, Multiagency agency best practice Group, Safeguarding Training Group.	Completed	Implemented	N/A	Director responsible for safeguarding Safeguarding Lead	Minutes of LSB meetings
	Longer term: We have a safeguarding group within the new governance structure.	31st July 2017	Ongoing	N/A	Audit & Information Manager Safeguarding lead	Terms of Reference for the Safeguarding Group Minutes of the Safeguarding Group meetings

	Safeguarding strategy developed and implemented.	31st December 2017	Safeguarding strategy written in the process of being implemented	N/A	Safeguarding Lead	Safeguarding strategy document Safeguarding strategy implementation updates
	To embed the importance of recording safeguarding concerns we are implementing a staff intranet so that this is fully communicated and monitored.	31st March 2018	Development of intranet agreed at Leadership Team; plans in progress	N/A	IT Consultant Marketing and Communications manager	Use of intranet Audits carried out through intranet
	Develop plan to address the issue of agency nurses accessing Care Partner and Ulysses	31st March 2018	Planned as part of the strategy work streams	N/A	Interim Registered Manager	Training records Agency use of electronic care records and reporting systems

Regulation 17, (1 2 b c), Good Governance, of the Health and Social Care Act 2008 (regulated activities) Regulations 2014: The provider must ensure that appropriate planning and governance processes are in place; this includes ensuring that environmental and patient risks are identified, captured, managed and communicated with patients, families and staff when making decisions that affect the service. **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 3:** Improve the recruitment and retention of staff						
How the regulation was not being met: The provider did not ensure that systems and processes were established and operating effectively to prevent abuse of service users. Staff did not report safeguarding concerns for patients on Allis unit	**Immediate:** New governance structure	31st July 2017	The new Governance groups have been identified; implementation has begun.	N/A	Audit & Information Manager Leadership Team	Governance structure Terms of Reference for Governance Groups
	We have implemented a system to manage operational or environmental changes across the organisation. A set of guidelines are available to all staff together with a Proposal for Change template to ensure that all operational/ environmental change proposals are presented in	Completed	Implemented	N/A	Leadership Team	Log of decisions made at Leadership Team and Board Level for operational & environmental change

	a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our Change Management Policy, which outlines the process to be followed when proposing operational or environmental change.					
	Ensure works programme is communicated to all involved personnel and that it links to relevant strategic change procedures	31st December 2017	In progress	Should not be any significant impact because of other measures	Director of Finance, IT & Support Services Maintenance Lead	Works programme documentation

Appendix B: Measuring our Quality Improvement

How will we know when we have achieved improvements in quality?

1. **Improved quality**, as measured by an improvement in CQC inspection grading, levels of complaints, accreditation of services

2. **Financial stability** from a day to day operations point of view.

3. **At least 90% occupancy**. We will require high occupancy levels but may reduce the number of beds we offer, if we find we can fund alternative services such as day patients, outpatients, inreach and outreach.

4. **Improved staff satisfaction**, as measured by the staff survey, by sick leave figures, by staff turnover, which should be reduced, by managers through management supervision and through the staff friends and family test

5. **High service user and family satisfaction**, as measured by service user and carer surveys, friends and family test, levels of complaints

6. **Positive outcomes** for service users, as measured by appropriate formal outcomes measures, long term mental wellbeing and no return to inpatient services, level of safeguarding incidents, comparison with similar patients in other services

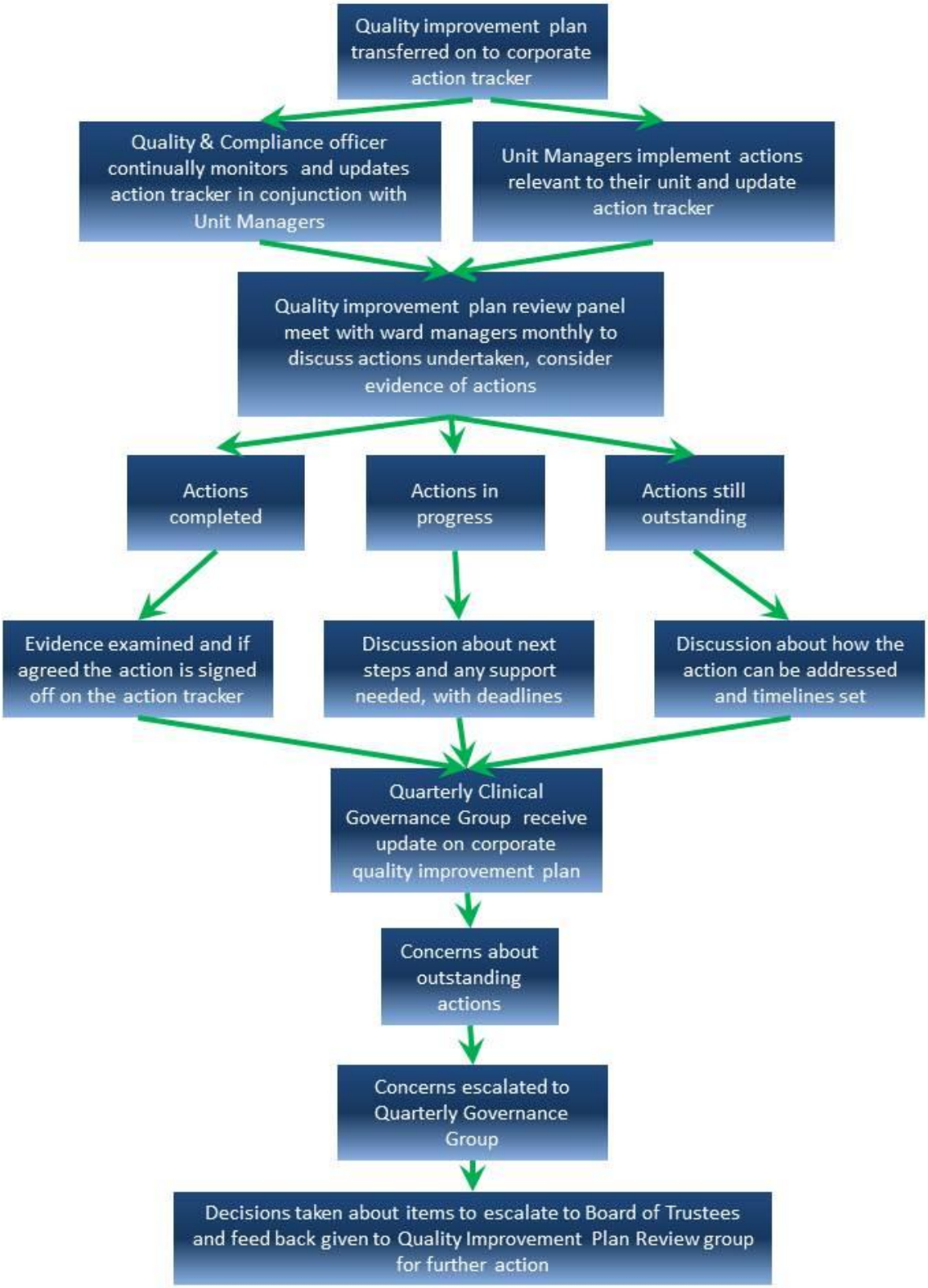
7. **Positive reputation**, as measured by levels of referrals, commissioner feedback, publications, press coverage, waiting lists for patients and for recruitment, invitations to conferences, fewer agency staff (because more employees), visitors from all over the world, invitations to become involved in policy development activities, numbers of appropriate and successful partnerships

8. **Development of practice based evidence**, as measured by numbers and quality of research publications, research grants awarded, presentations at conferences

9. **Expansion,** as measured by financial returns and number of Retreat locations

10. **Modern buildings,** resulting from actions taken from our Options Appraisal.

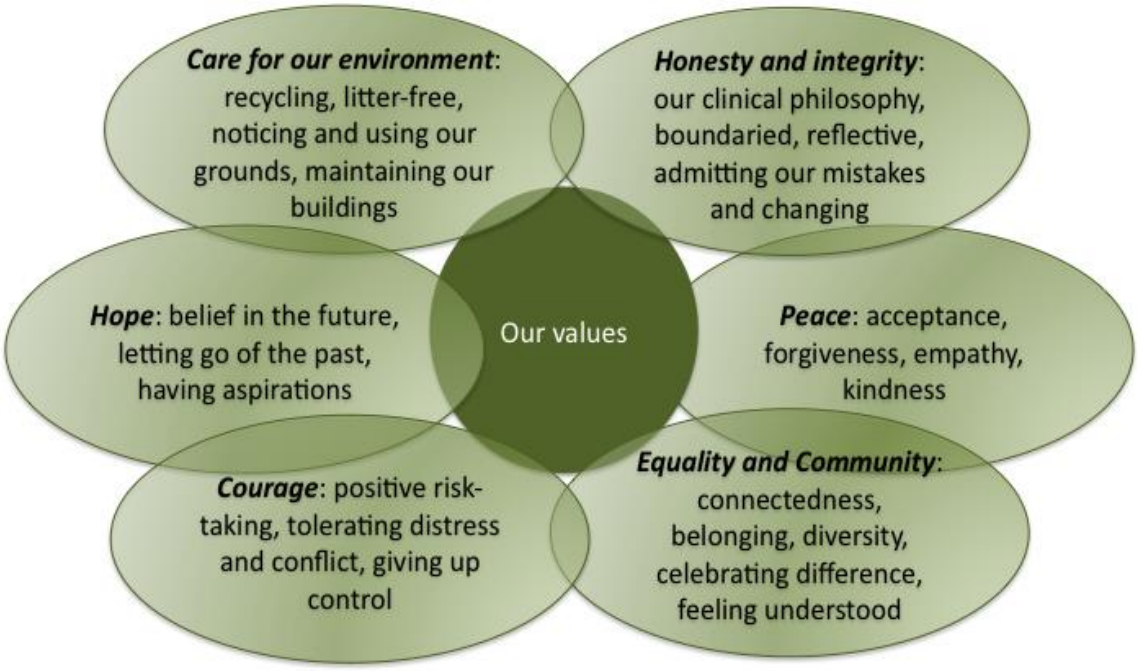
Appendix C: Progress Monitoring flowchart



Appendix D: The Retreat's Values

Our values are rooted in the Quaker values of Hope, Equality and Community, Courage, Care for our Environment, Peace, Honesty and Integrity. We aim to implement these values in every aspect of our work. The diagram below shows what this set of values means for The Retreat currently.

Our values



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The Retreat Community

Compassion Collaboration Community

CQC Action Plan Summary

Staffing levels

Recruitment of Night Site Coordinators to support units.
Review of Bank system to reduce agency use.

Safeguarding

Provide more comprehensive support for the implementation of learning from safeguarding training.

Managing operational change

Implement and embed a Change Management Policy.
Introduce Unit Impact Assessments as part of the process.

Medicines storage

Review clinical storage areas. Take action where necessary.
Monthly Medication Audits in place.

Emergency response

Audited Grab Bags available on all units and in other key areas.

Meaningful activity

Timetabled activity on George Jepson. Improved record keeping of meaningful activity.

Cleaning plans

Review of hospital wide cleaning operational plan and improve training for domestic team.

Our Vision	Our Mission	Our Values
To deliver innovative, high quality specialist mental health services through compassion, collaboration and community	In a beautiful setting, we promote and support the well-being of people affected by mental ill-health, working with them to nurture their unique potential so that they can have a life worth living	Care for the environment Honesty and Integrity Peace Equality and Community Courage Hope

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ANNEX 3

The Retreat - York

Quality Report

107 Heslington Rd
York
YO10 5BN
Tel: 01904412551
Website: www.theretreatyork.org.uk

Date of inspection visit: 13 February 2017
Date of publication: 14/06/2017

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

Ratings

Overall rating for this location	**Inadequate**
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Requires improvement**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

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

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

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

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

ANNEX 3

Summary of findings

Overall summary

We rated the Retreat York as **inadequate** because:

- In January 2017 hospital managers decided to move six patients to the previously closed Allis unit for a six week period. When we visited there were no patients on the unit, however Allis unit appeared dirty, damp and cold. There was limited hot water and unsuitable kitchen, toilet and bathing facilities. We saw a lack of proper planning and staff allocation in relation to the cleanliness of Allis unit. We did not see, and were told by one nurse that worked on Allis unit, that there was no grab bag on the unit; a grab bag contains items to use in an emergency such as resuscitation equipment or emergency medications. The provider told us that the closest grab bag was on another older people's unit directly below the Allis unit. There was no clinic room on Allis unit and medicines storage was not in keeping with best practice when we visited. Neither unit had an environmental risk register to identify and prevent risks to the patients that could have occurred because of the changes relating to the flooring refurbishment of George Jepson.
- We found there to be unsafe and unsuitable staffing levels and skill mix including the allocation and availability of qualified nursing staff on both Allis and George Jepson units. Staff were unable to spend meaningful time engaging with patients as they were responding to other patient needs.
- Units had ligature risks and blind spots that were not continually managed with observations. On George Jepson unit, patients were unable to use the conservatory, quiet room or access the garden. Staff could not always see patients on the unit when they were on observations. Staff locked entrance doors to the units and patients were not individually risk assessed to be able to leave the units unescorted or without permission. Not all staff had swipe fobs to be able to leave the unit or access to the duty room.
- We saw no record of timely discussions with patients or families in relation to the move to Allis unit. We saw that families had concerns regarding the Allis unit and did not find evidence that the provider had prioritised patient dignity in terms of the move. We saw evidence that families told the provider how their relatives had been disoriented on both units when the flooring work was being completed and gave examples of when staff had become distracted and had been unable to complete their personal care.
- We saw no effective system for identifying, capturing and managing issues and risks at team and organisation level in relation to the flooring work on George Jepson during our inspection or in any of the information provided by the Retreat York. There were significant issues that threatened the delivery of safe and effective care and these were not identified.
- We saw no documented evidence of a multidisciplinary discussion around suitability of patients to move or the impact on the patients that remained on the George Jepson unit. The provider was unable to locate and evidence details of personalised risk assessments, environmental risk assessments and personal evacuation plans.
- Families told us that there were not enough activities for the patients on the unit and we saw this to be the case.

However:

- George Jepson unit was clean and smelt fresh in both communal areas and patient bedrooms. Resuscitation equipment was available, medicines storage was well organised and we saw staff using correct equipment when moving patients as detailed in patient care plans.
- We saw that the provider monitored incidents and acted on incidents reported. Families and carers of patients were informed of incidents when they occurred.
- Patients who were able to communicate told us that they liked being on George Jepson unit and that staff were kind. Families described the staff as caring and supportive and George Jepson unit as a wonderful place in spite of the shortcomings.
- All staff described their close working relationships and enjoyment of their roles. We observed staff to be friendly and caring to patients; staff considered patients' needs; we saw that patients that needed help with personal care were clean.

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Summary of findings

Full information about our regulatory response to the concerns we have described in this report will be added to a final version of this report which we will publish in due course.

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Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for older people with mental health problems	Inadequate 	

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Summary of findings

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Inadequate

The Retreat York

Services we looked at

Wards for older people with mental health problems;

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Summary of this inspection

Background to The Retreat - York

The Retreat York was established in 1796 and is an independent specialist mental health care hospital for the treatment of up to 98 people with complex mental health needs. The hospital is located on a forty acre site on the outskirts of York. The main building is Grade II listed with a range of buildings situated in the grounds.

George Jepson unit is a 13 bedded unit located on the ground floor of the main building that provides specialist care and treatment for men who have a primary diagnosis of a functional or organic disorder such as dementia. It supports patients who may have challenging behaviour. There were 12 patients on the unit during our inspection.

George Jepson unit has been previously inspected on four occasions.

The previous inspection on 29 November 2016 rated wards for older people with mental health problems as requires improvement. We found that the following regulations were not being met:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care. The provider did not ensure that on older people's units, the care and treatment of all service users was appropriate and met patients' individual needs.
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. The provider did not ensure that staff responsible for the management and administration of medication were suitably trained, competent and reviewed. Staff were not following policies and procedures about managing medicines, including those related to infection control.
- Regulation 18 HSCA (RA) Regulations 2014 Staffing. The provider did not ensure that all staff received appropriate support, professional development supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

We have asked the provider to meet these requirements and provide an action plan.

There was an inspection on 27 October 2015 of wards for older people with mental health problems, specialist eating disorders services and the personality disorder therapeutic community that resulted in a requirement notice for Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. We found that the provider had not ensured the proper and safe management of medicines and that patients at risk of falls did not have comprehensive plans in place to mitigate this risk including wearing safe footwear. During this inspection we saw that patients had falls risk plans in place, however two patients during the inspection had no footwear on until the nurse prompted staff.

We undertook a focused inspection of the George Jepson unit on 10 May 2015. The inspection followed an anonymous whistle-blowing concern and safeguarding investigation. The inspection identified staffing shortages and was reported in the 27 October 2015 inspection report.

The last Mental Health Act visit to the George Jepson older peoples unit was on 27 October 2015. We did not see evidence of a range of therapeutic activities on the unit. The corridor leading on to the unit was used at times as a place for patients to eat meals. There was little evidence that discharge planning was taking place.

Allis unit is located in the main building of the Retreat York. Six patients were moved from George Jepson unit to Allis unit from 11 January 2017 to 3 February 2017. The provider previously closed the unit to inpatients in 2015 as it was unsuitable for the patient group that resided there. There were no patients on Allis unit on either occasion we visited the unit.

The Retreat York has been registered with the Care Quality Commission (CQC) since October 2010 to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Personal care

The hospital had a registered manager and a controlled drug accountable officer at the time of inspection. A registered manager is a person who has registered with

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Summary of this inspection

the Care Quality Commission to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

A controlled drugs accountable officer is a senior person within the organisation with the responsibility of monitoring the management of controlled drugs to prevent mishandling or misuse as required by law.

Our inspection team

Team leader: Clare Stewart, Inspector, Care Quality Commission.

The team that inspected the service comprised three CQC inspectors.

Why we carried out this inspection

We carried out an unannounced inspection of this service after the provider informed us that 13 safeguarding alerts had been reported to them by two staff members on 03 February 2017. The alerts related primarily to staff delivery of patient personal care, inappropriate moving and handling of patients, and staffing shortages. These alerts also contained reports of bullying within the staff team. The reported incidents had occurred during the period the 11 January 2017 to 3 February 2017 when six patients from George Jepson unit were moved to another unit, the 'Allis' unit , while refurbishment work took place on the George Jepson unit. The provider had not informed the Care Quality Commission of their intention to move patients for a six week period. The provider previously closed Allis unit to inpatients in 2015 as they found it unsuitable for the patient group that resided there. There were no patients on Allis unit on either occasion we visited as the provider had closed the unit on 3 February 2017 in response to the safeguarding alerts.

How we carried out this inspection

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

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

Before the inspection we reviewed information that we held about the Retreat York. This information suggested that the ratings of requires improvement for effective and responsive domains, that we made following our November 2016 inspection, were still valid. Therefore, during this inspection, we focused on those issues relating to the safeguarding concerns in the safe, caring and well-led domains. As this was a focussed inspection relating to the safeguarding concerns for George Jepson patients we did not inspect the female older adult unit.

Before the inspection, the inspection team spoke with the chief executive officer, two nurses and one social worker regarding the safeguarding alerts that were raised and attended a safeguarding strategy meeting.

During the inspection visit, the inspection team:

- visited the George Jepson unit, looked at the quality of the unit environment and observed how staff were caring for patients;
- visited the Allis unit and looked at the quality of the unit environment;
- spoke with the acting unit manager for George Jepson unit;
- spoke with four patients who were using the service;
- spoke with two carers of patients on George Jepson unit;
- spoke with six other staff members; including cleaning staff, nurses and support staff;
- attended and observed one handover meeting;
- looked at 12 care and treatment records of patients;
- observed two mealtimes;

Summary of this inspection

- observed one patient having a hoist assessment;
- carried out a specific check of the medication management on the units; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients that were able to communicate told us that they liked being on George Jepson unit and that staff were kind. There were no patients on Allis unit on either occasion we visited as the provider had closed the unit on 3 February 2017 in response to the safeguarding alerts. Families told us that there were not enough activities for the patients on the unit. We reviewed meeting minutes where families told the provider that their relatives had been disoriented on both units when the flooring work was being completed and gave examples of when staff had become distracted and had been unable to complete their duties. We saw meeting minutes where families described the staff as caring and supportive and George Jepson unit as a wonderful place in spite of the shortcomings. We saw in meeting minutes and were told that carers had not been made aware of their relatives moving to another unit prior to the move taking place and best interest discussions had not taken place.

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Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as **inadequate** because:

- Both units had ligature risks and blind spots. We found that staff could not always see patients on the unit. We found there to be unsafe and unsuitable staffing levels and skill mix on both units; during the move there was only one qualified nurse allocated to cover both units on a regular basis.
- Although there were no patients on Allis unit at the time of inspection, the unit was dirty, damp and cold; there was limited hot water and unsuitable kitchen, toilet and bathing facilities. We did not see, and were told by one nurse that worked on Allis unit, that there was no grab bag on the unit; a grab bag contains items to use in an emergency such as resuscitation equipment or emergency medications. The provider told us that the closest grab bag was on another unit directly below the Allis unit. There was no clinic room on Allis unit and medicines storage was not in keeping with best practice when we visited. On George Jepson unit cleaning charts were not available in all patient bedrooms and support staff were not adequately protected when cleaning.
- On George Jepson unit patients were unable to use the conservatory, quiet room or access the garden.
- Neither unit had an environmental risk register relating to the flooring refurbishment of George Jepson.
- On George Jepson unit staff were unable to spend meaningful time engaging with patients as they were responding to other patient needs.
- Patient risk plans were not all up to date and there were no patient risk assessments relating to the flooring work being completed on the George Jepson unit.
- Doors were locked on the units and patients were not risk assessed to be able to leave the units unescorted or without permission. Not all staff had swipe fobs to be able to leave the unit or access to the duty room.
- Not all incidents were reported on the provider's incident management system; this meant the provider could not act on minimising all risks to patients.

However:

- George Jepson unit was clean and odour free in both communal areas and patient bedrooms.
- Resuscitation equipment was available on George Jepson unit.

Summary of this inspection

- The provider used contracted agency staff that were familiar to the unit and patients where possible.
- On George Jepson, medicines were stored in a locked trolley that was attached to the wall. All medicines were in individually labelled boxes with patient names.
- Staff used the correct equipment when moving patients as detailed in patient care plans.
- The provider monitored incidents and acted on incidents reported; Families and carers of patients were informed of incidents when they occurred.

Are services effective?

Requires improvement

At the last inspection in November 2016 we rated effective as **requires improvement**. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating

Are services caring?

Requires improvement

We rated caring as **requires improvement** because:

- Families told us how their relatives had been disoriented on both units when the flooring work was being completed and gave examples of when staff had become distracted and had been unable to complete their duties.
- We saw no record of timely discussions with patients or families in relation to the move. We found that families had concerns regarding the Allis unit and did not find evidence that the provider had prioritised patient dignity in terms of the move.
- Staff were not able to see all patients during mealtimes and one patient was served multiple courses at one time which resulted in cold food.
- Patients did not always have appropriate footwear on the unit. We had highlighted this as a safety issue in a previous Care Quality Commission inspection.
- Families told us that there were not enough activities for the patients on the unit; the activities board was incomplete during our inspection and we saw no activities taking place.

However:

- Patients who were able to communicate told us that they liked being on George Jepson unit and that staff were kind. Families described the staff as caring and supportive and the unit as a wonderful place in spite of the shortcomings.
- We observed staff to be friendly and caring to patients; staff considered patients' needs; Almost all of the patients were clean and personal care was being attended to.

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Summary of this inspection

- Patients were mostly using specialised eating equipment at mealtimes.
- Patients had access to and made use of advocacy services and the provider welcomed advocacy services on the unit.

Are services responsive?

Requires improvement

At the last inspection in November 2016 we rated responsive as **requires improvement**. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- The provider had no effective system for identifying, capturing and managing issues and risks at team or organisation level in relation to the flooring work on George Jepson during our inspection or in any of the information provided by the Retreat York. There were significant issues that threatened the delivery of safe and effective care and these were not identified.
- We saw no documented evidence of a multidisciplinary discussion around the suitability of patients to move or the impact on the patients that remained on the George Jepson unit.
- The provider was unable to locate and evidence details of personalised risk assessments, environmental risk assessments and personal fire evacuation plans.
- The provider had not ensured the staff and facilities needed for cleaning the unit properly were in place prior to and during the patient move to Allis unit.

However:

- All staff described their close working relationships and enjoyment of their roles.

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Detailed findings from this inspection

Mental Health Act responsibilities

We did not review Mental Health Act responsibilities during this focused inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review Mental Capacity Act and Deprivation of Liberty Safeguards during this focused inspection. However we did note that there were no best interest discussions in relation to the move for patients that lacked capacity. Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for older people with mental health problems	Inadequate	N/A	Requires improvement	N/A	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate

Notes

At the last inspection in November 2016 we rated effective and responsive as requires improvement. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating. Ratings from our previous inspection for these domains are reflected in the current ratings for The Retreat York.

Inadequate

Wards for older people with mental health problems

Safe	Inadequate
Caring	Requires improvement
Well-led	Inadequate

Are wards for older people with mental health problems safe?

Inadequate

Safe and clean environment

George Jepson unit

The George Jepson unit consisted of two corridors in an L shape. The unit had blind spots (areas where staff could not see patients at all times). There was an increased risk of harm to patients because the unit contained ligature points. A ligature point is something, which people can use to tie something to in order to strangle themselves. These risks were mostly managed by the provider in line with their observation policy, and individual patient risk plans. The unit was trialling a new observation approach on the morning of our inspection. Observations were used to keep patients safe; when a patient was on a higher level of observation staff were required to check on the patient's whereabouts on a regular basis. The unit comprised of three zones and one member of staff was allocated to each zone. This was to allow staff to know the whereabouts of all of the patients at all times in order to keep them safe. The unit also had an additional two floating staff to support with personal care of patients.

The unit had a fully equipped clinic room available to allow staff to examine and treat patients. The clinic room had a grab bag and resuscitation equipment available and we saw that staff checked and audited these regularly. There was a defibrillator available, and the room was clean and tidy. The unit did not have a seclusion room and when we saw patients becoming agitated, staff distracted them to calm down. The unit was clean and tidy and we saw one domestic staff on duty. Patient bedrooms were clean and odour free. We saw nursing support staff taking patients for breakfast and then returning to patient bedrooms to change sheets and wipe down beds with sterile wipes.

However, staff were not adequately protected and wore no apron or gloves. Cleaning charts were not available in all patient bedrooms. This increased the risk of infection because staff did not follow infection control procedures to protect themselves and patients.

The unit was in the process of refurbishment work to the floor when we visited. The provider had halted the flooring work on George Jepson to settle the patients back on the unit. The Retreat York held a Leadership meeting on the 21st February 2017 to agree the most appropriate way to complete the work. The incomplete flooring was completed by the end of the following week, three and a half weeks after the patients had returned to George Jepson unit. Staff told us that the floor was being refurbished because it was scratched and did not look clean. In order to keep patients safe until the works were completed, staff had sectioned off an area where the uneven concrete floor (approximately one and a half centimetres lower than the rest of the floor) was exposed by placing four armchairs to block patient access. The sectioned off area included one bathroom, one bedroom (both not in use by patients) and access to the fire escape. This meant that patients would need to cross this area to access the fire escape. The uneven floor increased the risk of falls for patients who were already assessed as having poor mobility. We witnessed one patient pushing a wheelchair and another patient self propelling in a wheelchair towards this area. We also saw one patient was able to easily move one of the chairs, leaving the area accessible. Although staff were present on the corridor observing patients, they were not always at the end of the corridor where the flooring was incomplete, and this was potential risk to patient safety. We sought reassurance from the provider who told us that patients were using the area as an additional seating area and that no incidents had occurred in the time that the floor had been unfinished.

As a result of ongoing work to the George Jepson unit flooring, the unit had turned the quiet room, which was at the entrance to the unit, into a patient bedroom. The room

Wards for older people with mental health problems

did not have space for patients to store their personal belongings or clothing. Clothing was being stored in a laundry basket on the floor. The room still had a fully stocked bookcase and sofa left from its previous use. The patient's room had not been personalised. Privacy and dignity could not be maintained in the room as it had viewing panels and windows which faced two unit corridors. The unit had a quiet room, a dining room, a lounge and a conservatory for patients to use. However neither the conservatory nor the quiet room was available to the patients to use when we visited. The conservatory was cluttered and filled with patient belongings from the move to Allis unit. It was not possible for patients to access outside space as a result. Three patient care plans referred to the patients being able to access outside space as a way of calming them down should they become distressed. Maintenance staff from the Retreat York moved some of the belongings during the inspection and another member of staff commented that it was good to have another room for the patients to use. The quiet room was being used as a patient bedroom as an interim measure.

The dining room was small and clean. At mealtimes, patients chose to eat meals in the dining room, lounge or on the corridor. However not all patients could be seated in the dining area with staff supporting mealtimes at any one time. We observed one staff member not wearing an apron or head cover serving food to a patient in the kitchen; however staff adhered to the provider's hand washing policy and washed their hands prior to serving. We also observed that one member of staff had to break off feeding a patient on the corridor to redirect another patient away from the dining room to prevent a negative patient interaction. The patient was unable to feed themselves and required support from staff to eat. We saw that the fridge in the kitchen on George Jepson unit was used by staff to store personal food and drinks. For some items it was unclear where they had originated and not all food was dated.

One agency member of staff pointed out that a basin of urine was left on a chair in the hallway when they were on shift. They told us that they had worked on the unit before however when we saw them being assigned to a corridor for patient observations they did not know where to go. The provider told us that the staff member had worked at the Retreat before and a form was completed and signed confirming that the agency staff member had read all the policies and received orientation.

Staff had not completed the orientation board in the hallway fully. It showed the month and the weather but not the date. One patient's care plan suggested using the board to help orientate the patient; this was not possible on the day of our inspection. We also saw that the staff on duty board had not been completed and the feedback about the unit on display was from September 2016.

We asked the provider for a copy of the environmental risk assessment for the unit in preparation for the work being completed. They told us that it did not appear that an environmental risk assessment had been completed in advance of the work and that disciplinary procedures were being followed with staff involved in the planning because of the increased risk this highlighted for patients and staff.

Staff wore alarms that they could use should they feel at risk from a patient or need assistance to support a patient. Patient bedrooms had nurse call alarms on the walls which patients were able to use as needed. We witnessed the alarms being used when we visited.

Allis unit

We visited Allis unit on two occasions; the first on 9 February 2017, three days after the safeguarding alerts had been received and the second during our unannounced inspection. Allis unit is located on the second floor of the Retreat York main building. There were no patients on the unit on either occasion; all patients had been moved back to George Jepson unit on 3 February 2017 in response to the safeguarding alerts. Staff had reported that the environment was damp and cold and we visited to gain an understanding of the unit where the patients had been relocated to.

The Retreat York had previously closed Allis unit in 2015 as they considered it unsuitable for the patient group that resided there. During the period 11 Jan 2017 to 3 February 2017 six patients were relocated to this closed unit so that the flooring work on George Jepson could be completed. We also saw in handover and activity notes that one more patient from George Jepson unit had visited Allis unit on one occasion. We asked the chief executive officer if they knew of any additional patients visiting Allis unit from George Jepson unit and they told us that they were unaware of this visit.

Allis unit had a long corridor with rooms on either side. The environment was dirty in places with damp patches on walls and ceilings in communal areas such as bathrooms,

Wards for older people with mental health problems

lounges, hallway and patient bedrooms. Staff that had worked on Allis unit told us that the provider had renovated the unit in advance of patients moving, this included painting one patient bedroom to cover mould on the walls. Two of the sofas on the unit had a cushion removed or cushion covers removed.

Although meals were delivered to Allis unit, staff used the kitchen to make hot drinks and prepare snacks for patients. At the time of our visits the kitchen was damp and unclean. Staff told us that there was limited access to hot water on the unit and that they would carry water from the kitchen to patient rooms to help complete personal care. Staff said this was difficult if a patient had to be restrained for personal care.

We spoke with cleaning staff at The Retreat York and reviewed the cleaning communication book. Staff told us that one member of staff had cleaned the unit the day before patients from the George Jepson unit were moved onto Allis unit. We saw an entry in the cleaning communication book that commented that one member of staff had cleaned Allis unit from 10am to 1pm. We saw no clear plan to identify what cleaning needed to be completed in advance of the move. When we visited the unit, we saw blood in the top drawer of one patient's chest of drawers in their bedroom and faeces on another wardrobe door handle. The communication book showed that cleaning staff had queried how the unit was to be serviced for the six week duration when the patients were scheduled to be on Allis. The cleaning staff suggested a basic service, with all staff including clinical, 'mucking in'. On Allis unit we saw a cleaning task list for the unit night staff to complete but saw no records documenting that the tasks had been completed. We also saw in the communication book that a bottle of sanitizer was left in one patient's bedroom on Allis unit; we saw no incident report for this on the provider's incident reporting system.

On 3 February 2017 one member of staff commented in the communication book that patients were being moved back to the George Jepson unit due to the environment on Allis unit. They described the patients as having chest infections and one patient being admitted to hospital due to a chest infection.

We had concerns about the possible inappropriate storage of medications when patients were on the unit. The medicines fridge was located in the kitchen used for preparing food and drinks. Although there were no medicines in the fridge when we inspected, it was unclean and stained on the inside; this is not in line with infection control and medicines management guidance. The medicines trolley was stored in a room which appeared damp and was filled with boxes, when we visited parts of the floor had been lifted exposing pipework. Royal Pharmaceutical Society guidance recommends that 'the storage of medicines needs to be in the right place. Filing cabinets are not suitable for storing medicines, neither are: kitchens, bathrooms, toilets, sluices, windowsills or areas next to heaters. These places are too damp or too warm (or both) or unhygienic for storing medicine.' Humidity can also impact on medicines and as such the provider should follow manufacturer's instructions and risk assessed prior to storage.

On Allis unit there was not a fully equipped clinic room available to allow staff to examine and treat patients. Staff told us that there was no grab bag or resuscitation equipment available on the unit. The provider told us that in the event of an emergency, the care coordinator allocated to the shift would collect the grab bag from reception when responding to an incident. The provider later told us that there was another grab bag available on the female older people's unit on the floor below. The Royal College of Psychiatrists' standards identifies that emergency medical resuscitation equipment (crash bag), should be available within three minutes; we found that this would be unlikely for the crash bag in the reception area as the time is dependent on the fitness and location of the staff responding. The other crash bag on the female older people's unit would be accessible within three minutes providing it was not in use. The provider shared a plan in relation to the move completed by the unit manager. The unit manager's action plan stated that one member of staff on each shift was to be allocated the role of basic life support and fire warden. We saw no record of this in the handover notes that we reviewed. The plan associated with the move had no dates for completion, sign off of actions completed or action owners.

There was one shower room with commode on Allis unit and one bathroom. The shower had a high step into it and was unusable by patients at risk of falls on the unit. Staff told us there was no hot water in the shower. We were told of incidents where staff had to use foam soap to support patients with incontinence with their personal care as there was no bath suitable for patient use on George Jepson unit and they were unable to use the shower on Allis. We saw no

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evidence of the lack of facilities being recorded as an incident on the provider risk register or incident reporting system. The maintenance lead confirmed that there was an issue with the shower but this had not been reported to the maintenance team by staff on Allis unit. The provider could not confirm exact dates when both baths on George Jepson unit were available. They told us that the bath that was in working order was not suitable for the majority of the patient group due to its size and accessibility.

Access to the bathroom on Allis unit was up a ramp and handrails were available. However cubicles were not large enough for staff to support patients using the toilet. We saw an incident recorded where a patient had locked themselves in a cubicle; this resulted in a fall that was preventable.

The unit contained ligature risks and blind spots. Two patients' risk plans indicated they were at risk of suicide; these had not been updated for the move. We did not find that staffing levels limited the potential risks associated with the environmental. The provider told us that during the move no additional staff had been arranged; staff allocated to George Jepson unit also supported Allis unit. There was no formal rota in place differentiating staffing on the units. Staff told us there were three members of staff on the Allis unit to support the five patients that had been relocated there in order to finish the flooring work on George Jepson unit; we saw this recorded in handover notes. The Retreat York completed a review of staffing levels for the duration that the patients were on Allis and identified that a nurse was not always on the unit.

Two patients who moved to the unit had chest infections prior to the move. When we visited Allis unit on 08 February 2017 we found that the unit's temperature fluctuated between rooms; for example one patient's bedroom was very cold and the dining room was too hot. One member of staff told us the environment was cold in places, but that the heating was on when the unit was in use.

Allis unit was accessible via one passenger lift, one goods lift or stairs to the second floor. Staff told us that the lifts were not working consistently. The Retreat York provided incident data from 1 October 2016 to 11 February 2017 and we saw one incident where a patient became irate as both the passenger and goods lifts were not working.

At the time of inspection we found the premises and facilities on Allis unit to be unsafe however there were no patients located on this unit during the inspection period.

Safe staffing

George Jepson unit

The staffing establishment was set at two nurses (or one nurse and one occupational therapist) and five support workers on each day shift from 7am to 8pm. Night shift, which was from 7:30pm to 7:30am, had allocated one qualified nurse and four support workers on shift. This allowed for time for staff to handover information to the new shift each morning and evening. The unit also had a twilight shift where one member of staff worked until 11pm to support the busiest time on the unit. Where there was no twilight shift we saw that the provider increased the number of staff on a night shift. The staffing establishment did not include additional staff for one to one observations and only ensured coverage of zonal observations. During our inspection one patient was on one to one observations and planned staffing levels accommodated this. We reviewed the patient care records and saw that six patients were also on high level observations. This meant that staff on environmental observations had to know their whereabouts at all times to maintain patient safety. We observed this to be difficult during our inspection.

When we visited the unit, there was a qualified nurse on duty and six support workers on night shift. This was one more support staff than on the planned rota for the shift.

We attended the morning handover meeting at the start of the day shift; there was one qualified nurse and five support workers. Of nine members of staff scheduled to be on shift, one had phoned in sick, one was late and another staff's whereabouts were unknown. Staff discussed all patients from the previous 24 hours at the meeting. The acting unit manager explained a change to the unit's observation protocol in response to the recent safeguarding alerts. The change primarily focused on staff duties; the unit had reallocated staff so that there were now two 'floating members' of staff whose role it was to support patients with personal care needs including personal hygiene and fluids intake as well as observations. Staff were encouraged to be vigilant and pre-empt negative patient on patient interactions. The acting deputy unit manager explained that this new protocol would be reviewed and reassured staff that additional support from other staff was available to them if needed, for example

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from the nurse in charge. Staff response to the change in process was mixed; we observed one member of staff ask another about the new system, the staff member responded saying it was not their problem.

We spoke with four staff members who told us that where possible the provider used reliable contracted agency staff. However, three members of staff also told us it could be difficult when new agency staff were working on the unit. One member of staff told us that there were a number of staff off sick and it felt like there was one new agency staff per shift as a result. We did not request additional sickness data from the provider. However at our last inspection in November 2016 sickness and absence rates on George Jepson unit were below the organisation's target of 3%. We did however identify that there had been an issue with staff retention; George Jepson had nine staff leavers in the previous 12 months (35%). We did request that the provider send us copies of the actual staffing rotas to compare with the planned rotas but this information was not received. Staff told us that they were regularly understaffed and that they were unable to carry out additional therapeutic activities with patients such as baking and art. One staff member told us that there were not a lot of activities for patients. This was the case during our inspection. We saw only one day had activities listed on the weekly planner board during our inspection. In the afternoon of the inspection there was music group facilitated by the occupational therapist; this was not reflected on the weekly planner board. We saw that some patients attended this group with their family members. Staff tried to engage with patients, one member of staff gave a patient a sensory ring while they were sat in the corridor and another was reading to a patient but staff were limited in providing meaningful engagement due to the level of patient observations and shortage of staff.

One staff member told us that they were worried that the unit was understaffed and were concerned that something may happen if staffing levels continued. Two members of staff told us they were worried about the levels of patient aggression on the unit. During our inspection one member of staff was assaulted by a patient.

There was not always a qualified nurse in communal areas at all times. There were periods of understaffing or inappropriate skill mix, which were not resolved quickly. The agency staff to replace one support worker that had called in sick was not on shift for three hours after being notified and the second nurse was not replaced on the unit when we were there. We observed the nurse in charge completing the morning medicines round. The medicines round lasted three and three quarter hours from start to finish. All patients, except one, were taking medications. The nurse in charge explained that medicines round was usually conducted by two nurses, however this was not possible as the second nurse on the rota was unwell. We saw that the nurse dispensing the medication was not wearing anything to identify that they were conducting the medicines round and was interrupted by other staff throughout.

Allis Unit

There was no formal rota in place differentiating staffing between the units. Staff told us there were three members of staff on Allis unit to support the five patients moved from George Jepson unit for the period 11 January to 3 February 2017. On handover sheets we saw that three staff were on the early shift, two or three staff on the late shift and one member of staff on the twilight shift. The recording of night staffing was inconsistent; we were unable to confirm staffing numbers. A qualified nurse was not always on the unit. The Retreat York provided nurse allocation information from the 11 January 2017 to 3 February 2017. This showed that of the 72 shifts when patients were moved to Allis, there were 48 shifts (67%) where there was one qualified nurse on shift to support both the George Jepson and Allis units. We found there to be a shortage of staff on the unit and found that this increased the risks to the patients. One incident reported on the provider's incident management system occurred when all staff on the unit had left their tasked observations to support another patient on the unit with personal care. Staffing levels were not high enough to accommodate this.

Assessing and managing risk to patients and staff

George Jepson Unit

We reviewed all patients' fluid charts from the previous day and saw that staff recorded times and the volume given. Fluid balance is essential for patient health and wellbeing. Six patients were recorded as having five drinks or less and the other six patients had up to eight in the previous day.

We reviewed three electronic patient care records during the inspection and requested copies of all care records to review them in more detail. All patient care plans had a risk plan that detailed triggers for challenging behaviour for

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patients and a positive behavioural support plan with preventative strategies. However, of the three records we reviewed during the inspection, two patients had overdue risk plans. We requested dates of completed risk assessments for all patients from the Retreat York but this was not provided. We also asked the provider for evidence of individual risk assessments being completed prior to the refurbishment on the unit as the flooring work would create additional risk to the patients. The provider could not locate individualised risk assessments in relation to the flooring work.

A review of care plans showed that 11 of the 12 patients on the George Jepson unit required help from staff with personal care. Personal care included dental hygiene, support to move positions to prevent bed sores, and support to manage continence. The safeguarding alerts highlighted a lack of personal care being completed as an area of concern on Allis unit. We saw no evidence of patients not being attended to during our inspection of George Jepson for these areas of personal care. When a patient needed support, staff helped them immediately. However we noted that one patient was unshaven and another patient's teeth were dirty. One patient's jumper had a large patch of dried up food across the front.

Care plans detailed the nutritional needs of the patients. The safeguarding alerts highlighted fluid intake as an area of concern that staff were not supporting patients to drink enough and there was a risk of dehydration. We reviewed notes in the unit communication book asking staff to give patients the opportunity to drink; the unit communication book also asked that where patients declined a drink, staff should document this as the unit had identified gaps in recording. The dietician used this book to communicate with other unit staff when to increase fibre and fluids for patients, however the entry was not dated. Another two entries asked which staff had recorded two patient's fluid intake because it was not visible.

We viewed seven falls risk plans within the care plans. Where a risk was identified, there were well detailed plans in place. Falls risk plans for patients with increased risk were to be updated monthly. They detailed how staff were to move trip hazards, medications that increased the likelihood of falls, correct footwear for patients, identified the need to review at multidisciplinary team meetings and the incident reporting system to follow. Some patients had a bed sensor, roll mat and alarm. During our inspection we saw that two patients were not wearing appropriate footwear until support staff were prompted by the nurse in charge. One patient's falls plan indicated that there was a broken bone as a result of a fall; this patient was identified as being a low risk because staff were to be present to prevent any falls. During the inspection we did not see sufficient staff on the unit to do this. Falls risk plans were located in the locked duty room on the electronic record system, however not all staff had keys to access this room.

The most common reason for patients being restrained was for personal care. One family member described how their relative had progressed from four staff supporting with personal care to two. Another family member told us that they had never seen any bruises on their relative when they visited the George Jepson unit. The safeguarding alert identified that staff may not be following care plans to move patients safely. We saw one entry in a patient activity note where two members of staff correctly used a handling belt. During our inspection we saw no inappropriate holds of patients and observed a hoist assessment being conducted for one patient on the George Jepson unit. George Jepson did not have its own hoist so borrowed one from another unit at the Retreat York. This could cause delays to patient care and could leave a patient uncomfortable.

We saw blanket restrictions in place on the unit. A blanket restriction is a rule which applies to everybody regardless of their particular needs and circumstances. For example, staff locked the entrance and exit doors on the unit and informal patients could not leave without staff permission or support. We saw that one care plan referred to the unit as a 'locked unit'. We saw no evidence that individual risk assessments were undertaken in relation to leaving the unit so the locked door applied to all patients including one informal patient on the unit.

We reviewed the provider's risk register for 2016 -17. The provider had recorded a risk in the George Jepson environment because they felt it did not meet the required standards for dementia environmental audit or accreditation in October 2015. There was one completed item from 31 October 2016 associated with the flooring being completed on George Jepson; the action was to consider using another unit whilst redecorating in order to reduce risk of distress to patients. The action description identified that the move had to be carefully planned with leadership team and staff on George Jepson. We saw no

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effective system for identifying, capturing and managing issues and risks at team and organisation level in relation to the flooring work on George Jepson during our inspection or in any of the information provided by the Retreat York. We viewed unit meeting minutes that referred to the risk register item; however we could not confirm who attended as the minutes did not detail this.

Medicines were stored in a locked trolley that was attached to the wall. All medicines were in individually labelled boxes with patient names.

We reviewed 11 prescription charts. All charts had allergy stickers to indicate allergies. We found covert medication was recorded monthly, with the exception of one patient where there was no record for one month. We reviewed eight psychotropic monitoring forms; one had no date identifying when the test had been completed in the notes, another patient had no form. Best practice recommends physical health monitoring that is required for someone taking psychotropic medication. Where appropriate second opinion appointed doctors reports were attached. A second opinion appointed doctor is a doctor appointed by the Care Quality Commission in order to review a detained or a community patient's treatment where this is required by the Mental Health Act.

Allis Unit

Patients from George Jepson unit were moved to Allis unit from 11 January 2017 to 3 February 2017 to continue the flooring work on George Jepson unit. As part of the inspection on George Jepson unit we reviewed patient care plans and risk plans for five patients that were located on Allis unit. Although care plans included National Institute for Health and Care Excellence guidance, triggers and symptoms and positive behavioural support plans, we also saw that there were no individual risk assessments completed for the refurbishment on the George Jepson unit or the move to Allis unit.

We reviewed five falls risk assessments for the patients on Allis unit. We found that one patient was categorised as low apparent risk of falls but also as a high risk of falls and so the information contradicted itself. There was a detailed entry explaining that specialist equipment was necessary to move the patient after a fall yet there was no hoist on Allis unit.

We also saw in reported incidents data, submitted by the provider, that staff were asked to keep the doors locked on Allis unit when the patients were on the unit but we did not inspect when patients were on the unit.

We saw that two patients care notes recorded details of chest infections. By the time all the patients had returned to George Jepson unit, five of the six patients had a chest infection or flu like symptoms; two patients had also been admitted to the local acute hospital with bronchial infections where one patient subsequently passed away.

The provider sent the 2016-17 George Jepson and provider risk register. The provider had referenced patients moving to Allis within one George Jepson environment risk but there was no separate risk identified for Allis unit in terms of the suitability of the environment for the patient group or consideration of staffing risks.

Reporting incidents and learning from when things go wrong

George Jepson Unit

Staff knew how to report incidents and we saw some evidence of this. However, agency staff, including those with longer contracts, were unable to access the incident reporting system. Agency staff would report incidents with the help of permanent Retreat staff. We saw incidents in staff communication books and handover notes that were not reported.

The provider submitted incident data from 1 October 2016 to 11 February 2017. Staff frequently misspelt patient names; one patient had five different spellings and versions of their name including one entirely incorrect surname. There were 140 incidents reported for both units during this period. One incident raised that on one occasion there had been no permanent staff on the unit on night shift; all were agency. The nurse in charge had never worked on the unit and the support staff had varying levels of experience. The day nurse lent their personal access card to the unit so that staff could leave the unit. Agency staff did not have training or access to the electronic record system or incident reporting system. This meant that agency staff were unable to log incidents on the provider system. We saw another two records where the only member of staff with an access fob left the unit to support Allis unit; This left all patients and staff locked on the unit for half an hour on two occasions. In the event of a fire, staff and patients would not have been able to leave the unit. The provider told us

Inadequate

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they now had a sign in and sign out book for swipe access and keys. During the inspection we saw that not all staff had access to the duty room on the unit; this is where the patient records were kept, so limited access could impact on patient safety if staff needed to refer to care plans or documentation in the duty room. We saw that staff were able to leave the unit with swipe access fobs.

Allis Unit

We received incident data provided by the Retreat York. Between 11 January 2017 and 26 January 2017 the provider reported 16 falls incidents on Allis; of these 15 were for one patient. There were two instances where this patient had been found on the floor. The patient's care plan showed that staff were to check the patient every 15 minutes and have an awareness of where the patient was at all times. We excluded the 15 instances over the 15 day period when the patient was on Allis unit and saw that the provider had recorded 10 falls over the other 119 days for the same patient.

The Retreat York had identified this increase in falls and addressed this with the unit manager. The unit manager told the provider on 2 February 2017 that this increase was due to the worsening of a physical illness that the patient had. The provider told us that that patient's GP and physiotherapist agreed with this. We also saw that a patient with a known risk of falls had left Allis unit and was found knocking on the door to another unit down one flight of stairs. The staff on Allis unit told the provider that all three staff on shift were required to support a patient in a bedroom and as such left their allocated corridor observations. In addition to this, the front door to the Allis unit had been left unlocked and the patient had been able to exit the unit and descend the stairs. Although no harm came to the patient there was the potential for a more serious incident to occur. There was one nurse allocated to both wards on night shift when the incident occurred increasing the risk of an incident occurring. The patient was returned to George Jepson unit the following day.

We saw in care plans that two of the six patients who had been moved to Allis unit had a history of pneumonia and chest infections. One of the patients with a history of chest infections was admitted to an acute hospital for treatment relating to a bronchial condition and later passed away. Another patient from this unit was also admitted to the local acute hospital with a chest infection from Allis unit. There were ligature risks on Allis unit and we saw that two patients had a history of suicide attempts. We reviewed incident data and saw that on one occasion staff did not remain on their assigned observation points which increased the risk to patients in terms of ligatures.

Additional incidents logged on Allis unit included a patient locking themselves in a bedroom for an unknown length of time until the staff on shift realised they were not present; this period could have been up to 1 hour 45 minutes. The incidents log also showed that two patients were saturated in urine when staff arrived for the early shift, as well as four incidents of patient on patient or staff assault by patients.

Staff and families told us that the provider contacted families to notify them of the safeguarding alerts for Allis and George Jepson units. The involvement lead and the chief executive officer met and telephoned relatives to discuss the incidents.

Are wards for older people with mental health problems caring?

Requires improvement

Kindness, dignity, respect and support

George Jepson

Patients who were able to communicate told us that they liked being on George Jepson unit and that staff were kind.

We observed staff to be friendly and caring to patients. Staff explained what they were doing when they were helping patients and asked their permission before acting; for example, when putting a clothes protector on a patient at mealtimes. We witnessed one member of staff going into the dining room and hallways to say hello to all of the patients at the start of their shift. We saw staff smiling and laughing with patients and meaningfully stroking patients' hands for comfort. Where staff needed help moving a patient safely they sought help from another member of staff. Staff considered patients' needs; we saw one staff member making fresh toast for a patient where theirs had gone cold.

We observed warm, respectful interactions with patients during the medication round, and the nurse in charge talked with the patients throughout. The nurse in charge addressed patients at their level and kneeled to engage with patients who were sitting down.

Inadequate

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At lunchtime we saw that one patient had their hot custard pudding served at the same time as their main meal. The patient had no plate warmer and the duration of the meal meant that the patient's pudding was cold when they had finished their main course. This had been highlighted as an issue in the recent safeguarding alerts.

Staff encouraged patients to feed themselves with their own cutlery where possible.

We observed patients the majority of patients who needed support with personal care to be clean, well dressed and in their own clothes. However we noted that one patient was unshaven and another patient's teeth were dirty. One patient's jumper had a large patch of dried up food across the front. We also observed two patients wearing no footwear until the nurse in charge prompted staff during the medicines round. Inappropriate footwear was previously identified as a safety issue on this unit on a previous Care Quality Commission inspection.

There was not always a member of staff in the dining room or lounge with the patients when they were eating; staff would not be immediately aware if patients were to choke. Five patients on the unit had a choking risk identified in their risk plans.

We observed that some patients had specialised eating equipment, such as red bowls, lipped cups and plate warmers.

Families and carers were welcome on the unit. We spoke with two family members during our inspection. Families told us that regular staff on the unit were friendly and kind, however they also told us that the unit was in disarray and described the staff as 'run ragged'. One family member told us that the quality and variety of food was good, but their relative's food was cold when she visited at a mealtime. Relatives told us that there had not been an updated activity board recently and that evening and weekends had fewer activities for patients. We saw only one day had activities listed on the weekly planner during our inspection. Relatives also told us that staff attempted to engage with patients and include them in activities. Family members told us that their relatives were bathed regularly and that the unit was clean and tidy.

One family member told us that agency staff did not interact with patients in the same way when they were new in comparison with other staff, another family member told us that agency staff did not know their family member as well as other staff.

Families told us that contacting the unit via telephone was difficult.

Allis unit

We reviewed the activity notes of five patients that were relocated to Allis unit for the period 11 January 2017 to 03 February 2017.

We saw scheduled activities including a music group, sensory group and pets as therapy dog visit. The chaplain, psychology team, dietician and physiotherapy all visited the patients on the unit. We saw that patients were asked if they wanted to go out and engaged in non-arranged activities such as painting and trips to the Quaker pantry (which is an activities room on the ground floor of the Retreat York). We saw that patients played skittles, played with balloons and reminisced. One patient went out for lunch. However we also saw significant reference to patients sitting on the sofa and being in bed when there were no activities on the unit; activities were not recorded as occurring on a daily basis. We saw in handover notes that one patient slept on the sofa for the night. The majority of staff did not recognise the safety concerns relating to the unit and did not escalate concerns further than the unit manager.

Staff told us that some patients found the environment confusing and others were happy on Allis unit.

The involvement of people in the care they receive

George Jepson Unit

Patients had access to and made use of advocacy services and staff from advocacy services were welcomed on the unit.

Family members confirmed that they were involved in care planning and one relative told us that they were invited to multidisciplinary team meetings; when they could not attend, the psychiatrist on the unit had telephoned them with updates. One relative described their relative's care plan in their room and said that the unit promoted patient

Inadequate

Wards for older people with mental health problems

independence. We saw evidence in all of the care plans that families were involved in care. We saw that patients who had an advance decision in place were visible in patient care plans and handover sheets.

We reviewed emails and meeting minutes where the provider had informed families of the safeguarding alerts. One relative described communications as poor and said that staff did not always complete personal care observation sheets to indicate when their relative had been attended to. Carers also said that staff struggled to attend to the personal care of all the patients on the unit. During an afternoon visit, one relative described their family member as cold and only partially dressed. We did not see an incident recorded for this. The following day they found their relative warm and dressed.

Families felt that unfamiliar agency staff were a problem when they don't know the unit and thought that the unit manager should be more visible on the unit.

Families also described the Retreat York as a wonderful place in spite of the shortcomings and described the chief executive officer as visible and approachable.

Allis Unit

We reviewed emails and meeting minutes where the provider had informed families of the safeguarding alerts and spoke with two relatives during the inspection.

One family member spoke of the move of their relative to Allis unit. They told us that they had been contacted and told the day before the move. Staff at the Retreat York also confirmed that families had only been informed on the day before or on the morning of the move. We saw in patients' care plans that some patients moved to the Allis unit lacked capacity and would have been unable to consent to the move. We also saw no record of discussions with patients with capacity in relation to the move and no capacity assessments or best interest discussions for those without capacity. Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

Another relative described there not being a system on the Allis unit and described difficulty at gaining access to the unit. They described their concerns with medicine administration when on the unit, particularly as timing affects the medications' effectiveness. One carer agreed they had a concern over an access fob being left in their relative's room as the patient managed to leave the unit on a previous occasion. We saw no incident report form for the fob found in the patient's room.

One carer told us that the move to Allis unit had 'knocked their confidence' in the provider.

One relative described the Retreat York as caring and supportive, but they did wonder about the suitability of Allis unit for elderly gentlemen. Another described the staff as wonderful. We found that families had concerns regarding the Allis unit and did not find that the provider prioritised the patients' dignity in terms of the move.

Families also said that the provider had since kept them informed of all developments into the safeguarding investigation.

Are wards for older people with mental health problems well-led?

Inadequate

Leadership, morale and staff engagement

Staff told us that they knew how to use the whistle-blowing process. The safeguarding alerts relating to Allis and George Jepson units were raised by two members of staff; this resulted in the safeguarding team and leadership team sharing the concerns with the Care Quality Commission, commissioners, local authority and police. However, other staff who visited the Allis unit did not raise concerns about its suitability. Staff whistleblowing and feeling able to raise concerns internally had been a concern at other inspections.

Staff we spoke to felt able to raise concerns without fear of victimisation, however one staff member described the move to Allis as a 'done deal' and therefore saw no point to raise any concerns. Another member of staff told us they had raised their concerns around Allis unit to the unit manager but were told that the senior leadership team had approved the move; so they did not escalate their concerns further.

One member of staff described an occasion where they had raised an issue relating to staff bullying on George Jepson unit and the unit manager had discretely resolved the problem. Staff also told us that they were able to approach

Wards for older people with mental health problems

the senior leadership team and felt confident that matters would be resolved but that information wasn't communicated back to them. Staff also told us that there was not a lot of oversight and discipline on the unit; they described agency staff on the rota arriving late to work and there being no repercussions. One member of staff described morale on the unit as weary but all staff described their close working relationships and enjoyment of their roles. They described the stress they felt in terms of working on the unit; however the majority did not feel that staffing impacted on patient safety.

Communication and planning of the George Jepson flooring refurbishment

We asked the provider how the plan to move patients was communicated to staff. The provider told us that they could find no formal communication plan but that staff had been advised by the unit manager verbally. When we spoke with staff they told us that knew of the move but were assigned to Allis unit or George Jepson when they arrived on shift. There was no rota in place to differentiate staffing on the units and insufficient staff to maintain patient safety at all times. Initially, when the alerts were raised, the chief executive told the Care Quality Commission that the move to Allis was scheduled to be for two or three days. A plan of works from the maintenance team showed that patients were to be moved for six weeks. We saw no oversight of the senior leadership team in terms of the move and found the senior leadership including the chief executive, were not fully informed. There were significant issues that threatened the delivery of safe and effective care and these were not identified. We found there to be a lack of clarity about who had the authority to make decisions in regards to the move. The provider told us that there was no sign off of works at the leadership team meeting or at the board meeting. We requested meeting minutes as evidence of discussion but these were not submitted by the provider. The Retreat provided a copy of the capital purchase approval form signed by the chief executive for the costs associated the George Jepson flooring works. They also provided email content showing a response from a member of the senior leadership team to a request made by the chief executive that explained the rationale for the use of Allis during the work. The document included an overview of the cost of making Allis useable.

The provider also told us that they could not evidence any environmental risk assessment for either George Jepson or Allis units in advance or during the flooring work. The unit manager stated that they had completed environmental risk assessments and had left them in a folder on Allis unit. At the time of writing the provider had not been able to locate this information. The provider commented that it did not appear that any environmental risk assessments were done for either Allis Unit or George Jepson prior to the work commencing on George Jepson. We reviewed 12 care plans and found no evidence that patients had received individualised risk assessments in relation to the flooring work on George Jepson unit or move to Allis.

We asked the provider about their decision making regarding which patients were best placed to move from George Jepson unit to the Allis unit. The provider told us that this decision was based on the location of the patient's room on George Jepson unit. I.e. those closest to the door. We reviewed 12 patient records saw no evidence that the provider had considered the specific clinical needs of the patients prior to the move. Patients on both George Jepson and Allis units had physical health problems that were not considered in advance of the flooring refurbishment. We were told by one member of the nursing staff that there was no grab bag available on Allis unit and not always availability of nursing staff. The provider told us that a grab bag was available on another unit. We requested multidisciplinary team meeting minutes to review for evidence of discussion but the Retreat York could not provide documented evidence of a multidisciplinary discussion around suitability of patients to move or the impact on the patients that remained on the George Jepson unit.

The provider shared an action plan associated with the flooring; this referred to patients having personal fire evacuation plans in place. We were told that personal evacuation plans had been completed and they were stored in a folder on Allis unit. At the time of writing the provider was unable to locate this information. The unit manager confirmed that there were no fire evacuation drills. The risk register had a historic item relating to Allis unit when it had previously been used as an inpatient ward. This stated that the unit was situated on the second floor of the building and there were patients who had difficulty mobilising. It said it would be difficult to evacuate these patients to a place of safety in the event of a fire on the unit. We see no reason why this was still not the case based on the patient population relocated to Allis unit.

ANNEX 3

Inadequate

Wards for older people with mental health problems

Carers told the Retreat York that they had not been properly informed of the move and they had concerns over the Allis unit's suitability for the patient group. The provider told us that the unit manager stated that the move was discussed in carers meetings and that carers were advised as and when they came into the unit during the week of the move. The Retreat York has an involvement lead who liaises with patients; we saw no evidence of their involvement in engaging with relatives.

We asked the provider for evidence of deep cleaning activity and subsequent cleaning in line with infection control best practice. The provider told us that staff were routinely trained in infection control and that they would know the appropriate practice. At the last inspection in November 2016 all staff on George Jepson unit had completed infection control training within the past three years; this was the target as set by the provider. We saw that the George Jepson unit was clean during our inspection. However at the time of our inspection, following the patients return to George Jepson unit we observed Allis unit to be dirty and saw evidence of a lack of proper planning in the cleaning communication book and unit manager's action plan. The cleaners were understaffed at the time of the move and one member of staff cleaned the unit for three hours prior to the patients relocating to the unit. We saw that the cleaning staff did not have the capacity to offer anything more than a basic service when patients were on the unit.

The unit manager's plan highlighted that a staffing review was to be conducted after the first week of the move to Allis unit. The provider told us that a staffing review was conducted and verbally agreed between the unit manager, deputy unit manager and director of operations who was a member of the senior leadership team. They told us that the unit manager had said that staffing had been increased but that they could see no evidence of this in staff timesheets or off duty sheets. We reviewed handover notes for the period the patients were on Allis and saw that staffing had increased, one additional member of staff was allocated to the late shift. We also saw that there was not always a qualified nurse on both units at all times.

The safeguarding alerts received emphasised a lack of personal care and fluid intake for patients for both units when patients had been moved to Allis unit. We saw on patients' activity notes that fluids were being recorded and volume varied. We saw that personal care was being recorded, however patients activity notes also recorded that patients were urinary and faecal incontinent on a regular basis. The provider told us that they had been unable to find evidence confirming fluid intake and personal care completion on the electronic record system at the time of writing.

We queried in what way patients were orientated to Allis unit prior to the move and what activities were available for patients while on the unit. The unit manager told the provider that patients had been shown regularly around Allis in advance of the move and it would be recorded on the electronic record system. We were unable to locate this information in the patients' care records and the provider also confirmed that they were unable to find this information. We did see in the activity notes that staff from the multidisciplinary team visited Allis units when patients were on the unit and we saw evidence of patient outings to the Quaker pantry and other therapeutic groups being held on and off the unit; we did not find activities were recorded every day for all patients.

The chief executive confirmed that the areas found lacking were to be managed further under the Retreat York's disciplinary procedures.

Following the inspection on 13 February 2017, The Retreat York agreed to a request made by the CQC on 30 March 2017 not to use Allis unit without prior consultation and a visit from the CQC.

ANNEX 3

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that care and treatment is provided in a safe way for patients.
- The provider must ensure that risks to the health and safety of patients receiving the care or treatment are assessed and mitigated.
- The provider must ensure that all premises are clean and safe with suitable equipment and facilities.
- The provider must ensure that patient dignity and respect are considered and acted in accordance with at all times.
- The provider must ensure that all patient documentation is complete and filed appropriately on the George Jepson unit.
- The provider must ensure that all safeguarding incidents are reported.
- The provider must ensure that appropriate planning and governance processes are in place; this includes ensuring that environmental and patient risks are identified, captured, managed and communicated with patients, families and staff when making decisions that affect the service.

Action the provider SHOULD take to improve

- The provider should ensure patients have access to outside space and all facilities available on the unit.
- The provider should ensure that agency staff understand patients' needs and the unit environment.
- The provider should ensure all patients risk documentation is updated according to their own policy.
- The provider should review restrictive practices such as locked doors and ensure these are assessed on an individual basis.
- The provider should ensure staff have protective equipment for cleaning and serving food.
- The provider should ensure that there is a hoist available for patients on George Jepson unit.
- The provider should ensure there are appropriate staffing levels and skill mix to ensure staff can spend meaningful time with patients and observe patients at all times. Staffing levels and skill mix should be reviewed continuously and adapted to respond to the changing needs and circumstances of people using the service.
- The provider should ensure that food stored in fridges is labelled appropriately.
- The provider should ensure that patients are wearing safe footwear in line with patient care plans.
- The provider should ensure they engage in a timely way with patients and relatives regarding changes to care and treatment which may impact on the patients' wellbeing.

ANNEX 3

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider did not ensure that:** Each person's privacy must be maintained at all times including when they are asleep, unconscious or lack capacity. **How the regulation was not being met:** One patient on George Jepson unit had been moved to a room that was not personalised and did not offer the patient privacy; there was no privacy film on the door panel or windows. Patient belongings were stored in a basket on the floor in the room. This was a breach of 10(2)(a).

ANNEX 3

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider did not ensure that:** Systems and processes were established and operated effectively to prevent abuse of service users. **How the regulation was not being met:** Staff did not report safeguarding concerns for patients on Allis unit; this included nurses, support workers, psychologists, dietician, physiotherapy and the chaplain. One member of staff descried the move as a 'done deal' and another told us that they had raised concerns with the manager. This was a breach of 13(2).

Health, Housing & Adult Social Care Policy & Scrutiny Committee

25 July 2017

Report of the Assistant Director - Adult Social Care

Safeguarding Adults at Risk Annual Assurance Report

Summary

1. This report accompanies the York Safeguarding Adult Board Annual Report 2016-2017 and outlines arrangements in place to ensure that City of York Council discharges its responsibilities to protect adults with care and support needs from abuse and neglect, whilst maintaining their independence and well-being.

2. The Committee is asked to accept assurance that arrangements for safeguarding adults are satisfactory and effective.

3. The Care Act requires that each local authority must:

- Make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

- Set up a Safeguarding Adults Board.

- Arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them.

- Co-operate with each of its relevant partners in order to protect the adult. In their turn each relevant partner must also co-operate with the local authority.

4. Safeguarding duties under the Care Act apply to an adult who:

   - has need for care and support (whether or not the local authority is meeting any of those needs) and;

   - is experiencing, or at risk of, abuse or neglect; and

   - as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

5. The six key principles contained within the care act which underpin all safeguarding work are:

   - Empowerment – “I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens”.

   - Prevention – “I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help”.

   - Proportionality – “I am sure that the professionals will work for my best interest, as I see them and will only get involved as much as needed”.

   - Protection – “I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able”.

   - Partnership – “I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me”.

   - Accountability – “I understand the role of everyone involved in my life”.

Analysis

Key achievements for York Safeguarding Adults Board (SAB) 2016-2017.

6. 2016/2017 has been a year of significant progress for the partnership. Building on previous years work to implement Care Act requirements, this year has seen achievements in the roll out of 'making safeguarding personal' (MSP), learning lessons from practice, workforce development and improving policy and guidance.

7. CYC has led the MSP approach across the partnership. As part of the quality and performance work of the board, cases across partners are being audited against MSP standards and the learning used to improve practice. CYC have rolled out a revised training offer to all partners across the city for Safeguarding Adults and Mental Capacity Act. CYC are developing their approach to measuring the impact of training through the use of an impact assessment tool. CYC continue to chair the training sub-group and provide well regarded training across the statutory community and voluntary sector.

8. Working with other Safeguarding Adult Boards across North and West Yorkshire, SAB partners have produced a revised safeguarding adults policy to reflect MSP principles. This is expected to become operational in September following final consultation. CYC are working to complete more detailed procedures between North Yorkshire SAB and York SAB to provide a consistent approach across the county and city.

9. During 2016-2017 it has not been necessary to carry out a Safeguarding Adult Reviews. The lessons learned sub-group is now well established and has a rolling programme of cases it oversees to ensure that lessons are learned by partners in cases which do not meet a SAR threshold but which have the potential to inform and improve services and practice.

10. All partners continue to complete self assurance framework. In 2016/2017 this practice has developed to include peer reviewing of the self assurance framework.

11. The approach to deprivation of liberty safeguards has been improved with the recruitment by CYC of dedicated Best Interest Assessors (BIA), the establishment of the Association of Directors of Adult Social Services (ADASS) risk based approach to prioritising assessments of those potentially deprived of their liberty and further training of CYC staff as BIAs.

12. Work continues on the York SAB website. This was substantially overhauled at the start of the period and work continues to build its content to inform public and professionals and prevent abuse and neglect.

CYC Performance

13. In 2016-17 City of York Council received a total of 1215 Safeguarding Concerns. This figure is an increase from of 104 Safeguarding Concerns in the previous year.

14. All Concerns raised with City of York Council are scrutinised to see if they meet the Care Act's conditions for a Section 42 enquiry, and to consider our duties under the Wellbeing Principle (Section 1 of the Care Act) to offer support, advice and information to reduce the risk for the person in question and prevent further harm.

    Where the council is unable to resolve the concerns at this stage, further enquiries may take place, either under the auspices of S42 or using 'other' enquiry mechanisms as appropriate. The number of referrals progressed to S42 enquiry in 2016/2017 was 454 a reduction of 14 compared to the previous year.

15. A new national MSP measure was introduced in quarter 4 of the year. This is designed to move away from measuring whether risk was reduced to whether the person who is being safeguarded had their personal outcomes met. The percentage of people who were asked and expressed an opinion about personal outcomes was 69% of those subject to safeguarding procedures. Of those 61% had their outcomes fully met, 30% had them partially met and 9% did not achieve their outcomes.

    The full narrative on performance is contained within the annual report.

Peer Challenge

16. In January 2017 CYC requested a peer challenge of its approach to safeguarding adults using Local Government Association methodology.

    The peer challenge found good evidence of personalised approaches, commenting that "Making Safeguarding Personal" ran through York's social care practice like a stick of rock. York's front line staff were described as 'amazing!' and recognised as highly committed.

    The peer team found The Safeguarding Board understand the importance of talking through a case, and this demonstrates a learning organisation from the bottom up and top down.

The Peer challenge identified a number of areas where CYC could continue to improve how it meets the needs of adults with care and support needs. The action plan for this has previously been to this committee and a report of the adult 'Future Focus' programme will come to a future meeting to update on further progress.

Strategic Plan

17. The Safeguarding Adults Board Strategic Plan 2016-2019 continues to be implemented to the expected timetable. Details of the 2016/2017 actions are contained within the annual report which shows good progress on actions complete or in progress.

Council Plan

18. The proposals within this report relate to the Council Plan priority to focus on frontline services, ensuring all residents, particularly the least advantaged, can access reliable services and community facilities

Implications

Financial

19. There are no financial implications to this report. Safeguarding activity is undertaken within agreed budgets.

Human Resources (HR)

20. There are no HR implications.

Equalities

21. Safeguarding activity is important to all protected communities of interest. The performance report indicates a relatively high number of referrals.

Legal

22. There are no legal implications.

Crime and Disorder

23. All of the issues and actions relating to Safeguarding Vulnerable Adults contribute to the Safer Communities agenda. Specifically Safeguarding has strong links with the Domestic Violence agenda and to Hate Crime.

Information Technology (IT)

24. There are no IT issues relating to this report.

Property

25. There are no property issues relating to this report.

Risk Management

26. The recommendations within this report do not present any risks which need to be monitored.

Recommendations

1. The Health, Housing and Adult Social Care Policy and Scrutiny Committee note the SAB annual report and are assured that arrangements for safeguarding adults are satisfactory and effective.

2. The Health, Housing and Adult Social Care Policy and Scrutiny Committee receive further updates on an annual basis.

Reason: To assure the Committee arrangements for safeguarding adults are satisfactory and effective.

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Report Approved ✓ **Date** 13/07/2017

Wards Affected: **All** ✓

For further information please contact the author of the report

Annexes

Annex 1 – York Safeguarding Adult Board Annual Report 2016-2017

Abbreviations

ADASS – Association of Directors of Adult Social Services
BIA – Best Interest Assessor
CYC – City of York Council
MSP – Making Safeguarding Personal
SAB – Safeguarding Adults Board
SAR – Safeguarding Adults Review

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ANNEX 1

Safeguarding Adults Board (SAB)

Annual Report 2016/17

City of York Safeguarding Adults

www.safeguardingadultsyork.org.uk

CITY OF YORK COUNCIL

Contents

Introduction
by the Chair of the Safeguarding Adults Board (SAB)

I am very pleased to introduce the SAB Annual Report for the year from April 2016 to March 2017. As you will know, the City of York SAB became a statutory body under the Care Act 2014 on 1 April 2015, and one of our legal responsibilities is to produce an annual summary of our actions and the work of both the City of York Council and all our other partners in keeping vulnerable people safe.

Kevin McAleese CBE
Independent Chair, City of York Safeguarding Adults Board

It is vitally important that local safeguarding adults services are as good as they can possibly be, because the City of York's population of 200,000 includes some very vulnerable adults needing support to help keep them safe from harm. They include:

- Almost 9,500 older people in York with a long-term health problem. By 2020 this number is expected to rise to 10,000
- Approximately 14,000 older people who are living alone. In the next 10 years this is expected to increase to some 16,000 people
- Around 4,000 people in the City with a learning disability, over 800 of whom are already over the age of 65
- Some 12,500 working age adults in York with a moderate or serious physical disability
- Around 9,500 working age adults who have a mental health condition

We need to be as confident as we can be that the right of every adult, including the most vulnerable, to live in safety, free from abuse and neglect, is promoted and protected as fully as possible. York is a great place to live and work, and our job as the SAB is to help ensure that organisations work together to both prevent and where possible stop the risks of abuse and neglect. At the same time we have to make sure that the wellbeing of vulnerable adults is protected, including having proper regard to their views, wishes, feelings and beliefs in deciding on any action to protect them from harm.

Unlike Children's Safeguarding Boards, Adult Boards are not held to account by OFSTED as a regulator. So this year for the first time the Council decided to invite a "Peer Review" of safeguarding adults services in York, conducted under national guidance by a team of senior staff drawn from a range of other Local Councils and services in the region. The results of the review are very pleasing overall, and there are full details in Section 5 of this Report.

As I said a year ago, whilst a City of 200,000 people can never eliminate risk entirely, we need to be satisfied as a Board that arrangements in place for safeguarding adults in York are as effective as they can be. I hope that this Annual Report will help to keep you both informed and reassured about that, and thank you for reading it. Please also feel free to visit our website at www.safeguardingadultsyork.org.uk to find out more about our work.

Kevin McAleese CBE

The Board's work and its vision

York Safeguarding Adults Board (SAB) oversees and leads adult safeguarding across the city, in order that all agencies contribute effectively to the prevention of abuse or neglect of vulnerable people. It has been in existence since November 2008 and has a strong focus on partnership working.

Our Vision, stated in our Strategic Plan (see Section 8 below) is that we seek to ensure that agencies supporting adults who are at risk or in vulnerable situations, and the wider community, can by successfully working together:

- Establish that Safeguarding is Everybody's Business
- Develop a culture that does not tolerate abuse
- Raise awareness about abuse
- Prevent abuse from happening wherever possible
- Where abuse does unfortunately happen, support and safeguard the rights of people who are harmed to:
  - stop the abuse happening
  - access services they need, including advocacy and post-abuse support
  - have improved access to justice
  - have the outcome which is right for them and their circumstances.

Work Undertaken in 2016/17

Making Safeguarding Personal (MSP)

A key part of the Care Act is the establishment of a person-centred approach to safeguarding adults across all agencies. The SAB has been encouraging the development of an MSP approach across all agencies in the city, and the matter has been reviewed at Board Development Days too. There has undoubtedly been progress on the matter, and if you look at the individual returns from Board partners in Section 9 of this Report you will see evidence of that.

MSP is challenging work, not least because not all vulnerable people have the capacity to decide what is in their best interests and may need assistance to do so. Also, many safeguarding situations are complex, often involving the actions of friends or relatives, and the problems created are seldom easy to resolve. The two real MSP case studies below illustrate how this has worked:

Case Study 1

This case involved a lady in her eighties, who had previously been diagnosed with mental health issues but who had recently refused assistance from a Mental Health social worker, about whom a concern was raised by her friend. The lady was a regular attendee at church and also at a weekly social activity, where people had become aware that she was not attending to her

personal hygiene, to the extent that people were reluctant to sit next to her and she was at risk of becoming socially isolated.

The friend began to visit her twice weekly with meals and became aware then of the extent to which the lady was also unable to manage her house. It was apparent also that she was having some problems with her legs, but continued to decline offers of assistance. The degree of self-neglect was by now putting this lady at some risk.

The safeguarding process was commenced and an initial meeting held, which included the pastor from her church and her friend. Consideration was given to the degree to which the lady had the mental capacity to make decisions about her own health and welfare and whilst it was felt that she lacked capacity to some degree, it was felt that it was important to work with her in such a way that she could be empowered to make her own decisions.

A plan was outlined and over the coming months, with support from friends, family and social care working carefully and sensitively together, the lady's trust was gained and she eventually agreed to a social care assessment, a deep clean of her house and to move closer to her son and his wife into a care home. Regular meetings were held to ensure that outcomes were being achieved and although the lady herself did not attend, her views were represented by the people who knew her best in the community.

This case illustrates the way in which safeguarding processes under the Care Act are carried out around the needs and wishes of the person at the centre and, most importantly at their pace, instead of decisions being imposed upon them.

Case Study 2

This case involved a young woman under the care of Mental Health services, whose Care Co-ordinator raised a concern that she was being physically and emotionally abused by her mother. She does not live with her mother. The concern suggested that the young woman's mother had recently assaulted her with an implement, from the injuries she had received.

This was a complex case, the young woman was at first reluctant to admit what had been happening, but eventually admitted that her mother had been physically abusing her. She had not seen this as domestic violence however. After several conversations with a worker from the team, during which the young woman was assured that she would decide what happened next, and all the possible options open to her were explored, she eventually agreed to speak to the police. Support was also given by a friend of the woman, who eventually accompanied her to the police station to talk to them. At this stage, she was very clear, that she wished to maintain her relationship with her mother and did not want the police to take any action. Her Mental Health worker worked alongside this intervention and gave the young woman some coping strategies.

Further long discussions took place between the young woman and the Safeguarding Team worker to explore her options and to support her, working in a person-centred way, i.e. at the pace of the young woman and without trying to impose any interventions that she did not want.

Recently the young woman rang the team to say that she now felt stronger and able to manage her mother's behaviour, knew that she could contact the police and did not require the team to be involved currently. She knows that if necessary she can come back for further support.

Board sub-groups

A key part of this year's work was completion of a self-assessment framework for partners, to understand the progress their organisations are making in safeguarding adults. In addition, SAB partners contribute to Board sub-groups, of which there are now three:

Lessons Learned and Safeguarding Adults Reviews sub-group

This group is responsible for considering any lessons to be learned by partners from safeguarding cases and ensuring that cases are tracked and reported properly. The group is also responsible for recommending to the SAB Chair whether the death or serious injury of an adult as a result of abuse or neglect should become the subject of a Safeguarding Adults Review (SAR) under the Care Act 2014. SARs are full external investigations involving an independent reviewer. Under the Care Act only the SAB Chair has the statutory responsibility to make that decision.

Section 7 of the Report below gives information on Lessons Learned and any SARs in York during 2016/17.

Quality and Performance sub-group

This group is responsible for developing systems by which the SAB can assure itself of the performance of all Board partners, through the use of a Quality and Assurance Framework. The Framework was accepted by the SAB at its Mach 2017 meeting and there will be updates at every future meeting. The group has also developed a Risk Register which again will be updated at every SAB meeting.

Training and Development sub-group

This group is responsible for overseeing safeguarding training and development offered to partners within York, which is reported to the SAB on a quarterly basis. The group also oversees methods to judge the impact of training on individuals and their professional practice within their organisations, which is much harder to quantify than whether or not they attended a course. Some encouraging early work is already happening and showing some positive results.

Safeguarding policies and practices

Early in 2016 City of York decided to join the consortium of West and North Yorkshire Councils which share common safeguarding policies and practices, rather than continue to operate independently. This development was welcomed by partners like the NHS and North Yorkshire Police, which operate across a much larger geographical footprint than just York.

A major review is now under way of those policies and procedures in the light of the Care Act 2014, and senior staff from York are fully involved in developing them. It is anticipated that the work will be completed by September 2017, with a rollout to partners before the end of the year.

Safeguarding website

During 2016/17 the existing City of York Safeguarding Adults website was totally rewritten using best practice from other Councils like Hampshire. The address of www.safeguardingadultsyork.org.uk remains the same and users will find a range of new information and materials. There is also a feedback facility where users can give opinions or raise questions about safeguarding adults in general.

Performance and activity information

Adults collection

June 2017

Safeguarding concerns

1,215 concerns were received by the local authority - an increase of 104 from 2015

Ratio of concerns received

Female	Male
58%	**42%**
38% 18-64	**46%** 18 – 64
33% 65-84	**37%** 65-84
29% 85+	**18%** 85+

MSP New measure for Q4

Percentage of those who were asked and expressed an opinion was **69%**

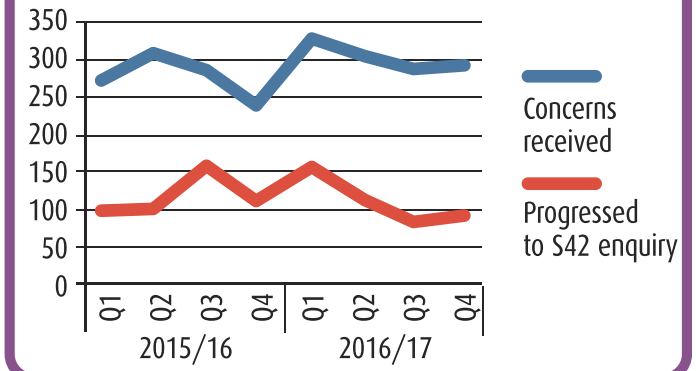
Of those:

61% - outcomes fully achieved

30% - outcomes partially achieved

9% outcomes not achieved

2 years data



Number of completed pieces of work

2015/16	2016/17
1071	**1178**

Gender of completed S42 enquiries

Female 60%	18-64 **36%**	65-84 **31%**	85+ **32%**
Male 40%	18-64 **46%**	65-84 **36%**	85+ **18%**

Number of completed S42 enquiries

2015/16	2016/17
391	**392**

Progress to formal S42

468 2015/16 → **454** 2016/17

Age range of completed S42 enquiries

40% 18 - 64

33% 65 - 84

27% 85+

Completed S42 enquiries

Location of abuse

38% in own home

9% in Nursing home

17% in Residential home

22% in hospital

7% in community setting

5% in services in the community

4% other settings

Source of abuse

49% Service provider

46% known to individual

5% unknown to individual

Types of abuse – completed S42 enquiries

6% sexual abuse	**3%** organisational
23% physical abuse	**28%** neglect
21% psychological/emotional	**2%** domestic abuse
15% financial	**3%** self neglect

Peer review of Adults Safeguarding

In January 2017 the Council invited a team from a number of local authorities to conduct a "peer review" under the guidance of the Local Government Association. Some nine officers and others came to the Council's offices in the week of the 23rd and conducted interviews with a full range of staff and service users, and inspected a range of documents.

In requesting the challenge, the Council sought an external view on the robustness of safeguarding arrangements plus the direction of travel that York was undertaking in the transforming of adult social care, and how York might improve outcomes for people using services, as well as a view on how the future sustainability of the health and social care system

The report resulting from the challenge highlights many of the strengths in both the Council and across its partnerships. It also provides useful analysis as to where further work may be required to ensure that these strengths are built on and services continue to improve.

The Peer Challenge report reflected that Council has a stable and committed senior management who are driving transformation of services based on a clear vision that is recognised by the council and partners. The peer team heard from staff with a "can do" attitude, and a sense of collective optimism in delivering the vision. The peer team found good evidence of personalised approaches, commenting that "Making Safeguarding Personal" ran through York's social care practice like a stick of rock. York's front line staff were described as 'amazing!' and recognised as highly committed.

The peer team found The Safeguarding Board understand the importance of talking through a case, and this demonstrates a learning organisation from the bottom up and top down

The peer team found that Council had strong partnerships and was both ambitious and lean. This means they need to continue to ensure that the right resources are always in place to enable the effective delivery of their ambitions

The Peer Challenge recognises the excellent work being done to support adults with care and support needs and safeguard them from abuse.

A copy of the report is available from:
https://www.york.gov.uk/downloads/file/13207/safeguarding_peer_review – 59k

Training

Introduction

The Workforce Development Unit (WDU) is responsible for ensuring that Safeguarding and Mental Capacity Act training is available at all levels for the workforce.

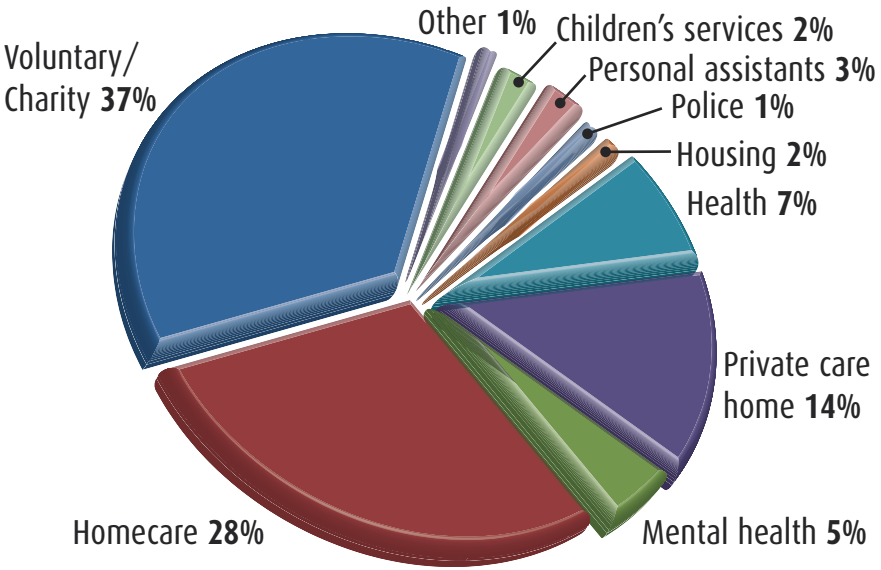
The Training Offer 2016/17

During 2016/17 our Safeguarding and Mental Capacity Act training was provided by Community Links.

Below shows a breakdown of courses that took place over 2016/17

Course	Number of Sessions	Total attendees	CYC attendees	PVI attendees	No Shows	% of internal CYC delegates	% of external PVI delegates
Safeguarding General Awareness	22	263	123	140	31	47%	53%
Working Together to safeguard Adults (Level 3)	8	82	25	57	12	30%	70%
Mental Capacity Act Awareness (or Level 1)	7	72	29	43	10	40%	60%
Mental Capacity Assessment & Best Interest Decision Making for Practitioners (Level 2)	6	61	30	31	12	49%	51%
Deprivation Of Liberty(Dols) responsibilities For Managing Authorities (Care Homes/ Hospitals (Level 3)	1	5	3	2	0	60%	40%
Mental Capacity Act Complex Decision Making for Practitioners and Managers (Level 4)	1	13	6	7	1	46%	54%
Safeguarding General Awareness Train the Trainer	3	13	1	12	1	8%	92%
Total	**48**	**509**	**217**	**292**	**67**	**43%**	**57%**

Breakdown of external delegates by area:



Charging Policy

In April 2015 the following pricing structure below was implemented, with the exception of Safeguarding Level 1 and Mental Capacity Act Level 1 which remain free of charge.

Full Day £40.00 **Half Day £20.00**

A non-attendance charge of £50.00 remained in place for all courses.

Developments

- This year the Workforce Development Unit have worked with the Safeguarding Board to revise both the Safeguarding and Mental Capacity Act training offers. We have hosted briefing events for both which have been very well attended and have resulted in feedback which has been used to shape the new offers. The Safeguarding training offer which was launched in September 2016 has been revised to embed the principles of making safeguarding personal. The new offer has received very positive feedback. The Mental Capacity Act offer will be launched in April 2017.
- The Workforce Development Unit has also developed a new course on encouraging a risk-enabling approach to underpin the approach across services to support people to take positive risks and to work in an outcome focused way, putting the individual and their wishes at the centre of decision making.
- An Impact Assessment tool for use by managers with staff attending training has been being piloted within the safeguarding courses this year. Feedback about the tool has been positive although more work needs to be done on raising awareness of the tool and how it can be used. This work is planned for 2017/18.
- The WDU have also undertaken some work with staff regarding risk enablement, which underpins an approach across the services to support people to manage risk.
- Thanks to support from the commissioning team, WDU are able to continue to offer a range of courses including safeguarding and mental capacity act, at no charge.
- The Board's Training and Development Subgroup is now meeting regularly and is providing helpful opportunities to ensure that learning and development opportunities are shared across agencies and any workforce development needs that arise through the SAR/Lessons Learned sub-group can be addressed on a multi-agency basis.

Safeguarding Adults reviews/lessons learned

It is a requirement of the Care Act 2014 that the details of any Safeguarding Adults Reviews (SARs) conducted during the year must be in the SAB Annual Report. As explained in Section 3.2 above it is the responsibility of the SAB Chair to decide whether or not a death or serious incident should be the subject of an SAR, which would involve commissioning an independent review and publishing a full report written by an author recruited for the purpose.

There were no Safeguarding Adults Reviews needing to be conducted during 2016/17, though a number of cases were considered to see if they met the threshold.

During 2016/17 the responsible Board sub-group received some briefing papers concerning serious safeguarding incidents where individuals had been in receipt of services from statutory bodies and other organisations. As Chair of the Board I decided, as I am required to do, that the facts of none of the cases warranted the establishment of an SAR. However, they contained issues which needed to be clarified so that the Board gained assurance both about what had been done to support the individuals concerned and also that the likelihood of any repetition had been minimised.

Two examples of lessons Learned cases considered during 2016/17 are given below:

Case 1 - Bernice had severe learning disabilities which manifested as non-verbal communication, variable moods, frequent involuntary movements and sleep disturbances. Bernice does not express pain. It was known that her involuntary movements could sometimes result in an accidental injury to herself.

Bernice has lived in supported housing with twenty four hour care for over twenty years, sharing with five other people. She attends day services in the city. In July 2015 Bernice was noted to have an injury to her arm and was taken to York hospital by care staff. An x-ray showed a fracture to a bone in her arm. Bernice was treated over a number of months and required an operation to fix the bone until it healed.

As the cause of the injury was unknown a safeguarding alert was made to the City of York Safeguarding Adult team. The subsequent investigation into the cause of the injury took six months to conclude with a consensus that 'on the balance of probabilities' temporary bed/bedrail entrapment had occurred which led to the injury.

Concerns were raised about the way agencies worked together during the safeguarding process and a decision was taken to undertake a learning lessons review.

The purpose of completing a learning lessons review is not to reinvestigate the case or to apportion blame. The purpose is to:

- Identify any lessons that can be learned about the way in which local professionals and agencies worked together to safeguard adults
- Inform and improve multi-agency practice
- Improve practice by acting on learning

A 'learning together' approach was used with representatives from each of the agencies involved in the care and treatment of Bernice coming together in a workshop to look at what the challenges were, how things could have been done differently and what needed to change. The main themes were frustrations in multi-agency working; confusion over roles and responsibilities and hearing Bernice's voice. The recommendations from the review will be reported to the Safeguarding Adults Board in June 2017 and a final summary of the review will appear in next year's Annual Report.

Case 2 - John

Concerns were raised to City of York Safeguarding Adult team about John's care at home following his death in hospital. As the City of York Council provided some of the services for John they asked the Designated Safeguarding Professional in the Partnership Commissioning Unit to look at the concerns and review his care.

Pen Picture and Summary of Concerns

John had a career in the Navy until his retirement following which he then worked in a local factory until he was seventy years old. He was married to Margaret for thirty-five years, a second marriage for both of them and between them they had four children. John was in his eighties and Margaret was in her nineties, both had long-term illnesses but supported each other and managed well at home with some family help.

Margaret was admitted to hospital following a short illness. The family felt that John would not manage at home alone. Although he was independent in many ways, he also had a deteriorating health condition and some short-term memory problems. An assessment of need completed by adult social care determined that John required three visits per day to help him with meals and reminding him to take his medications. However despite strenuous efforts by staff no home care agency could be found to supply the visits that John needed.

John became unwell with a chest infection and was given a course of antibiotics by his GP. Despite the efforts of several services and individuals stepping in to try to 'fill the gap', John unfortunately missed some evening doses of antibiotics. He was admitted to hospital in May 2015 and subsequently died three days later.

Following his death concern was raised by a family member to City of York Council in relation to care provided. John's family acknowledged that services tried to help him. They were concerned that despite recognising that he needed help that help was not always available in the community. Family members stated they did not want a big enquiry and weren't trying to find someone to blame but just didn't want this to happen to anyone else. In order to facilitate the review a chronology of events from the agencies involved was compiled. A visit to John's step-daughter and his sister was made to better understand the situation from their and John's point of view. John's family agreed that this summary could be shared as an example for those commissioning and providing services. The summary of the review is presented using the six principles of adult safeguarding.

Although John was an 'adult with care and support needs' (the definition used for safeguarding under the Care Act 2014) and therefore vulnerable – this case does not easily sit with safeguarding.

John was not abused by anyone. In the wider sense his situation and the lack of available services did mean that he was at risk of neglect. City of York Adult services recognised a potential conflict of interest in them reviewing their own services, so requested an independent review from partners that provided transparency and accountability.

It is recognised that services worked hard to try to provide care for John. It is also recognised that a more joined-up service between health and social care could have provided an improved service for John and less anxiety for his family in the place where he wanted to be – at home.

Key Points:

- Good practice in consistent application of Mental Capacity Act
- Good practice in not accepting care from non-approved provider
- Highlights the difficulty in obtaining domiciliary care in some parts of the City
- Highlights the lack of 'joined up' services – John fell through gaps in service provision

New Strategic Plan for 2016 onwards

The Strategic Plan for 2016/19 is in a very accessible format and is available of the website under "Board". It follows the six guiding principles of the Care Act:

Empowerment People being supported and encouraged to make their own decisions and informed consent.

Prevention It is better to take action before harm occurs.

Proportionality The least intrusive response appropriate to the risk presented.

Protection Support and representation for those in greatest need.

Partnership Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability Accountability and transparency in delivering safeguarding

The new Strategic Plan for 2016/19 has an Action Plan for every year and the progress report for 2016/17 is at Annex 3.

Contributions from individual member organisations

NHS England

Training & Development

Designated safeguarding professionals are jointly accountable to CCGs and NHS England and oversee the provision of safeguarding training for primary care medical services. The main source of training for other primary care independent contractors is via e-learning training packages.

NHS England Safeguarding Adults: Roles and competencies for healthcare staff - Intercollegiate Document has been awaiting final publication following review by - The Royal College of Nursing, The Royal College of Midwifery, The Royal College of General Practitioners, National Ambulance Safeguarding Group and The Allied Health Professionals Federation. The purpose of this document is to give detail to the competences and roles within adult safeguarding and the training guidance for healthcare professionals.

NHS England North hosted a safeguarding conference on 10 December 2016 which included presentations on forced marriage, honour based abuse, FGM and domestic abuse and adult safeguarding. The conference aimed to provide level 4 training for healthcare safeguarding adults and children professionals and leads in the North region. A conference was held on 11 November in York for named safeguarding GPs in Yorkshire and the Humber attended by Bradford named GPs, it was well evaluated and plans for a north region named GP conference are in place for 2017/18.

NHS England has updated and is due to circulate the Safeguarding Adults pocket book which is very popular amongst health professionals and has launched the NHS Safeguarding Guide App and a North region safeguarding repository for health professionals.

Sharing learning from safeguarding reviews

In order to continuously improve local health services, NHS England has responsibility for sharing pertinent learning from safeguarding serious incidents across Yorkshire and the Humber and more widely, ensuring that improvements are made across the local NHS, not just within the services where the incident occurred. The NHS England Yorkshire and the Humber Safeguarding Network meets on a quarterly basis throughout to facilitate this. Learning has also been shared across GP practices via quarterly Safeguarding Newsletters, a safeguarding newsletter for pharmacists has been circulation across Yorkshire and the Humber and one for optometrists and dental practices is being scheduled for March 2017.

Safeguarding Serious Incidents

All safeguarding serious incidents and domestic homicide's requiring a review are reported onto the national serious incident management system – Strategic Executive Information System (STEIS). During 2016/17 a review of current systems for recording safeguarding incidents and case reviews across the North Region was undertaken to support the identification of themes, trends and shared learning. The Yorkshire and the Humber process to jointly sign off GP IMRs, as CCGs responsibilities for commissioning of primary care

services is increasing, has been adopted across the north of England region to ensure consistency. NHS England works in collaboration with CCG designated professionals to ensure recommendations and actions from any of these reviews are implemented. Prior to publication of any child serious case reviews, serious adult reviews or domestic homicide reviews NHS England communication team liaise with the relevant local authority communications team regarding the findings and recommendations for primary care medical services.

NHS England responsibilities in relation to direct commissioned services

NHS England ensures the health commissioning system as a whole is working effectively to safeguard adults at risk of abuse or neglect, and children. NHS England is the policy lead for NHS safeguarding, working across health and social care, including leading and defining improvement in safeguarding practice and outcomes. Key roles are outlined in the Safeguarding Vulnerable People Accountability and Assurance Framework 2015.

Yorkshire and the Humber has an established Safeguarding Network that promotes shared learning across the safeguarding system. Representatives from this network attend the national Sub Groups, which have included priorities around Female Genital Mutilation (FGM), Mental Capacity Act (MCA), Child Sexual Exploitation (CSE) and Prevent. NHS England Yorkshire and the Humber works in collaboration with colleagues across the North region on the safeguarding agenda and during 2016/17 a Clinical Commissioning Group (CCG) peer review assurance process was undertaken covering all 44 CCGs in the North region.

Assurance of safeguarding practice

NHS England North developed a Safeguarding Assurance Tool for use with CCGs across the North Region, which was implemented in 2016/2017. NHS England North Regional Designated Nurses undertook the review which was intended to be supportive ,they reviewed all action plans to identify key themes and trends across the North Region with a view to identifying common areas requiring support. Themes from this process have influenced the commissioning of leadership training for safeguarding professionals and there are future plans for a national assurance tool for CCG's.

Learning Disabilities Mortality Review (LeDeR) Programme

Over the last 2 years a focus on improving the lives of people with a with learning disabilities and/or autism (Transforming Care) has been led jointly by NHS England, the Association of Adult Social Services, the Care Quality Commission, Local Government Association, Health Education England and the Department of Health. In November 2016 the national LeDeR Programme has been established following the Confidential Enquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD).

All NHS regions have been asked to establish the LeDeR process locally to undertake the reviews. LeDeR also complements the NHS Operational Planning and Contracting Guidance for 2017/19 which contains 2 'must-dos' for people with learning disabilities:

- "Improve access to healthcare for people with a learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.
- Reduce premature mortality by improving access to health services, education and training of staff, and by making reasonable adjustments for people with a learning disability and/or autism.

LeDeR involves:

- Reviewing the deaths of all people aged 4 years.
- Identify the potentially avoidable contributory factors related to deaths of people with learning disabilities.
- Identify variation in practice.
- Identify best practice.
- Develop action plans to make any necessary changes to health and social care service delivery for people with learning disabilities.

A national database has been developed and anonymised reports will be submitted. This will allow, for the first time, a national picture of the care and treatment that people with learning disabilities receive.
The LeDeR Programme is not a formal investigation or a complaints process and will work alongside any statutory review processes that may be required.

The LeDeR Programme recognises it is important to capture the extent of personalised services, including the use of reasonable adjustments, choice and control and the well-being of people with learning disabilities. Good practice examples will be written up and shared nationally.

Prevent

Across NHS England North there are a number of priority areas which are designated by the Home Office, who fund two Regional Prevent Coordinator posts. These posts support the implementation of the Prevent Duty and ensure that Health embeds the requirements of the Contest strategy and specifically Prevent into normal safeguarding processes. Funding to support this work was secured from the North Region Safeguarding budget which has facilitated a number of projects including supporting partnership working with the North East Counter Terrorism Unit, delivering a conference in October on 'Exploitation, grooming and Radicalisation 'and an Audit of referrals to Prevent /Channel where Mental Health concerns are understood to be a contributing factor .

A research project to scope the current, attitudes, awareness and practice amongst GP colleagues has also been commissioned in the Region.
In December 2016, a North Regional Prevent conference was held to raise awareness of Prevent, delegates found this event a good opportunity to increase their knowledge and confidence in the role of the health sector in Prevent . Feedback received supported that there was an overall improvement in understanding the requirements of health organisations e.g: CCGs under the new statutory duty.

Pressure Ulcers – "React to Red"

React to Red was launched on 01 February 2016 at the Pressure Ulcer Summit in Leeds. It is a bespoke training package for pressure ulcer prevention which is competency based and designed specifically for care home staff and care providers. Since its launch in February 2016, there has been significant interest in this resource from CCGs: private organisations; secondary care; hospices; domiciliary care providers; tissue viability nurses and care homes. During 2017/18 this work will continue to be a priority across NHS England North and will focus on embedding the programme as a quality improvement initiative using a focused approach co-ordinated by CCG's and robust evaluation by NHS England North.

Independent Care Group (ICG)

ICG is the representative body for independent care providers (care homes, homecare and supported living services) in York and North Yorkshire.

1. ICG keeps its members informed on all matters connected to Safeguarding including Safeguarding training and Mental Capacity Act training which is offered by CYC at no charge. It keeps members informed of DBS news.

2. ICG gives information on Safeguarding training and how to access it on its website.

Tees, Esk and Wear Valleys NHS Trust

Training

The information on training below is for York and Selby. At present the Selby data is unable to be removed.

Safeguarding adult's level 1 is mandatory for all staff in the organisation (fig 1). Safeguarding level 2 is mandatory for all clinical staff band 5 and above and contains prevent WRAP 3 (fig 2).

Fig 1

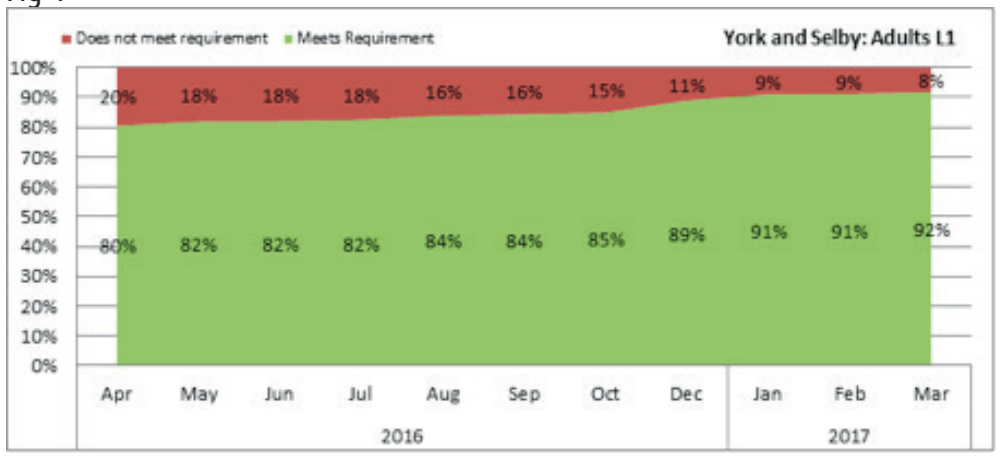
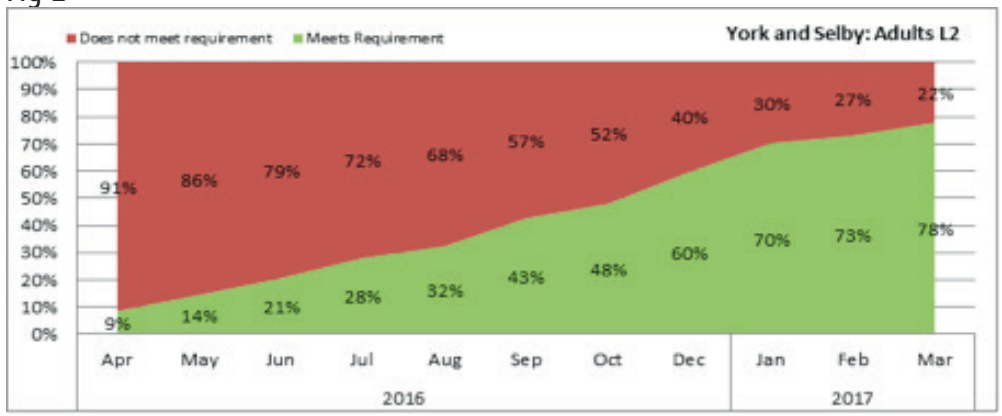
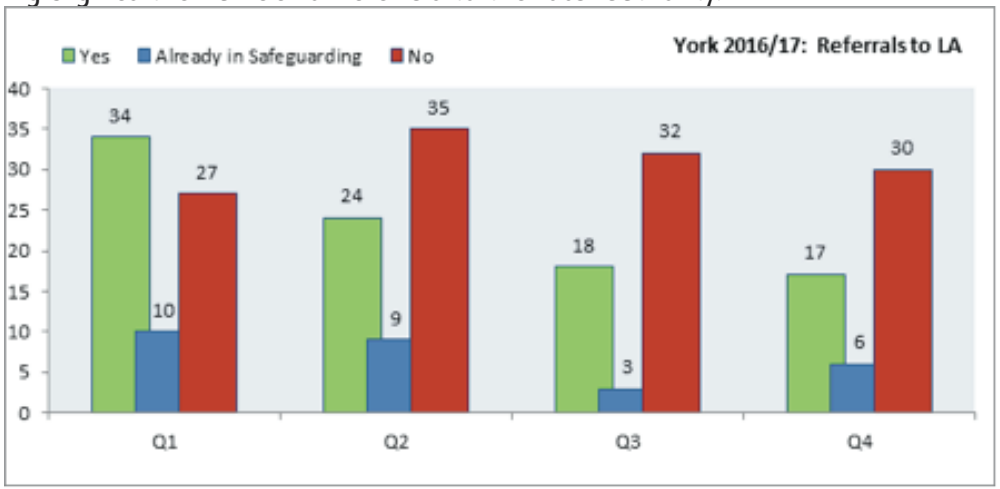


Fig 2



Referral/contact information

Fig 3 gives the number of referrals to the local authority.

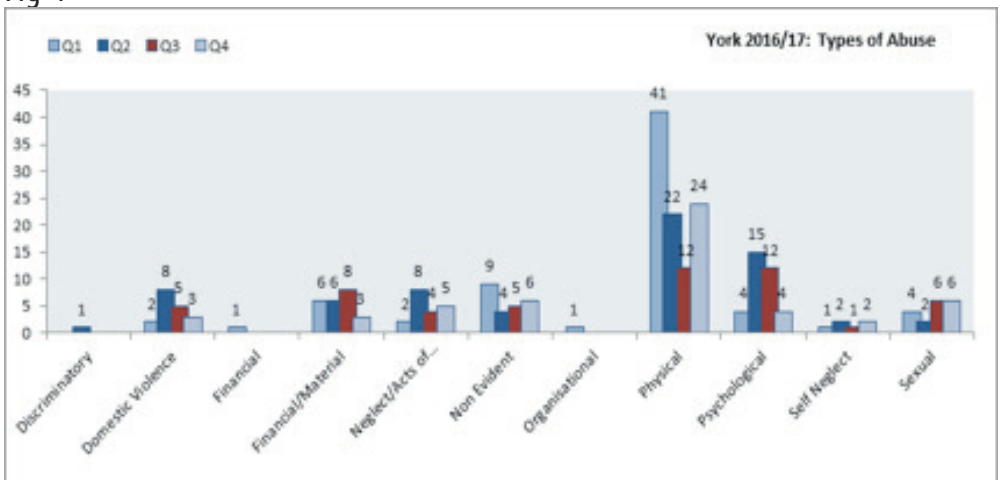


The numbers together give the total for the calls received by TEWV Trust safeguarding adults team. Identified in figure 3 is the number that progress to the local authority, those that were already in safeguarding and those that required no further action.

Types of abuse

Types of possible abuse that were discussed in the calls to the TEWV trust safeguarding adult's team (Fig 4). This is mostly physical abuse, with these being patient on patient. It is important to note that the Trust will review these to ensure that hot spots are identified. None were identified through this period.

Fig 4



TEWV completes an annual audit of compliance with the safeguarding protocol to ensure that staff are acting in a manner that is in line with the principles of making safeguarding personal, this looks at the empowerment and choice people were given prior to a concern was raised and the outcomes expected.

The Trust Safeguarding Adults team participates and engages in the SAB and SAB subgroups; the team actively participated in the safeguarding week in 2017 and is actively participating in preparation with the plans for the next safeguarding week.

The Trust Safeguarding Adults team has committed to attend the local safeguarding adults groups and work with other agencies to ensure the best outcomes for individuals who are at risk of abuse of neglect.

York Teaching Hospital NHS
NHS Foundation Trust

York Teaching Hospital

Training

Training is now fully embedded in Trust induction and statutory and mandatory training for York Sites – Level 1 and 2 which is a complete Safeguarding Adults, Mental Capacity Act and Deprivations of Liberty Safeguards package. This programme has been available for all sites since April 2013. Key individuals in high risk areas have received level 2 training (how to respond to a safeguarding concern) and the Trust has a training plan for the delivery of level 1 and further level 2 training on a 3 year rolling programme.

It is understood that NHS England will shortly publish "Safeguarding Adults Roles/Competences/ Intercollegiate" document and as a result the current training will be reviewed to ensure all aspects of the competences are addressed.

Safeguarding Adults Training Statistics for 2016

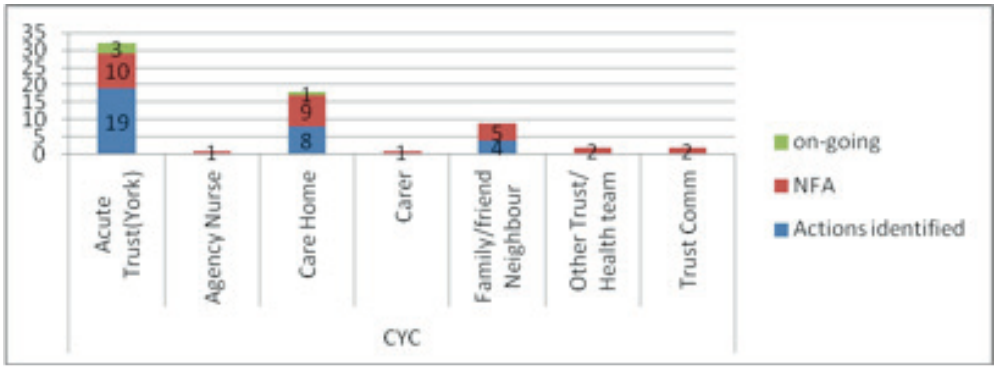
Training	Compliance 2016	Eligible staff
Awareness	90%	All Staff
Level 1	82%	All clinical staff B4 and below.
Level 2	83%	All clinical staff Band 5 and above, excluding doctors and consultants (who should complete Level 1) All doctors and consultants All managers of staff who complete L1 or Awareness
Learning Disabilities	87%	All patient contact staff
PREVENT	83%	All patient contact staff

Safeguarding Adults Activity 2016

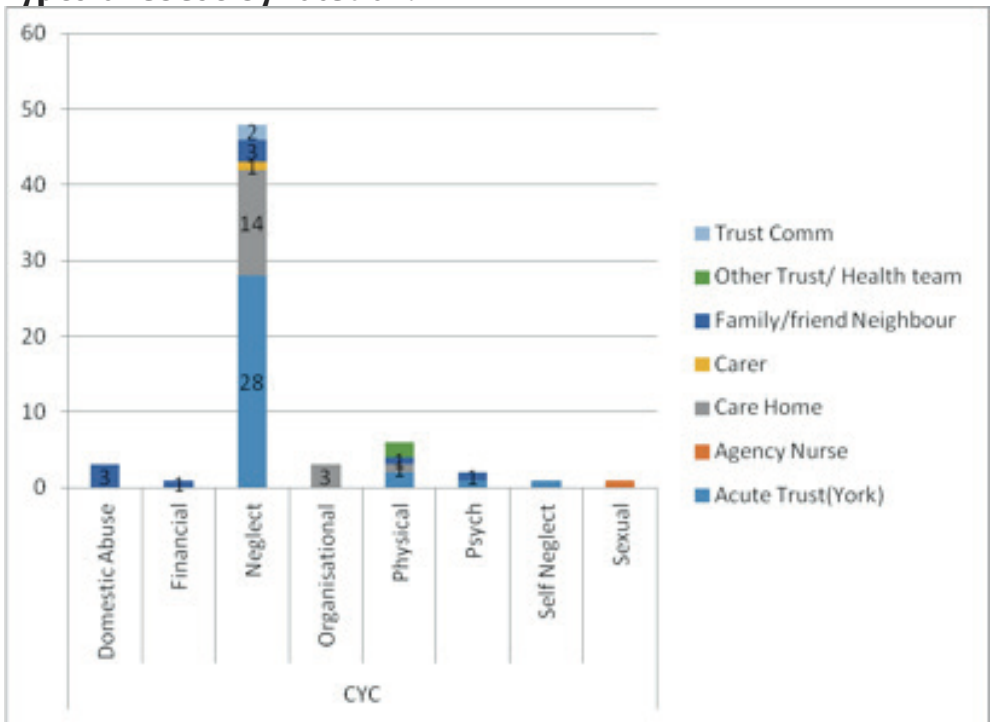
There were 118 Safeguarding Adults alerts received in 2016. This figure relates to all alerts referred through the Safeguarding Adults Team raised either against or by the Trust.

Of the 118 alerts 34 were raised against acute staff and 4 against community staff in the City of York Area.

Concerns raised and outcomes



Types of abuse by location.



Summary

The Safeguarding Adults Team continue to be a useful expert resource to staff for raising safeguarding concerns, management of enquiries, MCA/DoLS and Learning Disability Liaison Support.

Activity within the Safeguarding Adults team continues to become more complex.

The safeguarding Adults team is now fully resourced with the valuable addition of Admin support.

During 2016 Discharge remained the common theme emerging for which actions have been identified as a Trust-wide initiative and encouraging progress.

Making Safeguarding Personal

Making Safeguarding Personal is our largest challenge due to the nature of the care we deliver. However we are confident that by working with our multi-agency links, we can fulfil this aspect of the Care Act to provide on-going protection for vulnerable adults once they have left our care. However Making Safeguarding Personal underpins the following:

- Trust policy
- Trust training
- User leaflets for patients and their families involved in the safeguarding Process
- Multi-Agency Working and commitment
- Open visiting

Additionally the Trust Safeguarding Adult Strategy 2017 – 2017 focuses on the 6 key principles of the Care Act and as such the work plan from this strategy focuses on Making Safeguarding Personal.

Achievements

DoLS – Cheshire West Progress

In September 2016 Safeguarding Adults recruited administration support whose role was primarily to establish a robust data collection and ward/local authority system to manage applications made by the Trust for patients in our care.

Clear data collection is required externally by Local Authority Safeguarding Adult Boards, Clinical Commissioning Groups and CQC and internally through the Trust Safeguarding Adults Governance Group. This acts as assurance of both an embedded understanding and process for DoLS.

The DoLs process has been impeded by the backlog of referrals requiring assessment once they reach the Local Authority. Both NYCC and CYC DoLS team have recently reported delayed responses to applications and are implementing a priority system which does not include patients in an acute hospital setting.

This impacts of the Trust notifying the CQC of approvals/cancellations of applications as the patient is no longer in our care. The Trust CQC representative was informed of this challenge and has reported that is a well-recognised national issue and noted to be beyond the Trust's control.

In the meantime the Safeguarding Adults Team continues to support staff with this as follows:

- Monthly Ward visits to increase support awareness and identify potential Deprivations of Liberty
- Specialist Training to high risk areas
- High Risk Wards subsequently managing own applications with the Support of the Safeguarding Adults Team.
- Information Packs delivered to each ward
- Pocket guidance for Consultants/Medical staff
- Intranet Resource page with links to required paperwork and guidance
- Data analysis base developed to monitor applications and chase up outcomes.

It should be noted that there is now a substantial commitment from wards that now on the whole, make their own applications and follow process to good effect. However from recent data analysis there is a need to target wards where there would be an expectation of higher DoLS application and data suggests otherwise.

Leder Programme

The LeDeR Programme has been established as a result of one of the key recommendations of the Confidential Enquiry into the premature deaths of people with learning disabilities (CIPOLD). Commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England the LeDeR Programme supports local reviews of deaths of people with learning disabilities aged 4 to 74 across England.

The Trust Named Nurse for safeguarding adults has been nominated as organisational contact and is now also trained as a reviewer
Trust policies and procedures include the following:

- Safeguarding Adults Policy and Procedures (based on Multi- Agency Policy and Procedures) This has been amended in light of the Care Act.
- Therapeutic Restrictions Guidance
- Mental Capacity Act Guidance
- Deprivation of Liberty Safeguards (DoLS) Guidance
- Learning Disability Specification
- Prevent Policy

Learning from Safeguarding Adults Investigations

Learning from Safeguarding Adults Investigations have led to the following Trust initiatives:

- Task and Finish group to develop policies, training and risk management tools to support staff care for patients with Mental ill-health.
- Assistant Director of Nursing and Matron involvement in delivering actions arising from Safeguarding Adults Investigations
- Discharge Improvement Working Group, revised discharge tools
- Improved body marking systems and observation charts
- Development of communication tools for carers/family
- Care Planning for patients who decline care

North Yorkshire Police

North Yorkshire Police Officers, The Special Constabulary and Staff are trained on Safeguarding in a number of ways.

Student Police Officers & Special Constables & Police Community Support Officers

2016/17 New Starters
- Student Officer Initial Course 48 delegates.
- PCSO Initial Course 38 delegates
- Initial Learning 4 Special Constables Foundation Course 32 delegates.

Safeguarding Adults Training is included in new starter initial training. The Student officers, Special Constabulary and PCSO's complete a Vulnerability Training Package . Within the Vulnerability Training package new staff will learn about adult vulnerability, the Vulnerable Risk Assessment (VRA) which explores actions and solutions in dealing with people affected by alcohol, drugs and mental health issues and how to make referrals.
Students and Special Constabulary receive module base Domestic abuse training including Honour Based Abuse (HBA) and Forced Marriage (FM) / Sexual offences including Female Genital Mutilation (FGM) followed by two further inputs from the training department (Safeguarding Portfolio Trainer) and the Domestic Abuse Coordinator which will focus on operational , case study , administrative responsibilities, dynamics and legislation both criminal and Civil law remedies.

North Yorkshire Police use an e-learning programme called NCALT provided by the College of Policing where safeguarding packages/ updates, refreshers, changes in law and new legislation can be found.

Packages which are covered by e-learning include the following:-
- Mental Health and vulnerability - explores Section 136 of the Mental Health Act
- Stalking and Harassment
- Human Trafficking and Modern Day Slavery
- Dealing with people with Autistic Spectrum Disorder.
- Coercive and Controlling behavior in Domestic Abuse
- Cyber Crime
- DASH – Domestic Abuse Stalking and Harassment

All officers, staff and supervision have received Safeguarding training on their allocated training days .Training days provide an opportunity to cascade important changes operationally and legally .This is delivered by an Inspector. Supervisors & Specialist officers also have the opportunity to attend external training, which include regional Police training, College of Police training, subject specific conferences to ensure best practice is shared in relation to Investigative standards.

North Yorkshire Police continue to invest in Safeguarding. Investment into the MAST (Multi Agency Screening teams) In North Yorkshire and City of York providing experienced officers and Police staff to be co-located with key partners.

North Yorkshire Police submit referrals of a safeguarding nature to the relevant authority. North Yorkshire Police will also complete Vulnerable Risk Assessments which the local Community Safety Hubs manage. It is not possible to differentiate Adult and Children referrals due to the way North Yorkshire Police store and record.

North Yorkshire Police can provide the following data:

In 2016/17 North Yorkshire Police responded to 2389 PSW Collapse/Injury/ Illness/ Trapped within this category there are 30 subtypes.

In 2016/17 North Yorkshire Police Responded to 20,901 PSW concern for Safety type incidents within this category there are 49 subtypes.

These particular incidents were closed as a PSW Concern for Safety. This would prompt further action of varying types, some of which are highlighted below:

- A referral for Safeguarding (without consent)
- A referral for care and support needs assessment (with consent)
- Completion of a Herbert protocol
- Completion of a Vulnerable Risk Assessment
- Completion of a Domestic Incident form
- Strategy meeting
- Trigger plan
- Referral to MAPPA
- Referral to MARAC
- MAPPA

The list is not exhaustive.

North Yorkshire Police support the local authority-led initiative "Making Safeguarding Personal"

North Yorkshire Police take into account a victim's views in relation to prosecutions and will respect the decision made by victims who decide not to support the criminal justice process. (This is done with a review of risk) We will only pursue a victimless prosecution if we feel the risk is high or the victim is being controlled or intimidated in some way. This still involves the victim being informed throughout.

For those victims supporting a criminal complaint North Yorkshire Police involve victims by taking Victim Personal Statements or Impact statements this records and communicates what impact the incident has had on their day to day life and can assist in providing victims with the correct ongoing support once the legal process has ended.

North Yorkshire Police often attend incidents where engagement and decision making with the victim or alleged offender is not always possible. North Yorkshire Police deal with those where engagement hasn't been possible with dignity and respect and will share information with our partners to ensure the ongoing support is provided or addressed.

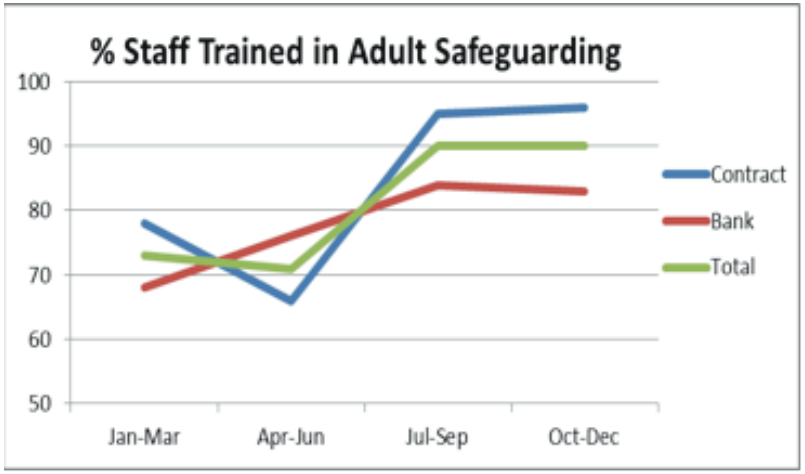
- 2016/17 Two new Safeguarding Managers were introduced following a peer review, the role is to provide the consistency and engagement with Partners.
- MAST (Multi Agency Screening Team) development for City of York
- Adult services and Police daily screening implemented.
- Domestic Abuse teams have Increased full time equivalent (FTE) to cope with recent new Law (Domestic Violence Protection Notices) , Domestic Violence Disclosure Scheme (DVDS also referred to as Claire's Law) and an overall increase in demand.

York House

Training

As you can see from the below graph there have been significant improvements in the amount of staff who are up to date with safeguarding training. This is delivered face-to-face in-house as part of the induction, with an e-learning package available for refreshing training. Following a review of the training procedures, the target for training was set at 85% which we are now achieving for contract staff and are on target to achieve by February 2017 for all staff (contract and bank).

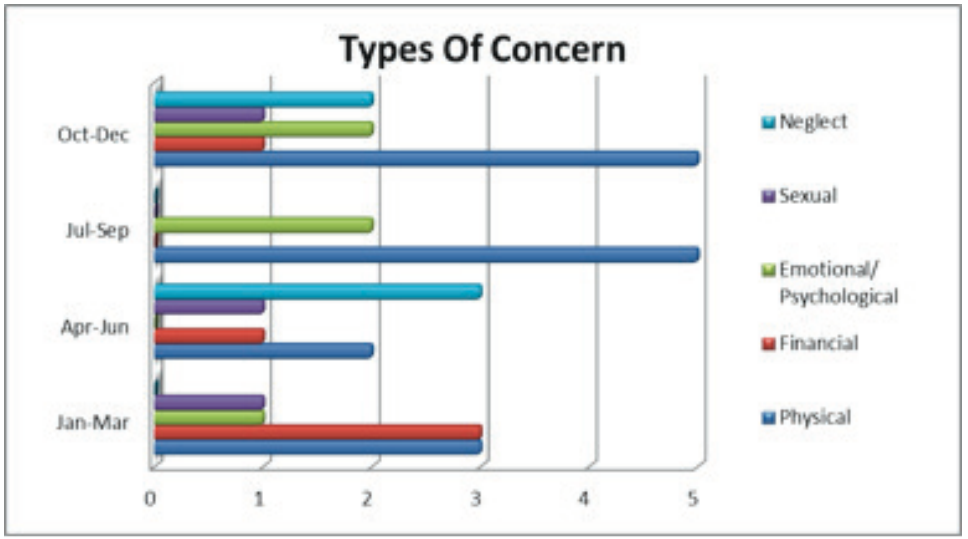
All members of the safeguarding team at York House have carried out the level 3 training provided by CYC and we aim to put senior clinicians and management through the training as it becomes available. We are also looking at sourcing this for the Trust, to be run by the learning and development department.



Types of Concerns

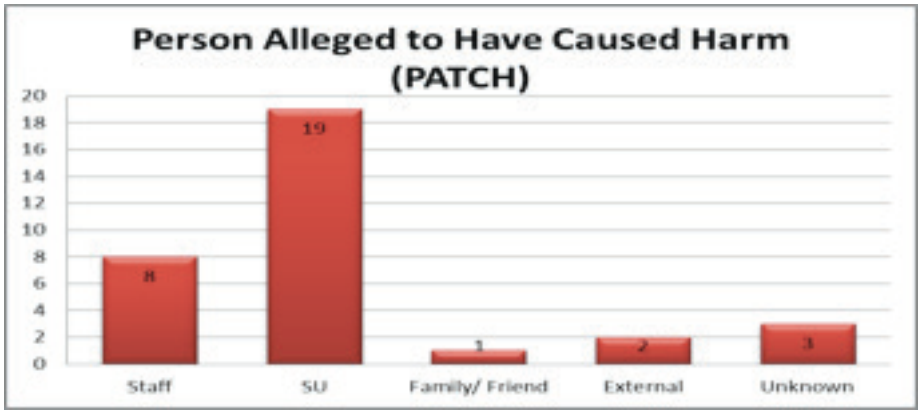
There were 33 concerns raised over the year at York House with 46% of these being physical abuse. From analysis we can see that they were all service user on service user altercations. This pattern was also evident in the previous year's annual report. We feel this is unlikely to change due to the nature of our service and the disinhibited behaviors displayed by those service users with an acquired brain injury.

Around the time this increased (June), we had a number of admissions in close succession and this disrupted the dynamics on the Dales unit. One individual service user is very verbally perseverative and this led to him being targeted by other service users through frustration.



PATCH

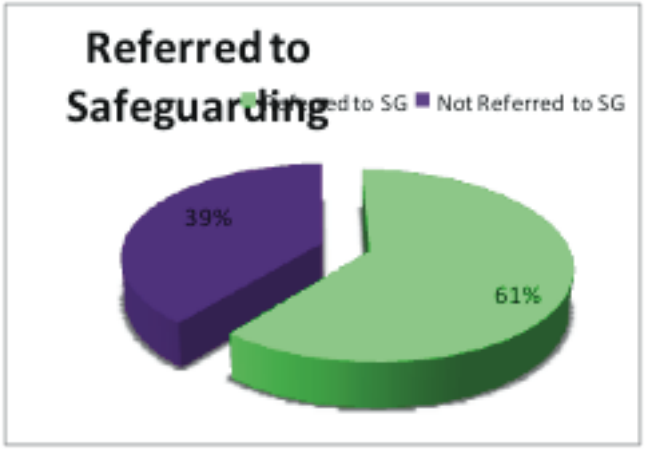
All incidents in relation to staff were fully investigated and disciplinary action taken where appropriate, however some of these were unfounded.



39% of incidents raised to the safeguarding team were either dealt with in-house and managed proportionately, or a verbal conversation was had with the City of York Council and not felt necessary to refer due to the actions already taken.

The number of alerts by unit accurately reflects the service user needs and the nature of the work carried out across the different units at York House. The staffing levels across the unit therefore reflect the need to manage the risk with a higher staff to service user ratio on The Dales unit.

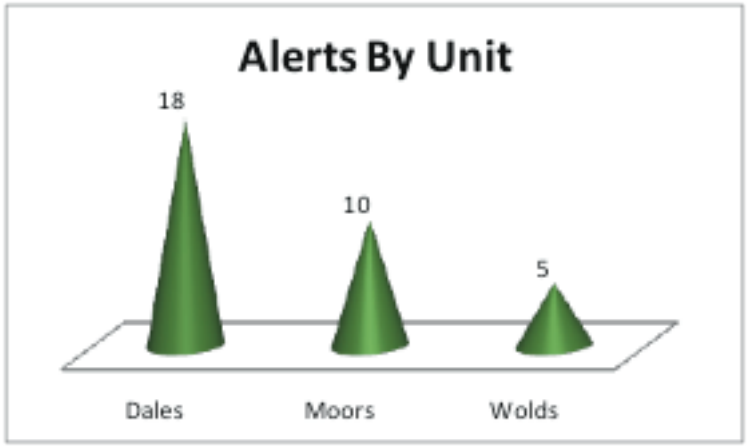
There have been two s42 investigations carried out in 2016 by York House as directed by CYC. Following the level 3 training attended by the social worker at York House the s42 enquiry which was submitted received good feedback on the standard of this report.



Making Safeguarding Personal

York House are currently involved in a task and finish group along with other members of the multi-agency sub-group looking at improving the way we report, record and evidence MSP in a meaningful way. This will run for a period of 6 months with monthly meetings scheduled. We currently ensure that service users are involved wherever possible in the safeguarding process with their views, wishes and where possible specific outcomes recorded. A Speech and language therapist is currently involved where appropriate in the safeguarding process to ensure that communication is accessible and appropriate to the individual's needs.

York House service users have good advocacy uptake which is often a crucial element where service users lack capacity in relation to safeguarding.



Garrow House

All clinical and non-clinical staff members employed within the service have received safeguarding awareness face to face training. Same for safeguarding awareness e-learning course.

We had seven concerns raised internally by frontline staff within the service this reporting year. Of these seven, three were subsequently after review passed onto the relevant local authority adult safeguarding team. Of these three, one resulted in a section 42 enquiry.

We have continued to seek and respect the wishes of patients involved in safeguarding concerns throughout the process where possible. The safeguarding adults policy within the unit states clearly how this should be done.

Nothing new this year.

This is a joint response from

Healthwatch York and York CVS

Siân Balsom has refreshed the level 1 safeguarding adults training (she has previously completed the Train the Trainer Course). This refresh is in advance of delivering Level 1 Safeguarding sessions in 2017. The first is for all our staff and volunteer team within Healthwatch York. However, to maximize the benefit Siân will also cascade this learning to York CVS reception team as a priority.

There were no completed enquiries in the year.

In the year, we have begun working on a coproduction strategy in partnership with City of York Council in preparation for the 'national coproduction week' taking place in July 2017.

We attended the 'making safeguarding personal' event in Bradford in the summer to explore how this approach can be more widely understood and embedded. Following this, we explored this with the sector through the forums we run, explaining this approach and inviting the sector to share their thoughts and views in relation to their own work. Safeguarding continued to be an active topic within the forums of which there were 21 during the year, with over 300 participants in total attending.

In addition, and following the event in Bradford, we reviewed our safeguarding adults policy with three aims; to ensure the approach of 'making safeguarding personal' was included and embedded, to make it more accessible and easy to use, and to be able to offer this to the third sector once completed. This work is in progress and will be completed later in the spring.

We continued to support the sub group structure and attend the board development days during the year. We were also engaged in the peer support process, and supported and attended National Safeguarding Week. We have begun work on supporting the National Safeguarding Week (due to take place in October 2017).

We continued to feature items in the Healthwatch magazine to raise awareness of issues of importance to the Safeguarding Adults Board. For example, there was a feature on suicide prevention in the Winter 2016/17 edition.

In summary, we continued to find ways to engage the third sector and the public in raising their awareness of 'making safeguarding personal' over the year.

NHS Vale of York Clinical Commissioning Group (CCG)

The PCU hosts adult safeguarding on behalf of the four North Yorkshire CCGs. The Deputy Designated Nurse from the Vale of York CCG moved into an interim designated role with the PCU to lead the safeguarding team in April 2016 and became permanent in the role of Designated Professional in October 2016. As such the following is a summary from both of the above organisations and also includes the work of the Nurse Consultant Safeguarding for Primary Care.

In 2016/17 training delivered to CCG staff and GP and primary care practitioners has included WRAP (workshop raising awareness of prevent)/ prevent awareness; domestic abuse; human trafficking and modern slavery. Embedding of changes made through the Care Act has also continued. A total of 671 staff have received training.

The Named GPs North Yorkshire and York CCGs, Nurse Consultant Safeguarding Primary Care and Designated Professionals Children and Adult hosted the first Northern Region Safeguarding Named GP Conference on the 11th November 2016 in York. The aim of the conference was to deliver safeguarding level 4 training for Named GPs, showcase and share local innovations in practice and to develop peer support networks for Named GPs within the Northern Region. The event was extremely successful and will as such be expanded across the Northern region in 2017.

The PCU safeguarding officers have completed the new 'Working together to Safeguard Adults' training, evaluating it as excellent. Three team members attended the Making Safeguarding Personal (MSP) full-day workshop hosted by ADASS in Bradford in May 2016. The workshop examined the different elements of MSP and provided a theoretical example using a theatre performance group and a real example from practice hearing the experience of a service user.

The Designated Professional has attended regional conferences and training:

- Prevent - Making The Link – June 2016 – (1 day)
- ADASS – delivering an effective safeguarding adults review November 2016 (2 days)
- Mental Capacity Act – held regionally each quarter (1day)
- NHS England - Managing Risk and Leading Change in Safeguarding – December 2016 – (1 day)

Following the introduction of the Care Act and the changes in safeguarding enquiry work the safeguarding officers have taken a joint role with City of York Safeguarding team on a smaller number of enquiries than in previous years. These mainly involve Independent Provider services and are predominantly in the category of neglect or omission of care. We have continued to embed 'making safeguarding personal' into enquiry work recording service user wishes. The intention for 2016/17 is to audit this practice.

In addition to enquiry work the safeguarding officers have also undertaken joint quality assurance visits picking up areas of concern before they reach the threshold for safeguarding. The team has provided a safeguarding health advisory and support role for GP and primary care colleagues; Adult Social Care; CQC and NHS provider services.

Safeguarding GP practice leads meetings are held quarterly in the CCG area. During 2016/17 these meetings have particularly focused on raising awareness of adult safeguarding policy and processes. This has directly led to a three-fold increase in GP engagement calls made to specialist nurses to advise on the management of adult safeguarding concerns.

Recognition and management of domestic abuse has been a priority for 2016/17 – with the promotion and involvement of health agencies in safeguarding week and the embedding of MARAC (multi-agency risk assessment conferences) processes into GP practices. Learning from Domestic Homicide Reviews has been incorporated into training events. Following learning from a national serious case review the team has begun to develop pathways and processes for managing MAPPA (multi-agency public protection arrangements) cases across the health economy.

The CCG provides safeguarding assurance to NHS England and in July 2016 an assessment of the CCG assurance framework was completed. This was followed with an assurance visit over two days to examine evidence of compliance. The CCG developed an action plan to address a small number of gaps noted namely in a training needs analysis and in guidance for staff.

In 2017/18 the PCU function will be re-aligned into CCGs. The safeguarding function for NHS Vale of York CCG will be hosted by NHS Scarborough and Ryedale CCG. The team will also undergo some re-modelling of function in line with the changing environment of the health economy. This will serve to appropriately strengthen the resource within the team and provide a re-energised commitment to safeguarding adults.

Leeds and York Partnership NHS
NHS Foundation Trust

Clifton House - Leeds and York Partnership

Safeguarding Adult Concerns raised with the LYPFT Safeguarding team from April 2016 to March 2017.

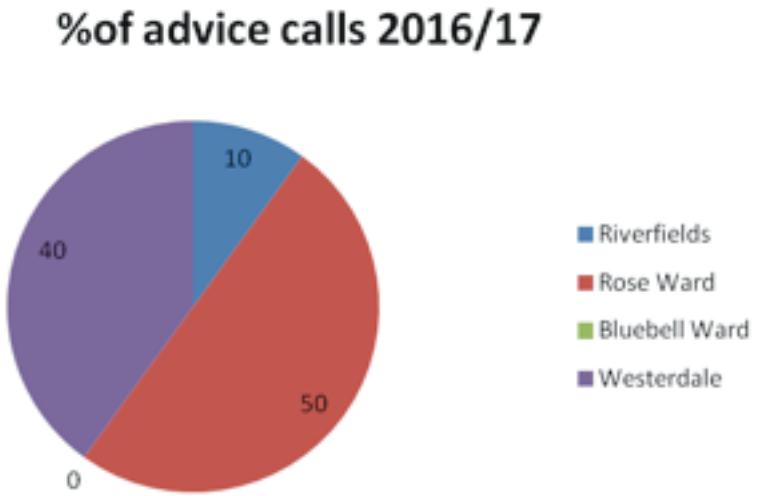
The following tables indicate safeguarding patterns of referrals (City of York alert/ referral form sent to the ASC safeguarding unit) and advice calls to the LYPFT team.

Westerdale Ward (temporarily closed from 2.12.16), Riverfield Ward, Bluebell Ward, Rose Ward.

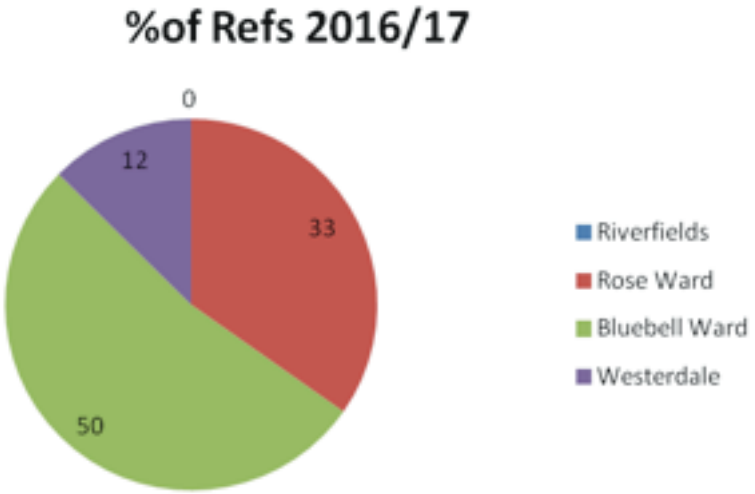
For the purposes of this overview we have defined 'advice' as calls to the LYPFT team for advice which may not reach the threshold for safeguarding but involve advice being given regarding care plans and protection plans. Much of this work aims to be preventative and encourage staff to report incidents at an early stage.

'Referrals' relate to incidents requiring further enquiry led by ASC and completion of the City of York alert/ referral form.

	No of advice calls 2015/16	No of advice calls 2016/17	%of advice calls 2016/17
Riverfields	2	1	10
Rose Ward	3	5	50
Bluebell Ward	1	0	0
Westerdale	0	4	40
Total	**6**	**10**	**100**



	No of refs 2015/16	No of refs 2016/17	%of refs 2016/17
Riverfields	1	0	0
Rose Ward	7	2	33
Bluebell Ward	3	3	50
Westerdale	0	1	12
Total	**11**	**6**	**100**



Due to the small numbers involved it is difficult to interpret the year to year data with confidence and with Westerdale being temporarily closed and overall bed reduction the data is skewed downwards. However, it appears that safeguarding concerns raised by the Clifton Ward practitioners remains fairly consistent with a downturn in referrals but an increase in advice.

The following chart shows advice/referral by type of abuse/ allegation for 2016/17

Type of abuse/allegation	Emotional	Financial	Physical	Psychological	Self-neglect	Sexual
	1	4	3	4	1	2

Training

Over 2016/2017 the LYPFT safeguarding team have delivered four Level 2 taught safeguarding training sessions at Clifton House in addition to the planned Trust-wide rolling programme of training. Drop-in safeguarding sessions are offered alongside safeguarding attendance at MDT meetings as required.

Current compliance for compulsory adult safeguarding training is at 94% for the specialist care group.

Level 3 taught safeguarding adult training has started to be implemented and 5 representatives from Clifton House have attended. This is aimed at senior clinical staff who have responsibility for supervising and leading staff. The long term aim is to have all clinical staff at NHS band 7 to be level three compliant the end of 2018.

Alongside e-learning, the LYPFT team have developed a Domestic Violence training pack and a rolling programme of taught sessions is being developed and offered across the Trust.

A new safeguarding supervision policy is also being disseminated with associated training and support. Staff will be required to access this 4 times a year.

Audit

The Trust has accepted the NICE guidelines for Domestic Abuse and the internal audit team is undertaking a series of benchmarking audits to inform the development of forthcoming work in the four guidance areas.

The Trust has participated in a LSAB review of service user records to determine if care act principles are being followed including Making Safeguarding Personal - this was completed in January 2017. We are still awaiting formal feedback and actions, but the interim feedback has been generally positive.

The Trust is also currently running a staff survey eliciting feedback in regards staff experiences of internal safeguarding processes and which areas of knowledge they believe they require extra support with from the safeguarding team.

Stockton Hall - Priory Healthcare

Information about Safeguarding training undertaken internally and externally during the year byrelevant staff plus any evidence of impact

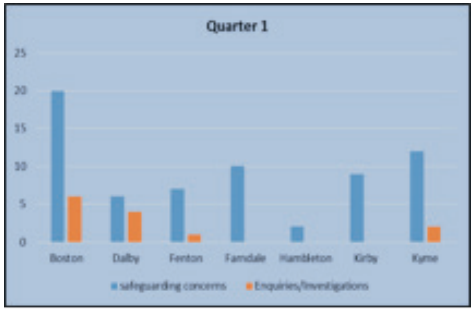
There has continued to be 100% compliance with safeguarding adults training for induction staff. This has involved attendance at a 1½ hour face to face training session. Safeguarding adults training for contracted clinical staff has also been facilitated on monthly basis, alongside induction training, with 83% compliance. There were 8 training sessions for non-clinical staff with attendance of 72, giving 94% compliance.

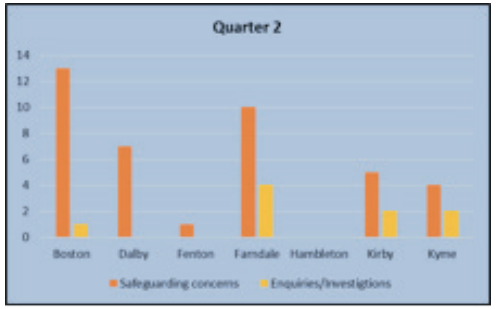
Three sessions of Safeguarding Enquiry and Investigation training were provided by an independent trainer in April and November 2016. A one day session was attended by 15 senior clinicians and managers at Stockton Hall Hospital, including doctors, charge nurses, and heads of departments. Two ½ day sessions were also facilitated by an independent trainer to 14 senior clinicians and 10 non-clinical managers from the hospital, regional Partnerships in Care units and the local independent hospitals. The feedback was very positive (70% excellent, 30% Good) and certificates were provided.

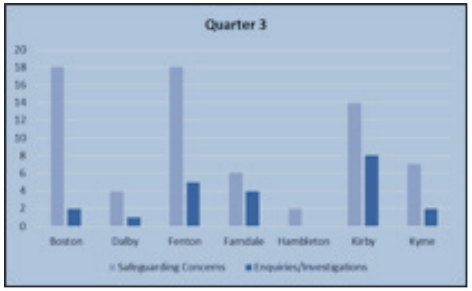
247 members of staff who have contact with adults and children attended the Workshop to Raise Awareness of Prevent training sessions during the year, which is a mandatory requirement in accordance with the NHS Contract. Feedback questionnaires are completed and forwarded to the Regional Prevent Lead, indicating that attendance at WRAP training significantly enhances knowledge and understanding of the Government's Counter Terrorism Strategy.

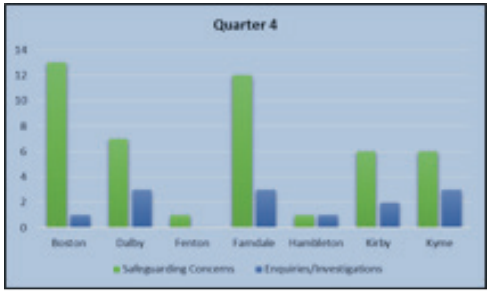
Information about any Safeguarding Concerns and Completed Enquiries during the year including analysis by location and type

Stockton Hall Hospital is a 112 bed medium secure psychiatric unit comprising seven wards, inclusive of women's services, mental illness, learning disabilities and personality disorders. The majority of patients have been admitted due to offending behavior, they are commissioned through NHS England and are all detained under the Mental Health Act 1983. Admissions are from across the country, with approximately 50% originating from the Yorkshire and Humber region.









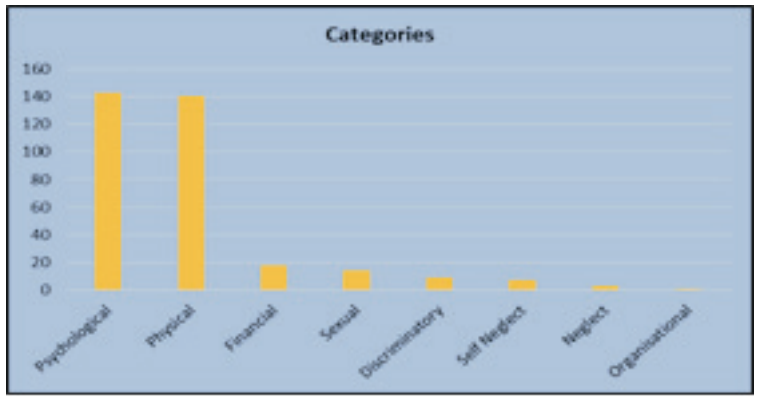
There were 221 safeguarding concerns during the year of which 57 were reported to City of York Council, requiring Section 42 Enquiries under the auspices of the Care Act 2014 or internal investigations completed by the hospital. This represented an increase of 77% compared with the number of safeguarding concerns the previous year and an increase of 14% of reported cases respectively. The increase in safeguarding concerns is likely to be due to the improvement in collating data from the wards following the introduction of the ward based safeguarding leads who provide monthly reports which are discussed at the Safeguarding Practice Meetings and form the basis of the monthly and quarterly safeguarding reports provided by the hospital's Safeguarding Lead to the Clinical Governance Meeting.

The numbers of persons alleged to have caused harm were as follows: Service Users 187 (85%), Staff 22 (10%), Relatives 4 (2%) and Not/Disclosed 8 (4%). This is broadly similar to previous years.

An analysis of safeguarding concerns on the wards indicates a variable level of activities. Boston, a 24 bed ward for men with a primary diagnosis of mental illness had 64 safeguarding concerns (29% of the total) of which 9 (14%) were reported to City of York Council, requiring further enquiry or investigation. Kirby, an equivalent sized ward with a similar client group had 33 safeguarding concerns (15% of the total) of which 12 (36%) were reported. Farndale, a 16 bed ward for females with a wide range of mental health problems, had 38 safeguarding concerns (17% of the total) of which 11 (29%) were reported.

Most of the wards demonstrated increased safeguarding concerns at different times of the year, reflecting a number of dynamics including the following. Adults at risk on Boston ward experienced specific difficulties during the period after the introduction of smoking cessation, with cigarettes reportedly being sold to patients on the ward leading to illicit smoking in

bedrooms and concerns about financial exploitation. This was ameliorated following an internal disciplinary investigation and staff changes. Kirby ward reported heightened anxiety among adults at risk due to the serious physical aggression presented by a patient on the ward towards staff and service users. Fenton, an 8 bed learning disability ward for patients presenting with symptoms associated with Autism Spectrum Disorders had relatively small numbers except for the third quarter when 18 safeguarding concerns were raised of which 5 were reported. A common factor on this ward, particularly with regard to cases reported to City of York Council was allegations of financial abuse. This was reported to the police and an internal investigation was requested, resulting in more effective methods of financial management at ward level. All the wards have reported an increase in trading between patients as a significant cause of safeguarding concerns being raised, including items of property and medication which may have been exacerbated due to the increase in disposable income.



Allegations of psychological and physical abuse continued to be predominant safeguarding categories. There were 7 recent safeguarding concerns under the category of self-neglect. Although this is a relatively small number it is a significant development. The primary cause of suspected self-neglect involved adults at risk failing to adhere to their physical health needs, including managing chronic conditions such as diabetes. Mental capacity issues were identified in several cases requiring capacity assessments to be undertaken, occasionally necessitating best interest meetings.

Information relating to Making Safeguarding Personal or other safeguarding outcome measures implemented during the year

A Service User Involvement Safeguarding Group was established towards the end of 2016. The purpose of the group was to ascertain the views and feelings of adults at risk within the hospital's safeguarding procedures and ensure the application of the principles of Making Safeguarding Personal are adhered to. The agenda has included discussions about how to enhance the active participation of service users, with the support of the Independent Advocacy Service. The intention is for adults at risk to feel that they are at the Centre of their safeguarding needs and to promote empowerment at all stages of the process.

Service users identified the following requirements to improve their involvement in safeguarding; a) The link worker role for the adult at risk and the person alleged to have caused harm needs to be clarified in order to improve communication and empowerment, b) The adult at risk and the link worker should sign the Safeguarding Plan with an agreed review date, c) Advocacy involvement will be consistently promoted at all stages of the safeguarding process, d) An outcomes meeting will take place at the next scheduled ward round or individual care review in order for the adult at risk can evaluate the effectiveness of the Safeguarding Plan and other agreed actions.

An outcomes based questionnaire to review safeguarding actions will initially be piloted on one of the wards and feedback discussed at the hospital's Clinical Governance Meeting. Thereafter the plan is for safeguarding outcomes to be a regular agenda item at all clinical team meetings. This will

enable the views and feelings of adults at risk and persons alleged to have caused harm to be elicited and for this information to be integrated into care planning to identify themes and avoid further safeguarding concerns from arising. Auditing this data should create a method of accurately evaluating the effectiveness of Making Safeguarding Personal within the hospital. Furthermore, Service Users and Rethink Advocates have begun to attend the monthly Safeguarding Practice Meetings, along with the ward based safeguarding leads and the clinical heads of departments, providing them with a direct voice in discussing changes to practices and procedures.

Any other achievements/developments relating to Safeguarding during the year

Following two meetings between Stockton Hall Hospital North Yorkshire Police and York City Council Safeguarding Adults Team and further liaison between these agencies a Memorandum of Agreement was agreed, providing minimum quality standards for patients who have reported criminal offences. This document was quality assured at the December Safeguarding Adults Board. The Memorandum of Agreement was formatted with the logos of the three organisations and has been forwarded to partner agencies for circulation to their staff, as required. This document will be reviewed within two years.

Stockton Hall Hospital has been actively involved in changing the terms of reference for the Safeguarding Implementation Group that is attended by the local independent mental health hospitals. It is now called the Multi Agency Safeguarding Group and its membership is expanding to include Clifton House Low Secure Unit. The meetings are also attended by representatives of the Clinical Commissioning Group and the City of York Council Safeguarding Adults Team and incorporate a safeguarding story/scenario discussion in order to share good practice and learn lessons from colleagues' experiences.

The Retreat

Safeguarding training

Safeguarding Adults General Awarness Training compliance for the hospital was 98% (335 people out of 343 required to complete); a 4% improvement compared to the previous year.

The safeguarding training level 1 is delivered face to face to all new starters (109) and as an eLearning refresher module (47). The refresher frequency is 3 years.

Compliance for external training: Working Together to Safeguard Adults was 100%.

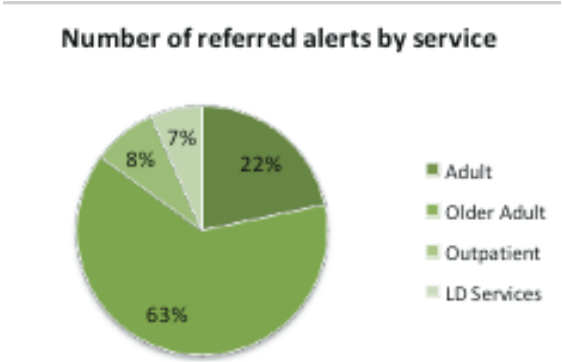
The Retreat has revised its Level 1 Safeguarding Training in line with City Of York Council's revised training package and in line with the Care Act 2014.

Safeguarding Concerns and Completed Enquiries

The number of reported safeguarding alerts (220) has been lower in comparison to the previous year: 236 in 2015/2016, a 7% reduction. The number of alerts which were later referred to the City of York Council Safeguarding Team and Care Quality Commission was higher in comparison with the previous years and for the 2016/2017 was 60 (previous year: 42).

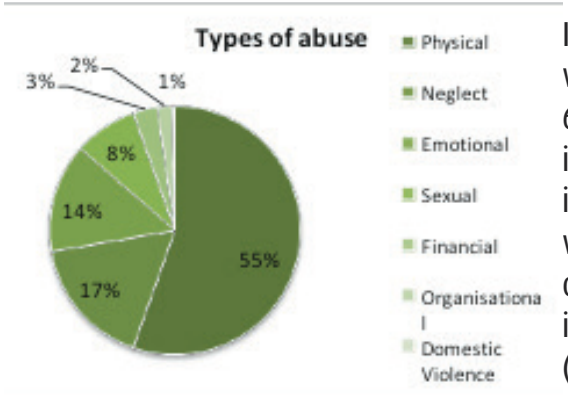
The new average for the quarter is 55 alerts, in comparison with 59 in the previous year. The average number of referred alerts per quarter is 15 (10 in the previous year).

The significant majority of alerts, 164 (75%), were submitted within older adult services in comparison with 38 (17%) reported on adult units, 11 reported within the Learning Disability (LD) services (5%) and 7 reported in outpatient services (3%). However when it comes to the referred alerts the figures present a different picture: 63% of cases were from older adult (38), 22% were from adult services (13), 8% from outpatient (5) and 7% from LD services (4).



Person alleged to cause harm (PATCH) was a current patient of The Retreat in 128 cases (58%). In 56 cases (26%) allegations were made against staff, and in 36 cases (16%) the PATCH was identified as external which includes family members, friends, ex-patients, agency staff and other agencies.

Cases of physical abuse account for the majority of all of the alerts: 122 (55%). Neglect was reported in 37 cases (17%), emotional abuse in 31 (14%), sexual in 18 (8%), financial in 7 (3%), organisational in 4 (2%) and domestic violence in 1 (1%).



In 92 cases the allegations were substantiated (42%), in 6 partially substantiated (3%), in 70 unsubstantiated (32%), in 27 cases the social workers were not able to determine the outcome (12%). The investigation is currently pending in 25 cases (11%).

Information relating to Making Safeguarding Personal or other safeguarding outcome measures implemented during the year

The Retreat has made significant progress with regards to Making Safeguarding Personal (MSP). Service users' views (or their carers/advocates where they lack capacity to engage in the safeguarding process) are sought on all occasions that a safeguarding concern is raised.

A sub group, of the Multi Agency Safeguarding Group which is attended, amongst others, by the Independent Hospitals in York has been set up to determine how we both measure and capture MSP in line with MSP guidance and in a way that is meaningful for our service users. The group is chaired by The Retreat's Involvement Lead.

The Retreat attend the Quality and Performance sub group of the Safeguarding Adults Board and will be providing data gathered re MPS as requested by this group.

Any other achievements/developments relating to Safeguarding during the year

The Retreat has one full time position (across two posts) that receive and process all safeguarding concerns raised. This has been further developed to allocate each of the safeguarding social workers to specific unit areas, thus allowing for a consistent approach with regards to proactive safety planning.

The Retreat is in the process of writing a safeguarding strategy; this will be done in conjunction with our service user and carers.

The Retreat continues to hold a strong relationship with City of York Council Safeguarding Team. We have an open and transparent approach to safeguarding, allowing us to act with advice in the best interest of our service users. A significant number of s.42 enquiries are entrusted to us by City of York Safeguarding Team.

The Retreat was fortunate to have been asked to be interviewed as part of City of York Councils Peer review to provide feedback on our experience of working with the local authority in relation to safeguarding. We consider this to be a positive reflection of our partnership working.

Annex 1:
Members of City of York Safeguarding Adults Board, March 2017

	Name	Title	Organisation	Address
1	Karen Agar	Associate Director of Nursing (Safeguarding)	Tees, Esk & Wear Valley (TEWV) NHS Foundation Trust	Flatts Lane Centre, Flatts Lane, Normanby, Middlesbrough, TS6 0SZ
2	Sarah Armstrong	CEO	York CVS	Priory Street Centre 15, Priory Street, York YO1 6ET
3	Kyra Ayre	Head of Service Safeguarding, MCA & DoLs	City of York Council	West Offices, Station Rise, York YO1 6GA
4	Sian Balsom	Healthwatch Manager	Healthwatch York	Priory Street Centre 15, Priory Street, York YO1 6ET
5	Michelle Carrington	Chief Nurse	NHS Vale of York CCG	West Offices, Station Rise, YORK YO1 6GA
6	Martin Farran	Corporate Director of Health, Housing and Adult Social Care	CYC	West Offices, Station Rise, York YO1 6GA
7	Beverley Geary	Chief Nurse	York Teaching Hospital NHS Foundation Trust	Wigginton Road, York YO31 8HE
8	David Heywood	Social Work Manager	Stockton Hall	The Village, Stockton-on-the-Forest, York YO32 9UN
9	Kim Bevan	Director of Business Development	The Retreat	Heslington Road, York, YO10 5BN
10	Kevin McAleese CBE	Independent Chair	York Safeguarding Adults Board	c/o West Offices, Station Rise, YORK , YO1 6GA
11	Michael Melvin	Assistant Director	CYC	West Offices, Station Rise, York YO1 6GA
12	John Pattinson	Deputy Director of Nursing & Quality	NHS England	Unit 3, Alpha Court, Monks Cross Drive, York, YO32 9WN

13	Christine Pearson	Deputy Designated Nurse, Safeguarding Adults	NHS Vale of York CCG	West Offices, Station Rise, York YO1 6GA
14	Cllr Carol Runciman	Cabinet Lead	City of York Council (CYC)	West Offices, Station Rise, York YO1 6GA
15	Sharon Stoltz	Director of Public Health	CYC	West Offices, Station Rise, York YO1 6GA
16	Keren Wilson	Chief Executive	Independent Care Group	10 North Park Road, Harrogate, HG1 5PG
17	Lisa Winward	Assistant Chief Constable	North Yorkshire Police	Newby Wiske Hall, Newby Wiske, Northallerton DL7 9HA

ANNEX 2:

City of York Safeguarding Adults Board Membership and Attendance 2016/17

(Key: Y = present or substituted; A = Apologies sent; NA = Not yet a member/replaced as a member)

Organisation	Designation	June 2016	Sep 2016	Dec 2016	March 2017	Nominated representative or substitute
	Independent Chair	N	Y	Y	Y	75%
City of York Council	Director of Adult Social Care	Y	N	Y	Y	75%
	Assistant Director , Adult Assessment and Safeguarding	Y	Y	Y	Y	100%
	Safeguarding Service Manager	NA	NA	Y	Y	100%
	Director of Public Health	NA	NA	Y	Y	100%
	Cabinet Member for Health, Housing and Adult Social Services	Y	Y	Y	Y	100%
Healthwatch York	Manager	Y	Y	Y	N	75%
Independent Care Group	Chief Executive	Y	Y	Y	Y	100%
NHS England	Assistant Director	Y	N	N	Y	50%
North Yorkshire Police	Deputy Chief Constable	Y	Y	N	Y	75%
Partnership Commissioning Unit (PCU)	Director of Partnership Commissioning	Y	N	Y	NA	66%
	Designated Professional for Adult Safeguarding	N	N	Y	Y	50%
The Retreat	Director of Operations	Y	Y	Y	Y	100%
Stockton Hall	Social Work Manager	Y	Y	Y	Y	100%
Tees, Esk & Wear Valley NHS FT	Associate Director of Nursing (Safeguarding)	Y	Y	Y	Y	100%
Vale of York CCG	Chief Nurse	Y	N	Y	Y	75%
	Designated Nurse, Safeguarding	N	Y	Y	Y	75%
York CVS	Representative	Y	N	Y	N	50%
York Teaching Hospital NHS Foundation Trust	Chief Nurse	Y	Y	Y	N	75%
Overall Board attendance		**88%**	**69%**	**94%**	**82%**	

Independent Chair's comments on Board attendance

As I commented last year, we have worked hard once again to ensure that all partner organisations on the Safeguarding Adults Board are represented by a post holder of sufficient seniority and expertise and that ideally the same person should attend each meeting.

However, there are inevitably operational pressures on individuals and organisations as well as annual leaves to be allowed for, given that the SAB only meets four times a year. There are also personal crises in the best managed of diaries, as well as reorganisations and role changes. In the ideal world the twelve partners would each have achieved 100% attendance records. During 2016/17, six of them managed to, one down from 2015/16 but the same as 2014/15. Well done to them for that!

Each SAB meeting ends with a meeting review in which all members comment on what went well during the two and three quarter hours and what would have been even better if it had happened. This feedback is included in the SAB minutes which are available on the SAB public website. Those reviews continue to confirm a broadly consistent picture, which is that SAB members find meeting together four times a year to be challenging, constructive and rewarding.

I am very grateful to the senior representatives of each organisation listed in Annex 1 who have given so much time, interest and commitment to the work of the Board during 2016/17.

ANNEX 3:

April 2016 to March 2019 action plan - March 2017 update

Priority Area 1 Empowerment: People know what abuse and neglect is and what they can do to keep safe and seek help				
Action	What we will achieve	How we will evidence this	Lead officer	Date
1a. The Safeguarding Adults Board will produce an information leaflet and develop a Board website about Adult Safeguarding. This will contain information about keeping safe, advice that explains types of abuse and neglect, and contact information to be used by anyone with a safeguarding concern.	People in the community will have increased knowledge about how to stay safe and what to do when they are concerned about their own safety; or the safety of another adult with care and support needs.	We will develop and roll out a communication/engagement strategy and launch it in the community	SAB Board Manager	31.03.17
		The website will include accessible information about abuse and neglect and a section for the wider public to access	SAB Board Manager	31.03.17
		We will agree a quality assurance framework that includes case files audits, single agency and multi agency audits.	SAB Quality & Performance Sub Group	31.03.17

Audit:
- Media and Comms strategy agreed by Board June 2016
- Keep safe guide to personal safety on website – further work required
- Audit tool has been to Quality & Performance group
- Audit tool designed and tested on 8 cases in CYC- partners to test
- Leaflet published
- New quality assurance framework almost complete

Priority area 2 Prevention We will need to demonstrate how we are working to prevent adults experiencing, or being at risk of experiencing avoidable abuse and neglect				
Action	What we will achieve	How we will evidence this	Lead officer	Date
2a. All Safeguarding Adults Board partners will be required to assure the Board on a regular basis about the actions they are talking locally to prevent people experiencing abuse or neglect. SAR policy at September Board for ratification	People in the community will be able to see how partners work together to commission safe and high quality services and how organisations hold themselves to account when concerns are raised about the quality and safety of their services.	We will commission Healthwatch to undertake a consultation with the community on adult safeguarding	SAB Board Manager	31.03.17
		We will publish a preventative strategy on the website that helps explain how we ensure we commission services that are safe and high quality.	SAB Quality & Performance Sub Group	31.03.17
		We will ensure there is a transparent process in place that demonstrates how we learn lessons when things go wrong and the SAB can provide proportionate responses under S44 of the Care Act 2014	Lessons Learned Sub Group	31.03.17
2b. The Safeguarding Adults Board will update and maintain the public section of its website using the accessible information standards, with a section on staying safe.	People in the community will have more access to information which will increase their knowledge about how to stay safe and what to do when they are concerned about their own safety or the safety of another person.	We will include information about how to keep safe on the public section of the SAB website. This will include information about door step crime, general home safety etc.	SAB Board Manager	31.03.17

Audit
- SAR policy has been ratified
- Lessons Learned sub group is processing cases and has case 'tracker' to actively monitor
- Referral form is on website plus video on reporting abuse

Priority area 3: Proportionality: People are asked what they want to happen as a result of a safeguarding concern being raised and their views directly inform what action follows				
Action	What we will achieve	How we will evidence this	Lead officer	Date
3. The Safeguarding Adults Board will ensure that when partners undertake an enquiry into safeguarding concerns, any actions taken are informed by the expressed wishes and feelings of the person at the centre of the concern, in accordance with The Care Act 2014 and Making Safeguarding Personal requirements.	People in the community will gain in confidence that any safeguarding adult plans are informed by people's wishes and feelings, balancing concerns for someone's personal safety with an understanding of how they see their own quality of life & wellbeing	We will have a clearly defined and transparent governance, performance management and quality assurance framework in place, which will comprise a series of single agency and multi-agency audits and quality assurance processes.	Quality & Performance Sub Group	31.03.17
		Healthwatch will lead on customer focused surveys to ensure people have the opportunity to feedback their experiences of adult safeguarding.	Healthwatch	31.03.17
		We will ensure that we use customer feedback to review and update our local adult safeguarding responses.	Quality & Performance Sub Group	31.03.17

Audit:
- Quality & Performance group developing the performance management framework
- Risk register has been developed and is monitored via Q and P group
- Healthwatch and CYC exploring possible options for ongoing feedback on people's experiences and consultation over regional review proposed changes to the Safeguarding Policy

Priority area 4: Protection: We will support people to manage the risks they experience as a result of abuse, or neglect and the help they receive makes their situation better				
Action	What we will achieve	How we will evidence this	Lead officer	Date
4a. The Safeguarding Adults Board will require all partners to ensure that there is an up to date assessment of mental capacity and any best interest decision on file, and will ensure the person is supported where required by an advocate or a independent mental capacity advocate	People in the community will gain confidence that that all adults who are assessed as lacking the mental capacity to decide how a safeguarding concern should be progressed are offered the appropriate support which ensures all decision are made in their best interests.	We will monitor and report on the use of advocates & IMCA's for individuals who are assessed as lacking mental capacity.	Quality & Performance Sub Group	31.03.17
		We will undertake case file audits to ensure best practice is followed in MCA and Safeguarding.	Quality & Performance Sub Group	31.03.17
4b. The Safeguarding Adults Board partners will ensure that when abuse or neglect has occurred, safeguarding adults plans are developed in a way which shows a balance between quality of life and concerns about peoples' safety.	People in the community will be able to see more clearly that work is undertaken in response to current and ongoing risks, supporting the person to recover from the abuse or neglect and keeping them more safe.	We will develop local operational guidance to support front line staff and managers, which will be supported by a new safeguarding adults training offer.	SAB Board Manager	31.03.17
		We will agree governance and quality assurance arrangements for partners to feedback themes and trends identified through case file audits.	SAB Quality & Performance Sub Group	31.03.17

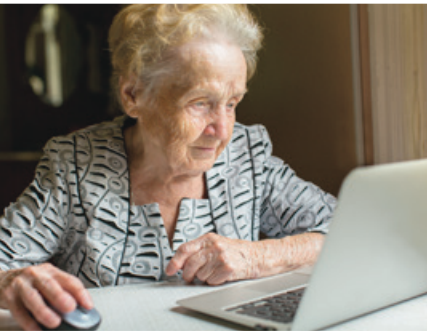
Audit:
- Use of advocacy is part of the performance reporting to the SAB
- Local Operational Guidance is on the website
- Audit tool is being piloted and Performance & assurance framework is almost complete

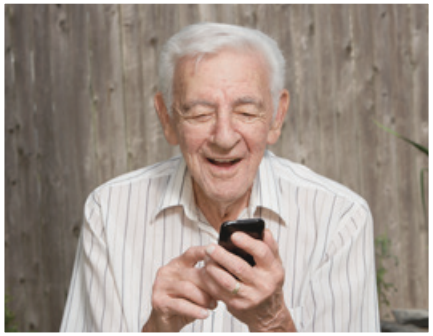
Priority area 5: Partnership: We will work together to ensure adults receive help and support from the people best placed to help them feel safer.				
Action	What we will achieve	How we will evidence this	Lead officer	Date
5a. Each Safeguarding Adults Board partner will ensure their organisation upholds their collective responsibilities to safeguard adults in accordance with the requirements of the Care Act 2014.	People in the community will gain in confidence that Care Act 2014 requirements are well established across every partner organisation in the City of York.	Each Board partner will report to SAB on an annual basis about the work their organisation has undertaken as required by the memorandum of understanding.	Quality & Performance Sub Group	31.03.17
5b. The Safeguarding Adults Board will work with the Children's Safeguarding Board and other local partners to host an annual Safeguarding week across the City of York.	We will help to raise the profile of whole life safeguarding and enhance people's understanding of all the work undertaken locally to help keep people safe.	The Safeguarding Boards will work with other partners (including local media) to plan and host an annual event. The information and feedback from events will be held on the respective Board websites.	SAB Board Manager	31.03.17

Audit:
- 5a. Annual SAB report been to Health & Wellbeing Board and Health & Social Care Policy and Scrutiny Committee
- 5b. Safeguarding week to be held including children and adult safeguarding in October 2017

Priority area 6: Accountability: The roles and responsibilities of individuals and organisations who have a responsibility for safeguarding adults is clearly understood and people know what action they can take if individuals or organisations do not fulfil their responsibilities.				
Action	What we will achieve	How we will evidence this	Lead officer	Date
6a. The Safeguarding Adults Board will agree and maintain common safeguarding adults policies and procedures for all partners to use.	People in the community will be able to understand how local partners work together to tackle any abuse of vulnerable adults.	SAB will officially adopt the West Yorkshire / North Yorkshire multi agency policy and procedures	SAB Board Manager	31.03.17
		SAB will agree a series of good practice guides/working protocols that embed Statutory safeguarding duties.	Quality & Performance Sub Group	31.03.17
6b. The Safeguarding Adults Board will produce an Annual Report explaining what it has done and how its partners have helped keep people safe in the City of York.	People in the community will be able to read the report, see how safeguarding adults operates and be helped to hold local organisations to account if they fail to work in accordance with policies and procedures.	The Safeguarding Adults Board Independent Chairman will present the Board's Annual Report to Health and Scrutiny panel, the Council's Health & Well Being Board, to standing community forums organised by York CVS, to Healthwatch York and to any other community groups which request a presentation.	Independent chair / Director of Adult Social Care.	31.03.17
		The SAB will develop and maintain a risk register to ensure that all identified risks are effectively identified and addressed.	SAB Board Manager	31.03.17

Audit:
- Local Operational guidance is on the website
- CYSAB participating of review of WYNYY procedures and in discussion with NYSAB
- Quality & Performance group have a risk register and monitor updates at each meeting
- Annual report complete with Easy Read summary on website





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City of York Safeguarding Adults

www.safeguardingadultsyork.org.uk

CITY OF YORK COUNCIL

Health, Housing & Adult Social Care Policy & Scrutiny Committee 25 July 2017

Report of Corporate Director of Health, Housing & Adult Social Care

An Introduction to Safer York Partnership

Summary

1. As the structure of Policy and Scrutiny Committees has changed, the Health, Housing and Adult Social Care Policy and Scrutiny Committee now holds the portfolio for Community Safety. This report provides a comprehensive overview of Safer York Partnership, the statutory community safety partnership (CSP) for the City of York.

Background

2. Following changes to the senior management structure within City of York Council in September 2016, Housing and Community Safety transferred from the former Directorate of Communities and Neighbourhoods to a newly formed Directorate of Health, Housing and Adult Social Care. The scrutiny arrangements which support all service delivery within City of York Council have also been realigned with the portfolio for Community Safety being held by the Health, Housing and Adult Social Care Policy and Scrutiny Committee.

2.1 The Police and Justice Act 2006 made provision for a range of changes to the way in which Community Safety Partnerships (CSPs) fulfil their responsibilities in relation to tackling crime, disorder and substance misuse in their locality. These changes contained in sections 19, 20 and 21 of the Act include a requirement that local authority scrutiny structures should consider crime and disorder matters.

2.2 The statutory partnerships originally created by the Crime and Disorder Act 1998 to develop and implement strategies to reduce crime and disorder were originally known as Crime and Disorder Reduction Partnerships (CDRP). Their role and remit has extended with changes in legislation to include reducing reoffending and changes to policing. The key changes have been as follows:

- Police and Justice Act 2006 – introducing the role of scrutiny and the requirement to undertake a Joint Strategic Intelligence Assessment to underpin the three year community safety strategy. Introducing the probation service as a statutory partner

- Police and Social Responsibility Act 2011- changing police accountability to introduce the role of the Police and Crime Commissioner

2.3 Despite amendments to the role and remit of a community safety partnership, the core requirements set out within the Crime and Disorder Act 1998 remain very much at the heart of the CSP remit. These are:

- Preparing an annual strategic assessment. This is a document identifying the crime and community safety priorities in the area, through the analysis of information provided by partner agencies and the community

- Producing an annual three year rolling partnership plan, laying out the approach for addressing those priorities

- Undertaking community consultation and engagement on community safety issues; and

- Sharing information between the responsible authorities other partners within the CSP.

2.4 Community Safety is not just about the police. Like every challenging outcome that local authorities and their partners deliver for communities, community safety needs a wide range of people and organisations to be involved and contributing to address crime and its causes. The statutory partners that make up a CSP are as follows:

- The local authority

- The police

- Fire and Rescue

- Health (Currently involving both Public Health and Clinical Commissioning Groups)

- Probation (now split to include National Probation Service and the Local Community Rehabilitation Company)

2.5 Local Authority

The council has a legal duty under Section 17 of the Crime and Disorder Act 1998 to carry out all its various functions with due regard to the need to prevent crime and disorder in its area. Many of the factors which affect levels of crime, offending and anti-social behaviour are the responsibility of the local authority, such as housing, education, social services, safeguarding, planning and alcohol licensing. They also have a significant role in relation to children and young people and local authority functions such as the Youth Offending Team and Local Children's' Safeguarding Boards are important contributors to community safety.

2.6 Police

The police pay a crucial role in preventing and detecting crime, protecting and reassuring communities and pursuing and bringing to justice those who break the law. They are a key partner but their role is much strengthened by the ability to contribute their warranted police powers to a much stronger and effective process of multi-agency problem solving.

2.7 Fire and Rescue

Fire and Rescue have a relatively focused remit, but are committed and enthusiastic members of community safety partnerships. Their main contribution is through fire safety education focusing on young people within communities who may be vulnerable, road safety, emergency response and being a positive mentor and role model to young people.

2.8 Health

Health are a critical partner where health has a role in community safety. This includes tackling misuse of alcohol, drugs and other substances and commissioning and providing treatment services. They also provide advice and treatment to those who put themselves at risk through their use of drugs or alcohol, provide crucial support to victims of domestic abuse and work with local partners to help prevent problems from occurring. Eg by alerting the police to locations where a lot of alcohol related injuries occur.

2.9 Probation

Probation play a key role in protecting the public, reducing reoffending, rehabilitation of offenders and ensuring that offenders are aware of the effect their behaviour has on communities. This is delivered through packages of support aimed at addressing those factors which contribute to offending behaviour. Their work is split between the National Probation Service and Local Community Rehabilitation Companies. Their respective contributions are pulled together under the Local Criminal Justice Board which has strong links to the CSP.

How Community Safety is Delivered in York

3. Safer York Partnership is the Community Safety Partnership for the City of York. It was established in 1999 under the Crime and Disorder Act 1998 and built on an already successful existing local partnership between the local authority and the police. York was part of the Safe Cities Scheme in the 1980s and as such had already formed a strategic partnership aimed at keeping the city safe. It is this strong foundation that has contributed to Safer York Partnerships success and reputation and this has frequently been recognised by the Home Office.

3.1 Safer York Partnership works with the police to carry out an annual Joint Strategic Intelligence Assessment which sets the priorities for the partnership and shapes the Community Safety Strategy. Each strategy is for three years but is refreshed annually to reflect changing patterns of crime in the city and allow the partnership to respond to emerging issues.

3.2 To reflect changes in local policing and reductions in the resources available to deliver community safety outcomes, the partnership has adapted to focus more on those issues which pose the biggest threat harm and risk to communities and in particularly those individuals who are most vulnerable. The recently adopted Community Safety Strategy is less focused on traditional crime types and places more emphasis on improving quality of life and reducing risk. The strategic priorities contained within the plan address those crime types which impact most significantly on quality of life and communities. However, the crime prevention role has not been lost. Through the Ward Planning teams, the Safer York Partnership Website and social media, the partnership is able to continue to empower communities by providing advice which will help to reduce their chances of becoming a victim of crime.

The Community Safety Unit

4. The work of Safer York Partnership is specifically supported by a Community Safety Unit located in West Offices. Since 2014, this unit has had the added benefit of five operational police officers working alongside City of York Council community safety staff. The unit fulfils a dual role supporting the wider partnership working and multi-agency problem solving that underpins delivery of the community safety plan but also works specifically to tackle anti-social behaviour – a priority for the police, local authority and communities across the city.

4.1 The Community Safety Unit links closely with the neighbourhood policing teams and the newly formed multi-agency Local Area Teams providing support, undertaking daily and weekly risk assessments and working towards resolving the most complex and highest risk cases of anti-social behaviour. A dedicated Neighbourhood Enforcement Team works to tackle environmental anti-social behaviour but also brings additional powers under the Anti-social behaviour Crime and Policing Act 2014 to provide quick responses to those issues which impact significantly on quality of life. Neighbourhood Enforcement Officers have access to police radios and participate in planned operations designed to address those issues of greatest concern including tackling the impact of alcohol on anti-social behaviour at weekends and carrying out patrols in hot-spot locations across the city.

4.2 The Community Safety Unit sits within the Directorate of Health, Housing and Adult Social Care within City of York Council. There are very strong thematic links across the services that make up the directorate including safeguarding adults, housing, alcohol and drug support services. However, the complex nature of the community safety agenda also means that the team work closely with many other local authority services including Children & Education, Planning, Public Protection and Licensing.

Council Plan

5. The Community Safety Strategy links to the following priorities within the Council Plan 2015-19:

- **A focus on frontline services –** to ensure all residents, particularly the least advantaged, can access reliable services and community facilities

- **A council that listens to residents** – to ensure it delivers the services they want and works in partnership with local communities

Implications

6. In producing this report the following implications have been considered

   - **Financial** – none identified
   - **Human Resources** – none identified
   - **Equalities** – none identified
   - **Legal –** Safer York Partnership is a statutory partnership identified within the Crime and Disorder Act 1998
   - **Crime and Disorder** - Safer York Partnership supports the Council's discharge of its crime and disorder duties under the Crime and Disorder Act 1998
   - **Information Technology** - none identified
   - **Property** – none identified
   - **Other –** No other implications identified

Risk Management

7. There are no identified risks relevant to this report.

Conclusions

8. The Police and Justice Act 2006 introduced a clear role for Overview and Scrutiny Committees in overseeing the work of Community Safety Partnerships and their constituent partners. This report provides some background to the CSP and sets out the way in which community safety is delivered in York. Under the council's scrutiny arrangements bi-annual performance reports from Safer York Partnership are presented to the Scrutiny and Policy Committee.

Contact Details

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Corporate Director Health, Housing and Adult Social Care
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Report Approved ✓ **Date** 13/07/2017

Wards Affected: **All** ✓

For further information please contact the author of the report

Abbreviations

ASB – Anti-Social Behaviour
CDRP – Crime and Disorder Reduction Partnership
CSA + E – Child Sexual Abuse and Exploitation
CSE – Child Sexual Exploitation
CSP – Community Safety Partnership
CYC – City of York Council
CYSCB – City of York Safeguarding Children's Board
IDAS – Independent Domestic Abuse Service
JCG – Joint Co-ordinating Group
JSIA – Joint Strategic Intelligence Assessment
MoRILE – Management of Risk In Law Enforcement
NEO – Neighbourhood Enforcement Officer
NYFRS – North Yorkshire Fire and Rescue Service
NYP – North Yorkshire Police
OCG – Organised Crime Group
RoSPA – Royal Society for the Prevention of Accidents
SOC – Serious Organised Crime
SYP – Safer York Partnership
YBAC – York Businesses Against Crime

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Health, Housing & Adult Social Care Policy & Scrutiny Committee

25 July 2017

Report of Corporate Director of Health, Housing & Adult Social Care

Community Safety Strategy

Summary

1. In accordance with S6 Crime and Disorder Act 1998, Safer York Partnership produces and implements a Community Safety Strategy for reducing crime and anti-social behaviour, combating misuse of drugs and alcohol and for the reduction of reoffending. This report summarises the partnership's Community Safety Strategy 2017-20 including the current trends, emerging priorities and the implications of the strategy. The attached community safety strategy shows how the Council and its partners will work together to reduce crime and anti-social behaviour and make progress to ensure that York remains one of the safest cities in the UK. It is a statutory three year plan that gets refreshed on an annual basis.

Background

2. Every three years, Safer York Partnership prepares a Community Safety Strategy which reflects the community safety priorities for the city. This strategy is refreshed annually to reflect the often rapidly changing patterns of crime and risk. Priorities are determined from local consultation and intelligence and from the production of a Joint Strategic Intelligence Assessment carried out by North Yorkshire Police but including data and information from a range of partners, from more detailed thematic problem profiles and other strategic needs assessments which are linked to community safety.

2.1 The last Community Safety Strategy was considered in 2014. This was in many ways a departure from previous strategies in that it reflected explicitly the huge potential impact of high profile events that could damage communities. These included possible terrorism and

radicalisation, child sexual exploitation, domestic abuse and anti-social behaviour. The strategy also recognised the individual impact of more everyday crime such as burglary, robbery and criminal damage.

2.2 In considering the new strategy, it has been recognised that these high profile risks to community safety have not declined and, therefore the new strategy focuses again on threat, harm and risk and those most vulnerable within our communities.

Consultation

3. The initial selection of strategic priorities within the strategy is undertaken through a Joint Strategic Intelligence Assessment. This is cross referenced with the results of the Council's 'Talk About' Residents Survey and the community consultation undertaken by the Police and Crime Commissioner in relation to the development of the police and crime plan. The strategy is developed through Safer York Partnership and as such, each draft includes the contribution of those partners who make up the Safer York Partnership Board. These include:

Police
Local Authority
Fire & Rescue
Office of the Police and Crime Commissioner
National Probation Service
Public Health
Yorkshire, Humberside and East Lincolnshire Community Rehabilitation Company

Options

4. Members are asked to note the content of the strategy and agree to provide support to the Council in delivering the strategic priorities contained within the strategy.

Analysis

5. The community safety strategy sets out the priorities identified through data and intelligence analysis and consultation and sets out how the partnership will work together to tackle crime and anti-social behaviour. It is underpinned by a joint Police and City of York Council Community Safety Unit based within City of York Council's headquarters and a delivery structure of thematic sub-groups reporting to the Safer York Partnership Board. The structure also recognises the input of existing

and relevant groups which contribute to the delivery of the Community Safety Partnership priorities. The strategic priorities contained within the plan include:

River and Road Safety
Keeping the City Centre Safe
Protecting People from Harm
Tackling Anti-social Behaviour
Tackling Serious Organised Crime
Tackling Substance Misuse (including the delivery of the community safety elements of the York Alcohol Strategy)

The strategy includes an assessment of each priority in terms of community impact and sets out the strategic objectives that will drive delivery of that priority.

5.1 The Strategy will be underpinned by more detailed one year action plans aligned to each strategic priority. Priorities will be owned by partners represented on the Safer York Partnership Board and a detailed update on two of the priorities will be presented to the Board at each quarterly meeting with other priorities reporting by exception in relation to the challenges they experience in delivering their action plans.

Council Plan

6. The Community Safety Strategy links to the following priorities within the Council Plan 2015-19:

- **A focus on frontline services –** to ensure all residents, particularly the least advantaged, can access reliable services and community facilities
- **A council that listens to residents** – to ensure it delivers the services they want and works in partnership with local communities

Implications

7. In producing this report the following implications have been considered:

- **Financial** – There are no financial implications however there will be implication in relation to specific actions

- **Human Resources (HR)**– The only HR implications relate to the Community Safety Team within City of York Council that supports Safer York Partnership and delivery of the Anti-social behaviour element within the strategy.
- **Equalities**– There are no equalities implications, a One Planet York assessment will be required
- **Legal** – The Community Safety Strategy is a legal requirement stated at S6 of the Crime and Disorder Act 1998.
- **Crime and Disorder** – The Community Safety Strategy is a key document aligned to the development and delivery of partnership work to tackle crime and anti-social behaviour.
- **Information Technology (IT)** –there are no identified IT implications
- **Property** – There are no identified property implications
- **Other –** There are no other identified implications.

Risk Management

8. There are no known risks.

Conclusions

9. The Community Safety Strategy was approved by Safer York Partnership Board at its meeting on 27th June 2017. Detailed action plans are being prepared which will determine the future performance management framework for the partnership and will be the basis of the bi-annual Safer York Partnership updates to the Policy and Scrutiny Committee.

Recommendations

10. Members are asked to note the content of the strategy and agree to provide support to the Council in delivering the strategic priorities contained within the strategy.

    Reason: To inform the Committee of the new Community Safety Strategy

Contact Details

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Report Approved ✓ **Date** 13/07/2017

Wards Affected: **All** ✓

For further information please contact the author of the report

Annexes

Annex 1 – Community Safety Strategy

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YBAC – York Businesses Against Crime

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SAFER YORK PARTNERSHIP

MAKING YORK A SAFER CITY

COMMUNITY SAFETY STRATEGY

2017-2020

Introduction

We are pleased to introduce Safer York Partnership's Community Safety Strategy 2017-2020. The Community Safety Partnership (CSP) brings together the local Council, North Yorkshire Police, North Yorkshire Fire and Rescue Service, Public Health, Probation and the Office of the Police and Crime Commissioner. Collectively, the agencies of the CSP work with one overriding objective – to make York a safe place to live, work and visit.

Safer York Partnership published its first Crime and Disorder Reduction Strategy 17 years ago. During that time, we have achieved significant reductions in crime and anti-social behaviour. We are proud of these achievements and are committed to preventing crime and anti-social behaviour, protecting people and bringing offenders to justice. However, we know that more needs to be done.

Reducing crime and anti-social behaviour is an important element in improving the lives of York residents. We will achieve this through partnership working, particularly through early intervention and prevention and challenging and changing behaviour.

We are keen to work with local people to make York safe and this strategy contains information on how residents can further get involved in volunteering.

Councillor Sam Lisle, Executive Member for Housing and Safer Neighbourhoods City of York Council

ABOUT SAFER YORK PARTNERSHIP

Under the Crime and Disorder Act 1998 Community Safety Partnerships (CSPs) are required to work together in formulating and implementing strategies to tackle local crime and disorder and reduce reoffending in the area and to have in place, partnership plans setting out their priorities.

To ensure that the partnership is proactive and well informed, we carry out an annual Joint Strategic Intelligence Assessment in order to review existing priorities and identify any new or emerging priorities that the partnership should focus on. This is not undertaken in isolation and is cross referenced with the Joint Strategic Needs Assessment undertaken by Public Health and consultation carried out to inform the Police and Crime Commissioner's Police and Crime Plan.

The Community Safety Strategy sets out the priorities identified through the above process and sets out how the partnership will work together to tackle crime and anti-social behaviour and achieve its priorities. It is underpinned by a joint Police and City of York Council Community Safety Unit based within City of York Council Headquarters and a delivery structure of thematic sub-groups reporting to the Safer York Partnership Board. This structure also recognises the input of existing and relevant groups which contribute to the delivery of the CSP priorities.

OUR PARTNERS

City of York Council
North Yorkshire Police
North Yorkshire Fire & Rescue
Humberside, Lincolnshire & North Yorkshire Community Rehabilitation Company
Office of the Police and Crime Commissioner
City of York Council Public Health
Vale of York Clinical Commissioning Group

THE CITY OF YORK

The City of York is a Unitary Authority covering 272km^2 and is surrounded by seven district councils that make up the county of North Yorkshire. The arterial routes of the A19 and A64 pass through the area and direct train services include destinations such as London and Edinburgh via the East Coast mainline and Leeds and Manchester on the TransPennine line

The population of the city is estimated to be 202,447. Population estimates forecast an increase in the older population in York, most notably in those over 85 years old.

York has a rich heritage having adapted from being a railway and confectionary making city into an international tourist destination, hub for science and technology and a national centre for education, financial and business services. As a world-famous historic city it attracts around seven million visitors every year, making it one of the UK's most visited tourist centres. York is also home to the University of York and York St John University and two higher education colleges. More than 20,000 students attend these higher education establishments and this affects the overall population profile with a higher percentage in the 15-24 age bands. The city is also home to a number of Military establishments including Imphal Barracks and Queen Elizabeth Barracks. Events such as York City League football matches, the festive St Nicholas Fayre and large race meetings significantly boost the number of people in the city.

York is a relatively prosperous city, however, there are pockets of deprivation with parts of the city amongst the most deprived in the country. Lower super Output Areas (LSOA) with the highest index of multiple deprivation within the city are concentrated within Guildhall, Hull Road, Clifton and Westfield Wards.

OUR PRIORITIES

Introduction

Each year North Yorkshire Police produce a Joint Strategic Intelligence Assessment (JSIA). This year's JSIA has been compiled utilising the National MoRILE (Management of Risk in Law Enforcement) threat matrix. In order to support the delivery of an evidence based and comprehensive assessment, a large number of thematic research reports have been generated to support the scoring process and these incorporate the full range of harm likelihood, confidence and organisational position measures. In addition, reference has been made to York's Joint Strategic Needs Assessment which identifies substance misuse and mental health as issues in York

Information has been obtained from North Yorkshire Police data bases, existing intelligence products, internal and external subject specialists, partners' reports and from a broad range of open and closed information sources including multiple local authority partners. However, it must be noted that the remit of a Community Safety Partnership (CSP) is broad and needs to reflect, not just those themes which pose threat, risk and harm from a policing perspective but also those of our partners and communities. The results of the Council's Talk About Survey and the York results from consultation carried out by the Office of the Police and Crime Commissioner have been analysed to ensure that the strategy addresses those priorities identified by our communities. Chosen priorities are those which impact most significantly on the city and those who work, live and visit there.

Our priorities are:

River & Road Safety

Keeping the City Centre Safer

Protecting People from Harm

Tackling Anti-social Behaviour

Tackling Serious Organised Crime

Tackling Substance Misuse (including delivery of the community safety elements of the York Alcohol Strategy)

River & Road Safety – Lead Agency North Yorkshire Fire & Rescue

York's Rivers

York is located at the confluence of two rivers: The River Foss and the River Ouse. It is prone to flooding from the River Ouse and has an extensive network of flood defences with walls along the river and a liftable barrier across the River Foss where it joins the Ouse at Blue Bridge. Until 2015 these defences had largely been effective but in December of that year severe flooding caused extensive damage to both residential and commercial properties in the city. In addition to the danger posed by flood water, both rivers have been the scene of a number of drowning fatalities. The circumstances of these fatalities range from suicide to accidental death, however, more recently a high proportion of fatalities have occurred where alcohol has been a contributing factor. In 2014, four deaths within a very short period of time at the start of the year, led to the commissioning of an audit of York's rivers by RoSPA. The resulting report made recommendations for increasing the security and safety measures along the rivers and these have been implemented by City of York Council in a programme of work which concluded in 2016. However, despite these improvements, there have been further fatalities, suggesting that work needs continue to educate and promote personal safety messages as an ongoing priority for Safer York Partnership.

Community Impact

Significant levels of concern are raised by residents in the city whenever an incident involving York's rivers receives media attention. Rivers are inherently a hazard but the impact increases significantly when combined with other risky behaviour and factors such as excessive consumption of alcohol . Following implementation of the RoSPA recommendations, the rivers and banks have been made as safe as is practical with the installation of additional grab rails, chain fencing, additional lifebuoys and better illumination. However, the issue of their danger remains when combined with additional factors such as alcohol consumption, risky behaviour and the low water temperature particularly during the colder months.

York's Roads

The historic centre of York is characterised by narrow pedestrian streets within the boundary of ancient city walls. Visitors are encouraged to use one of the Park and Ride Facilities located on the Ring Road as traffic congestion within the city is problematic at peak times. The main routes in and out of the city include the A1 and A64 with an outer ring road creating easy access to the surrounding towns and villages and into the popular tourist destinations within North Yorkshire.

In 2004 North Yorkshire County Council took the lead in establishing the 95 Alive partnership together with North Yorkshire Police, North Yorkshire Fire and Rescue and City of York Council. The partnership aimed to save 95 lives between 2005 and the end of 2010. At the conclusion of the campaign in 2011, 126 lives had been saved. But as casualty reduction remains a significant priority for the North Yorkshire County partners, the partnership has remained in place to continue its programmes of education and road safety advice across the county and city.

Although speed is less of a significant factor in road collisions in York due to the nature of the road network, other safety factors such as inexperienced drivers, use of mobile phones, correctly fitted child seats, high numbers of cyclists and exceeding speed limits in built up areas are all relevant to York's road users.

Despite many years of sustained campaigning, drink driving still remains a significant factor in relation to road collisions. However, of more concern is the growing tendency for people to drink large, unmeasured quantities of alcohol at home, which place them at risk of exceeding the permitted blood alcohol limit into the following day.

Community Impact

York encourages the use of cycles in the city and as such a large number of residents and employees in the city choose this form of transport. The narrow streets combined with traffic congestion in the city centre, do pose a risk to cycle users. Whilst the roads do not lend themselves to excessive speed, many are subject to a 30mph restriction which is often ignored, particularly within the villages on the outskirts of the city. Mobile technology has increased significantly with large numbers of the population owning and using smartphone technology, using their phone to access email, internet and music. However, using a mobile device whilst driving poses a significant risk if a driver's attention is taken away from the road. Changes to drinking habits, with more people consuming large volumes of alcohol at home also pose a risk from being 'over the limit' the following day.

We will:

- **Establish an active Water Safety Forum to address the broad issues of water safety and river usage**
- **Work with partners to increase awareness of the risk in, on and around the waterways amongst communities most at risk**
- **Engage with public, private and voluntary sectors with responsibility for waterways to ensure they understand the risks and have appropriate mitigation factors to address them**
- **Develop Stronger links between the Road Safety Task Group, 95 Alive and Safer York Partnership**

Keeping the City Centre Safer – Lead Agency North Yorkshire Police

York city centre is host to a diverse population of residents, employees, businesses and both local, UK and international tourists. It is also temporary home to a large student population. Part of York's charm is the compact nature of the city centre, bringing together both retail and tourist attractions into one easily accessed area. However, this poses other problems where licensed premises exist alongside shops and residential properties.

According to Crime Statistics, York is one of the safest cities in the UK with lower than average crime for a city that attracts so many visitors. However, due to the consequences of its layout and attraction as a weekend destination for large groups of males and females, tensions have been created between residents and visitors where alcohol consumption has lead to behaviour which is deemed to be anti-social. Whilst much work has been undertaken by Safer York Partnership to tackle these issues, working with North Yorkshire Police, City of York Council, the rail providers and British Transport Police it is an ongoing issue which needs continued attention to ensure that the problem does not increase to levels experienced by other UK cities.

During the summer tourist season, two issues regularly increase in the city centre and cause conflict with local businesses, residents and visitors. These are begging and anti-social behaviour associated with street drinkers. Due to the presence of Designated Public Place Orders and Alcohol Restriction Zones, the problem regularly becomes displaced to various locations across the city when enforcement action is taken.

York has a vibrant economy with many business and retail premises located in the City Centre and out of town retail/business parks. York Business Against Crime was established in 2015 to facilitate the exchange of intelligence in relation to offenders and provide advice and support in relation to combating travelling criminals and shoplifters.

Community Impact

Whilst York is has low levels of crime, the fear of crime and perception of crime is much higher. Positive perceptions of York are important to the city's status as a major tourist destination. The unique layout of the city with its mix of residential, commercial and licenses premises makes it difficult to avoid conflict between different user groups. Excessive consumption of alcohol can lead to anti-social and violent behaviour but equally raises issues of personal safety and links closely to the work that is being undertaken to prevent river deaths

We will:

- **Work in partnership to address issues of anti-social behaviour concentrated within the city centre**
- **Develop information and intelligence sharing between members of the business community and the police**
- **Develop scalable multi-agency counter terrorism control measures in order to protect city centre locations from possible terrorist attack**

Protecting People from Harm – Lead Agency CYC Safeguarding (Children & Adults)

Some communities, groups and individuals are more likely to be victims of crime because of specific vulnerabilities. Protecting vulnerable people through safeguarding and prevention helps to reduce crime and increase confidence, building safer and stronger communities.

Occurrence types with the highest potential victim harm include cyber enabled sexual crime, fraud, trafficking and slavery, domestic abuse and child abuse/neglect. Other categories of abuse include Hate and Mate crime, physical, sexual or psychological abuse, FGM, forced marriage or organisational abuse. Adult safeguarding issues remain a significant knowledge gap but are estimated to exceed the extent of child safeguarding concerns. Identifying, preventing and investigating the exploitation of the vulnerable, particularly in the adult safeguarding arena, remains a significant challenge. The publication and dissemination of information to the public about recognising abuse and knowing how to seek help, either for themselves or others must therefore be a priority

The national threat level remains at Severe due to an increase in the threat of international terrorism arising from the conflict in Syria. Engagement with a range of vulnerable and hard to reach communities is essential to ensure that community concerns and risk, including under-reporting, are effectively identified.

Community Impact

Cyber Crime

Focus on victims is key to tackling cybercrime as it is often difficult to track down and arrest offenders. Targeting those with internet access and those who are more at risk due to identified vulnerabilities including social isolation, loneliness, poor mental health or those that may be exploited due to age-related vulnerabilities may assist in preventing further or repeat crimes.

Fraud

According to the most recent findings of the Crime Survey, fraud and cybercrime are now the most prevalent crimes committed against people in England and Wales. Whilst large scale fraud continues to be committed against businesses, there is an increasing level of reported targeting of individual and often vulnerable victims within communities. Locally, older people are particularly at risk of scams such as doorstep fraud, bank and card account takeover, pension liberation and investment fraud. Younger people are more likely to be victims of online purchase related fraud relating to retail or auction websites.

Domestic Abuse

The numbers of both domestic abuse with and without injury reported to North Yorkshire Police continues to rise and are both at their highest recorded levels since 2008/9. This trend is linked to a focus on encouraged reporting. Independent Domestic Abuse Services (IDAS) report that they are experiencing an increase in the number of parents presenting because of domestic related issues with their children. Nationally there is a growing recognition of children being abusive towards family members. Domestic abuse, either committed against or witnessed by children and young people is a key push factor in them going missing from their home address. This then exposes them to a wider set of vulnerabilities including sexual or criminal exploitation.

Child Abuse and Neglect (Including CSA and E)

Protecting children and young people from significant harm (as a result of abuse or neglect) remains a key priority of he partnership. Close working between all agencies (in line with 'Working Together' and the local children safeguarding board (CYSCB) is critical to this. The scope of child abuse is broad and incorporates physical, sexual or emotional abuse and neglect. It has the potential to occur in any geographic, social or economic group. Current multi-agency analysis of child abuse and neglect is seeking to better understand the profile within York and North Yorkshire.

Prevent

Incidents across Western Europe in 2016 demonstrate the continued willingness of people to give up their lives for a cause. The diversification of approaches from the destruction of commercial airliners to the use of co-ordinated shooting incidents and low-

technology methods such as the lorry attack in Nice demonstrate the need for intelligence and law enforcement agencies, as well as a broad range of public, private and third sectors to be involved in the identification and response to vulnerable sites, routes and people. Social isolation, poor mental health as well as violent tendencies are becoming more understood as relevant factors to vulnerability to radicalisation alongside the traditionally seen element of religion.

We will:

- **Work collaboratively to ensure that domestic abuse becomes socially unacceptable and that the harm caused to victims and their families is reduced**
- **Take effective preventative and enforcement action to protect children from sexual exploitation**
- **Provide a multi-agency approach to support and reduce the vulnerability of people with multiple and complex needs from becoming victims or perpetrators of crime and anti-social behaviour**
- **Work proactively to prevent people from being drawn into terrorism and reduce the likelihood of extremism**

Tackling Serious Organised Crime – Lead Agency North Yorkshire Police

Although Serious Organised Crime (SOC) is often thought of in a regional, national or international context, its impact is most felt by local communities. It harms individuals, families and local businesses alike with rippling implications for even the smallest most rural communities. However, it is not a crime itself, SOC is controlled and led by organised crime groups (OCGs) that use intimidation tactics and corruption for unlawful gain. OCGs are deceitful and unscrupulous in their pursuit of money, power or personal gratification through the harm of others.

In January 2016, North Yorkshire Police produced a Serious Organised Crime Problem Profile for York and North Yorkshire. This profile was presented to both Community Safety Partnerships and it was agreed that Safer York Partnership would ensure that partners are engaged in supporting the police to gather and share intelligence and disrupt organised crime groups operating in the city.

Community Impact

These hidden crimes take place around us every day. Too often the theft of a mobile phone or possession of drugs for personal use enables a more insidious organised and pervasive criminality such as human trafficking or fraud. SOC has a significant social and economic cost – estimated at £24billion each year to the overall economy. These criminals often prey on vulnerable communities and individuals to profit financially or otherwise. They supply and distribute illegal drugs, commit fraud, tax evasion and facilitate human trafficking and child sexual exploitation (CSE).

Based upon local economic, crime and intelligence profiles, the types of human trafficking and modern slavery most prevalent within York and North Yorkshire are:

- Labour exploitation – being forced to work very long hours, often in hard conditions and to hand over the majority, if not all of their wages. Examples include car washes and nail bars
- Domestic servitude – being forced to work in private households, performing household tasks for long hours for little, if any pay.
- Criminal exploitation – involving forcing victims to engage in criminal activities such as cannabis farming, forced begging, pickpocketing and benefit fraud.
- Sexual exploitation – Includes prostitution, pornography and escort work. Men women and children can all be victims and many will have been groomed or deceived with promises of a better life before being controlled through violence and abuse

We will:

- **Work in partnership across the county and city to increase the sharing of intelligence relating to organised crime groups in order to bring those involved to justice**
- **Increase awareness of staff in order to improve the gathering of information and intelligence relating to human trafficking and modern slavery**
- **Work to in partnership to embed a programme of support to victims of Serious Organised Crime, Human Traficking and Modern Slavery**

Tackling Anti-social behaviour – Lead Agency, CYC Community Safety

In 2014 City of York Council and North Yorkshire Police established the Community Safety Unit essentially to tackle anti-social behaviour in a more joined up way. A team of City of York Council ASB Officers and six police officers work together to risk assess on a daily and weekly basis and facilitate partners to work together to address the most serious cases in the most effective and efficient way. In addition a Neighbourhood Enforcement team tackle environmental ASB such as graffiti, littering and flytipping, operates the council's domestic noise nuisance service at weekends and works proactively with police safer neighbourhood teams on planned operations to tackle local issues of ASB in the community.

Community Impact

Anti social behaviour is activity that impacts on other people in a negative way. It can include a variety of behaviours covering a whole range of unacceptable activity that can blight the quality of life for individuals, families and communities. Anti-social behaviour is most often defined as behaviour that causes or is likely to cause harassment, alarm, or distress to one or more peole not of the same household as the person responsible (perpetrator).

If anti-social behaviour is allowed to continue unchallenged, the effects for individuals and the community can be devastating. The Anti-social behaviour, Crime and Policing Act provides a community trigger which allows victims and communities the right to demand that anti-social behaviour is dealt with.

Hate crime is any criminal offence committed against a person or property that is motivated by hostility towards someone based on their disability, race, religion, gender identity or sexual orientation. Whilst levels of recorded hate crime in York are low, we have anecdotal evidence from a range of agencies working with communities of interest that the true extent may not be known. This may leave vulnerable individuals who feel unable to come forward and report issues which impact significantly on their own and their family's quality of life. Hate crime cases are dealt with by the Community Safety Unit and are addressed through discussion and action planning at the weekly multi-agency meetings.

We will:

- **Prevent anti-social behaviour and reduce the impact that it has on people's lives through using our collective resources to target offenders and address issues based on threat, harm and risk**
- **Help to reduce ignorance and prejudice by helping people to get to know each other and challenging myths and racism**
- **Defuse community tensions when they arise by recognising the signs early and having the right tools and skills available to reduce them.**
- **Tackle issues of environmental crime through programmes of education and enforcement action, empowering communities to tackle issues themselves**

Substance Misuse – Lead agency CYC Public Health

There are clear links between many aspects of the health and wellbeing agenda and community safety. Substance misuse (whether drugs or alcohol) is strongly linked to both crime and disorder. Substance misuse can also make some people more vulnerable and therefore at risk of becoming victims of crime.

The aim of the York Alcohol Strategy is for stakeholders to work together to reduce and prevent the alcohol related harms that people might experience within their lifetime. This will be achieved by encouraging responsible drinking and positive behaviour. By providing those who are drinking at risky and harmful levels with the right information, effective support or treatment, alcohol related harm will be reduced. As a major tourist destination, many visitors choose to come to York because it is such a vibrant, compact city with many venues offering food and alcohol. However, this can result in conflict with other tourist and resident groups within the city, particularly where alcohol is involved and anti-social behaviour becomes a consequence of excessive drinking. The strategy is supported by a vision for safe alcohol use. It will be delivered in collaboration with local stakeholders and will promote a whole life approach towards alcohol through encouraging positive behaviour, responsible drinking, reducing and preventing the harms associated with alcohol and providing effective interventions and treatment for those who are drinking at risky and harmful levels.

Community Impact

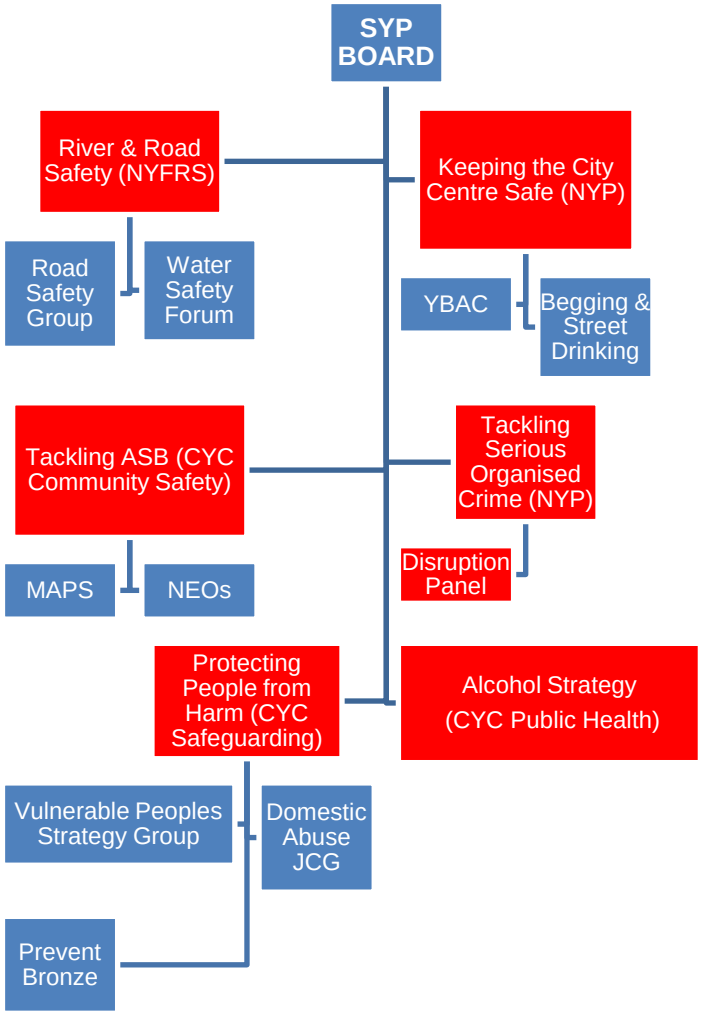
A large amount of resource is required to deal with alcohol related issues. The ambulance service, accident and emergency department, police, fire and rescue service and members of the public routinely deal with the consequences of alcohol. Harm to families, such as domestic abuse, child abuse and neglect as well as violent crime, binge drinking, absenteeism from work, drink driving, alcohol related accidents and anti social behaviour are all issues associated with alcohol.

We will:

- **Commission holistic drug and alcohol services to encourage, support and empower individuals to take control of their lives and minimise the harm caused by drug and alcohol misuse**
- **Work in partnership to drive the delivery of the Alcohol Strategy for York, connecting those areas of the community safety plan where alcohol has an impact**

DELIVERING THE PLAN (Lead organisation in brackets)

Our Priorities



Monitoring Performance

The Community Safety Plan is a living document and will be refreshed annually throughout its lifespan. Detailed action plans will be owned by the relevant leads and will be monitored by the Safer York Partnership Board.

How can you get involved?

You can have more direct involvement in the work of Safer York Partnership by interacting with us on Social Media. Find us @saferyork on Facebook and Twitter or visit our website www.saferyorkpartnership.co.uk You can also join the North Yorkshire Police Volunteer scheme or become a member of Neighbourhood Watch in your area.

We can be contacted at:
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Health, Housing & Adult Social Care Policy & Scrutiny Committee

Work Plan 2017-18

20 June 2017	1. Attendance of Executive Member for Housing & Safer Neighbourhoods 2. Attendance of Executive Member for Health & Adult Social Care 3. Annual report of HWBB 4. Six-monthly Quality Monitoring Report – residential, nursing and homecare services 5. Update on decisions taken on smoking cessation and their impact. 6. CCG Task Group Scoping Report 7. Work Plan 2017/18 8. Urgent Business – New Mental Health Hospital Update
25 July 2017	1. End of Year Finance & Performance Report. **Health** 2. Be Independent end of year position 3. Report on The Retreat action plan following CQC inspection. 4. Safeguarding Vulnerable Adults Annual Assurance report **Housing** 5. Introduction to Safer York Partnership 6. Report on new Community Safety Strategy. 7. Work Plan 2017/18 **Information Reports** Annual Report of Tees Esk & Wear Valleys Foundation Trust (AGM 19th July)

13 September 2017	1. 1st Quarter Finance & Monitoring Report **Housing** 2. Update Report on Implications of Homelessness Reduction Act 3. Update Report on Housing Revenue Account Business Plan. 4. Update report on fire safety and housing 5. Work Plan 2017/18
3 October 2017	**Housing** 1. Review of Allocations Policy & Choice-based Lettings 2. Work Plan 2017/18 **Information reports** • Further update report on community service provision • Annual Report of Chair of Teaching Hospital NHS FT • Annual Report of Chair of Yorkshire Ambulance Service (Annual meeting 26th September) • Annual Report of Chair of Vale of York CCG (Annual meeting 21st September)
15 November 2017	**Health** 1. Healthwatch six-monthly performance update 2. Work Plan 2017/18 **Information reports** • Winter Pressures • North Yorkshire Fire & Rescue Service

12 December 2017	1. HWBB six-monthly update report 2. 2nd Quarter Finance & Monitoring Report 3. Six-monthly Quality Monitoring Report – residential, nursing and homecare 4. Implementation of Recommendations from Public Health Grant Spending Scrutiny Review 5. Work Plan 2017/18
15 January 2018	1. Be Independent six-monthly update report 2. Homeless Strategy 3. Housing Registrations Scrutiny Review – Implementation Update 4. Safeguarding Vulnerable Adults six-monthly assurance report 5. Work Plan 2017/18
19 February 2018	1. 3rd Quarter Finance & Performance Monitoring Report 2. New Mental Health Hospital Update – full business case for new build. 3. Work Plan 2017/18
26 March 2018	1. Work Plan 2017/18 2. Update Report on Actions Against Community Safety Plan Targets
23 April 2018	1. Work Plan 2017/18
23 May 2018	1. Healthwatch six-monthly performance update 2. Work Plan 2017/18 **Information Reports** • North Yorkshire Fire & Rescue Service

On Going Issues

CCG Recovery Plan (possible this work can be taken on by proposed Task Group)

Better Care Fund

STP

Elderly Persons' Homes (Last on agenda December – Agreed regular updates be presented to future meetings)

Healthy Child Service (Service launch in June. Data to measure trends and KPIs)

Report at a future date on North Yorkshire and York Suicide Prevention Group (Agreed January 2017)