CITY OF YORK COUNCIL

Notice of a public meeting of

Health and Adult Social Care Policy and Scrutiny Committee

To: Councillors Doughty (Chair), Cullwick (Vice-Chair), Derbyshire, S Barnes, Craghill and Richardson

Date: Monday, 27 February 2017

Time: 5.30 pm

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

AGENDA

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 of the Health and Adult Social Care Policy and Scrutiny Committee held on 30 January 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 **Friday 24 February 2017** at **5:00 pm**.

Filming, Recording or Webcasting Meetings
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The Council's protocol on Webcasting, Filming & Recording of Meetings ensures that these practices are carried out in a manner both respectful to the conduct of the meeting and all those present. It can be viewed at:
http://www.york.gov.uk/download/downloads/id/11406/protocol_for_webcasting_filming_and_recording_of_council_meetings_20160809.pdf

4. **2016/17 Third Quarter Finance & Performance Monitoring Report - Health & Adult Social Care** (Pages 11 - 34)
This report analyses the latest performance for 2016/17 and forecasts the financial outturn position by reference to the service plans and budgets for the relevant services falling under the responsibility of the Corporate Director of Health, Housing & Adult Social Care and the Director of Public Health.

5. **Yorkshire Ambulance Service Inspection Cover Report** (Pages 35 - 102)
This report and its annexes provide the Health & Adult Social Care Policy & Scrutiny Committee with details of the Care Quality Commission's (CQC) findings (Annex 1) following its inspection of the Yorkshire Ambulance Service NHS Trust (YAS).

6. **Developing a new mental health hospital for the Vale of York: Public Consultation Outcome Report** (Pages 103 - 184)
This report provides information about the outcome from the formal public consultation into the creation of a new mental health hospital for the Vale of York.

7. **Update Report on Implementation of Recommendations from the Bootham Park Hospital Scrutiny Review**
(Pages 185 - 196)
This report provides the Health & Adult Social Care Policy & Scrutiny Committee with an update on the implementation of recommendations from the previously completed scrutiny review into the closure of Bootham Park Hospital (BPH).

8. **Work Plan** (Pages 197 - 200)
Members are asked to consider the Committee's work plan for the municipal year.

9. **Urgent Business**
Any other business which the Chair considers urgent.

<u>**Democracy Officer:**</u>

Name- Judith Betts
Telephone – 01904 551078
E-mail- judith.betts@york.gov.uk

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

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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 S Barnes	Works for Leeds North Clinical Commissioning Group
Councillor Craghill	Member of Health and Wellbeing Board
Councillor Doughty	Member of York NHS Foundation Teaching Trust.
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 and Adult Social Care Policy and Scrutiny Committee
Date	30 January 2017
Present	Councillors Doughty (Chair), Cullwick (Vice-Chair), Derbyshire, S Barnes, Craghill and Richardson

51. Declarations of Interest

Members were asked to declare, at this point in the meeting, any personal interests, not included on the Register of Interests, or any prejudicial or disclosable pecuniary interests that they might have had in respect of business on the agenda. None were declared.

52. Minutes

Resolved: That the minutes of the Health and Adult Social Care Policy and Scrutiny Committee held on 20 December 2016 be approved and then signed by the Chair as a correct record.

53. Public Participation

It was reported that there was one speaker registered to speak under the Council's Public Participation Scheme.

Gwen Vardigans spoke about the loss of intermediate care centres and referenced that she had spoken at the Committee's meeting in November when she had asked whether the item scheduled for April's meeting on the development of community services in the light of the Archways closure would go into greater depth. She felt that the response had been unclear and asked if a review was in hand.

The Chair commented that Members were receiving reports on this topic and the Committee had also received emailed reports about re-provision at Archways.

The Scrutiny Officer confirmed that no commitment had been made by the Committee to undertake a review into the development of community services, but the Committee would receive a report from health partners.

54. Safeguarding Vulnerable Adults Annual Assurance

Members received an update report which outlined 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 wellbeing.

The Assistant Director of Adult Social Care presented the report and highlighted that;

- There would be a new performance framework in place in time for the next report.

- Initial feedback from the Association of Directors of Adult Social Services (ADASS) Peer Review which had been shared with the Chair of the City of York Safeguarding Adults Board, commended the personal approach to safeguarding and good leadership.

- An action plan created using the recommendations from the ADASS Peer Review would be brought before Members.

With regard to Members' queries it was noted that;

- Clifton House had originally been run by NHS England and that partners had only been communicating within the past few months, particularly in regard to specialist commissioned services.

- A Suicide Prevention Co-ordinator had recently been appointed and the recommendations of the Suicide Audit had been endorsed by the City of York Safeguarding Adults Board and the Health and Wellbeing Board.

- One of the recommendations from the Suicide Audit had already been carried out. This was to establish a York Group which was a sub group of the North Yorkshire and York Suicide Prevention Task Group.

The Director of Public Health suggested that an update report be brought back on the work of the York sub Group of the North Yorkshire and York Suicide Prevention Task Group.

Resolved: (i) That the report be noted and that it is assured arrangements for safeguarding adults are satisfactory and effective.

(ii) That the Committee continue to receive further updates on a six monthly basis.

(iii) That an update report be received at a future meeting following the Safeguarding Adults Peer Review.

(iv) That a report on the work of the York sub group North Yorkshire and York Suicide Prevention Task Group be considered by the Committee at a future date.

Reason: To keep the Committee assured of safeguarding arrangements for Adults within the city.

55. Healthy Child Service

Members received an update report on the review of the Healthy Child Service (health visiting and school nursing) to inform them on the new service.

The Director of Public Health and Assistant Director, Education and Skills introduced the report and highlighted that;

- A number of efficiencies were being realised and the Service was stopping doing some things it no longer needs to provide.

- Hearing testing –routine screening was being stopped a more focused preventative approach was being introduced.

- The proposal to discontinue vision screening had not yet been discussed with the hospital’s eye clinic.

- Boots had developed an eye test for children and it was hoped that CYC could work with the hospital and the CCG in order to offer vision screening without having to fund it, in order to offer parental choice.

- Regular engagement was carried out with schools and signposting towards health provision was undertaken with vulnerable families.

- It was hoped that the new Healthy Child Service would narrow health inequality gaps and maximise outcomes.

Some Members felt that there was a difference between a universal service and a service where the onus was on parental action. Others suggested that social media could help to promote the newly developed service.

It was noted that no detailed data for service coverage existed. There was sufficient amounts of data to measure trends and work was underway to develop further measures and user case studies, along with Key Performance Indicators (KPI), before the Service's launch in June. This would then link into the performance of the NHS Local Area Teams.

Resolved: That the report be received and noted.

Reason: To provide an update on development and proposed changes in the Healthy Child Service.

56. Vale of York Clinical Commissioning Group

Members received updates on issues that been had requested from the Vale of York Clinical Commissioning Group such as the 2017/19 Operational Plan, Delayed Transfers of Care, Continuing Health Care and the Partnership Commissioning Unit.

In attendance to present these updates were the Accountable Officer, the Head of Planning and Assurance, the Interim Executive Director of Joint Commissioning and the Chief Nurse from the Vale of York Clinical Commissioning Group. The Director of Operations for York and Selby from Tees, Esk and Wear Valleys NHS Foundation Trust accompanied them to present the updates and answer Members questions.

2017/19 Operational Plan-Accountable Officer

The Accountable Officer informed the Committee that he could not present the Operational Plan, as the CCG was still under Legal Direction from NHS England which meant that they needed to wait to receive feedback before sharing the Operational Plan.

It was confirmed that although the Vale of York CCG had a financial deficit of £24.1m at the end of the year in 2016/17 this had now been revised to a forecast deficit of £28.1m. They predicted that within the plan the percentage spend was divided in the following way;

- 60% on acute care
- 25% on Continuing Health Care
- 15% on Mental Health and other issues (legacy issues not those with the current provider)

In order to secure the acute cost, a position had been agreed with the hospital to work together to contain the cost. This position would be agreed by 31 January. The Operating Plan would not be made public until March.

Members were informed that there were three localities from which the Operational Plan would be delivered were; the northern, city and central and southern areas of the Vale of York area.

It was felt that the new localities model reflected a realisation that the ‘one size’ fits all approach previously adopted had not worked. There would be a benefit to come together as these areas had distinct populations and so priorities in these areas could be bespoke, along with efficiencies that needed to be made alongside the financial deficit.

One Member asked about whether consideration would be given to how NHS building stock could be used. It was noted that to reduce costs, it was necessary to give encouragement to providers to design services around care in general practice, or nearer to people’s homes. A challenge still remained that the buildings themselves often inspired loyalty.

Delayed Transfers of Care (DTOCs)-Interim Executive Director of Joint Commissioning

The Interim Executive Director of Joint Commissioning informed Members that there had been a difficulty in providing mental health beds in the city earlier in the year due to a change in the method of reporting. Due to a change in provider to Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust the method in reporting had become more rigorous and this had led to a leap in the figures.

It was felt that the DTOC figures were only a proxy measure and did not give the full picture. Further joint work was needed and it was noted that Continuing Health Care (CHC) assessments were also often not measured alongside DTOCs.

Continuing Healthcare (CHC)- Chief Nurse, Vale of York Clinical Commissioning Group

Members were informed that there was an increasing cost in providing CHC. There was however, no one waiting in hospital for CHC above the timeframe.

Partnership Commissioning Unit

It was noted that staff consultation on service lines for commissioning arrangements would be taking place on 1 February, but no further details could be released.

The Accountable Officer confirmed to the Committee that he would show in a future report further details of the £28.1m deficit. The CCG would set out with partners that the allocation they had been given by NHS England would not exceed the cost of care. He stated that subject to availability, a report would be prepared in time for the March Committee meeting.

Resolved: (i) That the information provided in the report and its annexes, and at the meeting be received and noted.

(ii) That a report be received by the Committee in March to include further details on the Vale of York CCG deficit.

Reason: To continue to inform the Committee of the Vale of York CCG Improvement Plan and related issues.

57. Work Plan

Consideration was given to the Committee's work plan for the rest of the municipal year.

Resolved: That the work plan be noted with the following amendments;

- That a report be received on the work of the York sub group of the North Yorkshire and York Suicide Prevention Group at a future date.
- That a report be received with further details on Vale of York Clinical Commissioning Group's deficit at the March meeting.
- That a report be received in relation to the motion agreed at Council in regards to Access to NHS Services at the March meeting.
- That a report on public health services that are commissioned by NHS England be received, particularly in order to evaluate performance data. This report be received March meeting.
- That a report and the action plan from the City of York Safeguarding Adults Board Peer Review be received at the March meeting.

Reason: To ensure that the Committee have a planned programme of work.

Councillor P Doughty, Chair
[The meeting started at 5.30 pm and finished at 7.55 pm].

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Health & Adult Social Care Policy & Scrutiny Committee **27 February 2017**

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

2016/17 Third Quarter Finance & Performance Monitoring Report – Health & Adult Social Care

Summary

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

Financial Analysis

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

Table 1: Health & Adult Social Care Financial Summary 2016/17 – Quarter 3

2016/17 Quarter 2 Variation £000		**2016/17 Latest Approved Budget**			**2016/17 Projected Outturn Variation**	
		Gross Expen -diture £000	**Income £000**	**Net Expen -diture £000**	**£000**	**%**
+147	ASC Prevent	7,452	1,389	6,063	+167	+2.7%
+258	ASC Reduce	9,908	2,807	7,101	+199	+2.8%
+161	ASC Delay	12,745	7,624	5,121	-56	-1.1%
+1,169	ASC Manage	42,841	14,201	28,640	+1,501	+5.2%
+19	Public Health	9,094	8,717	377	0	0%
-1,500	Mitigation Options	-	-	-	-1,567	-
+254	**Health & Adult Social Care Total**	**82,040**	**34,738**	**47,302**	**+244**	**+0.5%**

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

3. The first quarter report for 2016/17 showed a projected net overspend of £341k, the second a £254k overspend and the latest position at Table 1 projects an overspend of £244k. This is an improvement of £97k since quarter one. The following sections provide more details of the significant projected outturn variations, and any mitigating actions that are proposed.

Adult Social Care Prevent Budgets (+£167k / 2.7%)

4. There is a net projected overspend of £96k on staffing budgets mainly due to additional senior practitioner hours within the Occupational Therapy service and additional hours in the Commissioning Team. An adjustment to the contract value for the services provided by Be Independent has not yet been made resulting in a pressure of £50k. A number of other more minor variations produce a net overspend of £21k.

Adult Social Care Reduce Budgets (+£199k / 2.8%)

5. A £159k pressure within direct payment budgets is forecast due to a higher number of customers than budgeted for, along with some short term delays earlier in the year in initiating the saving to reclaim unspent direct payments. Work on reconciling personal budgets has been undertaken and could help reduce this overspend. There is always some slippage in the resources allocated to support individuals, and actual spend, hence the reclaiming of any monies not used.

6. Small Day Services, a series of council run day support options for customers is forecast to underspend by £109k, mainly due to staffing vacancies. The hospital social work team is forecast to overspend by £125k due to additional posts being employed in a pilot to assess customers in the most appropriate setting with the aim of speeding up the discharge from hospital and improving the 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. The projection assumes these arrangements will continue until the year end. A number of other more minor variations produce a net overspend of £24k.

Adult Social Care Delay Budgets (-£56k / 1.1%)

7. The community support budget for Learning Disability customers is forecast to overspend by £196k.

This is offset by older people's home care forecasting a £91k underspend mainly due to an increase in Continuing Health Care (CHC) income and fewer customers with physical and sensory impairments than budgeted for (£173k). A number of other more minor variations produce a net overspend of £12k.

Adult Social Care Manage Budgets (+£1,501k / 5.2%)

8. There is a net projected overspend of £1,109k within external residential and nursing care placement budgets as a result of increased residential placements (+£543k) and delays in transferring some learning disability customers to supported living schemes (+£267k), partly offset by fewer than expected nursing placements (-£224k). There is a £147k pressure in the learning disability short stay budget due to greater use of Flaxman Avenue and an expensive mental health placement that was not budgeted for (+£92k).

9. Older People's Homes' budgets are projecting a net overspend of £204k, an improvement of £215k compared to quarter 1. The current overspend is mainly in respect of under recovery of income (£29k) and staffing (£169k). Income has been affected by a higher than budgeted number of vacant beds. Use of casual staff continues in the homes as permanent posts are kept vacant in order to allow flexibility within the reprovision programme, but the service is now increasing the use of additional hours and overtime as a more cost effective alternative. Staff sickness has also significantly reduced and the service continues in its commitment to bring spend back within budget by the year end.

10. There is a net projected underspend of £487k in supported living budgets. A number of places are being kept vacant in advance of the anticipated transfers of learning disability customers from external residential placements, and the service has also been successful in securing additional Continuing Health Care income.

11. Staffing budgets are projected to overspend by £133k due mainly to the temporary need for two group managers for the first half of the year. The half year saving expected from the deletion of two review manager posts has not been achieved and some social work vacancies have been difficult to fill on a permanent basis resulting in more expensive agency workers being employed to fill the void.

12. 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 £1,942k have been identified and implemented, leaving a shortfall of £1,058k. Plans are in place to deliver almost the entire shortfall from 2017/18, so this is a short term pressure.

13. The council's former £1,023k care act grant was transferred to mainstream funding from 2016/17. £507k is committed against this budget leaving £516k available to contribute towards other directorate pressures.

Public Health (£Nil / 0%)

14. Within Public Health there are net projected overspends on sexual health contracts (+£41k), substance misuse contracts (+£36k) and the healthy child programme (+£31k) due to one-off transition costs relating to the transfer of the school nurse and health visitor staff from York Hospital. These are offset by a projected underspend on staffing of £108k due to vacancies which were held prior to the implementation of the public health restructure.

Adult Social Care (ASC) Mitigations (-£1,567k)

15. ASC DMT committed at quarter 1 to look at several areas to bring down their projected overspend. Dealing with the budget pressures is a regular item at DMT meetings with all options available to further mitigate the current overspend projection being explored. To date mitigations totalling £1,567k have been identified including; bringing the existing OPH budget back into line (£204k); increasing Continuing Health Care contributions (£164k); reviewing Direct Payments (£120k); reviewing charging rates (£4k) and the use of the care act reserve (£1,075k).

Better Care Fund

16. The Better Care Fund has been agreed and the formal Section 75 agreement, setting out the legal basis for the operation of the £12m pooled budget, has been signed by the council and Vale of York Clinical Commissioning Group. Within the document is an agreement to share risk on a 50:50 basis between the two organisations on schemes that are expected to deliver savings of £1.2m.

Unfortunately these schemes are at serious risk of underperformance and it is possible that this will have a financial impact on the Council, although this is not currently included in the net outturn projection shown at Table 1.

Performance Analysis

Adult Social Care

17. Direct Payments: Direct payments are intended to give people direct control of their care. Studies show that direct payments and being in control of your care increase satisfaction with services.

18. At Q2 we remained under target and a lower position than at Q1. Our performance is lower than that of the National, Regional and Family averages. We are offering Direct Payments as Standard offer which is built into new systems and business processes. A workshop is planned to bring together Care Management, Commissioning and Supporting Organisations to create a joint plan on the delivery and support of people choosing to directly manage and pay for their own care.

19. Proportion of adults with a learning disability in paid employment: 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.

20. Our performance level is not on track to hit the 10% target, although improvements in the year which have exceeded last years position at the same point and maintain a higher level than regional or national outturns. The indicator remains a focus of the monthly performance clinics. Each client is subject to a review to review employment status. We are working jointly to improve opportunities for people who wish to work to have access to employment opportunities through commissioning and Learning City Partnerships strategy.

21. Proportion of adults with a learning disability who live in their own home or with family: Evidence shows that the nature of accommodation for people with a learning disability has a strong impact on their safety and overall quality of life and the risk of social exclusion.

22. Our performance level is not on track to hit the 85% target, although improvements in the year which have exceeded last years position at the same point and maintain a higher level than regional or national outturns.

The indicator, as with Learning Disability (LD) in Employment, will remain a focus of the monthly performance clinics and a full list of people without suitable accommodation has been provided for LD colleagues to review.

23. Long-term support needs met by admission to residential and nursing care homes, per 100,000 of population (18-65) and (Older people 65+): Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency. 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.

24. Our performance for 18-65 working age adults is on track and equates to a year end position of 6.09, achieving the required target of 9.9. This position in an improvement on the 15-16 data at this point and better than national and regional benchmarks. For older people (65+) the rates have fallen significantly over the year in Q3 and have brought performance to a better position that the national and regional average rates. We remain off our target of 238 new placements or less (a rate of 620 per 100k or less) by end of year. The target may be achieved if monthly admissions remain at or below 17 new entrants for the last quarter of 2016-17. A Residential Care Panel sits monthly and scrutinises new requests for Residential Care. The key is to ensure that this is the most appropriate option for the individual. Monthly targets are in place and exception reports will be taken to performance clinics where targets are exceeded.

25. Proportion of adults in Secondary Mental Health Services in paid employment and Proportion of adults in Secondary Mental Health Services who live in their own home or with family: Improving employment and accommodation outcomes for adults with mental health are linked to reducing risk of social exclusion and discrimination. Supporting someone to become and remain employed is a key part of the recovery process, while stable and appropriate accommodation is closely linked to improving people’s safety and reducing their risk of social exclusion. There is no comparable position in the last year as data was unavailable at this time. Employment: The data provided show that performance has improved in year and at Q2 is on target for a year end. Accommodation: outturns are significantly lower than the targets and lower than the 2015/16 year end outturns. This is a deteriorating position.

26. A manager from this provider now attends our monthly performance clinics within the directorate. We have requested access to these records to bring ongoing monitoring of the client data within our oversight. This approach will allow us to drive out any recording and practice issues. Data access, and performance reporting remains an issue.

27. Delayed Transfers of Care: 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. Discharges are made from Acute and Non Acute Care Pathways.

28. Discharges from Acute Care: Both Indicators are on Target. Performance has shown a steady improvement over the end of 2015-16 and into the first half of this year.

29. Discharges from Non Acute Care: Indicators here are not on Target. Performance had shown an improvement in the first quarter, however, from June 2016, an increase in Non Acute Delays, particularly in Mental Health has pushed the numbers back up and off target for the year.

30. Overall Position: Indicator is not on target due to the effect of Non Acute Delays in the System. We are taking the learning and processes from our success in Acute Care and applying these to the Non Acute pathway. Since June a Sitrep process has been put in place to monitor delays in Mental Health to mirror that of our Acute and Non Acute Hospital processes. In other areas of the Non-Acute pathway a similar approach to monitoring.

Public Health

31. Under 18 conceptions**:** 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.

32. There were 58 under 18 conceptions in York in the year to September 2015 and 14 in the most recent quarter. The latest annual rate is 19.6 per 1,000 females aged 15-17 in York - lower than regional (24.3) and national (21.2) averages. The latest quarterly rate is 18.9 per 1,000 females aged 15-17 in York - lower than regional (22) and national (19.5) averages. The longer term trend shows falling rates in York. 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). In 2014 in York 43.8% of under 18 conceptions lead to abortions - lower than regional (46%) and national (51.1%) averages.

33. Health Checks: 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.

34. The YorWellbeing service has started to deliver Health Checks to CYC staff at West Offices and Hazel Court. To date 37 checks have been booked in and 18 have been delivered. So far 3 clients have been referred to their GP and 6 have been advised to book in for a 3 month follow up with the YorWellbeing service. The service enables staff to learn about the risk of preventable but common health conditions and to be supported to live a healthier lifestyle to reduce the risk of future ill health.

35. Mortality Rate from Suicide and Injury of Undetermined intent: Suicide is a major issue for society and a leading cause of years of life lost. Suicide is often the end point of a complex history of risk factors and distressing events, but there are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

36. The annual number of registered deaths due to suicide in York fell slightly in 2016. There were 25 deaths in 2016 compared with 28 in 2015. There were 5 fewer deaths amongst men but 2 more deaths amongst women. The gender profile of those at risk from suicide seems to be changing: deaths amongst females now account for 40% of the total in York compared with 8% a decade ago.

37. Following the York suicide audit which was published recently, a Suicide Safer Community delivery group has been established to develop a programme of work to achieve 'Safer Suicide Community' accreditation by demonstrating the implementation and co-ordination of multi sector prevention initiatives on a sustainable and ongoing basis.

38. Smoking Status at the time of Delivery: 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.

39. In the year to December 2016, **11.5%** of mothers giving birth in York were smokers at the time of delivery (216 smokers out of 1,879 live deliveries). This is a slight improvement on the previous quarterly figure of 12%. The rate in York is below the regional average (**14.2%)** but higher than the national average (**10.4%**). There is a wide variation in smoking rates at the time of delivery across the City. Rates are over 4 times higher in some areas compared with others.

40. Pregnant smokers are able to access specialist stop smoking support through the Council's stop smoking service.

41. Successful Completions from Drug / Alcohol Treatment (without representation): 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.

42. In the latest 18 month monitoring period to December 2016, 313 people left treatment successfully (without representation within 6 months) out of a total of 1,294 clients in treatment in York. This is a rate of 24.2% 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.

43. 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.

44. Health Visitor Service Delivery Metrics: 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.

45. 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. Performance remains below the national average, although there has been an improvement in the percentage of timely new birth visits (70%) and 6-8 week reviews (79%) carried out in York. The percentage of timely 12 month and 2.5 year visits carried out remains low (22% and 23% respectively).

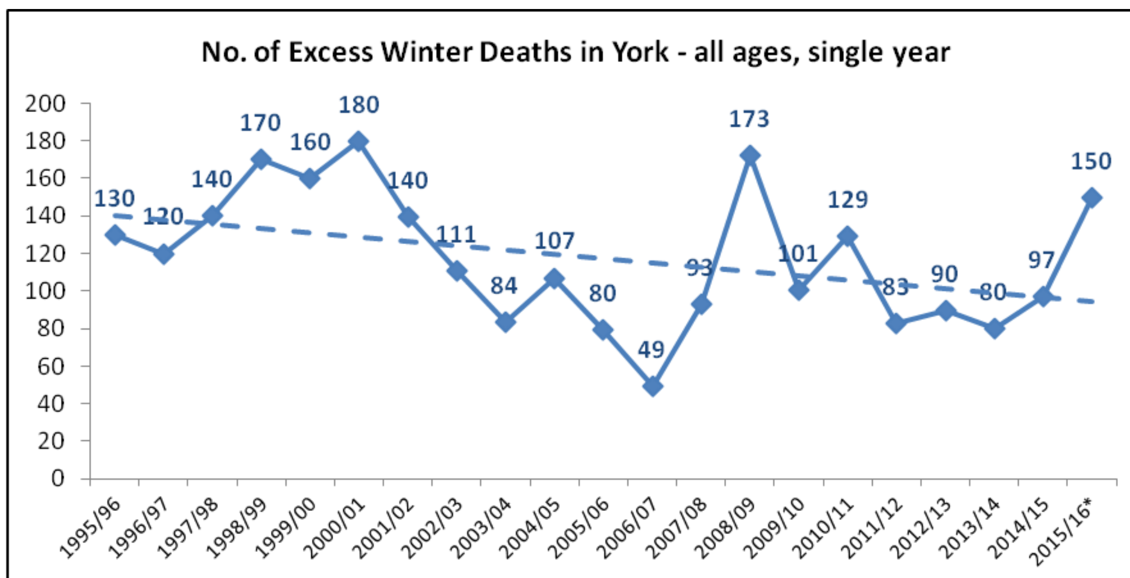
46. The service is currently being reviewed following the TUPE transfer from York Teaching Hospital NHS Trust to the Council on 1 April 2016.

47. Excess Winter Deaths (EWD) – (Additional Information as requested): We monitor how many more people die in the winter months (December to March) compared with the number we would expect to die based on average mortality rates in the non winter months. The number of excess winter deaths depends on the temperature and the level of disease in the population as well as other factors, such as how well equipped people are to cope with the drop in temperature. Most excess winter deaths are due to circulatory and respiratory diseases, and the majority occur amongst the elderly population

48. Local Mortality data shows that in 2015/16 there were 149 excess winter deaths in York. This is an increase of over 50% on the 2014/15 figure of 97 excess deaths. The excess winter deaths 'index' for York for 2016/17 is 27.5% which is higher than the England average of 14.6%.

49. Over the last 20 years there has been a gradual reduction in the number of EWDs in York although there are peaks and troughs in individual years.

The latest ONS report on Excess Winter Deaths states that 'Large fluctuation in EWDs is common and trends over time are not smooth'.



50. EWDs in York have not followed recent regional and national patterns. In 2014/15 the national rate was unusually high but the rate in York was low. In 2015/16 this appears to have been reversed.

51. Five-year aggregated data at ward level shows a large variation in the rate of excess winter deaths across the city. The wards with the highest rates are Guildhall, Micklegate, Fishergate, Clifton and Holgate. Four of these wards (Clifton being the exception) are priority wards for the 'Better Homes' programme which confirms that work is being focused in priority areas.

52. There is no obvious single explanation for the variation in excess winter deaths between wards. It is likely that there are multiple factors e.g. the age profile of the ward, the prevalence of underlying health conditions, the uptake of the influenza vaccine, the % of cold homes in the ward, rates of fuel poverty etc.

53. City of York Council conducted a Winter Health Promotion campaign ('Stay Well This Winter', including 'Right Care First Time'). The campaign delivered some key messages about staying well in winter (including promotion of flu vaccinations) and preventing avoidable harm to health by alerting people to the negative health effects of cold weather.

54. The complete flu vaccination coverage rates for 2016/17 are not yet available.

In recent years the rate for patients aged 65+ has been above the England average but below the 75% target. The rate for under 65 at risk patients has been below the national average and also below the 55% target coverage rate.

55. City of York Council is also working with Better Homes Yorkshire to provide energy efficiency improvements to private sector domestic dwellings including a grant programme aimed at fuel poor households.

Council Plan

56. 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

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

Recommendations

58. 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.

Contact Details

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Sharon Stoltz
Director of Public Health

Report Approved ✓ **Date** 16/02/2017

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

2016/17 Finance and Performance Monitor 3 Report, Executive 9 February 2017

Annexes

Annex A – 2016/17 Quarter 3 Performance Scorecard

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Annex A

No of Indicators = 62 | 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 February 2017

				Previous Years			2016/2017						
			Collection Frequency	2013/14	2014/15	2015/16	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Target	Polarity	DoT
Adult Social Care	PVP01	People supported through personal budgets or direct payments receiving community-based services (%) (ADASS Survey definition)	Discontinued	84.13%	91.29%	93.88%	90.69%	88.35%	NC	NC	-	Up is Good	Neutral
Adult Social Care	PVP02	Number of permanent admissions to residential & nursing care homes for older people (65+)	Monthly	-	241	260	70	63	36	-	-	Up is Bad	Neutral
Adult Social Care Outcomes Framework	ASCOF1E	Proportion of adults with a learning disability in paid employment	Monthly	7.7	13.7	9.7	7.12	7.28	7.73	-	10.0%	Up is Good	Bad
		Benchmark - National Data	Annual	6.7	6.0	5.8	-	-	-	-	-		
		Benchmark - Regional Data	Annual	6.2	6.6	6.3	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	-	9	30	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	3	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	82.6	91.8	82.6	84.30	84.32	82.44	-	85.0%	Up is Good	Bad
		Benchmark - National Data	Annual	74.9	73.3	75.4	-	-	-	-	-		
		Benchmark - Regional Data	Annual	79.2	81.4	78.6	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	-	5	48	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	5	1	7	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	-	1	6	-	-	-	-	-		
	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	11.5	9.9	11.3	2.28	3.05	6.09	-	10.00	Up is Bad	Good
		Benchmark - National Data	Annual	14.4	14.2	13.3	-	-	-	-	-		
		Benchmark - Regional Data	Annual	11.0	11.5	13.9	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	-	50	64	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	7	5	7	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	-	11	5	-	-	-	-	-		

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Adult Social Care Outcomes Framework	ASCOF2A 2	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	767.5	630.8	683.1	192.00	364.79	463.53	-	620.00	Up is Bad	Neutral
		Benchmark - National Data	Annual	650.6	668.8	628.2	-	-	-	-	-		
		Benchmark - Regional Data	Annual	644.1	726.9	699.5	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	-	72	92	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	13	6	7	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	-	8	13	-	-	-	-	-		
	ASCOF2 C1	Delayed transfers of care from hospital, per 100,000 population - (YTD Average)	Monthly	17.6	11.6	13.2	17.88	18.27	18.21	-	11.00	Up is Bad	Bad
		Benchmark - National Data	Annual	9.6	11.1	12.1	-	-	-	-	-		
		Benchmark - Regional Data	Annual	9.1	9.6	10.2	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	-	102	103	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	14	11	12	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	-	11	8	-	-	-	-	-		
	ASCOF2 C2	Delayed transfers of care from hospital which are attributable to adult social care, per 100,000 population - (YTD Average)	Monthly	11.1	6.3	6.9	10.13	9.43	8.87	-	4.00	Up is Bad	Bad
		Benchmark - National Data	Annual	3.1	3.7	4.7	-	-	-	-	-		
		Benchmark - Regional Data	Annual	2.5	3	3.4	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	-	133	123	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	15	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	67.4	67.1	64.0	-	-	-	-	-	Up is Good	Bad
		Benchmark - National Data	Annual	64.8	64.7	64.4	-	-	-	-	-		
		Benchmark - Regional Data	Annual	65.8	65.9	63.8	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	-	44	82	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	5	7	10	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	-	5	13	-	-	-	-	-		

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Adult Social Care Outcomes Framework	ASCOF4A	Proportion of people who use services who feel safe	Annual	63.4	62.3	66.9	-	-	-	-	-	Up is Good	Neutral
		Benchmark - National Data	Annual	66	68.5	69.2	-	-	-	-	-		
		Benchmark - Regional Data	Annual	66.2	67.7	69.9	-	-	-	-	-		
		National Rank (Rank out of 152)	Annual	-	131	101	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	11	13	13	-	-	-	-	-		
		Comparator Rank (Rank out of 16)	Annual	-	16	13	-	-	-	-	-		
Adults and Older People	PHOF15	% of adult social care users who have as much social contact as they would like	Annual	43	46.6	45.8	-	-	-	-	-	Up is Good	Neutral
		Benchmark - National Data	Annual	44.5	44.8	45.4	-	-	-	-	-		
		Benchmark - Regional Data	Annual	44.2	45.7	46	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	12	7	9	-	-	-	-	-		
Alcohol	LAPE03	Alcohol-specific mortality: Males, all ages (per 100,000 population)	Annual	14.60	11.3	13.3	-	-	-	-	-	Up is Bad	Neutral
		Benchmark - National Data	Annual	16.61	16.1	15.9	-	-	-	-	-		
		Benchmark - Regional Data	Annual	18.13	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	7.86	7.6	N/A	-	-	-	-	-	Up is Bad	Neutral
		Benchmark - National Data	Annual	7.47	7.4	N/A	-	-	-	-	-		
		Benchmark - Regional Data	Annual	8.73	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%	-	-		

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Employment	PHOF40	Gap in employment rate for mental health clients and the overall employment rate	Annual	62.9	63.2	-	-	-	-	-	-	Up is Bad	Neutral
		Benchmark - National Data	Annual	64.7	66.1	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	62.2	62.7	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	8	8	-	-	-	-	-	-		
Health	EH2	Proportion of population aged 15 to 24 screened for chlamydia	Annual	19.60%	23.60%	22.30%	-	-	-	-	-	Neutral	Neutral
		Benchmark - National Data	Annual	25.50%	24.50%	22.50%	-	-	-	-	-		
		Benchmark - Regional Data	Annual	24.40%	24.50%	21.20%	-	-	-	-	-		
Life Expectancy	PHOF36	Life Expectancy at birth - Male	Annual	79.4	80.1	80.2	-	-	-	-	-	Up is Good	Good
		Benchmark - National Data	Annual	79.41	79.55	79.5	-	-	-	-	-		
		Benchmark - Regional Data	Annual	78.5	78.7	78.6	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	3	3	3	-	-	-	-	-		
	PHOF16	Life Expectancy at birth - Female	Annual	83.5	83.5	83.4	-	-	-	-	-	Up is Good	Neutral
		Benchmark - National Data	Annual	83.12	83.2	83.1	-	-	-	-	-		
		Benchmark - Regional Data	Annual	82.2	82.4	82.3	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	2	2	2	-	-	-	-	-		
	PHOF37	Slope index of inequality in life expectancy at birth - Male - (Three year period)	Annual	7.4	6.5	-	-	-	-	-	-	Up is Bad	Good
		Regional Rank (Rank out of 15)	Annual	3	3	-	-	-	-	-	-		
	PHOF17	Slope index of inequality in life expectancy at birth - Female - (Three year period)	Annual	5.82	5.1	-	-	-	-	-	-	Up is Bad	Good
		Regional Rank (Rank out of 15)	Annual	3	3	-	-	-	-	-	-		
Mental Health	POPPI01	Total population aged 65 and over predicted to have dementia	Annual	2,623	2,680	2,717	-	-	-	-	-	Up is Bad	Bad
	CMHD02	IAPT Referrals (18+), per 100,000 population - (VoY CCG)	Quarterly	153.23	307.08	468.52	-	-	-	-	-	Up is Good	Good
		Benchmark - National Data	Quarterly	707.60	838.72	860.60	-	-	-	-	-		
		Benchmark - Regional Data	Quarterly	701.69	909.29	897.15	-	-	-	-	-		

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Mental Health	CMHD03	% of people who have completed IAPT treatment who achieved "reliable improvement" - (VoY CCG)	Quarterly	55.88%	61.40%	63.64%	-	-	-	-	-	Up is Good	Good
		Benchmark - National Data	Quarterly	61.92%	61.62%	63.70%	-	-	-	-	-		
		Benchmark - Regional Data	Quarterly	63.29%	60.17%	63.11%	-	-	-	-	-		
	CMHP15 A	Number of bed days in secondary mental health care hospitals, per 100,000 population - (VoY CCG)	Quarterly	4786.44	8285.59	4989.34	-	-	-	-	-	Up is Bad	Good
	PHOF32	Suicide rate (per 100,000 population)	Annual	10.13	9.94	13.98	-	-	-	-	-	Up is Bad	Bad
		Benchmark - National Data	Annual	8.77	8.94	10.15	-	-	-	-	-		
		Benchmark - Regional Data	Annual	9.33	9.26	10.72	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	10	11	14	-	-	-	-	-		
Mortality	PHOF33	Excess Winter Deaths Index (all ages single year)	Annual	14.71	16.84	27.7 (Prov)	-	-	-	-	-	Up is Bad	Bad
		Benchmark - National Data	Annual	11.63	27.67	14.7	-	-	-	-	-		
		Benchmark - Regional Data	Annual	12.25	25.84	15.2	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	11	1	-	-	-	-	-	-		
	PHOF46	Mortality rate from causes considered preventable (per 100,000 population)	Annual	189.04	173.77	169.3	-	-	-	-	-	Up is Bad	Good
		Benchmark - National Data	Annual	185.13	182.7	184.5	-	-	-	-	-		
		Benchmark - Regional Data	Annual	201.39	197.82	200.2	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	4	3	2	-	-	-	-	-		
	CHP02	Child mortality rate (1-17 years), per 100,000 population	Annual	10.8	10.3	10.3	-	-	-	-	-	Up is Bad	Neutral
		Benchmark - National Data	Annual	11.9	12.0	11.96	-	-	-	-	-		
		Benchmark - Regional Data	Annual	13.3	13.3	13.28	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	3	4	4	-	-	-	-	-		
	PHOF49	Under 75 mortality rate from all cardiovascular diseases (per 100,000 population)	Annual	73.3	69.41	67.8	-	-	-	-	-	Up is Bad	Good
		Benchmark - National Data	Annual	77.83	75.72	74.6	-	-	-	-	-		
		Benchmark - Regional Data	Annual	86.9	84.68	83.5	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	3	2	2	-	-	-	-	-		

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Mortality	PHOF55	Under 75 mortality rate from cancer (per 100,000 population)	Annual	149.89	140.02	130.5	-	-	-	-	-	Up is Bad	Good
		Benchmark - National Data	Annual	144.36	141.51	138.8	-	-	-	-	-		
		Benchmark - Regional Data	Annual	155.02	151.69	148.4	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	4	3	3	-	-	-	-	-		
	PHOF61	Under 75 mortality rate from liver disease (per 100,000 population)	Annual	13.59	13.58	14.9	-	-	-	-	-	Up is Bad	Neutral
		Benchmark - National Data	Annual	17.91	17.78	18	-	-	-	-	-		
		Benchmark - Regional Data	Annual	18.85	18.13	17.9	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	2	3	-	-	-	-	-		
	PHOF66	Under 75 mortality rate from respiratory disease (per 100,000 population)	Annual	33.11	31.6	31.2	-	-	-	-	-	Up is Bad	Good
		Benchmark - National Data	Annual	33.17	32.62	33.1	-	-	-	-	-		
		Benchmark - Regional Data	Annual	39.31	38.58	38.4	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	4	4	4	-	-	-	-	-		
Obesity	NCMP01	% of reception year children recorded as being obese (single year)	Annual	7.82%	7.03%	8.59%	-	-	-	-	-	Up is Bad	Bad
		Benchmark - National Data	Annual	9.48%	9.08%	9.31%	-	-	-	-	-		
		Benchmark - Regional Data	Annual	9.20%	8.83%	9.42%	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	1	2	-	-	-	-	-		
	NCMP02	% of children in Year 6 recorded as being obese (single year)	Annual	15.35%	14.97%	15.14%	-	-	-	-	-	Up is Bad	Neutral
		Benchmark - National Data	Annual	19.09%	19.08%	19.82%	-	-	-	-	-		
		Benchmark - Regional Data	Annual	19.22%	19.19%	20.29%	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	1	1	-	-	-	-	-		
	PHOF44	% of adults classified as overweight or obese	Annual	-	56.88	56.4	-	-	-	-	-	Up is Bad	Neutral
		Benchmark - National Data	Annual	-	64.59	64.8	-	-	-	-	-		
		Benchmark - Regional Data	Annual	-	67.09	67.4	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	-	1	1	-	-	-	-	-		

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Physical Activity	PHOF01	% of physically active and inactive adults - active adults	Annual	66.16%	62.18%	69.83%	-	-	-	-	-	Up is Good	Neutral
Physical Activity	PHOF01	Benchmark - National Data	Annual	56.03%	57.04%	57.05%	-	-	-	-	-		
Physical Activity	PHOF01	Benchmark - Regional Data	Annual	55.28%	56.08%	56.35%	-	-	-	-	-		
Physical Activity	PHOF01	Regional Rank (Rank out of 15)	Annual	1	2	1	-	-	-	-	-		
Physical Activity	PHOF02	% of active and inactive adults - inactive adults	Annual	21.09%	21.57%	17.54%	-	-	-	-	-	Up is Bad	Good
Physical Activity	PHOF02	Benchmark - National Data	Annual	28.34%	27.73%	28.65%	-	-	-	-	-		
Physical Activity	PHOF02	Benchmark - Regional Data	Annual	28.73%	29.21%	29.12%	-	-	-	-	-		
Physical Activity	PHOF02	Regional Rank (Rank out of 15)	Annual	1	1	1	-	-	-	-	-		
Public Health and Wellbeing	EH1	Chlamydia diagnoses (15-24 year olds), per 100,000 population	Annual	1728.26	1682.5	1462	-	-	-	-	-	Up is Bad	Good
Public Health and Wellbeing	EH1	Benchmark - National Data	Annual	2071.62	2035.3	1887	-	-	-	-	-		
Public Health and Wellbeing	EH1	Benchmark - Regional Data	Annual	2187.66	2240.1	2031.4	-	-	-	-	-		
Public Health and Wellbeing	EH1	Regional Rank (Rank out of 15)	Annual	13	13	14	-	-	-	-	-		
Public Health and Wellbeing	HV01	% of births that receive a face to face New Birth Visit (NBV) by a Health Visitor within 14 days	Quarterly	-	-	74.40%	74.32%	70.14%	-	-	-	Up is Good	Neutral
Public Health and Wellbeing	HV01	Benchmark - National Data	Quarterly	-	-	87.80%	87.60%	88.50%	-	-	-		
Public Health and Wellbeing	HV01	Benchmark - Regional Data	Quarterly	-	-	86.80%	87.40%	85.10%	-	-	-		
Public Health and Wellbeing	HV02	% of face-to-face NBVs undertaken by a health visitor after 14 days	Quarterly	-	-	21.70%	21.21%	19.64%	-	-	-	Up is Bad	Neutral
Public Health and Wellbeing	HV02	Benchmark - National Data	Quarterly	-	-	9.50%	10.00%	9.30%	-	-	-		
Public Health and Wellbeing	HV02	Benchmark - Regional Data	Quarterly	-	-	10.80%	10.70%	12.50%	-	-	-		
Public Health and Wellbeing	HV03	% of infants who received a 6-8 week review by the time they were 8 weeks	Quarterly	-	-	70.80%	75.22%	78.96%	-	-	-	Up is Good	Neutral
Public Health and Wellbeing	HV03	Benchmark - National Data	Quarterly	-	-	82.70%	81.60%	81.90%	-	-	-		
Public Health and Wellbeing	HV03	Benchmark - Regional Data	Quarterly	-	-	86.40%	86.10%	86.10%	-	-	-		
Public Health and Wellbeing	HV04	% of infants being breastfed at 6-8wks	Quarterly	-	-	30.10%	34.03%	36.87%	-	-	-	Up is Good	Good
Public Health and Wellbeing	HV04	Benchmark - National Data	Quarterly	-	-	43.70%	43.87%	44.4	-	-	-		
Public Health and Wellbeing	HV04	Benchmark - Regional Data	Quarterly	-	-	36.60%	37.96%	-	-	-	-		

Annex A

Health & Adult Social Care Policy & Scrutiny 2016/2017

No of Indicators = 62 | 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 February 2017

			Collection Frequency	Previous Years 2013/14	2014/15	2015/16	2016/2017 Quarter 1	Quarter 2	Quarter 3	Quarter 4	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%	23.98%	21.66%	-	-	-	Up is Good	Good
		Benchmark - National Data	Quarterly	-	-	73.60%	74.30%	75.50%	-	-	-		
		Benchmark - Regional Data	Quarterly	-	-	82.50%	81.10%	81.60%	-	-	-		
	HV06	% of children who received a 12 month review by the time they turned 15 months	Quarterly	-	-	70.00%	68.94%	74.81%	-	-	-	Up is Good	Neutral
		Benchmark - National Data	Quarterly	-	-	82.50%	82.05%	82.50%	-	-	-		
		Benchmark - Regional Data	Quarterly	-	-	88.50%	89.06%	88.80%	-	-	-		
	HV07	% of children who received a 2-2½ year review	Quarterly	-	-	11.60%	22.39%	23.08%	-	-	-	Up is Good	Good
		Benchmark - National Data	Quarterly	-	-	74.70%	76.27%	78.10%	-	-	-		
		Benchmark - Regional Data	Quarterly	-	-	81.30%	82.74%	82.60%	-	-	-		
	PHOF11	Cumulative % of eligible population aged 40-74 offered an NHS Health Check	Quarterly	20.93%	38.11%	70.67%	71.91%	-	-	-	-	Up is Good	Good
		Benchmark - National Data	Quarterly	18.42%	37.94%	56.44%	61.51%	-	-	-	-		
		Benchmark - Regional Data	Annual	14.41%	31.33%	49.80%	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Quarterly	2	4	2	-	-	-	-	-		
	PHOF11b	Cumulative % of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	Quarterly	41.54%	39.35%	37.57%	37.47%	-	-	-	-	Up is Good	Bad
		Benchmark - National Data	Quarterly	49.04%	48.93%	48.59%	48.37%	-	-	-	-		
		Benchmark - Regional Data	Annual	57.14%	52.23%	48.80%	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Quarterly	13	12	12	-	-	-	-	-		
	PHOF12	Cumulative % of eligible population aged 40-74 who received an NHS Health Check	Quarterly	8.69%	14.99%	26.55%	26.95%	-	-	-	-	Up is Good	Good
		Benchmark - National Data	Quarterly	9.03%	18.56%	27.42%	-	-	-	-	-		
		Benchmark - Regional Data	Annual	8.24%	16.36%	24.30%	29.75%	-	-	-	-		
		Regional Rank (Rank out of 15)	Quarterly	6	7	5	-	-	-	-	-		
	PHOF31	% of eligible population aged 40-74 who received an NHS Health Check	Quarterly	8.69%	7.32%	9.81%	-	-	-	-	-	Up is Good	Good
		Benchmark - National Data	Quarterly	9.03%	9.62%	8.99%	-	-	-	-	-		
		Benchmark - Regional Data	Annual	8.24%	-	-	-	-	-	-	-		

Health & Adult Social Care Policy & Scrutiny 2016/2017

Annex A

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Produced by the Strategic Business Intelligence Hub February 2017

				Previous Years			2016/2017						
			Collection Frequency	2013/14	2014/15	2015/16	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Target	Polarity	DoT
Public Health and Wellbeing	PHOF79	HIV late diagnosis	Annual	44.00%	56.30%	68.80%	-	-	-	-	-	Up is Bad	Bad
		Benchmark - National Data	Annual	45.00%	42.20%	40.30%	-	-	-	-	-		
		Benchmark - Regional Data	Annual	50.50%	49.70%	48.20%	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	14	3	15	-	-	-	-	-		
	YH13	% of mothers smoking at time of delivery - (Rolling 12 Month)	Monthly	-	-	12.05%	12.13%	12.01%	11.50%	-	-	Up is Bad	Neutral
Safeguarding (Young People)	CHP32	Hospital admissions as a result of self harm (10-24 years), per 100,000 population	Annual	401.21	552.96	-	-	-	-	-	-	Up is Bad	Bad
		Benchmark - National Data	Annual	412.07	398.80	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	394.68	367.90	-	-	-	-	-	-		
	PHOF06	Under 18 conceptions (per 1,000 females aged 15-17) (Calendar Year)	Quarterly	21.59	15.71	-	-	-	-	-	-	Up is Bad	Good
		Benchmark - National Data	Quarterly	24.35	22.8	-	-	-	-	-	-		
		Benchmark - Regional Data	Quarterly	28.53	26.35	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	3	1	-	-	-	-	-	-		
	PHOF27	Under 18 conceptions: conceptions in those aged under 16 (per 1,000 females aged 13-15) (Calendar Year)	Annual	2.83	2.13	-	-	-	-	-	-	Up is Bad	Good
		Benchmark - National Data	Annual	4.81	4.38	-	-	-	-	-	-		
		Benchmark - Regional Data	Annual	6.02	5.49	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	1	-	-	-	-	-	-		
Smoking	PHOF10	% of women who smoke at the time of delivery	Quarterly	10.63%	10.80%	12.06%	11.96%	9.70%	-	-	-	Up is Bad	Neutral
		Benchmark - National Data	Annual	11.99%	11.38%	10.65%	10.21%	10.40%	-	-	-		
		Benchmark - Regional Data	Annual	16.22%	15.56%	14.53%	14.24%	14.20%	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	1	4	-	-	-	-	-		
	PHOF20	% of population smoking (routine and manual workers) (APS)	Annual	32.39%	32.48%	27.82%	-	-	-	-	-	Up is Bad	Neutral
		Benchmark - National Data	Annual	30.64%	30.79%	28.22%	-	-	-	-	-		
		Benchmark - Regional Data	Annual	28.51%	27.97%	26.51%	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	10	10	6	-	-	-	-	-		

Health & Adult Social Care Policy & Scrutiny 2016/2017

Annex A

No of Indicators = 62 | 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 February 2017

				Previous Years			2016/2017						
			Collection Frequency	2013/14	2014/15	2015/16	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Target	Polarity	DoT
Smoking	PHOF45	% of population smoking (APS)	Annual	18.72%	17.24%	14.63%	-	-	-	-	-	Up is Bad	Good
		Benchmark - National Data	Annual	20.48%	19.86%	18.63%	-	-	-	-	-		
		Benchmark - Regional Data	Annual	18.39%	17.85%	16.93%	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	3	4	2	-	-	-	-	-		
	NGPP01	Gap in smoking prevalence rate between adult general population and adults in routine and manual occupations	Annual	13.66%	15.24%	13.19%	-	-	-	-	-	Neutral	Neutral
		Benchmark - National Data	Annual	10.16%	10.93%	9.59%	-	-	-	-	-		
		Benchmark - Regional Data	Annual	10.12%	10.12%	9.58%	-	-	-	-	-		
Sport	SSN004	Adult participation in 30 minutes, moderate intensity sport	Discontinued	42.37%	41.65%	45.54%	-	-	-	-	-	Up is Good	Neutral
		Benchmark - National Data	Discontinued	36.09%	35.55%	36.20%	-	-	-	-	-		
		Benchmark - Regional Data	Discontinued	35.07%	34.90%	35.15%	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Discontinued	1	2	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	Bad
	PHOF76	% of opiate users in treatment who successfully completed drug treatment (without representation within 6 months)	Quarterly	7.00%	5.20%	5.50%	6.07%	7.97%	8.05%	-	-	Up is Good	Good
		Benchmark - National Data	Quarterly	7.76%	7.38%	6.80%	6.97%	6.58%	6.58%	-	-		
		Benchmark - Regional Data	Quarterly	6.91%	6.24%	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	11	9	-	-	-	-	-	-		
	PHOF77	% of non-opiate users in treatment who successfully completed drug treatment (without representation within 6 months)	Quarterly	34.60%	40.10%	31.10%	32.51%	37.93%	37.89%	-	-	Up is Good	Neutral
		Benchmark - National Data	Quarterly	37.66%	39.19%	37.30%	37.17%	36.91%	36.75%	-	-		
		Benchmark - Regional Data	Quarterly	36.33%	40.19%	-	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	5	9	-	-	-	-	-	-		

Health & Adult Social Care Policy & Scrutiny Committee **27 February 2017**

Report of the Assistant Director – Legal & Governance

Yorkshire Ambulance Service Inspection Cover Report

Summary

1. This report and its annexes provide the Health & Adult Social Care Policy & Scrutiny Committee with details of the Care Quality Commission's (CQC) findings (Annex 1) following its inspection of the Yorkshire Ambulance Service NHS Trust (YAS).

Background

2. YAS provides 24-hour emergency and healthcare services to a population of more than five million people across an area covering almost 6,000 square miles.

3. The CQC carried out a follow-up inspection of the Trust from 13-16 September 2016 in response to a previous inspection in January 2015. In addition an announced inspection of the NHS 111 service was carried out on 10-12 October 2016.

4. In 2015 the Trust was rated as Requires Improvement. The CQC inspectors found that the Trust delivered services that were caring, but that work was needed to improve safety, leadership, effectiveness and responsiveness.

5. The 2016 inspections were to ensure the required improvements had been made and focused on five core services:

- Emergency operations centres
- Urgent and emergency care
- Patient transport services
- Resilience services, including the hazardous area response team
- NHS 111 services

6. Overall the CQC rated all of the five key domains as good which means the overall rating of the trust is also good and includes several areas of outstanding practice.

7. The Chief Inspector of Hospitals noted that YAS has worked hard to address the issues raised in the 2015 inspection and the improved rating reflects the changes that have been made through an improved approach to safety and effectiveness and by addressing national staff shortages through a range of local initiatives.

8. He concluded that the CQC has been impressed with the improvements and that YAS staff should be pleased with their new rating.

9. However, there are still areas of poor practice where the Trust needs to make improvements and it must ensure:

   - There are sufficient numbers of suitably skilled, qualified and experiences staff on duty at all times.
   - All ambulances and equipment within Patient Transport Services are appropriately cleaned and infection control procedures are followed.
   - Secure seating for children is routinely available in ambulance vehicles.

Options

10. Members can note the content of this report and its annexes and the details provided by Yorkshire Ambulance Service representatives and can:

    i. Ask for any further information, or not;

    ii. Comment on the improved performance of Yorkshire Ambulance Service

Consultation

11. The Quality Report at Annex 1 has been provided by the Care Quality Commission. Representatives from the Yorkshire Ambulance Service NHS Trust will be in attendance at the meeting to detail the improvements that have been made (Annex 2) and to answer any questions Members may have.

Analysis

12. Most of the issues raised in the 2015 inspection have been addressed and YAS has raised its rating from Requires Improvement to Good.

Council Plan

13. This report and its annexes are directly linked to the Focus on Frontline Services element of the Council Plan.

Risks and Implications

14. There are no risks or implications directly associated with the recommendations in this report.

Recommendations

15. The Committee are asked to:

    i. Consider and comment on the information provided in the annexes to this report and ask questions of the Trust representatives at the meeting should there be issues needing clarification

    ii. Congratulate the Trust on the work it has undertaken to raise its rating from Requires Improvement to Good.

    iii. Encourage the Trust to sustain the improvements that have been made.

Reasons:

i. To keep the Committee up to date on the work of the Trust.

ii. To recognise the improvements made by YAS.

iii. To ensure residents of York and the wider Yorkshire region receive the best possible emergency and healthcare services.

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Report Approved ✓ **Date** 15/02/2017

Wards Affected: **All** ✓

For further information please contact the author of the report

Annexes

Annex 1 – CQC Quality Report
Annex 2 – YAS presentation

Care Quality Commission

Yorkshire Ambulance Service NHS Trust

Quality Report

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Website: www.yas.nhs.uk

Date of inspection visit: 13-16 September 2016, 6 October 2016, 10-12 October 2016
Date of publication: 01/02/2017

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Yorkshire Ambulance Service NHS Trust (YAS) was formed on1 July 2006 when the county's three former services merged. The trust covers North Yorkshire, South Yorkshire, West Yorkshire, Hull and East Yorkshire covering almost 6,000 square miles of varied terrain, from isolated moors and dales to urban areas, coastline and inner cities. The trust employsover 4,670 staff and provides 24-hour emergency and healthcare services to a population of more than five million.

The trust provides an accident and emergency (A&E) service to respond to 999 calls, an NHS 111 service for when medical help is needed fast but it is not a 999 emergency, patient transport services (PTS) and emergency operation centres (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a resilience and hazardous area response team (HART).

We carried out a follow up inspection of the trust from 13-16 September 2016, in response to a previous inspection as part of our comprehensive inspection programme of Yorkshire Ambulance Service NHS Trust in January 2015. In addition, an announced comprehensive inspection of the NHS 111 service was carried out on 10-12 October 2016.

Focused inspections do not look across a whole service; they focus on the areas defined by the information that triggers the need for the focused inspection. We therefore did not inspect all of the five domains: safe, effective, caring, responsive and well led for each of the core services we inspected.

We inspected five core services:

- Emergency operations centres
- Urgent and emergency care
- Patient transport services
- Resilience services including the hazardous area response team
- NHS 111 services.

Overall, we rated all of the five key domains as good which meant the overall rating for the trust was also good.

Our key findings were as follows:

- The trust had undertaken a number of initiatives to improve staff engagement; the staff forum had become embedded since our previous inspection and was viewed positively by staff.
- Relationships between the trust and trade unions had improved since the previous inspection but there still more work for the trust to do.
- Staffing levels throughout the trust were planned and monitored. The trust had challenges due to national shortages however; it was addressing this through a range of initiatives.
- From April 2016 the trust was participating in the national trial of the ambulance response programme (ARP) which helped the service to dispatch appropriate ambulance resources. There were no performance targets for the ARP pilot. The trust monitored its performance on response times.
- At the previous inspection there had been concerns in relation to equipment checks, maintenance of equipment and consumable stock. At this inspection we found the trust had put in place a system to ensure equipment and stock was suitable to use.
- In most of the core services we found infection control procedures were followed and the ambulance stations and vehicles we observed were generally clean. However there were still inconsistencies in the way staff maintained vehicle cleanliness across the PTS service.
- There were systems in place to share learning from incidents and adverse events. Most staff we spoke with confirmed they received feedback by email after reporting an incident. A safety bulletin was produced and shared across the trust to share lessons learnt.
- There were high levels of compliance with safeguarding training at levels one and two, and all staff who were determined by the trust to require level three training, had received this.
- From April 2016 the trust had commenced a local review of mortality and morbidity, supported by local audits linked to the trust’s commissioning for quality and innovation (CQUIN) targets to explore all deaths in the care of the trust, where Recognition of Life Extinct (ROLE) had been invoked by YAS paramedics.

Summary of findings

- Within the NHS 111 service, call abandonment rate was 2%, compared to the national average of 3%. We saw that 89% of calls were answered within 60 seconds, compared to the national average of 87%.
- Within the PTS service there was a clear lack of management oversight and lack of ownership of roles and responsibilities, and governance systems were not fully embedded throughout the service.

We saw several areas of outstanding practice including:

- The red arrest team provided clinical leadership in the response to cardiac arrest patients, which had improved the success rate in the return of spontaneous circulation (ROSC).
- The 'restart a heart' team was commended for its CPR work with school children. More than 31,000 children were trained in hands-only CPR in conjunction with the British Heart Foundation.
- Community first responders were trained volunteers who were available to attend emergency calls and to provide initial care before the arrival of an ambulance. More than 300 community first responder schemes worked closely with the ambulance service.
- The service supported 670 public access defibrillators across the Yorkshire region which was available for use by members of the public. The scheme particularly helped people to access defibrillators in remote villages.
- A member of the air ambulance crew had completed training in Crew Resource Management (CRM). The qualification enabled the member of staff to undertake critique and feedback of incidents whilst taking account of human factors.
- HART staff presented evidence on the benefits of early antibiotic administration in open fractures. This treatment now has become standard practice within YAS.
- The trust was part of the urgent and emergency care vanguard programme, to support the development of new approaches to the provision of urgent and emergency care. The West Yorkshire urgent and emergency care network aimed to develop an integrated urgent care model for the region, building on the services provided by existing urgent care services.
- The trust had contributed to the development of a Pharmacy Urgent Repeat Medication Scheme (PURM) across the locality which enabled patients to access essential medicines from participating pharmacists out of hours. This scheme had won a 'Pharmacy Innovation' award.
- The NHS 111 service had implemented access to palliative care nurses on weekends and bank holidays, who were able to provide support to patients approaching the end of life.
- The trust had made use of a comprehensive workforce management tool to forecast anticipated call levels and deploy staff accordingly. The development of this tool and the transformation of planning within the organisation were recognised by a National Planning Award from the Professional Planning Forum.

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

Importantly, the trust must:

- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff.
- Within patient transport services (PTS) the trust must ensure that all ambulances and equipment are appropriately cleaned and infection control procedures are followed.
- The trust must ensure secure seating for children is routinely available in ambulance vehicles.

In addition the trust should:

- The trust should review the training requirements for operational staff in the PTS service for vulnerable groups such as patients living with dementia and patients experiencing mental health concerns.
- The trust should review the arrangements for operational staff to check their vehicle and equipment at the start of the shift to ensure they have sufficient time to complete the checks.
- The trust should review the audit procedures for reviewing the recording of controlled medicines.
- The trust should continue to ensure that equipment and medical supplies are checked and are fit for purpose.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Yorkshire Ambulance Service NHS Trust

Yorkshire Ambulance Service NHS Trust (YAS) was formed on1 July 2006 when the county's three former services merged. The trust covers North Yorkshire, South Yorkshire, West Yorkshire, Hull and East Yorkshire covering almost 6,000 square miles of varied terrain, from isolated moors and dales to urban areas, coastline and inner cities. The trust employsover 4,670 staff and provides 24-hour emergency and healthcare services to a population of more than five million. YAS is the only NHS trust that covers the whole of Yorkshire and Humber.

The trust provided an accident and emergency (A&E) service to respond to 999 calls, patient transport services (PTS) and emergency operation centres (EOC) where 999 calls were received; clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART). The trust also provided an NHS 111 core service for when medical help is needed fast but it is not a 999 emergency. This core service was inspected in October 2016 and is included in this report.

In 2015-16 the trust received 2.6 million calls and responded to 854,966 urgent and emergency calls. The NHS 111 service received 1,511,038 calls for the year which averaged at 4,139 calls per day. Within PTS in 2015-16 the service made around1,036,052 journeys transporting patients across Yorkshire and neighbouring counties each year.

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

Our inspection team

Our inspection team was led by:

Chair: Darren Mochrie

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team of 24 people included CQC inspectors, inspection managers, national professional advisor, pharmacy inspectors, inspection planners and a variety of specialists. The team of specialists comprised of

paramedics, emergency medical technicians, operational managers, patient transport service managers, emergency operation centre managers and operations directors.

How we carried out this inspection

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

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

The inspection team inspected the following:

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

Summary of findings

- Resilience Team including the Hazardous Area Response Team
- NHS 111 service

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the ambulance service. These included the clinical commissioning groups (CCGs), NHS Improvement, NHS England, and the local Healthwatch organisations. We talked with patients and staff from the trust and from a range of acute services who used the service provided by the ambulance trust. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

We carried out the announced inspection visit from 13-16 September 2016, the NHS 111 service between 10-12 October 2016, and we undertook an unannounced inspection on 6 October 2016.

What people who use the trust's services say

The CQC Ambulance Survey looked at the experiences of over 2,900 people who called an ambulance service in December 2013 or January 2014. Responses were received from 262 patients at Yorkshire Ambulance Service NHS Trust. The trust scored better than other trusts in two of the outcome measures and about the same as other trusts in the other two outcome measures.

We reviewed the most recently available Friends and Family Test (FFT) and patient satisfaction survey results for the NHS 111 service and found that between January and March 2016:

- 93% of respondents said that they were likely or extremely likely to recommend the service to friends and family
- 93% of patients were happy with the responsiveness of the service in answering their call
- 92% of patients said the call handler listened to them effectively
- 90% of patients said the call handler was reassuring
- 96% of patients said they understood what the call handler said to them
- 96% of patients said they had been treated with dignity and respect
- 96% of patients said they understood the information and advice they were given
- 89% of patients said the information and advice they received was helpful

Facts and data about this trust

The population the trust serves includes:

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

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

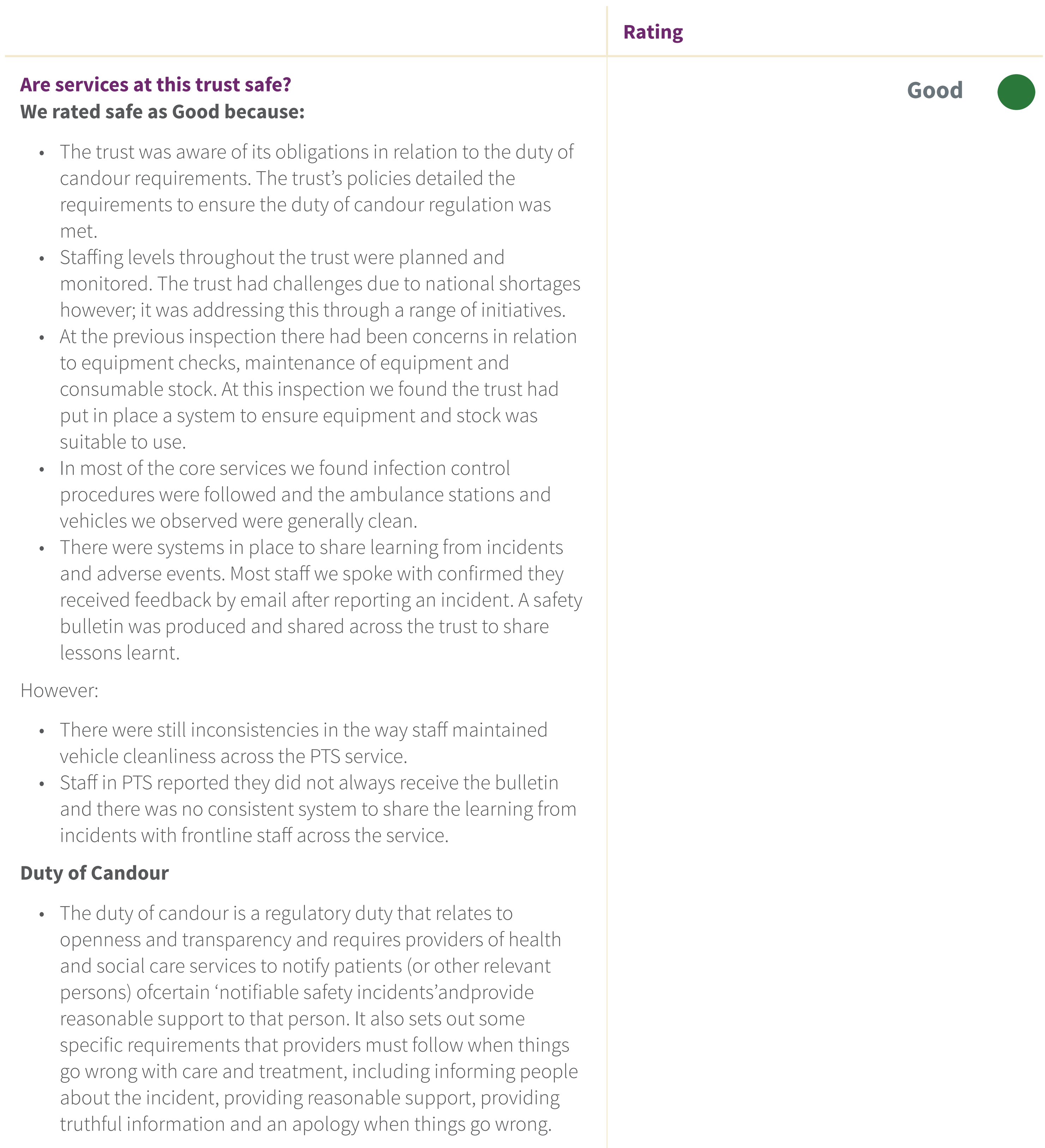
- Bassetlaw
- North Lincolnshire.

Activity

- In 2015-16 the trust's A&E service responded to 854,966 urgent and emergency calls.
- The total number of calls for 999 and NHS 111 handled by the trust was 2.6 million calls per year.
- Within PTS in 2015-16 the service made around1,036,052 journeys transporting patients across Yorkshire and neighbouring counties each year.

Summary of findings

Our judgements about each of our five key questions



	Rating
Are services at this trust safe?	Good

We rated safe as Good because:

- The trust was aware of its obligations in relation to the duty of candour requirements. The trust's policies detailed the requirements to ensure the duty of candour regulation was met.
- Staffing levels throughout the trust were planned and monitored. The trust had challenges due to national shortages however; it was addressing this through a range of initiatives.
- At the previous inspection there had been concerns in relation to equipment checks, maintenance of equipment and consumable stock. At this inspection we found the trust had put in place a system to ensure equipment and stock was suitable to use.
- In most of the core services we found infection control procedures were followed and the ambulance stations and vehicles we observed were generally clean.
- There were systems in place to share learning from incidents and adverse events. Most staff we spoke with confirmed they received feedback by email after reporting an incident. A safety bulletin was produced and shared across the trust to share lessons learnt.

However:

- There were still inconsistencies in the way staff maintained vehicle cleanliness across the PTS service.
- Staff in PTS reported they did not always receive the bulletin and there was no consistent system to share the learning from incidents with frontline staff across the service.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) ofcertain 'notifiable safety incidents'andprovide reasonable support to that person. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Summary of findings

- The trust had a 'Being Open Policy' which detailed the process undertaken by the organisation to ensure duty of candour was adhered to. Upon notification of a notifiable safety incident these were reviewed by the Quality & Safety Team to determine the accurate level of harm.
- If the level of harm had been confirmed to be moderate or above, the duty of candour process would be implemented. This involved initial contact with the patient and/or relative as soon as was practically possible.
- The trust would then invite the patient and/or relative to take part in the investigation and feedback was offered via a variety of options including face to face, telephone consultation or in writing, depending on the preference of the individual.
- The trust had implemented a system to ensure all notifiable safety incidents were captured. Any moderate and above incidents were also reviewed fortnightly by the Incident Review Group (IRG). Monthly, quarterly, bi-annual and annual audits were conducted of the process and reported against key performance indicators (KPIs) within the quality, governance & performance assurance directorate dashboard.
- Throughout the trust most staff we spoke with understood the duty of candour requirements and being, open and honest.

Safeguarding

- The executive director of quality governance and performance assurance was the executive lead on the board for safeguarding. They were supported by the deputy director of quality and nursing who was the trust lead for safeguarding children's and adults.
- At the time of inspection the trust were in the process of recruiting to the head of safeguarding role which had been vacant for a couple of months.
- The trust had a safeguarding policy which included arrangements for children, young people and adults at risk. Procedures were in place for all staff to make a safeguarding referral where concerns were observed.
- There was a dedicated health desk in the emergency operations centre responsible for reporting safeguarding concerns. The health desk was open 24 hours a day, 365 days a year.
- When safeguarding risks to children and families were encountered, an internal data flag was triggered to make ambulance staff aware of heightened risks when attending an identified address.
- Staff had undertaken their safeguarding training for children and adults as part of statutory and mandatory training and in

Summary of findings

addition to induction training. There were high levels of compliance with safeguarding training at levels one and two, and all staff who were determined by the trust to require level three training, had received this.

- Staff undertook safeguarding children's level one and two and safeguarding adults training every two years. Staff who required level 3 safeguarding training in relation to their specific role had received this.
- The intercollegiate document for safeguarding children and young people: roles and competences for health care staff (2014) states that; 'All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns should have level three safeguarding training. This included paramedics.

Incidents

- The trust had a web based incident management system. Staff told us they could also report incidents via a 24 hour dedicated telephone line. Staff described this as a useful service as it saved time and meant it allowed incidents to be reported in situations where it otherwise may not have been possible to report them, for example due to where they were working and lack of access to a computer.
- The service had two main policies for incident reporting, an incident and serious incident management policy and an investigations and learning policy. Incidents were graded according to severity which had been further refined during 2016 to support the appropriate investigation of incidents.
- Where a serious incident was identified, a root cause analysis (RCA) was carried out to establish the causes of the incident and to allow staff to identify risks and make appropriate changes to prevent similar incidents from occurring.
- Most staff we spoke with confirmed they received feedback by email after reporting an incident. Learning from the investigation of incidents was also shared. A significant events and lessons learned report was presented in alternate months to the trust quality committee and six-monthly a significant events and lessons learned report was prepared for the trust board in public.

Summary of findings

- A safety bulletin was produced and shared across the core services however staff in PTS reported they did not always receive the bulletin and there was no consistent system to share the learning from incidents with frontline staff across the service.
- Between 29 May 2015 and 30 June 2016 within EOC, there were 309 reported patient safety incidents. The main causes were delayed response, delayed dispatch and delayed back up. Of these, nine incidents were reported as "catastrophic." For example, a patient death had resulted. Five had been reported as major; examples included an inadequate clinical response, which resulted in harm to a patient. Fourteen incidents were reported as moderate harm; examples included delayed response or dispatch, which may have contributed to harm to patients.
- Twenty-five incidents reported were minor, such as a delayed response which may have contributed to harm or death. Eighty-seven incidents were reported as a near miss, where there may have been potential harm to the patient. One hundred and sixty nine reported incidents resulted in no harm caused whilst in YAS's care.
- For emergency and urgent care services 2369 incidents were reported between 1 January 2016 and 19 May 2016. The type of incidents included vehicle damage to ambulances or other vehicles, assaults on ambulance crews, injury to patients, equipment faults and drug errors.
- We found that 1149 (48.5%) of incidents were reported as "no harm", 15% were reported as "near miss" and in 863 incidents (36.4%) harm had been caused. Of the incidents where harm was caused, 64 of these affected patient care, which represented 2.7% of the total incidents. Five "catastrophic" incidents had occurred, where patients had died whilst in the care of the service. The reasons for this included missed diagnosis, failure to follow procedures, delayed dispatch and delayed response.
- We also found that from May 2016 to August 2016 there had been a further 263 incidents reported through the national reporting and learning system (NRLS), of which 90 (34.2%) had been reported as "no harm". Ten incidents were reported by the service as "severe" and included two incidents of excessive response times which had resulted in patient deaths.
- Five of these incidents were reported as "internal comprehensive". These were serious incidents which required investigation; of these, three related to patient deaths due to

Summary of findings

either excessive response times or the way the call was classified in the call centre. One of the internal comprehensive incidents referred to a delayed response to a road traffic collision which was beyond the control of the service.

- Within the PTS service there were 622 incidents reported from 1 January 2016 to 14 July 2016. The incidents included patient slips, trips and falls, vehicle damage, faulty equipment and aggression shown towards staff by the public.
- Of the incidents reported, 55% were reported as ‘no harm’. These included incidents such as equipment faults, patients not at the address to be picked up or patient falls while in the care of the service but who did not sustain an injury.
- In the same time period, 43% of incidents were reported as ‘minor’. These included vehicle damage after collision, minor injury to patients while in the care of the service or injury to staff while handling patients. A total of 2% of incidents had been reported as ‘moderate’, which included more significant injuries to patients such as a fractured hip sustained while in the care of the service or other significant injuries to staff.
- Of the 280 incidents which resulted in harm, 54% were recorded as damage to vehicles or equipment, 27% were recorded as harm to staff and 19% were recorded as harm to patients.
- There had been 60 incidents for the resilience service from 2 January 2016 to 25 June 2016. In 31 incidents, (52%) no harm was reported to have been caused. These incidents included damage to vehicles and broken ampoules of medication. 21 incidents (35%) were classed as minor harm; examples included minor damage to vehicles and minor injuries to staff from slips, trips and falls. Two incidents (3.3%) were classed as moderate, these both related to staff injury from falls.
- Six (10%) incidents were not classified, they included reports of HART staff dealing with multiple major traumas within a week including suicides, shooting incidents, and house fires, all with fatalities.
- Within the NHS 111 service an incident had occurred where a patient with testicular pain was directed to a next day GP appointment. The patient was subsequently found to have testicular torsion which required immediate medical attention. Following this incident, the provider notified NHS Pathways of an omission in the assessment algorithm. As a result the pathway was changed to include a question to identify whether pain was increasing within the last four hours, in order to better identify such cases. Testicular torsion occurs when the spermatic cord (the cord that supplies the testicles with blood) becomes severely twisted.

Cleanliness and Infection Control

Summary of findings

- At the previous inspection in January 2015 we found there were variable standards of cleanliness, infection control and hygiene across the areas visited. This was particularly relevant for ambulances in the HART/ resilience team and the urgent and emergency care services.
- Vehicle cleaning had been rated as a high risk on the corporate risk register control measures had been put in place and this had reduced the risk to moderate.
- At this inspection we found infection control procedures were followed and the ambulance stations and vehicles we observed were generally clean.
- Within the resilience service at the previous inspection a number of concerns had been identified and raised in relation to cleanliness and infection prevention and control these had been immediately addressed at the time of the inspection. On this inspection we found that these changes had been embedded and sustained.
- A vehicle "make ready" system to prepare vehicles for use had been introduced as a pilot and was due to be implemented across the service. At some ambulance stations, cleaning staff also cleaned the vehicle exteriors and the cab of the vehicle and vehicle cleaning was recorded daily.
- Vehicles were scheduled to receive regular deep cleaning at intervals of 35 days. A sticker in the vehicle gave the date of the last deep clean and when the next one was due. We found this plan was being followed for most vehicles. For example we inspected 24 ambulance vehicles within the urgent and emergency care service for the cleanliness of the vehicle. Of these, 20 were visibly clean, including the cab area. Re-usable equipment such as splints, blood pressure cuffs and slide sheets were visibly clean in 21 of the vehicles we inspected.
- Clinical audits for hand hygiene, vehicle cleanliness and ambulance stations were undertaken monthly. The results of audit were reported to the trust board in the integrated performance report. The trust reported that compliance with audit had improved over the previous 12 months, and most areas were achieving 95% compliance.
- Staff training in infection prevention and control was provided at induction and refresher training took place every second year. For 2015-16, 94% of staff had completed this training.
- Staff was seen to be compliant with IPC procedures in relation to bare below the elbows and using hand cleansing gel between patient contacts.

Summary of findings

- However in the PTS service we found variations in the cleanliness of the vehicles we checked. Some were very clean inside and out. However, some were found to have visible dirt on the inside particularly in the driver's area. General vehicle housekeeping standards were poor across all localities.
- There were inconsistencies in the way staff maintained vehicle cleanliness across the PTS service. We found cleanliness recording sheets present on some vehicles we checked but not present on others. Some staff we spoke with was not aware of a formal procedure for cleaning the PTS vehicles but other staff were able to explain this.
- The trust provided information which indicated that staff could clean the vehicles at the end of their shift if there was time if not this would be undertaken in the morning. However staff told us there was often insufficient time at the start or end of a shift to clean properly. Day to day cleaning of the exterior of the vehicles varied depending on the facilities at the station and the weather conditions. Staff also said time constraints meant cleaning the outside of the vehicle was not seen as a priority.

Environment and equipment

- At our previous inspection we found in the urgent and emergency care service the supply of consumable items and the maintenance of equipment was variable.
- At this inspection we found equipment and consumable supplies were readily available and in date. Regular logistics checks of equipment were being undertaken and disposal bins for out of date consumable items were provided in ambulance stations.
- Faulty equipment was clearly labelled as such and reported to the clinical supervisor. We reviewed a selection of consumable stocks at the ambulance stations we visited and found these were appropriately stored and on the whole in date. Any out of date items were identified to staff at the time of the inspection.
- A number of issues had been identified at the previous inspection within the resilience service in relation to equipment checks. Following this, equipment checks, and recording the findings had been implemented. During this inspection we found that daily checks were done of equipment on HART vehicles and each month vehicles would be completely emptied and a full check of all equipment on board was done. Tags with identity numbers provided ongoing assurance that the necessary equipment was available and any consumable items within date.
- We observed daily checks taking place during our inspection and each of the vehicles had a completed checklist on board.

Summary of findings

We spoke with staff about the daily and monthly checks and they said it had just become routine and part of their role. Staff said as they had taken on board the findings of the last report as a team; everyone had taken responsibility for the findings and been involved in addressing them. It was felt this was how the changes had been sustained. We were also told the checklists had been adapted following feedback from staff.

- We reviewed additional monthly checks of four HART vehicles from January, March and April 2016 and found these to be fully completed. Any issues were noted to be promptly addressed. For example, one vehicle had been moved and was not on a charging point and had a flat battery. It was documented that the vehicle had been plugged in and reported.
- We found the security at some of the ambulance stations to be poor. At Harrogate station, there was no gate at the entrance to the station. There was a hole in the fence, which backed onto a private garden. We also observed staff working alone in the garage area with the doors open. This was a risk to staff safety and vehicle security.
- At Scarborough ambulance station we saw there was no fire escape from the first floor. The trust provided information that showed the station had had a fire risk assessment in June 2016. The initial risk level in the Scarborough assessment was indicated as 'High', partly owing to the fire safety practice issues a number of actions had been completed and had reduced the risk to medium. There were six further actions to be completed and this would reduce the risk to low.

Staffing

- Before the inspection the trust provided information which indicated that the planned establishment for paramedics was 1208 whole time equivalent (wte). This included staff in management roles and within the urgent and emergency care and resilience core services. The actual number of staff in post was 1092 wte which meant there was a vacancy of 116 wte.
- The trust was able to provide information on the planned and actual numbers of staff employed in each part of the Yorkshire area. Paramedic staff were 5% below planned levels in North and East Yorkshire, but almost 5% over establishment in South Yorkshire. Similar variations were reflected in other areas and staff groups.
- A strategic workforce planning group was established during 2015. Workforce numbers were based on a recognised modelling approach supported by an external organisation.

Summary of findings

The workforce plan developed during 2016-17 reflected demand profiles for each area. The trust had undertaken recruitment events which included some which were aimed at recruiting people from black and minority ethnic backgrounds.

- The service had also introduced two emergency ambulance technician grades to increase the flexibility of the service.
- Planned workforce numbers and recruitment were monitored weekly and reported through the monthly service transformation programme board and to the trust executive group. We found the workforce plan had been communicated and understood by staff which had helped to support retention.
- Staff rotas were arranged up to six weeks in advance for an 11 week period. Staff start times were staggered to 7:00, 8:00 and 9:00 to provide cover for meal breaks and lessen the impact of shift changes. Staff told us they felt the meal break policy worked well in areas where shifts could be staggered.
- At the time of our visit staff were being consulted about significant changes to the rota. The executive directors within the trust reported they felt this was the right approach to engage with staff to ensure the implementation of new rotas would go as smoothly as possible.
- Information supplied to us from the trust indicated the PTS service had a budget for 726.7 whole time equivalent staff (wte) staff and the actual number in post was 692 wte. Other information showed there were vacancies equating to 20.9 wte staff or a rate of 16.4% in administration and clerical positions of all grades in the PTS communications and control team.
- The planned and actual staffing levels in most teams for the band 2 and band 3 ambulance care assistants matched. There were three wte band 2 vacancies in the North locality (23.4%) and 1.5 wte band 2 vacancies in the South locality (5.28%). There were also vacancies for band 4 staff with two wte vacancies (28.6%) in the South locality.
- The overall staff turnover in PTS service from April 2015 to July 2016 was 5.2%. This was similar to other services nationally.
- There were seven HART teams, each comprising of two supervisors and four operatives, with six staff on duty at any one time. This was in excess of the minimum requirement of five, in accordance with NHS Service Specification 2015/16 and NARU interoperability standards 1 – 7 and 12 national requirements for HART.
- Within EOC there were two centres at Wakefield and York which were open 24 hours a day, seven days a week.
- Information provided by the trust prior to inspection showed vacancies across the EOC service to be:

Summary of findings

    - 2.63 WTE (out of a budget of 13.5 WTE; -19.48%) staff on the health desk,
    - 16.82 WTE (a budget of 127 WTE; -13.24%) EMD staff,
    - 6.77WTE (a budget of 127.25WTE; -5.32%) dispatchers,
    - 2.69WTD (a budget of 26.5WTE; -10.15%) team leaders,
    - 0.56WTE (against a budget of 8.56WTE: -6.54%) senior managers and
    - 1 WTE (out of a budget of 5 WTE; - 20%) control centre staff.
- Within the NHS 111 service the trust acknowledged difficulties with access to clinical advisors for call handlers. The trust was carrying out active recruitment drives for clinicians, and had developed a home working protocol which was being used to attract suitably experienced clinicians to undertake these roles. A senior clinical advisor grade had been introduced to provide clinicians with career development options.
- The NHS 111 service had a comprehensive and rigorous recruitment and selection and induction programme for all staff. Induction included training on information governance, safeguarding, infection prevention and control, equality and diversity and confidentiality.
- We saw that staff attrition rate in the NHS 111 service was approximately 40% per year. The trust told us this was partly explained by the rigorous training and testing process, meaning not all staff were able to progress to satisfactory completion. In addition they told us that some staff were able to access career development opportunities to train in other roles such as paramedics and nurses, whilst other staff left as they found the call centre environment and shift patterns difficult to manage. They told us they had introduced a feedback tool for staff to use following completion of their training programme to identify any trends or issues identified.

Are services at this trust effective?
We rated effective as Good because:

Good

- Care and treatment was delivered based on National Institute of Health and Care (NICE) Guidance, Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines and the Resuscitation Council UK (RCUK) guidelines.
- Outcomes for patients had improved for the return of spontaneous circulation (ROSC). At our previous inspection we reported that the trust was one of the worse performing ambulance trusts at 23% for patients who had had a cardiac arrest returning to spontaneous circulation (ROSC) at the time of arrival at hospital. For this inspection, the service's cardiac

Summary of findings

arrest survival rates were ranked first in England for June 2016. Survival to discharge from hospital after an out of hospital cardiac arrest (Utstein) was 61.5% in June 2016, which also ranked first nationally.

- Following a heart attack the 74% to 92% of patients received the correct treatment in line with ambulance guidelines. Between August 2015 and July 2016 the trust performed above the national average for ten out of the 12 months.
- From April 2016 the trust was participating in the national trial of the ambulance response programme (ARP) which helped the service to dispatch appropriate ambulance resources. There were no performance targets for the ARP pilot. The trust monitored its performance on response times.
- Staff in the dialysis units and renal patients reported that overall the service was better than it was 12 months ago but the most significant improvements had only occurred in the last few weeks.
- From April 2016 the trust had commenced a local review of mortality and morbidity, supported by local audits linked to the trust's commissioning for quality and innovation (CQUIN) targets to explore all deaths in the care of the trust, where Recognition of Life Extinct (ROLE) had been invoked by YAS paramedics.
- Within the NHS 111 service call abandonment rate was 2%, compared to the national average of 3%. We saw that 89% of calls were answered within 60 seconds, compared to the national average of 87%.

However:

- Between August 2015 and July 2016 the proportion of patients receiving primary angioplasty (unblocking of a coronary artery) within 150 minutes was below the national average for all of the twelve months.

Evidence based care and treatment

- Throughout frontline services staff followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC guidelines) which provided evidence based clinical advice to ambulance services. The service also followed a number of national recommendations from NARU and The National Institute for Health and Care Excellence (NICE guidelines).
- Staff had access to policies and procedures and other evidence-based guidance via the trust's document management online system.
- The trust used the Department of Health's assessment criteria to determine whether a patient was eligible for patient

Summary of findings

transport. The PTS communication and control staff and hospital-based staff used specific questions to determine the patient's condition, mobility and disability as well as determining access to their home.

- There was an eligibility flow chart and checklist available to staff who made bookings for PTS. However, some PTS staff in the East Locality reported hospital staff not always understanding the type of transport the patient required when they made a booking. This sometimes resulted in the wrong type of vehicle or crew being dispatched to the patient.
- The resilience service had fulfilled all requirements in relation to International Organisation for Standardisation (ISO) 22313 for the last three years. YAS was the first ambulance trust to achieve this. ISO 22313 is a business continuity management system which enables organisations to plan, respond and recover from disruptive incidents as they occur.
- All operatives we spoke with from the HART and air ambulance team told us they used evidence based practice to underpin their care and treatment of patients. We reviewed a number of policies on the trust intranet, including amputation guidelines and thoracotomies in blunt trauma cardiac arrest. They were easy to access, in date with an author and version control evident.
- Operatives told us if they needed to practice outside of a standard operating procedure as they felt it was in the best interests of the patient they would always seek advice from the medical response team before proceeding.
- One of the operatives had developed an 'app' to allow easy access to all clinical procedures whilst at an incident. It included a quick reference guide for all extended skills staff may use.
- Within the NHS 111 service the NHS Pathways licensing agreement required all call handlers and clinical advisors to have at least three of their recorded calls audited each month to check their competency using the NHS Pathways triage system correctly. All staff completed a self-audit each month with two further calls audited by their team leader or a member of the practice development team. Recently appointed staff received five call audits per month.
- Where staff had 'failed' call audits they received five call audits in the following month, where they were expected to pass at least four of these. Although we saw evidence to indicate that call audits were being carried out, staff told us that face to face feedback from call audits was not provided for all staff. Staff were able to access details of their call audits via 'SharePoint'

Summary of findings

but not all staff were aware of this. The trust provided us an action plan which sought to address the call audit feedback process, raise awareness of the 'SharePoint' facility and increase the number of face to face 1:1s being held.

Patient outcomes

- The trust routinely collected and monitored information about patient care and treatment. Ambulance clinical quality indicators measured the overall quality of care and end-results for patients following care and treatment.
- Following a cardiac arrest, the Return of Spontaneous Circulation (ROSC) which included signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure, was a main objective for all out-of-hospital cardiac arrests, and can be achieved through immediate effective treatment at the scene. The ROSC is calculated in two patient groups. The overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out-of-hospital cardiac arrests. The rate for the 'Ustein comparator group' provides a more comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival.
- Outcomes for patients had improved for the return of spontaneous circulation (ROSC). At our previous inspection we reported that the trust was one of the worse performing ambulance trusts at 23% for patients who had had a cardiac arrest returning to spontaneous circulation (ROSC) at the time of arrival at hospital. For this inspection, the service's cardiac arrest survival rates were ranked first in England for June 2016. Return of spontaneous circulation after an out of hospital cardiac arrest (Utstein) was 85.7% in June 2016, which ranked first nationally. Survival to discharge from hospital after an out of hospital cardiac arrest (Utstein) was 61.5% in June 2016, which also ranked first nationally.
- Following a heart attack the 74% to 92% of patients received the correct treatment in line with ambulance guidelines. This includes certain drugs being given and observations being taken and recorded. Between August 2015 and July 2016 the trust performed above the national average for ten out of the 12 months.
- Heart attack or ST segment elevation myocardial infarction (STEMI) is caused by a prolonged period of blocked blood supply within the coronary arteries. Reductions in STEMI mortality and morbidity is influenced by those patients who received the appropriate care bundle, those who have timely

delivery to the cardiac catheter laboratory for intervention, and those who have timely thrombolysis (clot busting medicines). Between August 2015 and July 2016 the proportion of patients receiving primary angioplasty (unblocking of a coronary artery) within 150 minutes was below the national average for all of the twelve months.

- The urgent and emergency care service was involved with the development of sepsis pathways nationally and supported the development of a regional network for sepsis to improve outcomes of patients with sepsis.
- From April 2016 the trust had commenced a local review of mortality and morbidity, supported by local audit linked to the trust's commissioning for quality and innovation (CQUIN) targets. Over the last 12 months the trust had undertaken a pilot piece of work to explore all deaths in the care of the service, where Recognition of Life Extinct (ROLE) had been invoked by YAS paramedics. The procedure provided a mechanism to audit and screen all deaths whilst in the care of the trust and identify any patients where there were concerns about the management that may have contributed to their death. Common themes identified had been sepsis and recent contact with a health care provider.
- Although there was no national guidance in relation to the provision of PTS, the trust had adopted a similar service model to other ambulance services in England. Patient travel was linked to their appointment time and patients were given a set time band for when they might be collected. This was 120 minutes in this service.
- YAS NHS 111 service monitored their performance against the National Minimum Data Set (MDS) and KPIs, some of which were locally agreed. Performance was monitored by the clinical governance and quality assurance group. The average monthly performance for the YAS NHS 111 Minimum Data Set August 2015 to July 2016 showed:
  - 89% of calls were answered within 60 seconds compared to the England average of 87%.
  - 2% of calls were abandoned after at least 30 seconds compared to the England average of 3%.
  - 86% of calls were triaged compared to the England average of 87%.
  - 19% of calls were transferred to a clinical advisor compared to the England average of 22%.
  - 16% of calls were placed on a 'call back' queue compared to the England average of 13%.
  - The average episode length of calls was 22 minutes compared to the England average of 16 minutes.

Summary of findings

- The provider showed us evidence which indicated they were in the upper quartile nationally for ambulance dispositions of 8% and referral to emergency departments at 6%.

Response times

- For the year April 2016 to March 2016 YAS response times were measured and reported nationally following the agreed national response standards for Red 1, Red 2, and Category A19 calls. The national target for immediately life threatening Red 1 calls was that 75% of calls (the most time critical, where patients were not breathing, do not had a pulse or peri- arrest) were to be responded to within 8 minutes.
- Data showed that between April 2015 to March 2016 out of the eleven national ambulance trusts YAS was the ninth best performing ambulance service in NHS with responses at 70.8% against the target of 75%.
- Red 2 national performance standard was that 75% of Red 2 calls (still serious, but less immediately time critical, like strokes or fits) were to be responded to within 8 minutes. Data showed from April 2015 to March 2016 the trust was fourth of the eleven ambulance services in the NHS with responses at 71.4%.
- A19 calls national standard was that 95% of Category A calls should be responded to within 19 minutes with appropriate transport to convey the person to hospital. Data showed from April 2015 to March 2016 the trust was second of the eleven ambulance services in the NHS with responses at 95%.
- From April 2016 the trust was participating in the national trial of the ambulance response programme (ARP) which helped the service to dispatch appropriate ambulance resources to patients who were very unwell, for example those that had suffered a cardiac arrest. Yorkshire ambulance service was one of three ambulances services nationally to participate in the clinical coding trial, with evidence of performance monitored by NHS England and the national NHS England ARP Group to assess the impact on patients of both quality and performance. The aim of the trial was to enable the most appropriate clinical response to each 999 call. The trial aimed to test a new evidence-based set of clinical codes that better describe the patient’s problem and what response/resource was required.
- Incoming emergency calls were allocated to a category which determined the response, which was nationally agreed. For the ARP, Red calls, requiring a response within eight minutes, were for time critical responses to patients experiencing a life-threatening episode and requiring immediate intervention or resuscitation. Amber calls, requiring a response within 19 minutes, were for responses to patients with potentially serious

Summary of findings

conditions that may require rapid assessment, urgent on-scene intervention or urgent transport. Green calls requiring a response within 60 minutes, were for urgent responses to patients situations which were not immediately life-threatening that needed transport within a clinically appropriate timeframe or a further face-to-face or telephone assessment and management.

- A second stage trial was due to be undertaken by the trust between October and December 2016 to further refine the clinical code set.
- There were no performance targets for the ARP trial. The trust and NHS England's ARP team monitored its performance on response times and this was reported to the board in the integrated performance report. This showed the number of calls each month divided into different categories and the time from allocation to the team being mobile.
- We saw in the August 2016 integrated performance report the trust reported its performance as:
  - Red performance (8 minute response) year to date (YTD) was 69.3%
  - Amber R (19 minute response) YTD was76.1%
  - Amber T (19 minute response) YTD was 67%
  - Amber F (19 minute response) YTD was 72.4%
  - Green F (60 minute response) YTD was 94.9%
  - Green T (60 minute response) YTD was79%
  - Green H (60 minute response) YTD was 98.7%
- Within the resilience service data from April 2016 to September 2016 with the exception of three calls was achieved in less than 15 minutes. This demonstrated compliance with the NHS HART Interoperability Standard 8 in Appendix 3 of the NHS Service Specification 2015/16.
- Interoperability standard 11 requires that HART staff can be on scene within 45 minutes at strategic sites of interest. The location of the HART and resilience bases meant they had quick access to major road networks in the region. This allowed the required vehicles to reach a variety of locations in a timely way.
- The target for call handling in the PTS communication and control centres was for 80% of calls to be answered within three minutes. Information supplied showed this target was not achieved with 78.5% of calls answered within three minutes in April 2016, 58.9% in June and in September 2016, it was 71.3%. Staff based within a control centre told us they had been short staffed and it was a challenge to achieve this target.
- PTS performance was monitored through key performance indicators and these were reported to the board in the

Summary of findings

integrated performance report. In the August 2016 report this showed for arrival prior to appointment performance was above the target at 82.9%. Performance against the KPI for departure after appointment was 1.4% below a target of 91.7%.

- Combined localities performance data shows between September 2015 and August 2016, the percentage of inward patient journeys ensuring patients arrived between zero and 120 minutes prior to their appointment exceeded the target of 82.9% at 86.8%.
- There were variations in performance across the localities with the West locality only just achieving the target for patients arriving for their appointment on time and East and North localities exceeding this target by more than 4%.
- The target set by commissioners for PTS had decreased since our last inspection from 93.2% to 82.9%. Overall, performance had improved at 3.1% over target performance at this inspection compared to 0.9% over target performance at our last inspection although the percentage of patients arriving on time for their appointments had decreased from 91.8%.
- This performance data for September 2015 to August 2016 also showed the number of patients collected with 90 minutes after their appointment was 91.8% against a target of 91.7%. This is an improvement on the performance data supplied at our last inspection when 89.1% of patients were collected within 90 minutes of being ready against a target of 91.3%.
- The performance data supplied for August 2016 showed there had been deterioration in the performance in patients being collected since April 2016. This was particularly the case in the West locality. Senior managers were aware of this and attributed it to the introduction of the change programme and the auto planning system. Overall the performance data showed an improving trend.
- The PTS operated to a different set of quality standards when transporting renal dialysis patients. This was similar to other ambulance PTS services, which recognised the needs of this group of patients. The service was required to drop off patients no more than 30 minutes prior to their scheduled time and collect them again no more than 30 minutes after their treatment was complete. This adhered to NICE guidance which stated 'Adults using transport services to attend for dialysis are collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis'. However, there were still some patients who waited for more than 30 minutes for transport to arrive to take them home after their treatment was completed.

Summary of findings

- We spoke with 11 renal dialysis patients. Overall, they reported the service was better than it was 12 months ago but the most significant improvements had only occurred in the last few weeks. Staff in the dialysis units we visited also felt the service had improved over the last 12 months. However, there were still delays in return journeys back home with some patients being advised of delays of two hours or more.
- Within the NHS 111 service call abandonment rate was 2%, compared to the national average of 3%. We saw that 89% of calls were answered within 60 seconds, compared to the national average of 87%.

Multidisciplinary working

- Staff worked closely with hospital providers of emergency and other providers of services to coordinate appropriate pathways of care for patients.
- We observed the handover of patients between ambulance crews and staff in hospital emergency departments. The handovers we observed were well structured and comprehensive.
- Ambulance service managers met at least six weekly with their hospital emergency department counterparts where the response to ambulance vehicle delays and the local escalation plan were discussed. In response to excessive ambulance vehicle waiting times, the ambulance service sent a clinical supervisor to coordinate the situation and provide support for ambulance staff.
- We found the ambulance service worked closely with acute hospitals regarding long handover times in order to reduce heightened risks associated with the deteriorating patient.
- At one hospital, there was a joint task and finish group of hospital and ambulance staff and including social care and commissioners. The group met monthly to identify and reduce avoidable causes of delay. Actions were agreed and followed up, which included exploring diversional pathways. This initiative had already resulted in improved ambulance turnaround performance.
- The trust worked with residential and nursing homes to identify where patients who were unwell required transport to hospital and where care and treatment could be provided by an alternative healthcare practitioner, so that unnecessary hospital admissions were reduced.
- Referral pathways were in place with community services in some areas, for example the community nursing service, to reduce the transport of patients to hospital.

Summary of findings

- Within the resilience service we reviewed training exercises plans which had been undertaken detailing the outcomes and learning. They tested operational and multi-agency command in line with JESIP principles and involved other services such as the fire service as well as emergency operations centre (EOC) within YAS.
- We looked at the findings from one such training exercise, a building collapse. This stated due to the structure of the exercise and the use of mutual aid team's staff had to work with members from other NHS trusts. This enabled the standardisation of urban search and rescue (USAR) to be tested.
- The EOC were involved in the training exercises as the initial calls about the incident came to them, be this from a 999 call or being contacted by another emergency service.
- Patient transport services (PTS) formed part of the trust's overall emergency planning response. For example following a mass casualty incident patient transport services could be used to evacuate patients with minor injuries away from the scene.
- There was evidence of multidisciplinary working between PTS staff and other care providers such as care homes, hospitals and GPs. During our inspection, we saw cooperation between hospital staff, the communication and control centre and staff in the patient reception centres (PRC's).
- Some ambulance care assistants and staff in PRCs told us the staff in the communication and control centre lacked the local knowledge of road conditions, geography and specific locations, which resulted in inefficient route planning. This was in relation to auto plan in West Yorkshire. Overall, we observed good relationships between ambulance care assistants and staff in the communication and control centre. This was important in order to promote good team working and effective care for patients.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Mental health awareness and mental capacity was part of the trust's mandatory training schedule.
- The trust had specific policies relating to mental capacity and consent to examination or treatment and staff were aware of how to access these.
- Staff understood how consent and capacity issues affected the care of patients and patients' consent to care and treatment was documented in their records. We observed ambulance staff in their interaction with patients and saw that verbal and written consent was requested as appropriate.

Summary of findings

- Reference prompt cards were used by staff to confirm NHS England guidance about the Mental Capacity Act. The reference cards provided guidance, prompts, flow charts and contact numbers as to capacity assessments, making best interest decisions, and deprivation of liberty safeguards. The clinical hub service desk was also available to provide advice for staff.
- Within the resilience service, HART operatives demonstrated a good level of understanding. Staff described how they would always take on individuals' choices and views. We were told they acted in accordance with people's best interest during emergency situations. This meant that decisions about care were often made by the paramedics in accordance with their training.
- Staff in the NHS 111 service understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing telephone triage to children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Are services at this trust responsive?

Good

We rated responsive as Good because:

- A transformation programme had commenced which brought together actions taken following CQC's inspection with other work programmes including those mandated by NHS England. In conjunction with other organisations, the service was undertaking an assessment of the likely future needs of the region for emergency ambulance services.
- The trust was part of the urgent and emergency care vanguard programme, to support the development of new approaches to the provision of urgent and emergency care. The West Yorkshire urgent and emergency care network aimed to develop an integrated urgent care model for the region, building on the services provided by existing urgent care services.
- Within the NHS 111 service the trust understood the needs of the population it served and engaged with the lead commissioner and 23 associate commissioners to provide a service which was responsive to these needs.
- The NHS 111 service had implemented access to palliative care nurses on weekends and bank holidays, who were able to provide support to patients approaching the end of life.
- Systems were in place across the trust to electronically record additional information for vulnerable patients via the 'special notes' system.

However:

Summary of findings

- Staff expressed concern as to the limited availability of staff training to use bariatric equipment and in some types of vehicles there was limited room for manoeuvring equipment for bariatric patients.
- In the PTS service there had been an increase in complaints with a specific focus on renal services in West Yorkshire following the introduction of Auto plan. The trust had been taking actions to address the service issues and had been engaging with users of the service and voluntary agencies in the improvement process.

Service planning and delivery to meet the needs of local people

- Since the 2015 inspection, a transformation programme had commenced which brought together actions taken following CQC's inspection with other work programmes including those mandated by NHS England. In conjunction with other organisations, the service was undertaking an assessment of the likely future needs of the region for emergency ambulance services. This included elements of capacity and demand analysis, resource management and information management for performance improvement. The project used internal sources of information which included patient feedback, complaints and lessons from the investigation of incidents. It also took account of the impact of growth in demand, seasonal variations, financial constraints on the service, and challenges in recruiting qualified staff. The objective of the programme was to ensure emergency services were sustainable in the future.
- The needs of the local population influenced the planning and delivery of emergency ambulance services across the Yorkshire region. The service worked closely with commissioners to ensure that ambulance services were delivered as required by commissioners. Regular meetings were held with lead commissioners to discuss activity and service requirements.
- The trust was part of the urgent and emergency care vanguard programme, to support the development of new approaches to the provision of urgent and emergency care. The West Yorkshire urgent and emergency care network aimed to develop an integrated urgent care model for the region, building on the services provided by existing urgent care services. The project expected to commence in February 2017 with a three to four year implementation. The objective was improved coordination of services and reduced pressure on emergency departments and in turn on ambulance services.

Summary of findings

- The trust had plans in place to replace its oldest ambulance stations with 18 hubs forming a hub and spoke arrangement of locations over a period of several years, with four of these planned to be operational in the next five years. We visited the Manor Mill site which was the first of these hubs to be operational. The ambulance stations at Bentley and Doncaster were due to be replaced by a second hub.
- The PTS primarily operated a Monday to Friday 8.00am to 5.30pm service and had 415 vehicles within its fleet. However, the service also operated outside of these times to provide specific support to patients attending for renal dialysis when needed. There was also a dedicated discharge service which operated into the evenings in some localities; this was included within the main core contract.
- The PTS supported acute hospital discharges across the region. Operating times varied across the area, due to the commissioning arrangements. For example, in the East it operated between the hours of midnight to 11.00p.m and in the North it was 10.00a.m - 8.00p.m.
- The service had recently commenced a pilot in May 2016 using Auto Plan. This was an automated software planning system to schedule patient journeys. The PTS transported patients based on the time of their appointment and auto plan scheduled journeys to ensure patients were collected and delivered within an agreed window of time. The pilot, which was originally trialled in Leeds, was then rolled out to West Yorkshire. A senior manager told us there had been ‘teething problems’ such as patients travelling in the vehicles for long periods of time. As a result of this, the ambulance service was currently reviewing the software.
- Within the NHS 111 service the trust understood the needs of the population it served and engaged with the lead commissioner and 23 associate commissioners to provide a service which was responsive to these needs.
- NHS 111 staff were able to directly book appointments with the out of hours service for patients who lived in Wakefield, Sheffield and Huddersfield. Patients could also be directed to accident and emergency, local pharmacies or minor injuries units in accordance with the most appropriate disposition (outcome) identified for the caller.

Meeting people's individual needs

Summary of findings

- Translation services were available for patients whose first language was not English. A qualified interpreter was available on-line, usually within 90 seconds. Ambulance service managers met the providers of the translation service monthly to monitor and review the responsiveness of the service.
- Equality and diversity training was available to all staff to enable them to meet the spiritual needs of individuals. The training included providing an understanding of the spiritual needs of different faiths and how these might be addressed by staff
- The trust was the first ambulance trust to receive "working to become dementia friendly" recognition by the Dementia Action Alliance in 2014. The service procured ambulances vehicles with a dementia-friendly specification and these were identified with a dementia-friendly sticker in the vehicle.
- The trust had developed a learning resource to support staff called "Dementia learning resource for Ambulance staff". The document contained information on dementia/ delirium, agitated behaviour, pain and distress and communication. There was also online awareness training available to staff.
- The needs of patients with dementia could be identified for staff using a data flagging system. Staff could also be nominated as "Dementia Friends."
- The trust had produced 'life story' books which were aids to staff when supporting a patient with dementia however we found these were not always available on vehicles or in all ambulance stations.
- The special needs of patients with learning disabilities and physical disabilities could also be identified for staff using the data flagging system. Patients with physical disabilities were assessed using a complex manual handling risk assessment form and high risk patients had their addresses flagged to support a specialist response.
- The service employed a "YAS expert patient" who had worked with patients with physical disabilities including wheelchair users.
- We observed a vehicle used for the transfer of bariatric equipment and ambulance vehicles fitted with bariatric stretchers. We found the issue of equipment for these patients was the subject of consultation with staff. For some types of vehicles, staff expressed concern as to the limited room for manoeuvring equipment for bariatric patients.
- Staff also expressed concern as to the limited availability of staff trained to use bariatric equipment. The service was in the

process of addressing these concerns by extending access to bariatric equipment and the provision of replacement vehicles carrying stretchers and tail lifts for moving and handling bariatric patients.

- For bariatric patients known to the service, their needs were assessed and a care plan was prepared which reflected moving and handling risks. We found specialised equipment to support bariatric patients needed to be made more widely available and accessible to emergency ambulance crews.
- There was a policy in place for the transportation of bariatric patients and a pathway for the control centre to follow, to ensure the service met the needs of these patients. PTS had four dedicated bariatric vehicles and had a full inventory of equipment such as hoists and large wheelchairs. We spoke with a senior manager who told us it was unlikely all vehicles would be requested at the same time due to the careful booking and planning of these vehicles. Hospital staff we spoke with knew 48 hours' notice was required if a bariatric patient required transportation.
- We spoke with a locality manager who told us a risk assessment was completed by a team leader when a booking for a bariatric patient had been requested. Team leaders we spoke with confirmed this.
- Within the NHS 111 service the trust had implemented access to palliative care nurses on weekends and bank holidays, who were able to provide support to patients approaching the end of life. They were able to liaise with local pharmacies via the pharmacy urgent medications scheme (PURM) to obtain medicines during the weekends, and were able to arrange transfer to local hospices rather than accident and emergency departments, when appropriate.
- Systems were in place in the NHS 111 service to electronically record additional information for vulnerable patients via the 'special notes' system. The information was available to call handlers and clinical advisors at the time the patient or their carer contacted the YAS NHS 111 service. This assisted the staff member to safely manage the needs of these patients.
- Call handlers had received training to help them identify and support confused or vulnerable callers. Advice could be sought from a senior clinical floor walker, or transferred to a clinical advisor for further assessment.

Access and flow

- The trust had a Demand Management Plan (DMP) to support the trust to respond to situations where the available resource capacity did not match the demand across the Yorkshire &

Summary of findings

Humber region. This in turn was supported by Local Escalation Action Plan (LEAP) and Resource Escalatory Action Plan (REAP). The DMP was designed to be utilised in situations of excessive call volume or reduction in staff numbers, which resulted in the supply of ambulance service resources being insufficient to meet the clinical demand of patients.

- Alternative pathways of care were used including 'see and treat and hear and treat' leaving patients at home if appropriate following assessment, alleviating inappropriate admissions at hospitals.
- The ambulance service reported and monitored handover delays at hospital emergency departments across the Yorkshire region. The main causes of delays were attributed to a lack of assessment cubicles (in 20- 30% of instances); a lack of hospital beds for admission (in 40 50% of instances) and clinical staff availability (in 30- 40% of instances).
- Unnecessary journeys to hospital were reduced through the service's participation in the the ambulance response programme (ARP) which helped the service to dispatch appropriate ambulance resources. Incoming emergency calls were allocated to a category which determined the response. Ambulance crews we spoke with said the ARP helped in the response to very unwell patients categorised as Red. Patients categorised as Amber waited up to one hour, and this also included responses to seriously unwell patients. Crews were aware of the need to monitor closely the appropriateness of response for these patients. Benchmarking information between the two triage systems and between the three participating trusts was shared on a daily, weekly and monthly basis with the trial sites.
- Each call to the emergency services was assessed using a dedicated prioritisation system as part of the ARP. Red calls, requiring a response within eight minutes, were for time critical responses to patients experiencing a life-threatening episode and requiring immediate intervention or resuscitation. Amber calls, requiring a response within 19 minutes, were for responses to patients with potentially serious conditions that may require rapid assessment, urgent on-scene intervention or urgent transport.
- The PTS service had changed their procedures in May 2016, which meant renal patients had travelled with non –renal patients. This had commenced in the Leeds area initially and then was rolled out to the whole of West Yorkshire in June 2016. This resulted in large numbers of complaints by patients regarding the time they were waiting to be transported home. Patients had written to NHS England and their local MPs to

Summary of findings

advise of the difficulties they were experiencing and the impact it was having on their lives. Senior managers acknowledged the timeliness of transport particularly around the collection of patients. Measures were put in place to improve this and there had been written communication with renal patients directly from senior managers in the trust. Discussions were also on-going with the local hospitals in relation to patients being declared 'ready' in a timely manner to avoid delays. Yorkshire ambulance service had specifically appointed a new member of staff to improve this who commenced in August 2016.

- There were examples when patients care and treatment had been compromised because of problems with PTS. An example included patients who were taken off their dialysis treatment early as the transport had arrived and was unable to collect them later.
- Within the NHS111 service patient demand was increasing and staff recruitment, particularly of clinicians, was challenging. The trust was using innovative approaches to attract and retain staff. A senior clinical grade had been developed, to provide career development options for clinical staff. In addition, a homeworking pilot scheme for clinicians had been evaluated, and was being implemented. At the time of our inspection these posts were being advertised.
- The trust had experienced challenges in meeting their two hour KPI target for clinical call backs to patients in the NHS 111 service. In order to mitigate risk to patients, the clinical advice call back queue was closely monitored by clinical team leaders, utilising a standard operating procedure to ensure that urgent calls were prioritised, and clinicians were directed to deal with these.
- The NHS 111 service prioritised people with the most urgent need at times of high demand. Capacity and demand was estimated using a comprehensive workforce management tool, and was monitored closely at all times. A daily conference call was held across all three sites to assess staffing capacity and patient demand, with staff being offered shift slides or overtime to accommodate anticipated surges in demand. In addition the service held weekly and monthly organisational planning meetings to co-ordinate staff cover to best meet anticipated patient demand.

Learning from complaints and concerns

Summary of findings

- There was a policy for managing compliments, comments, concerns and complaints within the trust. Key performance indicators for compliments, comments, concerns and complaints were included in the monthly Board Integrated Performance Report.
- In the August 2016 integrated board report it showed that the trust had received 1,394 complaints YTD figures across all services. The proportion of complaints to demand was 0.08%.
- Themes highlighted in the Integrated Performance Report indicated that delayed response was the largest area of concern for YAS complainants for emergency operations and patient transport. Operations & Clinical/Patient were the largest number for the NHS 111 service, whilst attitude of staff is the most frequently reported issue for the urgent and emergency care service.
- Themes highlighted in the report indicated that delayed response and staff attitude were the two most common areas of concern for YAS from complainants for A&E operations. Delayed response was the largest area of concern for people using patient transport. Operations & clinical/patient were the most common concern for people using the NHS 111 service.
- The trust monitored its performance on a monthly basis against response times to complaints. Responses to complaints were being made in time in 88% of cases in August 2016 (date agreed with the complainant) with an average response time of 24 days. YTD compliance was 92% and average response time was 23 days.
- The trust used escalation rates to measure complainant satisfaction with the investigation of complaints. The trust reported that the percentage of concerns and complaints reopened due to dissatisfaction with the initial response was 1.8% (YTD figures).
- The incident review group met fortnightly and reviewed complaints graded red or amber. The quality committee reviewed the handling of complaints and compliments every second month to identify themes and trends and received an annual report of complaints.
- The clinical quality development forum received a quarterly lessons learned report highlighting trends and themes and identified actions. The trust board received an annual quality, risk and safety report which included complaints management. The quality accounts described changes made as a result of complaints.
- The trust told us they recognised the importance of sharing learning across the organisation when things have gone wrong, including learning from complaints. In 2015 the Safety Update

Summary of findings

was introduced which is a monthly bulletin, pulling together learning from across different inputs to share across YAS. This was then triangulated within the Quality & Safety Team alongside other inputs such as Clinical Case Reviews (CCRs) to identify trust wide learning.

- In the PTS service there had been an increase in complaints between June 2016 and August 2016 with a specific focus on renal services in West Yorkshire following the introduction of Auto plan. The trust had been taking actions to address the service issues and had been engaging with users of the service and voluntary agencies in the improvement process.
- Seven of the renal patients in the West Yorkshire area we spoke with advised us they had received a written apology from the service in relation to these delays. This letter also advised the service would ensure they arrived no more than 30 minutes before their appointment, and be picked up no later than 45 minutes afterwards. In all other localities, most renal patients were satisfied with their service and felt delays traveling home were acceptable as they felt the service was doing its best.
- Within the NHS 111 service information about how to complain was available and easy to understand and evidence showed the provider responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services at this trust well-led?
We rated well-led as Good because

Good

- The trust had an overall integrated business plan for 2014-15 to 2018-19. The plan outlined the trust's ambitions, aspirations and plans for the next five years which were 'to provide an ambulance service for Yorkshire and the Humber which is continually improving patient care, setting high standards of performance, always learning and spending public money wisely.
- There were a number of initiatives which were central to the strategic priorities. These included an expansion in the number of urgent care clinicians, expanding the existing NHS 111 service and developing care pathways for specialist groups such as frequent callers, mental health patients and palliative care.
- The trust had a governance framework that supported delivery of safe and high quality care from 'the frontline services to board'. There were a number of assurance groups including the audit committee, quality committee and finance and investment committee.

Summary of findings

- Relationships between the trust and trade unions had improved since the previous inspection but there still more work for the trust to do.
- The trust had undertaken a number of initiatives to improve staff engagement the staff forum had become embedded since our previous inspection and was viewed positively by staff.

However:

- The PTS service had developed an operational plan which set out its strategic objectives but staff we spoke with felt they had not been involved in this plan and were unclear about the future direction of the service.
- Within the PTS service there was a clear lack of management oversight and lack of ownership of roles and responsibilities and governance systems were not fully embedded throughout the service.
- There were inconsistencies in the monitoring and oversight of staff performance and adherence to policies and procedures. This meant there were differences across the PTS service in how information was shared following incidents, cleanliness of vehicles, equipment stored on vehicles and learning from complaints.

Vision and strategy

- The trust had an overall integrated business plan for 2014-15 to 2018-19. The plan outlined the trust's ambitions, aspirations and plans for the next five years which were 'to provide an ambulance service for Yorkshire and the Humber which is continually improving patient care, setting high standards of performance, always learning and spending public money wisely.'
- The trust's mission was 'Your Ambulance Service, Saving lives, caring for you' and the vision was 'Providing world class care for the local communities we serve.'
- The trusts operating plan for 2016/17 identified the key priorities, risks and milestones for the trust over the next year to help achieve the vision. The vision and mission were to be delivered through strategic objectives which included:
  - Deliver world class health outcomes in urgent and emergency care
  - Ensure continuous service improvement and innovation
  - Develop and retain a highly skilled, engaged and motivated workforce
  - Work with partners to provide system leadership and resilience

Summary of findings

- Provide a safe and caring service which demonstrates an efficient use of resources.

- There were a number of initiatives which were central to the strategic priorities. These included an expansion in the number of urgent care clinicians, expanding the existing NHS 111 service and developing care pathways for specialist groups such as frequent callers, mental health patients and palliative care.
- The trust had developed a set of values and behaviours based on an acronym We Care which stood for Working together for patients, Everyone counts, Commitment to quality of care, Always compassionate, Respect and dignity and Enhancing and improving lives.
- The YAS vision and values were displayed on staff notice boards and staff had access to communications bulletins via emails.
- The trust resilience planning was firmly based on the Civil Contingencies Act, National Ambulance Resilience Unit (NARU) and Joint Emergency Services Interoperability Programme (JESIP) guidelines. Emergency preparedness, resilience and response (EPRR) frameworks and Hazardous Area Response Teams (HART) interoperability standards fed into this. Senior trust staff were heavily engaged in the development and implementation of national policies and operational procedures. These had all been encompassed into one document of 21 standards to provide a specific resilience vision and strategy aligned with the overall trust and national guidance.
- The PTS service had developed an operational plan which set out its strategic objectives but staff we spoke with felt they had not been involved in this plan and were unclear about the future direction of the service.

Governance, risk management and quality measurement

- The trust had a governance framework that supported delivery of safe and high quality care from ‘the frontline services to board’. There were a number of assurance groups including the audit committee, quality committee and finance and investment committee. The assurance committees were attended by non-executive directors who provided challenge and scrutiny.
- The risk management strategy aligned key corporate risks with strategic objectives and was reviewed annually by the executive. The risk and assurance group provided oversight of potential risks to the trust identified in the risk register.

Summary of findings

- A Board Assurance Framework and Corporate Risk Register identified strategic and operational risks. We reviewed the corporate risk register, which documented actual risk, control measures and residual risk ratings. The Board Assurance Framework was presented regularly to the trust board.
- Risks on the corporate risk register included an inability to deliver performance targets and clinical quality standards, acute hospital reconfigurations and failure to learn from patients and staff experience and adverse events within the trust or externally.
- The trust had a business continuity policy; this described the roles, responsibilities, and processes to ensure continuity of services, protection of patients and staff and the reputation of the organisation.
- As part of the inspection we observed a quality committee meeting and we reviewed a sample of reports that formed part of the board papers, there were no concerns raised from this.
- Following our previous inspection the service had undertaken a review of the “well-led” committee structure during 2015 and a review of executive and senior management portfolios in 2015-16.
- A clinical governance group with executive representation met monthly and clinical governance risks were discussed and actions taken were recorded and monitored.
- An integrated performance report was prepared monthly which included key facts and figures for the trust and all core services, workforce scorecards, and demand and performance statistics, including a graphical presentation of daily performance for emergency and urgent care. Progress against the strategic objectives was assessed on an exception basis using red-amber-green ratings. Quality indicator results were compared with national benchmarks.
- Over the last 12 months the trust had undertaken a pilot piece of work to explore all deaths in the care of the service, where Recognition of Life Extinct (ROLE) had been invoked by YAS paramedics. The procedure provided a mechanism to audit and screen all deaths whilst in the care of the trust and identify any patients where there were concerns about the management that may have contributed to their death. Common themes identified had been sepsis and recent contact with a health care provider.
- Within urgent and emergency care the locality manager’s meeting was held monthly; meetings were recorded and

Summary of findings

actions reviewed and closed when completed. Actions included escalation of key risks and monitoring of local performance. Locality managers also met weekly to monitor performance and actions were reviewed at a monthly operational meeting.

- The PTS risk register contained six risks, four were moderate risk and two were low risk. The moderate risks related to patient slip, trips and falls and had been on the register since 2013 but had been reviewed regularly. The other moderate risks included the service for renal patients in the two West Yorkshire localities, unplanned accident and emergency operations affecting PTS and the lack of PTS bid resource.
- PTS completed operational risk reports, which were completed by the locality managers. They outlined specific risks to the service. Risks included the loss of technology to communicate to the staff, how transport should be dispatched in the event of a breakdown in the system, financial risk due to tendering and on-going risks of slips, trips and falls.
- There were inconsistencies in the monitoring and oversight of staff performance and adherence to policies and procedures. This meant there were differences across the PTS service in how information was shared following incidents, cleanliness of vehicles, equipment stored on vehicles and learning from complaints.
- Significant concerns had been identified in the resilience service at the previous inspection in terms of assurance processes, this related to equipment and cleanliness. This had been resolved at the time of inspection and robust audit and assurance systems had since been embedded and maintained.
- There was a clear governance structure for the resilience function within YAS. Team meetings fed into monthly managerial meetings. We reviewed a number of meeting minutes across the resilience service and saw how information was shared and communicated with external stakeholders such as the Local Resilience Forums. One example of this was the national pandemic influenza exercise.
- Within the NHS 111 service, the trust had introduced both internal and external ‘end to end review’ processes where, with patient knowledge and consent, selected calls were reviewed by a panel, and the patient journey through the healthcare system, including the incoming YAS NHS 111 call, was tracked. We saw evidence that learning gained from these processes was disseminated and was improving standards.
- There were arrangements for identifying, recording and managing risks and issues and implementing mitigating action plans. There was also a programme of continuous internal audit.

Summary of findings

- The trust supplied monthly performance reports for the NHS 111 service to the CCGs via the Contract and Performance Management Meeting, which summarised the ongoing work across the region and included statistical data relating to call activities, audits and trends as well as quality and patient safety updates. This gave an overview and assurance of the service for Commissioners. A risks and issues log was created, update action logs monitored progress towards completion of identified actions.

Leadership of the trust

- Since the previous inspection the chief executive had been appointed substantively into their post in May 2015. The executive director of operations had also been substantively appointed into their role in 2015.
- There had been two further interim appointments at executive director level into the roles of executive director of finance and executive director of workforce and organisational development. At the time of inspection the trust were actively recruiting to a substantive director of finance position.
- There had been a new chair of the trust appointed in July 2016 and a new non- executive director also appointed in 2015.
- Following the well-led review the trust had undertaken a director portfolio review and a new planned and urgent care directorate had been created.
- Changes to the executive leadership were recognised as positive by staff. The chief executive was seen as approachable by most staff however, some staff in some of the core services reported they had not seen the executive team during their work.
- The management structure for emergency and urgent care had been revised since our previous inspection. An executive director of operations and an associate director of locality operations had been appointed. Three locality directors (Band 8c) representing west, north and east and south localities reported to the associate director of operations. There were seven locality managers (Band 7) in each of three localities, who reported with a head of operations to the locality directors. Clinical supervisors (Band 7) reported to locality managers and paramedic and non-qualified ambulance staff reported to clinical supervisors.
- We found strong leadership throughout the resilience service, staff at all levels told us they felt supported and understood their role. Command support at a strategic level via the Health

Summary of findings

Gold Cell was a strength of the resilience service. As well as the knowledge and specialist roles of managers within the service. Resilience staff were experienced in their roles with many having been in post for a number of years.

- Within the PTS service there was a clear lack of management oversight and lack of ownership of roles and responsibilities and governance systems were not fully embedded throughout the service.
- Some staff within PTS services told us they rarely saw the locality managers for their area and it was sometimes very difficult to get in touch with a team leader.
- Within the NHS 111 service we saw that team leaders, shift co-ordinators and clinical team leaders were visible in all three call centres. Not all staff we spoke with had regular face to face contact with their team leader, however staff were aware of whom their team leader was, and described how they were able to access support if needed from a team leader or clinical team leader.

Culture within the trust

- The trust had commissioned an external company to undertake a cultural audit and the report had been finalised in December 2015. The audit had received 1,378 responses from trust employees.
- The report highlighted eight cultural dimensions which included shared vision, blame, quality and learning and facilitating change. The report made recommendations which included:
  - Promoting a vision for YAS that engages all staff in developing and delivering the vision
  - Development of a behaviours framework that can be used to help assess guide and reward positive behaviour and reduce/ eradicate negative behaviours.
  - Development and implementation of a programme of training for all leaders and managers.
- As a result we saw the trust had developed an action plan to address the points raised from the cultural audit and included actions on development of a behavioural framework for YAS leaders and staff and a greater focus on staff engagement.
- In the 2015 NHS staff survey the trust had a response rate of 40.6% against a national average of 35.5%. The trust had scored in three indicators better than the national average and in seven indicators worse than the national average.

Summary of findings

- The trust scored better than the national average in indicators for percentage of staff reporting errors, near misses or incidents in the last month, the percentage of staff appraised in the last 12 months and quality of non-mandatory training, learning or development.
- The trust scored worse than the national average in indicators for percentage of staff reporting good communication between senior management and staff, percentage of staff able to contribute to improvements at work, support from immediate managers and the percentage of staff reporting recent experience of harassment, bullying or abuse.
- The trust hada 'Freedom to Speak Up campaign, and several staff in different services had becomes guardians. The initiative had been launched by the trust in July 2016.
- The relationship between the trust and union representatives had improved since our previous inspection and the trust had recognised a number of unions who represented staff. The trust provided information which indicated union representation was included in a number of meetings. For example the safer responding group, health and safety committee and trust procurement group.
- There was also a staff side representation group which was attended by union representatives and senior service managers and operational staff. However union staff reported that there was still inconsistent attendance and involvement from executive directors.
- Within the EOC the service had several initiatives in place, which included, Favourable Event Reporting (FERF). This initiative encouraged learning from positive practice, by recognising and reinforcing successful events and behaviours. Staff had received positive feedback from their managers and they had acknowledged their behaviours and practice. This had been particularly evident at the staff away days.
- We found within some ambulance stations there were examples of inappropriate communication with staff from team leaders and line managers. We raised this with the trust who addressed this at the time of inspection.
- We saw in the NHS 111 service the trust had responded to a number of bullying and harassment issues within the call centre environment. An independent arbitrator had been appointed to assess the issues and made recommendations for actions to be carried out. The service had accepted the findings and adopted the recommendations, which included the appointment of mental health 'first aiders' within the call

Summary of findings

centre; development of the staff champion role and access to staff counselling for affected staff. The 'bullying and harassment' policy was being changed to a 'dignity and respect' policy, to widen the scope of the policy.

- The Workforce race equality standard (WRES) aims to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. In line with this standard the trust had developed a WRES action plan. The workforce within this trust has 4.3% BME representation, and has increased from 3.94% in 2015.

Fit and Proper Persons

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- We reviewed files of executive and non-executive directors and found they were compliant with the requirements.

Public and staff engagement

- The staff forum had become embedded since our previous inspection and was viewed positively by staff. The service used social media to engage with staff and provided feedback from adverse events and safety roadshows.
- YAS TV had been introduced across a number of stations across the trust. The purpose was to share learning through the use of videos and information which was cascaded to staff via the TV in stations.
- The trust had an expert patient role which had been developed in 2008 but had since expanded the scope so it now included attendance at core meetings, follow-up engagement meetings and review samples letters to patients from the patient relations team.
- Whilst on inspection the new HART vehicles were delivered, these were to replace some vehicles which had reached the end of their operational life. From speaking with staff they had been consulted and had been involved in the planning, the design and layout of the new vehicles. Staff felt they would further improve the service due to the improved layout, size and manoeuvrability of the vehicles.

Summary of findings

- The trust had established a Nurse Leadership Forum. The forum had been instrumental in developing a professional framework for nurses, acquiring online tools to help with nurse revalidation requirements and exploring means of improving recruitment and retention of nurses within the NHS 111 service.
- The trust had held a number of summer 2016 roadshows across the Yorkshire and Humber region. The events offered members of the public a chance to come along and learn more about the ambulance service; participate in first aid training or have a look into careers or volunteering opportunities at the trust.
- The events took place at a number of community venues across the region, at the roadshow in Bradford over 1,000 members of the public attended.
- The trust had a YAS forum which was chaired by the trust chair. The YAS Forum was structured with a total of 22 members: 13 publically elected (with one vacancy in East Yorkshire), four staff who had been elected and five appointed forum members who represented a wide range of external stakeholders with whom the trust worked in partnership to deliver services.
- The trust was in the process of re-introducing the YAS critical friend's network. Recruitment was in process to the network. People who want to be involved would need to have had some contact with the ambulance service in the last three years. The purpose of the network was to contribute ideas and thoughts to the trust regarding service developments.
- The trust website included a patient feedback link which enabled the public to make a complaint, report a concern, provide a compliment or make a comment (the four Cs).

Innovation, improvement and sustainability

- The YAS loggist role had been refreshed alongside the YAS command support assistants. This would provide a wider skill-set and capability and ensure a more robust command function at both tactical and strategic levels.
- The service had started the role of consultant paramedics for urgent and emergency care and introduced two posts to provide focussed clinical leadership for the emergency service.
- The red arrest team provided clinical leadership in the response to cardiac arrest patients, with the objective of improving the success rate in the return of spontaneous circulation (ROSC). A clinical supervisor attended the scene of a cardiac arrest. Staff commented that the service needed to be extended to more rural areas.

Summary of findings

- The 'restart a heart' team was commended for its CPR work with school children. More than 31,000 children were trained in hands-only CPR in conjunction with the British Heart Foundation.
- The service received national recognition for its clinical leadership in the development of the West Yorkshire urgent care vanguard. The West Yorkshire urgent and emergency care network planned to develop an integrated urgent care model for the region, building on the services provided by existing urgent care services. The project expected to commence in February 2017 with a three to four year implementation. The objective was improved coordination of services and reduced pressure on emergency departments and in turn on ambulance services.
- Members of ambulance staff had won national and regional awards in the last two years, for example the Queens Ambulance medal and the Yorkshire Evening Post awards. The YAS resilience team was highly commended in the category for "Emergency Response Worker of the Year".
- A member of staff was part of a project supported by the mental health charity MIND. The Blue Light programme was a project run across all emergency services, including the ambulance service. The aim of the project was to improve the mental health of staff working in emergency service by having 'Blue Light Champions' in each area of the service to act as support to staff.
- There was a proposal for a nursing internship provided by the trust. This gave the trust an opportunity to explore an innovative way to enhance the current workforce against the back drop of high attrition rates and recruitment challenges. The proposal offered nurses the option of working in the ambulance service and as such provided an exciting and new opportunity for nurses.

Overview of ratings

Our ratings for Yorkshire Ambulance Service Trust HQ

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Good	N/A	Good	Good	Good
Patient transport services (PTS)	Requires improvement	Good	N/A	Requires improvement	Requires improvement	Requires improvement
Emergency operations centre (EOC)	Good	N/A	N/A	N/A	Good	Good
Resilience	Good	Outstanding	N/A	N/A	Good	Good
Overall	Good	Good	N/A	Good	Good	Good

Our ratings for Yorkshire Ambulance Service NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	Good	N/A	Good	Good	Good

Notes

Nb. Focused inspections do not look across a whole service; they focus on the areas defined by the information that triggers the need for the focused inspection. We therefore did not inspect all of the five domains: safe, effective, caring, responsive and well led for each of the core services we inspected.

Outstanding practice and areas for improvement

Outstanding practice

- The red arrest team provided clinical leadership in the response to cardiac arrest patients, which had improved the success rate in the return of spontaneous circulation (ROSC).
- The 'restart a heart' team was commended for its CPR work with school children. More than 31,000 children were trained in hands-only CPR in conjunction with the British Heart Foundation.
- Community first responders were trained volunteers who were available to attend emergency calls and to provide initial care before the arrival of an ambulance. There were more than 300 community first responder schemes which worked closely with the ambulance service.
- The service supported 670 public access defibrillators across the Yorkshire region which were available for use by members of the public. The scheme particularly helped people to access defibrillators in remote villages.
- A member of the air ambulance crew had completed training in Crew Resource Management (CRM). The qualification enabled the member of staff to undertake critique and feedback of incidents whilst taking account of human factors.
- HART staff presented evidence on the benefits of early antibiotic administration in open fractures. This treatment now has become standard practice within YAS.
- The trust was part of the urgent and emergency care vanguard programme, to support the development of new approaches to the provision of urgent and emergency care. The West Yorkshire Urgent and Emergency Care Network aimed to develop an integrated urgent care model for the region, building on the services provided by existing urgent care services.
- The trust had contributed to the development of a Pharmacy Urgent Repeat Medication Scheme (PURM) across the locality which enabled patients to access essential medicines from participating pharmacists out of hours. This scheme had won a 'Pharmacy Innovation' award.
- The NHS 111 service had implemented access to palliative care nurses on weekends and bank holidays, who were able to provide support to patients approaching the end of life.
- The trust had made use of a comprehensive workforce management tool to forecast anticipated call levels and deploy staff accordingly. The development of this tool and the transformation of planning within the organisation was recognised by a National Planning Award from the Professional Planning Forum.

Areas for improvement

Action the trust MUST take to improve

- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff.
- Within patient transport services (PTS) the trust must ensure that all ambulances and equipment are appropriately cleaned and infection control procedures are followed.
- The trust must ensure secure seating for children is routinely available in ambulance vehicles.

Action the trust SHOULD take to improve

- The trust should review the training requirements for operational staff in the PTS service for vulnerable groups such as patients living with dementia and patients experiencing mental health concerns.
- The trust should review the arrangements for operational staff to check their vehicle and equipment at the start of the shift to ensure they have sufficient time to complete the checks.
- The trust should review the audit procedures for reviewing the recording of controlled medicines.

Outstanding practice and areas for improvement

- The trust should continue to ensure that equipment and medical supplies are checked and are fit for purpose.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) Care and treatment must be provided in a safe way for service users How the regulation was not being met: It was not always possible for ambulance crews to access secure vehicle seating for children. Specialised equipment to support bariatric patients needed to be made available and accessible to all emergency ambulance crews. Vehicles in the PTS service were visibly clean but the service did not have a robust system to monitor the daily cleanliness of vehicles and staff did not have sufficient time to clean the vehicles thoroughly. There were items of equipment stored in some vehicles in a way which posed a risk to patients and staff, such as oxygen cylinders which were not securely fastened. In nine vehicles in urgent and emergency care services we saw sharps boxes were either full, or open, or not dated and signed. Clinical waste was found in the cab or saloon of the vehicle in some instances. There were still examples across services where equipment was not available for staff to use or consumables or medication were pass their expiry dates.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) Systems and processes must be established and operated effectively to:

Requirement notices

(2) (a) assess, monitor and improve the quality and safety of services; (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users; (c) Maintain securely and accurate, complete and contemporaneous record of care; (e) seek and act on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving such services.

How the regulation was not being met:

The allocated time of six minutes for crews to check their vehicle and equipment at the start of their shift was insufficient for all essential equipment to be checked.

There were occasions where paper records were not always stored securely.

The recording of medicines administration contained some discrepancies which were not always identified through audit procedures.

Learning from incidents, complaints and audit was not always consistently shared across staff groups particularly in the PTS service.

Within the PTS Service there were identified risks missing from the risk register, so it was unclear what actions had been taken to mitigate these risks.

There were vehicles which were found to have faulty equipment and fittings in place, which were still in operation and had not been properly reported particularly in the PTS service.

There was no standardisation regarding the type of equipment to be carried on PTS vehicles. There was no consistency in the amount of equipment and supplies stored on board vehicles and where on the vehicles these should be stored.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty. How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

The planned establishment for paramedics was 1208 wte. The actual number of staff in post was 1092 wte which meant there was a vacancy of 116 wte.

There were vacancies equating to 20.9 wte staff or a rate of 16.4% in administration and clerical positions of all grades in the PTS communications and control team.

Staff attrition rate in the NHS 111 service was approximately 40% per year.

Reg. 18 (2) (a) Persons employed by the service provider in the provision of the regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out duties they are employed to perform.

How the regulation was not being met:

Within the EOC not all of the nursing staff was up to date with safeguarding training.

Within PTS services there were no formal arrangements for one to one meetings or supervision sessions between the team leaders and ambulance care assistants, neither was there a formal record of individual staff performance.

There was a lack of role specific training for staff within PTS services to enable them to carry out their role effectively.

Staff in PTS services was undertaking excessive manual handling activities due to insufficient training in the use of a particular carry chair and the limitations of the carry chair.

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Highlights from Care Quality Commission (CQC) Inspection Report

February 2017

Yorkshire Ambulance Service NHS
NHS Trust

Our Communities

YAS is the only NHS provider serving the whole Yorkshire and Humber region

- Provides A&E ambulance service, non-emergency Patient Transport Service, NHS 111 service; resilience and special services
- Covers over 6,000 square miles
- Commissioned by 23 clinical commissioning groups
- Ideally placed to support integrated care for patients and provide the gateway into urgent and emergency services

Annex 2

Activity

During 2015-16 we:

- received 855,015 emergency calls
- responded to a total of 730,329 incidents of which 314,987 were immediately life-threatening
- undertook 1,036,052 non-emergency Patient Transport Service journeys
- answered 1,511,038 calls to the NHS 111 urgent care service

Yorkshire Ambulance Service NHS
NHS Trust

Care Quality Commission

The CQC is the independent regulator of health and social care in England. It monitors, inspects and regulates health and social care services to make sure they meet fundamental standards of quality and safety:

Are they safe?

Are they effective?

Are they caring?

Are they responsive to people's needs?

Are they well led?

Inspections at Yorkshire Ambulance Service NHS Trust took place in September and October 2016 (NHS 111 in October 2016)

Annex 1

The CQC's Inspection

- Visited 14 ambulance stations
- Visited Hazardous Area Response Team (HART), Emergency Operations Centre (EOC) and Patient Transport Service (PTS) control room
- Visited NHS 111 call centres
- Visited hospital emergency departments and Patient Reception Centres
- Spoke to hospital staff
- Spoke to 23 PTS patients
- Observed the care of around 40 A&E patients
- Inspected 42 A&E ambulances
- Inspected 38 PTS vehicles
- Inspected 12 HART vehicles
- Reviewed 20 patient records

How did we do?

Yorkshire Ambulance Service NHS
NHS Trust

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Rod Barnes, Chief Executive of Yorkshire Ambulance Service NHS Trust, said:

"We are delighted with the outcome of the CQC's recent inspection of our organisation. Their assessment reflects the high quality of service provided by our dedicated staff who work tirelessly every day to provide timely and safe services for our patients. It makes me immensely proud that the commitment of our staff and volunteers and the great care they provide have been formally recognised."

Yorkshire Ambulance Service NHS
NHS Trust

Positive Feedback

All of our services demonstrated significant improvement and the CQC highlighted a number of areas of outstanding practice:

- Our Red Arrest Team providing senior clinical support for patients who suffer a cardiac arrest
- Partnership working to improve integrated urgent and emergency care across the region
- Introduction of palliative care nurses in our NHS 111 call centres to support end-of-life care
- Clinical developments within our Hazardous Area Response Team
- An 'outstanding' rating for effective resilience planning

Yorkshire Ambulance Service NHS
NHS Trust

The CQC also praised:

- the Trust's volunteer community first responder schemes
- our commitment to supporting the placement of public access defibrillators in local communities
- our *Restart a Heart* campaign to train schoolchildren in the vital skill of CPR

NHS 111

- One of the best performing NHS 111 services in the country
- We continue to work with our local commissioners to develop the service in response to patients' urgent care needs
- Recent innovations include the provision of more specialised advice for mental health, palliative and pharmacy-related calls
- Our NHS 111 service now employs specialist nurses and pharmacists who work in the call centres and they are able to provide specific advice to help patients

Must Dos

- Ensure there are sufficient numbers of suitably skilled, qualified and experienced staff
- Ensure all PTS ambulances and equipment are appropriately cleaned and IPC procedures followed
- Ensure seating for children is available in ambulance vehicles

Next Steps

- Awaiting contact from CQC to organise Stakeholder Quality Summit
- Opportunity to review Trust plan focused on must dos, should dos and sharing of observed good practice

Any Questions?

Annex 2

Yorkshire Ambulance Service NHS
NHS Trust

Agenda Item 6

Vale of York
Clinical Commissioning Group

Developing a new mental health hospital for the Vale of York

Public consultation outcome report

Published January 2017

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1. Introduction

1.1 NHS Vale of York Clinical Commissioning Group (CCG) is the organisation responsible for commissioning the majority of healthcare services across the Vale of York.

1.2 In 2014 the CCG announced plans for the creation of a new mental health hospital for the Vale of York. The CCG has carried out extensive engagement to seek the views of local people on the development of mental health services.

1.3 The CCG is clear that a clinical model, based on the principles of therapeutic care, and meeting the needs of what the local community has said it wants; is delivered in an environment that meets the fundamental principles of safety and dignity. Any hospital provision must be fit for purpose and comply with the quality standards set by the Care Quality Commission (CQC) as the regulator of services.

1.4 Between 23 September 2016 and 16 January 2017 the public engagement culminated in a formal consultation asking for feedback on the proposed number and configuration of beds and preferred location of a new mental health hospital (based on three possible sites).

1.5 A wide ranging programme of communication and engagement activity was planned and delivered in partnership with Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), the provider of mental health services for the Vale of York. Collaborative working enabled us to provide a joint approach to gather the views and opinions of the patients, public and stakeholders. Throughout the consultation we attended 31 consultation sessions, focus groups and meetings and received 387 responses to the survey questionnaire and 40 email responses.

1.6 This report contains information about the formal public consultation, the communications and engagement activity with our patients, public and stakeholders and analysis of the feedback and consultation findings.

2. Statutory duties and assurance

2.1 Duty to consult

2.1.1 Under the Health and Social Care Act 2012 (section 14Z2)[1] each CCG has a legal duty to involve the public in the commissioning of services for NHS patients, and in decisions that it is going to make about services that will be provided to them.

2.1.2 We are clear that the intention of this consultation is to capture the views and opinions of patients, the public and stakeholders about the proposed number and configuration of beds and potential location of the new mental health hospital.

2.1.3 This report sets out a number of recommendations based on the feedback gathered throughout the 16 week public consultation and the CCG will use the information and data collected to inform its plans. Recommendations are not restricted to actions exclusively for the CCG and where there are multi-agency impacts and responsibilities; the CCG will work with partners to take the relevant actions forward. In particular, the final decision on the most appropriate site is out of the direct control of the CCG. Further work is required to fully assess the suitability of the proposed sites. Feedback from the consultation will form part of the final appraisal of sites that meet the required criteria.

2.2 Assurance

2.2.1 The CCG is working closely with NHS England in line with guidance for strategic service change[2] and will, with partners, continue to do so as the recommendations in this report are implemented.

[1] https://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf
[2] https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf

3. Background and lead up to formal consultation

3.1 Opening the dialogue with the public about mental health services

3.1.1 It is important to us that we listen to what the Vale of York population has told us, and continue to tell us. This consultation builds on the conversations that the CCG has held over the last couple of years; such as the 'Discover' engagement events in 2014; the procurement, which led to TEWV being awarded the contract for services in 2015, Exchange events and the International Mental Health Collaborating Network symposium in March 2016.

3.2 Pre-consultation meetings

3.2.1 In April 2016, with input from the CCG, TEWV held a number of pre-consultation public engagement events to give local people an early opportunity to be involved in the development of the new hospital. These sessions took place in Selby, Easingwold and York and were supported by Healthwatch in York and North Yorkshire. Over sixty people attended the events, including service users and carers as well as representatives from City of York Council, Selby District Council, Rethink and other members of the public.

3.3 Recommendations and options to be considered

The pre-consultation review provided a series of recommendations and options which provided the basis for the formal consultation questions.

3.3.1 Proposed configuration of beds:
TEWV proposes four 15 bed wards with single, en-suite bedrooms. This includes two adult, single sex wards, each with its' own day space, therapy rooms and outdoor space. The older people's unit will have one ward for people with mental health problems; such as psychosis, severe depression or anxiety (functional illnesses) and one ward for people with dementia, such as Alzheimer's (organic illnesses). Each ward will have separate male and female bedroom areas, with shared therapy rooms, day space (with separate lounges for men and women) and outdoor space (appendix i). Seclusion and de-escalation facilities for both adults and older people will be included in the design of the building.

3.3.2 Preferred location:
Three sites were shortlisted based on availability of land, achievability, accessibility, cost, site layout and opportunity for expansion. A list of options was assessed against these criteria and eight, out of 11 sites, have already been discounted. The options that were offered as part of the consultation are:

Bootham Park Hospital site
York,
YO30 7YB

Bootham Park

Clifton Park
Shipton Road
York, YO30 5RA

Clifton Park

Haxby Road
(former Bio-Rad site)
YO31 8SD

Haxby Road

4. Communications and engagement activity

4.1 Who we engaged with

4.1.1 The public consultation ran for 16 weeks from 23 September 2016 to 16 January 2017. The aim of the public consultation was to ensure that the CCG followed statutory requirements and maximised all opportunities for stakeholders, patients and the public to get involved in proposals and have their say.

4.1.2 As part of the consultation, an extensive range of methods were adopted to encourage participation and involvement from patients, the public and stakeholders.

4.1.3 We worked closely with TEWV on planning communication and engagement activities. Regular weekly teleconference calls enabled us to coordinate a joined-up approach to the consultation to ensure we were involving our local communities. A communications work plan can be found in (appendix ii).

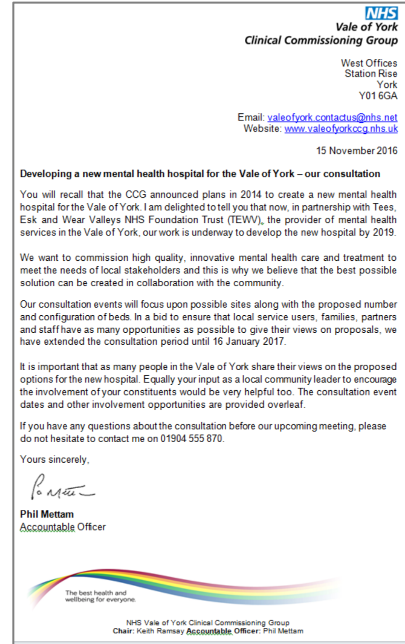
4.1.4 We engaged with a wide range of groups to ensure that the consultation captured views and feedback from our local populations and key stakeholders including:

- The local population of the Vale of York;
- People who use the mental health services;
- Local NHS and independent healthcare organisations;
- Vale of York GP practices and Patient Participation Groups (PPGs);
- Healthwatch - East Riding, York and North Yorkshire;
- Health and Overview Scrutiny Committees;
- Members of Parliament;
- Statutory and voluntary organisations;
- Community groups;
- Students;
- NHS Vale of York CCG and City of York Council staff.

4.2 How we communicated

In order to support the consultation a number of communications materials were created.

4.2.1 **Consultation document** – A consultation booklet was created outlining the background for the new mental health hospital, the proposed bed numbers and configuration, rationale, site options and how people could have their say (including details of public meetings). Copies were distributed and the online version was uploaded to the CCG and TEWV websites.



NHS
Vale of York
Clinical Commissioning Group

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Email: valeofyork.contactus@nhs.net
Website: www.valeofyorkccg.nhs.uk

15 November 2016

Developing a new mental health hospital for the Vale of York – our consultation

You will recall that the CCG announced plans in 2014 to create a new mental health hospital for the Vale of York. I am delighted to tell you that now, in partnership with Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), the provider of mental health services in the Vale of York, our work is underway to develop the new hospital by 2019.

We want to commission high quality, innovative mental health care and treatment to meet the needs of local stakeholders and this is why we believe that the best possible solution can be created in collaboration with the community.

Our consultation events will focus upon possible sites along with the proposed number and configuration of beds. In a bid to ensure that local service users, families, partners and staff have as many opportunities as possible to give their views on proposals, we have extended the consultation period until 16 January 2017.

It is important that as many people in the Vale of York share their views on the proposed options for the new hospital. Equally your input as a local community leader to encourage the involvement of your constituents would be very helpful too. The consultation event dates and other involvement opportunities are provided overleaf.

If you have any questions about the consultation before our upcoming meeting, please do not hesitate to contact me on 01904 555 870.

Yours sincerely,

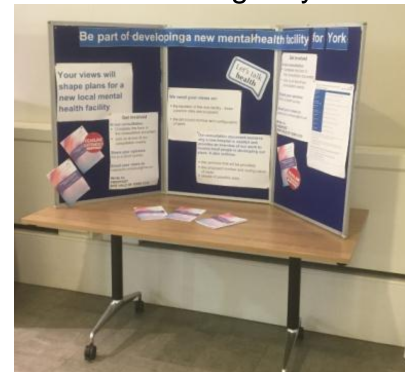
Phil Mettam
Accountable Officer

The best health and wellbeing for everyone.

NHS Vale of York Clinical Commissioning Group
Chair: Keith Ramsay **Accountable Officer:** Phil Mettam

4.2.2 **Online survey** – In addition to a paper version of the questionnaire, an online survey was launched. It was emailed out to our stakeholder list, advertised on the website, and publicised in letters and within the consultation document.

4.2.3 **Letter** – Over 470 key stakeholders received a letter on behalf of Accountable Officer for the CCG, Phil Mettam, inviting them to take part in the consultation and offering an invitation to discuss the proposals further. This included voluntary sector, community groups, networks associated with the protected groups, interested members of the public, GP patient participation groups, local councillors, healthcare and emergency services partners, university and higher education. Letters were emailed on 6 October 2016 and 6 January 2017.



4.2.4 **Information stand –** Leaflets and posters were placed on an information stand in the entrance of York City Council from 31 October 2016 until 16 January 2017.

4.2.5 **Flyers** – Flyers were distributed in the Park and Ride locations across York and in Pocklington to advertise the consultation and public meetings.

4.2.6 **Website** – The consultation document and information about the proposals were available to download from Vale of York CCGs and TEWV's websites. In addition, the consultation information was posted on York Press, The Northern Echo (covering Pickering, Easingwold and Helmsley), Minster FM, Healthwatch York and Age UK York's websites.

4.3 Conversations, workshops and face-to-face events

4.3.1 Events and workshops were held with patients, the public and stakeholders as a way of gathering qualitative feedback. In partnership with TEWV, we spoke to service users, the public, stakeholders and staff about the proposed sites, configuration of beds and the building of the new mental health hospital. The sessions provided an open environment for people and/or groups to discuss issues and concerns relating to the consultation questions.

31 public and stakeholder events

4.3.2 In partnership with TEWV, NHS Vale of York CCG representatives attended 31 public and stakeholder meetings (appendix iii). Within the arranged consultation meetings and focus groups (excluding scrutiny committees, local authority meetings and health and wellbeing boards) we had 184 total attendances with 166 individuals.

4.4 Public meetings and stakeholder events

4.4.1 **11 workshop style public meetings** with 78 public attendees**:** where the audience had the opportunity to discuss advantages and disadvantages of the site options and rationale for proposed bed numbers and configuration in groups. Within the consultation meetings we delivered a presentation, and had two table top discussions around the main questions. On each table we had a facilitator and a scribe.

Table 1: Formal public consultation venues

Date	Time	Venue
7 October 2016	3pm – 5pm	Community Hall, Burnby Hall, Pocklington, York, YO42 2QF
11 October 2016	3pm – 5pm	Community House, Portholme Rd, Selby, YO8 4QQ
24 October 2016	3pm – 5pm and 5.30pm – 7.30pm	New Earswick Folk Hall, Hawthorn Terrace, New Earswick, York, YO32 4AQ
31 October 2016	3pm – 5pm	Galtres Centre, Easingwold, York, YO61 3AD
8 November 2016	2.30pm – 4.30pm and 5pm – 7pm	Priory Street Centre, 15 Priory Street, York, YO1 6ET

Date	Time	Venue
18 November 2016	3pm - 5pm	Boys Sunday School, Tadcaster, LS24 9BL
21 November 2016	4pm - 6pm	Community House, Portholme Road, Selby, YO8 4QQ
25 November 2016	3pm - 5pm	Memorial Hall, Pickering, YO18 8AA
30 November 2016	3pm - 5pm	Old Court House, Pocklington, YO42 2DH

4.4.2 **One workshop-style event for staff from** NHS Vale of York CCG – 4 January 2017

4.4.3 **One consultation event for** patient participant group representatives and City of York Council – 4 January 2016.

4.4.4 **Two half-day open sessions** in the foyer of City of York Council to speak to public members entering the building to use council services – 14 and 15 December 2016.

4.4.5 **Three overview and scrutiny committees:**
East Riding of Yorkshire Overview and Scrutiny Committee – 4 October 2016;
City of York Council Overview and Scrutiny Committee – 18 October 2016;
North Yorkshire County Council Overview and Scrutiny Committee – 18 November 2016.

4.4.6 **Presentations at local authorities and stakeholder meetings:**
York Healthwatch Assembly – 25 October 2016;
Councillors meetings at Huntington and New Earswick – 9 November 2016;
York Health and Wellbeing Board – 23 November 2016;
North Yorkshire Health and Wellbeing Board – 25 November 2016.

4.4.7 **Informal conversations with specific groups**:
Mental Health Action for York – 23 November 2016;
York Older People's Assembly – 12 December 2016;
York Mental Health Carers' Group – 9 November 2016;
Age UK – 29 November 2016;
York CVS – 15 December 2016.

4.4.8 **Student consultation** with the University of York on 23 November 2016 and York St John Students on 5 December 2016.

4.4.9 **Two Patient Participation Groups (PPG)** hosted by GP practices on 11 January and 16 January 2016.

4.4.10 In addition to the face-to-face discussions mentioned above, TEWV undertook a number of engagement activities with its staff, governors and service users/carers who were using bed-based services to describe and talk through the issues set out in the consultation. Feedback from these events will be used by the CCG and TEWV, along with the consultation analysis to help inform the future implementation of approved plans.

4.5 Digital communication campaign

4.5.1 In addition to the communication materials mentioned above, we used a number of online and digital channels to promote information about the consultation, to encourage the public to have their say.

4.5.2 **Social media campaign:** Over 150 Tweets were sent via Twitter to raise awareness of the consultation, signpost to the websites, promote the public meetings and how people could have their say. Regular contact with key community groups, media and voluntary organisations via Twitter was also pursued to encourage promotion of consultation. Some of the most substantial retweets (organisations passing on the information to its followers) included Minster FM to 19,700 followers and City of York Council to 32,600 followers.

4.5.3 **Digital campaign** – We placed a digital campaign banner on York Press website, promoting the new mental health hospital consultation. It ran from the Friday 16 December 00.00hrs to Monday 16 January 23.59hrs with the following results:

- 65,014 page impressions
- 1,487 clicks to the consultation information on the CCG website
- 2.29% click through rate

4.6 E-bulletins

4.6.1 **Stakeholder news** – Information was included in the CCG's stakeholder news bulletin.

4.6.2 **Practice newsletter** – The mental health consultation was promoted in several editions of the weekly newsletter sent to all GPs, OOH GPs, practice staff and locums within the Vale of York.

4.6.3 **Internal communications (e.g. email, team brief)** – TEWV and the CCG used internal communication mechanisms, such as staff briefing sessions, internal emails and weekly e-newsletters to raise awareness of the consultation.

4.6.4 Item in **York CVS Newsletter** (1,500 subscribers)

4.7 Media

4.7.1 **Traditional media** – The CCG and TEWV communications team issued a press release, which was sent out to local and regional press to launch the consultation, signposting to more information and to promote the public

meetings. The story was included in York Press, The Northern Echo (covering Pickering, Easingwold and Helmsley) and Minster FM.

Table 2: Media coverage in local and national press

Date	Press outlet	Article
16 January 2017	York Press	Share your views and be a part of delivering in mental health for the Vale of York
13 January 2017	York Stories	Let's hang on to Bootham Park: your views needed – now
12 January 2017	The Northern Echo	NHS appeals for views over mental health services
2 January 2017	York Press	Have your say on health issues in York
22 December 2016	Minster FM	Consultation for New Mental Health Hospital
31 October 2016	York Press	Public urged to give opinions on new mental health hospital
10 October 2016	Health Service Journal	Shortlist for new hospital site revealed
03 October 2016	York Press	Hundreds turn out to support mental health services in York
03 October 2016	BBC News	Peppermill Court York's new mental health hospital opens
30 September 2016	Minster FM	People visibly moved by the #WalkbacktoBootham
29 September 2016	York Press	The people of York deserve a visionary new hospital
28 September 2016	York Mix	Hundreds expected on protest march marking one year since Bootham Hospital closure
28 September 2016	Minster FM	March for Bootham this Friday evening
23 September 2016	York Press	These are the 3 possible locations for York's mental health hospital
23 September 2016	Minster FM	The NHS to consult public on the new mental health hospital in York

4.7.2 **Radio interview** – Dr Louise Barker appeared on Minster FM to talk about the new mental health hospital proposals. The interview was re-played on the hour, every hour throughout the day during the news segment.

4.7.3 **Newspaper campaign** – A paid advert was placed on the front page of the York Press on 10 January 2017 and on page 3 on 16 January 2017, asking people for their views, reaching 92,700 people across Yorkshire.

READ BY 92,701 PEOPLE EVERY DAY IN PRINT AND @ thepress.co.uk

THE PRESS

REGIONAL DAILY NEWSPAPER OF THE YEAR

Cameras back in action

COPPERGATE

Traffic enforcement cameras

INSIDE

TOP SEVEN WAYS TO TONE UP

CONFIDENT OF MAKING A CHANGE

STYLE STAYS OUT IN FRONT

IN YOUR 8-PAGE FAMILY MATTERS

Pubgoer died despite months of hospital treatment

MAN WHOSE PUNCH KILLED VICTIM GETS 5 YEARS

Be part of delivering a new mental health hospital for the Vale of York

Share your views at www.valeofyorkccg.nhs.uk

NHS

4.8 Limitations and constraints to communication methods and data collection

4.8.1 Due to respecting respondents' anonymity and right to voice their views, we recognise that some members of the community could have expressed their opinions though several methods via public consultation, online and email. We acknowledge that this needs to be taken into consideration when reviewing the feedback.

4.8.2 It is also noted that there were members of the public who felt very strongly about the new mental health hospital proposals and took the opportunity to attend more than one public meeting to voice their concerns. As a result, we have recorded the number of attendees when publishing the figures of people at the public meetings.

4.8.3 We restricted the online service to a single IP address (a single computer location), so that the survey could only be counted from one individual computer location. This was to limit an individual being able to submit multiple responses.

5. Equality duty

5.1 Prior to the formal consultation we conducted an equality impact assessment (EIA) (appendix iv) to ensure the organisation had paid due regard to eliminate discrimination, advance equal opportunities and foster good relations between people of diverse groups; in particular on the grounds of the following characteristics protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation.

5.2 Through the EIA we identified additional key groups it was important to engage with, notably carers and students. We proactively communicated information about the consultation to community groups that had networks and links with protected groups, and extended the offer to meet face-to-face to discuss further. We held workshop-style events with those that took up the invitation including: Age UK, York Carers' Group, both of York's Universities, York CVS, York Older People's Assembly and GP Patient Participation groups.

5.3 York Lesbian, Gay, Bi-sexual and Trans (LGBT) forums declined the invite to have a member of our consultation team present at an event but contacted us to say they were 'glad to be asked for LGBT input – much appreciated.' Contacts representing this group replied to say they would push the survey with its members.

5.4 In order to ensure we were able to capture views of those with protected characteristics we added a number of diversity monitoring questions to the online survey and consultation document (through a questionnaire insert). These questions were not compulsory, and respondents could choose to bypass the question if they did not wish to provide an answer. As a result, we can only offer partial insight into the profile of respondents. However, it is encouraging to note that that approximately 64.6% per cent of the respondents answered at least one of the equality monitoring questions.

5.5 As part of the planning phase we wanted to ensure that the consultation reached across the geographical spread of the Vale of York CCG. We held public forums in New Earswick, Easingwold, Tadcaster, Selby, Pickering, Pocklington and York. Information regarding the consultation was shared with local newspapers and media outlets covering the whole 351,000 CCG population – see section 4 for more details of our communication activity.

5.6 To encourage views from localities we emailed key local community and social groups with a copy of the consultation letter and link to the online survey, and asked for it to be circulated to members. For all groups we offered a visit if they wanted to discuss the proposals in more detail. In

partnership with a Healthwatch member, we were asked to visit Pocklington town centre, in addition to the public meetings, to distribute leaflets and talk to local people about the new hospital proposals.

6. Consultation responses – numbers

6.1 Throughout the period of the formal consultation we received 387 responses to the survey questions. In addition we received 40 general 'contact us' emails (the CCG's email address).

6.2 Where members of the public had highlighted a preferred option via email or letter, these have been incorporated in the overall survey response figures – in total this accounted for 33 of the 387 responses. A wealth of qualitative feedback was also gathered from 31 formal public consultation events and meetings with stakeholders and focus groups.

6.3 Within this next section of the report we will cover the results and findings associated with the:

1. Proposed number and configuration of beds;
2. Site options: Preferred location;
3. Comments and opinions of key stakeholders and groups.

387 survey responses

40 email responses

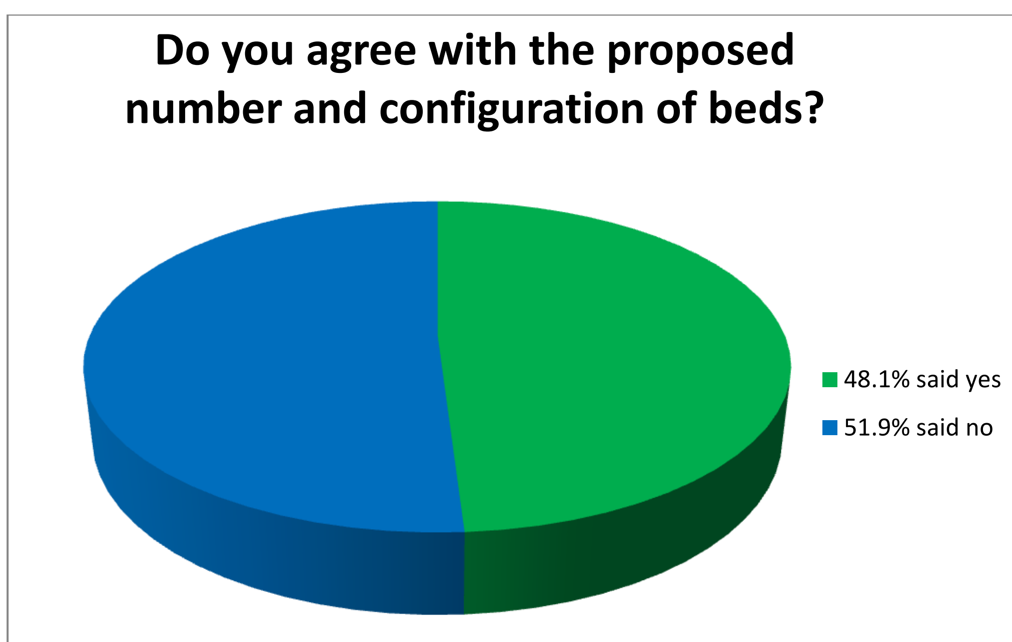
31 public and stakeholder meetings

7. Proposed number and configuration of beds

7.1 Online and paper survey results

7.1.1 The survey results show that 343 out of 387 respondents provided an answer to the question: Do you agree with the proposed number and configuration of beds?

- 48.10% of respondents (165 people) agreed with the proposals,
- 51.9% of respondents (178 people) disagreed.



7.1.2 Of the 178 survey respondents who disagreed with the proposal, 157 individuals provided comments in the free text area to explain why they had chosen this response. Analysis of the qualitative data outlines a number of strong themes that emerged.

7.1.3 **Provision of beds for patients with dementia**
One of the most common themes appeared in relation to the configuration of beds for dementia patients. In particular, concerns were expressed about the reduction of organic (dementia) beds from the current allocation of 28 beds to15 beds under the new proposals. Several of the comments linked to an 'ageing population' and 'growing demand'.

It is important to stay local and not have to be supported in a far off city

7.1.4 **Provision of beds for elderly patients**

Several comments reflected upon the demographics of an increasing elderly population and questioned whether there would be enough beds to accommodate the predicted ageing profile of the population. One respondent commented that reducing beds further would place a 'massive strain/pressure on community over 65 units'. This comment came from an electronic survey response, and reflects concerns raised in the public consultation events. At the open forums TEWV colleagues were able to discuss the developments in community services that would support a reduced bed base.

7.1.5 **Out-of-area admissions**

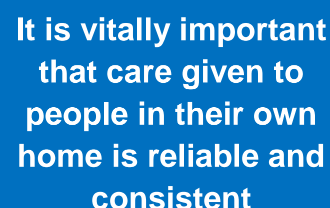
A high proportion of the responses touched on instances where patients believed there to be a 'lack of availability of local beds' within York. One patient wrote that it was a 'trauma' when her husband was sent to an out-of-area hospital and another advocated that it can be 'detrimental to care.' A survey respondent stated that it is important to 'stay local and not have to be supported in a far off city away from friends and family.'

7.1.6 **Specialised services and Psychiatric Intensive Care Unit (PICU)**

A significant number of responses mentioned the absence of specialised services within York, including mother and baby unit and services for eating disorders. In addition, several responses noted the absence of PICU as being a concern. Information regarding the reasons for why these services are not included as part of the consultation is highlighted in section 11 of this report.

7.1.7 **Making the service future proof**

Several comments were raised in relation to ensuring that, in particular, the new facility is 'flexible' and 'future proof' in light of a growing population.



7.1.8 **Provision of community services**

Many responses mentioned the correlation between the number of beds and the need for community services to be in place. One respondent commented that 'it is vitally important that care given to people in their own home is reliable and consistent' and another stated that 'without upfront investment in community teams, it will put pressure on other parts of the system'.

7.1.9 **Young people and child mental health services**

There were several replies which touched on the absence of provision of services for children, and queried why they were not incorporated into plans. In addition, comments were made with regards to services for young adults (18-24 years old), in particular about being on wards with more elderly patients and that it would be a 'frightening' period in their life.

7.2 Formal consultation meeting feedback

7.2.1 In order to add some wider context to the survey results on the proposed configuration and number of beds, the data is further supported by feedback received at our face-to-face events.

7.2.2 At the 11 formal consultation meetings and at some of the focus groups where requested, time was allocated for table-top sessions to discuss questions posed in the consultation. Several conversations took place between TEWV and CCG representatives and the public to understand more and try to alleviate concerns. The open dialogue allowed attendees to have a frank discussion, find out more about the proposals and receive immediate feedback. As a result, although similar themes emerged, concerns were weighted more towards topics around flexibility, ward layout and community services.

It seems reasonable if people can be adequately cared for in community settings

7.2.3 **Formula used to calculate the number of beds**
During the meetings a number of conversations took place about the methods used to calculate the proposed number of beds. TEWV representatives were able to explain the process and rationale for the formula. When specifically discussing the proposed number of beds, some of the positive comments included that 'it felt about right' and another that the beds feel 'comfortable.' The Healthwatch Assembly believed it was good to have gone to the 'top end' of the formula and that the number 'seems reasonable if people can be adequately cared for in community settings'.

7.2.4 **Flexible beds**
The ability to flex the beds on the wards was taken as a positive measure. One member of the public commented that it is 'good to have a plan where individual wards meet for flexibility', another stated that they 'liked the opportunity of flexibility and capacity to increase ward bed base.'

I like the opportunity of flexibility and capacity

7.2.5 **Design and layout**
Comments on the design were also collated. The separation of male and female bedrooms was considered a good design. In addition, one member commented that they were 'happy with the provision of ensuite facilities'. Feedback about the importance of outside space 'not just to visit but to see' was also

It's fantastic that it's all on the ground floor

captured and one member of the public commented that 'it's fantastic that it's all on the ground floor'.

7.2.6 **National concerns**

Those members of the public who disagreed with the proposed amount and configuration of 60 total beds commented on this number and linked it to 'national concerns around insufficient bed numbers'. Similar to the survey response feedback, there were still several concerns raised that the reduction of overall bed numbers to 60 seemed 'huge'.

7.2.7 **Community services**

Within the consultation event, much more of the conversation focused on the provision of community services to help support the number of mental health in-patient beds. One attendee questioned the sustainability of care in the community and suggested that it needs to 'be ramped up and be robust' and another wanted 'assurances that services will be in place.' One attendee stated that 'the premise of enhancing community beds and reducing beds has validity, but depends on that enhancement actually happening'. There were also some comments about the absence of community support in more rural areas. At these meetings TEWV responded in real-time to questions raised and more information will be highlighted in a dedicated frequently asked question section on the Vale of York CCG website.

Has the future ageing population had been taken into consideration?

7.2.8 **Population growth and ageing population**

Similar themes arose from the conversations about the number of beds in light of the population growth and the dependence on community provision. At several meetings the public questioned the rationale for the specified number of older people and dementia beds, and wondered if the 'future ageing population had been taken into consideration'. One member of the public raised a concern with the 'number of beds and doubling number of York residents'.

7.2.9 **Ward layout**

Several questions were raised about the decision not to separate wards into male and female areas for older people and those with dementia. In addition, a strong theme formed around the accommodation of young adults in the same ward as patients who are older. One member of the public commenting: 'How will you manage different age ranges on adult wards – e.g. an 18 year old sharing with a 53 year old?' This reflects concerns raised within the online survey.

Is there room for expansion?

7.2.10 **Care home provision**
There were also queries raised over care home provision. One member of the public stated '15 beds for the elderly is not enough if there are no care homes in the community to support'. Others asked about the links with nursing homes and if there would be care home provision in place.

7.2.11 **Site expansion**
At most of the meetings there was a discussion around the ability to expand the site if the number of beds was not sufficient. The importance of having enough room on the site to adapt services in the future if needed was highlighted by TEWV.

7.2.12 Overall, the general comments collated through the online survey, consultation events and meetings indicate that there is a very mixed response about the number and configuration of beds. There is a strong concern about the reduction of overall beds, despite the calculations, and some of this is related to personal or family experience of patients having to be supported for their mental health needs out of area. It appears that some of the ambiguity is due to needing to seek further clarification on areas such as provision of community services, the rationale for decreasing the number of older people beds, the explanation for flexing of beds and the understanding of the provision of specialised services.

7.2.13 Although similar themes are mirrored in the online survey and consultation events, it is apparent that respondents at the face-to-face sessions benefited from question and answer sessions where much more focus was placed on understanding the community provision that is used to support inpatient beds. Transcripts capture some of the two-way conversations that were held between the public members and representatives from TEWV and the CCG on the CCG's website.

7.2.14 There were a number of additional queries about challenging behaviour, respite facilities, facilities for visitors, prayer and multi-faith facilities, and funding for the new hospital. Many of these queries were unrelated to the location or number of beds. However, they still remain an important part of the consultation and will be used to inform the future provision of mental health services.

7.2.15 Verbatim comments will be made available, and common queries that have been raised will be responded to in the Frequently Asked Questions (FAQ) section of the CCG website.

7.3 Emails

7.3.1 On all of our communications, emails, and letters and within the literature we offered a 'contact us' address. Through several emails we received a number of generic comments in addition to the consultation proposals.

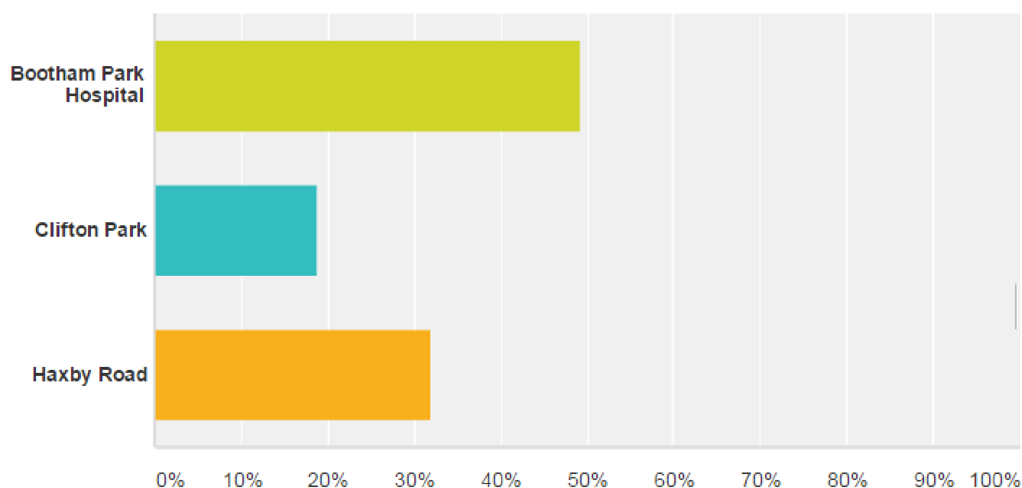
7.3.2 Of the 40 contact us emails, 30 were in direct response to the consultation questions and have therefore been incorporated into the 387 questionnaire responses. The remaining responses have been captured in the general themes gathered from other activities and some more specific questions have been fed into the Frequently Asked Questions.

8 Site options and preferred location

8.1 Survey results

8.1.1 The survey results show that 367 of the 387 respondents indicated a preferred site option.

- **Bootham Park Hospital** had the most support with 49.32% of respondents (181 people) preferring this option
- **Haxby Road** site was the next most popular with 31.88% of respondents (117 people) preferring this location
- **Clifton Park** was the least popular with 18.80% of respondents (69 people) showing a preference for this site



8.1.2 In addition, there were a number of individual preferences captured at the formal consultation events. Within the meetings it was not an explicit requirement for each member of the audience to have to give a choice of their preferred location. However, it is recognised that, through some of the discussions, members of the audience specified a preference and these are outlined below. If a member of the public voiced a preference within the public meeting we are not able to verify if an additional survey was also completed. As such, public consultation responses remain separate from the online survey figures.

- 17 preferred Bootham Park Hospital
- 4 preferred Haxby Road
- 2 preferred Clifton Park

8.1.3 From the feedback received, there are many advantages and disadvantages noted for each site. Key themes have been captured below and incorporate the responses from the survey, emails and the stakeholder meetings.

8.2 Bootham Park Hospital – reported advantages

8.2.1 Central location, close to amenities, York Hospital and the city centre. The strongest theme that was noted at all of the workshops, and throughout the survey responses, was the location of Bootham Park Hospital (Bootham).

Central location

Convenient access

8.2.2 Attendees and respondents felt that the central position of Bootham was a key positive aspect of the site as it is close to amenities and the city centre allowing for 'convenient access'. It is near to the 'community' as well as neighbouring York Teaching Hospital, which many deemed better for 'integrating physical and mental health care'. One respondent comments that it is important to be 'close to York centre as it is essential for people visiting and for patients to rehabilitate back into society.'

8.2.3 Good transport links - It was emphasised that Bootham Park Hospital had good cycling and walking access to the site. In particular, it was felt that the proximity to public transport was a huge advantage for patients and visitors. One person expressed that you 'can walk from every bus service in York' and another stated that the 'transport links from all over the catchment area are adequate to Bootham Park.'

You can walk from every bus service in York

8.2.4 Historical significance and aesthetics of the site - At many of the meetings there was a discussion about the historical significance of the site, supported by themes from the online survey. Respondents commented that 'we shouldn't break with the long tradition' and that the building has 'national importance' and 'heart and soul'. Some commented that it is a 'fine' and 'beautiful' building and one member of the public stated that 'people love what they are used to and have affection for the building'. Another person commented that it would 'look great to put old and new together' and thought that it could be accommodated as part of the design for the new hospital as it would be 'easy to extend and expand'.

Fine and beautiful building

8.2.5 Tranquil site with green space - The public commented on the 'nice grounds' and 'good outdoor space' available at Bootham Park Hospital which made it a 'restful, peaceful' and 'therapeutic' location for patients and would 'assist with patient recovery'.

Nice grounds

Good outdoor space

8.2.6 A recognised site - On several feedback forms it was expressed that it was already an established site and should be maintained for ‘continuity and consistency’ and for ‘familiarity for users and their families’. University students highlighted that it was good access from the university and that it was a known site so people are ‘aware it exists’. In addition, many commented that the infrastructure was already in place.

8.3 Bootham Park Hospital – reported disadvantages

8.3.1 Limitations of listed building and feasibility of incorporating a new design **-** One of the main concerns raised at many of the meetings was the question as to whether the new single storey hospital design would fit onto the site. One public member commented: ‘you can’t have what you need at Bootham and preserve the building’ and a staff member stated that were ‘strongly against Bootham as the listed status may distract from patient care by compromising design’. A GP patient participation group representative highlighted that there would be ‘difficultly balancing historic consideration, cost and patient need’ and several survey respondents commented that ‘it is no longer fit for purpose’. A survey respondent expressed the fact ‘that people suffering mental ill-health have been cared for in such an old and inadequate facility shows how marginalised people with mental illness have become.’

It may distract from patient care by compromising design

8.3.2 Access for patients with a disability - In particular, several comments arose around the fact that ‘disabled access could be limited’ due to Historic England restrictions and that there would be a ‘challenge’ to keep the building one storey or offer ‘room for expansion’. It was also raised by a member of the public that ‘in a time of diminishing resources would we be tying up all our money in a building?’ and another highlighted that ‘limited funds are important to people.’

Disabled access could be limited

8.3.3 Stigma - The topic of ‘stigma’ arose at many of the meetings. Some members of the public felt that the stigma attached to the site had dissipated. One university student commented that if Bootham Park Hospital could be ‘re-branded’ this would help. However, several members of the public still felt that there was ‘stigma’ attached to Bootham Park Hospital, and a student emphasised the ‘very negative patient experience’ of inpatients at

Should we be tying up all our money in a building?

Bootham and the outcome of the Care Quality Commission report. One member of staff suggested that we should just 'leave it be' and a survey respondent thought Bootham 'has had its time'.

8.3.4 Traffic Congestion - In addition, strong concerns were raised over the traffic congestion and parking facilities.

8.3.5 Too central - As for the location of Bootham, it was highlighted by a member of staff that it could almost be 'too central' and that 'acutely unwell patients may not need city access.'

8.4 Clifton Park – reported advantages

Best road links

Avoids the clogged up city centre

8.4.1 Transport - One of the positive themes that emerged was that people felt there was good access to the site for visitors and staff by car due to having the 'best road links' and therefore 'avoiding the clogged up city centre'. A member of the public at one of the public meetings mentioned that it was good access for Easingwold and a survey respondent suggested that there was 'easy access from most points of the city' and it was 'close to the ring road'. Others mentioned the park and ride route and that there was a path access to the site.

8.4.2 Amenities - At the consultation meetings, attendees felt that the site was in a good location due to the proximity to amenities such as Tesco and the cinema. It was also highlighted that the new hospital may increase facilities in the area.

Peaceful

Green spaces nearby

8.4.3 Green space - Some members of the public proposed that the trees could provide privacy and that there was a possibility of using recreational allotments for therapeutic purposes. One survey respondent stated that it is 'quiet area' with 'green spaces nearby' and another expressed that the surrounding environment is 'peaceful' and that this 'can be key for relaxing/less environmental pressures for rehabilitation of patients and relatives.'

8.4.4 An NHS owned site **-** Some conversations at meetings drew on the fact that there are already existing NHS facilities on the site, which may make it easier to build upon, as well as the potential to increase links with the forensic services and police. This theme was mirrored in the online survey responses, with one respondent stating that they had chosen the option 'due to all services being together in one place'.

8.5 Clifton Park – reported disadvantages

8.5.1 Flood risk **-** The greatest issue raised at the vast majority of the meetings, and through survey responses, was around the potential flood risk of the site – incurring extra cost and higher insurance and the 'inconvenient and distressing' impact it could have for patients and visitors. The Healthwatch Assembly said they were 'very concerned' as this could impact design and a student questioned the possible 'cost of defences'. Some asked if the building could be raised to prevent the flood risk.

Very concerned about the flood risk

8.5.2 Public transport limitations - Access and public transport was another area that was considered a major drawback.
Some expressed concern that it is 'quite a long way to walk' from the bus stop. In addition, one member of the public highlighted that the park and ride 'isn't brilliant as it closes at 8pm'. Rush hour would be difficult to access as it gets congested and the A19 was considered a very busy road. A university student and some members of the public highlighted that there would be 'multiple switches of transport' involved.

Compromised designs

Loss of green space

8.5.3 Capacity to expand - As for the site itself, several concerns were raised over the size of the land and the 'capacity to build extensions' and if this would 'compromise designs'. A member of the public highlighted that they 'wouldn't see this as a positive development' as it would 'impact and spoil the views' and another commented on how there would be a 'loss of green space'. In addition, some people raised concerns about the proximity to residential areas and wondered if there would need to be 'consultation with residents'. A survey respondent comments that it would have to 'encroach on the allotments and open space'.

8.5.4 Stigma **-** The issue of stigma was also indicated as a concern by several members of the public with one commenting that they felt there was 'far worse stigma than Bootham'.

8.6 Haxby Road – reported advantages

8.6.1 Optimal design and capacity for expansion - The most prominent theme that was evident in public consultations and through the survey, was the advantage of the size, shape and orientation of the Haxby Road site. People

commented that Haxby Road is the 'biggest site of all and most suitable for expansion' and 'large enough to be future proof'. One person stated that 'we should have a new mental health hospital in a place that gives us capacity and opportunities for the future'. Haxby Road was considered the 'least restrictive', 'most optimal for design' and 'the most straightforward of the three options in terms of the practicalities associated with such a build'

Large enough to be future proof'

Most optimal for design

8.6.2 Transport - When discussing the transport options and availability, some thought that it has the 'best access for out of town' and that there are good parking facilities. Some mentioned that it was on a 'well-serviced' bus route with 'good access'. According to one consultation attendee it was 'one of the best' routes in York and a representative from York Mental Health Carers stipulated that it was a 'fantastic bus route', and that the bus stop is near to the proposed facility. In addition, several people commented that it is a good location for cyclists.

8.6.3 Brownfield site - Haxby Road's status as a brownfield site was seen as an advantage to some as it is 'less environmentally damaging' and 'better use of land than using an existing greenfield site'.

8.6.4 Green space - In terms of location of the site at Haxby Road, people felt that it was 'surrounded by green space' and in a 'quiet, discrete location'. Some members of the public highlighted the close proximity to the New Earswick facilities and the potential to link into the local community.

8.6.5 'Fresh start' - There were many comments collated from meetings, and via the survey, about the opportunity for Haxby Road to provide 'a fresh start'. A member of the Healthwatch Assembly commented that we can 'welcome services into the 21st century'. Survey respondents expressed that it was beneficial to have 'a new site to allow for a modern hospital' and another that it would 'allow the development of new modern day services without the hangover and stigma of the past'.

Welcome services into the 21st century

Allow for a modern hospital

8.7 Haxby Road – reported disadvantages

8.7.1 Possible flood risk - Several questions arose about the possibility of the site flooding and its proximity to the river.

8.7.2 Brownfield status and contamination risk - Another strong theme was around the brownfield status of

Unknown factor

Decontamination

the site. The public raised concerns about its decontamination and the 'unknown factor of the ground quality' and 'pollution'. One member of the public questioned if too much money would be spent clearing the site.

8.7.3 Transport - The issue of transport was a concern for many. Some members of the public felt that the bus access was poor – especially on a Sunday. One member of the public did not like the fact that it was 'not within walking distance of the city' and that there was 'poor access' from the west of the city. There were also concerns about traffic congestion.

8.7.4 Location – isolation: The location of the site was seen as 'too far out' for some and perceived as 'less accessible' and 'isolated' as there were no amenities close by. Others raised concerns that the lighting and walking routes to the site would need to be improved and there would need to be increased security and safety.

8.7.5 In addition to the individual comments around each site, it is acknowledged that some respondents felt they needed more information about the cost, the flood risks and the feasibility of whether the design can be incorporated into each of the sites.

Priority should be given to sites with space to build the right building for our current needs

8.7.6 Other members of the public stipulated that the design of the building was the most important aspect of the new hospital over the location – as one respondent stated: 'priority should be given to sites with space to build the right building for our current needs, with an eye to the future as needed.'

9. Responses and opinions from specific groups and key stakeholders

As part of the engagement process we identified a cohort of our population that we wished to seek views from and opened the invitation to discuss the proposals in more detail. We carried out sessions with the specific groups of stakeholders in the way that suited the target group, which ranged from workshop-style focus groups with facilitators to closed question and answer sessions. We have provided this analysis as a separate section to the document as we feel it can offer some interesting insight into the opinions these groups.

9.1 Carers

9.1.1 On 9 November 2016, a workshop was held with the York Mental Health Carers Group. Conversations at this session were primarily focused on the sustainability of community services and the importance of 'continuity of care'. In particular, several concerns were raised about 'crisis' care – with focus on the need for services to help 'avoid a crisis'. Discussions were had about up-skilling of staff to support de-escalation and on the importance of communication.

Community services are crucial… it underpins the whole model

Support for carers is crucial in supporting positive outcomes.

9.2 Healthwatch

9.2.1 On 25 October 2016 TEWV and the CCG attended the Healthwatch Assembly mental health consultation. Discussions took place about the numbers of beds and the feeling that they are 'reasonable'. The flexibility of 'swing beds' was also seen as favourable. However, it was recognised that community provision was seen as a key component – 'getting the right care in the right place'. It was raised that 'community care feels challenging' at the moment and that a 'single point of access' would be useful.

Key is community

Single point of access would really help

9.2.2 Concerns were also voiced about demographics and 'capacity' for future need. Other common topics included staff training, ensuring there is the right skill mix, and recognising the role and importance of the carer stating that they are 'crucial in supporting positive outcomes'. It was also noted that it needs to be seen in the wider context, with reference to prevention and public health initiatives.

Contingency needs to be built in if there are new/different needs

9.3 Mental Health Action York

9.3.1 We were invited to hold a closed session with Mental Health Action York (MHAY) on 23 November 2016. This session focused on a range of questions that MHAY prepared in advance of the meeting. CCG and TEWV colleagues attended the session and discussed the issues raised. Many of the questions raised by MHAY have been raised in other forums throughout the consultation and have been incorporated in the frequently asked questions.

9.3.2 The session was delivered in this way as several of the MHAY group had already attended one or more public event, and as a result, wanted a more in-depth and focused conversation.

9.4 Patient Participation Groups

9.4.1 As part of our conversations with patients and representatives from GP practices we were invited to a Patient Participation Group (PPG) to carry out a session. Comments recorded in the facilitated workshop queried the decrease in beds (with an ageing population and increased demand) and capacity of community provision. Site accessibility and parking was noted as being important and they stated that they were 'impressed' by the flexibility of the wards.

Impressed by the flexibility

9.5 Staff

9.5.1 The CCG consulted with staff from VOY CCG and the CYC. Over 20 members of staff attended. Conversation focused on designs and capacity – asking where the inspiration was taken from, the flexibility and potential expansion of the site and what will happen to existing facilities. In addition, a number of other comments about need for out-of-hours provision, crisis team operating hours, support for families and for university students, and whether the community services are 'ready for this'.

9.5.2 The tensions that exist between the perception of reducing bed numbers and the financial costs of commissioning empty beds were specifically highlighted. In addition, TEWV undertook informal discussions within teams/meetings and encouraged staff to feedback using the consultation processes.

9.6 Students

9.6.1 Within the equality impact assessment (EIA), consultation with students was highlighted as a priority. With an increasing student population

Patients get better with local support

within the CCG's footprint, it was deemed important to engage with this section of the population. As a result we met with groups of students from University of York on 23 November 2016 and York St John on 5 December 2016.

9.6.2 The new mental health hospital was viewed favourably, as it would allow 'capacity for enhanced services and joint working'. However, several conversations were held about the provision of community care and how it would work in a university environment.

9.6.3 It was suggested that having community care in student accommodation 'puts a lot of pressure on flat mates' and they 'don't want to worry families'. They also raised concerns about 'more community counselling' as 'a priority' and were anxious about the 'lack of capacity' at peak times.

9.6.4 Where a location was discussed, four of the York University students felt that Bootham was the preferred option – 'especially with a rebranding' as it is a central and peaceful location, close to amenities. They also raised that 'pathways need to be made clear' and that 'patients get better with local support'.

What steps are you taking to ensure that things are in place to avoid a crisis?

9.7 Voluntary sector

9.7.1 We delivered a consultation workshop with York CVS and Age UK. During the sessions points were raised about taking into consideration those with visual impairments, and the concern over the Clifton bus stop being far from the site. One attendee mentioned that it is important to 'co-balance bed reduction with improvement of community care' and that the 'voluntary sector could contribute'. Age UK representatives discussed specialised services, timeframe and volunteering.

9.8 York Older People's Assembly (YOPA)

9.8.1 On 12 December 2016 we attended the York Older People's Assembly to present on the consultation for the development of a new mental health hospital. On 10 January 2017 the CCG received a formal letter of response from the York Older People's Assembly, which thanked the CCG and TEWV for the 'extensive consultation programme, whatever the outcome.'

Extensive consultation programme

9.8.2 Overall, it stated that it was 'broadly in support of services being developed within local

communities in non-institutional settings, but recognise the need for some in-patient facilities'.

9.8.3 In relation to number and configuration of beds, concern was expressed about the lack of forward projections locally of those requiring access to mental health services.

9.8.4 Commenting on design requirements, YOPA is 'supportive of the design proposals'. However, it suggests that 'a two-storey design should not be ruled out if it was restricted to staff and ancillary accommodation.'

9.8.5 With reference to the site options, YOPA commented that it is difficult to arrive at a preferred view until key information concerning the views of the Planning Authority on the three shortlisted sites is available. Recognising that the existing Bootham site is 'highly problematic' YOPA highlighted that 'easy physical movement between the Mental Health Hospital and York Hospital is highly desirable.'

9.9 Local authority responses

9.9.1 City of York Council: The City of York Council (CYC) affirmed its support for the CCG's plan to build a new state-of-the-art mental health hospital for York. It supports the notion that a new hospital is needed to ensure the dignity, privacy and safety of those needing it to help them recover from mental ill health. CYC made some very detailed suggestions around design features. It also has asked for more clarification on several areas:

- a better understanding of the contribution of a new mental health hospital within an overarching strategy for dealing with mental health illness in the Vale of York;
- the rationale that will be used to achieve a balance of provision between hospital and community based provision. CYC seeks assurance that reducing the bed base will result in investment in improved community services;
- assurance that steps will be taken to engage, on an on-going basis, the local community so that the final proposal, whichever location is chosen, will integrate within its local setting.

9.9.2 North Yorkshire County Council (NYCC): On 13 January 2017 NYCC offered a response to the consultation. It was noted that the CCG and TEWV have made a 'concerted effort' to 'seek the views of people who use services, carers, the wider public and partner agencies.'

Responding on the topic of proposed bed numbers, NYCC believes it to be a 'pragmatic response', noting that the TEWV average is 49 beds for these

types of services. However, concerns were raised about the proposed down-scaling of bed numbers for older people with dementia, including:

- the rationale for the change in bed numbers;
- the replacement of services in Selby and York with a single unit in York decreasing the ability to be able to receive care and support locally, and
- the forecast bed requirement data not allowing for any indication of the split that may be needed between dementia and functional conditions for older people.

In response to the preferred site option it was highlighted that the Clifton and Haxby Road sites are more accessible for North Yorkshire residents, however they are not good for residents of Easingwold or Selby. NYCC feels that Bootham may be a better location due to public transport access, however it was recognised that the history of the site may be 'unacceptable' to people with mental health needs.

In addition, issues were highlighted about the provision of mental health services across the North Yorkshire patch in comparison to neighbouring areas, and NYCC welcomed the opportunity to work with the CCG to explore any future opportunities.

9.10 Responses from local Overview and Scrutiny Committees

9.10.1 We attended the three Overview and Scrutiny Committees that cover the CCG population and have been invited back to report on the findings and discuss the outcome of the consultation in more detail as follows:

- East Riding of Yorkshire Overview and Scrutiny Committee – 4 October 2016;
- City of York Overview and Scrutiny Committee – 18 October 2016;
- North Yorkshire County Council Overview and Scrutiny Committee – 18 November 2016.

9.10.2 All of the Overview and Scrutiny Committees were satisfied with the consultation plan and had no specific issues to be addressed. All of the Committee members were encouraged to attend public consultation events and an offer was extended to councillors to follow up on an individual basis if required.

9.11 Responses from health partners

9.11.1 We invited the Yorkshire Ambulance Service (YAS) to comment on the new hospital proposals. The new section 136 suite was welcomed as it would 'reduce transports to Leeds and Scarborough but the Service stated that it

wanted assurance that staff in this facility will be able to undertake clinical assessment. YAS suggested the opportunities for strengthening partnership working with the potential for shared posts in the mental health hospital, and highlighted the access for the 24/7 mental health clinicians in the YAS control room into local mental health teams.

9.12 Responses from interested parties

9.12.1 On 13 January 2017 York Civic Trust (YCT) wrote to the CCG to offer an opinion on the proposals for the new mental health hospital site options. In particular, YCT responded in relation to the Bootham Park site. YCT believes the Bootham Park Hospital is of ‘national architectural and social interest’ and requested that the Bootham Park buildings are ‘appraised against the same criteria as the other sites, in a transparent process.’ It offered its assistance with regard to heritage matters.

10. Equality monitoring information

As part of the survey we asked a series of questions to find out more about the demographic of the respondents. It is encouraging to note that, although this section of the survey was only optional; we received 250 responses to some of the questions. All of the data on respondent profile can be found in appendix v and the responses from different protected groups will continue to be analysed and used to inform future plans within the development of mental health services. An overview of those who responded to the survey and chose to answer the demographic and equality monitoring questions can be viewed below.

Table 3: Equality monitoring question - In what capacity are you responding?

In what capacity are you responding?	Number	Percentage
Member of the public	147	59.04
Patient or community group	14	5.62
Patient carer	15	6.02
Partner organisation	20	8.03
Staff clinician	56	22.49
Other	40	16.06

We were able to capture some of the information around location of respondents. We arranged consultations out of York City Centre, in localities and used local and regional media outlets. In total 86.03% of respondents who answered the demographic question stated they lived in York.

Table 4: Equality monitoring question – Location of respondent

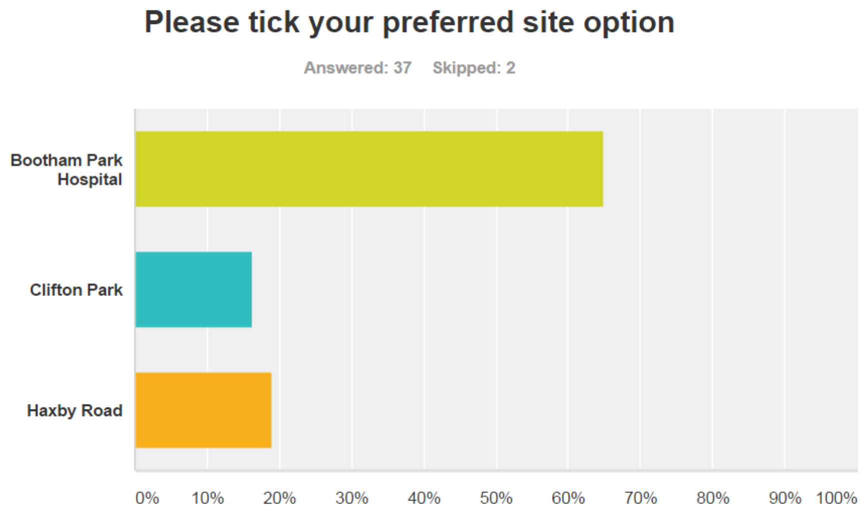
Location	Number	Percentage
York	197	86.03
Selby	15	6.55
Easingwold	4	1.75
Tadcaster	1	0.44
Pocklington	5	2.18
Ryedale	7	3.06

10.1 Survey responses split by demographic and equality monitoring information

10.1.1 Asking respondents to fill in the equality monitoring aspect of the document was to enable us to analyse responses by specific strands of the population.

10.2 Respondents living with a mental health condition

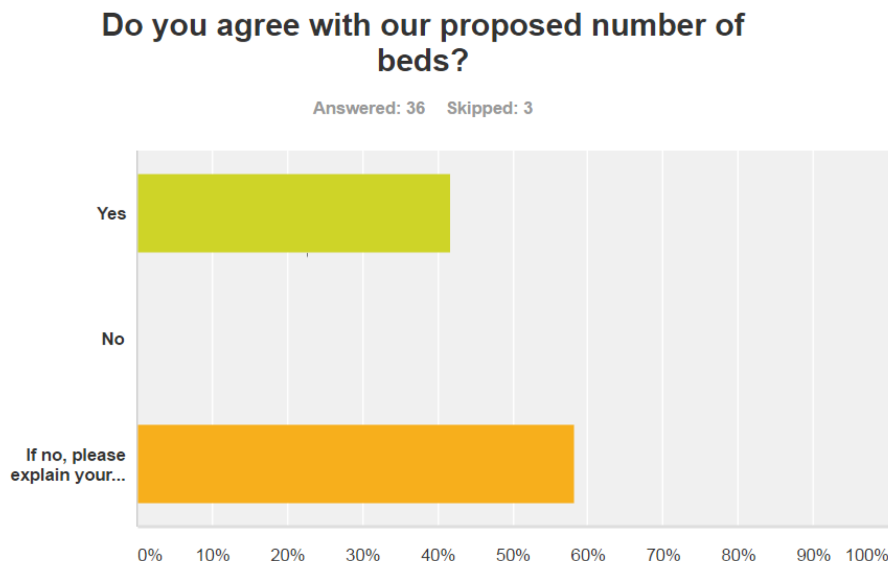
10.2.1 Through the online survey we were able to collate a number of insights from those who identified themselves as living with a mental health illness. 39 people (16.53%) of the respondents identified themselves as having a mental illness:



- 64.86 % (24 respondents) preferred Bootham Park
- 18.92% (7 respondents) preferred Haxby Road
- 16.22% (6 respondents) preferred Clifton Park.

10.2.2 Good transport links, accessibility, being close to York Teaching Hospital and familiarity of an established site were highlighted as important reasons for preferred choice of location.

10.2.3 When asked about the proposed number and configuration of beds, 41.67% (15 respondents) felt it was sufficient and 58.33% (21 respondents) % did not.



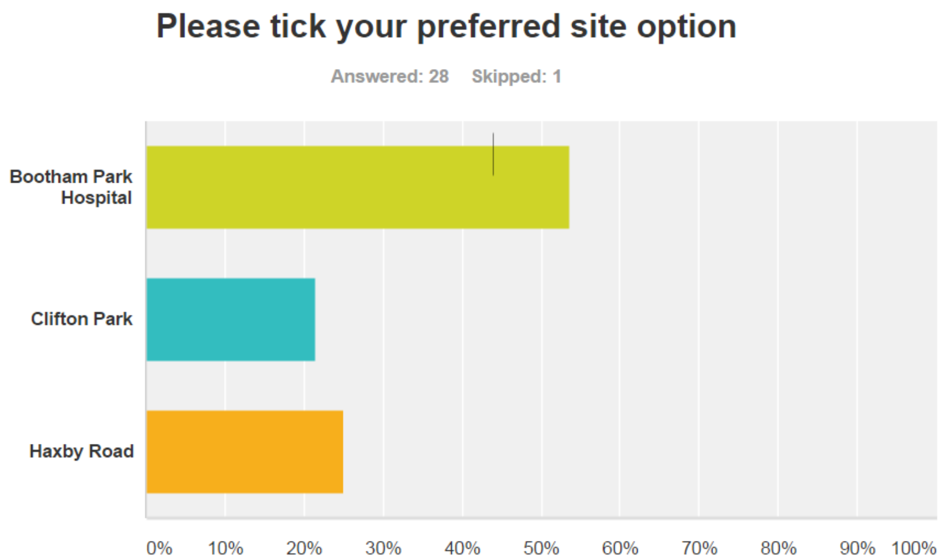
10.2.4 Pertinent themes that emerged from this group of respondents included concerns about community services, shortage of beds and being treated out of area. Some stated that there was 'too little wiggle room' in the current system and another suggested that 'if there had been a bed available my recovery would have been quicker.' With regards to design of the new facility, it was highlighted that chaplaincy and quiet-room provision, accessibility for those with disabilities, access to outside space, single rooms and single-sex facilities are very important. One service user had found it 'distressing' to have had to share facilities with the other sex.

10.2.5 In relation to ensuring the service meets the diverse needs of its population there were several comments about ensuring 'inclusivity', 'not alienating patients' and 'listening to marginalised people's views'. In addition, a strong message of person-centred care was expressed by one respondent about not adopting a 'one size fits all' approach and 'seeing the person not the illness'.

10.3 Patients who considered themselves to have a disability

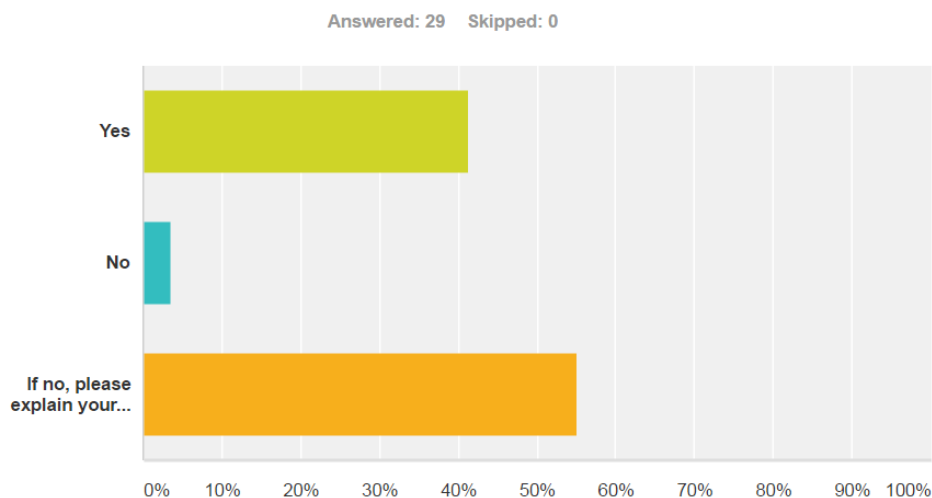
10.3.1 We received 28 (12.28%) responses from people who considered themselves to have a disability. In relation to potential site location:

- 53.57% (15 respondents) preferred Bootham Park
- 25% (7 respondents) preferred Haxby Road
- 21.43 % (6 respondents) preferred Clifton Park.



10.3.2 In relation to bed numbers

- 41.38 % of the respondents (12 people) agreed with the proposed number and configuration of beds and
- 58.26 % of the respondents (17 people) disagreed.



10.3.3 Respondents were concerned with the ‘so few’ bed numbers in light of a ‘population demanding more of mental health services’. Whereas some thought the ‘total numbers may be adequate if the room usage can be flexible’.

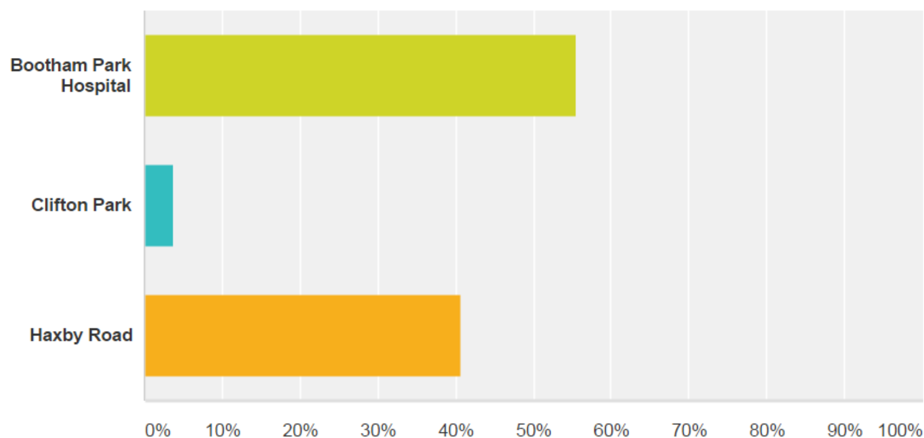
10.3.4 General comments about providing a service to meet the needs of our diverse population included concerns around meeting the needs of an elderly population, as well as ensuring a good transition between child and adult mental health services. In terms of design, it was highlighted that the ensuite rooms need to be accessible for users with disabilities.

10.4 Young adults (18-24)

10.4.1 As provision of services for ‘young adults’ has been a consistent theme throughout the consultation, we have analysed results for those who stated they are between 18-24 years of age.

10.4.2 In relation to potential site location,

- 55% (15 respondents) preferred Bootham Park,
- 41% (11 respondents) preferred Haxby, and
- 4% (1 respondent) preferred Clifton Park.



10.4.3 In relation to bed numbers, 60 % of the respondents (17 people) agreed with the proposed number and configuration of beds and 40% of the respondents (11 people) disagreed.

10.4.4 General comments revolved around ensuring the location is convenient and accessible, close to universities as 'students struggle with mental health a lot' and on good public transport routes. Other feedback was received about concerns that there appeared to be too few beds and it is always 'good to have spare'.

10.4.5 Respondents also commented on the provision of services for young adults; one respondent stating that 'being under 25 but over 18 is terrifying' and 'especially when you have been unwell for many years ' and may be 'functioning at a lower age than your chronological age'. Another young adult expressed the opinion that 'student mental health is a massive issue'.

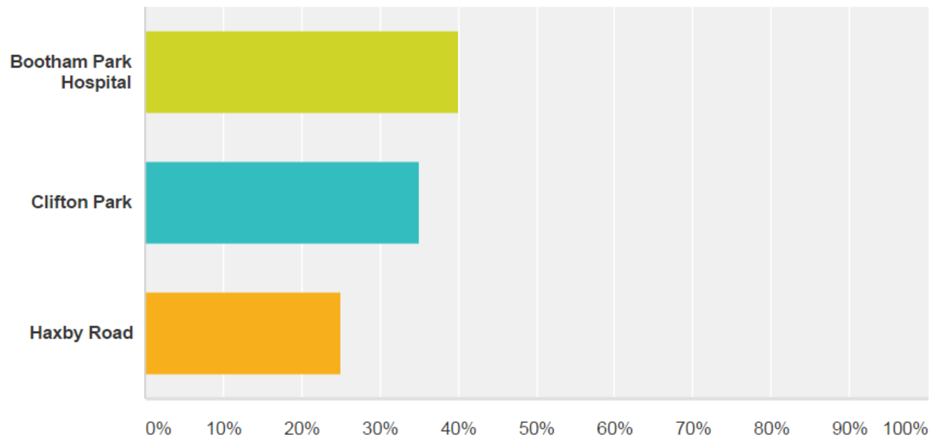
10.4.6 When asked about shaping the services around the diverse needs of the population, questions were raised around provision for non-binary gender identify and transgender patients.

10.5 Lesbian, Gay, Bisexual and Trans (LGBT)

10.5.1 We received 20 responses to the consultation from people within the LGBT community.

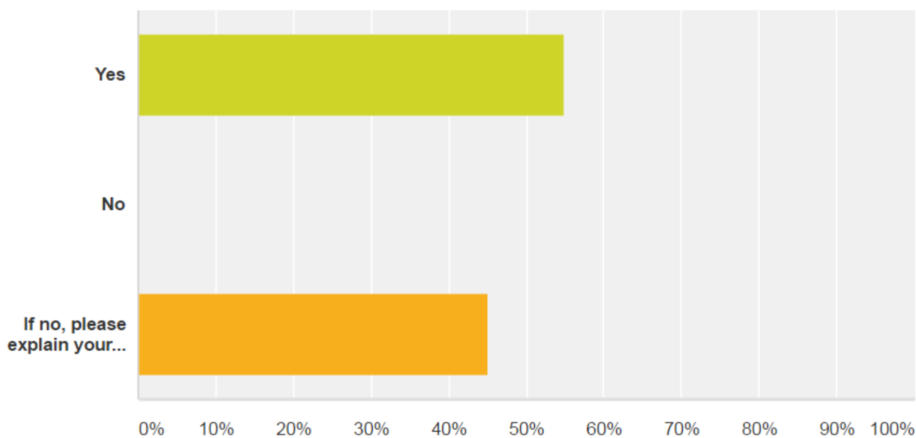
10.5.2 In relation to potential site location:

- 40% (8 respondents) preferred Bootham Park
- 35% (7 respondents) preferred Haxby Road
- 25 % (5 respondents) preferred Clifton Park.



10.5.3 In relation to bed numbers

- 55 % of the respondents (11 people) agreed with the proposed number and configuration of beds and
- 45% of the respondents (9 people) disagreed.

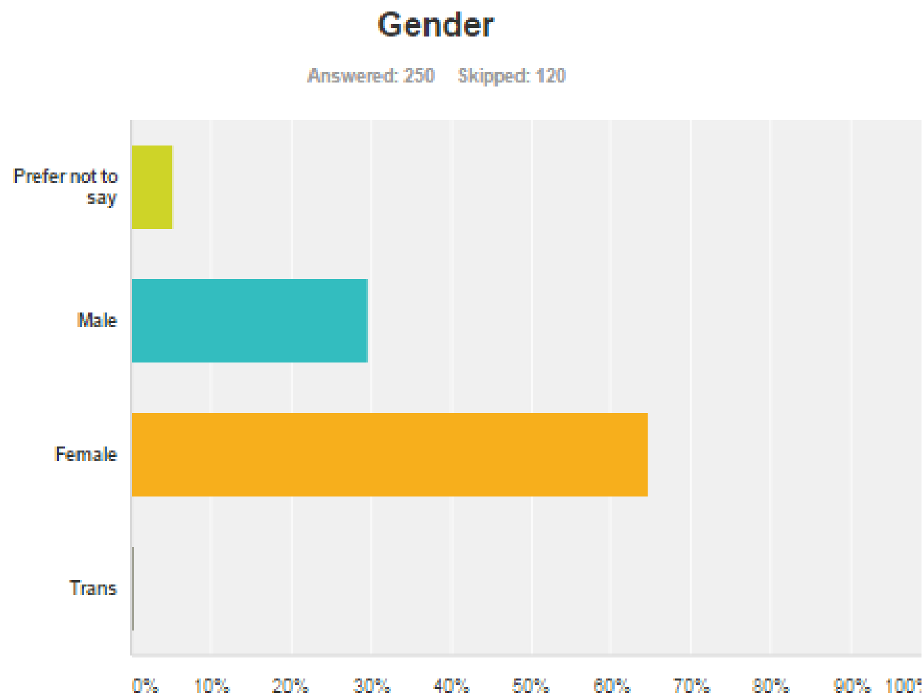


10.5.4 General feedback about the number and configuration of beds focused on concerns about current capacity, patients having to go out of area and whether future population growth has been taken into consideration. Respondents expressed the view that the site needs to have good public transport, be accessible for those with disabilities and have space for relatives to visit. Other comments focused on provision for the student population in terms of mental illness and psychological therapies, the absence of 'outreach work within the LGBT community' and concerns around providing a safe environment and how staff would deal with homophobia.

10.6 Gender

10.6.1 The split of the respondents was:

- 64.8% (162) female
- 29.6% (74) male
- 0.40% (1) trans
- 5.2% (13) prefer not to say



10.6.2 Female respondents commented on design features – around space for multi-faith quiet reflection room, facilities for young adults and considerations for all diverse needs. Preferred choice was Bootham Hospital with 51.3%, Haxby with 32.92% and Clifton Park with 14.91%. In relation to proposed bed numbers there was concern that there would be enough for the elderly population and 51.9% did not agree with the proposed number and configuration of beds.

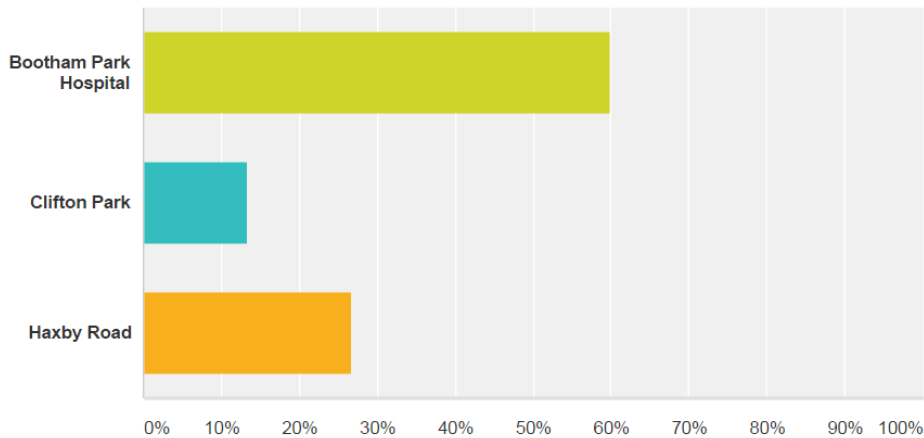
10.6.3 For male respondents – the preferred choice was Bootham Hospital with 51.3%, Haxby with 25.71% and Clifton Park with 22.86%. A total of 55.71% did not agree with the proposed number and configuration of beds. Themes were in line with those highlighted in other areas of the document.

10.6.4 We had one transgender respondent who indicated Bootham Park as the preferred location due to buildings already being in place, and its access and surroundings. They agreed with the proposed bed numbers. In addition a

number of comments were raised throughout the consultation about provision for transgender patients.

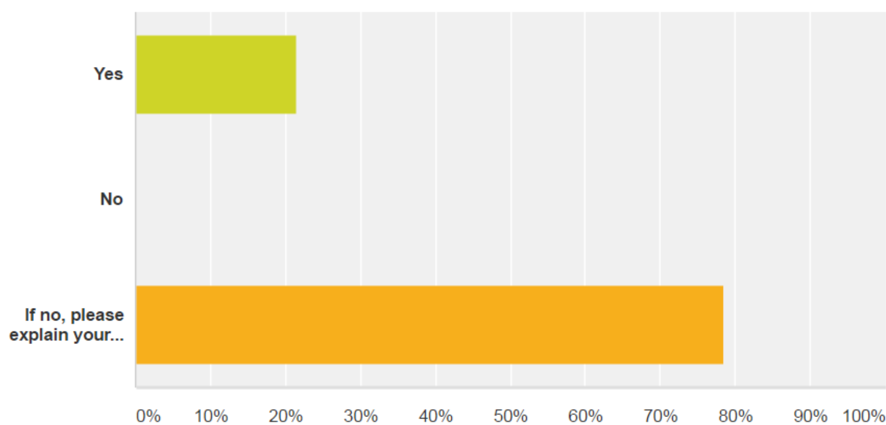
10.7 Patient carers

10.7.1 Within the online survey, there is some insight into the views and opinions of carers, through information captured via the equality monitoring section. A total of 15 respondents identified themselves as a patient carer.



10.7.2 Of these, 60% (nine respondents) indicated Bootham Park as their preferred choice, with 27% (four respondents) opting for Haxby Road 13% (two respondents) opting for Clifton Park.

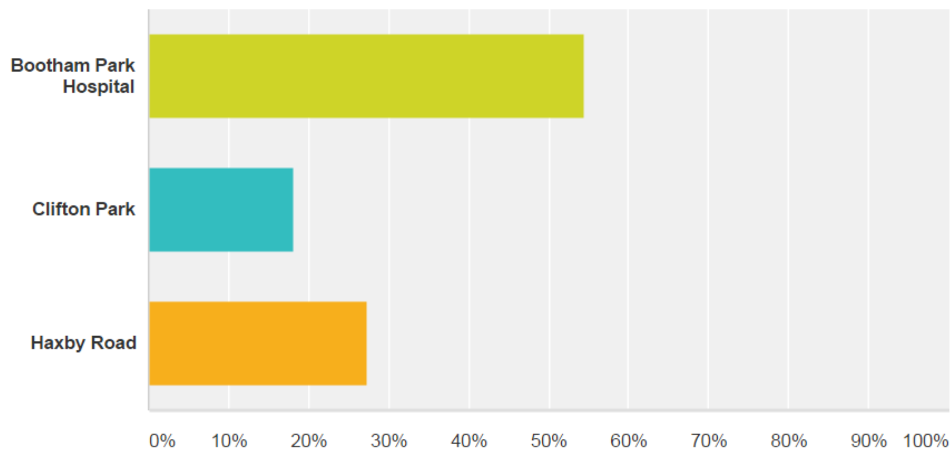
10.7.3 In answer to the question about the proposals for the configuration and numbers of beds, only three respondents (21%) stated they agreed with the proposals, while 11 respondents (79%) disagreed.



10.7.4 Several views were captured from the free text comments. One carer thought that 'care in the community is a good idea, but when it is not working hospitalisation is required'. Several of the responses alluded to the negative impact felt by patients having to go out of area for specialised services, one carer stating that it 'increases the pressure on the patient and their families and can only have the adverse effect on the recovery process.'

10.8 Over 65s

10.8.1 We received 22 responses from respondents who stated they were over 65 years of age. The preferred choice was Bootham Hospital with 54.55%, Haxby with 27.27% and Clifton Park with 18.18%.

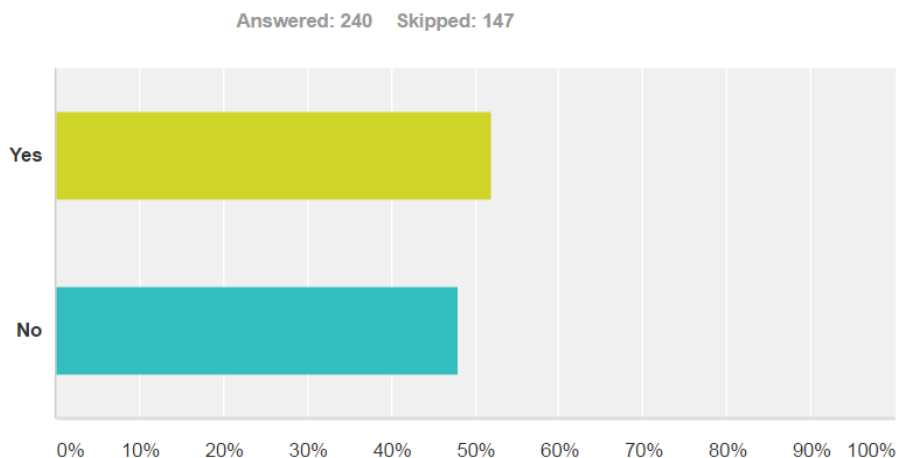


10.8.2 Concerns were raised about the underfunding of mental health services and the increasing population figures. One respondent highlighted the importance for older people to 'be able to access both mental and physical health care at the same time' and another suggested that there may be more older women than older men, so flexibility in male/female bed allocation should be built in.

10.9 Shaping services around the diverse needs of our population

10.9.1 Within the demographic and equality monitoring information section of the survey, we posed a key question to respondents about shaping our services around the diverse needs of our population. We wanted to capture information about any issues we need to consider in relation to this topic.

Question we asked: We want to shape the services around the diverse needs of our population. Are there any issues you think we need to consider in relation to diverse need?



- 240 out of 387people responded to this question and we received 144 free text comments.

- 52% of respondents (125 people) said there were issues that are needed to consider in relation to the diverse needs of the community and 48% of respondents (115 people) answered no.

10.9.2 Of the 144 comments a number of key themes emerged, in particular around the design of the new ward and provision of services for those with mental ill health.

10.9.3 Many of the themes captured were directly linked to understanding more about how TEWV will ensure the design meets the needs of a diverse and changing population. Within this section some very valuable and important qualitative data has been captured about the concerns of the local community including:

- provision of services for young people and students;
- ensuring services will meet the needs of an ageing population;
- clear access for patients with disabilities and visual impairments;
- provision of areas for quiet reflections and prayer, as well as ensuring it meets the needs for multi-faith purposes;
- facilities and support for those who are undergoing gender reassignment and provision for those with non-binary gender identity;
- equality and diversity awareness and training for staff.

11. Specialised services

11.1 During the consultation, the community raised a number of helpful issues that we could not include in the consultation report as they were about mental health services that are not commissioned by the CCG. These include:

- Specialised eating disorders – provided in York by the Retreat;
- High secure and medium secure mental health – provided at specialist units;
- Low secure mental health – provided in Leeds by Leeds and York NHS Partnership Foundation Trust;
- Specialised hearing impaired mental health – provided at specialist units;
- Gender identity – provided at specialist units;
- Perinatal mental health (mother and baby inpatient unit) – provided in Leeds by Leeds and York NHS Partnership Foundation Trust and Northumberland Tyne and Wear NHS Foundation Trust in Morpeth;
- Tier 4 child and adolescent mental health (CAMHS) – provided at Mill Lodge in York by Leeds and York NHS Partnership Foundation Trust;
- Tier 4 severe personality disorder (adults) – provided at specialist units;
- Mental health specialised forensic child and adolescent mental health service (CAMHS) secure – provided at specialist units.

11.2 We will ensure that any comments related to these are shared with our colleagues in NHS England, who are responsible for commissioning these services.

12. Next steps

12.1 Following the closure of the consultation on 16 January 2017, and consideration of the findings outlined in this report by the CCG's Governing Body on 2 February 2017, the following milestones will be progressed by TEWV unless stated otherwise:

Table 5: Outline timetable for next steps

Milestone	Date
Option appraisal	February 2017
Outline Business Case (OBC) completed	March 2017
OBC approved	April 2017
OBC to CCG, NHS Property Services, NHS England	May 2017
Full Business Case (FBC) completed	December 2017
FBC approved	January 2018
FBC CCG, NHS Property Services, NHS England	February 2018
New hospital completed by	December 2019

12.2 The cost and progression of new mental health services sits with TEWV in line with the current contractual arrangements. This means that the final decision on the configuration of beds and site from the current options will be made in January 2018 when the Full Business Case is considered by TEWV. Formal assurance of the on-going process from 2 February 2017 will be at the point of receiving the Outline and Full Business Case in May 2017 and February 2018 respectively.

12.3 **It is important to note that the timetable above and milestones within it are as currently planned.** However, these are subject to impact from external agencies. Issues that could have an effect may include: planning permissions, site option appraisals and further detail on financial feasibility and building timescales. The CCG will follow up the recommendations set out in this report through the Executive Committee and this will be monitored by the CCG's Director of Joint Commissioning.

13. Summary

13.1 The consultation provided the opportunity to collect views from local stakeholders through a broad range of engagement methods. The wide range of ways available for people to get involved and have their say provided opportunities to reach people across the whole Vale of York footprint. The consultation's Equality Impact Assessment helped to identify groups with protected characteristics and views from these groups were actively sought and included in the analysis.

13.2 Although there were variances in the raw data due to different methodologies, there were strong themes that came through the feedback. These gave a consensus view from those who engaged in the consultation. These themes can be broadly summarised as follows:

Table 6: Feedback themes

Feedback theme 1	Bed numbers may be appropriate but are dependent on robust, effective community services for all cohorts of the population being in place before further reduction in the bed base is made.
Feedback theme 2	Future needs and flexibility for the on-going development of services should be a key component of any design and clinical model.
Feedback theme 3	Respondents gave a preference for the location of the new hospital to be on the Bootham Park site.
Feedback theme 4	Respondents wanted to understand more about the criteria considered by TEWV in identifying the 3 sites, which were consulted on, and when/how a final decision would be made.
Feedback theme 5	People wanted to remain involved and engaged in the detailed design and plans. Having sight of initial project designs was helpful for people to understand the configuration of beds and how services would actually be delivered.
Feedback theme 6	A number of issues relating to broader mental health service provision and delivery were highlighted as part of the feedback, which need to be addressed by the relevant partners.

14. Recommendations

14.1 Analysis of qualitative and quantitative data collected from the consultation feedback has informed the following recommendations, and these respond directly to the key themes in section 13.

Table 7: Recommendations

Recommendation number	Response to feedback theme	Detailed action
1	**Response to feedback theme 1**	The CCG should seek further assurance from TEWV about 24/7 community services provision in the form of a detailed implementation plan to ensure that the proposed bed numbers (60) are sufficient for the population of Vale of York.
2	**Response to feedback theme 2**	The CCG should seek further assurance from TEWV on the robustness of the proposed bed numbers in light of the future trend for the demographic changes profiled for the population of the Vale of York.
3	**Response to feedback theme 2**	TEWV should ensure the organisation of in-patient mental health services reflect current best practice and are developed in a flexible way to meet future models of care. The CCG recognises the need to work with the wider system and partners to maximise effective use of resources.
4	**Response to feedback theme 3**	TEWV should progress the further detailed site / option appraisals guided by the preference stated by respondents. If there are constraints by any of the criteria within the detailed site / option appraisal, the remaining options should be progressed in line with preferences in the feedback.

14. Recommendations (continued)

Recommendation number	Response to feedback theme	Detailed action
5	**Response to feedback theme 4**	TEWV should maintain an open, honest and transparent approach with the public and its partners in the consideration of the detailed site / option appraisals and provide timely updates around any constraints or limitations. Information and regular updates should be available via TEWV's website and stakeholder communication channels, such as its newsletter.
6	**Response to feedback theme 4**	The CCG should remain involved in the on-going consideration of the detailed site / option appraisals within the context of its responsibilities as commissioner of mental health services for the population of the Vale of York. The CCG expects this to be evident through regular updates and discussions.
7	**Response to feedback theme 5**	To help ensure that stakeholders have an influence on the way services will be delivered, the CCG requires TEWV to continue to actively involve service users, their carers and partners in designs and plans.
8	**Response to feedback theme 6**	To address issues that were highlighted as areas of concern, but were not directly related to the number and configuration of beds or the location of a new mental health hospital, the CCG will share the consultation findings with partners across the system.

15. Appendices

Appendix i

Calculations used for the number of beds:

TEWV used PRAMH (person based resource allocation for mental health), which is used by NHS England, to help it work out how many beds it need. This approach looks at the population, taking into account a number of factors such as age, sex, prevalence of mental health conditions and their severity, accommodation and employment status, ethnicity and length of contact with mental health services. Alongside this TEWV compared it with other information such as the National Benchmarking Network Mental Health Toolkit as well as established bed numbers across TEWV's other localities (where current occupancy levels average 86%).

Table 8: Calculation of bed numbers

Summary

Bed numbers	Adult	Older people	Total
Maximum required (based on PRAMH)	37	26	63
Minimum required (based on PRAMH)	21	19	40
National benchmarking toolkit (mid point)	29	31	60
TEWV average	27	22	49
Proposed bed numbers	**30**	**30**	**60**

How does this compare with current bed numbers?

	Current	Proposed
Adult	24 beds (Peppermill Court)	30 beds
Older people		
- Functional	18 beds (Cherry Trees)	15 beds
- Organic (dementia)	28 beds (Meadowfields and Worsley Court)	15 beds

Appendix ii

Sections taken from the communications and engagement work plan

Table 9: Stakeholders and key communication/ engagement channels

	Purpose		Communication / Engagement channel				
Stakeholder Group	**Inform**	**Engage**	**Social media / online**	**Consultation document**	**questionnaire**	**Open or pre-arranged meetings**	**External communications (press release / websites)**
Service users and their families	√	√	√	√	√	√	√
Staff directly impacted by the proposals	√	√	√	√	√	√	√
TEWV staff	√	√	√	√	√	√	√
Staff at CCG	√	√	√	√	√	√	√
Healthwatch	√	√	√	√	√	√	√
Health Overview and Scrutiny Committees	√	√	√	√	√	√	√
Councillors	√	√	√	√	√	√	√
Service user and carer groups	√	√	√	√	√	√	√
Local voluntary and statutory organisations	√	√	√	√	√	√	√
GPs	√	√	√	√	√	√	√
MPs	√	√	√	√	√	√	√
TEWV governors and members	√	√	√	√	√	√	√

Table 10: Engagement work plan

Activity	Communication platform	Audience	Lead by	Outcomes / measures	Completed
Consultation document posted online on day one of consultation, including details of public meetings	N/A	All	JJ	Posted	23/09/16
Media release issued	Media Website	All	JJ	Distributed / posted	23/09/16
Social media posts to announce start of consultation and public meetings	Twitter and Facebook	All	JJ	Posted	23/09/16
Consultation document sent to stakeholders with covering letter including offer to meet / attend events / meetings and details of how to give feedback	Email and post	External stakeholders	JJ/KM	Distributed Electronic and hard copies of consultation document sent	23/09/16
Social media posts to advertise public meetings and to promote consultation throughout three month period	Twitter and Facebook	All	JJ/KM	Posted	Throughout Oct / Nov / Dec / Jan
Letter sent to governors and members with information about consultation and details of how to access more information	Email and letter	TEWV members and governors	JJ	Letters sent	w/c 23 Sept
Attend meetings / events as requested by stakeholders	Meeting	Stakeholders	JJ	Record of meetings and feedback	Throughout Oct / Nov / Dec / Jan
Hold workshop style public meetings – 11 meetings in York, Selby, Pocklington, Easingwold, Tadcaster and Pickering	Meeting Group work	All	JJ	Record of meetings and feedback Opportunity for people to learn more about the options and discuss at tables with access to clinical experts	Throughout Oct / Nov
Article in TEWV e-bulletin for staff with links to more information about consultation and how to give feedback	E-bulletin	TEWV staff	JJ	E-bulletin article	Oct 16
Item in TEWV core team brief	Team brief	TEWV staff	JJ	Core brief item	Oct 16
Item in CCG Staff Update for staff with links to more information about consultation	Staff Update	CCG staff	KM	Staff Update	Throughout Oct / Nov / Dec / Jan

Activity	Communication platform	Audience	Lead by	Outcomes / measures	Completed
and how to give feedback					
Item in Practice Communication (weekly GP newsletter)	Practice Communication	GPs, Practice Nurses, Practice Staff, CCG Staff	KM	Practice Communication	Throughout Oct / Nov / Dec / Jan
Leaflet distribution in Pocklington (hard to reach audience)	Leaflet	Pocklington community	HS	Leaflet distribution	23/11/16
Article on Age UK website	Age UK website	Age UK stakeholders	KM	Posted on homepage	22/11/16
Digital advertising	The Press	All	SH	Posted on the York Press website	23/12/16 – 16/01/17
Print media advertising	The Press	All	SH	Front page and third page 92,000 readers	16/12/16 – 16/01/17
Item in CCG Stakeholder Newsletter	Stakeholder Newsletter	CCG stakeholders	KM	Stakeholder Newsletter	23/12/16
Radio interview with Minster FM	Radio	All	KM	News item to 158,000 listeners	29/12/16
Raising awareness / call to action with staff at CYC, NYCC, ERYC and YTHFT	Email	CYC, NYCC, ERYC, YTHFT staff	KM	Email sent	01/12/16
Information shared with and meeting opportunities offered to MPs	Email	MPs	HF-D	Email sent	15/11/16
Information shared with and meeting opportunities offered to LGBT stakeholders	Email	LGBT community	KM	Email sent	01/12/16 and 04/12/16
Information shared with and meeting opportunities offered to local universities and colleges	Email	Higher York	KM	Email sent	01/12/16 and 04/12/16
Information shared with and meeting opportunities offered to Selby AVS	Email	Selby AVS	KM	Email sent	01/12/16 and 04/12/16
Follow up email to MPs	Email	MPs	HF-D	Email sent	29/12/16
Information shared with and meeting opportunities offered to PPGs	Email	PPGs	SV	Email sent	07/12/16
Meetings with PPGs	Meeting	PPGs	SV/EW	Record of meetings and feedback	Jan 17

Activity	Communication platform	Audience	Lead by	Outcomes / measures	Completed
Information stand in West Offices foyer	Information stand	West Offices visitors / staff	HF-D	Surveys collated	Nov 16 – Jan 17
Manning of information stand to collate views / encourage survey completion	Face-to-face	West Offices visitors / staff	SV	Views / surveys collated	14/12/16 – 15/12/16
Item in York CVS Newsletter (1500 subscribers)	York CVS Newsletter	York CVS stakeholders	KM	York CVS Newsletter	24/11/16
Email to all York CVS subscribers (1000 subscribers)	Email	York CVS stakeholders	KM	Email sent	24/11/16
CYC OSCs	Committee meeting		EW	OCS attended	
Two consultation events held with CCG and CYC staff	Meeting Group work	CCG and CYC staff	EW/MD	Record of meetings and feedback	04/01/17
Media release issued announcing consultation extension and extra events	Media Website	All	KM	Distributed	15/11/16
Social media posts promoting deadline extension and extra events	Twitter and	All	KM/JJ	Social media posts	15/11/16 – 30/11/16
Media release issued – final reminder	Media Website	All	KM	Distributed	10/11/16
Social media posts promoting final reminder	Twitter	All	KM/JJ	Social media posts	10/11/17 – 16/11/17
Targeted twitter activity – students, LGBT community, people with disabilities	Twitter	Students, LGBT community, people with disabilities	KM	Social media posts	Jan 17
Governing Body meeting – to present engagement report	Governing Body meeting	All	EW		02/02/17

Appendix iii

A list of all venues and dates for the formal consultation sessions can be found below. The sections highlighted in pale blue provide details of the sessions held by TEWV as part of their own feedback exercise. The CCG was not present at these meetings and these are not considered in the 31 stakeholder and public meetings.

Table 11: List of venues and dates of face-to-face events and meetings

Date	Time	Organisation	Event/meeting	Venue
4/10/2016	10am	East Riding of Yorkshire Council	Health Care and Wellbeing overview and scrutiny committee	County Hall, Beverley, HU17 9BA
07/10/2016	3-5pm	Pre-Consultation meeting	Pocklington venue	Burnby Hall, Pocklington
11/10/2016	3-5pm	Pre-Consultation meeting	Selby venue	Community House, Selby
18/10/2016	5:30-7pm	City of York Council (CYC)	York Health Scrutiny Committee	West Offices, York
24/10/2016	3-5pm, 5:30-7:30pm	Consultation meeting x 2 sessions	New Earswick Consultation	Folk Hall, New Earswick
25/10/2016	2pm-5pm	York Health Watch Assembly	York Health Watch Assembly	Priory Street
27/10/2016	9am	TEWV	Appraisal training event for TEWV staff	Sports Club, Shipton Road. Clifton.
31/10/2016	3-5pm	Consultation meeting	Easingwold Consultation	Galtres Centre, Easingwold
08/11/2016	2:30-4:30pm and 5-7pm	Consultation meeting x 2 sessions	York Consultation	Priory Centre, York
09/11/2016	7-9pm	Huntington and New Earswick Councillors	Huntington and New Earswick Ward Meeting	Orchard Park Community Centre, Huntington
09/11/2016	7-9 pm	York Mental Health Carers Group	Carers Group meeting	Sycamore House Reading Café, 30 Clarence Street.
10/11/2016	10:00am-3:00pm	TEWV	TEWV public recruitment event	Royal York Hotel, York
18/11/2016	10:30/45am	North Yorkshire County Council (NYCC)	Scrutiny of Health Committee (NYCC OSC)	County Hall, Northallerton
18/11/2016	3-5pm	Consultation meeting	Tadcaster Consultation	Tadcaster Boys Sunday School
21/11/2016	4-6 pm	Consultation meeting	Selby Consultation	Community House, Selby
23/11/2016	1-2:30PM	York University Student Union	York University Student Consultation	York University, James College room J/Q/005
23/11/2016	7:30-9pm	Mental Health Action York	Mental Health Action York	Briar House, Museum Street, York

Date	Time	Organisation	Event/meeting	Venue
23/11/2016	4:30pm	CYC	York Health & Wellbeing Board	West Offices, York
25/11/2016	3-5pm	Consultation meeting	Pickering Consultation	Memorial Hall, Pickering
25/11/2016	10:30-12.30	NYCC	North Yorkshire Health & Wellbeing Board	Evolution Business Centre, Northallerton
29/11/2016	3.00 pm	Age UK	Age UK meeting	Early Music Centre, Walmgate in York
30/11/2016	3-5 pm	Consultation meeting	Pocklington Consultation	The Old Court House, Pocklington
05/12/2016	3pm-4:30pm	York St John student/staff consultation	York St John University	York St John University, Room HG013 (Holgate Building)
12/12/2016	2pm-4pm	York Older People's Assembly	York Older People's Assembly	The Garth, White Rose Avenue, New Earswick
14/12/2016	12pm-4pm	Open session in York City Council Foyer	General public consultation	West Offices, York
15/12/2016	9am-1pm	Open session in York City Council Foyer	General public consultation	West Offices, York
15/12/2016	1pm-3:30pm	Consultation Meeting	York CVS Consultation	Priory Street
19/12/2016	1pm-	Inpatient consultation event		Cherry Tree House, York
04/01/2017	11:30-1:30pm	Staff consultation	NHS Vale of York CCG staff	West Offices, York
04/01/2017	1:30-3:30pm	Consultation meeting	City of York Council and Patient participant groups	West Offices, York
10/01/2017	2pm-	Inpatient consultation event	General public consultation	Meadowfield, York
11/01/2017	3:30pm-5pm	Patient participant group consultation	Patient participant group consultation	Scott Road Surgery, Selby
13/01/2017	1pm	Inpatient consultation event	Inpatient consultation event	Peppermill Court, York
16/01/2017	6.30pm-8.00pm	Patient Participant Group general meeting	Slot assigned during meeting to CCG, consultation raised.	Elvington Surgery, Elvington.

Appendix iv

EQUALITY IMPACT ANALYSIS FORM

Table 12: Equality impact analysis form

1.	**Title of policy/ programme/ service being analysed**
	Developing a new mental health hospital for the Vale of York – consultation on proposed bed numbers and alternative sites.
2.	**Please state the aims and objectives of this work.**
	To obtain feedback from the public (including service users and carers) on the alternative proposals for the siting of a new mental health hospital and proposed bed numbers.This is a living document that will be regularly reviewed and updated throughout this piece of work.
3.	**Who is likely to be affected? (e.g. staff, patients, service users)**
	• Patients/ service users • Staff • Carers • Service providers • Other public sector and voluntary sector organisations (e.g. police for Section136 place of safety) 1 in 4 British adults experience at least one diagnosable mental health problem in any one year and 1 in 6 experiences this at any given time (The Office for National Statistics Psychiatric Morbidity report, 2001). Although mental disorders are widespread, serious cases are concentrated among a relatively small proportion of people who experience more than one mental health problem (The British Journal of Psychiatry, 2005). More than 5700 people in the UK died by suicide in 2010 (The British Journal of Psychiatry, 2005). The suicide rate among people over 65 has fallen by 24% in recent years, but is still high compared to the population overall (Samaritans Information Resource Pack, 2012). The UK has one of the highest rates of self-harm in Europe, at 400 per 100,000 population (Samaritans Information Resource Pack, 2004). People with current mental health problems are 20 times more likely than others to report having harmed themselves in the past. (National Collaborating Centre For Mental Health).

4.	**What sources of equality information have you used to inform your piece of work?**
	• 2011 Census data • National research and evidence referenced in EIA
5.	**What steps have been taken ensure that the organisation has paid <u>due regard</u> to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics**
	Vale of York CCG serves a population of more than 351,000 people living in York, Selby, Tadcaster, Easingwold and Pocklington and the surrounding towns, villages and rural areas, with City of York making up about 60% of the population. It is mainly rural with a number of small market towns and the main urban centre of York and it covers three local authority boundaries - North Yorkshire County Council, City of York Council and East Riding of Yorkshire Council. The Vale of York is a comparatively affluent area but with pockets of significant deprivation in the York, Selby and Sherburn-in-Elmet areas. The local health profile shows: • Life expectancy to be slightly higher than the national average. • A higher proportion of the population is over 50 than the national average. • There is a higher proportion of 20-24 year olds due to the transient population of two universities based in York. • In 2011 around 16% of people reported that their day to day activities are limited or a lot by their health • The percentage of people over 65 is expected to grow by 10%. • The percentage of people over 85 is forecast to increase by 18% The 2011 census states that for city of York: • 94% of the population in York identified itself as “white” compared to 86% residents in England and Wale and 89% in Yorkshire and Humber • The largest non-White group in York was Chinese at 1.2% of the population • In York 59.5% of residents recorded their religion as Christian, which was similar to the national picture • 90.8% of York's population was born within the UK with 2.7% born in other EU countries and 5.5% born outside the EU During 2014, the CCG consulted extensively with mental health service user and carer groups and the whole population as part of the DISCOVER engagement process, using the appreciative inquiry model, which involved over 90 groups and a wide range of the population. The current consultation process will be built on earlier discussions around the provision of mental health services for the locality.

	Tees Esk and Wear Valley NHS trust (TEWV)took over the responsibility of providing services in October 2015 and have held four engagement events in March and April 2016 to give people an opportunity to share across their views and be involved in the development of mental health and learning disability services across the Vale of York. There is no equality monitoring data available from the initial engagement events, but a wide range of organisations and patients, carers and the public were invited and the workshops took place across Selby, Easingwold and York to ensure a geographical spread. We have put in place processes to capture equalities monitoring information (on a voluntary basis) at future events. The CCG is currently about to start further engagement with local people, patients and carers to ascertain their views on the proposals and the three option sites as part of the pre consultation process. This engagement activity will include equality monitoring in order to demonstrate that the CCG has engaged with a representative sample of local people, patients and carers.
6.	**Who have you involved in the development of this piece of work?**
	It is important to listen to what the Vale of York population has told us, and continue to tell us. This consultation builds on the conversations that the CCG has held over the last couple of years; such as the 'Discover' engagement events in 2014; the procurement, which led to TEWV being awarded the contract for services in 2015, and the International Mental Health Collaborative Network symposium in March 2016. In April 2016 TEWV led, with input from the CCG a number of pre-consultation public engagement events to give local people an early opportunity to be involved in the development of the new hospital. These sessions took place in Selby, Easingwold and York and were supported by Healthwatch in York and North Yorkshire. Over sixty people attended the events, including service users and carers as well as representatives from City of York Council, Selby District Council, Rethink and other members of the public.
7.	**What evidence do you have of any potential adverse or positive impact on groups with protected characteristics?** **Do you have any gaps in information?** **Include any supporting evidence e.g. research, data or feedback from engagement activities**

Disability People who are learning disabled, physically disabled, people with mental illness,	Consider building access, communication requirements, making reasonable adjustments for individuals etc.

sensory loss and long term chronic conditions such as diabetes, HIV)	

People with disabilities use health and care services more often than people who do not have a disability, however, evidence suggests that they routinely struggle to access appropriate care and support; because of this many disabled people experience less favourable health outcomes.[3]

An estimated 25-40% of people with learning disabilities also have mental health problems.[4] People with learning disabilities are more vulnerable to more of the risk factors associated with mental ill health, such as adverse life events and lack of social support, and are much less likely than the general population to be able easily to access psychiatric services.[5]

Sex Men and Women	Consider gender preference in key worker, single sex accommodation etc.

Women are more likely to have been treated for a mental health problem than men (29% compared to 17%). (Better Or Worse: A Longitudinal Study Of The Mental Health Of Adults In Great Britain, National Statistics, 2003).

Depression is more common in women than men. 1 in 4 women will require treatment for depression at some time, compared to 1 in 10 men. The reasons for this are unclear, but are thought to be due to both social and biological factors and depression in men may have been under diagnosed.[6]

Nine out of ten of the 1.15 million people in the UK who have an eating disorder are female. (Eating Disorders Association (2004).

Women are also more vulnerable than men to risk factors linked with poor mental health including; poverty; social isolation, child sexual abuse, domestic violence and sexual violence and rape. In addition, women's greater life expectancy also means they are:

- more likely to experience bereavement in old age;
- more likely to experience institutional care;

[3] Sir Michael, J. (2008) Healthcare for All: Report of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_106126.pdf.

[4] Department of Health (1993). Services for people with learning disabilities, challenging behaviour or mental health needs. Project group report. London: Department of Health.

[5] Bouras N, Holt G, Gravestock S (1995). Community care for people with learning disabilities: deficits and future plans. Psychiatric Bulletin 19: 134−137.

[6] National Institute For Clinical Excellence, 2003

- more likely than men to suffer from physical ill health and long-term disability.

5.4% of men have a personality disorder diagnosis and men are three times more likely than women to be alcohol dependent and twice as likely as women to use class A drugs. (12 Wilkins D (2010). Untold problems: a review of the essential issues in the mental health of men and boys. London: Men's Health Forum).

72% of male prisoners have two or more mental health problems and more than twice as many male psychiatric inpatients are compulsorily detained (Wilkins D (2010). Untold problems: a review of the essential issues in the mental health of men and boys. London: Men's Health Forum).

Suicide remains the most common cause of death in men under the age of 35 (Five Years On, Department Of Health, 2005), with three quarters of suicides being male (Wilkins D 2010). British men are three times as likely as British women to die by suicide (Samaritans Information Resource Pack, 2004).

Race or nationality People of different ethnic backgrounds, including Roma Gypsies and Travellers	Consider cultural traditions, food requirements, communication styles, language needs etc.

For members of many minority ethnic communities, the stigma attached to any suggestion of mental illness influences their decision when deciding whether to acknowledge the problem and seek treatment, or to conceal it.

BME patients are over-represented in acute care but under-represented at the counselling or psychiatric therapy stage. In other words, their treatment tends to be via by medication rather than by "talking therapy". In addition, they may often be misdiagnosed at this stage and are not informed of the diagnosis that is applied to them.

The most recent systematic review of prevalence of mental health disorders in adult minority ethnic populations shows that Black or Black British people are more likely than white people to have used services and more than twice as likely to have spent time in hospital as White people. People from other ethnic groups are much more likely to have used services but no more likely to have been hospital.[7]

Immigrants to the UK are typically at two to eight times' greater risk of psychoses than native- born groups. This higher risk extends into the second generations. Factors that explain raised rates in immigrants and their descendants include: stressful life events, discrimination, urban living and socio-economic deprivation.[8]

[7] Prevalence of mental health disorders in adult minority ethnic populations in England: a systematic review. Rees R, Stokes G, Stansfield C, Oliver E, Kneale D, Thomas J (2016)

[8] Foresight Mental Capital and Wellbeing Project (2008). Final project report. London: The Government Office for Science

Women refugees and asylum seekers have higher rates of post-traumatic stress disorder and other mental illness.[9]

Age This applies to all age groups. This can include safeguarding, consent and child welfare	Consider access to services or employment based on need/merit not age, effective communication strategies etc.

The consultation process relates to adult mental health services. The Health and Social Care Information Centre's Mental Health Bulletin, Annual Report for 2014-15, states the following.

Dementia affects 5% of people over the age of 65 and 20% of those over 80. (National Institute For Clinical Excellence, 2004). About 700,000 people in the UK have dementia (1.2% of the population) at any one time. (National Institute For Clinical Excellence, 2004)

Incidence of mental health problems is higher in older people in the UK: For every 10,000 people aged 65 or over, there are:

- 2500 people with a diagnosable mental illness
- 1350 people with depression (1135 receiving no treatment)
- 500 people with dementia (333 not diagnosed)
- 650 people with other mental illness

Over a quarter of admissions to mental health inpatient services are people over the age of 65. Approximately 700,000 people in the UK have dementia, and this is predicted to rise to over one million people by 2025. There is evidence of ageism in relation to:

- exclusion of older people from mental health services that are available to adults
- very low levels of referrals from GPs to specialist units for older mental health sufferers, and
- a general lack of age appropriate service provision. Older people do not have the same access as working age adults to assertive outreach, crisis home treatment and early intervention services, or to rehabilitation, psychotherapy and general hospital liaison services.

Due to the large numbers of students this will be picked as a separate group in other disadvantaged groups.

[9] Department of Health (2002). Women's mental health: into the mainstream. London: Department of Health

Trans People who have undergone gender reassignment (sex change) and those who identify as trans	Consider privacy of data, harassment, access to unisex toilets & bathing areas etc.

There is limited published research into trans health issues outside of gender reassignment pathways of care. There is also limited research into the long term impact of hormonal treatment, although there is evidence of increased incidence of metabolic syndrome in male to female trans individuals using hormones.

The largest survey of trans people in England found that 20% of trans people identify as heterosexual, 58% have a disability or chronic health condition including 8.5% who were deaf and 5% who were visually impaired, 18% were carers with 7% giving significant levels of care.

41% of trans people reported attempting suicide compared to 1.6% of the general population. Care pathways for trans people are not meeting the international standards as set out by the World Professional Association for Transgender Health (WPATH). Care pathways remain inconsistent due to uneven commissioner and GP awareness of trans people's needs; 25% of trans people have been refused health treatment because a practitioner did not approve of gender reassignment (JSNA, LGBT Foundation 2012).

Sexual orientation This will include lesbian, gay and bi-sexual people as well as heterosexual people.	Consider whether the service acknowledges same sex partners as next of kin, harassment, inclusive language etc.

Gay men and lesbians report more psychological distress than heterosexuals, despite similar levels of social support and physical health as heterosexual men and women.[10] They are also more likely than other patients to report a negative experience of using health services, and less likely to report that they have been treated with dignity and respect. Anxieties, depression, self-harm and suicidal feelings are more common among lesbian, gay and bisexual people than among heterosexual people. Rates of drug and alcohol misuse are also higher among lesbian, gay and bisexual people. In all studies, bisexual men and women are

[10] King M, McKeown E (2003). Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales. London: Mind

usually found to have the highest levels of mental distress, including suicidal feelings.[11]

The JSNA, LGBT Foundation 2012 (http://lgbt.foundation/policy-research/JSNA) found:

- Significantly higher rates of attempted suicide, self-harm and mental ill health across all minority groups compared to the general LGB&T population.
- Domestic violence rates higher among minority LGB&T groups than in the general LGB&T population.
- Variation between different ethnic groups of LGB people in their health risks and health behaviours.
- New migrant gay men are at particularly high risk of mental ill health and sexually transmitted diseases, including HIV.
- Surveys suggest a slightly higher proportion of the LGB&T population are living with a disability than the general population.
- Fewer LGB disabled people are accessing the health, mental health and social care services they feel they need than heterosexual disabled people.
- Fewer LGB disabled people are out to their GP or healthcare professionals than non-disabled LGB people.
- There is limited research into bisexuality. However, there is evidence for bisexual men and women of increased risk of eating disorders, mental ill health and increased alcohol consumption compared to lesbians and their heterosexual peers.
- The lack of inclusion of sexual orientation and gender identity in routine data collection means that few studies have a large enough group of participants to be able to analyse differences between sub-groups within the LGB&T population. This therefore limits the ability to understand and compare the impact of multiple identities on health outcomes.

Religion or belief Includes religions, beliefs or no religion or belief	Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc.

Health inequalities for people of different religions or beliefs are not well understood, but some minority ethnic groups consistently report lower satisfaction with health and social care services than the rest of the population[12].

[11] King M, McKeown E, Warner J et al (2003). Mental health and quality of life of gay men and lesbians in England and Wales. British Journal of Psychiatry 183: 552-558

[12] Care Quality Commission (2013) *A New Start: Consultation on changes to the way CQC regulates, inspects and monitors care services – Equality and human rights duties impact analysis.* www.cqc.org.uk/sites/default/ les/documents/20130616_eia_a_new_start_consultation_ nal.pdf

Previous research has shown that certain groups face considerable access issues, which can lead to poorer health outcomes. For instance, older Muslim and Sikh women, particularly those with a lower level of English language skills, appear to suffer heavy burdens of ill health, disability and also caring responsibilities. These women are also often in a weak position to negotiate religiously appropriate support from statutory services [13].

Marriage and Civil Partnership Refers to legally recognised partnerships (employment policies only)	Consider whether civil partners are included in benefit and leave policies etc.

This is relevant for employment and any issues should be picked up through staff engagement and consultation and it is therefore important that any staff engagement activity captures equality monitoring data.

Pregnancy and maternity Refers to the pregnancy period and the first year after birth	Consider impact on working arrangements, part-time working, infant caring responsibilities etc.

At least one new mother in ten will experience post-natal depression. (15 Mind (2006). Examples of these illnesses include antenatal and postnatal depression, obsessive compulsive disorder, post-traumatic stress disorder (PTSD) and postpartum psychosis.
However, any inpatient mental health services should follow the 'Guidance for commissioners of perinatal mental health services'.

Carers This relates to general caring responsibilities for someone of any age.	Consider impact on part-time working, shift-patterns, options for flexi working etc.

NHS England Carer facts (https://www.england.nhs.uk/commissioning/comm-carers/carer-facts/) found:

- There are around 5.4 million people in England who provide unpaid care for a friend or family member (2011 Census Analysis: Unpaid Care in England and

[13] Allmark, P., Salway, S. and Piercy, H. (eds.) (2010) *Life and Health: An evidence review and synthesis for the Equality and Human Rights Commission's Triennial Review 2010.* Centre for Health and Social Care Research, Sheffield Hallam University. www.equalityhumanrights.com/uploaded_ les/triennial_review/triennial_review_life_health_omnibus.pdf

Wales, 2011 and comparison with 2001).

- Between 2001 and 2011, the number of unpaid carers grew by 600,000 with the largest increase being in those who provide fifty or more hours of care per week.
- Unpaid care increased at a faster pace than population growth between 2001 and 2011 and an ageing population with improved life expectancy for people with long term conditions or complex disabilities means more high level care provided for longer.
- Increasing hours of care often results in the general health of carers deteriorating incrementally. Unpaid carers who provide high levels of care for sick, or disabled relatives and friends, are more than twice as likely to suffer from poor health compared to people without caring responsibilities. (In Poor Health: the impact of caring on health)
- Caring responsibilities can have an adverse impact on the physical and mental health, education and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes. These in turn can affect a carer's effectiveness and lead to the admission of the cared for person to hospital or residential care (Assessment, eligibility and portability for care users and carers)
- 84 percent of carers surveyed for the 2013 State of Caring Survey said that caring has had a negative impact on their health, up from 74 percent in 2011-12 (The State of Caring 2013)
- Carers attribute their health risk to a lack of support, with 64 percent citing a lack of practical support (In Sickness and In Health)
- There is an increasing prevalence of 'sandwich carers' (2.4 million in the UK) – those looking after young children at the same time as caring for older parents. It can also be used much more broadly to describe a variety of multiple caring responsibilities for people in different generations (Sandwich generation concern is growing)

This increased risk for people with disabilities and older people to need to use the service means that it will be very important to engage with carers, who themselves may also be at increased risk of mental health problems.

Other disadvantaged groups This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, and people with HIV.	Consider ease of access, location of service, historic take-up of service etc.

Students

Mind found that:

- 2 out of 3 students feel down at some point during their studies
- Over 50% of students don't feel comfortable admitting they're not coping to someone else
- 1 in 8 students experience suicidal feelings at university
- 20% of higher education students consider themselves to have a mental health problem
- The number of students who took their own lives increased by 50% between 2007 and 2011 (http://mind.org.uk/get-involved/students/)

Prison Population

More than 70% of the prison population has two or more mental health disorders. (Social Exclusion Unit, 2004, quoting Psychiatric Morbidity Among Prisoners In England And Wales, 1998)

Male prisoners are 14 times more likely to have two or more disorders than men in general, and female prisoners are 35 times more likely than women in general. (Social Exclusion Unit, 2004, quoting Psychiatric Morbidity Among Prisoners In England And Wales, 1998)

The suicide rate in prisons is almost 15 times higher than in the general population: in 2002 the rate was 143 per 100,000 compared to 9 per 100,000 in the general population. (The National Service Framework For Mental Health: Five Years On, Department of Health, 2004; Samaritans Information Resource Pack, 2004)

8.	**Action planning for improvement** Please outline what mitigating actions have been considered to eliminate any adverse impact? • See below
9.	Please state if there are any opportunities to advance equality of opportunity and/ foster good relationships between different groups of people? • An Equality Action Plan template is appended below to assist in meeting the requirements of the general duty

Table 13: Equality Action Plan

Category	Action	Target Date	Person responsible and their team
Engagement with people with protected characteristics or disadvantaged groups (Involvement and consultation)	Equalities monitoring form to be handed out at meetings, attached to consultation documents. Re: Disabilities The consultation process needs to make efforts to engage with people with a range of disabilities including physical disabilities, sensory disabilities and people with learning difficulties. The Engagement and Communication plan needs to give consideration to the Accessible Information Standard and ensure that communication and engagement formats are appropriate for the communication needs of people with disabilities, including plain English, BSL signers, large print, braille etc. Re: Gender It is important that the consultation is able to disaggregate the views and opinions of men and women as they tend to use health services differently and evidence suggests different patterns in mental health. Re: Ethnicity Although the BME population in VoY is relatively small efforts need to be made to engage with this community as the small numbers can exacerbate feelings of isolation and lack of awareness and evidence suggests some BME groups are over represented in inpatient services. Consideration should be given to	Throughout the consultation period	Joint CCG/ TEWV SIROs

	interpretation and translation needs. Re: Age The Vale of York area has a higher than average older population and therefore there is likely to be increasing demand on the service by this age group. The consultation process should ensure that it engages with older people and their carers. Re: Trans Although there remains a lack of robust data on the health and health needs of trans people and there are issues around confidentiality and monitoring, the consultation process needs to ensure that any engagement activity is inclusive and open to this group. Re: Sexual Orientation The evidence suggests an increased risk of mental ill health and well-being for LGB people who are also disabled and efforts should be made to engage with this group. Re: Religion/ Faith Due to a lack of data and monitoring, the consultation process should be proactive in engaging with different religious groups and ensure that engagement activity captures equality monitoring data.		
Data collection and evidencing **(What gaps in data have you got)**	Equalities monitoring data to be collected	End of consultation period	

Analysis of evidence and assessment	Update, post consultation closure on 25.1.17 250 out of 387 responses filled out at least one of the Equality monitoring questions – representing 64.6% of the respondents. During the process we stated that options were available in different formats upon request. We also offered to visit groups to talk about the proposals face-to face in more detail. We proactively communicated information about the consultation to community groups that had networks and links with protected characteristics, and extended the offer to meet face-to-face to discuss further. Through the EIA we identified additional key groups it was important to engage with, notably carers and students. We held workshop-style events with those that took up the invitation including: Age UK, York Carers Group, both of York's Universities, York CVS, York Older People's Assembly, GP Patient Participation groups. We received 12.28% of responses from patients who considered themselves to have a disability, and 16.53% (39) of respondents identified themselves as having a mental health condition. We are able to disaggregate the views of women, male and transgender for the 250/387 responses and these were published in the final consultation report. The split of the respondents was: • 64.8% (162) female		

	• 29.6% (74) male • 0.40% (1) trans • 5.2% (13) prefer not to say Age: As part of the formal consultation workshops we met with Age UK, York Mental Health Carers. We also contacted the York Older People's Assembly for a formal response to the consultation. We proactively contacted the York Lesbian, Gay, Bi-sexual and Trans (LGBT) forums to ask for information to be cascaded through their networks. The LGBT forums decline the invite to have a member of our consultation team present at an event but contacted us to say they were 'glad to be asked for LGBT input – much appreciated.' Contacts representing this group replied to say they would push the survey with its members. We received one response from a transgender respondent – however many respondents in the free text section of the transgender community commented about transgender. As part of the planning phase we wanted to ensure that the consultation reached across the geographical spread of the Vale of York CCG. We held public forums in New Earswick, Easingwold, Tadcaster, Selby, Pickering, Pocklington and York. Information regarding the consultation was shared with local newspapers and media outlets covering the whole 351,000 CCG population. The report outlines the communications activity. To encourage views from localities		

	we emailed key local community and social groups with a copy of the consultation letter and link to the online survey, and asked for it to be circulated to members.		
Monitoring, evaluating and reviewing	We have continued to monitor our communications and engagement with specific groups. In particular we have ensured that information has been sent out by email to groups and networks that have links with each protected characteristic. We have monitored where we have received responses.		
Transparency (including publication and dissemination to stakeholders)	The equalities and monitoring information has been published as part of the final report to the governing body on 26 January 2017 and can provide more in-depth information.		

Table 14: EIA sign off

Sign off
Pia Bruhn Equality and Diversity Manager
September 2016
Elaine Wyllie, Director of Joint Commissioning
Date analysis was approved by responsible Director

Appendix v

As part of the survey we asked a series of questions to find out more about the demographic of the respondents. It was not mandatory that respondents completed the equality monitoring information. We asked a series of questions and the outcomes are listed below:

Table 15: In what capacity are you responding?

Type	Number	Percentage
Member of the public	147	59.04
Patient or community group	14	5.62
Patient carer	15	6.02
Partner organisation	20	8.03
Staff clinician	56	22.49
Other	40	16.06

Table16: What is the first part of your post code?

Postcode	Total	Areas covered
YO31	37	Huntington, Heworth and Tang Hall area
YO24	30	Dringhouses, Holgate Road and Woodthorpe
YO30	29	Clifton, Rawcliffe, Skelton and Shipton area
YO32	29	Haxby and Wigginton, Strensall, New Earswick and Stockton on Forrest
YO10	20	Fulford, Heslington and Hull Road area
YO23	18	Bishopthorpe, Copmanthorpe, Appleton Roebuck, Askam Bryan and Rufforth area
YO26	17	Nether and Upper Poppleton, Tockwith, Green and Kirk Hammerton area
YO8	10	Selby, Cawood and Thorpe Willoughby area
YO42	5	Pocklington
YO61	5	Easingwold, Tollerton and Stillington area
YO19	4	Dunnington, Wheldrake and Riccall area
YO17	3	Malton, Rillington and Scampston area
YO1	2	York City Centre
YO6	2	Huby and Sutton on Forrest area
YO12	2	Scarborough
YO60	2	Terrington and Sheriff Hutton area
YO18	1	Pickering
YO25	1	Driffield and Wetwang area
YO41	1	Elvington and Stamford Bridge area
YO62	1	Helmsley and Kirkbymoorside area
HG5	1	Knaresborough

Postcode	Total	Areas covered
YO	3	
HG	2	
LS2Y	1	
D16	1	
GP	1	
YO3	1	
N/A	1	
Rather not say	1	

Table 17: Which GP practice are you registered with?

Medical Groups	Total
York Medical Group	38
Priory Medical Group	32
Haxby Group	29
Jorvik Gillygate	14
Unity Health	12
MyHealth	11
Old School Medical	9
Dalton Terrace	8
Scott Road Practice	5
Pocklington	5
Front Street	5
Milffield Surgery	4
Strensall	4
Beech Tree	3
Minster Health	2
Tollerton Surgery	2
Posterngate	2
Tadcaster Medical	2
Escrick	1
Helmsley	1
Pickering	1
Out of CCG area	
Derwent Practice (Malton)	3
Driffield	1
Park Parade, Harrogate	1
Mowbray House, Northallerton	1
West Ayton, Scarborough	1
Other	
Prefer not to say	2
Not relevant	2
"One in Selby"	1

Ethnicity

241 out of 387 responded to this question. 92.94% of respondents who chose to answer this question were ‘white’. This is broadly in line with the 2011 census for York, where 94% identified themselves as ‘white’ for York and 89% for Yorkshire and Humber.

Table18: Ethnicity responses

First part of post code	Number	Percentage
White - British	217	90.04
White - Irish	4	1.66
White – Any other white background	3	1.24
Mixed - White and Black Caribbean	1	0.41
Mixed - White and Black African	0	0
Mixed - White and Asian	1	0.41
Mixed - Any other Mixed background	3	1.24
Mixed - Asian or Asian British-Indian	0	0
Asian or Asian British - Pakistani	0	0
Asian or Asian British - Bangladeshi	0	0
Asian or Asian British - And other Asian background	2	0.83
Black or Black British - Caribbean	0	0
Black or Black British - African	0	0
Black or Black British - Any other Black background	0	0
Chinese	1	0.41
Prefer not to say	9	3.73

Table 19: Gender responses

Gender	Number	Percentage
Prefer not to say	13	5.2
Male	74	29.6
Female	162	64.8
Trans	1	4.0

Table 20: Sexual orientation responses

Sexual orientation	Number	Percentage
Heterosexual/straight	182	81.25
Gay/lesbian	9	4.02
Bisexual	11	4.91
Prefer not to say	19	8.48
Other	3	1.34

Table 21: Age range responses

Type	Number	Percentage
18-24	28	12.02
55-44	78	32.62
45-64	94	40.34
65-74	18	7.73
75-84	5	2.15
85+	1	0.43
Prefer not to say	11	4.72

Table 22: Religion or belief responses

Type	Number	Percentage
Christian	111	93.28
Buddhist	6	5.04
Jewish	1	0.84
Muslim	0	0
Sikh	0	0
Hindu	1	0.84

Table23: Are you a resident of?

Type	Number	Percentage
York	197	86.03
Selby	15	6.55
Easingwold	4	1.75
Tadcaster	1	0.44
Pocklington	5	2.18
Ryedale	7	3.06

Table 24: Do you consider yourself to have a disability?

Type	Number	Percentage
No disability	157	66.53
Physical impairment such as difficulty moving your arms or mobility issues	10	4.24
Wheelchair user	1	0.42
Sensory impairment such as being blind or having a visual impairment	1	0.42
Sensory impairment such as being deaf or having a hearing impairment	4	1.69
Mental health condition such as depression, dementia or schizophrenia	39	16.53
Long-standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease or epilepsy	9	3.81
Learning disability or difficulty (such as Down's syndrome or dyslexia) or cognitive impairment (such as autistic spectrum disorder)	4	1.69
Prefer not to say	11	4.66

16.Glossary

BPH	Bootham Park Hospital
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CYC	City of York Council
EIA	Equality Impact Assessment
FBC	Full Business Case
GP	General Practitioner
IP	Internet Protocol
LGBT	Lesbian, Gay, Bi-sexual and Trans
MHAY	Mental Health Action for York
MHSOP	Mental Health Services for Older People
NHSE	National Health Service England
OBC	Outline Business Case
OSC	Overview Scrutiny Committee
PICU	Psychiatric Intensive Care Unit
PPG	Patient Participation Groups
TEWV	Tees, Esk and Wear Valleys NHS Foundation Trust
VOY CCG	NHS Vale of York Clinical Commissioning Group
YAS	Yorkshire Ambulance Service
YCT	York Civic Trust
YOPA	York Older People's Assembly
YTHFT	York Teaching Hospital NHS Foundation Trust

Agenda Item 7

Health & Adult Social Care Policy & Scrutiny Committee **27 February 2017**

Report of the Assistant Director – Legal & Governance

Update Report on Implementation of Recommendations from the Bootham Park Hospital Scrutiny Review

Summary

1. This report provides the Health & Adult Social Care Policy & Scrutiny Committee with an update on the implementation of recommendations from the previously completed scrutiny review into the closure of Bootham Park Hospital (BPH).

Background

2. Bootham Park Hospital was closed following an unannounced inspection of the psychiatric inpatient services by the Care Quality Commission (CQC) in September 2015. The CQC reaffirmed that the service being provided to patients from Bootham Park Hospital at this time was not fit for purpose and that all clinical services had to be relocated from 30 Sept 2015.

3. In October 2015 this Committee met to consider the circumstances leading to the closure of BPH and heard evidence from NHS Property Services; Leeds and York Partnership Foundation Trust; Tees, Esk and Wear Valleys NHS Foundation Trust; the Care Quality Commission and the Vale of York Clinical Commissioning Group (VoY CCG). As a consequence the Committee agreed to write to the Secretary of State for Health supporting a call for an inquiry / urgent investigation into the hospital's closure.

4. In November 2015 the Committee agreed to carry out its own review of the BPH closure utilising the support of an Independent Expert Adviser, who was prepared to provide his services on a pro bono basis, and NHS England who were carrying out their own lessons learned review

5. The remit of the review was: *"To understand the circumstances leading to the closure of Bootham Park Hospital, to establish what could have been done to avoid the gap in services in York, particularly for in-patients and their families, and identify any appropriate actions for relevant partners."*

6. Over a series of meetings involving NHS England and all health partners the Task Group and Independent Expert gathered information in support of the scrutiny review. The final report and the Task Group recommendations were endorsed by the Health & Adult Social Care Policy & Scrutiny Committee at their meeting in late September 2016 and by the Executive in November 2016.

Review Recommendations

7. Having considered the evidence gathered in support of the Bootham Park Hospital Scrutiny Review, the Health and Adult Social Care Policy & Scrutiny Committee and the Executive endorsed the following Task Group recommendations.

8. NHS England should ensure that:

    i. The NHS nominates a named person to be responsible for the overall programme of sustained improvements to mental health services in York. That person to provide regular progress reports to the Council and meet this Committee when requested to review progress;

    ii. Specific details are provided of all mental health services currently provided or planned in the City of York area, with timescales for provision or replacement where appropriate;

    iii. Commissioning agents sign up to an understanding that they are more proactive in engaging with people to avoid the sudden closure of health facilities.

9. Tees, Esk and Wear Valleys NHS Foundation Trust and the Vale of York Clinical Commissioning Group:

    iv. Carry out a full and robust consultation process ahead of the procurement of a new mental health unit in York and that details are shared with this Committee.

10. The Care Quality Commission:

v. Should consider varying its internal processes so that there is a procedure for service transfers between providers, rather than treating them as a full deregistration and re-registration procedure.

Consultation

11. No consultation was required in the production of this report, other than liaising with health partners in relation to progress against the original review recommendations. As part of that review, the Task Group, Independent Adviser and Scrutiny Officer consulted extensively with NHS England who in turn were involved in detailed consultation with the partner organisations. The Committee was also able to question all health partners about the circumstances leading to the closure of BPH. Furthermore, Healthwatch York carried out a major piece of work on behalf of the Committee to gauge the impact of the BPH closure on people who use mental health services in the city, their families, carers and staff.

Options

12. Members may decided to sign off any the recommendations where implementation has been completed and can:

    i. Request further updates and the attendance of relevant officers at a future meeting to clarify any outstanding recommendations to the above review or;

    ii. Agree to receive no further updates on this review.

Analysis

13. The response on behalf of the Chief Executive of NHS England is included at Annex 1. In relation to the review recommendations:

    i. NHS England named the nominated person as the Accountable Officer of the Vale of York CCG;

    ii. Details of mental health services planned or provided in the Vale of York area are regularly shared with the Committee

    iii. An update on the action plan following the NHS England Lesson Learnt Review is being updated and still needs to be signed off. NHS England is continuing to work with the organisations named in the plan and ensure all actions are delivered.

iv. Tees, Esk and Wear Valleys NHS Foundation Trust and the Vale of York Clinical Commissioning Group are consulting extensively with the Committee ahead of the procurement of a new mental health hospital in York and members agreed in November 2016 that they are satisfied with the level of consultation that has been carried out.

v. A response from the Chief Executive of the Care Quality Commission is attached at Annex 2. In addition, a response on behalf of the Secretary of State for Health is attached at Annex 3.

Council Plan

14. This report is linked to the Focus on Frontline Services and A Council That Listens to Residents elements of the Council Plan 2015-2019.

Implications

15. There are no risks of implications associated with this report. The risks and implications associated with the review recommendations were detailed in the Bootham Park Hospital Scrutiny Review Final Report.

Recommendations

16. Members are asked to note the contents of this report and sign off all the recommendations from the Bootham Park Hospital Scrutiny review that have been fully implemented.

Reason: To raise awareness of any recommendations which are still to be fully implemented.

Contact Details

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Chief Officer Responsible for the report:
Andrew Docherty
Assistant Director – Legal & Governance
Tel: 01904 551004

Report Approved ✓ **Date** 10/02/2017

Wards Affected: **All** ✓

For further information please contact the author of the report

Annexes

Annex 1 – Response on behalf of the Chief Executive of NHS England
Annex 2 – Response from the Chief Executive of the Care Quality Commission.
Annex 3 – Response from Secretary of State for Health

Abbreviations

BPH – Bootham Park Hospital
CCG – Clinical Commissioning Group
CQC – Care Quality Commission
NHS – National Health Service
VoY CCG – Vale of York Clinical Commissioning Group

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Annex 1

NHS England

Our Ref: MK/BPH

Date: 06th January 2016

Margaret Kitching
Chief Nurse North
NHS England
3 Piccadilly Place
Manchester
M1 3BN

Executive Assistant: Nicola Pollard
0113 825 5189 / N.Pollard@nhs.net

Cllr Paul Doughty
Chair
Health & Adult Social Care Policy & Scrutiny Committee
City of York Council

Sent via email - steven.entwistle@york.gov.uk

Dear Cllr Paul Doughty,

Thank you for your email addressed to Simon Stevens on 22nd December 2016. Simon has asked me to respond on his behalf.

In your letter you ask that: *The NHS nominates a named person to be responsible for the overall programme of sustained improvements to mental health services in York. That person to provide regular progress reports to the Council and meet this Committee when requested to review progress.*

As you may be aware Phil Mettam has recently been appointed Interim Accountable Officer with the Vale of York CCG. In this capacity Phil will be the nominated person who will be able to provide regular progress reports and respond to the Council including meeting with the committee as and when requested to do so. As Accountable Officer Phil, in conjunction with CCG colleagues, has responsibility for commissioning services appropriate to the needs of the residents of York. Could I ask that you liaise with Phil directly in relation to the full list of recommendations.

Kind Regards,

Margaret Kitching
Chief Nurse North Region
NHS England

CC:
Steve Entwistle , City of York Council
Phil Mettam, Vale of York CCG
Moira Dumma, Yorkshire & Humber NHS England
Linsey Watson, Chair and Chief Executives Office, NHS England

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NE1 4PA

Telephone: 0300 061 6161
www.cqc.org.uk

Councillor Paul Doughty
Chair
Health and Adult Social Care Policy
and Scrutiny Committee
City of York Council

By Email: Steven.Entwistle@york.gov.uk

13th January 2017

Dear Councillor Doughty,

Thank you for your email of 22 December 2016 and for sharing with the Care Quality Commission (CQC) the Committee's Final Report on the closure of Bootham Park Hospital, together with the NHS England Reflections, Learning and Assurance Report and the Healthwatch York report.

At CQC, we make sure that health and care services in England provide people with safe, effective and high-quality care. We monitor, inspect and rate the quality of care of providers and inform them of any improvements they need to make in their standards of care. If a provider does not meet the legal requirements, known as fundamental standards, we take action to make sure it improves.

CQC is confident that its actions in relation to Bootham Park Hospital were appropriate and proportionate to the risks that we found during our inspections. Throughout we acted to protect the health, safety and welfare of patients at Bootham Park Hospital and of potential future patients.

Our position remains that our decision in late September 2015 not to approve Tees, Esk and Wear Valley's (TEWV) variation application in relation to Bootham Park was an entirely proper exercise of our regulatory functions and that it took account of considerations which were relevant to the unusual circumstances with which we were presented. We had significant concerns about patient safety at Bootham Park and were not satisfied that action proposed by TEWV would meet those concerns.

It was also unusual for a significant change in provider to take place within the short timescales set by the Vale of York CCG. Normally, where there is a change of provider, the transfer date is moveable. CQC requested an extension of the contract to ensure that Leeds and York Partnership Foundation Trust remained responsible for the regulated activities at Bootham Park Hospital. The Vale of York CCG would not agree to this. It appears that the CCG did not understand that CQC has the right to refuse applications for registration, including adding an additional location, where providers are unable to satisfy us that the regulations will be met.

CQC gave full consideration to the impact of a closure of Bootham Park Hospital and as outlined above did consider alternatives to allow for an ordered closure. We do recognise how difficult it was for patients, their families and carers. However, CQC did inform Leeds and York Partnership NHS Trust of its concerns and its proposed regulatory intentions much earlier than the four or five days alluded to within the report. The Trust was aware of the significance of the concerns as early as October 2014, following the announced comprehensive inspection, and these were reinforced immediately following the unannounced inspection of 9 and 10 September 2016.

CQC welcomed the opportunity to be a part of the NHS England Reflections, Learning and Assurance review and accepted the findings of that review. We recognised that CQC was one of a number of organisations whose actions contributed to the decision to remove the location Bootham Park Hospital from Leeds and York Partnership NHS Foundation Trust which at that time was commissioned to provide services from there.

We have, since the review, completed all of the actions identified for CQC with one exception - the joint working protocol that describes what the roles of the various system players are when a hospital closes. We have now indicated our willingness to sign this and the protocol is back with NHS England for finalisation.

CQC has worked closely with Tees, Esk and Wear Valleys NHS Foundation Trust to ensure that services return to York as quickly as possible. We are confident that the proposed new mental health hospital will provide the people of York with a modern mental health facility that is fit for purpose. We look forward to working closely with Tees, Esk and Valleys NHS Foundation Trust to play our part in delivering that facility.

Once again, I would like to thank you for your review and hope that you are assured that CQC continues to use these opportunities to inform our learning and improvement.

Yours sincerely,

Sir David Behan
Chief Executive

Department of Health

From Nicola Blackwood MP
Parliamentary Under Secretary of State for Public Health and Innovation

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Councillor Paul Doughty
Chair
City of York Council Health and Adult Care Policy Scrutiny Committee
By email to: Steven.Entwistle@york.gov.uk

25 JAN 2017

Dear Cllr Doughty

Thank you for your correspondence of 23 December to Jeremy Hunt about Bootham Park Hospital.

Thank you too for your comprehensive update on Bootham Park Hospital, and for the proactive and positive response made by your committee in leading and co-ordinating the local response to improving mental health service provision following the Care Quality Commission's instruction to close the hospital.

I fully expect that the Committee's report will make a valuable contribution to driving improvements to mental health service provision in York, and I hope that you will continue to work with local health commissioners and Tees, Esk and Wear Valleys NHS Foundation Trust to provide valuable oversight.

Best wishes

Nicola

NICOLA BLACKWOOD

Annex 3

Health & Adult Social Care Policy & Scrutiny Committee Work Plan 2016-17

Meeting Date	Work Programme
Wednesday 22 June 2016 @ 5.30pm	1. Attendance of Executive Member for Health and Adult Social Care to explain her challenges and priorities for the municipal year 2. Be Independent End of Year Position 3. Verbal update on Bootham Park Hospital Scrutiny Review 4. Work Plan 2016/17
Tues 19 July @ 4pm	1. End of Year Finance & Performance Monitoring Report 2. TEWV report on consultation for proposed new mental health hospital for York. 3. Safeguarding Vulnerable Adults Annual Assurance report 4. Position report on Healthy Child Service Board 5. Pre-decision Report on Re-procurement of Substance Misuse Treatment and Recovery Services 6. Work Plan 2016/17
Wed 28 Sept @ 5.30pm	1. Health & Wellbeing Board six-monthly update report 2. 1st Quarter Finance & Performance Monitoring Report 3. Report on change of services at Archways Intermediate Care Unit 4. Update report on CCG turnaround and recovery plans 5. Bootham Park Hospital Draft Final Report. 6. Work Plan 2016/17

Tues 18 Oct @ 5.30pm	1. Annual Report of the Chief Executive of York Teaching Hospitals NHS Foundation Trust. 2. Further update on actions against York Hospital Action Plan. 3. Tees, Esk and Wear NHS Foundation Trust – One Year On in York 4. Work Plan 2016/17 **Circulated Reports** 5. Front Street / Beech Grove GP Practice Mergers 6. Re-procurement of community services and wheelchair services.
Wed 30 Nov @ 5.30pm	1. Healthwatch six-monthly Performance Update report 2. 2nd Quarter Finance & Performance Monitoring Report 3. Briefing Report on Ambulance Cover in York. 4. Update Report on STP 5. Further Update report on CCG turnaround and recovery plans. 6. Work Plan 2016/17 **Circulated Reports** 7. Update Report on Archways and Home-Based Care 8. Update Report on Winter Pressures
Tues 20 Dec @ 5.30pm	1. Update Report on Elderly Persons' Homes 2. Six-monthly Quality Monitoring Report – Residential, Nursing and Homecare Services.

	3. Be Independent six-monthly update report 4. Draft report on new Joint Health & Wellbeing Strategy 5. Healthwatch York six-monthly Performance Update Report (deferred from November) 6. Work Plan
Mon 30 Jan 2017 @ 5.30pm	1. Safeguarding Vulnerable Adults Six-Monthly Assurance Report 2. Update Report on Healthy Child Service 3. Update Report on CCG Improvement Plan including: • Delayed Transfer Of Care • Continuing Health Care • Partnership Commissioning Unit 4. Work Plan 2016/17
Mon 27 Feb 2017 @ 5.30pm	1. 3rd Quarter Finance & Performance Monitoring Report 2. Yorkshire Ambulance Service CQC Inspection report 3. TEWV / CCG report on outcome of consultation for new mental health hospital 4. Update on implementation of recommendations from Bootham Park Hospital Scrutiny Review 5. Work Plan 2016/17
Wed 29 March 2017 @ 5.30pm	1. Annual report of Health & Wellbeing Board 2. Further Update Report on CCG finance and recovery plan 3. Peer Review Action Plan 4. Update Report on Health Protection Assurance 5. Council Motion – Access to NHS Services 6. Work Plan 2016/17

Wed 19 April 2017 @ 5.30pm	1. Six-monthly Quality Monitoring Report – Residential, Nursing and Homecare Services 2. Hospital updates on: • Winter experience • Development of community services in light of Archways closure 3. Work Plan 2016/17
Wed 31 May 2017 @ 5.30pm	1. Healthwatch six-monthly Performance Update report. 2. Work Plan 2016/17