Notice of a public meeting of

Health, Housing and Adult Social Care Policy and Scrutiny Committee

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

Date: Monday, 15 January 2018

Time: 5.30 pm

Venue: The George Hudson Board Room - 1st Floor West Offices (F045)

A G E N D A

1. Declarations of Interest (Pages 1 - 2)

At this point in the meeting, Members are asked to declare:

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

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

2. Minutes (Pages 3 - 8)

To approve and sign the minutes of the meeting held on 12 December 2017.

3. Public Participation

At this point in the meeting, members of the public who have registered their wish to speak regarding an item on the agenda or an issue within the Committee's remit can do so. The deadline for registering is **5:00 pm on 12 January 2018.**

Filming, Recording or Webcasting Meetings
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4. The Retreat Quality Improvement Plan 2017 - Update Report (Pages 9 - 70)

To provide members with an update on the response of The Retreat to the CQC inspections of November 2016 & February 2017 and the safeguarding investigation from February-July 2017.

5. Six-monthly Quality Standards Monitoring Report - Residential, Nursing and Homecare (Pages 71 - 78)

To provide Members with information on the performance and standards of provision across care services in York.

6. Update on the Older Persons' Accommodation Programme (Pages 79 - 98)

To provide Members with an update on progress towards delivering the Older Persons' Accommodation Programme including programme delivery, resource deployment and risk.

7. Housing Registrations Scrutiny Review - Implementation Update (Pages 99 - 108)

To provide Members with an update on the implementation of the recommendations arising from the Housing Registrations scrutiny review.

8. Review of Allocations Policy & Choice-based Lettings (Pages 109 - 122)

To provide Members with an update on the review of the Council's Housing Allocations Policy and Choice-Based Lettings.

9. Work Plan 2017/18 (Pages 123 - 128)

Members are asked to consider the Committee's work plan for the municipal year.

10. Urgent Business

Any other business which the Chair considers urgent.

Democracy Officer:

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

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

Contact details are set out above

This information can be provided in your own language.

我們也用您們的語言提供這個信息 **(Cantonese)**

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

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

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

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

☎ **(01904) 551550**

Agenda Item 1

Health and Adult Social Care Policy and Scrutiny Committee

Declarations of interest.

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

Councillor Doughty	Member of York NHS Foundation Teaching Trust.
Councillor Mason	Registered Paramedic Managing Director of Yorkshire Emergency & Urgent Care Services Ltd Proprietor of YorMed, with NHS contracts Interim CEO of York Blind Society
Councillor Richardson	Niece is a district nurse. Ongoing treatment at York Pain clinic and ongoing treatment for knee operation.

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City of York Council	Committee Minutes
Meeting	Health, Housing and Adult Social Care Policy and Scrutiny Committee
Date	12 December 2017
Present	Councillors Doughty (Chair), Cullwick (Vice-Chair), Cannon, Warters and Steward (Substitute for Cllr Richardson)
Apologies	Councillors Mason, Pavlovic and Richardson

39. Declarations of Interest

In addition to Members' standing declarations, Cllr Doughty declared a personal interest as his partner was the chief executive officer of a mental health charity who had done some work on the STP work streams.

40. Minutes

A request was made to include in the minutes of the meeting held on 15 November 2017 the question asked regarding York Teaching Hospital NHS Foundation Trust's involvement in the development of the Council's Local Plan regarding levels of funding compared to population changes in the future.

Resolved: To approve and sign the minutes of the meeting of the Health, Housing and Adult Social Care Policy and Scrutiny Committee held on 15 November 2017 as a correct record with the above amendment.

41. Public Participation

It was reported that there had been one registration to speak under the council's scheme of public participation. It was agreed that Cllr Craghill would speak under the relevant agenda item (minute 46).

42. 2nd Quarter Finance and Performance Monitoring Report

Members considered a report on the latest financial and performance position for 2017/18 for services falling under the responsibility of the Corporate Director of Health, Housing and Adult Social Care. A correction was made to Table One of the report. The heading "2016 Outturn" should

instead read “Quarter One”. Richard Hartle, Finance Manager for Adults, Children and Education, and Terry Rudden, Strategic Support Manager for Adults and Public Health, were in attendance to take questions. During discussion of the report, the following points were raised:

- Efforts were being made to increase the take-up of direct personal payments for health and social care by making the process more accessible for users. It was reported however that this was not the best option for all service users for a variety of reasons. An update briefing report would be prepared and shared with committee members.
- The under-spend on Small Day Services had not prevented service users from having their needs met and work was ongoing with the voluntary and community sector to support a more flexible and community-focused style of service delivery.
- Government guidance on the sale of high value property was forthcoming but had not yet been released.
- A dispute regarding the value of the Section 106 agreement outlined in paragraph 16 of the report was historic and ongoing.

Sharon Stoltz, Director of Public Health, explained that work was ongoing with external service providers, in-house services and through the contract-management process to consider how local data could complement the performance indicators used nationally. She explained the local data could not be used to benchmark the council against other authorities but that it could support the internal scrutiny process through provision of more up-to-date information on service delivery outcomes.

Resolved: To receive the report for information

Reason: To update the committee on the latest financial and performance position for 2017/18

43. Health and Wellbeing Board Six-monthly Update Report

Members received an update on work of the Health and Wellbeing Board by Cllr Runciman, Chair of the board. The following points were highlighted:

- The Board’s partnerships remained strong and an important role of the Chair of the Board was to continue to strengthen and maintain these in order to enable the board to fulfil its remit.
- A reduction in visits to GPs was detailed which was attributed to increased social prescribing which supported individuals to manage some health issues themselves through community-based provision.

An evaluation of this had been conducted by York St John University and this would be circulated to committee members. The focus of social prescription was to improve health outcomes and to use resources more effectively rather than to make cash savings.

- A Whole System Review had been conducted with results to be available soon and decisions would need to be made around spending priorities and where investments were made. Integrated working between the CCG, hospital and council remained important in a period of financial challenges.
- It was explained that formal meetings of the Health and Wellbeing Board were held in public. Informal discussion sessions were sometimes held privately but these did not include policy-setting activity.
- Young people's health and support services had moved to Sycamore House. This had been successful and a report would be provided to the committee on this work.
- A planning application for a new mental health hospital would come to a future meeting of the committee for their consideration.

Resolved: To note the contents of this report.

Reason: To keep members of Health, Housing and Adult Social Care Policy and Scrutiny Committee up to date with the work of the Health and Wellbeing Board.

44. Update on the Progress of Humber, Coast and Vale STP

Members considered an update on the Humber, Coast and Vale Sustainability and Transformation Partnership (STP) including local place-based work in York. Linsay Cunningham, Strategic Lead for STP Communications and Engagement Humber Coast and Vale, Phil Mettam. Accountable Officer for the Vale of York Clinical Commissioning Group and Mike Proctor, Deputy Chief Executive of York Teaching Hospital NHS Foundation Trust, were in attendance to present the report and to respond to Members' queries. The following points were made:

- It was reported that there were challenges in the varied geography of the area covered by the STP model but that work was ongoing to identify the positive impact the STP could have on health provision in York.
- The provision and cost of social care was under discussion across the region, including the potential added pressures of the winter period. The Home First model and community based work were given as examples of models of supporting issues such as mental health,

longer life expectancy, and higher levels of complex learning difficulties. The challenge of balancing health needs with social care needs were discussed in regards to both service delivery and allocation of service budgets.
- A distinction was made between stakeholders and partners with regards to the engagement described in paragraphs 29-32 of the report and it was explained that local authorities were usually regarded as partners in this work.

Resolved: To note the content of the report and update.

Reason: To keep members informed of the ongoing efforts to improve local health and care services through the work of the Humber Coast and Vale STP.

45. Provision for Homeless People Over the Winter Period

Cllr Craghill addressed the committee under the Council's scheme of public participation. She thanked the committee for discussing her motion to Council and expressed a wish to see more comprehensive data on how many rough sleepers had been turned away from services and the capacity of current hostel and emergency accommodation. She also asked that further clarity was provided on the provision of longer term social housing and on the reasons for homelessness and rough sleeping.

Members considered the report on the measures being taken by the Council to provide support for people who are homeless. Tom Brittain, Assistant Director for Housing and Community Safety, and Becky Ward, Service Manager for Homelessness, were in attendance to present the report and respond to Members' questions. It was reported that the figures provided in paragraphs 21 and 26 of the report were incorrect and would be updated. During the discussion, the following points were made:

- The Housing First model used by the council offered a range of support with housing, employment and emotional challenges and could provide intensive multi-agency support for individuals who met certain criteria. Funding for Making Every Adult Matter (MEAM) had now been confirmed.
- A small number of homeless people remained unwilling to engage with services. Reasons for non-engagement were unique for each individual but could include an unwillingness to be part of the system (for example applying for social welfare payments), not wishing to live by the rules that governed hostels, or the belief that begging was more lucrative than employment. A small number are excluded from

accommodation, for example after displaying violent behaviour or for drug use.

- The Council's No Second Night Out policy covered provision of emergency accommodation for those at immediate risk of rough sleeping. This could comprise beds made up on hostel floors and was not a sustainable option in the long term not least because such spaces were not paid for but still required staff support and other associated costs. Rough sleepers without a local connection could be supplied with the means to return to the appropriate local authority to access support.
- Work was ongoing to look at Tier One and Move-On accommodation to help people out of hostels and into independent living. It was important to balance the needs of rough sleepers with others requiring social housing within the city.
- Alternatives to hostel accommodation, including more "old fashioned" style night shelters were discussed but such options raised safety concerns related to ungoverned open buildings. It was also reported that this would not provide a sustainable way of reducing rough sleeping and homelessness in the longer-term.
- More work was required to increase public understanding of the support available to rough sleepers and on alternatives to offering money to those begging by making donations to charities instead.

Resolved: To note the content of this report and to request additional information be included on work to engage with members of the public most likely to give to beggars.

Reason: So Members are satisfied that issues around homeless people are being addressed.

46. Implementation of Recommendations from Public Health Grant Spending Scrutiny Review

Members considered the first update of the implementation of the recommendations from the Public Health Grant Spending Scrutiny Review completed in March 2017. The health strategy had been delayed over the summer due to staff sickness but had since been progressed.

It was explained that programmes funded through internal grants were not subject to assessment against KPIs as in the case of externally-funded programmes. This meant there were fewer mechanisms for collecting robust information on tangible project outcomes and the impact of funding was more likely to be assessed through more informal means. Members agreed that it would be useful for further information to be provided under

the report headings to give a narrative of how the £50k health and wellbeing grant was allocated. It was explained that following the planned removal of the fund's ring-fence in 2018, the way in which the fund was allocated would be reconsidered and options for a more structured assessment approach may be more usefully explored at this later stage.

Resolved: To note the content of the report and its annex and to defer signing off the recommendations in the Public Health Grant Spending Scrutiny Review until further information had been received as detailed above.

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

47. Work Plan 2017/18

Resolved: To note the Committee's work plan for the municipal year.

Reason: To keep the Committee's work plan updated

Cllr Doughty, Chair
[The meeting started at 5.30 pm and finished at 8.25 pm].

UPDATE FOR THE YORK HEALTH, HOUSING AND ADULT SOCIAL CARE POLICY AND SCRUTINY COMMITTEE: THE RETREAT QUALITY IMPROVEMENT PLAN 2017

An update for the Scrutiny Panel to the response to the CQC inspections of November 2016 & February 2017 and the safeguarding investigation from February-July 2017.

The Retreat Community

Compassion Collaboration Community

One of the most important institutions for the care and treatment of mental health

Contents

Section 1: Introduction

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

The CQC carried out a comprehensive inspection of The Retreat inpatient services in November/December 2016. This resulted in an overall rating of 'Requires Improvement' with two requirement notices. This inspection was followed by a focused inspection on The Retreat in February 2017 in response to a number of safeguarding concerns that we had raised with the City of York Council and about which we had notified the CQC. As a result of that focused inspection, on a single current unit for older males, we received an 'inadequate' rating and further requirement notices. In addition, as a result of the safeguarding concerns that were raised in February 2017 a major safeguarding investigation was carried out by the City of York Council. The outcome from this investigation was a series of recommendations, some of which were already covered as part of the CQC actions, some of which are included in the QIP as additional actions.

Outcome of The Retreat's most recent CQC inspection – November 2017 (Draft)

Due to the reflective and considered approach, the hard work and focus on improvement that The Retreat has had since the previous inspections and the safeguarding investigation, our most recent CQC inspection rated us as **'Good' in all areas** – safe, caring, effective, responsive and well-led. Whilst the report is still in draft, this indicates that the organisation has affected a significant turnaround, showing the capacity we have to change and to improve. The inspection report states:-

> "The organisation had made improvements following feedback from our previous inspections…and improvements meant patients received safe care and treatment. The unit managers had a good understanding of their units and shared good practice. Staff were respectful and courteous at all times. Staff treated patients with dignity and respect and saw each patient as an individual. Staff involved patients, carers, and advocates in decisions about their care and treatment and … helped patients engage with their environment and take part in meaningful activities".

In addition, the report states

> "The leadership and culture of the units reflected the organisation's vision and values. Staff knew who their senior managers were and spoke highly of the support they offered. Senior managers from the senior leadership team visited units and attended team meetings to listen to staff concerns and keep staff informed of service developments".

We are in the process of turning ourselves into a learning organisation, with a culture of continuous improvement.

The 'good' rating will not make us complacent – we understand that there is always room to improve and to provide better services for the people we care for. Our aim now is to work towards becoming an outstanding organisation, a centre of excellence for mental healthcare.

Section 2: Progress

We provided our Quality Improvement Plan to the Scrutiny Committee in July 2017. Section 2 provides an update indicating our progress on each of the actions in response to the CQC inspections and in response to the recommendations made as a result of the safeguarding investigation. We can provide evidence of the progress made, if required, though our most recent CQC inspection report of the inspection carried out in November 2017, which, as stated in the previous section, rated The Retreat as 'Good' in all five areas – safe, effective, responsive, well-led.

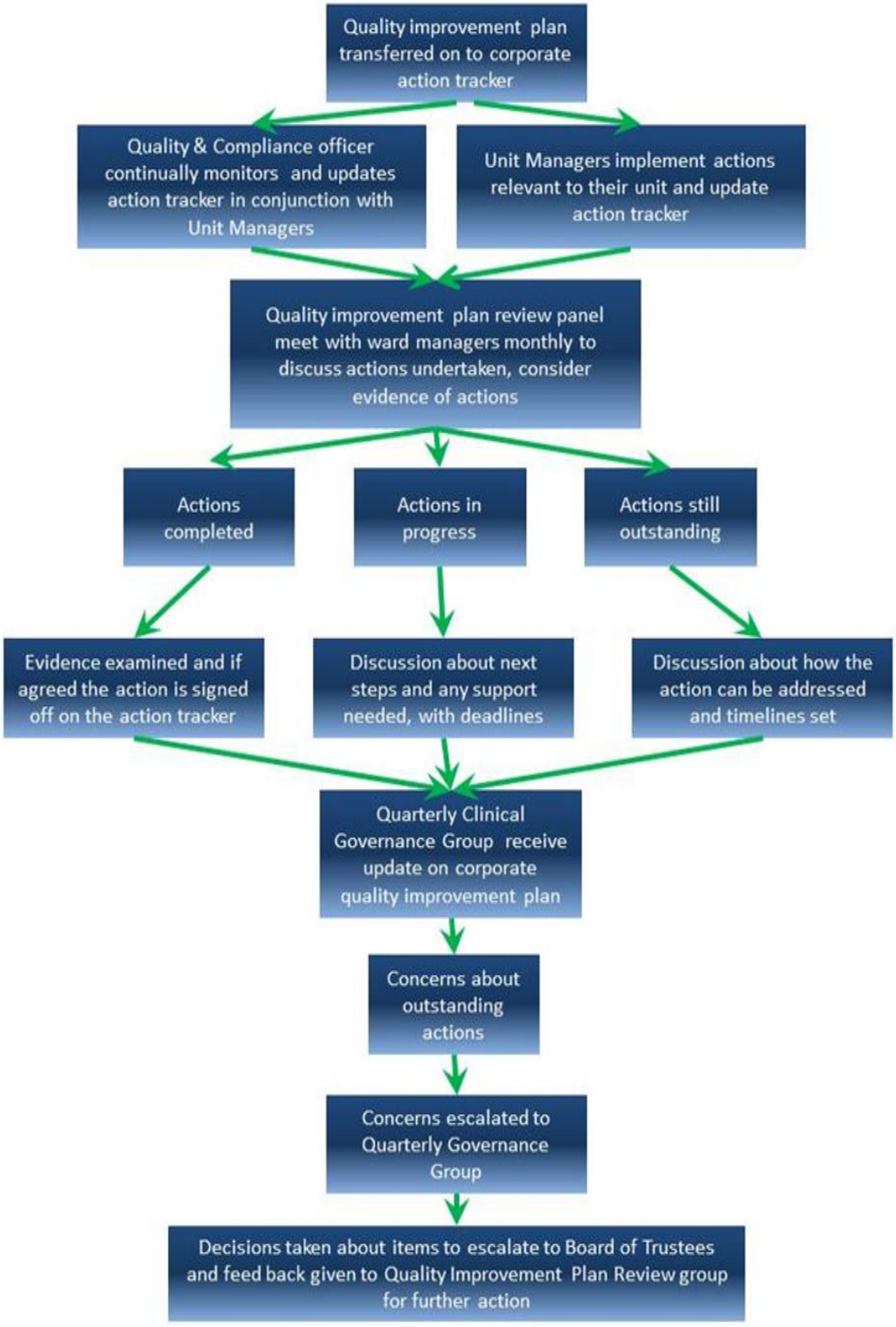
As the CQC acknowledge, we have monitored our progress carefully, using the governance process shown in Figure 1 below. In Section 3 you will see a detailed breakdown of progress made on all actions to date – green for completed, yellow for in progress and red for not yet started. Where an action is in progress or has not yet started we have outlined the impact on patients in the interim and mitigating factors.

In summary, we are pleased to confirm that we have made the following progress:-

Corporate actions	Unit specific actions	Safeguarding actions
68% completed – 31% in progress – 1 action not yet started	100%	43% completed – 57% in progress

As the Scrutiny Committee are aware, we are seeking to work more effectively with local partners, to become part of the wider mental health agenda with our STP, with local health commissioners, with NHS England and with the City of York Council to support the re-design and improved efficiency and effectiveness of our local mental health offer. We would be keen to support the implementation of York's mental health strategy and to be part of the wider implementation of the Government's Five Year Forward View.

Figure 1: Governance arrangements for monitoring progress on the QIP.



Section 3: Update on the Quality Improvement Plan

The CQC acknowledges the improvements we have made since our last inspection. Specifically, the progress we have made on our Quality Improvement Plan actions are shown in the table below, using this key:

Not yet started	In progress, with improvements being made	Completed

Quality improvement is a continuous process and we are still working on a number of areas to give us the chance to move, in the near future, from 'good' to 'outstanding'.

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 4:** Develop as a Centre of Excellence in compassionate care						
How the regulation was not being met 1: Patients on older people's units had significantly long lengths of stay. On George Jepson unit the average was 6.8 years and on the Katherine Allen unit it was 6.1 years; For some	**Immediate:** 1. Within the first week of admission, each patient will have a person centred discharge plan in place this will enable and support the client in their progress to discharge. Where possible the plans will reflect patient preference. For existing	31st August 2017		Patients may have longer stays than is beneficial for them	Unit Manager MDT	Care plan audit carried out every two months.

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
patients, the placement was not appropriate. We did not see evidence that the provider had made every effort to support patients to move on from hospital to less restrictive settings.	patients a discharge plan will be created to present at their next CPA and discharge planning will be added to the CPA checklist.					
	2. Discharge planning will be discussed at each CPA (every 6 month) this will be written into the CPA report which will sit on Care Partner. Discharge planning will include discussions with the patient where possible, their families and carers and care coordinators/ home teams.					Included in MDT Notes on Care Partner

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	3. Discharge planning will also be discussed at a named MDT every 3 month. This will be evidenced and documented in the clinical notes on care partner.					
How the regulation was not being met 2: On George Jepson 57.5% of non-medical staff had received an annual appraisal. On Katherine Allen 65% of non-medical staff had received an appraisal. On Naomi 59% of non-medical staff had received an appraisal. On Acorn 73% of	4. All non-medical staff will receive an annual appraisal after 12 months or more service	1st May 2017		N/A	All line managers	Managers' records On appraisal database
	5. Managers to record appraisal dates on the excel database provided. When an appraisal is not due dates of probation must be recorded and a date set for the forthcoming appraisal.	1st June 2017		N/A	All line managers	Monthly appraisal audit
	6. HR to produce policy and guidance on	30th August 2017		N/A	HR Manager	Evidence through policy

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
non-medical staff had received an appraisal. On Kemp 40% of non-medical staff had received an appraisal 33% of managers had an appraisal.	appraisal's which will include how /where statistics will be recorded.					
	7. HR department to set up and maintain and review their recording system so that they can provide a report on the percentage of appraisals completed.	30th August 2017		N/A	HR Manager	Monthly report on the percentage of appraisals completed.
Regulation 10 HSCA (RA) Regulations 2014 Dignity and Respect: The provider must ensure that patient dignity and respect are considered and acted in accordance with at all times **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 3:** Improve the recruitment and retention of staff **The Retreat's Strategic Objective 4:** Develop as a Centre of Excellence in compassionate care **The Retreat's Strategic Objective 5:** Enable the people who use our services to find meaningful engagement within their communities						
How the regulation was not being met 1:	8. Enable access to the conservatory and garden area by clearing	Completed		N/A	Unit Manager	Visual inspection

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
On George Jepson patients were unable to use the conservatory, quiet room or access the garden.	the furniture and other items and making a clear path through the conservatory to the garden					
	Immediate					
How the regulation was not being met 2: On George Jepson unit staff were unable to spend meaningful time engaging with patients as they were responding to other patient needs.	9. Timetabled activity programme to be put in place on George Jepson	Completed		Positive impact	George Jepson Unit manager	Briefing sheet outlining what meaningful activity looks like on George Jepson.
	10. Sharing the Learning: Katherine Allen to share how they record meaningful activity.	Completed		Activity already in place so impact negligible	Katherine Allen Unit manager	
	11. Put a key worker role in place to record individual, meaningful engagement which is fed into the MDT via the OTs.	Completed			George Jepson Unit manager OTs	MDT notes
	Longer term					

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	12. George Jepson will take a step by step approach to improving record keeping around meaningful activity.	1st March 2018		Negligible because activity taking place	George Jepson Unit manager	Care plans Activity records Meaningful engagement strategy document
	13. We are developing a Meaningful Engagement Strategy as part of our Strategy Work streams	31st March 2018		Negligible because activity taking place	OT Lead	Meaningful engagement strategy
How the regulation was not being met 3: Doors were locked on the units and patients were not risk assessed to be able to leave the units unescorted or without permission. Not all staff had swipe fobs to be able to leave the unit or	**Immediate**					
	14. Unescorted leave to be included on MDT forms and discussed at MDT and then incorporated into the risk assessment. This will be linked to the Restricted Practice Plan. This will occur on all units, not just to GJ unit.	1st September 2017		Some possible restrictions relating to unescorted leave, but mitigated by individual approach to patient requirements and MH status	Unit managers	MDT form MDT notes Restricted Practice Plan Risk Assessments Section 17 Leave Policy

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
access to the duty room.	15. Section 17 Leave Policy revised to include risk assessment.	1st September 2017			MH Law Lead Policy Development & Ratification Group	Section 17 Leave Policy revised to include risk assessment.
	16. Agency staff will have monitored fobs, all of which will be numbered as part of the sign out process.	30th June 2017		N/A	George Jepson Unit manager	Fob records
	Longer term					
	17. There will be an identified person responsible for Security for each unit - responsible for distributing and recalling keys and alarms.	1st October 2017		N/A	Unit managers	Security person role description
	18. George Jepson will replace all mortice locks with fobs.	1st November 2017		N/A	George Jepson Unit manager Maintenance Lead	Mortice locks no longer in place

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
Regulation 12 HSCA (RA) Regulations 2014: Safe care and treatment **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 3:** Improve the recruitment and retention of staff **The Retreat's Strategic Objective 4:** Develop as a Centre of Excellence in compassionate care						
How the regulation was not being met 1: George Jepson unit No reasons for missed dose codes were recorded or action taken to encourage administration or inform prescriber. The medicines electronic record in the daily notes did not always correspond to the codes documented on the medication	19. All nurses to have a medications competency assessment on a yearly basis.	31st December 2017		N/A	Unit Manager Deputy Unit Manager	Daily checking system to ensure appropriate codes are used/signature on medicine chart.
	20. Nurses will document missed dose codes and will be recorded on the IRF system as a medication error, triggering a reflective account. If regular medications missed the prescriber should be informed and review the patient.	Completed		N/A	Unit Manager Deputy Unit Manager	Absence of codes/signatures triggers an IRF and reflective account.

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
administration record or provide details of outcome of administration or reasons why medicines had been refused. Care plans did not always provide detailed medicines information or cover all aspects of care. They were not always updated when changes had occurred. Medicines were covertly administered to some patients, best interest meetings were documented in records but reviews were not documented at the frequency stated on the care plans.	21. Team managers to ensure nurses document in the daily clinical notes and reflect reason for non-administration of medication	Completed		N/A	Unit Manager Deputy Unit Manager	Results of random audit of 5 patients notes submitted as part of the monthly report
	22. Care plans should specify prescribed medications and PRN medications this should be updated after changes are made. A reference to the MARs sheet should be made for correct dosage.	30th October 2017		Minimal	Unit Manager Deputy Unit Manager	Use 'Quality of clinical records audit tool' to measure progress via monthly record keeping audit
	23. Best interests meetings will always take place where decisions will made about administering medications covertly. This will be care planned and include	30th September 2017		Minimal	Unit Manager Deputy Unit Manager	Weekly care plan checks carried out on each unit.

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
Body maps were not consistently used to identify the locations where transdermal patches had been placed.	dosage of medications and patients' preference for administration .Reviews will take place at MDT and will be recorded on Care Partner at the time of decision making.					
	24. Body maps to identify the locations of where transdermal patches are placed to be used each time a patch is replaced. These will be scanned onto the Care Plan.	Completed		N/A	Unit Manager Deputy Unit Manager	Body maps kept with the patient's medication chart.
How the regulation was not being met 2: Kemp unit Weekly stock checks had not been completed in line with the	25. Pharmacist to check stocks of medications on the unit weekly.	Completed		N/A	Pharmacist Unit Manager Deputy Unit Manager	Monthly Medicines management audit.
	26. All nurses to have an administration of	31st March 2018		Minimal because there are robust	Pharmacist	Records to be kept on each unit in a

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
hospital's medicines code. No system was in place to ensure staff had completed up to date medicines training or that they had read and understood the hospital's medicines code. Medicines reviews were not documented and completed in line the hospital policy As & when required reviews not documented as per hospital medicines code Nursing staff administration signatures did not always correspond with the prescribed medicines	medication competency assessment			checks in place around the administration of medication	Unit Manager Deputy Unit Manager	folder. Also logged on the individuals training record. Training records Clinical notes MAR chart
	27. All nurses to complete on line training in Medicines Management.	31st March 2018			Pharmacist Unit Manager Deputy Unit Manager	
	28. Medicine reviews to be documented in clinical notes and care plans reviewed where applicable. Reviewed alongside pharmacy in MDT / Report out	1st October 2017			Unit Manager Deputy Unit Manager	
	29. The timing of medication and the recording of the actual time medication was administered on the MAR chart will be more accurate.	1st August 2017			Unit Manager Deputy Unit Manager	

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
instructions.						
How the regulation was not being met 3: Naomi unit Medicines related care plans did not always provide detailed information with regards to dosages or patient preference for administration. For 'when required' medicines symptoms were not always indicated to guide staff when to administer. For patients with multiple medicines no written guidance was available as to which item was to	30. Nurses to update care plans to reflect information about medication administration where applicable e.g. liquid, tablet.	30th September 2017		Some risk that care plans may not be up to date in terms of medication, but as it's being worked on the risk is minimal	Unit Manager Deputy Unit Manager	Monthly Care plan Audit
	31. Prescribers to indicate when/why a PRN medication should be used. This should be included in the care plan also.	30th August 2017			Unit Manager Deputy Unit Manager	
	32. Specific instructions will be included in the care plan with regard to what medication should be given first, and the dose.	30th August 2017			Unit Manager Deputy Unit Manager	
	33. Reasons for omitting doses of medication	30th August 2017			Unit Manager Deputy Unit	

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
be given first or when to administer the second item. Reasons for missed doses were not documented in narrative and any actions taken were not recorded.	should be coded on the medicine chart and an entry made in the clinical notes as to why dose was missed.				Manager	
Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 3:** Improve the recruitment and retention of staff						
How the regulation was not being met 1: Both units had ligature risks and blind spots. We found that staff could not always see patients on the unit.	**Immediate** 34. Update the Environmental Risk Policy (HSR 20) to include: • Changes in roles and responsibilities; • Inclusion of a specific Ligature Risk	7th September 2017		Minimal - mitigate risks through heightened awareness of environmental risk assessment process	Interim Registered Manager/Audit & Information Manager	New version of the Environmental Risk Policy HSR 20 policy & procedures (which includes formats for the assessment of environmental risks).

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	Assessment Form; • Review the current Risk Assessment Form in place for the overall unit environment (including bedrooms).					
	35. Complete all environmental and ligature risk assessments (including bedrooms) on each Unit as per guidance outlined in the policy. This will involve: • Ligature audits being completed annually unless there have been changes made to the room. • Risk assessments for patients should be completed regularly particularly on admission and when there is a change in circumstance with their clinical presentation.	30th September 2017		Minimal - mitigate risks through heightened awareness of environmental risk assessment process	All Unit Managers	MDT minutes. Individual Risk Assessments. Updated Care Plans. Unit Manager checks of Care Plans and Risk Assessments to be included in managers' monthly report.

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	• Uploading specific patient risks to individual risk management plans on the Care Partner EPR System. • Including Unit wide risk on the Unit Risk Register via the Ulysses System. This leads to identified risks in the environment consequently feeding into individual risk management plans on the Care Partner EPR System and these will be shared with the wider MDT and staff team. • Carrying out periodic checks on individual Care Plan and Risk Assessments to monitor that they reflect current unit environmental risks.					
	Longer term					

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	36. Improve the awareness, embedding and use of Policy HSR 20 and its procedures through the development and implementation of a staff intranet, which will allow the organisation to monitor awareness and understanding of all policies.	31st December 2017		Staff awareness, understanding and use of the environmental risk process is being closely monitored, so patient impact should not be negative	IT Consultant/IT Officer Learning & Development Manager	Implementation of an Intranet. Data from intranet quizzes and read audits.
	37. We are carrying out a site feasibility study to bring about change to the environments to include mitigation of ligature and blind spot risk. Risk areas that remain will be picked up on the unit environmental risk assessments.	31st December for feasibility study report Between June 2018 – June 2020 for the work emerging from the feasibility study		Risks mitigated through observations, environmental risk assessments, MDT discussions, care planning and individual risk assessments	Feasibility Study working Group Leadership Team & the Trustee Directors	Feasibility Study report Works plans

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
How the regulation was not being met 2: Patient risk plans were not all up to date and there were no patient risk assessments relating to the flooring work being completed on the George Jepson unit.	**Immediate**					
	38. To ensure that risk assessments are always updated each unit has a log to act as a prompt.	31st August 2017		Impact mitigated by additional monitoring by Unit managers are part of their monthly reporting	All Unit Managers Audit & Information Manager Risk & Quality Officer	Unit managers' monthly report and bi-monthly care plan audits as part of the annual Clinical Audit Programme. Monthly patient records check Management supervision notes
	39. It is the responsibility of the key worker & associate key worker to update the risk assessment. This will be outlined in our Risk Management Policy and Procedures.	31 August 2017		N/A	All Unit Managers All Key workers & associate key workers	Care Partner records and the monthly Care Plan Audit programme
	40. To address systemic issues relating to decision making for changes we have	Ongoing 2017 (already in place)		N/A	Leadership Team	Log of decisions made at Leadership Team and Board Level for operational &

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	implemented a Change Management system. A set of guidelines are available to all staff together with a Proposal for Changes template to ensure that all operational/ environmental change proposals are presented in a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our Change Management Policy which outlines the process to be followed when proposing operational or environmental					environmental change

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	change.					
	41. To ensure that we have up to date risk plans when change such as the flooring work on George Jepson is proposed the proposal for change process must always include relevant risk assessment and patient impact assessments. See Proposal for Change Protocol & guidelines	In place		N/A	Unit managers Leadership Team	Examples of proposals for change (George Jepson Phase 2 flooring)
	Longer term					
	42. Embed importance of incorporating relevant risk assessments into all Proposals for Change and subsequent project plans we are improving access to related	31st December 2017		Negative impact mitigated by additional monitoring by unit managers	Unit managers Leadership team IT Consultant Sales & Marketing Manager	Care Partner records

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	policies & procedures by implementing a staff intranet.					
How the regulation was not being met 3: Not all incidents were reported on the provider's incident management system; this meant the provider could not act on minimising all risks to patients.	**Immediate**					
	43. Ensure there is a robust IT incident reporting system that all staff are trained to use to report all incidents. The Risk & Quality Officer will visit all units to ensure they understand the system & how to use it. In addition, the Risk & Quality Officer will have a session during the staff induction programme on incident reporting	Completed		N/A	Risk & Quality Officer All staff – incident reporting is everyone's business	Daily incident reports Quarterly analysis of incidents for the Clinical Governance Group.
	Longer term					
	44. Implement a staff intranet to embed the importance of	31st March 2018		Negative impact mitigated by Risk manager and unit	Unit Managers Leadership Team	Intranet Checks of access to policies and

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	recording incidents and improve access to policies			managers raising awareness through attending unit business meetings and including it in Management Supervision.	IT consultant Marketing and Communications Manager Learning development manager	procedures
How the regulation was not being met 4: We found there to be unsafe and unsuitable staffing levels and skill mix on both units; during the move there was only one qualified nurse allocated to cover both units on a regular basis.	**Immediate**					
	45. In March 2017 Unit Managers carried out a review of their safe staffing levels which resulted in adjustments to the agreed establishment figures and budgets. Staffing levels will be discussed as a daily agenda item at the morning Unit Managers meeting.	31st March 2017		Minimal because patient care will only be impacted if staffing issues cannot be resolved. Even if staffing issues cannot be resolved the skill mix in the shift should minimise patient impact.	All Unit Managers	Actual staffing levels (from HR)
	46. Database of daily staffing records to be developed	31st March 2018		No direct impact on patient care	Director of Operations	Database records

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	47. Each morning the Site Co-ordinator will contact each of the Units to identify deficits in daily staffing, as will be stated in revised Site Coordinator Procedure.	Ongoing throughout 2017		Minimal	Site Co-Ordinators	Site Coordinator records in handover book
	48. If staffing levels are identified as low it is the role of the Site Coordinator to support and coordinate additional staffing. The process is as follows: Step 1 - The Site Coordinator will liaise with the nurse in charge to find resource within the hospital. Step 2 - Obtain staffing support from Bank. Step 3 - As a last resort obtain staffing support from agency. This procedure is outlined in	Ongoing throughout 2017		Use of agency staff can have a negative impact on patients – mitigated by this action	Site Co-Ordinators	Site Coordinator Procedure

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	the Site Coordinator Procedure.					
	49. Recruiting a Night Site Coordinator to manage the bank and oversee agency use. This will ensure that staffing is more closely monitored and that use of agency and bank are managed more effectively	30th September 2017		See above	Director of Operations	Presence of a Night Site Coordinator
	50. Learning & Development Manager will ensure that Site Co-ordinator training supports the requirements of the Site Co-ordinator procedure	31st March 2018		See above	Learning & Development Manager	Site Co-ordinator training programme contents and training stats
	Longer Term					
	51. Employer of Choice Work stream	31st December 2017	Work stream established, change	N/A	HR Manager & HR Consultant	New Recruitment and Retention

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	implemented to develop a Recruitment and Retention Strategy, which will be accompanied by implementation plans. Where additional staffing is required we will use our Proposal for Changes Template. (See Change Management Policy and Procedure for further information)		management process being used, but recruitment and retention strategy still in development			strategy Fewer staff leaving More staff recruited
	52. Employer of Choice Strategy Work stream includes a Rostering Project to improve the efficiency and effectiveness of staffing rotas.	31st May 2018	Work stream established, discussions ongoing relating to rostering	N/A	HR Manager & HR Consultant IT Manager & IT Consultant All Unit Managers	New Rostering system in place
	53. We're conducting a formal review of Bank and Agency usage. This	31st October 2017		N/A	Interim Registered Manager Night Site	New process for bank and agency use

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	will inform future planning for staff shortages.				Coordinator HR Consultant & IT Consultant	
	54. We are implementing a staff intranet to improve communication and improve access and embedding of operational policies and procedures	31st December 2017			Marketing and Communications Manager	Staff intranet to improve communication and improve access and embedding of operational policies and procedures
Regulation 17, (1 2 b c), Good Governance, of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 3:** Improve the recruitment and retention of staff **The Retreat's Strategic Objective 4:** Develop as a Centre of Excellence in compassionate care						
How the regulation was not being met 1: Neither unit had an environmental risk register relating to	**Immediate**					
	55. To ensure that environmental risks are registered when bringing about	Completed		N/A	Leadership Team	Log of decisions made at Leadership Team and Board

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
the flooring refurbishment of George Jepson.	operational and environmental changes we have implemented a Change Management system. A set of guidelines are available to all staff together with a Proposal for Changes template to ensure that all operational/ environmental change proposals are presented in a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our new Change Management Policy which outlines the process to be					Level for operational & environmental change

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	followed when proposing operational or environmental change.					
	56. Unit managers to familiarise themselves with the Change Management Policy & Procedures	31/8/17		Minimal	Unit Managers	Part of key policy sign-off
	Longer term					
	57. To embed the importance of incorporating environmental risks into all proposals for change and subsequent project plans we are implementing a staff intranet.	31st March 2018	Intranet is now live but the embedding of environmental risks is an ongoing effort	Negative impact mitigated by the Risk & Quality Officer and Unit Managers raising awareness through attending unit business meetings and including it in Management Supervision.	Unit Managers Leadership Team IT consultant Marketing and Communications Manager	Examples of proposals for change (George Jepson Phase 2 flooring)
How the regulation was not being met 2:	**Immediate**					
	58. Undertake monthly Medication Audits	Completed		N/A	Pharmacist	Medication audits as part of annual

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
There was no clinic room on Allis unit and medicines storage was not in keeping with best practice when we visited.	which include a question about the safe storage of medicines. If that indicates any issues with medicines storage the unit manager will take immediate action in line with recommendations from the Clinical Audit Action Plan.				Unit managers Audit & Information Manager	Clinical Audit Programme Log of decisions made at Leadership Team and Board Level for operational & environmental change
	59. All operational and environmental changes to be governed by the Change Management Policy.	Completed		N/A	Leadership Team	
How the regulation was not being met 3: We did not see, and were told by one nurse that worked on Allis unit, that there	**Immediate**					
	60. All units now have access to grab bags on their unit.	Complete		N/A	Unit managers Reception staff Site Coordinator	Presence of grab bags Grab bag checks
	61. The Resuscitation Policy (PC10) states that the	Complete		N/A	Unit managers	Grab bag checks

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
was no grab bag on the unit; a grab bag contains items to use in an emergency such as resuscitation equipment or emergency medications. The provider told us that the closest grab bag was on another unit directly below the Allis unit.	Unit Manager is responsible for the weekly auditing of grab bag contents and location using a checklist.					
	Longer Term					
	62. Weekly Grab Bag check results are part of unit weekly check records.	31st August 2017		N/A	Unit managers	Unit weekly checks
How the regulation was not being met 4: On George Jepson unit cleaning charts were not available in all patient bedrooms and support staff were not adequately protected when cleaning	**Immediate**					
	63. Discuss cleaning requirements with Unit Managers and implement appropriate improvements as per their recommendations	30th September 2017		N/A	Director of Development	Immediate actions
	Longer term					
	64. Create & implement a hospital wide cleaning	31st March 2018	Changes to the Domestic	The immediate actions will mitigate	Director of Development	Place assessments Completed

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	operational plan with Unit Managers. This will involve:- • A review of daily checking system and checklist • Domestics' Supervisor to check works complete against a checklist. • Once complete checklist should be signed by Supervisor and Unit Manager.		Services management arrangements have delayed this plan, but it is in progress	the impact, ensuring that cleanliness and records of cleaning are maintained	Unit managers Domestic Supervisors	checklists Reports from unit managers
	65. Training needs analysis for domestic team and training plans for the team, including:- • Defensible documentation • Infection control • Mental Health Awareness • Safeguarding • Incident reporting	30th November 2017	Changes to the Domestic Services management arrangements have delayed this plan, but it is in progress	The immediate actions will mitigate the impact, ensuring that cleanliness and records of cleaning are maintained	Learning & Development Manager	Training records

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	66. Conduct a review of culture and systems within Domestic services as part of strategy workstreams.	31st March 2018		PLACE and infection control identifies when things go wrong and immediate actions can be put in place.	Director of Development Interim registered manager	PLACE checks Staff survey Cleaning records Central Services Audit Quarterly Clinical Governance Report
How the regulation was not being met 5: The provider did not ensure that systems and processes were established and operating effectively to prevent abuse of service users. Staff did not report safeguarding concerns for patients on Allis unit	**Immediate**					
	67. New governance structure	31st July 2017		N/A	Audit & Information Manager Leadership Team	Governance structure organigram Terms of Reference for Governance Groups
	68. Implement a system to manage operational or environmental changes across the organisation. A set of guidelines are available to all staff together with a	Completed		N/A	Leadership Team	Log of decisions made at Leadership Team and Board Level for operational & environmental change

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	Proposal for Change template to ensure that all operational/ environmental change proposals are presented in a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our Change Management Policy, which outlines the process to be followed when proposing operational or environmental change.					
	69. Ensure works programme is communicated to all	31st December 2017		Should not be any significant impact because of other	Director of Operations Maintenance Lead	Works programme documentation

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	involved personnel and that it links to relevant strategic change procedures			measures		
How the regulation was not being met 6: Although there were no patients on Allis unit at the time of inspection, the unit was dirty, damp and cold; there was limited hot water and unsuitable kitchen, toilet and bathing facilities.	**Immediate**					
	70. Enter into a voluntary agreement with the CQC not to use the Allis unit unless significance works have been completed and approved by the CQC. We have no intention of using this unit again without CQC approval.	Completed		N/A	Chief Executive	Letter of voluntary agreement
	71. To ensure that a similar situation will never occur again introduce a Change Management system for all operational and environmental changes. A set of guidelines are	Ongoing (already in place)		N/A	Leadership Team	Log of decisions made at Leadership Team and Board Level for operational & environmental change

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	available to all staff together with a Proposal for Changes template to ensure that all operational/ environmental change proposals are presented in a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our Change Management Policy which outlines the process to be followed when proposing operational or environmental change.					
How the	**Immediate**					

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
regulation was not being met 7: The provider did not ensure that systems and processes were established and operating effectively to prevent abuse of service users. Staff did not report safeguarding concerns for patients on Allis unit	72. All staff trained on safeguarding prior to working on any clinical unit, as part of induction, with regular updates.	Complete		N/A	Safeguarding Lead Learning & Development manager Social work team	Training records
	73. Information about how to raise a safeguarding alert is clearly visible on the ward.	Complete		N/A	Safeguarding Lead	Check units for presence of poster
	74. All Management Supervisions include a check on safeguarding – reminder on management supervision template	Complete		Provided this check is in place and used, there should be no impact on patients	All managers	Management supervision template Management supervision records
	75. Ensure that we have a robust IT safeguarding reporting system that all staff are trained to use to record all safeguarding concerns and the Risk & Quality	30th September 2017		IT system and training already in place, but until it is all completely embedded culturally the unit managers will need to ensure it's	Risk & Quality Officer Unit managers All staff (safeguarding is everyone's business)	Training records Safeguarding reports (quarterly for governance and externally for LSB)

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	Officer visits all units to ensure they understand the system & how to use it. In addition, the Risk & Quality Officer has a session during all staff inductions on incident reporting which also covers reporting safeguarding concerns.			checked regularly to ensure all safeguarding concerns are being reported.		
	76. Social Work Team to visit all units to ensure they understand roles and responsibilities within safeguarding	Completed			Social work Lead All managers All staff	Social work team log
	77. Robust IT systems in place to report on and identify safeguarding themes.	Completed		N/A	Risk & Quality Officer All staff	Quarterly Clinical Governance report
	78. Service users and carers are also trained / and or provided with	Completed	Though this is a constant process, as service users and carers	Positive impact because they understand	Social work team Involvement team with Unit staff	Service users and carers' reporting

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	information on safeguarding.		change	safeguarding		
	79. Positive working with the CYC, Director sits on Local Safeguarding Board, Multiagency agency best practice Group, Safeguarding Training Group.	Completed		N/A	Director responsible for safeguarding Safeguarding Lead	Minutes of Local Safeguarding Board meetings
	Longer term					
	80. Have a safeguarding group within the new governance structure.	31st July 2017		N/A	Audit & Information Manager Safeguarding lead	Terms of Reference for the Safeguarding Group Minutes of the Safeguarding Group meetings
	81. Develop and implement a Safeguarding strategy.	31st December 2017		N/A	Safeguarding Lead	Safeguarding strategy document Safeguarding strategy implementation updates

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	82. To embed the importance of recording safeguarding concerns implement a staff intranet so that this is fully communicated and monitored.	31st March 2018		N/A	IT Consultant Marketing and Communications manager	Use of intranet Audits carried out through intranet
	83. Develop plan to address the issue of agency nurses accessing Care Partner and Ulysses	31st March 2018		N/A	Interim Registered Manager	Training records Agency use of electronic care records and reporting systems

Section 6: Recommendations for action

The following table sets out recommendations rather than mandates from the CQC inspections. These are organised under the relevant Key Lines of Enquiry (KLOEs)

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
Safe: people are protected from abuse and avoidable harm						
The provider should ensure that all shifts meet the planned staffing establishment level to ensure patient safety	84. As part of the 'Employer of Choice' strategy work stream, the processes and terms and conditions for staff will be reviewed	31/1/17	This has been implemented but it is a work in progress because we still have to use agency staff to ensure safe staffing levels	Patients do not respond well to agency staff who are new to the unit and risk levels may increase.	HR Consultant HR Manager	Staffing levels daily register Agency levels
The provider should ensure that all staff are offered regular supervision in line with its own policy. Supervision rates were low on the units and did not adhere to the provider's own policy.	85. Unit manager to ensure every nurse has line management supervision. Line management pro-forma to be reviewed to include compliance to policy standards on risk assessments and care plans	Complete		N/A	All managers across the organisation	Management supervision records
The provider should ensure that an	86. The provision and need of the ECG to be	Complete		N/A	Interim operational manager	ECG machines in place

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
electrocardiograph machine can be accessed on each site	reviewed					
The provider should ensure that informal patients are made aware of how they can leave the units.	87. Information for informal patients on all units is provided and will be included in care plans	31/7/17		If patients do not have the information they require their rights could be infringed	Involvement Lead	Information available Information in care plans
The provider should ensure that training in all courses including fire safety, record keeping, professional boundaries and prevention and management of aggression and violence meet training compliance targets on all units.	88. Management supervision pro-forma to include a question about training. Staff member who fails to meet mandatory training target to be performance managed	31/8/17		N/A	All line managers	Management supervision records Training records
The provider should ensure that all staff members have access to training	89. Management supervision proforma to include a question about other training					

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
specific to their role.	staff member requires for their role					
The provider should ensure that there is an effective process to ensure learning from investigations into incidents and complaints.	90. Re-introduce 'Sharing the Learning' information to be place in The Retreat Press, aiming to celebrate and share good practice. This will include a reflective account from a unit nurse / support worker on how they use de-escalation instead of restraint.	31/1/18	Changes in personnel delayed this slightly, but it should be in place by the end of January 2018	N/A	Marketing and Communications Manager	The Retreat Press evidence
	91. Use Share the Learning bulletin to communicate high level themes from investigations for example, complaints RCA, safeguarding and service evaluation.	30/9/17		N/A	Safeguarding Lead	Share the Learning Bulletin
The provider should	92. Develop a standardised	31/1/18	A local induction	There is a risk that	Director of	Check of the

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
ensure that all bank agency and staff covering shifts receive local inductions to units.	induction pack for agency and bank staff, with consistent section headings and local procedures for local induction.		is provided, but we have not yet produced a standardised pack	without a standardised and thorough induction agency staff will not understand how best to care for patients on the unit	Operations	induction pack Feedback from agency staff on usefulness of the pack
The provider should ensure that when patients refuse physical healthcare checks a care plan and risk assessment is in place to mitigate and reduce risk.	93. Include a section on choice in both care plans and risk assessments	31/10/17	Changes in personnel have impacted on the implementation of physical healthcare check record keeping, but this is in progress	Minimal	Director of Operations	Care Partner
	94. Implement a procedure to ensure risk assessments and care plans are updated to reflect mitigation of risk when patients refuse physical healthcare checks	31/8/17		Minimal	Unit Managers	Audit of care plans and risk assessments
The provider should ensure that people are supported if they wish to make a	95. Review Advocacy contract	30/9/17	And it is part of the agreement to have an annual review	Minimal	Director of Development	Reports from advocacy Complaints records

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
complaint.	96. Advocacy policy to be reinstated and reviewed with clear guidance for staff	30/9/17		Minimal	Director of Development	Advocacy policy Staff guidance for use of advocacy
The provider should ensure that informal patients are made aware of how they can leave the units.	97. Continue to roll out Positive Behavioural Support frame work in care plans	30/9/17		Minimal	Director of Operations Unit Managers	Monthly Care plan audit
	98. Every care plan to include section on restrictive practice reduction	30/9/17		Lack of PBS	Director of Operations	Monthly Care plan audit
	99. Every unit to have a restrictive practice reduction programme	30/9/17		There may be a minimal risk of restrictive practice, but our practice values do not support that approach	Director of Operations	RPR programme documentation
Caring: The provider must ensure that they involve and treat people with compassion, kindness, dignity and respect.						
The provider should ensure patients have	100. We will continue with a central register of	Complete		N/A	Involvement Lead Unit Manager,	Dignity council standards to be live

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
access to outside space and all facilities available on the unit.	dignity champions and roles on unit				Katherine Allen	and observed on all units
Actions determined by The Retreat related to involvement and dignity	101. Increase celebration of Involvement by including staff accounts of how they involve and a service user account of what this means to them in The Retreat Press	30/9/17	We have included some such accounts, but it is not a regular feature as yet	N/A	Marketing and Communications Manager	The Retreat Press
	102. Laundry service review with the aim of developing a personalised laundry service if capacity allows	31/10/17	The review has been carried out and there is an action plan in place, but personalisation has not yet been implemented	Risk of poor laundry service	Director of Development Lead Domestic Services	Feedback from patients and carers
Responsive: Services are organised so that they meet people's needs						
The provider should ensure patients have access to outside space and all facilities available on	103. Wherever possible, maintain an environment, across all our services, which	31/10/17		Risk of some restrictive practices	Director of Operations	Unit accessibility and use of outside space

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
the unit	provides service users with access to a range of facilities that promote recovery, comfort, dignity and confidentiality without the barrier of locked doors.					
Action from The Retreat	104. Service users will be consulted when changes such as relocating to another unit. The new change management policy stipulates the all views must be sought	30/9/17		Risk of lack of consultation with patients	Director of Development	Change management policy Proposals for change
The provider should ensure that there is sufficient space for all patients to access a seat in the dining room at mealtimes.	105. Patients and staff do not feel that the dining facilities on the Naomi Unit are big enough to accommodate everyone. This is on our corporate risk	Review 30/9/17	At present, we cannot change the environment on the unit, but this will be part of the options appraisal we are carrying out	Lack of space for patients when dining	Director of Operations	Naomi unit space Dining survey

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	register and we will continue to monitor it.					
The provider should ensure that people are supported if they wish to make a complaint.	106. Review the complaints, concerns and compliments policy to reflect current practise, best practise in line with government guidance.	30/9/17		Risk of some lack of willingness to complain	Risk Officer	Complaints policy Number and nature of complaints
Effective: People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.						
CQC reported that they saw patient care plans that had not been updated in the last three months	107. Remedial action to be taken to ensure care plans are all updated regularly and frequently	30/6/17		N/A	Unit Managers Director of Operations	Monthly Care Plan audit. Unit Managers' monthly report
Ensure all Mandatory Training courses have a minimum of 80%	108. Monitor mandatory training completion and follow up	30/6/17		N/A	Training manager HR Unit Managers	Quarterly Clinical Governance Performance Report

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
staff trained by Unit.						
The provider should ensure that all staff are offered regular supervision. Supervision rates were low on the units and did not adhere to the provider's own policy.	109. Monitor supervision and ensure staff have access to it on a regular basis	31/8/17	This was completed but it is an ongoing process and we need to monitor it regularly	N/A		Clinical Supervision Monitoring audit schedule in the Clinical Audit Programme for Q3.
Not all patients had an allocated social worker	110. Ensure all patients have an allocated Social Worker	31/7/17		Risk that some patients will not get the support they require	Social Work Lead	Social Work allocations
The CQC saw that three patients had no crisis plans visible. Crisis plans allow staff to know how best to look after patients when in crisis.	111. Ensure crisis plans are in place where appropriate	31/8/17		Risk that staff will not know how to support patients in crisis effectively	Unit Managers	Crisis plans in place

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
Well led: the leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.						
The provider should ensure that staff concerns relating to blame culture and victimisation continue to be monitored and ensure that action is taken to review and address progress.	112. All staff to be aware of the supervision process. Individuals to be aware of their own responsibilities within this. Managers to monitor the supervision rates and act accordingly.	31/12/17	This is checked at management supervision, but it is an ongoing process	N/A	CEO All managers across the organisation	Staff survey
The provider should review administrative and maintenance support to the units to ensure administrative tasks are undertaken in a timely manner where linked to patient care.	113. Review administrative services across the hospital	30/9/17		N/A	Director of Development Lead Administrator	Admin review document
	114. Implement recommendations from the administrative review, where appropriate	31/12/17		N/A		Feedback from units
	115. Admin lead to provide a Proposal for Change	31/10/17		N/A		Proposal for Change

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
The provider should ensure that an electrocardiograph machine can be accessed on each site.	116. New ECG machine to be provided, where necessary	31/8/17		Minimal, but there may be some delays	Medical Director	ECG availability
The provider should ensure that all staff have access to training specific to their role	117. Eating disorder specialist training to be sourced and provided	30/9/17	Some restrictions on training related to individual development has been imposed but this will be reviewed in early 2018	Minimal because all essential training is mandatory	Consultant Psychiatrist, Naomi Unit	Staff knowledge
	118. DID training to be sourced and provided	30/9/17			Consultant Psychiatrist, Kemp Unit	Staff knowledge

Actions from the Safeguarding Investigation carried out between February and July 2017

Recommendation	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
Risk assessments and care plans to be reviewed and updated in a timely way in response to an identified change in need and/or environment, in order to adequately inform safe and effective care delivery.	119. Units to ensure that system is in place to enable relevant staff to review and update risk assessments and care plans	31/10/17		N/A	Director of Operations Unit Managers	Care Plan Audits
	120. Unit managers to discuss the importance of updating risk assessments and care plans responsively, with their staff, in their individual management supervision	31/10/17		Risk of having out of date risk assessments and care plans, resulting in incorrect care being delivered to patients	Unit Managers	Management Supervision Records

Recommendation	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	121. Director of Operations to check with Unit Managers, during their management supervision, on their care plan audit outcomes against reviewing and updating care plans and risk assessments responsively	31/10/17		N/A	Director of Operations Unit Managers	Care Plan Audits Management Supervision Records
A robust audit system to be in place to ensure that care plans and risk assessments are up to date and accurately reflect and address the current risks.	122. Head of Nursing & Patient Safety[1] is to establish the frequency of risk assessment and care planning reviews, and embed into everyday monitoring practice, to ensure each care plan reflects and	30/09/17	This has begun and is in progress but until we are sure it is embedded we are not signing this off	N/A	Head of Nursing & Patient Safety Unit Managers	Nursing Practice Standards Care Plan Audits

[1] Please note that we have put in place interim arrangements for the Head of Nursing and Patient Safety role because the substantive post-holder is on long-term sick leave.

Recommendation	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	mitigates current risks.					
	123. Head of Nursing& Patient Safety to expand current care plan audit tool to ensure it is capable of measuring performance against the stated frequency for reviewing patient risk assessments and care plans.	30/09/17	Changes in personnel have impacted on this, but it is in progress	N/A	Head of Nursing & Patient Safety	Nursing Practice Standards Care Plan Audit
	124. Head of Nursing & Patient Safety to provide regular monthly KPI outcome measures, to the leadership team, to assure ourselves that the monitoring of risk assessments and care plans, and regular review of each, is effective and that any required corrective	31/10/17	Changes in personnel have impacted on this, but it is in progress	N/A	Head of Nursing & Patient Safety	KPI Dashboards Care Plan Audit

Recommendation	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	actions are taken in a timely manner					
Handwritten entries on daily monitoring charts should be signed, in accordance with defensible documentation standards.	125. Head of Nursing & Patient Safety to establish and communicate clear standards of practice in relation to all documented entries, including where handwritten entries are made.	31/10/17	In progress	N/A	Head of Nursing& Patient Safety Unit Managers	Care Plan Audits Nursing Practice Standards
	126. Head of Nursing & Patient Safety to create an audit tool capable of measuring performance outcomes against practice standards in relation to defensible documentation	31/10/17		N/A	Head of Nursing& Patient Safety	Nursing Practice Standards Audit Tool

Recommendation	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	127. Unit Managers to ensure all staff, including other colleagues, apply consistent practice against defensible documentation practice standards, and address any non-compliance with these standards, in a timely manner	31/10/17		N/A	Unit Managers	Nursing Practice Standards Audit Tool Management Supervision Records
Unit Manager/PMVA trainer to ensure that any identified staff training needs in relation to PMVA are addressed (including via 'bespoke' problem solving advice/support as necessary).	128. Director of Operations and Training Manager to conduct a full review of how PMVA training is managed, monitored and delivered	31/10/17		N/A	Director of Operations Training Manager	Revised PMVA Training Plan
	129. The PMVA Trainer to work with Unit Managers, staff and patients to ensure all	31/10/17		N/A	Training Manager Unit Managers	Care Plan Audit MDT Meeting

Recommendation	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	PMVA requirements have been assessed, and PMVA responses are person centred , and is reflected in the patients care plan; regular weekly reviews will occur within the MDT process ; and that PMVA Training Needs have also been assessed and delivered					Minutes Training Needs Analysis
Ensure that care delivery is reflective of the care plan – in particular, where the care plan requires daily monitoring and recording, records should evidence this (e.g. repositioning, personal care) and should contain sufficient detail.	130. Unit Managers to ensure all care plans accurately reflect the care required, and that appropriate records and/or forms provide the necessary detail required to evidence the level of care required and provided.	30/09/17		N/A	Unit Managers	Care Plan Audit
Ensure an appropriate wound	131. Head of Nursing &	31/10/17		Risk of wounds not being managed	Head of Nursing &	Wound Assessment

Recommendation	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
management system is in place (including assessment and monitoring) and wound documentation is completed to evidence best practice.	Patient Safety to develop a wound assessment tool that incorporates NICE guidance and the National Early Warning Score mechanism, and takes into account: ✓ All complex cases e.g self-harming ✓ All pressure ulcers ✓ All leg ulcers			and reviewed in a timely manner	Patient Safety	Tool
A robust system of auditing is to be in place to ensure that actions cascaded down to senior staff to implement are followed up on to ensure their implementation.	132. Head of Nursing & Patient Safety to complete a gap analysis on current audit tools and to identify and bridge any gaps; develop and audit system capable producing regular dashboards.	31/10/17		N/A	Head of Nursing & Patient Safety	Revised Audit Tools

Health, Housing and Adult Social Care Policy and Scrutiny Committee **15th January 2018**

Report of the Head of Commissioning, Adult Social Care

Residential, Nursing & Homecare Services – Quality Standards

Summary

1. Members of the Scrutiny Committee will recall the last report they received on the 20th June 2017 detailing the performance by organisations providing a service in York against Care Quality Commission standards. Members will also recall that there are robust processes in place to monitor the quality of services delivered by providers of Residential/Nursing Care and Homecare in York and are reminded that services are also regulated and monitored by the Care Quality Commission.

2. In October 2017, CQC published its "State of Adult Social Care 2014-2017" report which detailed findings from CQC's initial programme of comprehensive inspections across England in Adult Social Care. The report looks at the trends, highlights examples of good and outstanding care, and identifies factors that maintain high-quality care.

3. Key Headlines from the CQC national report show that 2% of services were rated as outstanding, 77% of adult social care services were rated as good, 19% were rated as requiring improvement and 2% as inadequate.

4. The report acknowledged that there is fragility in the adult social care sector influenced by funding and resource pressures but as the quality regulator, their focus is on the quality of adult social care services and the impact that this has on people who use services.

5. Key findings from the CQC report were;

    - At the end of their initial comprehensive inspection programme, almost four out of five adult (79%) social care services in

England were rated as good or outstanding overall. Nearly a fifth of services (19%) were rated as requires improvement and 2% as inadequate.

- CQC observed differences in performance from region to region, with the East of England showing almost 10% more locations rated as good or outstanding than the North West.

- Of the five key questions that they ask all services, safe and well-led have the poorest ratings, with around a quarter requires improvement and inadequate.

- Of the 5 key Questions, 'Caring' was the best rated with – 92% organisations good and 3% outstanding.

- Nursing homes remain the biggest concern.

- Generally, smaller services that are designed to care for fewer people were rated better than larger services.

- The public values the information in CCG inspection reports

6. Members will note the improved performance from the report received in June 2017. At that period 26.3% of providers in York were listed as requires improvement. At the time of writing in December 2017, there are still no providers rated as inadequate and the percentage requiring improvement had fallen to 16% with 83% of settings rated as Good and 1% as Outstanding. The performance is above national averages reported by CQC.

7. Well Led (Management and Leadership) continues to be a area of concern and the Council is working with it's partners through the Adult Social Care Workforce Strategy to address these issues and provide additional support to the sector. It is the only area where services in the City are below National indicators and Members should note further improved performance in other areas.

Background

8. All Residential, Nursing and Home Care services are regulated by the Care Quality Commission (CQC) and, as the regulator, it carries out regular inspection visits and follow-up visits (announced/unannounced) where applicable. The frequency of CQC inspections will be

dependant on the provider's rating and on intelligence received in between scheduled inspections. All reports are within the public domain and CQC have a range of enforcement options open to them should Quality and Standards fall below required expectations.

9. The Adults Commissioning Team work closely with CQC in the sharing of concerns and information relating to provision but the Council also adopts its own monitoring process (Quality Assessment Framework). The standards that it sets are high and providers are expected to achieve compliance in all aspects. Should performance fall below the level that is acceptable, a provider will be placed on enhanced monitoring or improvement plan. This can also lead to placements being suspended, often on a mutual basis, until quality and performance improves. The team on occasions will also undertake visits jointly with colleagues from the Vale of York Clinical Commissioning Group where it felt necessary or there are safeguarding concerns.

10. The Adult Commissioning team have a programme in place to undertake monitoring visits on an annual basis. These will be appropriate to the services provided and will consist of an Observation visit and /or a Quality Assurance Visit and consultation with residents/customers. Reports are shared with the provider and with CQC colleagues to inform their programme of inspections.

11. In addition to the visits listed above, the Commissioning team have regular Business Meetings with Social Care Providers and take a proactive partnership approach to effective working with providers in order to both support and encourage good practice and to work with providers where practice is not as expected to prevent issues escalating. Members will also recall the consultation that is undertaken jointly in care settings between the Adults Commissioning Team and Healthwatch.

12. CQC ratings of Outstanding, Good, Requires Improvement, or Inadequate are given both as an overall rating as well as for each of the five key questions. The tables below compare the current overall CQC ratings of York services to National figures published by The Care Quality Commission. CQC have identified nationally that "good systems and management are important drivers that support caring staff to deliver better services"

Analysis - Performance and Standards in York

13. The following tables provide an analysis of quality standards across care provision in York against those reported in the CQC report, nationally and on a regional basis across Yorkshire and Humber.

a) CQC Ratings (all settings) against National Levels

Overall Rating	Outstanding	Good	Requires Improvement	Inadequate
York	**1%**	**83%**	**16%**	**0%**
National (CQC Report)	**2%**	**77%**	**19%**	**2%**
Yorkshire & Humber (CQC Report)	**1%**	**74%**	**23%**	**2%**

York is largely on a par when compared to performance nationally and Members may wish to note that performance is slightly above that reported across the Yorkshire and Humber region.

- Members will note that not all York providers have had an inspection rating published to date (1 Nursing Home and 3 Home Care Services are outstanding). Where providers have not yet been inspected, this is due to administrative changes within the service, a change of premises, change of trading name or new provision.

- Copies of all CQC reports can be found at www.cqc.org.uk

b) Social Care Ratings by Key Questions

Area	Safe	Effective	Caring	Responsive	Well led
York	**84%**	**95%**	**99%**	**92%**	**72%**
(CQC Report)	**75%**	**82%**	**95%**	**85%**	**76%**

As well as the overall rating, CQC give all adult social care services a rating for each of the five questions that they ask of all care services.

These allow the reports to consider in greater detail all the issues that matter to people: are services safe, effective, caring, responsive to people's needs and well-led. The table below compares performance in York against the National position derived from the CQC report and shows that York services largely perform in line with National figures although effective and caring at 88% and 99% compliance are higher than National levels but well-led at 72 % is lower than national averages as we have highlighted previously to Members at Scrutiny Committee. The customer facing aspects of services are areas where York performs well on, with performance been higher in four domains compared to national figures.

c) Residential and Nursing Care Homes in York

Care Homes		
Outstanding	**1**	**2.6%**
Good	**28**	**73.7%**
Requires Improvement	**9**	**23.7%**
Inadequate	**0**	**0.0%**

Of the 39 homes in York, 38 have an inspection rating to date. The tables above detail the findings of these inspections and Members will note that 9 homes have been rated as requires improvement.

d) Home Care Service Inspections - York

Home Care		
Outstanding	**0**	**0.0%**
Good	**35**	**92.1%**
Requires Improvement	**3**	**7.9%**
Inadequate	**0**	**0.0%**

Of the 40 registered domiciliary care services providing homecare and supported living in York, 38 have been inspected to date. The above tables detail the findings of these inspections and Members will note that no services have been rated as inadequate although 3 have been rated as requiring improvement.

e) Compliance by Service Area

Residential Care

	CYC Residential Care Homes	CQC National Report
Outstanding	5%	1%
Good	77%	80%
Requires Improvement	18%	18%
Inadequate	0%	1%

Nursing Care

	CYC Nursing Care Homes	CQC National Report
Outstanding	0%	1%
Good	69%	67%
Requires Improvement	31%	29%
Inadequate	0%	3%

Domiciliary Care

	CYC Domiciliary Care Services	CQC National Report
Outstanding	0%	2%
Good	92.1%	80%
Requires Improvement	7.9%	18%
Inadequate	0%	1%

Summary

14. Alongside the above, Members may also wish to note the outcome of the latest Customer survey on Homecare which is undertaken by the Adults Commissioning Team. Out of a total of 215 customers or carers surveyed, 91 % stated that they were satisfied with the quality of the services they received.

15. Whilst some providers may be compliant within CQC inspections, there are instances where the pro-active monitoring and Quality Assessment Framework process adopted by the Council has identified some concerns that may lead to an improvement planning process being initiated or enhanced monitoring applied. Part of this process is often to adopt a mutually agreed suspension on new placements whilst issues are addressed.

16. Where providers are classed as 'requires improvement' for the Key Questions of Safe, and Well Led, this is largely due to staffing levels as providers continue to find recruitment and retention of suitable staff a challenge, both from a 'front line' and management perspective.

Implications

Financial

17. There are no financial implications associated with this report.

Equalities

18. There are no direct equality issues associated with this report

Other

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

Risk Management

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

Recommendations

21. Members to note the performance and standards of provision across care service in York.

Reason: To assure Members on the quality of adult social care services in York and the impact that this has on people who use these services

Contact Details

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Report Approved ✓ **Date** 20th December 2017

Specialist Implications Officer(s)

Wards Affected: **All** ✓

For further information please contact the author of the report

Health, Housing and Adult Social Care Policy and Scrutiny Committee

15th January 2018

Report of the Programme Director, Older Persons' Accommodation

Update on the Older Persons' Accommodation Programme

Summary

1. This report provides an update on progress towards delivering the Older Persons' Accommodation Programme (the "Programme") including Programme delivery, resource deployment and risk. The report shows that the Programme has been successful in delivering new Extra Care accommodation, allowing an increasing number of residents with high care needs to continue to live independently, in beginning to transform the Burnholme school site and is on track to deliver at least 700 new care beds and/or Extra Care homes by 2020. The report also reviews the impact of change upon the wider "care system" and highlights that a key risk to progress is the obtaining of Planning Consent for new developments.

2. The following summarises the status of the Programme:

Overall Status	On Target
Previous Status	On Target
Trend	Same
Risks	Under control, although the failure to achieve planning consent for key sites is now the key risk.
Update since last report	The Programme has progressed well, including: a) Completion of the 27 home extension of Glen Lodge. b) The Centre @ Burnholme is half way through construction and work on the new access road is nearly complete. c) Our partner to deliver the Burnholme care home has been awarded planning consent for their 80 bed home and construction work will being in February 2018.

	d) Willow House and Woolnough House older persons' homes have safely closed. e) The planning applications for the Lowfield Green development have been submitted and should be considered by Committee in the spring. f) Planning consent has been awarded for the new care home at Fordlands Road with the Council enabling this development by sale of the site. However, this decision may be the subject of Judicial Review.
Programme next steps	To progress the Programme the team will: a) Engage with and monitor the progress of the judicial review that has been sought in respect of the Fordlands Care Home planning consent. b) Support partners to submit the Oakhaven Extra Care scheme planning application. c) Submit the Marjorie Waite Court Extra Care Extension planning application. d) Develop plans for the sustainable and long-term future of sport provision on the Burnholme site. e) When they are ready, support the Priory Medical Group to submit a planning application for the health hub at Burnholme. f) Subject to obtaining planning consent, begin procurement of the care home at Lowfield. g) Subject to Executive approval, procure a partner to take over the ownership and management of Haxby Hall care home. h) Agree the future investment in accommodation with care at Lincoln Court. i) Work with residents at Windsor House older persons' homes to safely move them to new accommodation. j) Support partners in building new care accommodation at Fordlands, Burnolme and New Lodge and, subject to planning consent, at Regency Mews, Green Lane and on the Carlton Tavern site. k) Complete the sale of Grove House and Willow House and progress the future uses of the Woolnough House and Windsor House sites.

Recommendations

3. That the Committee review the update on progress to deliver the Older Persons' Accommodation Programme.

4. That the Committee note the good progress in delivering the Programme.

5. That the Committee request that a further update is presented at a future meeting.

Background

6. The Health, Housing and Adult Social Care Policy and Scrutiny Committee last received an update on the Programme at their meeting on 20th December 2016 and asked for regular updates. The Audit and Governance Committee also received an update on the Programme on 28th September 2016, looking particularly at programme management.

7. The Council's Executive on 30th July 2015 approved the Business Case for the Older Persons' Accommodation Programme. This will:

   a) fund 24/7 care support at Auden House, Glen Lodge and Marjorie Waite Court Sheltered Housing with Extra Care schemes;

   b) progress with plans to build a 27 home extension to Glen Lodge;

   c) seek the building of a new Extra Care scheme in Acomb;

   d) seek the procurement of a new residential care facility as part of the wider Health and Wellbeing Campus at Burnholme; and

   e) encourage the development of additional residential care capacity in York including block-purchase of beds to meet the Council's needs.

8. Executive on 7th December 2016 agreed additions to the Programme:

   a) authorising consultation on the option to seek a partner to take over the ownership and management of Haxby Hall with a commitment to deliver improved care facilities on the site; and

   b) agreeing to the procurement of a new residential care home on the Lowfield Green site.

9. Executive on 31st August 2017 agreed a further addition to the Programme:

   a) authorising a £6.6m investment in 33 home an extension to Marjorie Waite Court Extra Care scheme.

10. Sites affected by the Programme are shown on the map at **Annex 1**.

11. The context for the Programme is that there is a shortage of suitable accommodation with care for older people in York. This is caused by historic under-investment and an expected growth in the size of the over 75 population of the city (the 75+ population is expected to increase by 50% over the next fifteen years, from 17,200 to 25,800). 81% of York's 75+ population own their own home.

Progress Update

Glen Lodge Extra Care scheme

12. Construction of the extension to Glen Lodge Extra Care facility in Heworth is complete. The completion date was three months later than originally planned because of agreed additional works to the existing entrance area, poor weather over the winter, difficulties securing utility connections and poor organisation of finishing works by the contractor.

13. To date 14 residents had moved in by Christmas. Up to five apartments and one bungalow will be used for Step-down Care over the winter. The remaining seven apartments will be let and occupied in the new year.

14. The team now focus on fully mobilising the service and integrating existing and new residents, ensuring we give life to our vision of creating a safe and welcoming community for those who live independently but need care.

Burnholme Health & Wellbeing Campus

15. Construction of The Centre @ Burnholme [library and community facility] is progressing well. The existing building and new extension is being prepared for first fix with external walls up and roofs water tight. The new car park to the east of The Centre is complete. Work has re-started on the construction of the access road although cost responsibilities are still under negotiation. Work is on target for completion in May 2018.

16. Our partner Ashley House has received planning consent for the Care Home @ Burnholme and plan to begin construction in February 2018.

17. Executive have agreed to sell land to Priory Medical Group to accommodate their 4,000 m2 health hub. They propose a building which "sits" well between The Centre and The Sports facilities and which delivers both health facilities and, potentially, some upper floor housing accommodation. They plan a public engagement event in Q1 2018 to seek views and comments. They plan to re-locate GP services from three centres, bringing them together at Burnholme: the surgeries at

Tang Hall Lane, Millfield Avenue and Heworth Green. They have begun the appropriate consultation on these moves.

18. We have begun to engage GLA, the Council's leisure operator, in planning the future of the sport facilities at Burnholme.

Oakhaven Extra Care Facility

19. Ashley House have appointed a Housing Association partner to be involved in the management of the Oakhaven Extra Care Scheme.

20. They have sought planning guidance on their proposals and expect to submit their plans in Q1 2018. Before these are submitted we will hold a public engagement event.

Marjorie Waite Court Extra Care scheme

21. Executive agreed in August 2017 to invest £6.6m in an extension to Marjorie Waite Court Extra Care scheme. This will deliver 29 new apartments, four new bungalows, a 172 m2 community facility and enhancements to the services in the wider complex. It will include homes to rent and homes to buy.

22. Work has begun on preparing the planning application for this work. These plans were well received during tenant and neighbour engagement in December and we expect the planning application to be submitted in January 2018.

Lowfield re-development

23. The planning application for the Lowfield site including a detailed application relating to the housing, roads and public open space and an outline application relating to the care home, health centre, roads and public open space and community & self-build was submitted in October 2017 and is expected to considered by the Planning Committee in the spring of 2018.

24. Executive have agreed that the Council should be the developer of the Housing on the site. Cost consultants are engaged to price the proposals in order to confirm the affordability and profitability of the development.

25. With regard to the Yorspace land, we have obtained an independent valuation of this site and entered into an Exclusivity Agreement for sale.

26. Executive have noted the progress being made to deliver new football pitches at the Ashfield estate and agreed that we can engage in a

Community Asset Transfer to secure their long term use. The planning application for these works is being prepared and we have met with the Football Federation and Sports England, who support the proposals. This will ensure that replacement provision is available to allow the re-development of sports pitches at Lowfield.

Existing Older Persons' Homes

27. Consultation with residents, relatives, staff and potential partners at Haxby Hall is concluded and we will report this to Executive in January 2018 and await their decision regarding procuring a partner to take over the provision of services at Haxby Hall.

28. The proposal for a 64 bed care home at Fordlands has secured planning permission and construction work was planned to begin in Q1 2018. However, a request for a Judicial Review of the planning decision has been received and following the submission of our initial response we are currently awaiting the decision as to whether the Review will be allowed.

29. The proposal to deliver 33 apartments on the Grove House site has been approved by the Area Planning Committee and sale of this site will now proceed.

30. McCarthy & Stone are progressing well with the re-development of the Oliver House Older Persons' Home site (the home closed in 2012) to provide 36 retirement apartments.

31. Bids for the purchase of the Willow House Older Persons' Home on Long Close Lane, Walmgate, are being pursued although one developer, who planned student accommodation on the site, has withdrawn and, therefore, we will seek further "best and final offers" from the remaining bidders prior to concluding the matter.

32. Woolnough House older persons' home was closed in November 2017, with residents moving safely to new accommodation. We are exploring housing options for the re-use of this site.

33. Following consultation on the option to close Windsor House on Ascot Way, Executive has resolved that the home should close with residents moving to new accommodation. At the time of writing, 12 residents were left and more are expected to move during January 2018. Executive also agreed that the site should be used for the Centre for Excellence for Disabled Children and their families and, should this use not be feasible, for housing use and should this use not be possible, then for the site to be sold forthwith in order to generate a capital receipt to support the wider Older Persons' Accommodation Programme.

New Independent Sector Care Home provision

34. The Chocolate Works care home has opened, providing 90 care beds. The operator is slowly letting bedrooms so as to ensure a steady step up of service.

35. The plan to build a 76 bed care home on the site of the Carlton Tavern on Acomb Road (next door to Oakhaven) to deliver an integrated care solution for older people with a range of care needs was approved for consent by Planning Committee in October 2017. However, a challenge to that decision meant that the Committee refused the application when they meet in December 2017. The applicant is likely to appeal the decision to withhold consent.

36. An application to build a 66 bed care home on Green Lane in Clifton has been submitted and will be considered by the Planning Committee early in 2018.

New Independent Sector Extra Care provision

37. Work has begun on the construction of the care home and Extra Care apartments at New Lodge in New Earswick. The Joseph Rowntree Housing Trust expects the first phase of accommodation to be ready by Q2 2019 and work will continue until late 2020.

38. The Abbeyfield Society has submitted plans for the construction of a 25 home extension to their scheme at Regency Mews off Tadcaster Road. We agreed nomination rights to a proportion of these homes and expect the Planning Committee to consider the matter early in the new year.

THE NEXT PERIOD

39. Residents will continue to move into the new accommodation at Glen Lodge and a focus will be given to creating the therapeutic community that is desired.

40. Lessons learnt from the design and construction of Glen Lodge will be applied to the design of Marjorie Waite Court.

41. Work will continue on the construction of The Centre at Burnholme.

42. Public engagement events will be held to seek views on the proposed Health Hub at Burnholme.

43. Construction of the Care Home @ Burnholme will begin early in 2018.

44. We will submit the planning application for the Marjorie Waite Court Extra Care extension in January 2018.

45. Public engagement events will be held in January 2018 to seek views on the design of the Oakhaven Extra Care scheme and, following that, a planning application will be submitted.

46. A public engagement event will be held in January to seek views on the proposed football pitches at the Askham site and, following that, a planning application will be submitted.

47. The remaining residents at Windsor House will safely move to new accommodation during January and February.

48. In January 2018 we will seek Executive consent to begin procurement of a partner to take over Haxby Hall older persons' home.

49. In January 2018 we will achieve vacant possession of the Fordlands Care Home and move to conclude the sale to Octopus Healthcare so that they are in a position to begin construction. We will engage in the Judicial Review process and support the progression of this development in a timely manner.

50. Determination of the applications for the Regency Mews Extra Care extension and the Green Lane Care Home will take place early in 2018.

Moving Homes Safely

51. To date, the Programme has, following consultation, closed (or is closing) five council run care homes. These have closed because the buildings are no longer fit for purpose.

52. Residents from the four homes which have fully closed have moved safely to other accommodation with care, as follows:

Table 1: Destination of residents moving from closed care homes

	Grove House	Oakhaven	Willow House	Woolnough House	
In hospital	0	1	5	0	9%
Haxby Hall	8	6	6	2	32%
Care Home	7	11	9	7	49%
Extra Care	1	1	1	0	4%
Out of area	0	1	1	1	4%
Home	0	0	1	0	1%
TOTAL	**16**	**20**	**23**	**10**	**69**

53. The Programme has also invested in new Extra Care accommodation in the city as a viable alternative to residential care. To date this has delivered 152 new units of accommodation.

54. Extra care accommodation allows an individual or couple to live independently in their own home and benefit from on site domiciliary care, available night and day. This arrangement provides the support and safety which allows those with higher care needs to live independently.

55. Of the there schemes where we have invested in 24/7 care and new accommodation, we now see an increasing number of residents living with care needs, as the table below shows. At the beginning of the programme just 8% of Extra Care residents had "high" care needs; the UK benchmark is 30%. Table 2 below shows that our fleet of Extra Care schemes now accommodate more people with care needs than previously and that the percentage with high care needs has grown to 13%.

Table 2: Care needs of residents living in Extra Care

Level of planned care need funded by the Council	**Auden House**	**Glen Lodge**	**Marjorie Waite Court**	**TOTAL**
Total number of homes	41	69	42	152
High Care needs (more than 14 hours of care per week)	7	10	3	20
Medium care needs (8 to 14 hours of care per week)	7	16	6	29
Low Care needs (less than 8 hours of care per week)	9	10	3	22
Percentage with care	**56%**	**52%**	**28%**	**46%**
... and with high care needs	17%	14%	7%	13%

Note: 24/7 care at Marjorie Waite Court only began in April 2017.

56. Of the new lettings to our Extra Care schemes, the level of care at the point of moving in was:

    a) Auden House: six new lettings of which 4 had medium care needs and 2 had high care needs.

b) Glen Lodge: 20 new lettings of which 2 had low care needs, 13 had medium care needs and 5 had high care needs.

c) Marjorie Waite Court: two new lettings, 1 to a person with high care needs and 1 to a person with low care needs.

57. Further work will be undertaken during 2018 to ensure that we continue to increase the number of people accommodated in Extra Care who have high care needs, aiming to move closer to the national benchmark of 30%.

Programme Plan

58. The Programme plan is proceeding well.

Tasks & Milestones Status	On Target
Previous Tasks & Milestones Status	On Target
Tasks & Milestones Status Explanation	A high level project plan is in place and this will be reviewed and updated as the Programme proceeds. Detailed project plans are in place for the Burnholme Health & Wellbeing campus. Draft project plans are in place for the new Extra Care facility at Oakhaven, the Marjorie Waite Court extension, the new care home at Lowfield Green and changes at Haxby Hall.

Key Milestones

Date	Milestone
Q1 2018	Burnholme care home start on site.
Q1 2018	Submit Oakhaven Extra Care facility planning application.
Q1 2018	Submit the Marjorie Waite Court Extra Care extension planning application.
Q1-3 2018	Procure the Haxby Hall partner.
Q2 2018	Complete The Centre @ Burnholme
Q2 2018	Start on site at the Marjorie Waite Court extension
Q2/3 2018	Procure the Lowfield Green Care Home provider.
Q3 2018	Submit planning the application for works to Lincoln Court.
Q4 2017	Oakhaven Extra Care facility starts on site.
Q4 2018	Transfer service at Haxby Hall to new provider.
Q1 2019	Complete the Fordlands care home.
Q2 2019	Complete the Burnholme care home.

2020	Complete the Oakhaven Extra Care facility.
2020	Complete the Marjorie Waite Court extension.
2020	Complete the Lowfield Green care home.

Resources Deployed

59. The financial model for this project is now in place. The model has been used to support the Business Plan which was approved by the Executive on 30th July 2015. We have reviewed the model with the Programme Board in December 2017 and it remains on track to deliver savings of at least £553,000 by 2020.

60. Programme Board, CMT and the Executive agree that any capital receipts (up to the value of £4m) from the sale of existing elderly persons homes are ring-fenced for use on the Older Persons' Accommodation Programme. To date, approximately £9m is expected to be received from the sale of closed care homes. However, only £995,000 has been received to date as other receipts are subject to conditions

61. The £10m spent on the Glen Lodge extension and the Marjorie Waite Court extension are HRA funded investments, drawing upon grant from the Homes & Communities Agency alongside recycled Right to Buy receipts, section 106 monies as well as other funds and loans from the Council.

62. The costed business case for the Burnholme Health & Wellbeing campus and the enabling investment of £993,000 for the Lowfield Green development have been approved by Executive and Council.

63. The Programme is supported by the following staff resource:

    a) A Programme Director, four days per week.
    b) The Burnholme Project Manager, three days per week.
    c) Moving Homes Safely Care Reviewer, three days per week.
    d) Funded internships, approximately two per year.
    e) Project Associate, full time until winter 2018 [vacant].
    f) Programme Co-ordinator, full time until winter 2018 [currently vacant and covered by the Project Associate but

expected to be filled early in 2018].

g) The consultation on closure of OPHs and any subsequent closure process is led by the Head of Operations.
h) The full time Project Manager post is currently held vacant.
i) In addition, project management for the Glen Lodge extension and the Marjorie Waite Extra Care scheme is provided by the Housing Development team.
j) HR, financial, legal, procurement and other advice is provided by corporate colleague or external partners.

64. In 2018 additional programme support will be required in order to assist with the preparation for occupation of The Centre @ Burnholme, the Haxby Hall procurement, the Lowfield Green Care home procurement and the Marjorie Waite Extra Care procurement. Potential candidates for the Programme Co-ordinator and Project Associate posts are being evaluated at present.

Programme Outcomes

65. The Programme is expected to deliver the following outcomes by 2020. Good progress is being made towards this goal, as shown in Table 3 below.

Table 3: Expected outcomes from the Programme

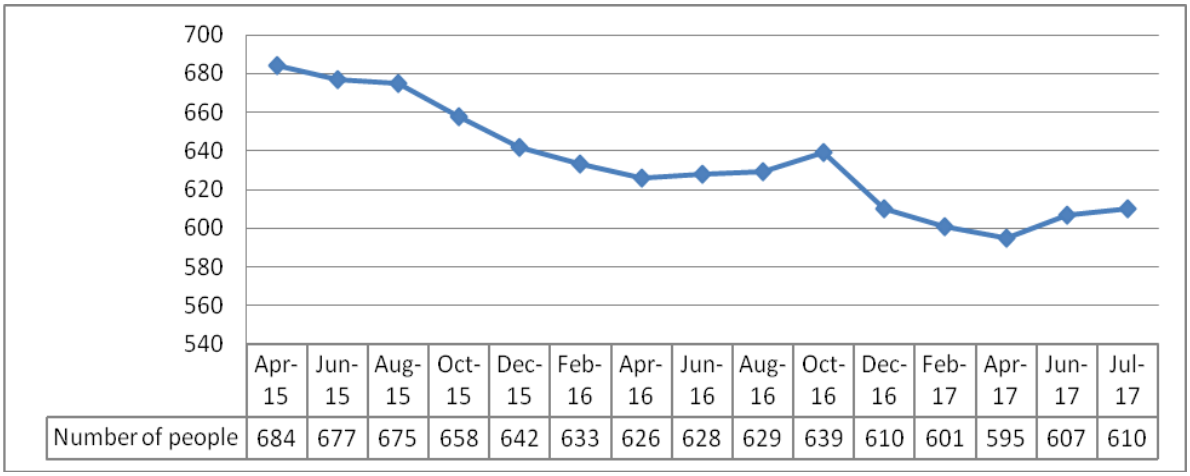
Activity	TOTAL	2014	2015	2016	2017	2018	2019	2020
Availability year on year	[redacted]	1655	1696	1684	1777	1749	2134	2368
TOTAL new provision	861	[redacted]						
Net New provision	713	[redacted]	41	-12	93	-28	385	234
New provision with planning consent		[redacted]	41	42	159	0	228	65
Sheltered Housing convert to Extra Care		[redacted]	41	42	42			
Chocolate Works Care Home		[redacted]			90			
Glen Lodge Extra Care extension		[redacted]			27			
New Lodge Care Home		[redacted]					44	
New Lodge Extra Care		[redacted]					40	65
Burnholme Care Home		[redacted]					80	
Fordlands Care Home		[redacted]					64	
Sub total, new provision	*535*	[redacted]						*0*
Planned new provision awaiting consent		[redacted]	0	0	0	0	157	169
Regency Mews Extra Care		[redacted]					25	
Oakhaven Extra Care		[redacted]					56	

Activity	TOTAL	2014	2015	2016	2017	2018	2019	2020
Lowfield Green Care Home								70
Green Lane Care Home								66
Carlton Tavern Care Home							76	
Marjorie Waite Court Extra Care extend								33
Sub total, new planned provision	326							
Closed or potential closed provision			0	-54	-66	-28	0	0
Oakhaven, closed				-27				
Grove House, closed				-27				
Willow House, closed					-33			
Woolnough House, closed					-33			
Windsor House, closing						-28		
Morrell House, to be the subject of consultation to close						-29		
Sub total, closed or potential closed provision	*-177*							

The operation of the care market in York

66. As the Programme has progressed, and as we continue to drive to support people to living independently in their own home as an alternative to nursing and residential care, we have seen a slow but steady reduction in the number of older people who are supported by the Council to live in permanent residential and nursing care, as shown in Table 4.

Table 4: Numbers of people in permanent residential and nursing care funded by the council, both CYC provision and independent sector (Snapshot at month end)

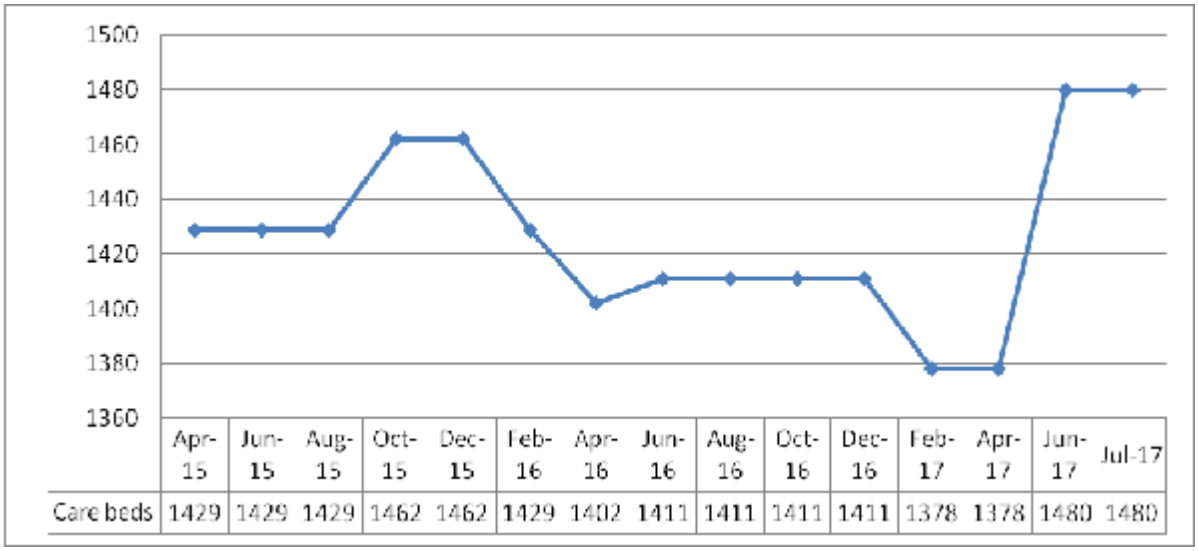


	Apr-15	Jun-15	Aug-15	Oct-15	Dec-15	Feb-16	Apr-16	Jun-16	Aug-16	Oct-16	Dec-16	Feb-17	Apr-17	Jun-17	Jul-17
Number of people	684	677	675	658	642	633	626	628	629	639	610	601	595	607	610

67. At the same time, the total number of care beds available for use in the city has initially fallen (as Council-run homes are

closed) and is now beginning to increase as new provision, such as The Chocolate Works, is brought into use, see Table 5.

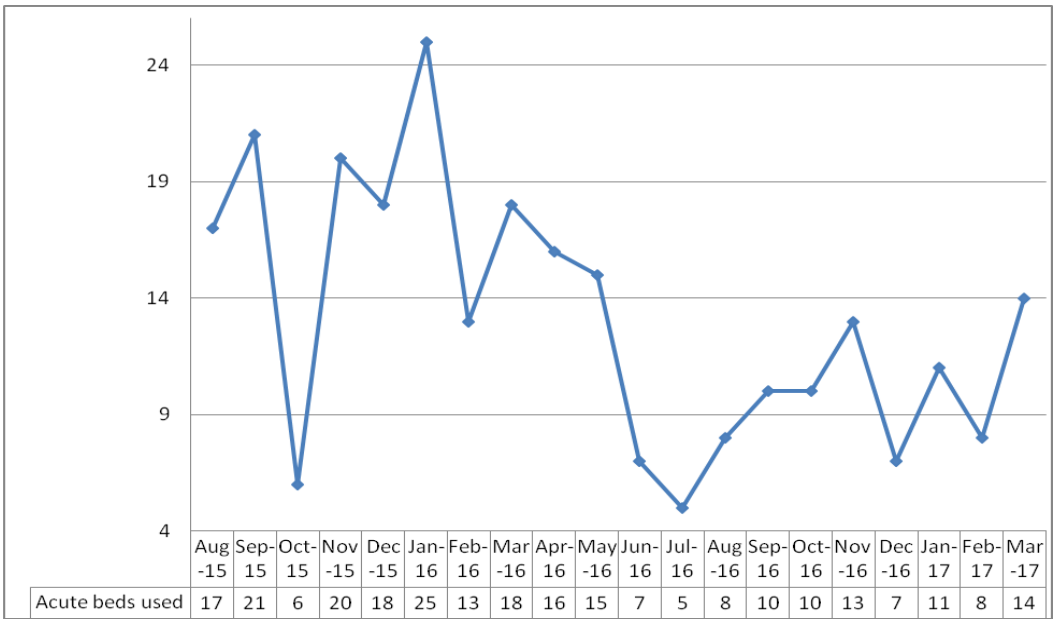
Table 5: Care beds available for use



	Apr-15	Jun-15	Aug-15	Oct-15	Dec-15	Feb-16	Apr-16	Jun-16	Aug-16	Oct-16	Dec-16	Feb-17	Apr-17	Jun-17	Jul-17
Care beds	1429	1429	1429	1462	1462	1429	1402	1411	1411	1411	1411	1378	1378	1480	1480

68. The changes in the number of residential care beds over the same period and including the closure of Grove House, Oakhaven and Willow House, does not appear to have had a detrimental effect upon the number of people awaiting discharge from hospital, as the graph in Table 6 shows.

Table 6: Numbers in acute hospital beds occupied by someone "awaiting discharge" (Snapshot on last Thursday of month)

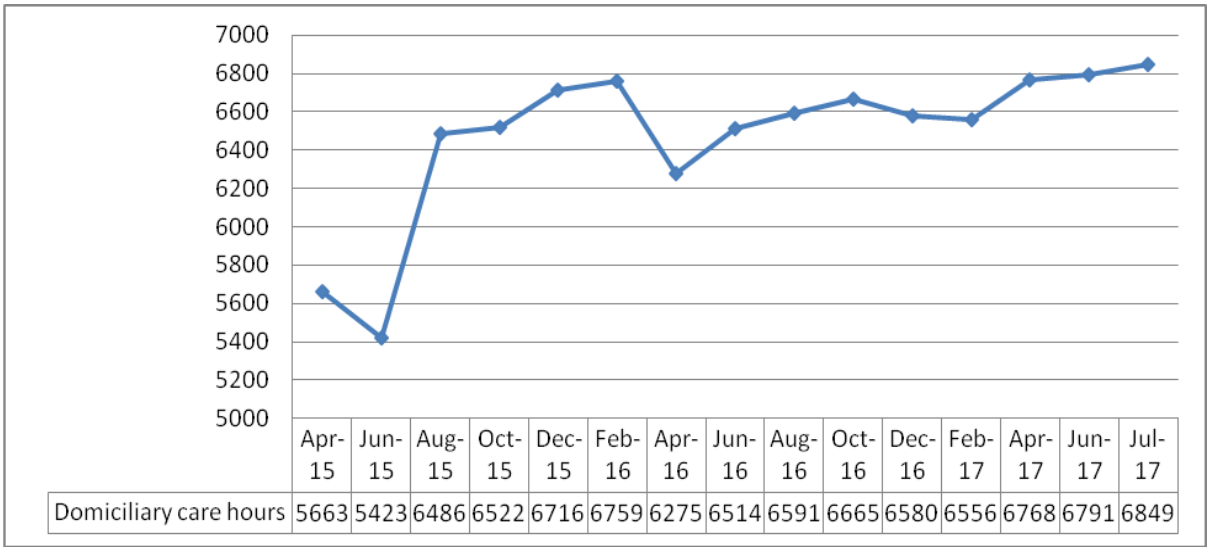


	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Acute beds used	17	21	6	20	18	25	13	18	16	15	7	5	8	10	10	13	7	11	8	14

69. Finally, we see from the trend in use of domiciliary care over

the same time period that more activity is recorded, suggesting that those with higher care needs are being helped to continue to live independently at home, as Table 7 shows.

Table 7: Net change in domiciliary care hours



	Apr-15	Jun-15	Aug-15	Oct-15	Dec-15	Feb-16	Apr-16	Jun-16	Aug-16	Oct-16	Dec-16	Feb-17	Apr-17	Jun-17	Jul-17
Domiciliary care hours	5663	5423	6486	6522	6716	6759	6275	6514	6591	6665	6580	6556	6768	6791	6849

70. Risks

Risks Status	On Target
Previous Risks Status	On Target

Key Risks

71. Key risks are kept under review and mitigations are pro-actively managed. Recent progress in mitigating risks include:

a) The acceptance of a good offer above original estimate for the site of the Fordlands care home and the potential for a good offer for the Willow House site, subject to Executive and planning consent.

b) Appointment of a partner to build the Burnholme care home on terms acceptable to the Council and the award of planning consent for their proposal.

72. The key risk for the Programme as we move into 2018 is the award of planning consent. While a positive planning decision regarding Burnholme have been made, the change of decision regarding the Carlton Care Home (a change from approve to refuse) and the request for a Judicial Review of the Forldands planning consent approval illustrates the risk that failure to achieve planning approval poses to the delivery of new accommodation with care at these sites and elsewhere.

73. A further key risk remains lack of partner interest in our proposals. Once more, good interest has been shown in the offer at Burnholme but we have yet to see sufficient progress at Oakhaven to satisfy a reduction in the risk score in this respect. Further, as we seek partners for the Lowfield Green care home and for Haxby Hall we must keep in mind the risk of lack of interest. Should there be no interest in taking on Haxby Hall as a going concern then we will need to consider reverting to the original plan of consulting on the option to close the site.

74. Other risks for this project have been identified and appropriate mitigations have been identified and will be managed.

	Risk	Control/action	Gross	Net
75.	Anticipated level of capital receipts not realised.	Work closely with partners and CYC finance to maximise capital receipts.	**19**	**8**
76.	Incorrect procurement of capital works.	Applying due diligence to ensure Council's normal approach to procurement of capital works.	**13**	**2**
77.	Increase in interest rates.	Ensure impact is capped or controlled through the contracts.	**19**	**14**
78.	Rising cost of external residential care providers.	Agreement of the Actual Cost of Care rates for a three year period.	**19**	**14**
79.	Project does not deliver the right number and type of care places required by the city.	Good progress has been made in delivering a range of accommodation with care options across the city.	**19**	**6**
80.	Loss of morale for existing OPH staff leading to negative impact on service provided to current OPH residents.	Maintain staff morale and focus through regular briefings/updates; engagement through OPH Managers and staff groups; investment in staff training, support and development.	**19**	**13**

	Risk	Control/action	Gross	Net
81.	Challenge and negative publicity from existing OPH residents and relatives.	Development of good communications via briefings to residents and relative, Executive, group leaders, TUs, OPH Management & Staff, OPH Programme Wider Ref Group, media etc.	**19**	**13**
82.	Burnholme - Disposal of redundant school assets not approved by Department for Education.	Consent awarded.	**8**	**0**
83.	No long term commitment from NHS Provider Organisations.	Early engagement with CCG as commissioning body. Bidding for development resources.	**19**	**14**
84.	Burnholme - Private Sector not attracted to financial viability.	Partner appointed to deliver the care home at Burnholme.	**19**	**6**
85.	Burnholme - Planning Permission not granted / onerous.	Planning consent awarded for two of the five elements of the development, both without public objection.	**18**	**12**
86.	Burnholme - Phasing & Construction Conflict.	Consider in deliberations regarding commercial options.	**19**	**14**
87.	Burnholme - Construction Costs exceed pre-tender estimates.	Secure qualified technical advice when considering financial modelling, anticipate need for value engineering.	**19**	**14**

Contact Details

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<tr><td colspan="5">Specialist Implications Officer(s)
Legal – Walter Burns (Ext 4402); Gerard Allen (Ext 2004)
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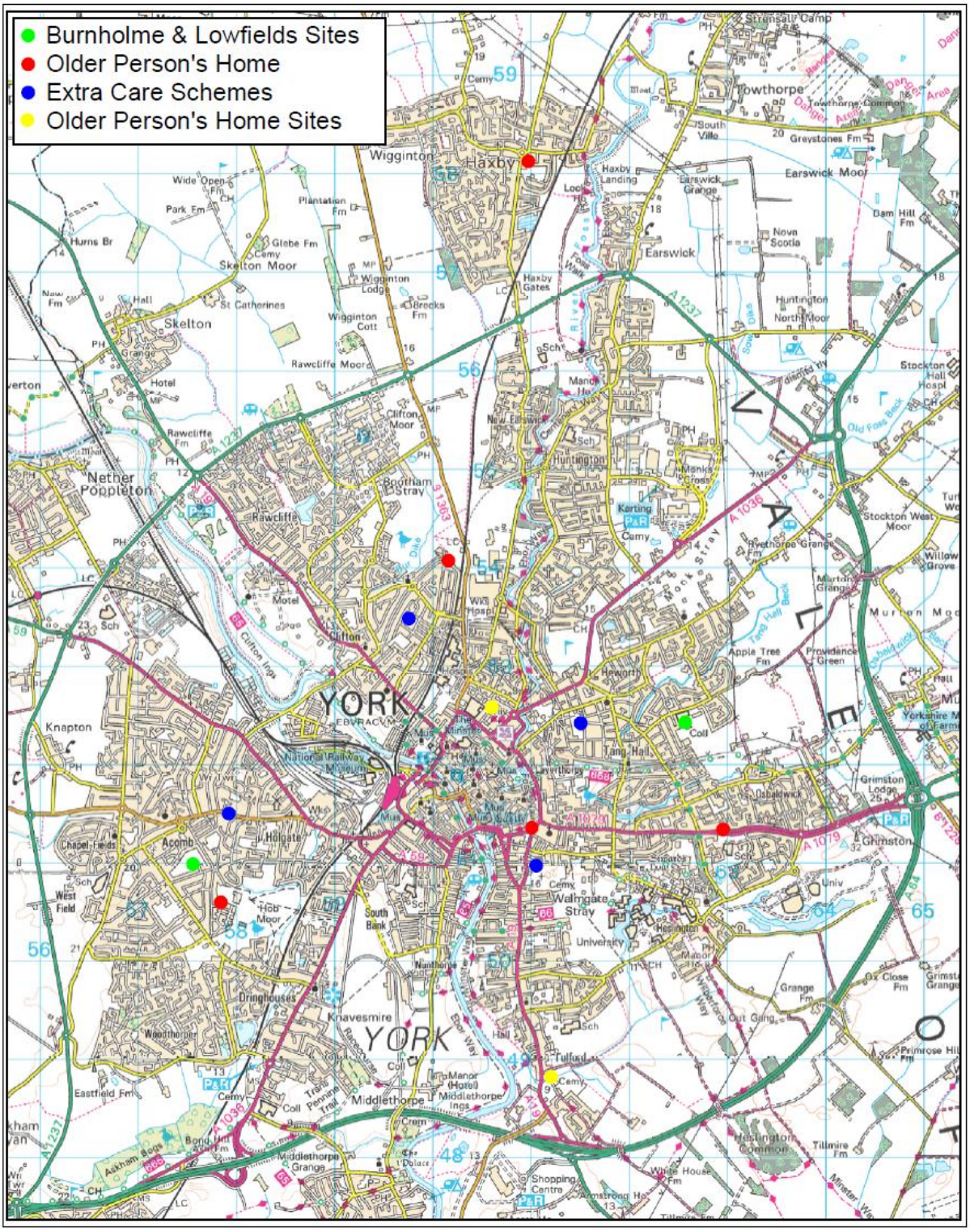
Property – Philip Callow (Ext 3360) and Ian Asher (Ext 3379)</td></tr>
<tr><td colspan="3">Wards Affected: List wards or tick box to indicate all</td><td>All</td><td>✓</td></tr>
<tr><td colspan="5">For further information please contact the author of the report</td></tr>
</table>

Annex 1: Plan: CYC Homes and Sites included in the OPAP



CITY OF YORK COUNCIL

CBSS
Asset & Property Management

Older Person's Accommodation Programme Sites

N
W E
S

SCALE 1:50,000 DRAWN BY: DH DATE: 16/11/2015

Originating Group: Asset & Property Management

Drawing No.

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Health, Housing & Adult Social Care Policy & Scrutiny Committee **15 January 2018**

Report of the Assistant Director, Governance & ICT

Further Update on Implementation of Recommendations from the Previously Completed Housing Registrations Scrutiny Review

Summary

1. This report provides the committee with a further update on the implementation of the recommendations arising from the previously completed Housing Registrations scrutiny review, and asks Members to sign off any recommendations now considered to be either fully implemented or no longer appropriate.

Background

2. In March 2016 the former Communities & Environment Policy & Scrutiny Committee received an overview of the council's Housing Allocations & Choice Based Lettings system. This provided an update on an ongoing officer review of the Council's current working methods, and the legislation and North Yorkshire Homes Choice (NYHC) allocations policy that governs those processes.

3. The Committee agreed they would like to participate in the ongoing review and a Task Group was formed. In early May 2016 the Task Group met for the first time to receive introductory information in support of their review and agreed the following review aim and objectives:

   Aim

   'To actively engage with and contribute to the ongoing officer review, to help shape improvements to the Council's housing allocations process and contribute to the decisions and actions to be taken around the Council's Housing Allocation & Choice Based Lettings System.'

Objectives

i. To review the Housing Registrations service to understand the Council's policy, process, systems and application criteria.

ii. To consider national good practice, visits and findings of the 'Allocations Service Development Officer Review' work to date.

iii. To consider proposed changes to the Housing Registrations service, systems and policy and the implications associated with any changes.

6. The Task Group worked closely with Housing Officers and the review final report with the recommendations arising from the review (see Column 1 of Annex A) was presented to the former Communities & Environment Policy & Scrutiny Committee in July 2016, resulting in all of the arising recommendations being endorsed and fed into the ongoing officer review.

7. The Housing Team subsequently completed their review and their report on the review of the Housing Registrations Service was considered by the Executive Leader at his decision session in October 2016.

8. An update of the implementation of the review recommendations was considered by the former Communities & Environment Policy & Scrutiny Committee in May 2017 with recommendations (ii) and (ix) being signed off as fully implemented. Members agreed that a further update on the remaining recommendations be provided to the relevant Scrutiny committee in January 2018.

Consultation

8. The Housing Officers supported this scrutiny review and will be present at this meeting to provided further information on the ongoing work to respond to changes in housing related legislation.

Options

9. As the outstanding recommendations will be implemented in time through either the introduction of the Council's new Local Plan, or as part of the council's ongoing work to address changes to housing related legislation Members may choose to sign off the outstanding recommendations on the understanding that this scrutiny committee will in future receive overview reports relating to housing and the council's allocations policy.

Council Plan 2011-15

13. The Housing Registrations Scrutiny Review supported the Council's priority to listen to residents and deliver frontline services.

Implications & Risk Management

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

Recommendations

15. Members are recommended to:

    i. Note the implementation update information detailed in Annex A.

    iii. Sign off the remaining recommendations and request that this committee receive regular updates on the ongoing work to respond to changes in housing related legislation etc.

    Reason: To conclude this review in line with scrutiny procedures and protocols and inform the future work of scrutiny

Contact Details

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Report Approved ✓ **Date** 2 January 2018

Wards Affected: **All** ✓

For further information please contact the author of the report

Annexes:

Annex A – Further Update on Housing Registrations Review Recommendations

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Housing Registrations Scrutiny Review

Recommendations endorsed on 18 July 2016	Implementation Update as of May 2017	Implementation Update Jan 2018
i) A new IT system to be introduced	Approval was granted in December 2016 to purchase a new ICT system (£1.2m). However it is likely to take up to 2yrs to have a new system in place as the new Allocation Policy will need to inform the requirements of the system.	Project team is in place and is working with the business on developing a specification to go to procurement for April 2018. Housing are looking to combine 17 systems and sundry peripheral records in to one system.
ii) Personal interviews for new applicants to be introduced	These were introduced in early 2016 – information on the impact of those interviews in detailed in Annex B.	This action has been completed. All applicants have a comprehensive personal / phone interview. This process has reduced the numbers of bronze band (adequately housed) on NYHC.
iii) An online waiting list for applicants to view to be introduced	This requires the new ICT system to be in place	As above.
iv) That both the bronze band and the 'potentially homeless' gold band status be removed from the allocations policy, with some minor exceptions	This will be considered as part of the review of the allocations policy, which is due to be consulted on later this year. There has been an increase in the number of applicants within all bands	Stage 1 staff consultation completed. Public consultation will take place early 2018

v) Housing officers give further consideration to the implications of introducing a mixed approach to allocations i.e. some choice based lettings for some customer groups initially, with the option for officers to allocate if customers are not placing sufficient bids to resolve their housing need.	since the scrutiny review was undertaken and in spite of the introduction of personal interviews	As above but likely to recommend remaining with CBL
vi) That the council endeavours to add to its housing stock in the future through the introduction of multiple occupation properties	It is recognised that the introduction of multiple occupation properties will require additional management resources. The implications associated with their introduction will need to be considered in full as part of future policy changes.	The dropping of legislation intended to extend the local housing allowance rates on social housing including the single room rate for under 35s has reduced the need for this. It may be explored as part of the council's development vehicle.
vii) That the council proactively increases the availability of social/affordable housing through the Local Plan	The new Local Plan will include specific policies on the delivery of affordable housing. Officers in Housing are seeking to maximise the delivery of affordable housing whilst ensuring that developments remain viable. Although robust affordable housing policies in the local plan will be of critical importance, there are measures and initiatives that have been taken in advance of that to increase the numbers of affordable homes being provided. • A programme of council house	The local plan is out for consultation and will be in place in 2018. It will include agreed levels of affordable housing on new developments. Further announcements by the government on funding for development and infrastructure will present new opportunities. The schemes detailed previously are progressing.

	building has seen 65 new homes built with another 35 currently on site and 68 more proposed. • A £2.76m grant from the Homes and Communities Agency (match funded by the HRA Investment Fund) to deliver 65 shared ownership homes. • £850k Homes and Communities Agency Funding towards the capital costs of the Extra Care development at Glen Lodge • Housing association led development continues at Derwenthorpe and recently completed affordable homes at Hobstone, York. • A partnership with the Homes and Communities Agency to accelerate housing development on strategic sites in York including York Central and sites in the council's ownership including the former Lowfield School and the former park and ride site at Askham Bar	A further £20m development fund has been created via the Housing Revenue Account Business plan which includes potential to buy on the open market and first refusal on former council homes in certain cases party using retained Right To Buy receipts. A number of small pipeline developments are being worked up on housing land which is very limited. The Older Persons Accommodation Programme progresses with the intended development of Marjorie Waite Court submitted for planning permission.
viii) That revisions may be required to planning guidance in order to encourage the building of more affordable family homes and help address the pressure on the city's 2/3-bed social housing stock	As part of the Preferred Sites Consultation 2016 the Strategic Housing Market Assessment (SHMA) and the SHMA Addendum produced for the Council by consultants GL Hearn were released, on July 18th 2016, as supporting documents.	At the Executive in July 2017 Officer's sought approval to undertake consultation on a Pre publication draft Local Plan. To support this process the report considered future housing and employment growth for York, and a

	This work updated the Objectively Assessed Need (OAN) previously undertaken to support the emerging Local Plan. The OAN in the SHMA of 841 dwellings per annum uses the 2014 based Sub National Population Projections (SNPP) as the demographic starting point which was released by the Office for National Statistics on 25th May 2016. Following the approval at Executive for the Preferred Sites Consultation the Department of Communities and Local Government (DCLG) released the Sub National Household Projections (SNHP) which updates the previous 25th May 2016 release. In addition over ten alternative OAN reports produced by consultants on behalf of landowners/developers were submitted as part of the 2016 Preferred Sites Consultation. It is important that both the DCLG update and the alternative OAN are considered in full. This requires further technical analysis and GL Hearn have been commissioned to update the SHMA and to analyse the specific relevant representations that have been received through the Preferred Sites Consultation. This work is underway and	series of sites to meet the related arising demand. It also included recommendations on non sites related policies including affordable housing. This work was subject to assessments of viability. A city-wide consultation on the Local Plan Pre Publication Draft commenced on the 18th September and finished on 30th October 2017. It was carried out in compliance with the Council's adopted Statement of Community Involvement (2007). The consultation included contacting individuals and organizations on the Local Plan database, public exhibitions, meetings, a special edition of 'OurCity, and information via both local and social media. Officers are currently processing the response and formulating policy recommendations. These will be considered by the Local Plan Working Group and Executive in January.

	will be reported back to Members, as a part of the Local Plan. Work to write the policies for the Local Plan will need to be completed and reported to Members. This will take account of national policy changes and local evidence base updates. Therefore, work is currently being undertaken to update the housing policies, within the Local Plan. This will include taking account of national policy changes, including the implications of the recent Housing White Paper and local evidence base updates including the SHMA. This will be informed by the technical analysis that GL Hearn have been commissioned to undertake.	
ix) CYC to re-negotiate the current arrangements in order to address the findings from the CYC's officer review. Should this prove unsuccessful the Task Group recommends that CYC withdraw from that partnership and attempt to negotiate a new mini partnership with a reduced number of other specific local authorities in order to focus on the needs of York residents and those in the closest locality.	A period of negotiation was undertaken with North Yorkshire Nome Choice partners but it was unsuccessful. They have since been informed of CYC's intention to withdraw from the partnership.	Current NYHC partners remain committed to NYHC and as such do not wish to negotiate a mini partnership. Providers with housing stock in York have confirmed they will continue to work with CYC if the final decision is to have a York only policy.

Annex A

Health, Housing & Adult Social Care Policy & Scrutiny Committee 15 January 2018

Report of the Assistant Director – Housing & Community Safety

Update report on Housing Allocations & Choice Based Lettings Update

Background

1. A previous report was presented to the former Communities & Environment Policy & Scrutiny Committee on 18 July 2016 which set out a series of options regarding the future involvement of City of York Council (CYC) with North Yorkshire Home Choice (NYHC) common allocations policy and choice based lettings system.

2. The report outlined officers' concerns in relation to North Yorkshire Home Choice, including the IT system, internal process, sub regional consistency and benefit to York residents.

3. A Task Group was established to participate in an ongoing officer review and agreed that:
    - Consideration should be given to reconfiguring the council's social housing stock e.g. the introduction of multiple occupation social housing opportunities for suitable applicants.
    - The need for additional social housing across the city to be addressed through the Local Plan.
    - Planning guidance should better reflect the urgent need for more affordable family homes to alleviate the pressure on the city's 2/3-bed social housing stock.

The Current Position

4. The situation has changed since Task Group made its recommendations in the following ways:

    - Internal changes have taken place in respect of some concerns around efficiency and duplication through the service review of

the CYC Housing Registrations Team. This restructure, which commenced on 4th January 2016, has enabled the team to deliver face to face or personal telephone interviews rather than online applications with all customers and consequently staff are able to give more personal / realistic housing advice. Outcomes include the reduction in applications from those with no housing need and improved service to customers, up front realistic advice and a single named contact, although some customers are still dissatisfied as we are unable to offer accommodation in a timescale to suit them.

- The project to replace all Housing ICT systems is underway and due for implementation 2018/19. This should address issues with void times. The existing ICT system is inflexible and requires significant manual intervention and creates failure demand.
- The Homeless Reduction Act 2017 (comes into force 3rd April 2018) has introduced new statutory duties to prevent and relieve homelessness, recording and statistical requirements which will impact on any IT system.
- That consultation has taken place with stakeholders and staff to develop a draft CYC allocations policy.
- Discussions with partners in NYHC have taken place and all other partners remain committed to NYHC for the foreseeable future. They do not wish to form a mini-partnership with York as an alternative.
- Partners have indicated that if York left NYHC they would work with us via CYC allocation policy. Registered Social Landlords (RSLs) would not guarantee 100% vacancies but would revert to historic nomination rights (circa 70%). Some RSL's would not apply a local connection to the remaining 30%.
- Recent announcements regarding amendments to current welfare benefits regulations in particular that local housing allowance will not be applied to social rents and as such the pressure to provide more bedsits shared housing has reduced.

5. Current NYHC statistics show the move to personal contact reduced demand in York for households with little / no housing need.

		Emergency	Gold	Silver	Bronze	TOTAL
31/3/14	York	3	220	1166	922	2311
	Sub Region	19	804	3864	5474	10161
31/3/16	York	3	213	878	518	1612
	Sub region	10	627	2792	3409	6838
12/10/17	York	2	224	988	462	1676
	Sub region	9	689	3000	3287	6985

6. Statistics also show that overall more people move from the York area than in to York via NYHC. For example:

- In January 2016 14 households moved from York to other partner areas with 9 moving in.
- In October 2017 15 households left York for other partner areas and 7 moved in.

See **Annex A** for more detailed information on these months for movement across partner areas. Whilst this is one of the advantages of the partnership this has to be balanced against the inefficiencies of the system and inflexibility of the ICT system.

7. There are some proposed changes to NYHC policy agreed by the board. These will be implemented shortly subject to legal advice on these currently being sought.

- Financial Assessments to be completed for applicants.
- All non-bidders will receive a letter on a 12 month rolling review basis. They will be given 28 days to contact us in order to remain on the register and will need to re-register if the application is ended.
- Sharing Facilities – this would only apply to non family members in a household who would retain Silver Band
- Good Tenant Scheme maximum band silver rather than moving up a band as happens currently where the maximum band is gold.
- Reduction in the age to qualify for a bedroom without the need to share from 21 to 16 in line with benefits legislation. Currently policy allocates a bedroom to an adult 21 years or above, which

means that you could have a 20 year old of the same sex sharing with a 6 year old.

8. CYC is committed to NYHC until the new CYC IT system is introduced but a decision is required in summer 2018 in order to incorporate any changes into the new IT system. The proposed policy makes reference to new legislation, in particular the Homeless Reduction Act 2017.

A draft allocation and lettings policy for City of York Council area

9. In the event that CYC decide to leave the NYHC partnership there would be a need for a York specific policy that RSLs with stock would adopt for York based properties that they own and where CYC enjoy nomination rights.

10. A draft policy based on initial consultations with partners and staff is currently being finalised.

11. The significant changes between the NYHC policy and the proposed York specific policy will be contained in the public consultation process. These can be found at **Annex B** and include:

- Information on different aspects of the policy
- Reason for having them in the policy
- An agree / disagree indicator with a request for comments

Consultation

12. The statutory public consultation on this policy will take place during January and March 2018 with a paper to executive for final decisions in June 2018

13. Members of the this committee are invited to take part in the formal consultation.

Council Plan 2015-19

23. A review of the Council's Housing Allocations process would support the Council's priorities to focus on frontline services and listen to residents.

Implications & Risk Management

24. There are no implications or risks associated with the recommendation in this report.

Recommendations

25. Members are asked to:

I. Note the information in this report

II. Consider and comment on leaving the NYHC partnership and allocation policy

III. Consider and comment on the method for allocating properties via a York allocation and letting policy (direct lets or choice based lettings)

IV. Consider and, comment on the significant changes as detailed in **Annex B** to form part of the overall consultation.

Reason: To proceed with the work on the allocations policy for York residents (subject to formal decision) and of scrutiny in line with scrutiny procedures and protocols

Contact Details

Author:	**Chief Officer Responsible for the report:**
Becky Ward, Service Manager, Homelessness & Housing Options.	Tom Brittain AD Housing & Community Safety
Denis Southall, Head of Housing	**Report Approved** ✓ **Date** 5/01/2017

Specialist Implications Officer(s) N/A

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers: N/A

Annexes -

Annex A – Movement between NYHC partner areas
Annex B – Draft consultation document on substantial changes in allocation and lettings policies

Abbreviations:

NYHC - North Yorkshire Homes Choice
CYC – City of York Council
RSL – Registered Social Landlord

Movement between NYHC partner areas:

January 2016

	Craven	Hambleton	Richmond-shire	Ryedale	Scarborough	Selby	Into York ↓	To ↓
Craven →	12	0	0	0	0	1	0	13
Hambleton →	0	53	0	0	1	0	1	55
Richmondshire →	0	3	22	0	0	0	1	26
Ryedale →	0	5	1	11	1	1	3	22
Scarborough	0	0	0	1	74	1	0	76
Selby →	0	2	0	2	0	26	4	34
From York →	1	0	0	8	1	4	90	104
Total	13	63	23	22	77	33	99	330

October 2017

	Craven	Hambleton	Richmond-shire	Ryedale	Scarborough	Selby	Into York ↓	↓
Craven	10	0	0	0	0	0	0	10
Hambleton	0	31	0	5	0	0	3	39
Richmondshire	0	2	19	1	2	2	0	26
Ryedale	0	2	0	10	3	0	2	17
Scarborough	0	0	0	0	84	0	1	85
Selby	0	0	0	0	0	26	1	27
From York →	1	3	0	4	0	7	36	51
Total Tenancy Started→	11	38	19	20	89	35	43	255

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Annex B – Consultation on substantial changes in allocation policy

Eligibility. The following people would not to be able to register for social housing in York	**Why**	**Agree? Provide Comments**
To add: That someone who is assessed as not having mental capacity should only be able eligible to register following a best interest meeting	To protect vulnerable	YES or NO
Qualification criteria. The following people would not to be able to register for social housing in York		
To restrict registration for applicants with no housing need other than 60+, who wish to move Independent Living Community (previously sheltered or Sheltered with extra care) or specific 60+ housing	To ensure appropriate housing / support for older person	YES or NO
To restrict registration for applicants with no housing need other HM Forces.	Legally obliged to give reasonable preference	YES or NO
Rent arrears – The document will give a clearer definition of rent arrears, and will incorporate private rent arrears. '*People who owe current rent whether to a social housing provider or a private landlord which is in excess of 8 weeks payable rent.*	Cleared definition of arrears, consistency in private rented sector	YES or NO
People who have outstanding housing related debt and have made no payment arrangement	To accept responsibility for behaviour	YES or NO
To add: People who lack the relevant skills to maintain a tenancy	To prepare someone for a successful tenancy	YES or NO
Home owners or people who part own their home or people who are applying / living with someone who owns a home whether they currently reside in it or not. They do not have a housing need or are assessed as being able to meet their own housing need, this can be either by purchasing, renting in the private sector or other affordable housing solutions.	Majority of home owners do not need social housing	YES or NO
Where the applicants and or dependents who are part of the household have a combined household income and or savings of above the criteria unless alternative housing has been assessed as unaffordable. Account will be taken of statutory payments (eg court fines, child maintenance). Reassessment of income levels will be reviewed periodically and the policy updated. Proposal 1 bed need	High earners do not need social housing	YES or NO

£45,000 income, 2 bedroom need £55,000 income, 3 bed plus £60,000		
For consideration, should the income criteria also apply to a tenant wishing to transfer, need to consider someone who wants to downsize	High earners do not need social housing but may free up alternative properties if allowed to move	YES or NO
To change from 3 suitable offers to 2 suitable offers. Take someone off the register if they have refused 2 suitable offers of accommodation. Can reapply in 12 months time	CBL gives choice, applicants should make realistic decisions. Reduce administration, focus on housing those in need	YES or NO
To add: Where an applicant was previously a tenant, joint tenant or was a named member of a household but has left the property is disqualified from applying for 12 months from tenancy start date	Had been housed in past 12 months	YES or NO
Where there is an identified housing need and the applicant has not placed any bids in a 12 month period. They will be removed from the register and cannot reapply for a further 12 months	CBL gives choice, applicants should make realistic decisions. Reduce administration, focus on housing those in need	YES or NO
Where there is an identified housing need and the applicant has not placed any appropriate bids in a 12 month period. They will be removed from the register and cannot reapply for a further 12 months	CBL gives choice, applicants should make realistic decisions. Reduce administration, focus on housing those in need	YES or NO
Local Connection		
How long should someone live in York before they can register for housing a) Retain the status quo – 6/12 months or 3/5 years in line with homeless legislation b) Currently live in the City of York Council Local Authority (CYC LA) Area and have been resident for a minimum of 2 years c) Currently live in the City of York Council Local Authority (CYC LA) Area and have been resident for a minimum of 4 years.		A, B or C
How long should someone have worked in York before they can register for housing a) Retain the status quo are employed		A or B

in the CYC LA Area; employment is defined as meaningful permanent full time or part time not casual or seasonal. b) Are employed in the CYC LA Area for 6 months; employment is defined as meaningful permanent full time or part time not casual or seasonal.		
Care leavers placed in an out of area placement as defined in the Homeless Reduction Act 2017	Legislative requirement	Information only
Clarification that local connection is only awarded when an individual is living in York though choice (not placed). Residence in a hospital, prison, approved premises, mental health hospital, residential schools, and student accommodation including shared accommodation sourced through student services which is not their principal home, short term holiday lets and approved premises under licence do not gain residency qualification or a local connection.	Clarification	YES or NO
For discussion: if a rough sleeper should gain local connection by virtue of living rough in York for prescribed time (local connection criteria above)	Do you agree, as concerns that this would encourage people to move to York and rough sleep and then be able to access social housing in York	Comment
Review		
That there is only 1 right of review by a senior officer reduced from 2)	Here is no longer a NYHC Board and process. There is no right of appeal other than via judicial review (plus complaint, ombudsman)	YES or NO
Verification		
What proofs we ask for at application. To include photographic evidence of all applicants.	To prevent fraud / subletting	YES or NO
That checks are carried out on applicants and all household members over the age of 18 and individual applicants aged 16 and 17, which can include but are not exhaustive of PNC checks, tenancy checks for current and former tenancies, credit checks, medical condition confirmation, land registry checks, immigration status checks	To prevent fraud / subletting, minimise risk	YES or NO

Banding		
Emergency Band To add the offender initiative to gold band to encourage termination of tenancy at point of prison sentence. NB this is for existing tenants only, with no arrears or tenancy related anti-social behaviour	Currently a direct let only but this would give offenders who were previously tenants who had no arrears or nuisance behaviour and who had given up a council property a planned move back into the community.	YES or NO
Gold Band To strengthen the wording to acknowledge that bedroom size will be taken into consideration when considering overcrowding	Clarification	YES or NO
Gold Band To introduce a category for applicants occupying a CYC or a participating landlord bedsit with a child over one year old or more than one child. This will be considered to be lacking 2 bedrooms.	To differentiate between bedsits and 1 bed flats	YES or NO
Delete Gold Band Potentially homeless category.	Remove as duty under Homeless Reduction Act 2017 is to prevent / relieve and is not limited to priority / unintentionally	YES or NO
Gold Band To increase priority of this circumstance. Applicants whose home permanently lacks basic amenities, not due to the failure of the applicant and that cannot be resolved via reasonable building / works or enforcement action	Reasonable Preference Categories People occupying insanitary or overcrowded housing or otherwise living in unsatisfactory housing conditions	YES or NO
Silver band Applicants where the Local Authority has a duty to relive homelessness under Homeless Reduction Act 2017	Reasonable preference but does not discriminate priority need, unintentionally homeless in accordance with Homeless Reduction Act 2017. Presume less applicants in Gold band as such should be rehoused form silver	YES or NO

Silver Band Applicants occupying CYC or participating landlord bedsits with a child under the age of one year old.	To differentiate between bedsits and 1 bed flats	YES or NO
Silver Band Single / couples who share kitchen / bathroom facilities with separate households[1] who will not be moving with them.	Insufficient supply of 1 bedroomed properties.	YES or NO
Silver Band There is no current category for these applicants. Applications from hospital / prison who are ready for independent living	To assist with Homeless Reduction Act 2017	YES or NO
Bronze band, there will be limited applicants in bronze band as it will be restricted to the following 2 categories. Those with no housing need will not qualify for the register.	This is an administrative process only, as only elderly applicants are housed from bronze band	YES or NO
Bronze Band Applicants who have an assessed need for accommodation in an Independent Living Community who would be otherwise adequately housed	To ensure appropriate housing / support for older person	YES or NO
Bronze Band HMF with valid cessation notice but outside remit of Homeless Reduction Act 2017	Reasonable preference	YES or NO
Consultation on retaining Good Tenant Status. Currently applicants who are classified as Good Tenants will be given one band higher than their assessed housing need band, the maximum banding award being Gold Band	This is seen to reward good tenants, when actually that household is just adhering to the tenancy agreement. In light of universal credit it is often difficult to maintain a clear rent account if a new UC claim. There is also concern that this discriminates families living in overcrowded situations where condensation and mould problems may be deemed to be disrepair. Causes additional void times	Retain good tenant YES or NO

[1] Separate households do not include family members

	and rent loss	
Direct offers clarification and amendment to who is offered a direct let (as oppose to being allowed to bid / choose) **Direct let only, no bidding:**		
Statutory homelessness cases (full duty) in accordance with this policy. No area choice other than in special circumstances		YES or NO
Applications from foster carers, those approved to adopt, or those persons being assessed for approval to foster or adopt, who need to move to a larger home in order to accommodate a looked after child or a child who was previously looked after by a local authority child	As silver band never enabled a move	YES or NO
Housing First which is an initiative to help complex individuals into housing with intensive support	Recent scheme to add to policy	YES or NO
Direct offers can be made to (but can also bid):		
Applicants where fixed term tenancy is at an end an they require alternative accommodation	To improve use of stock	YES or NO
Management transfers		
To extend policy to be given a move for significant serious intimidating harassment which cannot be resolved through landlord management (Currently only for threats or actual violence or racial harassment)	To incorporate harassment into criteria for a management transfer	YES or NO
Property size		
That families with 2 children same sex will be eligible for a 3 bedroom property when one child becomes 16	To improve use of stock and reduce demand for 2 bedroomed properties	YES or NO
Minimum standards will be considered: statutory overcrowding		YES or NO
Bidding cycle		
To reduce the bidding cycle to Thursday – Monday	To provide an additional administrative day	YES or NO

Health, Housing & Adult Social Care Policy & Scrutiny Committee

Work Plan 2017-18

20 June 2017	1. Attendance of Executive Member for Housing & Safer Neighbourhoods 2. Attendance of Executive Member for Health & Adult Social Care 3. Annual report of HWBB 4. Six-monthly Quality Monitoring Report – residential, nursing and homecare services 5. Update on decisions taken on smoking cessation and their impact. 6. CCG Task Group Scoping Report 7. Work Plan 2017/18 8. Urgent Business – New Mental Health Hospital Update
25 July 2017	1. End of Year Finance & Performance Report. **Health** 2. Be Independent end of year position 3. Report on The Retreat action plan following CQC inspection. 4. Safeguarding Vulnerable Adults Annual Assurance report **Housing** 5. Introduction to Safer York Partnership 6. Report on new Community Safety Strategy. 7. Work Plan 2017/18 **Information Reports** Annual Report of Tees Esk & Wear Valleys Foundation Trust (AGM 19th July)

13 September 2017	1. 1st Quarter Finance & Monitoring Report **Health** 2. Consultation on Mental Health Strategy for York. 3. Update report on York Hospital's financial situation **Housing** 4. Update Report on Implications of Homelessness Reduction Act 5. Update report on fire safety and housing 6. Work Plan 2017/18
3 October 2017 **CANCELLED**	**Health** 1. Future Focus **Housing** 2. Review of Allocations Policy & Choice-based Lettings 3. Update Report on Housing Revenue Account Business Plan. 4. Work Plan 2017/18 **Information reports** • Further update report on community service provision • Annual Report of Chair of Teaching Hospital NHS FT

	• Annual Report of Chair of Yorkshire Ambulance Service (Annual meeting 26th September) • Annual Report of Chair of Vale of York CCG (Annual meeting 21st September)
15 November 2017	**Housing** 1. Update Report on Housing Revenue Account Business Plan. **Health** 2. Healthwatch six-monthly performance update 3. York Hospital Winter Plan Briefing Presentation 4. Future Focus programme 5. Work Plan 2017/18 **Information reports** • North Yorkshire Fire & Rescue Service
12 December 2017	1. 2nd Qtr Finance and Performance Monitoring Report **Health** 2. HWBB six-monthly update report. 3. Update Report on progress of Humber, Coast and Vale Sustainability and Transformation Partnership. 4. Implementation of Recommendations from Public Health Grant Spending Scrutiny Review

	Housing 5. Update report on homelessness 6. Work Plan 2017/18
15 January 2018	**Health** 1. Update report on The Retreat Improvement plans 2. Six-monthly Quality Monitoring Report – residential, nursing and homecare 3. Update Report on Elderly Persons' Homes. **Housing** 4. Housing Registrations Scrutiny Review – Implementation Update 5. Review of Allocations Policy & Choice-based Lettings 6. Work Plan 2017/18
19 February 2018	1. 3rd Quarter Finance & Performance Monitoring Report 2. Update report on increase in mental health crisis call handled by NYP 3. New Mental Health Hospital Update – full business case for new build. 4. Be Independent six-monthly update report 5. Work Plan 2017/18
26 March 2018	1. Homeless Strategy 2. Update Report on Actions Against Community Safety Plan Targets 3. Work Plan 2017/18

23 April 2018	1. Work Plan 2017/18
23 May 2018	1. Healthwatch six-monthly performance update 2. Work Plan 2017/18 **Information Reports** • North Yorkshire Fire & Rescue Service

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