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Doncaster
Metropolitan Borough Council

To all Members of the

HEALTH AND ADULTS SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

AGENDA

Notice is given that a Meeting of the above Panel is to be held as follows:

VENUE: Council Chamber, Civic Office, Doncaster
DATE: Wednesday, 23rd September, 2015
TIME: **10.00 am**

Members of the public are welcome to attend

Items for Discussion:

1. Apologies for absence.

2. To consider the extent, if any, to which the public and press are to be excluded from the meeting.

3. Declarations of Interest, if any

4. Minutes of the Health and Adult Social Care Overview and Scrutiny Panel held on 29th July, 2015. *(Pages 1 - 6)*

5. Public Statements

   [A period not exceeding 20 minutes for Statements from up to 5 members of the public on matters within the Panel's remit, proposing action(s) which may be considered or contribute towards the future development of the Panel's work programme].

A. Items where the Public and Press may not be excluded

Jo Miller
Chief Executive

If you require any information on how to get to the meeting by Public Transport, please contact (01709) 515151 – Calls at the local rate

Issued on: Tuesday, 15th September, 2015

Senior Governance Officer for this meeting:	Caroline Martin (01302) 734941

6. Public Health Self-Assessment/Public Health Commissioning. *(Pages 7 - 52)*

7. Personalisation/Direct Payments - considerations of actions to promote greater personalisation and direct payments. *(Pages 53 - 56)*

8. Health and Adult Social Care Overview and Scrutiny Panel Work Plan Report 2015/16. *(Pages 57 - 88)*

MEMBERSHIP OF THE HEALTH AND ADULTS SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

Chair – Councillor Tony Revill
Vice-Chair – Councillor Cynthia Ransome

Councillors Elsie Butler, Rachael Blake, Jessie Credland, Linda Curran, George Derx and Sean Gibbons

Invitees:
Lorna Foster – Union Representative

DONCASTER METROPOLITAN BOROUGH COUNCIL

HEALTH AND ADULT SOCIAL CARE
OVERVIEW AND SCRUTINY PANEL

29th JULY, 2015

A MEETING of the HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL was held at the CIVIC OFFICE, DONCASTER on WEDNESDAY, 29th JULY, 2015 AT 2.00PM

PRESENT:

Chair – Councillor Tony Revill

Councillors Elsie Butler, Jessie Credland, Linda Curran, George Derx, Sean Gibbons and David Nevett.

Also in attendance:
Councillor Pat Knight, Cabinet Member for Public Health and Well-being
Gary Jones, Head of Adult Commissioning and Contracts
Michaela Pinchard, Head of Modernisation and Improvement
Louise Robson, Public Health Specialist
Jackie Wiltschinsky, Assistant Director Public Health

APOLOGIES:

Apologies for absence had been received from Councillor Cynthia Ransome and Lorna Foster, UNISON.

		ACTION
1.	DECLARATIONS OF INTEREST	
	There were no declarations of interest.	All to note
2.	MINUTES OF THE MEETING HELD ON 24th MARCH, 2015	
	Resolved that: the minutes of the meeting held on 24th March, 2015 be agreed as a correct record and signed by the Chair.	All to note
3.	PUBLIC STATEMENTS	
	There were no public statements.	All to note
4.	PRESENTATION – HEALTH AND SOCIAL CARE TRANSFORMATION PROGRAMME UPDATE	
	The Panel received a presentation from Gary Jones,	

	Head of Adult Commissioning and Contracts and Michaela Pinchard, Head of Modernisation and Improvement relating to the Councils single approach to Adult, Health and Social Care transformation and the Care Act.	
	Members were informed that the Health and Adult Social Care Transformation programme would support people to maintain their independence for as long as possible with personalised and appropriate support services being addressed. Members noted the following: • 3 Key outcomes and key activities; Outcome 1 – people are independent with good health and wellbeing; Outcome 2 – When in need of care and/or support, it is personalised, flexible and appropriate; Outcome 3 – when people are in urgent need or crisis, there will be responsive, effective services that meet their needs. • The Challenge; • What success would look like; • What will be different for local people, services and providers and the workforce; and • With regard to the Care Act, the Council was in a good position in relation to implementation of the 2015 reforms but with more work to do to embed and re-profile plans, as a result of the Government's announcement regarding the 2016 reforms.	
	Following the presentation Members addressed the following issues: • Vulnerable people who live alone and have no support – concern was expressed that there were vulnerable people without families to assist with ensuring the correct care package was put in place. It was noted that support needed to be encouraged from the community, neighbours and not just statutory agencies. Resources also needed to be redirected differently to ensure the community was involved to the correct extent; • Well-being Officers – these posts had been rolled out over the last couple of years to offer guidance and support. Staff training was highlighted as important to ensure they encourage the older community to be active contributors. Councillors	

	sought assurances that people were not falling through gaps in service and all possible connections made; • Rescript work – the programme addresses what the older community could achieve and not what they cannot do, but to encourage the independence agenda; • Access to information – this was identified as a challenge with a mix of information provision required from modern technology to traditional paper information; • Domiciliary Care – it was noted that checks and balances undertaken on how domiciliary care was delivered, required consideration, however it was noted that there were not enough staff to constantly monitor and had to rely on providers to quality check. It was noted that some providers wait for an Inspection to tell them what is wrong with the service provision rather than being more proactive; • Dementia – risks with people remaining at home were recognised, however, it was noted that the majority of people wished to remain in their own home as long as possible. It was acknowledged that it could be safer for a person to remain at home, with the correct care package and technological assistance, rather than going into long term care too early; The risk assessment for all people with dementia was critical, to ensure discussion with families provided a balanced care package; • Re-enablement programme – activities were key to making a person more independent and more investment was being provided to this service together with Health; • Telecare – the take up of technology had improved but it was still not as good as it could be. Further training and improved knowledge of products with professionals was required and work with Health colleagues was being undertaken to promote the service. The Cabinet Member for Public Health and Wellbeing reported that she had recently made an advertisement with Trax FM and the Free Press to promote, due to the low uptake; and • Well North Project – this issue was to be considered later on the agenda, however, the Cabinet Member outlined work being undertaken in Denaby Main. She stressed that the project, with community drive, had assisted with the	

	provision of a café in the village, as it was highlighted through community consultation that there were no facilities available where people could just simply meet and have a drink. The Panel concluded that it supported people living at home independently and be enabled to do so as much as practicable.	
	Resolved that: 1. The presentation be noted; 2. Leaflets relating to Telecare be placed in each Members pigeon hole in the Member's Support area; and 3. The latest Telecare figures be provided to Members.	Director Health and Adult Social Care
5.	REFRESH OF DONCASTER HEALTH AND WELLBEING STRATEGY 2015-20	
	The Panel considered the draft refresh of the Joint Health and Well-being Strategy 2015-20. It was noted that the Strategy now had four separate themes, as follows: 1. Wellbeing; 2. Health and Social Care Transformation Programme; 3. Areas of Focus; and 4. Reducing Health Inequalities. A Member stressed that he was concerned there was no mention of drug abuse and NPS (legal highs) in the crime and disorder section, and due to its prevalence wished for it to be make more explicit. With regard to Well North, it was noted that this was a Public Health England led approach with Doncaster being one of the pilot sites. The pilot takes a social approach to reducing health inequalities, with Denaby Main being the first site allocated for an enquiry following detailed analysis. Members noted the discussion in the previous agenda item. The Cabinet Member for Public Health and Wellbeing stressed that the document was out for consultation and encouraged all Scrutiny and Member input. She also highlighted the partner membership on the	

	Health and Wellbeing Board and that Overview and Scrutiny was always welcome to attend the bi-monthly workshops. A Member of the Panel requested information relating to the Liverpool Pathway, which the Senior Governance Officer said she would investigate.	
	Resolved that the Strategy Refresh be supported and consideration be given to including additional information relating to drug abuse and NPS (legal highs).	Director Health and Adult Social Care
6.	HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL WORK PLAN REPORT 2013/14	
	The Senior Governance Officer and Director of Health and Adult Social Care highlighted progress with the work plan and themes for consideration throughout 2015/16. The Chair updated the Panel on work with the Joint Health Overview and Scrutiny Panel for Yorkshire and Humber, particularly with regard to the Children's Cardiac Surgery.	
	Resolved that: the report be noted.	Senior Governance Officer

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Doncaster
Metropolitan Borough Council

Agenda Item No: 6
Date: 23 July 2015

To the Chair and Members of the Health and Adults Social Care Scrutiny Panel

Public Health Self-Assessment/Public Health Commissioning

Relevant Cabinet Member(s)	Wards Affected	Key Decision
Cllr Pat Knight	All	

EXECUTIVE SUMMARY

1. The Public Health function has self assessed itself using the Sector Led Improvement methodology designed across Yorkshire and the Humber. The majority of areas are rated as developing with 5 areas rated as basic and 5 as excellent. A draft action plan has been proposed and this will be updated following the meeting today and following consultation with partners.

EXEMPT REPORT

2. N/A

RECOMMENDATIONS

3. The Health and Adults Social Care Panel is asked to:

(a) **COMMENT** on the approach to assurance of the public health function and Sector Led Improvement.

(b) **CONSIDER** the self-assessment and draft action plan

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

4. An effective public health function protects the health of the population, improves the health of the population and ensure partners include public health considerations in their decision making about health and care issues.

BACKGROUND

5. The assurance of the public health function.

The public health function transferred into the council on 1st April 2013 from Doncaster Primary Care Trust as a result of Health and Social Care Act (2012). The Act places a number of new duties on Local Authorities including the responsibility for health improvement, health protection and health care public health. The assurance that these functions were effectively delivered was previously carried out by the NHS through systems such as world class commissioning, annual governance visits and direct reporting through to regional public health structures.

The transfer of public health teams has happened in a number of ways and in Doncaster the team transferred initially as a standalone directorate but has now moved to be part of the new adults, health and wellbeing directorate. The assurance of the new public health function is now left to Local Authorities. There are a number of ways to assure the effective delivery of the public health function and these include assessment of progress against the public health outcomes framework, the effective financial management of the function, delivery of the corporate plan and in depth scrutiny of specific aspects e.g. health protection. Another way to provide some assurance of the effectiveness of the public health function is using Sector Led Improvement.

6. Sector Led improvement and the public health function.

The Directors of Public Health in Yorkshire and Humber have worked together to design a Sector Led Improvement approach to assurance aligned with the approaches that already happen across adult social care and children's services.

The Sector Led improvement approach consists of a self-assessment exercise followed by a peer visit. The self-assessment approach covers 6 areas of practice

- Health improvement
- Health protection
- Healthcare public health
- Knowledge and Intelligence
- Capacity building
- Governance and systems

Each area is self assessed into one of three categories basic, developing or excellent. The full framework is attached as an appendix.

7. Doncaster self-assessment

Doncaster has agreed to have a peer review visit in 2016. However the team decided to conduct a self-assessment as part of the first '100 day plan' of the new DPH. The key findings are presented below and a more detail action plan is included as an appendix.

Key findings

Most areas were self-rated as developing. A number of areas were self rated as excellent these included:

- Partnership working for health improvement
- Community engagement for individual projects
- Health protection assurance framework
- Drugs and substance misuse
- Information governance, data flows and information gathering

The 5 areas that were rated as basic included:

- Ensuring the public health function could demonstrate it was embedded across the council and was used effectively and could demonstrate impact
- Ensuring the public health function could demonstrate it was embedded across the Clinical Commissioning Group and was used effectively and could demonstrate impact
- Joined up community engagement and community development with partners
- Ensuring there were embedded clinical governance approaches
- The need for a public health audit programme

8. Next Steps

The draft action plan is attached for comment, it prioritises a number of potential actions which will be considered by the public health team, adults, health and wellbeing and the directors. The self-assessment and draft action plan will be sent to key stakeholder for comment e.g. other parts of the council and other partner agencies.

IMPACT ON THE COUNCIL'S KEY PRIORITIES

9.

	Priority	**Implications**
	We will support a strong economy where businesses can locate, grow and employ local people. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Be a strong voice for our veterans* • *Mayoral Priority: Protecting Doncaster's vital services*	Public health function can support this priority
	We will help people to live safe, healthy, active and independent lives.	Public health function can support this priority

	• *Mayoral Priority:* Safeguarding our Communities • *Mayoral Priority:* Bringing down the cost of living	
	We will make Doncaster a better place to live, with cleaner, more sustainable communities. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Safeguarding our Communities* • *Mayoral Priority: Bringing down the cost of living*	Public health function can support this priority
	We will support all families to thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	Public health function can support this priority
	We will deliver modern value for money services.	Public health function can support this priority
	We will provide strong leadership and governance, working in partnership.	Public health function can support this priority

RISKS AND ASSUMPTIONS

10. Doncaster requires an effective public health function to deliver the new duties placed on the council following the Health and Social Care Act (2012).

LEGAL IMPLICATIONS

11. N/A

FINANCIAL IMPLICATIONS

12. The public health function is funded from the Public Health Grant.

HUMAN RESOURCES IMPLICATIONS

13. No immediate HR implications, although delivering the action plan may require changes to roles, responsibilities and structure of the public health team.

EQUALITY IMPLICATIONS

14. None

A due regard statement is being developed alongside the refresh strategy and will be updated throughout the consultation process.

CONSULTATION

15. The action plan has been developed by the public health team

This report has significant implications in terms of the following:

Procurement		Crime & Disorder	
Human Resources		Human Rights & Equalities	
Buildings, Land and Occupiers		Environment & Sustainability	
ICT		Capital Programme	

BACKGROUND PAPERS

16. Public Health self-assessment tool for Sector Led Improvement Programme
PH self-assessment action plan

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Public health self-assessment tool for Sector Led Improvement programme

Developing Excellence in Local Public Health

Completion of this self-assessment by host PH departments will help to guide SLI reviewers to focus attention most appropriately during their visit. There are six elements to this framework:

1. Health improvement
2. Health protection
3. Healthcare
4. Knowledge and intelligence
5. Capacity building
6. Governance and systems

For each element there are three sets of descriptors for different levels of practice:

	Basic	**Developing**	**Excellent**
1 Health improvement			
1.1 LA health inequality assessment in JSNA, JSIA including asset based assessments *(note related questions in sections 3.2 and 4.3)*	Health inequalities referenced in the HWB strategy, intelligence systems in place to map multiple disadvantage and how it changes over time. Social determinants of health are addressed across the LA by close working with environmental services, economic development,	Includes up to date reference to core data sets, links to a range of outcome indicators and clear evidence of outcome focus actions. Use of local research and nationally available evidence to advance local knowledge about how health outcomes can be	These data sets used to influence decision making, including resource allocation in the LA, CCGs, NHS providers and other stakeholders. Data used by local communities to secure NHS investment using the PH Grant as leverage. Evidence of qualitative

	transport, housing, children and young peoples' and social services, benefits advice, etc. Basic asset based assessments completed.	improved, e.g. use of NICE guidance on behaviour change. Well-developed asset based assessments completed and used in strategic planning.	information, case studies and asset based assessments used to influence strategy. Evidence of information on inequalities being specifically referenced in strategies and initiatives that successfully improve health and wellbeing and reduce inequality.
1.2 PH programme development	Commission appropriate and effective health and wellbeing initiatives based on the JSNA, JSIA, asset based assessments and HWB strategy. They must reflect the broader LA role in addressing health inequalities. Programmes are in line with NICE quality standards.	Detailed specification in programmes built on local research and other available evidence. Evidence of infrastructure and cultures across the organisation that incorporates PH strategies, e.g. designated lead roles.	Evidence across all LA departments of PH input. Evaluation that specifically measures the impact of health and wellbeing programmes on local people. Local implementation of national PH policy leading to sustained improvement of outcomes in the PHOF and NHSOF.
1.3 Partnership working for health improvement *(note related section 5.3 partnerships to build PH capacity)*	Strategic alliances and partnerships built and sustained within the local health economy evidenced by development and implementation of joint projects. Functioning HWB evidenced by regular meetings and attendance	Well-functioning HWB evidenced by good engagement and participation across programmes resulting in joint actions. Resources managed via pooled budget arrangements to supplement the PH Grant and	Positive working relationships evidenced by good examples of joint working with LA members and officers, CCGs, NHS providers, PHE, statutory sector partners, the voluntary and community sector and private sector organisations.

	by partners. Evidence of joint funding of programmes with internal and external partners to address health inequalities. Examples of health impact and combined impact assessments across sectors. Examples of use of LA legal and regulatory powers to improve health.	appropriate use of the Better Care Fund. Evidence of the use of health impact and combined impact assessments across sectors to shape policies affecting the wider determinants of health. Effective use of LA legal and regulatory powers to improve health.	PH plays a leading role in the HWB which has a clear sense of purpose, is focussed on its strategic priorities and is effective in driving the agenda. Explicit responsibilities for each HWB member and they are held to account in a constructive way. Clear relationships between the HWB and other strategic partnerships in the locality.
1.4 Community engagement	Community representative engagement in JSNA, HWB and Healthwatch.	Community engagement in consultations on all health improvement programmes.	Community engagement in programme development and delivery using a range of techniques such as consultations, surveys, focus groups, participatory appraisals, action research, etc.
1.5. Communication and PH	Reference PH function in addressing health inequalities in HWB strategy and other LA plans.	Use of a range of communication tools including the media to inform people of the risks and benefits to health and wellbeing of particular lifestyle, social and environmental factors. Reference local research and other available evidence to demonstrate impact.	Local engagement from community leaders and the general population in targeted campaigns to improve health. Evaluation of effectiveness of communication in targeted campaigns.

1.6 PH capability and capacity	Awareness of the PH Knowledge and Skills Framework across the LA. Evidence of using it in planning, strategic developments and of mapping requirements to the PHOF. *(See web link to PHKSF at end of this document)*	LA leads the sustainable development of capacity and capability to improve population health and wellbeing. Use of specific initiatives evidenced in the JSNA, JSIA and HWB strategy. Evidenced in financial returns of use of value for money and return on investment tools to inform spending allocations.	Evidence of planning and delivery of training programmes to build PH capacity across the LA workforce and other in sectors. Evidence of financial controls applied across all local government spend.

2 Health protection			
2.1 Health protection assurance framework	Agree it with local stakeholders an overarching health protection assurance framework. It should include: Identification of key elements of health protection and allocation to an appropriate lead; Assessment of risks for each element and control measures put in place; All risks are reviewed regularly at least annually; Governance arrangements are in place to oversee health protection work; An annual review of the assurance framework, with new risks being identified, and existing risks reviewed.	Health Protection Group, Board or Committee is in place, meets at least quarterly and implements the assurance framework.	New risks in health protection work are efficiently identified within year and incorporated into the assurance framework. HWB is fully engaged and is assured of the delivery of health protection functions. Local authority independent scrutiny panel undertakes annual review of health protection.
2.2 Vaccination and immunisation	Assurance provided to the LA from NHS England (Commissioner for the service), that the programmes are being effectively delivered. Governance arrangements are in place with appropriate	There is access to relevant information on the LA website, e.g. LA contact person for health protection, web-link to relevant sites. Take active role in promoting	Mechanisms in place for reporting, accountability and scrutiny of vaccination programmes by HWB and Scrutiny Panel. *(See web link to Centre for Public*

	representation from LA PH staff. Regular performance reports are produced. Regular risk assessments carried out and assurance statements received outlining progress or lack of it, and control measures are put in place. PH provides local advice to promote programmes.	vaccination and immunisation, e.g. through school place offer letters, etc. Take steps where performance is inadequate to improving performance. Lessons from untoward incidence are built into service improvement.	*Scrutiny's "10 questions to ask if you are scrutinising local immunisation services" at end of this document)* Overall performance against PHOF measures for all vaccination and immunisation in the top quartile of national performance or are showing significant and sustained improvement.
2.3 Screening	Assurance provided to the LA from NHS England (Commissioner for the service), that the programmes are being effectively delivered. Governance arrangements are in place with appropriate representation from LA PH. Regular performance reports are produced, standards are met and targets achieved. Regular risk assessments carried out and assurance statements received outlining progress or lack of it, and control measures are put in place.	Health Protection Group, Board or Committee is in place, meets at least quarterly and implements the assurance framework. Take steps where performance is inadequate to improving performance. Lessons from untoward incidence are built into service improvement.	Overall performance against PHOF measures for screening in the top quartile of national performance or are showing significant and sustained improvement. Mechanisms in place for reporting, accountability and scrutiny of vaccination programmes by Health and Wellbeing Board and Scrutiny Panel.

2.4 Infection prevention and control (IPC)	To be assured that there is a safe and effective system of IPC in place in the district. Commission appropriate and effective IPC service in the community Ensure LA has access to IPC specialist advice (either in-house, or commissioned service, or as part of a memorandum of understanding with CCG). Governance on IPC in place (e.g. District Infection Prevention and Control Committee; or Health Protection Committee/Group). All commissioned providers are compliant with CQC standards and relevant legislation in relation to IPC; and they meet set national government targets for IPC.	IPC specifications are embedded in contracts of all relevant LA commissioned services. Identification of gaps in IPC and commissioning of appropriate services to meet those gaps. A plan is in place to manage IPC generally and manage specific risks such as C. Difficile and MRSA. Annual statements of declaration by providers of commissioned services that they are compliant with IPC standards, as part of contract review.	Mechanisms in place for reporting, accountability and scrutiny of IPC programmes by HWB and Scrutiny Panel. Healthcare acquired infection targets are met.

2.5 Environment including: enforcement, trading standards, food, animal health, water, air quality and health and safety	Demonstrate joint working with Environmental Health department in LA, with reference to PHOF indicators where ever possible. Joint work on creating a sustainable environment: energy efficiency, housing standards, contaminated land and landfills, air quality, radon, airborne radiation, and climate change. Collaboration on environmental enforcement (antisocial behaviour): noise nuisance, PH nuisance (litter), filthy and verminous premises, dangerous dogs, etc. Joint work on trading standards: underage sales of tobacco, and alcohol; protection of children from harm; injuries from unsafe products, etc. Joint work on corporate health and safety, licensing occupational safety, skin piercing, alcohol licensing etc.	Demonstrate successful partnership working between PH and Environmental Health department in all areas, e.g. by development of a joint action plan, pooled budgets to fund the joint action plan, etc. Effective data collection of relevant PHOF indicators. Ensure issues related to health protection are incorporated into work programme, e.g. actions to reduce impact of fast food outlets on health through licensing process, work with schools, and raising awareness, joint work on fire safety, etc.	Mechanisms in place for reporting, accountability and scrutiny of environmental programmes by HWB and Scrutiny Panel. Demonstrate health outcomes for relevant PHOF indicators are significantly better than the national average or are showing significant sustained improvement, e.g. excess winter deaths, tobacco control profiles, LA profiles, obesity, etc.
2.6 Drugs and substance misuse	Effective strategy development group in place.	Identify gaps in service provision and develop action plan to address gaps.	Mechanisms in place for reporting, accountability and scrutiny of substance misuse

	Commission drugs and substance misuse services as required. Harm reduction strategy in place. Governance arrangement in place to monitor performance against outcomes. Achieve national targets for drugs and substance misuse; Compliance with NICE Guidance on substance misuse, e.g. interventions to reduce substance misuse amongst vulnerable young people and needle and syringe programmes.	Develop standards on other substances such as “legal highs” or prescription drugs. Commissioning of widespread community access to hepatitis testing in venues such as community pharmacies. Harm reduction strategy in place which captures the harm reduction interventions in addition to of needle exchange, blood born viruses, such as overdose prevention training, wound care for injecting drug users, etc.	programmes by HWB, other relevant strategy boards and Scrutiny Panel. Exceed national BBV targets, provision of ‘gold standard’ for needle exchange (a minimum equipment offer specified by the 2009 NICE guidance on Needle and Syringe Programmes updated 2014). Offer of foil within specialist and needle exchange provision, as per 2014 Home Office guidance. Provision of training from specialist providers to community pharmacy needle exchanges.
2.7 Prevention of injury and suicide prevention	Have in place actions to prevent unintentional injury. Have a plan in place to address deliberate self-harm. Identify lead on suicide prevention. Establish suicide prevention group with relevant partners with agreed strategy and action plan.	Recording and sharing of data related to unintentional injury, self-harm and deaths due to suicide. Undertaking on going suicide audit. Achieving national outcomes and targets.	Health outcomes are significantly better than the national average or are showing significant sustained improvement. Mechanisms in place for reporting, accountability and scrutiny of programmes by HWB, other relevant strategy boards and Scrutiny Panel.

2.8 Sexual health	Commission a fully integrated sexual health service based on the needs of the local population. This should include: STI screening and treatment, partner notification, the full range of contraception, health promotion function, and outbreak management. There is an established Sexual Health Partnership Board works to an agreed strategy and action plan and which monitors performance. Compliance with national guidance, including NICE, BASHH, etc. key outcomes are achieved.	Link with other commissioners such as NHSE and PHE, who are responsible for related services to ensure full integration at a local level. Coordinate all providers and stakeholders to ensure that people are seen in the right part of the system at the right time by the right person. Data collection and performance reporting . Focus on health outcomes.	Overall performance against outcome measures for sexual health in the top quartile of national performance or are showing significant sustained improvement. Mechanisms in place for reporting, accountability and scrutiny of programmes by HWB, other relevant strategy boards and Scrutiny Panel.
2.9 Emergency preparedness, resilience, and response (EPRR), incidents and outbreaks	Protect the health of the population from hazards and threats ranging from relatively minor outbreaks and incidents to full scale emergencies such as influenza pandemic, infectious disease outbreaks, flooding, major transport incidents, terrorist attack, etc. Relevant plans are in place including: • Major incident plan • Mass casualty plan • Pandemic Flu plan	Compliance with national guidance and standards for local areas. Systematic review of service level agreements or memorandum of understanding with partners to provide assurance that plans meet national standards, core competencies and requirements. Emergency plans in place for psychosocial support and recovery, excess deaths, mass	Plans reviewed by HWB annually and reports of significant incidents received and reviewed. Full engagement with other relevant groups e.g. LRF, LHRP.

	• Excess death plan • Severe weather plan Undertake regular exercises to test plans and ensure that they are effective. Ensure governance arrangements are in place (e.g. Local Health Resilience Partnership) and clarify the role of PH in the arrangements. Staff trained in communications and plans are in place to warn and inform the public during incidents. Staff can undertake risk assessments to identify and prioritise work streams in an incident. Assurance received from providers regarding their emergency plans and business continuity arrangements. Ensure PH incidents and outbreaks are dealt with effectively at the most appropriate level. .	treatment plan. Ensure flexible approach to learning from major incident events and exercises. Escalation protocol for health protection concerns are in place. Action plans are produced following incidents and exercises identifying key improvement areas.	
2.10 Surveillance of communicable	DPH receives assurance from PHE of competent surveillance of	Data recorded in a dashboard or similar format, and stored in such	Performance reports and information on outcomes received

disease	infectious (notifiable) diseases; systems are in place in the LA to receive relevant information and take appropriate action. Infectious diseases information is monitored and systems are place so that appropriate PH actions are taken, e.g. up to date surveillance report (NOIDS, situation reports) are received, staff are trained appropriately, clear communication systems are in place, there is an on-call system. Review of communication of surveillance information that needs to be received at local level.	a way that it can be interrogated and analysed effectively, e.g. on TB incidence. Agree stakeholders to be included in circulation of information. Systematic review of service level agreements or memorandum of understanding with partners, to provide assurance.	by Health and Wellbeing Board and appropriate action taken. Surveillance intelligence is uses to prevent further incident, near misses or unnecessary escalation.
2.11 Public Health capacity and capability	Appropriate senior PH, other professional and support staff in place to ensure capacity and capability to manage health protection functions in the LA. Delivery of delegated PH functions by LA cabinet in compliance with Faculty of PH standards and guidance.	Annual audit of workforce capacity and capability to identify any potential gaps and develop action plans to address any such gaps. Develop and agree standard for PH workforce capacity and capability in the LA.	Relevant performance outcomes in the PHOF are in the top quartile nationally, or are showing significant sustained improvement.

3 Healthcare			
3.1 Health services commissioning - governance *(note that although this section is written as if a PH team relates to one CCG it is acknowledged that some PH teams relate to two or more CCGs.)*	Agreed Memorandum of Understanding (MoU) or similar document with local CCG(s) that details: • evidence that MoU meets statutory requirements • resource that will be available for this function • agreed annual work plan. Delivery of MoU identified within PH staff objectives job plans. At least twice yearly liaison meetings between PH team and CCG to discuss work plan. MoU identifies PH staff working on commissioning health services.	Clear plans and timescales in place for reviewing and re-specifying MoU. Escalation plan to ensure resolution in the event of disagreement. Quarterly 3 way meetings between the lead consultant PH, the DPH and CCG lead. PH staff co-located with CCG. PH staff membership of CCG executive group or equivalent. PH staff have access to CCG IT and desk space and to CCG staff and mandatory training needs jointly agreed, and staff fully compliant.	Evidence that there is in year flexibility in delivery of MoU and annual work plan. Jointly funded PH posts in place. Formal appraisal and performance management of PH consultant lead includes feedback from CCG. PH staff in attendance at CCG Governing body and delegation of authority from DPH. PH staff are members of CCG integrated commissioning teams.
3.2 Health and social care service prioritisation	CCG, LA Adult Social Care and LA Children's Social Care prioritisation discussions involve PH staff. PH input into development of	PH demonstrably providing explicit evidence-based advice evaluating clinical and social care and the cost effectiveness of interventions to inform	CCG, LA Adult Social Care and LA Children's Social Care budget setting and commissioning plans clearly show the influence of PH expertise.

	business cases. JSNA includes clear priorities for the CCG. Where part of MoU with CCG, PH staff have advisory role in Individual Funding Requests (IFR).	decision making. PH demonstrably critically appraising business cases of proposals for new CCG service developments or re-configurations. CCG explicitly uses JSNA in its planning and priority setting. Where part of MoU with CCG, evidence that PH staff actively contribute to the development of IFR policy and governance.	CCG and LA 2 and 5 year plans show link to population need. Use of health economics in evaluation of proposals and to inform prioritisation decisions. CCG explicitly uses JSNA, JSIA and Health and Wellbeing Strategy in its planning and priority setting. Where part of the MoU with CCG, evidence that PH staff lead the development of IFR policy and that this is evidence based and equitable.
3.3 Equity	LA PH team and CCG have agreed approach to equity, including agreed shared definition. CCG recognise that they have a contribution to make to reducing health inequalities, through clinical commissioning and through actions by member practices.	PH team influences CCG to undertake Health Equity Audits and Equity Impact Assessments. LA PH team and CCG have agreed the contribution that health services commissioning can make to addressing health inequalities. The CCG has a strategy for reducing health inequalities that has had input from PH and has changed how they do business.	Demonstrable commissioning or re-commissioning of clinical services as a result of HEA or EIA that leads to a demonstrable increase in health equity. Health inequalities demonstrably reduced as a result of PH input and CCG action.
3.4 Quality	LA PH team and CCG have agreed approach to quality,	Demonstrable PH input into CCG service specifications that	Quality of services demonstrably improved as a result of PH

	including agreed shared definition.	include clearly identified clinical, quality and productivity outcomes. Information on service quality reviewed by PH, including benchmarking against other Districts, and NICE guidance, as appropriate.	involvement in drawing up service specifications or monitoring of service quality.
3.5 Evaluation *(Note evaluation included with more detail in section 4.5)*	PH role in evaluation identified in MoU.	One or more topics (e.g. services delivery, service changes, re-commissioning) evaluated against explicit criteria and using a variety of evaluation techniques.	Evaluation demonstrably impacts on commissioning plans, service delivery and outcomes.
3.6 Patient safety	LA PH team and CCG have agreed approach to safety, including agreed shared definitions.	PH staff participate in risk analysis, interpretation of data on incidents and serious untoward events.	PH staff have major role in risk analysis, interpretation of data on incidents and serious untoward events.
3.7 Healthcare development	PH role in healthcare developments identified in MoU	Any significant new healthcare development is explicitly informed by a needs assessment (if not already covered in JSNA) an equity audit or equity impact assessment.	New healthcare developments have demonstrable impact on health of population overall (to improve it) or health inequalities (to reduce them). Care pathways or clinical services re-specified and re-commissioned based on PH advice to CCG.
3.8 Leadership	Senior PH staff have attend meetings with senior clinicians in local provider units, in both primary	Senior PH staff have good, effective relationships with senior clinicians in local provider	Clear evidence of respect for PH leaders across the health and social care economy as a whole in adult

	and secondary health care and with LA senior managers in adult and children's social care.	units in both primary and secondary health care and with LA senior managers.	and children's services.

4 Knowledge and intelligence			
4.1 Information governance *(Information teams will have a working knowledge of the NHS IG Toolkit. See web link below.)*	Working towards Level 2 NHS IG Toolkit Assessment if council-wide or 100% Level 2 if hosted user.	100% Level 2 NHS IG Toolkit across the council or working towards Level 3 if hosted user.	Working towards Level 3 NHS IG Toolkit Assessment across the council or 100% Level 3 if hosted user.
4.2 Data flows and information gathering *(This section draws on the Public Health Knowledge and Skills Framework – see web link at the end of this document).*	Source data/information from routinely available public sources. Access, extract and use data from established flows from partner organisations. Submit requests to established partner organisations for variations or bespoke extracts of data.	Recognise the limits of routine information, research the sources of publicly available information and identify source organisations to liaise with. Scope requirements for new data/information flows. Identify the benefits of new data/information sources to the PH function.	Negotiate with data/information source, SIRO's, Caldicott Guardians on access/extracts to data/information. Access a network of key intelligence colleagues across organisations to discuss sources and their quality. Contribute to national debate on data/information flows into LA PH teams.
4.3 Joint strategic needs assessment	Meets minimum statutory guidance and referenced in the HWBS.	Includes information on communities of interest,	Intelligence and insight relating to communities of interest, vulnerable

(see linked questions in section 1.1)	Includes information on population, demography, wider determinants, health inequalities, health behaviours, communicable and non-communicable disease and care services. Process of producing the JSNA engages key stakeholders including voluntary, community and faith sector and is accessible and available to professionals and the public alike. Owned, led, managed and subject to timely review by the HWBB. Uses both quantitative and qualitative data.	vulnerable groups, protected characteristics, unmet need, community assets and equity. Range of methods used to develop the evidence including asset based approaches, audit, analysis, evaluation, rapid reviews and research. Explicit links made between needs identified and priorities, outcomes, actions and interventions in the HWBS. On-going needs assessment programme which includes an action plan for addressing gaps and involves stakeholders in taking it forward.	groups, protected characteristics, unmet need, community assets and equity is readily available and regularly updated. Discernible 'golden thread' from the needs assessment through the HWBS to commissioning plans, outputs and outcomes for a range of topics. Culture of needs assessment in the organisation which actively involves service managers, front line staff, clients/patients and carers.
4.4 Knowledge management	Staff are able to access a wide range of data sets, indicators, tools and resources about the population's health and wellbeing including those developed or managed by HSCIC and PHE. Staff are able to access and use an appropriate variety of electronic knowledge and evidence resources including ATHENS and	Staff are able to access support in commissioning/developing knowledge and intelligence to support their decision-making. NICE and related guidance is systemically forwarded to named staff to act on and an audit trail of improvement actions exists.	There is a single local knowledge and intelligence portal (incorporating JSNA) which may be accessed via partners, professionals and the public alike. Integrated knowledge and intelligence is used to support commissioning priorities, strategies and plans.

	NICE. Staff are updated regularly on latest news, relevant publications and up to date national and local intelligence on health and wellbeing trends as appropriate. Registered with NICE as a stakeholder and with other 'what works' centres as they formalise their process and this guidance is distributed to staff.	Evidence reviews, evaluation and new and emerging evidence of local need and what works to improve health and wellbeing are routinely scanned, forwarded to and assessed by HWBB and commissioners as appropriate.	An annual development programme for knowledge management and commissioning intelligence is agreed jointly with the HWBB and partner agencies. Staff take part in NICE consultations, production of evidence reviews and sharing of best practice (including publication in peer-reviewed journals).
4.5 Research and evaluation	Advice and guidance is available on conducting, commissioning and using research and evaluation and this includes ethical practice, data quality and methods. All commissioned interventions include success criteria and outcomes to be achieved. There are examples of regular academic collaboration. The PH team has access to academic resources (e.g. Athens accounts).	Strategic and commissioning decisions are informed by research evidence, with an audit trail of actions. Evaluation uses robust outcome measures and is built into all PH commissioned interventions from the outset. PH collaborates with other organisations in carrying out research. The PH team is actively engaged in knowledge generation (research and evaluation) in collaboration with partner organisations, academic	Audit and evaluation is built into the development agenda. This includes cost-benefit analysis, equality and health impact assessment. PH undertakes original research that is linked with work within the LA and has appropriate research governance in place. Evaluation actively contributes to a robust local evidence base of what does (and does not) work to improve health and wellbeing. Evidence-informed practice is reported in publicly available form.

		and other institutions.	
5 Capacity building			
5.1 Leadership for public health	DPH is a leader in the LA with some access to influencing decisions at executive director level. PH staff are engage and work collaboratively with a range of people and agencies to improve population health and wellbeing and reduce inequalities. Identify opportunities and develop structures to take forward approaches to improve population health and wellbeing. Coordinate programmes or projects to improve population health and wellbeing.	DPH is a leader in the LA with good access to influencing decisions at executive director level. PH role with LA members identified and developed. Work effectively with different media to communicate key issues relevant to health and wellbeing. Demonstrate leadership within and across organisations to improve population health and wellbeing outcomes and reduce inequalities.	DPH is an important and effective leader in the LA and is able to influence decisions across the organisation with a seat at executive director meetings. Demonstrate PH staff leading change in a complex environment handling appropriately uncertainty, the unexpected and conflict. Leadership in delivery of PH excellence regionally, sub-regionally and nationally. Demonstrate the PH advocacy role and an independent voice on behalf of the public and an ability to influence LA decisions.
5.2 Organisational development	PH makes some contribution to annual priority setting processes for the city/borough/county and for the LA as an organisation. System in place for staff take part in an annual review of their work,	PH contributes to developing health related priorities for the city/borough/county and for the LA as an organisation. All staff take part in an annual review of their work, negotiate	PH leads on developing all health related priorities for the city/borough/county and for the LA as an organisation. Effective systems in place to cascaded priorities down through

	negotiate objectives for the coming year that are related to departmental and organisational objectives and they have a personal development plan. PH structure in place to meet organisational and PH priorities. Capacity sufficient to respond to basic requirements of the PH function and to emergencies.	objectives for the coming year that are related to departmental and organisational objectives and they all have a personal development plan. Development of the wider PH workforce in LA and key partners. Development work with elected members on health and wellbeing.	the organisation in a way that produces transformation change and enables individuals and the organisation to grow. Develop assurance system and processes across the health and wellbeing system
5.3 Partnerships to build PH capacity *(see section 1.3 partnerships working for health improvement)*	Partnership working happening within the LA and with other organisations. Partners recognise their role in contributing to PH outcomes.	Partnership working well developed within the LA and with other organisations. PH staff sit on all key committees and groups that contribute to achieving PH outcomes. Choice of formal and informal partners is seen as crucial to managing change and development.	The LA, CCG, local providers, PHE, NHSE and VCS structures work effectively together. They are collectively capable of developing and delivering responses to the key health challenges and contributing to improving PH outcomes. Mature partnerships use system based approach. Difficult and challenging discussions take place that lead to positive outcomes Partners leading and investing in PH related interventions.
5.4 Workforce:	The training of PH specialty	PH specialty registrars progress	The location is seen as an

training PH specialist registrars, the PH team and the wider workforce	registrars is supported. The LA achieves and maintains accreditation as a training location by ensuring that it meets the standards required for specialty training. This is demonstrated through the annual reporting mechanism and Quality Panels. Development and training opportunities are available for all PH staff. Capacity is built in the wider workforce. PH training is available for LA staff and partner organisations e.g. MECC, mental health first aid, HIA, etc.	well through their training achieving relevant milestones in a timely manner. The location provides a rich and diverse training experience for all PH staff. Workplace based initiatives in the LA and with partners includes training and support to improve staff health, stress management, managing LTCs. Evidence available of investment in capacity to deliver this training. PH secondment opportunities developed across a variety of organisation.	attractive location for specialty registrars in which to develop their careers. Enhanced PH capacity of the overall workforce is seen as an outcome of health and wellbeing interventions and programmes. CPD development programmes run in the LA with local partners, sub regionally and regionally. Bespoke training and development for specific services such as housing, planning, environment, etc., to enhance their PH capacity.
5.5 Community	Evidence of community engagement across the area. Evidence of community development in high need areas. Data available to assess the health and wellbeing of local communities and monitor the impact of interventions.	Community capacity built through commissioning training for health champions and advocates. Asset based assessments of communities which lead to co-production of health and wellbeing interventions and community resilience initiatives. Interventions in place which build individual and community	Successful programmes in place with strong evidence that they contributes to improving outcomes in local communities (and in dispersed communities of interest that exist amongst larger populations). The impact of interventions is monitored. Evidence that community voice is heard and responded to. –‘ *you said….. so we did…..’*

		capacity and social capital to improve PH outcomes.	
6. Governance and systems			
6.1 Overall governance *(note that information governance is covered in section 4.1)*	PH structures and processes are included where appropriate, within the LA constitution. There is a clear understanding from LA officers and members regarding the role and function of PH within the LA. PH business and financial plan are in place and are formally signed off as part of LA processes.	There is a clear understanding from partner organisations regarding the role and function of PH within the LA. PH business planning can be clearly linked across LA departments and NHS organisations.	There is a clear understanding across the community regarding the role and function of PH within the LA. The Overview and Scrutiny function addresses the health and wellbeing agenda, the work of the PH and the HWB and is well informed and well supported.
6.2 Risk management	PH contributes to the LA assurance system and the production of the risk register for the organisation including a comprehensive assessment of PH risks.	PH contributes fully to the LA assurance system recognising that the production of the risk register for the organisation and actions to mitigate risks are key tasks. PH risk register links with both LA and partners registers and includes a shared understanding of nature and grading of risks.	Risk register is routinely used in framing strategy and policy. There is a clear process for decision making regarding mitigating actions arising from the risk. These actions are recorded and assessed as to whether they are effective.
6.3 Clinical governance and	Clinical governance requirements are embedded within contracts and	Reports on the clinical governance of commissioned	Clinical governance processes are seamless across health,

patient safety	including arrangements for dealing with serious incidents. Clinical governance is understood within the wider LA and recognised within their governance and risk management systems.	services are received and reviewed. Findings are fed in to the commissioning process. Robust links are made with clinical governance systems across local health and social care.	social care and children's services.
6.4 Audit	Audit work is undertaken by individual staff in line with professional requirements.	Departmental audit programme in place linking up individual activities with records of how audits have affected practice.	Full programme of PH audit documented and in place with priorities identified and audit cycles fully completed. Audits and their outcomes are clearly linked to changes in service planning and service outcomes.
6.5 Use of evidence	Use of national and international evidence of effectiveness in policies and strategies across the LA including NICE and other guidelines.	Comprehensive policy in place for the introduction of new guidelines and the use of evidence in strategy and commissioning decisions including a system for monitoring use of guidelines. .	Use of evidence embedded in the work of the LA and linked to relevant outcomes in the PHOF.

Reference documents:

Details of the 2008 (updated 2009) reference document for the Public Health Knowledge and Skills Framework can be found at the following website:

http://www.sph.nhs.uk/sph-documents/phscf/

2013 updates can be found at:

http://www.phorcast.org.uk/page.php?page_id=313

The Centre for Public Scrutiny's "10 questions to ask if you are scrutinising local immunisation services" are found at:

http://www.cfps.org.uk/domains/cfps.org.uk/local/media/downloads/L12_94_CfPS_IMMUNISATION_10_Questions_FINAL.pdf

The NHS Information Governance Toolkit can be found at the following web-link (you will need an organisation code, user ID and password which should be available in each information department):

https://www.igt.hscic.gov.uk/

The LGA have produced a short document (9 pages text and 5 paged appendices) outlining the methodology and guidance for Health and Wellbeing Peer Challenge. This could be used as a basis for training and a guide for the SLI process or it could be customised for this purpose.

http://www.local.gov.uk/documents/10180/49968/health+and+wellbeing+peer+challenge+methodology+and+guidance+14+pages+accessible+jan+2014.pdf/0434d00c-f100-483f-8ac5-415739e35fd8

Health Improvement

Dimension	Assessment	Gaps	Actions required	Priority
1.1 LA health inequality assessment in JSNA, JSIA including asset based assessments	Developing/excellent (included in Joint Strategic Needs Assessment, JSIA, asset based approaches in dementia)	Links with the Data Observatory.	1. Revamp of observatory and new ways of working.	medium/High
		How PPPR2 will effect this area.	2. Follow up consultation of PPR2	High
		Embedding these data sets within the decision making process.	3. Continued use of the data sets and within the processes across the partners.	Medium
		Health inequalities agenda.	4. Ensure inequalities agenda is part of HWB strategy and HIF.	High
1.2 Public Health programme development	Developing (Health and Wellbeing strategy, plans on a page with other DMBC teams and partners, national healthy child programme implemented locally)	Evidence across all LA depts. Of PH input.	5. Plans on the page help but need to communicate with other members of staff.	Medium
		Evaluation that specifically measures the impact of health & wellbeing programmes on local people.	6. Need to ensure all programme areas have an evaluation as part of their delivery plans, all specialists to embed this. Need to communicate where this has happened and good outcomes etc.	Medium
		Local implementation of national PH policy leading to sustained improvement of outcomes in PHOF and NHSOF, maybe include ASCOF.	7. Lots of good examples of this but have we got a comprehensive picture. Work with Performance to look at this.	Medium
1.3 Partnership working for health improvement	Excellent (Health and Wellbeing Board , agreed Better Care fund plan, increased	PH is focussed on its strategic priorities and is effective in driving the agenda.	8. Undergoing priority setting as outcome of this assessment.	High
		Explicit responsibilities for each HWB member and they are held to account in a constructive way.	9. Need to reinvigorate board members particularly as there are new members. The HIF will enable some of this.	Medium/high

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Working towards excellence: gaps and actions

	use of LA regulatory powers e.g. tobacco)	Clear relationships between the HWB and other strategic partnerships in the locality.	10. This will be addressed through the partnerships review.	
1.4 Community engagement	Excellent (engagement in JSNA and health and wellbeing strategy, consulted on health improvement programmes using a range of techniques)	Embedding some of our expertise across the partnerships.	11. Better use of toolkit produced but also offering support to partners.	low
1.5 Communication and PH	Developing (starting to use social media, using local data)	Local engagement from community leaders and the general population in targeted campaigns to improve health. Evaluation of effectiveness of communication in targeted campaigns.	12. Via the PH comms group to hold us to account to ensure we do this for our campaigns for both these gaps.	medium
1.6 Public Health capability and capacity	Basic/developing (some evidence of workforce planning)	Awareness and use of PH knowledge and skills framework across LA.	13. Map out the use of the framework in delivery of the PHOF.	Medium/low

ACTION PLAN: Health Protection. Overall assessment score = Developing

Date: 14th July 2015. Completed by Victor Joseph, Consultant in Public Health

Dimension	Assessment[1]	Gaps	Actions required	Who	Priority[2]	When
2.1 Health protection assurance framework	Excellent (health protection assurance framework)	HWB is fully engaged and is assured of the delivery of health protection functions.	14. Need health protection on regular agenda of HWBB	RS	Medium	
			15. Need to develop outbreak control plan	JW		
2.2 Vaccination and immunisation	Developing / Excellent (assurance from NHS England, increased work with schools to raise awareness)	Regular risk assessments carried out and assurance statements received outlining progress or lack of it, and control measures are put in place.	16. Agree a common assurance reporting mechanism from NHSE on vaccination programme to all the local authorities in South Yorkshire		Medium	
		Overall performance against PHOF measures for all vaccination and immunisation in the top quartile of national performance or are showing significant and sustained improvement.	17. Need to have Doncaster in the top of peer group of PHOF for vaccination in the short and medium term.	VJ		1-3 years
			18. Promote uptake of vaccination in schools	SP		5 years
			19. Long-term: Doncaster vaccination rate in top			

[1] Assessment: Basic, Developing, and Excellent

[2] Priority: High, Medium, Low

Dimension	Assessment[1]	Gaps	Actions required	Who	Priority[2]	When
			quartile nationally			
2.3 Screening	Developing (assurance from NHS England)	Regular performance reports are produced, standards are met and targets achieved. Overall performance against PHOF measures for screening in the top quartile of national performance or are showing significant and sustained improvement.	20. Improve Doncaster's performance in order to be top in performance in the peer group. 21. Regular monitoring through Health Protection Assurance Group. 22. Work in partnership with NHSE.	VJ	Medium	
2.4 Infection prevention and control (IPC)	Developing (IPC service commissioned, district wide IPC committee)	IPC specifications are embedded in contracts of all relevant LA commissioned services.	23. Embed standard paragraph in all relevant local authority contracts.	VJ	High	
		Annual statements of declaration by providers of commissioned services that they are compliant with IPC standards, as part of contract review.	24. Conduct annual audit compliant of with CQC standards;	Contract Monitoring Team (Sarah Ferron)	High	
		Healthcare acquired infection targets are met.	25. Contract monitoring against performance of IPC service	VJ	High	
2.5 Environment including: enforcement, trading standards, food, animal health, water, air quality and health and	Developing (joint work with environmental health and recent workshop with health and wellbeing board)	Effective data collection of relevant PHOF indicators.	26. Link PHOF with Heads of Service Plans 27. Strengthen and develop existing joint working between Public Health and Environmental Health.			
		Ensure issues related to health protection are incorporated into	28. Continue to work closely with Air Pollution Team to			

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Working towards excellence: gaps and actions

Dimension	Assessment[1]	Gaps	Actions required	Who	Priority[2]	When
safety		work programme, e.g. actions to reduce impact of fast food outlets on health through licensing process, work with schools, and raising awareness, joint work on fire safety, etc.	educate residents & colleagues on the effects of air quality on health. 29. Continue to support active forms of travel as alternative to car use.			
		Demonstrate health outcomes for relevant PHOF indicators are significantly better than the national average or are showing significant sustained improvement, e.g. excess winter deaths, tobacco control profiles, LA profiles, obesity, etc.	30. Identify the relevant PHOF indicators 31. Monitor progress on relevant PHOF	VJ/LM	High	
2.6 Drugs and substance misuse	Excellent (harm reduction strategy, novel psychoactive substance work, paraphernalia supplied (foil and needles))	Gap in ensuring links between obesity and health check services are in place in order to assess levels of alcohol, offer brief intervention and sign post when appropriate.	32. Establish links between obesity and health check services are in place in order to assess levels of alcohol, offer brief intervention and sign post when appropriate.	HC/RM	Medium	
2.7 Prevention of injury and suicide prevention	Developing (suicide prevention group and gap analysis)	Gap: Achieving national outcomes and targets. Health outcomes are significantly better than the national average or are showing significant sustained improvement.	33. Implementation of local suicide prevention strategy and action plan; and monitor performance	DL	High	

Dimension	Assessment[1]	Gaps	Actions required	Who	Priority[2]	When
2.8 Sexual health	Developing (integrated service commissioned and being mobilised for adults)	Overall performance against outcome measures for sexual health in the top quartile of national performance or are showing significant sustained improvement.	34. Implementation of local action plan, and performance monitoring of existing contract	AB/HT		
2.9 Emergency preparedness, resilience, and response (EPRR), incidents and outbreaks	Developing (all plans in place, reporting to health and wellbeing board to be agreed)	Relevant plans are in place including: a. Major incident plan b. Mass casualty plan c. Pandemic Flu plan d. Excess death plan e. Severe weather plan f. psychosocial support and recovery	35. Update of the following major emergency plans: (1) mass treatment and vaccination plan; and (2) communicable diseases outbreak plan. 36. Test existing major emergency plan e.g. Pandemic Flu Exercise 37. Capture learning from real events and translate them into actions.	CW		
		Plans reviewed by HWB annually and reports of significant incidents received and reviewed.	38. Annual report to HWB	JW		
2.10 Surveillance of communicable disease	Developing (assurance from PHE in place, local mechanisms to be reviewed)	Review of communication of surveillance information that needs to be received at local level.	39. Establish standard operating procedures (protocol) for dealing with health protection surveillance information received at the DMBC: situation report; weekly notification, and	VJ	High	

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Working towards excellence: gaps and actions

Dimension	Assessment[1]	Gaps	Actions required	Who	Priority[2]	When
			national surveillance.			
		Performance reports and information on outcomes received by Health and Wellbeing Board and appropriate action taken.	40. Agree mechanism of reporting to Health and Wellbeing Board.	RS/VJ		
2.11 Public Health capacity and capability	Developing (needs to be reviewed on an annual basis)	Annual audit of workforce capacity and capability to identify any potential gaps and develop action plans to address any such gaps.	41. Undertake annual audit of capacity and capability in PH Team	RS/VJ		
		Develop and agree standard for PH workforce capacity and capability in the LA.	42. Develop and agree PH standard	VJ		
		Relevant performance outcomes in the PHOF are in the top quartile nationally, or are showing significant sustained improvement.	43. Monitor PHOF performance through the PH Governance Group	LM		

ACTION PLAN: Healthcare Public Health. Overall assessment score = Developing

Date: 14th July 2015. Completed by Victor Joseph, Consultant in Public Health

Dimension	Assessment[3]	Gaps	Actions required	Who	Priority[4]	When
3.1 Health services commissioning - governance	Developing (MOU with CCG)	PH staff co-located with CCG.	44. Explore with CCG mechanism of joint working with DMBC re: hot desk arrangements during MOU review meetings.	RS/VJ	Medium	
		PH staff have access to CCG IT and desk space and to CCG staff and mandatory training needs jointly agreed, and staff fully compliant.	45. Explore with CCG mechanism of a more integrated working arrangements with Local Authority PH.	RS/VJ		
		Jointly funded PH posts in place.	46. Consider with CCG whether or not this is an approach to be taken locally.	RS/VJ		
		Formal appraisal and performance management of PH consultant lead includes feedback from CCG.	47. Annual review of the MOU and work programme	RS/VJ		
		PH staff are members of CCG integrated commissioning teams.	48. Continue public health engagement at CCG Governing Board; and Strategy Forum, and any	RS/VJ		

[3] Assessment: Basic, Developing, and Excellent

[4] Priority: High, Medium, Low

Dimension	Assessment[3]	Gaps	Actions required	Who	Priority[4]	When
			other relevant group.			
3.2 Health and Social Care Prioritisation	Developing (agreed Better Care fund plan)	Where part of MoU with CCG, PH staff have advisory role in Individual Funding Requests (IFR).	49. NOT APPLICABLE: IFR is a service commissioned by the CCG to be administered by a different body on its behalf. Therefore, PH is rarely involved in IFR (e.g. commenting on policy).		Low	
		PH demonstrably critically appraising business cases of proposals for new CCG service developments or re-configurations.	50. Explore proactive engagement in CCG Strategy Forum to influence commissioning agenda.	VJ		
		Where part of MoU with CCG, evidence that PH staff actively contribute to the development of IFR	51. N/A			
		Where part of the MoU with CCG, evidence that PH staff lead the development of IFR policy and that this is evidence based and equitable.	52. N/A			
		CCG, LA Adult Social Care and LA Children's Social Care budget setting and commissioning plans clearly show the influence of PH expertise.	53. Joint working on shared agenda: e.g. Better Care Fund			
3.3 Equity	Developing (needs to be developed as part of 5 year forward view	LA PH team and CCG have agreed approach to equity, including agreed shared definition.	54. Lead presentation and discussion at CCG Strategy Forum	VJ	High	
		LA PH team and CCG have agreed the contribution that health services commissioning can make to	55. Establish what the CCG strategy on reducing health inequalities is, including	VJ/RS		

Dimension	Assessment[3]	Gaps	Actions required	Who	Priority[4]	When
	response in 2015/16)	addressing health inequalities. The CCG has a strategy for reducing health inequalities that has had input from PH and has changed how they do business.	what constitute the Prevention Agenda of the CCG.			
		Health inequalities demonstrably reduced as a result of PH input and CCG action.	56. Monitor through PHOF indicators and NHSOF.	LM/Eilsa Leighton		
3.4 Quality	Basic	Demonstrable PH input into CCG service specifications that include clearly identified clinical, quality and productivity outcomes. Information on service quality reviewed by PH, including benchmarking against other Districts, and NICE guidance, as appropriate.	57. Explore joint input into the developments of each other service specification (PH in the LA, and CCG)	VJ	High	
		Quality of services demonstrably improved as a result of PH involvement in drawing up service specifications or monitoring of service quality.	58. Performance monitoring of commissioned services in achieving outcomes	LM/Eilsa Leighton	High	
3.5 Evaluation	Developing (bespoke evaluation carried out to a high standard)	One or more topics (e.g. services delivery, service changes, re-commissioning) evaluated against explicit criteria and using a variety of evaluation techniques.	59. Deliver work plan between CCG and PH in the DMBC. Some evaluation areas covered in the work plan.	VJ	Medium	
		Evaluation demonstrably impacts on	60. Deliver work plan between			

Dimension	Assessment[3]	Gaps	Actions required	Who	Priority[4]	When
		commissioning plans, service delivery and outcomes.	CCG and PH in the DMBC.			
3.6 Patient safety	Developing (jointly agreed approach to patient safety)	PH staff have major role in risk analysis, interpretation of data on incidents and serious untoward events.	61. Be involved in Patient Safety and Quality Committee of the CCG; 62. Take part in public health risk assessment, and review.	VJ/PH Governance Group	High	
3.7 Healthcare development	Developing (improved pathways in alcohol and dementia)	New healthcare developments have demonstrable impact on health of population overall (to improve it) or health inequalities (to reduce them).	63. Support innovation in healthcare delivery, with embedded evaluation.	VJ	High	
3.8 Leadership	Excellent	None	64. Maintain leadership	VJ/RS	High	

Knowledge and intelligence

Dimension	Assessment[5]	Gaps	Actions required	Priority
Information Governance	Developing	Working towards level 3 IG; achieving level 3 status is essential to ensure and maintain on-going PH intelligence but there is limited capacity within the directorate to lead this on behalf of the organisation	65. Work to ensure that this work is led by the appropriate central team within the authority.	HIGH
Data flows and information gathering	Excellent	Local CSU have lost their licence	66. Update PH risk register at next refresh	MEDIUM
		Assurance that there is a minimum level of PH specialist competence in use of data/information gathering (in light of PPPR2)	67. Develop assurance framework 68. Develop a knowledge exchange programme around use of data	LOW/MEDIUM
JSNA	Developing	Discernable 'golden thread' from the needs assessment through the HWBS to commissioning plans, outputs and outcomes for a range of topics is absent	69. Develop an evaluative framework for the JSNA	MEDIUM
		Lack of a routinized needs assessment culture	70. Audit needs assessment activity	LOW
Knowledge Management	Developing	Lack of integrated knowledge and intelligence; approach to synthesis within a complex decision making environment	71. Development action to further understand end user needs and tailor outputs appropriately	HIGH
		NICE guidance is systematically	72. Review NICE guidance and consider	HIGH

[5] Evidence to support this decision is contained within the full dataset

		forwarded within the team but it is recognised that more work could be done to support implementation	ways to offer implementation support drawing on implementation science approaches	
Research and Evaluation	Developing	Ad hoc approaches to evaluation; evaluation not embedded in the culture	73. Undertake skills assessment and signpost identified staff to the Evaluation training being developed by SfPH colleagues	MEDIUM
		Limited of routine audit carried out	74. Run a Knowledge exchange on audit as a reminder and use a BAR to develop a directorate wide audit plan	LOW
		Limited development of and use of actionable tools from research	75. Set a standard to ensure actionable tools as an output from collaborative research 76. Ensure that use of the ERepository of research derived actionable tools (in development)[6] is encouraged within the team	MEDIUM
Developmental		There is a need to explore useful and meaningful metrics to measure the impact of this work.	77. Develop a basket of indicators to evaluate impact of this work stream	LOW

[6] Part of NHS England Knowledge Mobilisation work
Rupert Suckling
Public Health Self Assessment Tool for Sector Led Improvement
Working towards excellence: gaps and actions

Capacity building

Dimension	Assessment[7]	Gaps	Actions required	Priority
Leadership for Public Health	Developing	Roadmap for population health system required.	78. Develop roadmap for population health system	HIGH
		Refresh and communication of PH programmes	79. Refresh and communicate PH programmes and work programmes	
		Media work could be more effective	80. Review effectiveness of media work	
		Relatively few PH leadership roles across sub-region, region and national	81. Look for opportunities for sub regional, regional and national leads across the team	
		PH advocacy	82. Establish PH advocacy role	
Organisational development	Developing/ Excellent	Development of wider PH workforce in LA and key partners	83. Develop engagement and development plan for wider PH workforce	MEDIUM
		Development of work with elected members	84. Develop the role of elected members as PH champions	
		Structure unchanged, need to assess added value	85. Develop methodology to assess PH staff added value to support review of structure	
Partnerships to build PH capacity	Developing	Partners leading and investing in PH related interventions	86. Identify 1-2 areas for partners to lead and invest in PH related interventions	MEDIUM
		Effectiveness of partnerships not routinely measured	87. Develop maturity matrix approach for key partnerships	

[7] Evidence to support this decision is contained within the full dataset

		Changing decision making processes and structures	88. Map key decision making structures and process and ensure PH involvement.	
Workforce: training PH specialist registrars, the PH team and the wider workforce	Basic/Developing	PH training for LA staff and partner organisations (e.g. MECC, MH first aid, HIA) Bespoke training	89. Review PH role in training LA staff and partner originations, including bespoke training	HIGH
		Workplace health initiatives not embedded	90. Embed workplace health initiatives	
		CPD development programme needs to include local partners	91. Develop CPD programme to include local partners	
Community	Basic/Developing	Community engagement through communities team as part of adults health and wellbeing directorate and Health and Social Care transformation approach	92. Develop shared approach with the communities team on community engagement including 'universal' and 'targeted' approaches.	HIGH

Governance and systems

Dimension	Assessment[8]	Gaps	Actions required	Priority
Overall Governance	Developing	Unsure of understanding of partner organisations and community of PH role	93. Communicate with partners and community on role and test understanding via 360 feedback	HIGH
		PH business plan needs linking across other NHS organisations	94. Revise and share PH business plan	
Risk management	Developing/ Excellent	Ensure PH risk register feeds into LA and partners risk registers	95. Clarify reporting/escalation measures from PH governance group to corporate risk register	MEDIUM
		Uncertain of the role of the risk register in strategy formulation	96. Use risk register in developing future strategies	
Clinical Governance and patient safety	Basic	Clinical governance not embedded within the LA's governance and risk management system	97. Review approach on clinical governance initially with adults health and wellbeing	MEDIUM
		Clinical governance reports from commissioned services need to be reviewed alongside activity/finance and other quality indicators	98. Develop, request and receive clinical governance reports from providers	
		Need to join up clinical governance processes across health, social care and children's services	99. Ensure two-way communication with QSG	
Audit	Basic	Need a Public Health audit programme	100. Develop Public Health audit programme	MEDIUM
Use of evidence	Developing	Approach current limited to public health, not explicitly linked to PHOF	101. Expand current approach pending PPPR-2 review	LOW

[8] Evidence to support this decision is contained within the full dataset

Doncaster
Metropolitan Borough Council

Agenda Item No: 7

23rd September, 2015

To the Chair and Members of the

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

TO UPDATE ON PERSONALISATION/DIRECT PAYMENTS – CONSIDERATIONS OF ACTIONS TO PROMOTE GREATER PERSONALISATION AND DIRECT PAYMENTS.

Relevant Cabinet Member(s)	Wards Affected	Key Decision
Cllr Glyn Jones	All	No

EXECUTIVE SUMMARY

1. A Key outcome of the 2015/16 Adults Health and Wellbeing Transformation programme is ensuring that when people need care and support it is personalised flexible and appropriate.
2. The development of direct payments is a response to this outcome and forms a key part of the helping persons to live at home; ensuring that where people can manage their own care and support there is easy access to efficient and flexible support and processes to help them to achieve this.

EXEMPT REPORT

3. This is not an exempt report.

RECOMMENDATIONS

4. That the Health and Adult Social Care Scrutiny Panel note this report and the actions being taken to continue to develop personalisation and direct payments to service users, their carers and families. This will be achieved by maximising the use of available resources to support and maintain independence and self-determination wherever possible.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

5. The increase in the use of direct payments means that more people will have choice and control of their care and support and receive a more personalised service that best meets their needs to remain independent.
6. The benefits of direct payments are that they offer an alternative to traditional services that encompasses personalisation, choice, flexibility and ownership for people. E.g. they can employ their own staff and have consistent carers without relying on agency staff.

BACKGROUND

7.

- There are currently 2104 people in receipt of helped to live at home services but only 422 use a direct payment to manage their own care.
- Direct payments are now made under sections 31 to 33 of the Care Act (2014) – with the Care and Support (Direct Payments) Regulations 2014 (SI 2014/2871).
- The direct payment figure for citizens receiving their service via a direct payment in Yorkshire and Humber is 25.3% and for Doncaster itself is approximately 20% leaving Doncaster lower than other local authorities.
- The directorate targeted this area for additional support and training to increase the uptake of direct payments to improve the performance indicator in the ASCOF returns.
- It also offers more choice and control to the citizens of Doncaster. There is some evidence to suggest that if people have personalised services, therefore reducing dependency on care agencies that it can reduce the number of people entering long term residential care.
- The increase in direct payment is anticipated to have an impact on the admissions to long term residential care for people in Doncaster, which is also above the national average.

OPTIONS CONSIDERED

8. Option 1: Continue with the current traditional models of providing care and support which will mean a reduced and less flexible and modernised offer and not respond well to the duties set out in the care Act.

   Option 2: Continue developing direct payments as a help to live at home option.

REASONS FOR RECOMMENDED OPTION

9. Option 2 is recommended as it provides greater choice and control, to an individual enabling them to design and shape the services they need. This option also responds to the legislative duties set out in the Care Act and is a key element in Doncaster Councils modernisation of Adult Social Care.

IMPACT ON THE COUNCIL'S KEY PRIORITIES

10.

	Priority	**Implications**
	People live safe, healthy, active and independent lives. • *Mayoral Priority:* Safeguarding our Communities • *Mayoral Priority:* Bringing down the cost of living	Improve capacity in local communities to maintain people in their home. Complies with the Care Act. Should reduce admission in to long term care.

	Council services are modern and value for money.	Enhances quality of life. Offers employment opportunities for local people.

RISKS AND ASSUMPTIONS

11. Failure to increase the take up of direct payments will result in an over reliance on traditional services that will not comply with the Care Act and may result in more people being admitted into long term residential care placements.

12. The risk to an individual having greater choice and control over how they live their lives is also increased, if the take up of direct payments does not increase in line with regional and national averages.

LEGAL IMPLICATIONS

13. There is a general duty on a local authority under the Care Act 2014 to promote the individual's well-being.

14. "Well-being", in relation to an individual, includes control by the individual over their day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);

15. In exercising its functions under the Care Act a local authority must in addition to other matters have regard to the importance of beginning with the assumption that the individual is best-placed to judge their well-being, to consider the individual's views, wishes, feelings and beliefs, and ensure the individual participates as fully as possible in decisions relating to them.

16. Where a personal budget for an adult specifies an amount which the local authority must pay towards the cost of meeting the needs to which the personal budget relates, and the adult requests the local authority to meet some or all of those needs by making payments to the adult or a person nominated by the adult. Subject to various conditions the local authority must make the payments to which the request relates to the adult or nominated person.

FINANCIAL IMPLICATIONS

17. There are no specific implications relating to this report, these have been addressed through other reports.

HUMAN RESOURCES IMPLICATIONS

18. None

TECHNOLOGY IMPLICATIONS

19. None

EQUALITY IMPLICATIONS

20. In undertaking the assessment of an individuals eligible unmet needs and in the promotion of direct payments as a product to meet those needs, the Council ensures that individuals are not disadvantaged and the equality of opportunity to access appropriate services is a priority. This includes those people with protected characteristics.

CONSULTATION

21. In establishing the systems and processes associated with direct payments and the relevant services that support individuals, consultation with stakeholders and individuals have taken place.

22. This report has significant implications in terms of the following:

Procurement	X	Crime & Disorder	
Human Resources		Human Rights & Equalities	X
Buildings, Land and Occupiers		Environment & Sustainability	
ICT		Capital Programme	

BACKGROUND PAPERS

23. Personalisation/direct payments presentation to be provided at the meeting.

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Doncaster
Metropolitan Borough Council

Agenda Item No: 8
23rd September, 2015

To the Chair and Members of the Health and Adult Social Care Overview and Scrutiny Panel

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL WORK PLAN REPORT 2015/16

Relevant Cabinet Member(s)	Wards Affected	Key Decision
Councillor Pat Knight – Cabinet Member for Public Health and Wellbeing	All	None

EXECUTIVE SUMMARY

1. The Panel is asked to note and consider the updated work plan report for 2015/2016.

EXEMPT INFORMATION

2. Not exempt

RECOMMENDATIONS

3. The Panel is asked to;

   (i) consider and comment on the revised workplan attached at Appendix A;
   (ii) note the attached CQC inspection report on Yorkshire Ambulance Service in Appendix B and to consider the proposed scrutiny approach by Wakefield CC on behalf of the Yorkshire and South Humber local authority scrutiny committees, in taking this issue forward.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

4. The Overview and Scrutiny function has the potential to impact upon all of the council's key objectives by holding decision makers to account, reviewing performance and developing policy. The Overview and Scrutiny of health is an important part of the Government's commitment to place patients at the centre of health services. It is a fundamental way by which democratically elected community leaders may voice the views of their constituents and require local NHS bodies to listen and respond. In this way, local authorities can assist to reduce health inequalities and promote and support health improvement. The Health and Adult Social Care Overview and Scrutiny Panel have been designated as having

responsibility of carrying out the health scrutiny function.

BACKGROUND

5. Overview and Scrutiny has a number of key roles which focus on:

- Holding decision makers to account
- Policy development and review
- Monitoring performance (both financial and non-financial)
- Considering issues of wider public concern.

Health and Adult Social Care Overview and Scrutiny Workplan Update

6. Attached for the Panel's consideration at Appendix A is the work plan report. This workplan takes account of issues considered at the informal Health and Adult Social Care Overview and Scrutiny work planning meeting held on the 5th June 2015 and was agreed by formal OSMC on the 25th June 2015. Any further updates since the publication of this report will be provided to the Panel at the meeting.

Monitoring the Work Programme

7. An updated version of the work plan will be regularly presented to the Health and Adult Social Care Overview and Scrutiny Panel for consideration and this will include copies of correspondence and briefings in relation to recommendations resulting from Scrutiny Panel reviews and meetings. In this way, Members will be able to see more clearly the progress and impact being made. The work of OSMC and the Panels will be reported annually to full Council and the progress of the standing Panels will be reported to OSMC and where appropriate to the Chairs and Vice Chairs Liaison Group.

Yorkshire Ambulance Service NHS Trust

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

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

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

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

OPTIONS CONSIDERED

12. There are no specific options to consider within this report as it provides an opportunity for the Committee to develop a work plan for 2015/16.

REASONS FOR RECOMMENDED OPTION

13. This report provides the Panel with an opportunity to develop a work plan for 2015/16.

IMPACT ON COUNCIL'S KEY OBJECTIVES

	Priority	**Implications**
1.	We will support a strong economy where businesses can locate, grow and employ local people. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Be a strong voice for our veterans* • *Mayoral Priority: Protecting Doncaster's vital services*	The Overview and Scrutiny function has the potential to impact upon all of the council's key objectives by holding decision makers to account, reviewing performance and developing policy through robust recommendations, monitoring performance of council and external partners services and reviewing issues outside the remit of the council that have an impact on the residents of the borough.
2.	We will help people to live safe, healthy, active and independent lives. • *Mayoral Priority:* Safeguarding our Communities • *Mayoral Priority:* Bringing down the cost of living	
3.	We will make Doncaster a better place to live, with cleaner, more	

	sustainable communities. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Safeguarding our Communities* • *Mayoral Priority: Bringing down the cost of living*	
4.	We will support all families to thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	
5.	We will deliver modern value for money services.	
6.	We will provide strong leadership and governance, working in partnership.	

RISKS AND ASSUMPTIONS

14. To maximise the effectiveness of the Overview and Scrutiny function it is important that the work plan devised is manageable and that it accurately reflects the broad range of issues within its remit. Failure to achieve this can reduce the overall impact of the function.

LEGAL IMPLICATIONS

15. The Council's Constitution states that subject to matters being referred to it by the Full Council, or the Executive and any timetables laid down by those references Overview and Scrutiny Management Committee will determine its own Work Programme (Overview and Scrutiny Procedure Rule 6a).

16. Specific legal implications and advice will be given with any reports when Overview and Scrutiny have received them as items for consideration.

FINANCIAL IMPLICATIONS

17. The budget for the support of the Overview and Scrutiny function 2015/16 is not affected by this report however, the delivery of the work plan will need to take place within agreed budgets. There are no specific financial implications arising from the recommendations in this report. Any financial implications relating to specific reports on the work plan will be included in those reports.

EQUALITY IMPLICATIONS

18. This report provides an overview on the work programme undertaken by Health and Adult Social Care Overview and Scrutiny. There are no significant equality

implications associated with this report. Within its programme of work Overview and Scrutiny gives due consideration to the extent to which the Council has complied with its Public Equality Duty and given due regard to the need to eliminate discrimination, promote equality of opportunity and foster good relations between different communities.

CONSULTATION

19. The work plan has been developed in consultation with Members and officers.

BACKGROUND PAPERS

20. None

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Appendix A

Health and Adult Social Care (H&ASC) Overview & Scrutiny Panel Workplan 2015/2016 & 2016/2017 – Fixed Panel Meetings

2pm 29th July 2015	10am 23rd September 2015	10am 25th November 2015	10am 26th January 2015	10am 16th March 2015
Implementation of the Care Act – July 2015 (1st Meeting) – Retrospective and Prospective.	Public Health Self-Assessment/Public Health Commissioning	Healthy High Street (following on from Royal Society of Public Health report)	Implications of ageing population (not just dementia).	Public Health Protection Responsibilities
H&WB Strategy Refresh (incl. inequalities and 'Well North')	Personalisation/Direct Payments – considerations of actions to promote greater personalisation and direct payments	Modernisation and peer review plan – tracking progress and challenge	Children's health early years 0-5 including health visiting and family nurse partnership (jt with CYP)	Integration of Health Colleagues – what does this mean for Doncaster
Better Care Fund – update/progress including low level prevention service		Adult Safeguarding Annual Report	Review of arrangements to deliver high quality care for people in residential homes/care homes/admissions long term care	Cancer (TBC)

Ongoing Areas
Update on Regional Joint Health Overview and Scrutiny Committee re: Children and Adults Cardiac review: - • **Mid-September** meeting to look at to understand the outcome/implications of the review

H&ASC O&S Areas (May Change – TBA)
• Quality accounts - review • Yorkshire Ambulance Service – failure to meet targets/Industrial issues – CQC undertaking inspection (see what the outcome is) • Cancer – Education and awareness (specific scope to be agreed) H&WB looking at it in Nov 2015 • Sexual Health (Informal Meeting TBA Mid Nov) – Signposting for young people/partnership working (how successful is this) – informal joint meeting with CYP O&S • Transfer of health – outline what is now in the contract and responsibilities - informal joint meeting with CYP O&S

Workplan Ideas 2016/17
•

Yorkshire Ambulance Service NHS Trust

Quality Report

Springhill 2, Brindley Way
Wakefield 41 Business Park
Wakefield
West Yorkshire
WF2 0XQ
Tel: 0845 124 1241
Website: www.yas.nhs.uk

Date of inspection visit: 13-16 January 2015,19 January 2015,9 February 2015
Date of publication: This is auto-populated when the report is published

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

Ratings

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

Letter from the Chief Inspector of Hospitals

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

Summary of findings

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

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

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

We inspected four core services:

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

Overall, the trust was rated as requires improvement. Effectiveness, safety, responsive and well-led were rated as requires improvement. Caring was rated as good.

Our key findings were as follows:

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

The trust had major difficulties in recruiting staff, national shortages of paramedics contributed to the trusts difficulty in recruiting paramedics which impacted on the ability to be responsive and also enable staff to attend training and other activities.

The trust was working hard to be more outward facing, working in partnership with commissioners and improving consultation with patients and public.

We saw several areas of outstanding practice including:

For the trust:

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

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

Summary of findings

Importantly, the trust must:

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

In addition the trust should:

- The trust should ensure all staff receive an appraisal and are supported with their professional development. This must include support to maintain the skills and knowledge required for their job role.
- The trust should ensure risk management and incident reporting processes are effectively embedded across all regions and the quality of identifying, reporting and learning from risks is consistent. The trust should also ensure staff are supported and encouraged to report incidents and providing feedback to staff on the outcomes of investigations.
- The trust should ensure all ambulance stations are secure at all times.
- The trust should review the provision and availability of equipment for use with bariatric patients and staff are trained to use the equipment.
- The trust should review the safe management of medication to ensure that there is clear system for the storage and disposal of out of date medication. The trust should also ensure oxygen cylinders are securely stored at all times.
- The trust should ensure records are securely stored at all times
- The trust should ensure consistent processes are in place for the servicing and maintenance of equipment and vehicle fleet.
- The trust should all staff have received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The trust should ensure performance targets in relation to patient journey times and access to booking systems continue to be monitored and improve.
- The trust should ensure there are appropriate translation services available for staff to use to meet the needs of people who use services.

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

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Yorkshire Ambulance Service NHS Trust

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

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

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

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

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers

Head of Hospital Inspections: Julie Walton, Care Quality Commission

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

How we carried out this inspection

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

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

The inspection team inspected the following:

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

Summary of findings

• Resilience Team including the Hazardous Area Response Team

Prior to the announced inspection, we reviewed a range of information that we held and asked other

Organisations to share what they knew about the hospital. These included the clinical commissioning

Groups (CCGs), the Trust Development Authority, NHS England, and the local Healthwatch's.

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

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

What people who use the trust's services say

Friends and Family Test

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

Hear and Treat Survey 2013-2014

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

Patient surveys

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

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

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

A&E Patient survey

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

Patients views during the inspection

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

Facts and data about this trust

The population the trust serves includes:

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

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

- Bassetlaw
- North Lincolnshire.

Activity

Summary of findings

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

Summary of findings

Our judgements about each of our five key questions

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

Summary of findings

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

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

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

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

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

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

Summary of findings

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

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

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

The trust had developed a policy for duty of candour and being open. The policy statement stated that

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

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

Summary of findings

Are services at this trust effective?

Requires improvement

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

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

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

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

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

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

Summary of findings

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

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

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

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

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

Are services at this trust caring?

Good

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

Summary of findings

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

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

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

Are services at this trust responsive?

Requires improvement

The trust had five specific vehicles which had an enhanced range of equipment available for patients considered to be bariatric or obese. These had been introduced as an improvement beyond the basic capability of the existing fleet. However staff told us these ambulances were not always able to respond in a timely way for emergencies and described incidents where the patient's dignity had to be balanced with the need for emergency care.

In 2013/14, the trust had 14.6% of all Red 1 calls in England and 9.1% of all Red 2 Calls in England. The trust had been dealing with a steady number of calls since 2012; in April to September 2014, the trust had 15% of Red 1 calls and 9.3% of Red 2 calls in England.

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

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

Summary of findings

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

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

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

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

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

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

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

Summary of findings

Are services at this trust well-led?

Requires improvement

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

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

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

Vision and strategy

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

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

Governance, risk management and quality measurement

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

example, a Trust Board paper from the Audit Committee (8 January 2015) provided the quality committee risk assurance report. One of the key risks reported was that of the adverse clinical outcomes due to failure of reusable medical devices and equipment. A reduction in risk was stated as “contingent” on the recruitment of a new head of medical devices, at the time of the inspection this post had not been recruited to.

- The trust had a Board Assurance Framework (BAF) and a corporate risk register in place, subject to a quarterly cycle of peer review through the risk assurance group, the trust executive group and Board committees. This was used to prioritise risks that the trust should review through the quality committee, with a report of the outcome to provide to the audit committee.
- The latest version of the Board Assurance Framework was agreed in October 2014 and further updated in December 2014. The risk statements on the BAF were underpinned by the risk registers and the information was used to support risk management of the delivery of the trust’s corporate objectives and the annual governance report.
- The main risks on the register were with regard to the lack of staff to provide a paramedic service within the north and south of Yorkshire areas, meeting regulatory requirements regarding health and safety checks and the cleaning of vehicles, and the inability to maintain a cleaning regime for the ambulances. In addition, risks to meeting performance targets included attending red calls were considered high.
- When we visited the resilience team, including the HART service, we found that there were governance failings to ensure that the equipment, including lifesaving equipment and consumables were safe to use, with in-date products and appropriately charged. The vehicles used for a regional response also were unclean both the exterior and interior of the vehicles. This matter was raised with the trust at the time of the inspection, which acknowledged the failings and took immediate actions to make the service safe and ready to respond.
- There had been audits undertaken within the HART service, as referenced on the risk register and these had not identified the deficiencies and so no actions had been taken to address the failings.
- The trust had assessed and identified prior to the inspection the following seven areas as key challenges:
- Clinical supervision, embedding a professional culture and consistent implementation of clinical supervisor across operational areas.

Summary of findings

- Meeting increased red demand with wider system pressures such as hospital turnaround times.
- Staff engagement there was geographical issues and shift patterns across the trust, with a strong unionised culture.
- Management and leadership capacity and capability there had been a number of interim executives, historic deficit in middle to senior management capability, variation in quality and performance management across localities.
- Support functions such as Fleet and Estates teams, not always well-aligned to needs of front-line staff.
- Complaint Response times there was an increased number over 25 day target for response.
- Commissioner engagement and strategic direction the trust had to manage and work with a complex arrangement of CCG's and a lack of coherent commissioner and trust view of future regional strategy. The trust was commissioned by 23 clinical commissioning groups.
- The feedback from the lead commissioner reported that there was a much more positive working relationship developing between the trust and the commissioning bodies.
- We reviewed the trusts corporate risk register and found the trust did not have robust governance processes to manage risks in a timely and effective way. We found the pertinent risks from the risk register showed the trust had been aware of the issues for a number of years and had failed to put sufficient actions in place to minimise the risks. The trust acknowledged that there was further improvement needed to embed the processes across the trust.
- The trust reported there was a national shortage of paramedics and subsequently had significant difficulties in recruiting staff, particularly paramedics, which impacted on the ability to be responsive and also enable staff to attend training and other activities. There were concerns over places not being taken up on paramedic courses leaving shortages in the future and also that funding would not roll over into the next year. This had been on the risk register since May 2013.
- The Trust told us at the time of inspection they had significantly expanded opportunities for technicians to become paramedics and that places available were under-subscribed with the Trust actively encouraging uptake. However some staff within the trust told us they did not feel the organisation supported them to train to become paramedics.

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

Fit and Proper Person Requirement.

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

Leadership of the trust

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

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

Culture within the trust

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

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

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

Public and staff engagement

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

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

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

Innovation, improvement and sustainability

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

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

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

Overview of ratings

Our ratings for Yorkshire Ambulance Service

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

Our ratings for Yorkshire Ambulance Service NHS Trust

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

Notes

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

Importantly, the trust must:

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

In addition the trust should:

- The trust should ensure all staff receive an appraisal and are supported with their professional development. This must include support to maintain the skills and knowledge required for their job role.
- The trust should ensure risk management and incident reporting processes are effectively embedded across all regions and the quality of identifying, reporting and learning from risks is consistent. The trust should also ensure staff are supported and encouraged to report incidents and providing feedback to staff on the outcomes of investigations.
- The trust should ensure all ambulance stations are secure at all times.
- The trust should review the provision and availability of equipment for use with bariatric patients and staff are trained to use the equipment.
- The trust should review the safe management of medication to ensure that there is clear system for the storage and disposal of out of date medication. The trust should also ensure oxygen cylinders are securely stored at all times.
- The trust should ensure records are securely stored at all times
- The trust should ensure consistent processes are in place for the servicing and maintenance of equipment and vehicle fleet.
- The trust should all staff have received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The trust should ensure performance targets in relation to patient journey times and access to booking systems continue to be monitored and improve.
- The trust should ensure there are appropriate translation services available for staff to use to meet the needs of people who use services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18 We found that the Trust did not always protect patients from unsafe or inappropriate care as not all staff had received mandatory training and had an appraisal. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must ensure there are suitable arrangements in place for staff to receive appropriate training, supervision and appraisal including the completion of mandatory training. This must include support to maintain the skills and knowledge required for their job role. The trust must ensure risk management processes were effectively embedded across all regions and the quality of identifying, reporting and learning from risks was consistent. The trust must ensure that equipment and medical supplies are checked and are fit for purpose. The trust should ensure there is an effective system for reporting incidents and providing feedback to staff on the outcomes of investigations. The trust should ensure records are securely stored at all times. The trust should ensure consistent processes are in place for the servicing and maintenance of equipment and vehicle fleet. The trust should ensure records are securely stored at all times.