Requires Improvement

Leeds Community Healthcare NHS Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community Dental Services	Head Quarters	RY6X6
Community Health Services for Adults	Head Quarters	RY6X6
Community Health Services for children, young people and families	Head Quarters	RY6X6
Community Health Services for children, young people and families	Hannah House	RY6X3
Inpatient Services	Community Intermediate Care Unit	RY6X2
Inpatient Services	South Leeds Independence Centre	RY6X1
Children's and Adolescent Mental Health Services	Head Quarters	RY6X6
Children's and Adolescent Mental Health Services	Little Woodhouse Hall	RY6X8

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

Summary of findings

Ratings

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

Overall rating for community health services at this provider	Requires Improvement 
Are services safe?	**Requires Improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Requires Improvement** 
Are services well-led?	**Good** 

Summary of findings

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Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

Whilst a number of individual services were judged good, concerns within community inpatient services, and community child and adolescent mental health services, means that overall we have judged the trust as requires improvement.

The provider was not meeting regulation 15 premises and equipment at Little Woodhouse Hall, and regulation 17(2)(d) good governance within the community children's and adolescent mental health service. There were concerns with regards to staffing levels across a number of services, and concerns regarding the transcription of medication in district nursing services.

The trust had a good incident reporting culture, and there was evidence of improvements following incidents, but these were not always shared across teams. Staff were positive regarding informing patients if there had been an incident and some were aware of the recently introduced Duty of Candour. Staff could access mandatory training, and the majority of premises were suitable with the exception of Little Woodhouse Hall.

Staff were aware of and used national guidance in the delivery of their care, though there was an inconsistent approach to assessment within the South Leeds Independence Centre (SLIC). Pain relief was effective and patients nutritional and hydration needs were effectively assessed where appropriate. Multidisciplinary team working was effective, as were consent processes with the exception of some do not attempt cardiopulmonary resuscitation (DNACPR) consent at SLIC.

Whilst some audit activity took place, overall the trust needed to improve its plans and overall approach to audit. Some services utilised outcome data, but there were other services particularly in the community where there was limited data to demonstrate the impact of service provision.

Patient feedback was good, and surveys confirmed this. Staff treated patients with dignity and compassion, and ensured that patients were involved in the development of their care. On the whole services promoted independence and supporting patients to move to self care, though this could be developed further on the SLIC.

There was variation in the planning and delivery of services, in particular some length of stay on the SLIC, and waiting times for community children's and adolescent mental health services. Staff ensured that services met the individual needs of patients and took into account patient preference in most circumstances, and there were some good examples of where staff had looked to meet the needs of vulnerable people.

Locally many staff felt they had good support from their immediate line managers; however morale was low and many staff were uncertain regarding their and their services' future. There was inconsistency in how and when staff were communicated with regarding changes to their roles and services. Governance of the organisation, whilst improving had been reliant on reassurance, not assurance, and we identified examples of incidents and risks that had not been investigated in a timely fashion, and risk registers which were not effectively produced to afford the necessary controls to reduce or remove risk.

The culture of the organisation whilst reported as open and supportive to learning from incidents reflected a change weary staff group, with above average levels of sickness, including stress related long term sickness.

Leadership was improving; the new chief executive was affecting change to improve access to executive and non executive staff. There were examples of innovation across different services, and numerous examples of staff being recognised for their work and endeavour at local and national award ceremonies.

Summary of findings

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

We always ask the following five questions of services.

Are services safe?

Requires Improvement

We judged the provider as requires improvement for the safety domain. The provider was not meeting regulation 15 premises and equipment at Little Woodhouse Hall, and regulation 17(2)(d) good governance within the community children's and adolescent mental health service. There were concerns with regards to staffing levels across a number of services, and concerns regarding the transcription of medication in district nursing services.

The trust had a good incident reporting culture, and there was evidence of improvements following incidents, but these were not always shared across teams. Staff were open regarding informing patients if there had been an incident and some were aware of the recently introduced Duty of Candour. Staff could access mandatory training, and the majority of premises were suitable with the exception of Little Woodhouse Hall. Cleanliness and infection prevention measures were good. Patient risk was assessed but there were concerns with the recording of risk within the community children's and adolescent mental health service.

Safeguarding arrangements were appropriate and staff were aware of what action to take should they suspect a safeguarding concern.

Are services effective?

Good

We judged the effectiveness of services to be good. Staff were aware of and used national guidance in the delivery of their care, though there was an inconsistent approach to assessment within the SLIC.

Pain relief was effective and patients nutritional and hydration needs were effectively assessed where appropriate. Multidisciplinary team working was effective, as were consent processes.

Appraisal rates were almost to target, though supervision rates varied across services.

Discharge arrangements were appropriate though focus on the discharge plan could be improved on the SLIC.

Whilst some audit activity took place, overall the trust needed to improve its plans and overall approach to audit. Some services utilised outcome data, but there were other services particularly in the community where there was limited data to demonstrate the impact of service provision.

Summary of findings

Are services caring?

Good 

We judged caring to be good across all services. Patient feedback was good, and surveys confirmed this. Staff treated patients with dignity and compassion, and ensured that patients were involved in the development of their care.

On the whole services promoted independence and supporting patients to move to self care, though this could be developed further on the SLIC.

Are services responsive to people's needs?

Requires Improvement 

Overall we judged the responsiveness of services to require improvement. There was variation in the planning and delivery of services, in particular some length of stay on the SLIC, and waiting times for community children's and adolescent mental health services.

Staff ensured that services met the individual needs of patients and took into account patient preference in most circumstances, and there were some good examples of where staff had looked to meet the needs of vulnerable people.

There were examples of flexible community services to help meet the needs of people, but a lack of formal assessment process for patients being admitted to the community beds was adding to the difficulties of increasing dependency levels particularly on the SLIC, though a new tool was being piloted at the time of the inspection.

Are services well-led?

Good 

Overall we judged how well led the trust was as good. Locally many of the staff felt that had good support from their immediate line managers; however morale was low, and many staff were uncertain regarding their and their services' future. There was inconsistency in how and when staff were communicated with regarding changes to their roles and services, and many felt they were not being listened to, and were weary of having to justify their roles.

The culture of the organisation whilst reported as open and supportive to learning from incidents reflected a change weary staff group, with above average levels of sickness, including stress related long term sickness.

Leadership was improving and as noted staff felt supported by their immediate line managers. The new chief executive was affecting change to improve access to executive and non executive staff.

Summary of findings

Governance of the organisation, whilst improving had been reliant on reassurance, not assurance, and we identified some incidents that had not been investigated in a timely fashion and risk registers which were not effectively produced to afford the necessary controls to reduce or remove risk.

There were examples of innovation across different services, and numerous examples of staff being recognised for their work and endeavour at local and national award ceremonies.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Fiona Stephens, Clinical Quality Director, Medway Community Healthcare

Head of Inspection: Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; school nurse, health visitor, GP, nurses, therapists, senior managers, and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

Leeds Community Healthcare NHS Trust was inspected as part of CQC's inspection programme. The trust is also seeking to become a foundation trust. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

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 always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services

Before visiting, we reviewed a range of information we hold about Leeds Community Healthcare NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between 24 and 27 November 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 29 locations which included 3 community inpatient facilities. We carried out unannounced visits on 26 November to the twilight service and child development services.

Information about the provider

Leeds Community Healthcare NHS Trust is responsible for providing a range of community healthcare services for adults and children in the Leeds area, including community nursing, health visiting, physiotherapy, community dentistry, primary care mental health, smoking cessation, prison health and sexual health services.

Summary of findings

The health of people in Leeds is generally worse than the England average. Deprivation is higher than average and about 22.5% (30,600) children live in poverty. Life expectancy for both men and women is lower than the England average.

Priorities for Leeds include tackling the inequalities gap, reducing smoking and giving every child the best start.

What people who use the provider's services say

We spoke with a number of people across all services, including those receiving care in their own homes as well as community clinics and inpatient settings. Overall people felt that they were cared for well by staff who considered their dignity and involved them in decisions about their care. Some patients on the South Leeds Independence Unit commented that staff were often very busy and unable to support them, and that they were often bored with no activities taking place.

Good practice

- The trust had a member's zone which encouraged children and young people to become involved and influence how services were delivered. The trust provided information which showed there were 134 public members aged 14-16 years and 69 aged 17-18 years of the member's zone.
- The stammering centre promoted self-help we saw an after school teens group for young people aged 12-17 years old which provided young people with an opportunity to meet other young people who stammer and fun activities to practice fluency.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must make sure that patients are protected against the risks associated with unsafe or unsuitable premises. Staff had not identified all the potential risks to patients from fixtures on the ward that could be used by them to self-harm by hanging. The trust had identified the premises were not suitable, but did not have a clear timescale for moving to new premises or how the present premises could be improved upon whilst they waited for the move.
- The trust must make sure people are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them in their records. Staff had not always recorded peoples risk assessments on the computer system.
- The trust should make sure that young people, children and families are able to access community child and adolescent mental health services they need within a reasonable time frame.
- At Little Woodhouse Hall staff should collate the number, type and staff involved with the restraint to enable patterns or triggers to be identified to reduce risks to patients.
- At Little Woodhouse Hall the trust should make sure Leeds General Infirmary Security Guards, who assist on an evening if a patient becomes violent, are suitably trained to carry out the restraint of a child.
- The trust should ensure investigations into clinical incidents are undertaken in an appropriate timescale to ensure sufficient measures are put in place to prevent a reoccurrence.
- The trust should review staffing levels in adult community teams to ensure they are safe, especially at times of high vacancies.
- Within SLIC ensure staffing levels and skill mix are suitable for staff to effectively provide the necessary support to patients.

Leeds Community Healthcare NHS Trust

Detailed findings

Requires Improvement

Are services safe?

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

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

Summary of findings

We judged the provider as requires improvement for the safety domain. The provider was not meeting regulation 15 premises and equipment at Little Woodhouse Hall, and regulation 17(2)(d) good governance within the community children's and adolescent mental health service. There were concerns with regards to staffing levels across a number of services, and concerns regarding the transcription of medication in district nursing services.

The trust had a good incident reporting culture, and there was evidence of improvements following incidents, but these were not always shared across teams. Staff were open regarding informing patients if there had been an incident and some were aware of the recently introduced Duty of Candour. The majority of staff could access mandatory training, and the majority of premises were suitable with the exception of Little Woodhouse Hall. Cleanliness and infection prevention measures were good. Patient risk was assessed but there were concerns with the recording of risk within the community children's and adolescent mental health service.

Safeguarding arrangements were appropriate and staff were aware of what action to take should they suspect a safeguarding concern.

Our findings

Incident reporting, learning and improvement

The trust had a positive patient safety incident culture with all staff spoken with during the inspection understanding what constitutes an incident and how to report this. The latest data from the National Reporting and Learning System (NRLS) in September 2014 placed the trust in the top 25% of reporters in its peer group of community trusts with a reporting rate of 97 incidents per 1000 bed days against a median of 52 for this peer group. In addition to this the trust maintained low levels of incidents where moderate, severe or catastrophic harm was caused.

Staff we spoke with were able to describe their role in reporting incidents, and whilst there was mixed feedback from staff on learning from incidents; we did see numerous examples where changes had been put into practice

Requires Improvement

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following the investigation of incidents. We also saw 'action logs' for falls and medication errors. These logs provided further analysis of these categories of incidents and discussed actions taken.

Serious incidents were investigated using recognised root cause analysis tools. Actions were reported to and monitored at the quality committee in addition to other committees in the trust's governance structure. The trust had an in date process for monitoring safety alerts from the central alert broadcasting system. We were told that the trust has never had an alert go beyond its planned/ required completion date. This correlated with the information provided to the trust board on a monthly basis via the integrated performance report.

We reviewed a range of meeting records from clinical teams which outlined how learning from incidents was shared with staff and teams. Staff corroborated this during interviews.

Duty of candour

We asked staff about the Duty of Candour that had been implemented in the NHS following recommendations made following the public enquiry regarding the Mid Staffordshire Hospitals NHS Foundation Trust. The Duty of Candour was to ensure "the volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information had been requested and whether or not a complaint or a report about that provision had been made." Senior managers were aware and the trust had taken steps to implement the requirements. Some clinical staff were also aware of the duty specifically, but even those who were not, spoke about the need to be open with patients and relatives following an incident.

Safeguarding

Staff across all services were aware of and followed safeguarding procedures. The trust had appropriate policies and procedures in place.

The trust had a safeguarding team which included named nurses and nurse advisors who gave members of staff advice, training and planned supervision. The trust had a named doctor for safeguarding children. We were told the current doctor's designated time equated to one session per week (one half day) which was low in comparison with other trusts. The usual number of sessions were at least 4 sessions per week. However, the trust had a number of roles in place to support the designated doctor's role, including 3 band 7 nurses, and 2.6 WTE administration staff.

The current named doctor had been employed via a locum consultant contract since October 2013. The designated doctor role was currently covered by the trust's board level medical director who was also a paediatrician and lead for the service.

From data made available to us the majority of staff received safeguarding training that was appropriate to the services they worked within.

Medicines management

In the majority of cases medicines were managed appropriately. Within in patient settings, patients told us they received pain medication when they required it, and medication records were appropriately completed School nurses were aware of the need to maintain the 'cold chain' with regard to immunisations.

We identified some good practice in community services for adults where health care assistants had been trained to give insulin and Tinzaparin through a competency based training programme. Competencies of staff were reviewed by qualified staff. The training had been developed in partnership with the local university. This had allowed professional development opportunities for support staff. Support workers were also suitability trained to complete tasks.

However we also identified a number of medication records that had been transcribed from other information sources. We spoke with 3 band 5 nurses at one location who confirmed they routinely transcribed prescribed medication. They had not received guidance or additional training. Managerial staff we spoke with were unaware of any guidance in relation to transcribing. The Nursing and Midwifery Council guidance on medicines management specifies that whilst registered nurses can transcribe, this should only be undertaken in exceptional circumstances and employers are responsible for ensuring there is a rigorous policy for transcribing that meet local clinical governance requirements. Medicines that were transcribed and/ or prescribed had been administered.

Safety of equipment and facilities

Requires Improvement

Are services safe?

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The majority of community clinics that we visited were well maintained and suitable for the purposes they were designed for. Equipment was appropriate and maintained and or clean as per the manufacturer's instructions.

At one dental practice we visited, a compressor, used to power drills wasn't working correctly and although this would not affect patient safety, this was brought to the attention of the manager

At the SLIC we observed a variety of equipment, including resuscitation equipment. Not all equipment that may be required in an emergency was available on the resuscitation trolley. During the week of the inspection a decision was made by the trust to clarify the expectations of staff during a cardiac arrest. The trust had decided to retain the AED and remove all other resuscitation equipment. The trust intended to ensure staff were clear about when an emergency ambulance needed requesting.

Most other equipment within the inpatient units were well maintained and appropriate for use, with the exception of some host slings on the SLIC which were very warn.

We did identify risks with regard to the children's and adolescent mental health services (CAMHS) in patient unit Little Woodhouse Hall. Whilst the trust did not own Little Woodhouse Hall and so were unable to make changes to the building without the landlord's permission, staff had not identified all the potential risks to patients from fixtures on the ward that could be used by them to self-harm by hanging.

The trust had identified the premises were not suitable, but did not have a clear timescale for moving to new premises or how the present premises could be improved upon whilst they waited for the move.

We looked at the design layout of the ward where patients were cared for and found the environment was not safe or suitable. For example;

- The corridors were narrow and only allowed for enough room for patients to pass two abreast, which would have presented a problem when assisting patients who had mobility difficulties.
- The security and safety of the patients was compromised due to unclear lines of sight and patients being able to get to other areas of the building. The trust had informed us two patients absconded from the ward area between September 2013 and September 2014.
- At night the staff told us the doors at either end of the bedroom corridor were locked from 8.30 pm to 7 am to ensure patient safety.
- We identified issues with regards to potential risks where patients could use objects to harm themselves for example ligature points in bathrooms and bedrooms. During the inspection we asked the ward manager to review the ward environment for any potential risks to the patient's. The ward manager provided us with information following our inspection to show this had been carried out.

We found risks to patients were managed locally by closer observation when they were at risk of self-harm. The trust had recognised the need for new premises and a working party had started to look at the ward moving to new premises. However the local environmental health and safety register did not include any potential risks to patients from objects which could be used by patients to self-harm by hanging. This meant staff may not have been aware of all of the potential environmental risks to patients or have considered ways of removing the risks.

Records management

The majority of records we reviewed were appropriately managed and organised. Previous concerns on the SLIC had been rectified. There was a mixture of paper and electronic records in use and staff had mixed views on how effective the electronic records were at supporting them to undertake their roles.

Case note audit results we reviewed demonstrated compliance rates on average over 90%. We did identify a concern within children's and family services regarding the retrieval of archived health visitor records if a safeguarding concern had been identified. We were told by senior staff a process had been developed to facilitate this following a recommendation from a serious case review. However, during our inspection we found that some staff were unaware of the retrieval process for archived health visitor records, when they had identified safeguarding concerns of school aged children.

Cleanliness and infection control

Premises that we visited during the inspection were all visibly clean and well maintained. Staff were observed following appropriate hand hygiene practices, and personal protective equipment was available.

Requires Improvement

Are services safe?

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Little Woodhouse Hall was safe and suitable. The building was clean throughout and there was good practice in the control and prevention of infection. Practice was supported by staff training.

Although the national staff survey highlighted that only 42% of staff said hand washing materials were always available which was lower than the national average for community trusts at 57%; we found that hand washing materials including hand gels and PPE were available for all staff for use in the clinical area and for home visits.

Mandatory training

We received a range of information regarding mandatory training. There were various training events that staff were required to undertake, and this was often split between clinical mandatory training and universal statutory mandatory training. Staff across all teams that we spoke to did not raise any particular concerns regarding access to training, though some did comment it was difficult to access due to work commitments due to staff pressures.

Attendance levels for mandatory training ranged from the low 80% to 100% across the different staff groups and clinical services.

Assessing and responding to patient risk

There were various systems and processes in place to assess patient risk. On the community inpatient units an early warning score assessment was used by staff to help identify if patients conditions were deteriorating.

In dental services appropriate risk assessments were carried out for local and general anaesthesia, staff in community services were aware of how to escalate risk, and we observed community staff reviewing risk assessments during home visits.

Within CAMHS services we identified two main risks. Within in patient services whilst risk was effectively assessed and managed, we identified that the hospital had an arrangement that Leeds General Infirmary security guards would assist on an evening if a patient became violent. However, we found the agreement was not clear whether security staff had completed the appropriate training to carry out the restraint of a child.

In the CAMHS community service, young people were asked to attend an initial consultation meeting where staff and the young person completed a risk assessment called 'My plan'. Staff indicated that risks to individuals were effectively assessed and managed, including clinical and health risks, and risks of harm to the person and to others. They said people were involved in and agreed to their risk assessments. The staff said they completed the risk assessments as written documents and then transferred them to the computer database (carenotes). However, when we looked at the notes on computer we found six risk assessments had not been completed. In addition we were provided with information from the trust of 'the CAMHS risk and current view documentation audit for August 2014', which demonstrated staff had not always completed risk assessments. Staff we spoke with told us that administration staff had been tasked with the role of data cleansing and reminding staff to complete the risk assessments on the computer system. We therefore concluded the systems to ensure that staff adhered to defensible documentation were not robust.

Corporately the trust had introduced a 'Quality Challenge' during summer 2014. This was largely based on the domains of safe, effective, caring, responsive and well-led and involved all services undertaking a self-assessment. Following the self-assessments, the services developed action plans for improvement. Many of the staff we interviewed told us about the 'Quality Challenge' and how this had helped them identify variance in practice across services within each business unit. One clinical lead told us how this process had also identified good practice and that the learning from one service would help the other services within the business unit. The overall aim would be for consistency across all business units.

Staffing levels and caseload

There were a range of concerns regarding staffing levels across different services at the trust. Within community dental services there were sufficient staff in the majority of services at the time of the inspection. However there was a service review taking place, which was due to be finalised in February 2015, so the judgement at this inspection was based on the current establishment.

In the community CAMHS service there had been a reduction in staff. There were various reasons for this, cuts to budgets, changes in commissioning, and increase in demand and an increase in urgent referrals from accident and emergency services. This had been recognised by the trust but was resulting in increasing caseloads and an inability to deliver all the necessary services.

Requires Improvement

Are services safe?

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In community services for adults, the number of clinical units (15 minutes of face to face contact with a patient) for some district nurses was between 26 and 28 per day and not the recommended 16 to 22. Many of the staffing rotas we reviewed indicated that actual staff numbers per shift were less than the number required and planned for. In the twilight service recent changes to neighbourhood teams had meant that teams were stretched and there was variation in caseload. In some cases up to 50% of shifts were being covered by bank staff. There were also a number of vacancies in the musculoskeletal service.

In children's and family services, the trust was on trajectory to recruit the number of health visitors it required to meet health visitor implementation plan, but caseloads were still above those recommended by Lord Laming and the Community Practitioner and Health Visitor Association, though the trust had reviewed local deprivation to ensure that caseloads were lower in areas of high deprivation and higher in areas of low deprivation. There were enough school nurses to meet the 'schools pyramid' of one full time, year round, qualified school nurse for each secondary school and its cluster of primary schools.

We also identified concerns in the child development unit regarding the number of locum community paediatricians that had been employed over a number of years. Staff were unclear on the continuity arrangements for staff in the locum positions.

Staffing arrangements on the two community inpatient units varied. On the SLIC the care assistants were employed by another organisation, and at the time of the inspection, due to sickness and vacancies, the unit was down by around a third of care assistant staff. Although bank and agency staff were being used, this was affecting the continuity of care, and workload of the permanent staff that had to support the agency staff.

On the community intermediate care unit (CICU), there was a much better permanent workforce, who were employed by the trust. Whilst there had been problems on the unit in 2013, changes to leadership (and location on the unit) had much improved staff morale and retention.

Managing anticipated risks

We reviewed contingency plans for the two community inpatient units. Those on the SLIC were well detailed and the business continuity plan in particular was well presented. There were fewer available on the CICU, and provided less detail for staff.

Within community dental services there were a range of guidance for managing potential risk as a consequence of dental procedures for example bleeding sockets following a tooth extraction.

There were lone working arrangements in place of which community staff were aware and had measures in place to maintain their safety. Some district nurses expressed concern about lone working on the twilight shift and we identified from staffing records there were occasions where in the Wetherby neighbourhood 50% of shifts only had one member of staff on duty.

Major incident awareness and training

The trust had both an annually updated major incident plan and an overarching organisational business continuity plan. The trust also had an emergency planning manager who was responsible for the review, update and testing of the plan. A full debrief/ lessons learned report was produced following each testing exercise of the plan.

The board was provided with an annual emergency planning report which detailed any significant 'emergency preparedness, resilience and response' (EPRR) related issues over the previous year, what work had taken place within the trust regarding EPRR and what the key work streams were for the forthcoming year.

The trusts emergency planning arrangements, including the major incident plan, were embedded within local, regional and national emergency planning arrangements. All local provider plans had been produced to work with each other and follow the same regional and national guidelines.

Are services effective?

Good

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

Summary of findings

We judged the effectiveness of services to be good. Staff were aware of and used national guidance in the delivery of their care, though there was an inconsistent approach to assessment within the SLIC.

Pain relief was effective and patients nutritional and hydration needs were effectively assessed where appropriate. Multidisciplinary team working was effective, as were consent processes.

Appraisal rates were almost to target, though supervision rates varied across services.

Discharge arrangements were appropriate though focus on the discharge plan could be improved on the SLIC.

Whilst some audit activity took place, overall the trust needs to improve its plans and overall approach to audit. Some services utilised outcome data, but there were other services particularly in the community where there was limited data to demonstrate the impact of service provision

Our findings

Evidence-based care and treatment

Staff used available evidence based practice guidance to deliver care. The guidance was a mixture of that available through the National Institute of Health and Care Excellence (NICE), and other national guidance. In addition to this there were appropriate policies and procedures in place such as a standard operating procedure for the Deprivation of Liberty Safeguards.

Within the two community inpatient units whilst we noted the use of appropriate guidance and assessment tools, there was an inconsistent approach to assessment by the various professional groups, with a lack of timeliness or detail in the patient records regarding treatment and goal setting. Care plans on the CICU were on the whole person centered, those on SLIC were less so, and tended to be pre-printed and generic in nature. These did not provide clear detail of the care and treatment the person required, for example with regard to their bathing needs.

Within children's and family services, the Healthy Child Programme (HCP) and UNICEF baby friendly initiative were all in operation. The service was currently accredited with level 3 of the UNICEF programme. The trust delivered the HCP and was looking to introduce additional contact at three/ four months. Health care records we reviewed contained full assessments of the needs of the maternal moths, and included assessments for postnatal depression.

In the CAMHS service young people received care, treatment and support that achieved good outcomes, promoted a good quality of live and was based on the best available evidence.

The trust had a process for monitoring NICE guidance, which was managed centrally and in the business units. Examples were provided of the gap analyses undertaken by the business units, with accompanying action plans updated until completion, and recorded centrally.

Pain relief

Where applicable pain relief was administered appropriately, and there was evidence of effective assessment and review. Patients we spoke with indicated they were comfortable with regard to any pain and would receive prompt attention should they require pain medication.

Nutrition and hydration

Where appropriate patients received an assessment of their nutrition and hydration needs, and records we reviewed confirmed this. Community services such as the diabetes service offered specific advice and guidance on nutrition; in children and families services, a number of baby cafes and breastfeeding support groups were in operation.

Approach to monitoring quality and people's outcomes

There was variation in the approach to monitoring quality and outcomes. The trust acknowledged that clinical audit was an area of weakness. The number of audits undertaken has reduced over recent years and audit was not undertaken in a planned way against trust priorities. The trust had priority areas identified for 2012-2015 in terms of themes but did not develop an annual forward plan for clinical audit or monitor audit throughout the year. We were told that there were some challenges in ensuring that audits were registered with the central team and that on occasion clinicians were undertaking audits outside of the

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trust's processes. A central log of audits was maintained for audits that were registered including the ability to capture improvements made as a result of the audit. Clinical audit was only on the formal work-plan of the quality committee once to present the annual report.

The business unit leads told us that they tried to aim for each service to undertake at least two clinical audits, one of which must be the documentation audit. There was an expectation that all services would complete a documentation audit. We were told that four services did not do this in 2013/ 2014 and that there had been further slippage this year. The business units all had a forum for clinical governance to be discussed at, and audits were presented there.

We were told that there was a lack of clinical outcomes for services to monitor themselves against. Some of this was a wider issue for community trusts although the trust acknowledged that part of the problem was being able to extract the data that went into SystmOne in a meaningful way. There were plans in place to continue to identify meaningful outcome data and quality indicators.

There were examples of where services had developed and used outcome measures, including key outcomes against the Healthy Child Programme in children and family services; the falls team in community adult services used the Fall Efficacy Scale – International (FES-I) and TINETTI balance assessment tool on initial assessment and discharge to measure outcomes which were reported on quarterly.

An annual activity and performance report was also produce measuring the impact of the community inpatient beds, and included length of stay and patient outcomes. Therapy services also used the therapy outcome measures (TOMs), and the EQ5D health outcomes tool.

Competent staff

There was variation in the numbers of staff who had received an appraisal as well as regular supervision. Staff told us that they felt well supported by their managers and believed that they could access the training they required.

Data we reviewed as part of the inspection indicated that around 85% of staff within children and family services had receive an appraisal in the last year, whilst information for SLIC and CICU put the appraisal rate at 73% and 87% respectively. In 2013/ 2014 dental services had achieved the trusts target of 90% of staff receiving an appraisal.

Supervision levels were lower, for example staff working in community children and adolescent mental health services told us there was effective supervision and appraisal in place. Both group and individual clinical supervision were available to staff. Weekly clinical supervision and group supervision was provided and this was treated as a priority and staff were expected to attend. However, the information provided to us by the trust showed that only 12.5% of the south team and 40% of the east team had received the necessary supervision.

The trusts' 2013/ 2014 Quality Account reported that the percentage of staff receiving clinical supervision fell in 2013/ 2014 and the trust did not meet its target. The trust had stated that clinical supervision was one of their effectiveness priorities for 2014/ 2015.

Multi-disciplinary working and co-ordination of care pathways

Across all services we observed and staff described good examples of multidisciplinary working both across the trust and with other organisations. Within inpatient units multidisciplinary team meetings took place. In adult services, close work with cardiac nurses and the acute trust in the management of cardiac patients to ensure continuity of treatment.

Within health visiting and school nursing we found staff worked less closely together to meet the needs of children and young people. Staff reported they were involved in child protection cases at the same time but did not routinely undertake joint working with a family. We found the service had developed a standard operating procedure for staff to follow when children transferred from the health visiting teams to the school nursing service. Standards had also been developed for communication between midwifery and health visiting.

Referral, transfer, discharge and transition

Across adult community services and dental services there were pathways for effective discharge of patients once treatment had been completed.

Within the community inpatient units there was variation in discharge practices between the two units. On the CICU,

Are services effective?

Good

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

there was clear focus on discharge planning and we noted a number of clearly outlined discharge plans for patients including discussions held with families and the patient. MDT meetings discussed patient progress in detail and focused on moving the patient forward in terms of preparedness for discharge.

Patients and families we spoke with on CICU were clear about their discharge arrangements and what the next steps of the care involved.

On the SLIC, the discharge planning process and decision-making around patient's care were not always clear. We reviewed patient records and, in many instances, there was a lack of focus in terms of preparing patients for discharge and goal setting.

We attended an MDT meeting on SLIC and there was a lack of decisiveness and clarity in terms of patient discharge, goal setting and time-stated plans. This impacted on the timeliness of some patient's discharge and the rehabilitation timescales for some patients seemed disproportionately long.

Availability of information

Information was available to patients and others in a variety of formats, and covering a range of clinical conditions. In addition to this information was available for referrers into services to ensure the correct referrals were made. For example in community dental services the information and guidance for referrers was provided to ensure that people were referred to the correct service and location. Most staff could access SystmOne and therefore access community information, though some GP's used a different system which meant staff accessing two different record systems.

Consent

We observed staff seeking consent from patients before they carried out procedures. This included both written consent before dental treatments, as well as verbally before treatment carried out by district or other community staff. Staff were familiar with the Mental Capacity Act and best interest decisions, and we saw examples where staff had undertaken mental capacity assessments effectively, including the involvement of the patient, their family and other appropriate professionals.

We identified some concerns regarding DNACPR consent on the SLIC where there was a lack of documented involvement of patients and families in that process.

Good

Are services caring?

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

Summary of findings

We judged caring to be good across all services. Patient feedback was good, and surveys confirmed this. Staff treated patients with dignity and compassion, and ensured that patients were involved in the development of their care.

On the whole services promoted independence and supporting patients to move to self care, though this could be developed further on the SLIC.

Our findings

Dignity, respect and compassionate care

Overall we found that staff treated patients with respect, maintained their dignity and provided compassionate care. The care we observed being delivered was done so in a compassionate way, and many patients told us they felt at the centre of care delivery.

Within the community children's and adolescent mental health team we were provided with the people's feedback from the period between September and November 2014. This showed 133 out of 135 parents and 92 out of 97 children had responded that the help was good.

Patient understanding and involvement

Patients we spoke with told us they felt involved in the planning of their care and understood what the treatment they were receiving was for. In dental services, staff provided dental sensory packs to children, who often had complex needs. The packs included tooth brushes, tooth paste and face masks that would be worn by the dental staff to help the children understand what treatment they may have and why the dental staff might be wearing masks.

On the trust website we found there was a member's zone which encouraged children and young people to become involved and influence how services were delivered. The trust provided information which showed there were 134 public members aged 14-16 years and 69 aged 17-18 years of the member's zone. We saw information which showed the school nursing service had sought views from young people and parents on the development of app and website based information for people to access. This information was publicly available on the trust's website for people to access.

Emotional support

Patients and relatives that we spoke with told us that they felt supported by staff. Conversations we observed between patients, relatives and staff included emotional well-being.

Promotion of self-care

We saw examples of care that promoted self-care across all services. We did note that on the SLIC, whilst patients were supported to become more independent, opportunities were sometimes missed, and care plans were not always focussed on encouraging independence.

Are services responsive to people's needs?

Requires Improvement

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

Summary of findings

Overall we judged the responsiveness of services to require improvement. There was variation in the planning and delivery of services, in particular some length of stay on the SLIC, and waiting times for community children's and adolescent mental health services.

Staff ensured that services met the individual needs of patients and took into account patient preference in most circumstances, and there were some good examples of where staff had looked to meet the needs of vulnerable people.

There were examples of flexible community services to help meet the needs of people, but a lack of formal assessment process for patients being admitted to the community beds was adding to the difficulties of increasing dependency levels particularly on the SLIC, though a new tool was being piloted at the time of the inspection.

Our findings

Planning and delivering services which meet people's needs

There was variation in the planning and delivery of services across different services. Across children's and family services, dental services and adult community services, whilst there may have been pressures often due to reduced levels of staff, services continued to be planned and delivered to meet the needs of patients, with services delivered both from the patient's own home or from clinic bases.

In dental services a recent review had identified an increasing number of did not attend (DNA) events, the trust had taken a range of action including sending text messages to patients to remind them if appointments, which had seen a reduction in the DNA rates.

Within community inpatient services, the acuity of patients on the SLIC was impacting on some lengths of stay, with average length of stay up to September 2014 at 32 days on SLIC, and 20 on CICU against a national benchmark of 26 days.

Length of stay for intermediate care beds on the SLIC were good at around 20 days, but for long term care patients, the target of 28 days was often double that for patients within the intermediate care beds. This was a recognised problem and a review was currently under way across Leeds to review all community inpatient beds.

We identified a range of concerns within community children and adolescent mental health services, with regard to access to services, including;

- Waiting time for young people to access the attention deficit hyperactive disorder (ADHD) clinic were about 26 weeks. This was confirmed by information provided by the trust which showed there were 42 people on the waiting list and 22 had waited longer than 18 weeks.
- Waiting times for young people to access autistic spectrum disorder assessments was over 40 weeks and one person had waited 61 weeks. This was confirmed by information provided by the trust that showed there were 106 on the waiting list and 59 had waited over 18 weeks.
- The waiting list for young people and children and families to access the incredible year's group was 33. Six had waited over 18 weeks. Staff informed us that the number of groups had recently been reduced from two each school term time carried out by the three teams to two over all of the three teams. As a consequence they had expected the waiting time to increase. The Incredible Years programme is one identified by NICE (National Institute For Health and Clinical Excellence) as effective for the treatment of conduct disorders.

In addition, we were told by staff that the thresholds had risen to access the CAMHS community service. Feedback from both children and young people and their families reflected this.

Equality and diversity

Staff across all services endeavoured to ensure all patients were treated equally and to meet their individual needs. Staff undertook equality and diversity training, and interpretation services were available as required. Printed information was also available in other formats including braille.

Within inpatient units, people's individual needs were taken into account, but as previously noted a more generic approach was taken on SLIC.

Are services responsive to people's needs?

Requires Improvement

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

Meeting the needs of people in vulnerable circumstances

A range of services were provided particularly in community dental services to meet the needs of vulnerable people. A leaflet called "my visit to the dentist" had been produced by the community dental service which used a pictographic format to help explain to people with a learning disability what it was like visiting the dentist, and what they should expect.

Health promotion services were provided on an outreach basis to homeless people in shelters and on the streets. A service which was also provided to vulnerable children in local schools, and to people with a learning disability in care homes. Part of this service involved teaching teachers and the professional carers of people with a learning disability how to give dental health promotion advice.

In community adult services, in conjunction with the voluntary sector had developed a directory to support and promote advocacy in Leeds. These services had been developed to support different groups of patients. For example the district nursing and community matrons provided information about Carers Leeds who were able to give practical help and support for patients and their families.

Access to the right care at the right time

The majority of access targets were consistently achieved by the trust, though some waiting times had lengthened recently due to staff vacancies. The main exception to this as noted were community children's and adolescent mental health services.

Flexible services, for example additional support for mothers experiencing low mood as part of the Healthy Child Programme were offered by the majority of community services. These services ensure that patients could access services from a range of locations to suit their needs.

Data was available that provided an overview of referral times for community beds on the inpatient units, which were managed through a single point or urgent referral. However, we noted that the process for assessing the suitability of patients and whether SLIC or CICU could manage to meet the needs of certain patients, and had adequate resources, was not a formalised process and was dependent on the judgements of particular staff. There was no set process whereby the dependency levels of existing patients were taken into account or other factors such as how many patients required hoisting, how many were receiving one-to-one care and the number of agency staff.

We were informed that this had been recognised as an issue and a care needs tool had been introduced as a way to formalise the process and develop some consistency with decision-making.

Complaints handling and learning from feedback

The trust had a complaints policy and procedure in place. Patients and their families knew how to complain and staff were familiar with the process and where possible would try to resolve complaints at a local level. The trust consistently achieved 100% in its target of acknowledging a complaint within 3 days. During September 2014, the average length of response time for a complaint was 51 days. This was longer than the average up to end of August 2014 (35 days) due to 5 responses exceeding the trust's 60 working day target. Examples of learning from complaints were provided and were summarised each month for the trust board via the Integrated Performance Report Quality Indicators.

Are services well-led?

Good

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

Summary of findings

Instructions

Overall we judged how well led the trust was as good. Locally many of the staff felt that had good support from their immediate line managers; however morale was low, and many staff were uncertain regarding their and their services' future. There was inconsistency in how and when staff were communicated with regarding changes to their roles and services, and many felt they were not being listened to, and were weary of having to justify their roles.

The culture of the organisation whilst reported as open and supportive to learning from incidents reflected a change weary staff group, with above average levels of sickness, including stress related long term sickness.

Leadership was improving and as noted staff felt supported by their immediate line managers. The new chief executive was affecting change to improve access to executive and non executive staff.

Governance of the organisation, whilst improving had been reliant on reassurance, not assurance, and we identified some incidents that had not been investigated in a timely fashion and risk registers which were not effectively produced to afford the necessary controls to reduce or remove risk.

There were examples of innovation across different services, and numerous examples of staff being recognised for their work and endeavour at local and national award ceremonies.

Our findings

Instructions

Vision and strategy

There were a number of individual strategies for services that were shared with CQC during the inspection. For example The Leeds Community Beds Strategy 2014 – 2019 provided an analysis of the current provision and of the future requirement for short-stay beds, both in terms of capacity and the expectations of what the beds should provide to meet the needs of the people using them.

However, this was not the case for children's and family services, which whilst there were individual service strategies, for different children's' services, there was no strategy linking health visiting and school nursing which supported how both services worked together to support children, young people and their families. Senior staff told us there had been discussion about developing a 0-19 service, but there were no firm plans in place at the time of our inspection.

The trust was in the midst of a major reorganization which for some services had been ongoing for a considerable amount of time. Communication was not always clear or timely with staff regarding the reorganization, both in how it affected them individually and how it fitted into the trusts own vision going forward. Staff were weary of change, the impact it had on them, and the impact it was having on their ability to deliver services.

Governance, risk management and quality measurement

The trust had an updated risk management strategy, which was approved in October 2014 and ratified for use in November 2014. As such, the trust was at a reasonably early stage of their journey for improving risk management. The business unit triumvirates were all clear on their risk processes and how they engaged and escalated with the overall trust structure. All three business units had implemented clinical governance forums and structures. The triumvirates could describe these structures and give examples of how they were monitoring key governance areas and implementing changes in practice appropriately. Staff within the business units had regular meetings through which quality and risk matters were discussed, and lessons learnt from incidents were shared.

Corporately, the risk registers we were provided with were of variable quality and did not provide a great deal of evidence of risks being appropriately managed. For example, the corporate risk register (risks of ≥15) included only four risks, one of which was identified in 2011 and two in 2012. Only one risk had been identified over the last year. The risk descriptions were poor in terms of articulating the risk condition, cause and consequence and review dates had passed (some years ago) with no updates recorded. There was no evidence of these risks being managed by the trust. We were told that there was agreement that the risk register we had been provided was inadequate and that

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work had recently been undertaken to improve the corporate risk register. We were told that this had been undertaken in November 2014 and would be presented to the board in December 2014.

Likewise, the business unit risk registers did not always provide a clear description of the risk. Controls appeared to be consistently identified and were rated in terms of their adequacy. However, a significant proportion of the controls were actually actions as opposed to existing controls in place, such as policies, guidelines, current practice etc. There appeared to be weaknesses in the planned actions to address the risks, the updates on actions and the timeliness of actions taken. For example, a risk was identified in August 2013 around the ligature risks in the inpatient CAMHS unit. The controls identified were all planned actions not existing controls; these included the appointment of a projects manager to work on an estates project to look at the possibility of inpatients relocating, senior staff conducting a site visit and the 1 December (year not recorded) as a review date for the potential move. These were not controls. However, the initial risk rating of 15 has been reduced to 12. The target risk of 'low' had a date of the 1 December 2014. Despite this being some 16 months after the risk was identified and recorded on the risk register, the target risk was not be achieved by this date. The latest update (November 2014) explained that an options appraisal was considered in October 2014 and that a working party would begin to look at potential alternative locations. This was not an isolated example of the risk register management and the trust recognised that this was an area it wished to improve on.

The board assurance framework was developed with board members in 2013 with risks identified under each strategic objective. The risk descriptions did not include the cause(s) of any of the risks, which made it difficult to determine whether the planned actions would reduce the risk in line with the target risk ratings. We asked about the timeframes for the target risk ratings and were told that the trust did not set annual targets or refresh the BAF on an annual basis but did recognize that it was difficult to assess whether the risks were being managed appropriately without target dates. We were told that this was identified at the previous quality committee and that it had been agreed to introduce dates for each target risk score.

We were told that the trust, in the past, has received reassurance as opposed to assurance. This was felt to have impacted on the self-assessment scores by the board against Monitor's quality governance framework. The trust had fully reviewed this process and had now introduced a full action plan with fortnightly meetings of the senior management team with a strong focus on evidence against the required standards. All senior staff were aware of this process and the actions that were required to meet the trust's aim of a score of 3.5 by the end of December 2014. There were varying levels of confidence as to whether this would be achieved by this timescale. However, all staff interviewed were confident about how the current score of 5.5 had been agreed, that this was an accurate reflection, and that they had identified the correct actions to reduce this. The timescales were of concern to a number of staff but the confidence in the ability to continue to improve was shared by all.

We found some medical staff in CDC had not always received timely feedback from clinical incidents or concerns they had raised. For example we were told by staff of an incident/ near miss which had occurred in August 2013. Staff told us that the investigation into this was only about to take place in November 2014, over a year after the original incident had occurred. In another incident we reviewed we identified that the incident had been reported in December 2013 but the investigation was not completed until September 2014. It was unclear whether the service put any immediate actions in place to stop a reoccurrence however the delay in the investigation and identification of any learning points meant the service could not be assured that there were sufficient measures in place to prevent a reoccurrence of the incident.

Leadership

Staff clinically spoke positively regarding their immediate line managers, and felt valued and well supported. However staff morale was reported as being low throughout the organisation. The annual staff survey results from 2013 reflected this. As noted above staff were change weary with one person telling us that they were 'weary trying to prove your own worth'.

Within the SLIC, staff felt that leadership was 'bottom heavy' insomuch as there was a lack of senior leaders. Recent steps had been made to change that with the addition of a second band 7 nurse on secondment to the unit. The relatively high use of agency support workers was also causing some tensions, and we were informed that the issue was relatively long-standing; three separate papers

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had been presented to the executive team prior to the opening of the SLIC about staffing levels and the short-falls. The active response in relation to the issues raised with staffing had not been effective in ensuring the service could deliver its core objectives.

There had been a number of changes at board level. During 2014 the director of finance acted as interim chief executive, and there had been new non-executive directors and a number of interim posts. The substantive chief executive commenced in post on 1 October 2014.

Staff commented that the new chief executive (CE) had recently started. They were aware of the CEs weekly bulletin and the "Ask Thea" email system for staff to ask the CE questions. Many nurses also commented on the visibility and support of the senior nurses. Staff told us that they could use the Ask Thea function on the intranet to raise concerns with the chief executive if needed.

The board approved a reshaped organisational development strategy at its meeting in June 2014. Leadership and development work was continuing and a specific and detailed implementation plan was presented in October 2014 in order to enable consultation with clinical leaders and direct input of Thea Stein the incoming chief executive. It is acknowledged that this version and language of organisational development is not readily accessible for staff so a summary would be produced.

Leadership development that the trust has participated in includes ILM 4 & 5 and the Franklin Covey programme.

Culture across the provider

Staff told us that the organisation had an open culture, and they were encouraged to report incidents and learn from errors.

However as noted above staff were tired of change. Sickness absence rates were higher than average, there were a number of vacancies which were impacting on some service delivery. The trust turnover position was monitored within a target range of 7 – 12%. It had consistently remained within this range and detail was set out in the integrated performance report (IPR) on a monthly basis. In the period April to November 2014 this had been maintained, with the year to date figure in November of 10.9%. A concentrated piece of work was underway to establish the reasons for sickness absence, with management support being offered to affected staff.

Many staff were aware of the trusts vision and values; however staff morale was particularly low across the organisation. Individually and collectively, staff were uncertain about the future direction of the trust that many of them had fought to keep as an individual NHS organisation just a few years previously.

A non-executive director had expressed concern that staff were triggering long term sickness. It was noted in a board meeting that much of the long term sickness was stress related which could be attributed to service reviews and high spend on agency and bank staff. The director of workforce had benchmarked against ten actions to be taken in order to improve sickness absence in the NHS in response to previous enquiries by the business committee.

On SLIC, the culture was different to that on CICU which was mainly around the fact there were two employers; one for care assistants and facilities staff and one for nursing staff and allied healthcare professionals. When SLIC opened the care assistants employed by another organisation were given the choice of working at SLIC or being redeployed to an alternative residential establishment. The unit was delivered in partnership between the two organisations with the trust as the lead provider.

Fit and proper person requirement

Although the requirements for the fit and proper person test were relatively new, senior managers we spoke with were aware of the changes and what these meant for the organisation. Some staff across the organisation were aware of the fit and proper person test, but these were in the minority.

Public and staff engagement

There was variation in staffs' perception of how well the trust engaged with them. Their view of engagement was predominantly with regard to organizational redevelopment, and this was often mixed. A significant proportion of staff across services told us that they had been communicated with and that they were aware of the changes that had been proposed. However, the majority reported that they weren't listened to and that change was being done to them.

Directors told us about the service review model and how this sought to engage with staff and ensure that their input was obtained for taking forward change. This change was

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part of the cost improvement programme, although many senior staff told us that they were focusing on the improvements that could be made for patients and that the savings were not the main driver.

The trust sought patient feedback through a variety of mechanisms including patient satisfaction surveys. These were generally positive, for example in the adult business unit overall satisfaction was 94%.

The trust board had patients come and share their experiences in person, with all board meetings commencing with a patient story. It was also normal practice for the Quality Committee to begin with a patient story.

We were provided with examples of posters summarising how patient feedback had been used to make changes for cardiac, the community falls service, the continence, urology and colorectal service, and the MSK service.

Innovation, improvement and sustainability

There was a range of innovation and improvement taking place across the trust, and whilst in some services staff were concerned about the sustainability of their service, there was evidence that action was being taken across various services to develop sustainability. For example as noted above the sustainability of community inpatient beds formed part of the Leeds Community Beds Strategy 2014 – 2019 and the aims for how the service would be sustained were clear.

Across adult community services various improvements had been achieved, including the implementation of an adult integration programme - a model for integrated health and social care for adults in Leeds. Social workers were aligned and worked within the neighbourhood teams to provide a more person centred service.

In addition to this, staff and various services across the trust had been nominated for both local and national awards, for example, the tissue viability service achieved second prize at the British Journal of Nursing Tissue Viability Team of the Year Award 2013.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises We found that the registered person had not protected people against the risk of unsafe or unsuitable premises at Little Woodhouse Hall. This was in breach of regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must make sure that patients are protected against the risks associated with unsafe or unsuitable premises at Little Woodhouse Hall. Staff had not identified all the potential risks to patients from fixtures on the ward that could be used by them to self-harm by hanging. The trust had identified the premises were not suitable, but did not have a clear timescale for moving to new premises or how the present premises could be improved upon whilst they waited for the move.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises We found that the registered person had not protected people against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them in their records. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must make sure people are protected against the risks of unsafe or inappropriate care and treatment

Compliance actions

arising from a lack of proper information about them in their records within the community child and adolescent mental health service. Staff had not always recorded peoples risk assessments on the computer system.