Leeds Community Healthcare NHS Trust

RY622

Community health services for children, young people and families

Quality Report

Leeds Community Healthcare NHS Trust
RV6
Tel: 0113 282 9173
Website:

Date of inspection visit: 31 January to 2 February 2017
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RY622	Hannah House		

This report describes our judgement of the quality of care provided within this core service by Leeds Community healthcare NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement 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.

Where applicable, we have reported on each core service provided by Leeds Community Healthcare NHS Trust and these are brought together to inform our overall judgement of Leeds Community Healthcare NHS Trust.

Summary of findings

Ratings

Overall rating for the service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

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Summary of findings

Overall summary

Overall we rated Hannah House as requires improvement because:

- There was limited documented evidence of sharing of learning from incidents. Eleven staff we spoke with were unable to provide examples of learning or changes in practice in response to an incident. The trust said that learning from incidents took place during clinical supervision and safeguarding supervision within the unit
- There were concerns over safeguarding training; there was a requirement for staff to be trained to level three and not all staff had received this traininig**.** Safeguarding supervision levels were 82% this was below the trust target of 90%.
- Not all medicines were being transcribed correctly and some medication being used had past its expiry date. Following a discussion with the trust an action plan was developed. This outlined areas for improvement with leads identified and clear timescales for actions to be competed.
- Staff sickness levels were high at 22% and as a result some short breaks had been cancelled. However, safe staffing levels were being maintained at all times.
- Staff appraisal rates were 75% this did not meet the trust improvement trajectory target of 85%.
- There was a lack of evidence in relation to staff skills and competence. The competency documentation was incomplete and some staff expressed concerns over this.
- The bed occupancy targets of 85% had only been met in four out of ten months. This had been impacted by the transition bed being occupied which required a staff to child ratio of 1:1. The unit was also closed on two occasions on the advice of the infection prevention and control team.
- Data was not collected on how many allocation requests were given to individual families and carers. Therefore the trust could not provide evidence that they were fair and equitable in the allocation of short breaks.
- Risks to the service were not clearly identified and escalated. There was a lack of management oversight in the unit because of sickness and vacant posts. There was an interim manager in post at the time of inspection.

However:

- There were detailed and clear escalation plans in place for each child if they became unwell whilst at Hannah House.
- There were clear plans in place to ensure the nutritional and hydration needs of children and young people were met.
- Children and young people's needs were assessed and care was delivered in line with current legislation, standards and recognised evidence based guidance.
- Staff were passionate about the care they provided. Parents gave positive feedback and felt confident their children were safe whilst at Hannah House.
- Emergency access was always available for families if a crisis occurred.
- There were clear vision and values within the organisation and staff were aware of them.
- Staff reported good support from their line manager.

Summary of findings

Background to the service

Information about the service

Leeds Community Healthcare NHS Trust was established in 2011 and employs around 3000 staff. The trust serves a population of 850,000 people and staff are based at health centres and community sites across the Leeds area.

An inspection of Leeds Community NHS Foundation Trust was carried out on in November 2014. At this time services for children young people and families were rated as good. Due to information of concern a responsive inspection of Hannah House was planned and this was combined with the planned follow up inspection of the trust.

Hannah House is a purpose built, self-contained facility which provides planned and emergency short break care for children with complex health needs. It is located in a residential area of Leeds.

Hannah House is open 24 hours a day 365 days a year and is accessible to children and young people from birth to 19 years. Those who are registered with a Leeds GP or live within the Leeds geographical boundary and have been assessed and meet the criteria can access the service.

Hannah House had six bedrooms; four of these are used for planned short breaks. One is for emergency short break care and one is used for children who meet the continuing care criteria and require a slow planned transition from hospital care to home. There is a multi-sensory room and an outside play area. Children are cared for by a Home Manager and registered sick children's or learning disability nurses 24 hours a day.

At the time of inspection there were approximately 55 children on the caseload for Hannah House.

During our inspection we spoke with 11 staff, reviewed seven electronic care records and five medication records. We spoke with two parents and a young person; we spoke with three parents by phone after the inspection.

Our inspection team

Our inspection team was led by:

Chair: Carol Pantelli

Team Leader: Amanda Stanford Care Quality Commission

The team inspecting Hannah House included a CQC inspector, two members of the medicines management team and two specialists with a background in children's services.

Why we carried out this inspection

We inspected Hannah House as a responsive inspection.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 31 January and 1 and 2 of February 2017. During the visit we spoke with a range of staff who worked within the service, such as nurses, support workers and managers. We talked with people who use services. We observed how children and young people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We carried out an unannounced visit on 15 February 2017.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

Summary of findings

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

What people who use the provider say

During the inspection, we heard many positive comments from families and carers of children and young people. We spoke with two parents and a young person; we spoke with three parents by phone after the inspection.

Parents described Hannah House as 'home from home' and that they could refresh and have 'peace of mind' during their child's stay.

Parents reported feeling happy that their child was safe and it gave them an opportunity to spend time with their other children.

Parents reported they felt assured they would be contacted if their child became unwell and they could contact Hannah House at any time for an update.

Good practice

- The development of Hannah House as a clinical hub has enabled additional services to be offered which have benefited children and young people and their families. For example home visits to resolve problems with feeding tubes.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service MUST take to improve

- The provider must ensure all registered staff have undergone level three safeguarding training and have regular safeguarding supervision which is formally recorded.
- The provider must ensure there is safe management of medicines and there is documentation to support this.
- The provider must ensure staff are appropriately skilled and trained to meet the care needs of children at Hannah House.
- The provider must ensure there are robust governance procedures to ensure risks are identified and escalated appropriately and any actions are shared with staff.

Action the service SHOULD take to improve

- Ensure processes are in place for environmental safety checks.
- Ensure that safeguarding supervision is completed.
- Ensure learning from incidents and complaints is shared with staff.
- Ensure daily records of care are completed.
- Consider Wi-Fi access for children during their stay at Hannah House.
- Consider how the service engages with families to enable them to contribute to service development.
- Reduce the number of cancelled short break stays and review the reasons for cancellations

Leeds Community Healthcare NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- We found limited sharing of learning from incidents from speaking with staff. This included a safeguarding concern. However post inspection the trust told us that learning from incidents takes place during clinical supervision and safeguarding supervision within the unit.
- There had been a requirement of having an effective system for recording safeguarding supervision following the last inspection. Supervision rates were 82% which was below the trust target of 90%.
- Staff were not clear about the level of safeguarding training undertaken and not all staff had completed the level of training required for their role. An action plan was in place at the unannounced inspection and some staff were booked to attend training.
- There were concerns over medicines management, a number of errors and omissions were seen. Following a discussion with the trust an action plan was developed. This outlined areas for improvement with leads identified and clear timescales for actions to be competed.
- There were delays in implementing some environmental safety checks such as ensuring water temperatures were checked and weekly running of taps to prevent legionella.
- Staff sickness was high at 22% and subsequently achieving safe staffing levels was a challenge with some short breaks being cancelled as a result. However safe staffing levels were maintained at all times.

However:

- There were clear individual plans in place if a child became unwell whilst at Hannah House.

Requires improvement

Are services safe?

- Electronic records allowed the sharing of clinical information between GP's and community nursing teams.

Detailed findings

Safety performance

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Whilst Hannah House did not report on The NHS Safety Thermometer, the quality board which was introduced in August 2016 was updated daily and this included all the domains within the children and families version of the NHS safety thermometer.
- The home manager also contributed to monthly leadership meetings where performance was discussed and escalated to the business unit performance meeting. This included areas such as patient safety, incidents and patient experience.
- Incidents were reported via the trusts electronic reporting system. The trust also held an annual quality challenge of their services reviewing ten standards based on care and treatment. The service was red, amber, green (RAG) rated and an action plan developed from the findings.
- We reviewed the report from April 2016 which related to children's services including Hannah House. Three areas were rated amber; these related to medicines management, infection prevention and the mental health needs of patients. These areas were identified as requiring improvement with associated action plans in place. Examples included introducing a red tabard to be worn by staff at Hannah House when administering medications.
- Trusts are required to report serious incidents to Strategic Executive Information System (StEIS). These include never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. During the reporting period of December 2015 to November 2016 there had been no serious incidents or never events attributable to Hannah House.
- All deaths were discussed at the Children's Business Unit, Mortality Surveillance Group which fed into the Trust Mortality Surveillance Group.

Incident reporting, learning and improvement

- Between the 1st of July 2016 and the 31st December 2016 there had been 17 incidents reported at Hannah House. Of these, four related to a medical device or equipment and three related to administration or supply of medication. The remaining incidents were split between nine incident sub types.
- Information provided showed there had been one occasion in November 2016 and two in December 2016 where short breaks had been cancelled as there were issues with drug charts.
- Whilst we had no comparable data in terms of the number of incidents reported, only two of the staff we spoke with could recall completing an incident form. With the exception of one staff member we spoke with, all other staff had worked at Hannah House for over 16 months. Two of the staff were able to talk about an incident that had been reported, however none of the staff were able to articulate any learning or changes in practice.
- We were told by managers there was a good culture of incident reporting however, one staff member felt improvements could be made in the reporting of near misses and another gave an example of being discouraged from reporting an incident.
- We were told incidents were discussed at monthly team meetings. Due to sickness, the last team meeting had been in November 2016. We reviewed meeting minutes from October 2016 and November 2016, whilst incidents were a standing item, there was little detail in relation to the incidents discussed. Following the inspection we were told learning from incidents took place during clinical and safeguarding supervision, however none of the 11 staff we spoke with informed the inspection team of this.
- We reviewed nine sets of weekly leadership team meetings for the children's nursing service from October 2016 to January 2017. Learning from incidents was a standing agenda item, however there was little detail. For example at the December meeting under learning from incidents for Hannah House it said, 'ensuring children are checked before going on transport'.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

health and social care services to notify patients (or other relevant persons) ofcertain 'notifiable safety incidents'andprovide reasonable support to that person.

- Staff we spoke with were aware of the duty of candour and spoke about being open and honest with patients and families when things went wrong. During the inspection a drug error occurred, this was reported and the parent of the child was informed.
- Work had been completed to ensure duty of candour was part of the electronic incident reporting system.

Safeguarding

- The last inspection children's services at the trust in 2014 required the trust to ensure they had an effective system to record safeguarding supervision.
- Safeguarding supervision was a standing agenda item at the team brief, performance and governance monthly meeting. The meeting minutes from September 2016 noted there needed to be a 'push' to get staff to record their supervision in a timely way. The staff we spoke with reported having group safeguarding supervision on a quarterly basis. Figures displayed at the entrance to Hannah House showed child protection supervision was 25%. We requested further data which showed that 19 (82%) of the 23 staff had undergone recent supervision.
- This information was being recorded on a sheet of paper and staff were expected to log it electronically. Managers told us, and we saw in meeting minutes, that staff were being actively encouraged to record this information formally.
- Staff were not always clear of the level of safeguarding training they had or were required to undertake. We were provided with training compliance figures for Hannah House for December 2016 to January 2017. These showed adults safeguarding compliance was 96% and children's safeguarding was 95%. This met the trust target of 90%, however the level of safeguarding training was not provided.
- The intercollegiate document for safeguarding children and young people: roles and competences for health care staff (2014) states that "All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns" should have level three safeguarding training. We asked for information on the number of staff who had undergone level three safeguarding training. The information provided said two staff were trained to this level at Hannah House.
- At the unannounced inspection we saw an action plan that had been commenced following the announced inspection. This stated all registered staff were required to attend level three safeguarding training. Three staff had been booked on a course in March 2017.
- The trust had policies and procedures in place which related to safeguarding children. This included a safeguarding policy and clear pathway for reporting and dealing with child protection and safeguarding concerns. This could be accessed on the trust intranet and a copy of the flow chart and safeguarding contacts was contained in the 'on call' file carried by the nurse in charge.
- Staff were aware of the policies and understood their responsibilities and felt confident in recognising safeguarding concerns. Monthly leadership safeguarding meetings took place with the named nurse and team leaders. One of the staff from Hannah House was a child protection supervisor and was a point of contact and advice for staff if there were any safeguarding issues.
- There was a trust policy on restraint this was not specific to Hannah House. However one staff member had undergone training on restraint reduction and de-escalating situations to meet the specific needs of a child.
- Any children who were subject to a child protection plan would have an alert on their patient records. Patient records were electronic and shared between the health professionals involved in each child's care.
- The annual documentation audit had a safeguarding element. The data from February 2016 of 12 records showed poor compliance against the standards. For example only two of the records had evidence of the bruising protocol being followed. Following the inspection further information from the trust explained that the questions asked in the audit had a 'yes' or 'no' option only. This meant in some of the records reviewed the bruising protocol may not have been applicable but this information was not captured.
- There had been one child safeguarding referral made in relation to Hannah House. Information from the trust

stated the outcome of any safeguarding referral is shared with the individual staff member. However we were concerned that staff were not aware of the wider learning from this.

Medicines

- We looked at the arrangements for medicines reconciliation at the service. The children's responsible clinician wrote medicines charts. The charts and medicines were brought in with the child for each stay then returned home. Medicines were 'checked in' using a specific form, which was filled out by nursing staff to confirm the medicines were correct.
- Controlled drugs were stored securely and the key held by the nurse on duty. Nursing staff kept records of controlled drugs appropriately. The cupboard did not contain any controlled drugs at the time of our visit.
- We observed that medicines were stored securely and the keys were held by the nurse on duty. Since August 2016 a 'tiny tag' data logger had been in use to record room temperatures 24 hours a day. The data was downloaded every three to four months and over seen by the medicines management team. In addition to this daily monitoring should still be undertaken as a second check. However we found room temperatures had not been manually recorded since November 2016.
- Maximum and minimum fridge temperatures were recorded daily; however no current temperature was recorded in line with the policy. There were two fridges at Hannah House, one for storing medication and one for feeding products. The fridge for feeding products had exceeded the recommended range on 12 occasions in January 2017, no actions had been documented and the manager was unaware. At the time of the unannounced inspection a priority order had been placed for a new fridge.
- We looked at the systems in place for medicines management. We assessed five medication records and looked at medicines storage, reconciliation and administration at the service. We found that appropriate arrangements for the safe handling of medicines were not in place.
- We found during our visit that medicines had not always been 'checked in' accurately, for example, one medicines labelled dose was different to that on the medicines chart. A second medicines strength was different to that which had been written on the chart. We saw for one patient four medicines which had been issued on their GP repeat summary but were not recorded on the current medicines chart. Incorrectly written and incomplete medicines charts increase the risk of the patient not receiving their medicines as prescribed. We found that medicines with reduced expiries once opened, did not always have the date opened recorded. This meant staff could not assure themselves that the medicines were fit for use. One medicine we looked at to treat epilepsy had expired.
- We saw that when medicines were not administered codes were not always recorded correctly and nursing staff did not always record why medicines had not been administered in the patient's notes. Nursing staff did not always record the number of doses given when medicines were prescribed with a variable dose.
- The quality challenge report from April identified a 'red tabard' had been introduced for when staff were administering medications and were made available from August 2016. We observed three staff administering medications; the tabard was only worn by one of them.
- Two of the patients whose charts we reviewed received their medicines via a Percutaneous Endoscopic Gastrostomy (PEG) tube. Staff followed trust guidelines when administering medications in this way.
- One of the children used a fluid thickener to aid swallowing had a care plan in place dated 29 December 2014, which was overdue a review in June 2015. The care plan stated their fluids should be thickened to syrup consistency. We asked the carer how they knew what consistency fluids needed to be thickened to. The carer was only aware that the person's food needed to be pureed. Failure to ensure fluids are thickened to the correct consistency increases the risk of choking.
- The National Patient Safety Agency produced guidance on food textures. Part of this included standard terminology for describing the texture of a modified diet. For example, B would be a thin puree diet. We found no reference to this in the care plan we reviewed and staff did not use these descriptors.
- We also saw a cream prescribed which had a stop date of 6 September 2016. This had been administered on three occasions in December 2016. We asked the nurse about this medicine they stated they were 'unsure why it had a stop date recorded' there was no care plan in place to cover topical preparations.

Requires improvement

Are services safe?

- A complaint to the service had highlighted medication in relation to a missed dose. The associated action plan had a deadline of December 2016 for medication competencies to be completed for staff. This had not been met.
- The medicines management team had completed a review of medicines handling at Hannah House in November 2016. This showed there had been 13 medication incidents between October 2015 and September 2016. These incidents although small in number were similar to what we found during our inspection. We identified the same themes during our inspection and brought this to the attention of the management team so further action could be taken.
- A discussion over medicines management was held with senior staff at the trust following the inspection. We were told there was a clear programme of work in relation to medicines management. We were not made aware of this during our inspection and medicines management was not highlighted to us as an area of risk.
- Following the discussion with the trust an action plan was developed. This clearly outlines areas for improvement with leads identified and clear timescales for actions to be competed. For example, developing a standard operating policy for checking expiry dates; this included reconstituted medications.
- Medicines management was a 'core competency' within the training and development records for staff. We reviewed five of these documents and found them to be incomplete. The completion of these competencies to provide assurance of knowledge was included within the trusts action plan.

Environment and equipment

- Secure keypad access was in place for staff to enter the building; all other visitors could only access the building by using the intercom system. There was a 'sign in' book for visitors.
- The building was purpose built with six individual bedrooms and adapted bathrooms. There was a main lounge area and separate rooms which were multipurpose and contained a television, games console, DVD player and books. There was a sensory room with lights, music and a bubble tube and an outside play area.
- Feedback from staff and our observations were that the décor, particularly in the bedrooms needed updating. An ideas board had been put on the wall for staff to contribute to. This meant staff could share ideas in relation to refurbishment work and applications for charitable funding.
- The windows had restrictors in place only allowing a small gap when they were open. Two of the rooms had doors which could open to the outside play area; these were locked and had alarm sensors fitted. There was a door at the rear of the building which was also alarmed. We tested this, the alarm worked and staff responded when it triggered.
- There were some areas of damage to walls behind doors and headboards. These had been identified during an audit in January 2017 and we saw evidence of repairs being actioned.
- The medication area was next to the kitchen, access to this was via a door with a keypad.
- It was noted that door hinges did not have finger guards to prevent children's fingers getting trapped. There was a notice board in the lounge area which had drawing pins at a low level. Whilst it was acknowledged many of the children may not be mobile these were potential risks.
- It was noted and discussed with staff that there were no restrictors on taps in the shower rooms. We asked staff how they were assured the temperature was at a safe level. The temperature was being checked by staff testing the water on themselves. We were told, and we saw from meeting minutes this was raised by a staff member in November 2016. No action had been taken following this. At the unannounced inspection a thermometer had been purchased to check water temperatures. A standard operating policy was being developed as one was not in place.
- There was an equipment register detailing service scheduling and staff reported good support from estates and facilities staff. We checked various pieces of equipment for electrical safety testing and found these to be in date.
- Staff reported that they had access to all the equipment they needed to provide care and children often brought their equipment from home such as feeding pumps.
- There was a large range of toys and equipment available for children such as craft items and musical instruments.
- We saw that there was appropriate disposal and segregation of waste and laminated guidance displayed. Laundry was done on site and there were systems in

place to manage soiled laundry. We did note that the fire door in to the laundry room was propped open, this was mentioned to staff and during the unannounced inspection we found the door was closed.

Quality of records

- Hannah House used an electronic system for patient records. This linked with other community services and GP practices. This allowed sharing of information related to each child. Staff reported this was a benefit especially if a child wasn't known to them as they could still access information. For example if they were attending for replacement of a feeding tube.
- One of the challenges of electronic records was that whilst bank had access to the system, agency staff did not. When on duty, agency staff relied on the permanent or bank staff to update records on their behalf. We were told there were no plans to address this as each staff member required their own card to access the system.
- Staff also reported getting quick access to information could be a challenge. To mitigate this, basic patient information had been put on white boards in the main lounge area. This was information such as times of medications and nutritional needs.
- We reviewed seven records. We found that individualised care plans and risk assessments were in place and had a review date. There was a section for daily needs to be recorded however we were not assured this was always completed thoroughly. For example in one record for a child who had a gastrostomy there was no evaluation of the care related to this during their stay. For another child there was no evidence from the care records that 'cough assist' had taken place the previous day.
- We spoke with staff about this who said whilst they had training on how to use the electronic system, this did not include what should be documented in the daily reviews are care.
- The annual documentation audit from February 2016 showed from the 12 records reviewed only 58% of the assessments and 42% of the care plans had met the requirement of being updated within the last six months. Responsibility for this to be achieved had been given to team leaders.
- The same audit showed core standard compliance was 96% this related to information such as date of birth and entries in chronological order being completed. Qualitative standard compliance was 86% this looked at areas such as abbreviations not being used and interventions being implemented in accordance with treatment plans.

Cleanliness, infection control and hygiene

- During our inspection we observed staff wash their hands and use hand sanitiser appropriately. Staff were 'arms bare below the elbow' in accordance with trust policy and personal protective equipment (PPE) was available such as aprons and gloves. It was noted there was no hand sanitiser at the entrance of Hannah House, we saw evidence that one had been ordered in January 2017.
- The cleaning resource at Hannah House was on the risk register. Significant work had been done following two outbreaks of gastric illness at Hannah House in 2016. A number of infection prevention and control audits had been undertaken and an action plan developed as a number of issues had been identified. These included things such as clutter and storage issues and non-laminated posters displayed.
- We were provided with updated information during our inspection from an audit in January 2017. This showed compliance was at or above the trust target of 85% in six of the seven areas looked at; these being, environment, hand hygiene, PPE, prevention of blood and bodily fluid exposure incidents, management of waste, equipment management and organisational controls. The area still below 85% was environment although this has still improved from 76% to 84%.
- Areas for improvement on the action plan had a nominated lead and a timescale for completion. However we were concerned that the audit from June 2016 had identified a record of weekly tap running for legionella could not be located. We asked about this at the announced inspection and this was not in place. A system had been implemented when we returned for the unannounced inspection.
- We found that a cleaning schedule had been implemented with laminated prompt sheets in each room. Previously the service had 22.5 hours per week allocated cleaning resource time with supplementary cleaning by the care staff. Recently this had been increased to seven day cover with the use of agency staff. However a permanent positon was being advertised.

Requires improvement

Are services safe?

- We found that generally the environment was visibly clean and tidy. However in room four the headboard and bedrail protector was dirty with splash marks on it. This room had a sign on the door indicating it had been cleaned ready for the next patient. We discussed this with the manager who explained alternative covers without Velcro were being sourced for easier cleaning. However the splash marks were along the cover and not where the Velcro fastening was.
- Each room had a small box in the storage cupboard; there was a contents list however we found in each room some of the contents were missing. We also found some of the contents were out of date for example sani-wipes. Some boxes also contained scissors which were not in a packet and were not clean. We discussed this with the manager as the purpose of the boxes was unclear.
- A monthly mattress audit was in place and we saw data to support this.

Mandatory training

- Staff training matrices were available for managers and were RAG rated to indicate compliance levels. Green was achieved with a percentage of 90 or above. Individual members of staff were responsible for making sure they were up to date with all of their own training, however, line managers would prompt staff if required.
- To help with the completion of training, days had been arranged at Hannah House to cover several elements at a time.
- Mandatory training had six elements which all staff had to complete. This included; equality and diversity, fire safety, health and safety, infection control, information governance and moving and handling. Data from January 2016 showed that compliance figures for two elements were slightly below the trust target. These were infection control (78%) and fire safety (89%).
- Clinical staff were required to undertake additional mandatory training which included; cardiopulmonary resuscitation (CPR), conflict resolution, mental capacity act and safeguarding. There additional elements all met the trust target with the exception of CPR training which was 85%. These figures were seen on site via the dashboard and were from January 2017.
- We were told the cardiopulmonary resuscitation was not specific to paediatrics although an element of this was included within the training. We asked for information on the number of staff at Hannah House who had undergone paediatric immediate life support training (PILS) and were told no staff had completed this.

Assessing and responding to patient risk

- There was a pre-determined criteria for children and young people accessing Hannah House. This involved several stages and was multidisciplinary. An early help Assessment, or Core Assessment or Education, Health and Care Plan (EHC) had to be completed, followed by a comprehensive assessment using the Leeds children's nursing dependency tool.
- The children who used the transition bed were carefully assessed and planning for them to come to Hannah House took place well in advance of them coming to Hannah House. This involved staff from Hannah House going to the paediatric intensive care unit (PICU) at the neighbouring hospital trust to familiarise themselves with the child and their individual needs. Staff from PICU may also come to Hannah House to support with equipment training.
- During our inspection there was a child utilising the transition bed. In addition to electronic records we saw a laminated care plan and flow chart for the management of acute respiratory illness. This included signs and symptoms and a clear escalation plan. Staff told us they had good communication links with staff on the PICU if they had any concerns over children in the transition bed.
- There was emergency equipment available for individual children as required. For example; portable suction and a tracheostomy kit. However staff provided us with examples of where they had worked with equipment they were not familiar with. We asked staff about individual procedures and lacked assurance about their knowledge and understanding. Although they said they would always seek advice if they were unsure.
- We discussed our concerns with the manager as we also could not be provided with evidence of staff competence in skills such as tracheostomy care and care of feeding tubes.
- Following the inspection the trust provided further information in relation to specific skills such as tracheostomy care. When a transition plan is in place for a child, staff from Hannah House would spend time

working alongside staff in PICU to gain confidence and refresh any skills. The child would only move to Hannah House when both teams are happy to provide the care needed.

- From the records we reviewed we saw that individual risk assessments were completed and evaluated. Staff told and if any new information or changes were received from parents this would be updated in the child's electronic record. We saw some evidence of this in the notes we reviewed.
- The annual documentation audit from February 2016 showed that only one record from the 12 reviewed had a pressure ulcer prevention assessment in place. This had been identified as an issue following a complaint to the service.
- Twice daily skin checks were included in the electronic notes. This consisted of a tick box and a free text box to give further detail. An assessment tool had been implemented in September 2016 to assess and monitor pressure areas although staff we spoke with said it was not really suitable and was therefore not being used. We saw from a team meeting in October 2016 there was an expectation that the tool should be completed for each child attending Hannah House.
- There were clear guidelines for when a child became unwell. This would be discussed with parents as part of their initial assessment and clearly documented in the child's records. We saw evidence of this in the records we reviewed. The staff at Hannah House would take the lead from the child's parents or guardians if they became unwell. Depending on the individual child this may result in the child being taken home or taken to the local GP.
- If the child deteriorated significantly then an emergency ambulance would be called as there was no medical cover on site. If a child did require emergency transfer to hospital a member of staff would always travel with them.
- Most of the staff could describe a situation where a child had become unwell and they reported no concerns over the management of the situation as there were clear guidelines in place.
- Limitation of treatment actions (LOTA's) were in place where appropriate. These plans clearly detailed at what point treatment and escalation would stop.
- Children and young people were monitored whilst sleeping and staff sat on the corridors outside bedrooms at night. Regular checks were undertaken and for some children baby listening or video monitors were used. The level of monitoring was based on the individual needs of the child and with discussions with parents.

Staffing levels and caseload

- Staffing was being managed on a day by day basis, with staff working flexibly to cover gaps. The nurse in charge was spending time each shift looking at staffing for the following day.
- Staff had to work more flexibly often working days and nights in the same week and regularly swapping shifts. Although staffing gaps were being covered we were concerned over how sustainable this was and the impact it was having on staff and the service.
- We saw guidance on the criteria for classification of need. This document outlined the level of supervision needed for each child based on their clinical condition. We found no evidence of this tool being referenced with regards to the staffing rotas. Whilst we were assured staffing levels were appropriate, the information relating to acuity and level of supervision needed each shift was not formally recorded.
- Staff sickness at Hannah House had been an ongoing issue since the end of the previous year. At the time of inspection the sickness levels were 22%. Staff sickness was not on the risk register and from speaking with managers we were not assured that the senior management team had full oversight of the issues. However we were assured that safe staffing levels were maintained.
- Staffing was being managed by utilising staff from the community nursing teams and with overtime, bank and agency staff. Hannah House was the 'default base'; if a community visit was cancelled the staff member would go there.
- We were given examples of where short breaks had been cancelled as safe staffing levels could not be achieved. For example in August 2016 this had occurred on six occasions, in December 2016 this had occurred on nine occasions.
- The staff turnover rate for 12 months up to October 2016 was zero. The current vacancy position was 2.0 whole time equivalent.

Managing anticipated risks

Requires improvement

Are services safe?

- Hannah House had one bed designated as an emergency bed. We were provided of examples of when this had been used, such as when a parent becoming ill and required hospitalisation.
- Hannah House also had a bed designated for transition. This was for children and young people who met the continuing care criteria and who required a planned slow discharge from hospital.
- Staff we spoke with told us adverse weather conditions had been managed well. When there had previously been snow staff and children had been kept safe by staff staying over.
- We were provided with an example of a potential gas leak which has been managed quickly and safely.
- All equipment had a backup battery but in the event of a power failure staff were aware of the importance of being proactive particularly if there was a child requiring support from a ventilator. If this situation occurred PICU would be contacted for the child to be transferred.
- Managers and staff followed the trust major incident plan and worked collaboratively with the local council.

Requires improvement

Are services effective?

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

We rated effective as requires improvement because:

- We lacked assurance and evidence of staff competence with regards to specific skills needed to care for children and young people at Hannah House. The competency documents we reviewed were incomplete and some staff expressed concern over this. Trust deadlines for completion of these documents had not been met.
- From speaking with staff we lacked assurance over their knowledge and understanding in relation to clinical procedures.
- Staff appraisals rates were 75% this was below the trust target of 85.7%. There was an improvement trajectory in place; however there were no plans in place to ensure outstanding appraisals were undertaken.

However:

- Policies and guidelines were evidence based.
- We saw care plans related to nutrition and hydration and were assured individual needs were met.
- We saw good evidence of multi-disciplinary working across the service.

Detailed findings

Evidence based care and treatment

- Children and young people's needs were assessed and care was delivered in line with current legislation, standards and recognised evidence based guidance. Policies and procedures were based on guidance produced by the National Institute for Health and Clinical Excellence (NICE) or other nationally or internationally recognised guidelines. For example the infant feeding policy was based on guidance from UNICEF and the Healthy Child Programme.
- However, the October 2016 trust performance report showed that compliance with NICE guidance within one year was RAG rated as red.
- As Hannah House was a short break service there was limited audit activity. The service had not participated in any local or national audits in the last 12 months as these were not applicable. However local audits had been completed such as documentation and infection prevention and control audits. We also reviewed the data on the balanced scorecard which looked at indicators such as bed days, patient satisfaction and sickness levels.
- There were audit plans provided which included an annual documentation audit and an audit into cancellations of short breaks.
- We saw individualised care plans with some evidence of goals/targets identified. For example to aim for tracheostomy tube changes very two weeks.
- We also saw suction care plans with individualised records for length of suctioning to avoid internal tissue damage.

Nutrition and hydration

- From reviewing records; guidance around a child's nutritional needs were recorded in their individual plan of care. This included twice daily mouth care checks.
- Many of the children and young people were unable to eat and received nutrition via feeding tubes. However we saw an example in a care plan of a young person who could not eat but they liked to 'lick' certain foods just to taste.
- For those children who could eat, meals were prepared on site and feedback from parents said there was good variety in the meals offered. Special requirements such as halal meals could be catered for.
- There was a food hygiene policy at Hannah House and staff had undertaken food hygiene training.
- We observed that meals times were made sociable with everyone gathering at the table in the lounge area. We also observed parents joining.

Technology and telemedicine

- Hannah House had moved to electronic records in 2015 and these were well established. All permanent staff had access to laptops to access records. As they were based at Hannah House there were no issues with connectivity.

Patient outcomes

Requires improvement

Are services effective?

- We saw evidence that children and young people were thoroughly assessed before care and treatment started and there was evidence of care planning. This meant children and young people received the care and treatment they needed.
- The model at Hannah House was commissioned using assessment of eligibility through pre-determined criteria and was not linked to the achievement of outcomes.

Competent staff

- Staff were provided with training and development records. These contained core and role specific competencies with associated learning objectives. Staff were expected to demonstrate knowledge by undertaking training or reading guidance; be observed performing the skill then would then be signed as being competent.
- However, the three records we looked at were all incomplete. The records were for staff who had worked at Hannah House for over 12 months. For example in one record we looked at, 19 of the competencies were blank the remaining 11 were only partially completed. Several entries that had been signed were from the week preceding the inspection.
- In addition another member of staff who had been employed since November 2016 did not have a booklet, yet was carrying out some of the skills listed within it.
- We spoke with staff who had worked at Hannah House for over 18 months to ask if competency had been reassessed. It had not as most had still to be fully signed off. We were also concerned that competency was being assessed by staff who themselves did not have a completed record of competence.
- Some skills were difficult to gain competence in, for example changing a tracheostomy tube, as this may not need doing during a child's stay. To help gain this skill staff could go on visits with community staff to planned tube changes to gain experience.
- It was noted from team meeting minutes from November 2016 that staff had been encouraged to have their competencies 'signed off'. The quality challenge improvement plan from May 2016 had a deadline of these to be completed by the end of January 2017. This had not been met.
- At the unannounced inspection an action plan had been developed which included staff competencies. A database was to be developed to log individual competencies with a completion date of the end of February. This however did not address the concerns regarding staff skill and knowledge.
- Training was provided in basic life support; however PILS training was not undertaken by staff at Hannah House. If there was an emergency situation an ambulance would be called. Staff would not be expected to manage significant deterioration of a child.
- Information provided by the trust showed in January 2017 75% of staff had undergone an annual appraisal against a trust target of 85.7%. There was an improvement trajectory in place working towards 95% compliance by the end of 2017/2018.
- There had been a gap in management due to sickness and the interim manager was aware appraisals needed to be completed. However the high sickness levels meant finding time to complete appraisals was a challenge. Appraisals planned for January had not been done and we were not assured there were plans in place to ensure outstanding appraisals took place.
- At the unannounced inspection we found that additional training had been arranged to support staff development with the speech and language therapists.
- Two staff members were trained non-medical prescribers.
- An interim manager was in place at the time of inspection. They worked across the children's continuing care and short breaks service.

Multi-disciplinary working and coordinated care pathways

- The use of electronic records meant staff from all services shared information appropriately. Services for children and young people worked together with each other and with external agencies to assess, plan and co-ordinate the delivery of care. Staff described a patient-centred approach with involvement of parents or guardians.
- Staff reported good links with their colleagues in the community nursing teams and GP's. There was close working with the PICU at the local NHS hospital for children accessing the transition bed.
- As many children and young people came to Hannah House directly from school there was good communication with local schools.

Referral, transfer, discharge and transition

Requires improvement

Are services effective?

- Hannah House provided a service for children and young people ages 0-19. Transition processes were in place; these were led by social workers. Planning for transition began well in advance and staff at Hannah House would support individuals as appropriate.

Access to information

- Staff we spoke with told us they were able to access policies, standard operating procedures and best practice guidance on the trusts intranet system. We observed that this was easy to navigate.
- Electronic records could be accessed by all permanent staff and information from GP and community nursing teams could also be viewed.

Consent

- Consent was obtained from parents and children, as appropriate during the initial assessment.
- Many of the children were not able to communicate verbally so staff took non-verbal ques or referred to comprehensive care plans to guide what their preferences were. Where consent could be gained it was and we saw examples of staff asking what children would like to do.
- Parents would be contacted for consent over treatment decisions if a child became unwell. For example whether to give analgesia or seek medical advice from a GP.

Good

Are services caring?

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

Summary

We rated caring as good because:

- The parents we spoke with all gave positive feedback about the staff and the care given to their child whilst at Hannah House.
- Children and young people were treated with compassion and respect.
- We saw staff taking steps to ensure that dignity and privacy were maintained.
- Parents were involved in their child's care and contributed to care plans.

Detailed findings

Compassionate care

- We spoke with two parents and one young person during our inspection and spoke with three parents by phone after the inspection. We observed staff interactions with eight children during the inspection.
- The parents we spoke with said they felt confident to leave their children in the care of staff at Hannah House and described them as 'fabulous' and gave them 'peace of mind' whilst their children were there. The young person we spoke with was very positive about the staff and felt they were caring.
- Staff treated children and young people with kindness, dignity, respect and compassion. We observed several interactions between staff and children and saw care that was led by the needs of the individual.
- All staff we spoke with were passionate about their roles and were clearly dedicated to making sure children and young people were the focus of their care.
- Staff showed respect for the personal, cultural, social and religious needs of children and young people. For example, if they did not wish to participate in certain activities or celebrations.

Understanding and involvement of patients and those close to them

- The parents we spoke with felt involved in their child's care. Many described it as 'home from home'.
- One parent said even though their child could not communicate verbally, they knew staff at Hannah House would pick up on non-verbal signs and know if something was wrong and what to do.
- There was ongoing communication with parents over care as children's preferences could change between stays. However this was done on an ad hoc basis. Most of the staff we spoke with commented that they felt there should be scheduled meeting with parents to have face to face discussions. We were given examples of children who had been using Hannah House for a significant period of time and they had never met their parents. Whilst this did not affect the care of the child most staff commented it would be nice to meet parents.
- Review of care plans took place when a child came back to Hannah House and any updates and or changes were documented in their records.
- Staff supported parents with skills needed for children transitioning from PICU to home. A parent gave an example of attending Hannah House with an issue with their child's feeding tube. Staff explained and showed them how to resolve the issue if it occurred again.
- Some parents said they called several times a day for an update whilst their child was at Hannah House and fell reassured by the information given.
- Parents reported feeling able to 'switch off' whilst their child was at Hannah House and have a break.
- Staff felt happy that they could see how parents and carer's had been able to 'recharge' after their child had been for a stay at Hannah House.

Emotional support

- We saw that care plans included some calming measures that could be used to reassure children.
- We saw that children had personal items in their rooms such as teddy bears and blankets to provide comfort.

Requires improvement

Are services responsive to people's needs?

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

Summary

We rated responsive as requires improvement because:

- The bed occupancy targets of 85% had only been met in four out of ten months.
- Data was not collected on how many allocation requests were given. Therefore we were not clear how the trust ensured that they were fair and equitable in the allocation of short breaks.
- Data showed there were a number of cancellations of short breaks each month. We were not aware of any plans to look into the reasons why and to try and reduce the numbers.
- Feedback from parents and staff was that more activities could be planned to make stays at Hannah House a better experience for children and young people. There had been no day trips from Hannah House in the last 12 months.
- Whilst the number of complaints was extremely low, we were not assured of sharing and learning as a result.

However:

- The services offered by the development of the clinical hub had benefitted parents and in some situations saved them from having to take their child to hospital.
- The emergency bed could always be accessed by families in situations of need.

Detailed findings

Planning and delivering services which meet people's needs

- The short break service at Hannah House was part of the contract for Children's Nursing Services and monitored through the Children's Nursing Service specification. The model was based on an assessment of need and eligibility through a pre-determined criteria. All children and young people eligible for continuing care were offered residential health short breaks.
- Hannah House was purpose built to meet the needs of children with complex health needs. As children and young people attended Hannah House from the age of 0-19 having an environment which was suitable for older and younger children was a challenge. Staff identified there needed to be a focus on teenagers and their needs. Parents identified access to Wi-Fi would make a big difference for older children.
- Hannah House had been operating as a 'clinical hub' for the last two years. This meant that if a child's feeding tube became dis-lodged or gastrostomy care was needed, parents could attend Hannah House rather than having to go to the emergency department. Feedback from a parent from when such a situation occurred was positive. Hannah House already knew their child and it saved a long wait in hospital.
- If staffing levels allowed home visits could also be undertaken to resolve problems with feeding tubes.
- Another element of the clinical hub was enabling children referred for overnight oximetry (monitoring of blood oxygen levels) to be given the option of attending Hannah House to collect a monitor and receive training.
- There were some arrangements in place to involve parents in service design and delivery. Staff identified this as something they would like to develop.

Equality and diversity

- Staff told us they did have access to translation services although these were rarely used.
- Equality and diversity training was mandatory. Data provided showed compliance rates from January 2017 were 98%, this exceeded the trust target of 90%.

Meeting the needs of people in vulnerable circumstances

- Two staff were trained in Makaton, which is a way of using signs and symbols to help people communicate. Staff used the pictorial exchange system (PECS) to communicate with children who were non-verbal.
- There was not a play specialist to provide additional support. On a daily basis the activities would be determined by the staff on duty based on what the child young person liked to do. We spoke with staff about this and asked what types of activates the children would be involved with. We were given examples of floor play, watching a DVD or listening to music. Several staff commented that it would be beneficial to have a play specialist and more planned activities.

Requires improvement

Are services responsive to people's needs?

- There had been no trips out from Hannah House in the last 12 months. Parents commented on this when asked about any improvements that could be made. Staff also commented on how trips out were rare.
- A parent commented that whilst they did not expect a huge range of activities to take place after school they would like more activities at a weekend.
- A review of the short breaks service by the Clinical Commissioning Group in May 2016 commented that the focus at Hannah House seemed to be more on providing a 'break' for parents rather than the experience for the child.

Access to the right care at the right time

- When a child had been assessed and met the criteria for Hannah House an allocation request form was sent to parents. Most families were entitled to 36 or 48 nights stay each year. There was guidance on the booking form for families. For example half their allocation could be used for weekends and school holidays.
- The form recommended parents complete their forms as soon as they were able to "avoid disappointment". The form also stated "after the 25 January bookings will be made on a first come first served basis, taking into account the level of need of the children already booked in". The form also stated the previous year there had been very little flexibility in swapping of weekends and school holiday stays and this was not expected to change.
- A form would be sent back to parents confirming the dates of their child's short breaks.
- We asked managers how many requests were able to be given and what systems were in place to have oversight of requests and allocations. This could not be clearly articulated and we were told it generally worked itself out.
- Some parents chose not to take all of the allocated stays. Additional stays could then be offered to other families however there seemed no clear process or system of monitoring how this was allocated.
- The emergency bed was used for short breaks but parents were made aware it could be cancelled on the day if it was needed for an emergency.
- The transition bed had been occupied from April to September 2016 and again from December 2016 up to the time of inspection. There were plans in place for another child to transfer into Hannah House when the current child was discharged home.
- We were given several examples of when the emergency bed was needed from staff and from parents we spoke with. Emergency stays were always accommodated. These were situations when a parent had been admitted to hospital or there was a crisis situation.
- The bed occupancy rate as agreed with the clinical commissioning group was 85%. We requested monthly data on occupancy levels. This information was collected at the end of each month and looked at bed occupancy rates, cancellations, and use of the transition and emergency bed.
- Data from April 2016 to January 2017 showed that the target of 85% had only been met during four of the ten months. In December 2016 occupancy was 65% and in January 2017 it was 68%.
- This led to discussions over why there was a waiting list for Hannah House. Information from the provider showed there were six children on the waiting list. We were told where there was capacity families on the waiting list would be offered day care to begin to familiarise their child with Hannah House.
- Cancellations at Hannah House accounted for a significant proportion of 'lost' bed days. For example in August 2016 there were 30 cancellations and in December 2016 there were 35. 37 of these were because they were 'not wanted' by parents. This supported our concerns that proactive system to management of allocations was not in place. We were not aware of any work ongoing to understand why parents were not using all of their allocated stays.

Learning from complaints and concerns

- Staff proactively worked in partnership with children, young people and their families, which minimised the need for people to raise complaints. Staff knew what actions to take when concerns were raised and this included trying to resolve problems as they occurred. Conflict resolution training was mandatory and compliance rates for January 2017 were 96%.
- There were very low numbers of complaints about Hannah House. There had been two between December 2015 and November 2016. One of these was not upheld as there was no evidence to support the complaint, the other was partially upheld.
- Concerns and complaints were items at team meetings. However the complaint which had been made in

Requires improvement

Are services responsive to people's needs?

October 2016 was not discussed at the October or November team meeting. Subsequently when staff were asked about this they were not aware of the complaint or any learning included in the action plan.

- We reviewed minutes of weekly leadership team meetings for the children's nursing service from October 2016 to January 2017. Complaints were not discussed and were not a standing agenda item.
- A trust-wide policy included information on how people could raise concerns, complaints, comments and compliments with contact details for the Patient Advice and Liaison Service (PALS).

Inadequate

Are services well-led?

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

We rated well led as inadequate because:

- At the time of inspection there was a lack of leadership at the service. The deputy and home manager were on long term sick leave. The clinical service manager role was vacant for some time which had led to gaps in decision making, oversight of effective systems and processes, information sharing and learning with staff. Evidence for learning and reflective practice was minimal.
- The processes to ensure effective governance were limited and did not provide sufficient assurance to support decision making, monitor performance and quality standards. Risks to the service were not clearly identified and escalated, for example, staff sickness levels and staff competency assessments.
- Information used to monitor performance for example data and targets provided for areas such as training and appraisal was unrealiable.
- Although staff were aware of the overall trust strategy and vision there was no credible statement of vision and guiding values specific to Hannah House.
- We were provided with some evidence of engagement with the public and staff, such as visits to the unit by executive and non-executive directors. However staff reported feeling disconnected from the rest of the trust and felt there was no platform for them to develop service improvement.

However:

- Staff reported good support from their line manager.

Detailed findings

Leadership of this service

- The service manager had responsibility for children's community nursing services at the trust. The home manager and deputy home manager, managed the team of 22 nurses and senior healthcare support workers at Hannah House.
- There were clear management structures however the home manager and deputy manager were on long term sick and the clinical service manager role had been vacant since December 2016. This vacancy had been recruited to but was not in post.
- The lack of leadership had affected staff morale and some areas, for example, information sharing via team meetings and staff appraisals had been impacted.
- To mitigate a team leader from the children's continuing care team had been brought in as interim manager. Staff reported it had been a challenging time however things were 'getting done' with a manager in place.
- Staff felt well supported by their current line manager. Staff reported they were approachable that they were able to share concerns.
- Management and leadership development programmes and training were in place to support and develop staff in these roles.
- Staff told us that they were aware of who the executive team in the organisation were, and how to contact them; however they did report feeling disconnected from the rest of the trust.

Service vision and strategy

- Following the previous inspection of the trust in 2014 the quality improvement plan identified that a 0-19 service strategy needed to be developed. Original deadlines for this had not been met due to re-tendering of the Healthy Child pathway.
- Looking forwards, managers anticipated ongoing demand and utilisation of the transition bed. The focus on the personalisation agenda would also impact how families of children and young people used their individual budgets. The NHS plan (2014) identified the need for patients to have greater control over their own care and treatment, including the option of shared health and social care budgets. This meant services would have to be more flexible and support disabled children and young people to participate more with the local community.

Inadequate

Are services well-led?

- The trust's vision and values were based on 'our 11' these comprised of one vison which was providing the best possible care to each community the trust served; three values and seven behaviours such as leading by example.
- These had been embedded at recruitment and staff appraisal to review how individuals demonstrated the trust behaviours and vision.
- Staff we spoke to were aware of the trust's vision and values and information was displayed at Hannah House.

Governance, risk management and quality measurement

- There were clear lines of accountability within the management structure, however from our discussions with staff we were not assured that the systems in place for sharing information, monitoring and identifying risks were effective.
- We reviewed performance, leadership and governance meeting minutes, which were brief. We did not see evidence staff reviewed and discussed risks regularly at team meetings. We lacked assurance over learning from incidents and complaints, staff were unable to provide any examples of feedback.
- Hannah House placed any risks on the children's business unit and corporate risk register in line with trust policy. There was one risk specific to Hannah House which related to the cleaning resource. We were not assured that there were processes in place to identify and escalate risks within the service. Staffing in particular was not included on the risk register. We saw a risk assessment that had been undertaken in 2015 when four staff were on long term sick. The sickness position at the time of inspection was worse than this yet no action plans had been put in place, it was being managed at a local level.
- As a response to the concerns raised at the announced inspection, an action plan was developed. This had ownership at band six level with appropriate support by the quality lead and clinical lead for the Children's Business Unit. They reported directly to the executive director of nursing providing assurance that concerns had been recognised at a senior level.
- Following the inspection we had a discussion with the senior management team over our concerns in relation to management of medicines. As a result of this a comprehensive action plan was developed. Whilst this was positive we were not assured the concerns would have been identified and acting upon without our intervention.

Culture within this service

- Staff worked well together. We heard positive examples of how staff were very supportive of each other. They reported how they had 'pulled together' in response to the staffing shortages. However staff morale was low in some staff we spoke with due to the pressures and gaps in leadership.
- Many staff also felt the service could be doing more to make stays at Hannah House more enjoyable for children.
- Staff spoke with passion about their work and were proud of what they did. Staff knew about the organisation's commitment to the community and the values of the organisation.
- We asked about support for staff when a child stopped attending Hannah House after a long period of going or if a child passed away. Staff reported counselling could be accessed via occupational health and support was given by peers.

Public engagement

- There was some engagement with the public. We were told that the trust had reached the gold standard for involvement in relation to engaging and involving parents. There had been parties in the summer and at Christmas where parents were invited to Hannah House.
- Although staff did meet with parents this generally was instigated by parents coming to Hannah House and not all parents did this. Most staff mentioned they felt more structured processes were needed to be in place to have regular updates from parents.
- Some parents mentioned they would like more opportunities to meet other parents who had children with complex health needs.

Staff engagement

- There was no service specific data from the 2016 NHS staff survey in relation to staff engagement. However the overall score remained slightly below the national average.
- Staff had lots of ideas to improve the service but did not feel they would be implemented, and there was no platform to put their ideas forward.

Inadequate

Are services well-led?

Innovation, improvement and sustainability

- The development of Hannah House as a clinical hub has enabled additional services to be offered which have benefited children and young people and their families. For example home visits to resolve problems with feeding tubes.

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 12 (1) Care and treatment must be provided in a safe way for service users; (2) (g) the safe management of medicines. **How the regulation was not being met:** Care and treatment was not provided in a safe way for patients, as medicines were not managed in a safe and proper manner.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Nursing care Treatment of disease, disorder or injury 17 (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 17 2 (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. 17 2 (e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of regulated activity, for the purpose of continually evaluating and improving such services.

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

The provider did not ensure systems or processes were established and operated effectively to ensure compliance with the regulation.

The provider did not have governance systems in place that were of a sufficient quality to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

The provider did not act on feedback from relevant persons and other persons on the services provided in the carrying on of regulated activity, for the purpose of continually evaluating and improving such services.