Leeds Community Healthcare NHS Trust

Quality Report

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Date of inspection visit: 31 January - 2 February 2017
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Core services inspected	CQC registered location	CQC location ID
Community Health Services for Adults	Trust Headquarters	RY6X6
Community Health Inpatient Services	South Leeds Independence Centre (SLIC) Community Independent Care Unit (CICU) Community Neurological Rehabilitation Centre (CNRC)	RY686 RY6X2
Community health services for children, young people and families	Hannah House	RY6X3
Sexual Health Services	Trust Headquarters	RY6X6
Community Child and Adolescent Mental Health Wards	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	Good 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

Summary of findings

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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.

Letter from the Chief Inspector of Hospitals

We last inspected this trust in May 2014 and we rated the provider as 'requires improvement' overall. In reaching our judgement, we told the trust that they must make improvements to: staffing levels, quality of records particularly risk assessments, management of falls, planning and delivery of care, clinical supervision, governance and risk management processes and risks associated with unsafe or unsuitable premises.

We carried out an announced follow-up inspection of this trust between 31 January – 2 February 2017 and an unannounced inspection on 15 February 2017 to make sure improvements had been made. As part of the inspection, we assessed the leadership and governance arrangements at the trust and inspected the core services that required improvement at the last inspection. We inspected sexual health services, which had not been included at the last inspection, and because we had received a whistle blowing concern. We also included an inspection of Hannah House, part of the community services for children, young people and families because we had received concerns regarding medicines management. We inspected the following services:

- Community health services for adults;
- Community services for children, young people and families (Hannah House)
- Community inpatient services;
- Sexual Health Services
- Child and Adolescent Mental Health Wards (Little Woodhouse Hall)

Whilst a number of individual services were judged good, Hannah House was rated as requires improvement, community child, adolescent mental health services (Little Woodhouse Hall) was rated as requires improvement and sexual health was also rated as requires improvement.

We have rated Hannah House at location level and not as part of the overall provider because we did not inspect the whole of the community children, young people, and families' service.

The overall rating for the provider is good.

Our key findings were as follows:

- In most areas, medicines were managed appropriately however; arrangements for the safe handling of medicines at Hannah House were not consistent showing omissions in recording.
- There were high levels of staff sickness at Hannah House, which was affecting areas of the service to run effectively such as cancellation of short breaks. However safe levels of staffing were maintained.
- Not all staff were clear about the level of safeguarding training undertaken or required particularly staff working with children.
- Staff could access mandatory training however not, all staff at Little Woodhouse Hall were trained in restraint, and on some shifts there were not enough trained staff to carry out restraint if needed.
- Not all services had consistent methods for monitoring environmental safety checks.
- There remained some issues regarding the suitability of premises at Little Woodhouse, although the trust had mitigated a number of risks, not all of the actions were complete.
- There was a lack of assurance and evidence of staff competence about specific skills needed to care for children and young people at Hannah House due to the lack of recording in competency assessments. Processes to ensure staff working at Little Woodhouse Hall to receive training specific to Child and Adolescent Mental Health services prior to starting work on the unit also required improvement.
- Governance and assurance processes were in place to measure quality however; these arrangements were not as effective at Hannah House or in child and adolescent mental health inpatient services. As a response to the concerns raised at the announced inspection, an action plan was developed. This had ownership at senior staff levels with appropriate

Summary of findings

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.
- There were some inconsistencies in the approach and systems to meet the Fit and Proper Person requirements.
- There was good staff engagement particularly in adult and inpatient services however staff engagement was variable with morale being lower at Hannah House and Little Woodhouse Hall where there was a feeling of disconnect from the rest of the trust.
- The trust had a good incident reporting culture in most areas, and there was evidence of improvements following incidents, but systems for sharing information in some services was not as strong.
- There were processes to ensure good and effective infection prevention and control.
- Across community, services staffing levels and skill mix were suitable for staff to provide the necessary support to patients. Recruitment was continuing and additional funding for staffing agreed.
- 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. Services promoted independence and supporting patients to move to self-care.
- Patients were able to access the right care at the right time. Services met the individual needs of patients and took into account patient preferences. There were some good examples of where staff met the needs of vulnerable people.
- There was a stable leadership, which appeared cohesive and worked collectively. The leadership were aware of the challenges to provide a good quality service and identify the actions needed to address these.

We saw several areas of outstanding practice including:

- The speech and language therapy team had developed an award-winning choir, which helped patients in their speech and language skills and provided social opportunities.
- Senior therapists saw musculoskeletal (MSK) and rehabilitation patients at the initial assessment. The MSK service in Leeds was trialling alternative models of care both to support increasing demand and support capacity in Primary Care.
- There was a project to improve patient flow. This involved looking at patient pathways and journeys through the inpatient unit and identifying any delays and 'blockages' in the current system which could reduce patient's length of stay and improve patient flow.

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

Importantly, the provider must:

- Ensure that processes are in place for the safe handling of medicines at Hannah House.
- Ensure that staff receive appropriate training and development of their competencies, skills and experience at Hannah House.
- Ensure bank and agency staff working in child and adolescent mental health are trained in the use of restraint.
- Ensure staff working in child and adolescent mental health receive specialist training in working with young people, in line with quality standards for this type of service.
- Ensure that governance processes and quality measures are strengthened at Hannah House and the child and adolescent mental health ward.
- Develop a seclusion policy for young people in crisis.
- Ensure that all staff are trained in the appropriate level of safeguarding children and adults for their service.

Community Health Services for Adults

- Ensure systems are consistent to monitor environmental issues in community clinics.

Community Inpatient Services

- Replace the patient call system and the falls sensor system at SLIC.
- Introduce audits to assure the quality of patient records.
- Continue to review systems to improve response rates for patient feedback.
- Improve patient participation in self-medication at CICU and SLIC.

Summary of findings

- Consider improving the variety of food and timings of meals at SLIC.
- Ensure processes are consistent to complete mental capacity assessments for patients who require these.
- Continue to address the recommendations in the Legionella Risk Assessment.

Sexual Health Services

- Ensure daily checks of the emergency oxygen bag and areas in the management of medicines.
- Continue to address the provision of clinical supervision for staff in sexual health services.
- Ensure key performance indicators are improved to avoid long waiting times in clinics.
- Consider communicating waiting times in clinics.

Hannah House

- Ensure processes are in place for environmental safety checks.
- 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.

Trust-wide

- Review systems to ensure consistency in meeting the Fit and Proper Person requirements.
- Ensure consistency in recording risks on the risk register in all services.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Carole Panteli, Director of Nursing

Team Leader: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: including: children's services nurse, mental health nurse, and psychologist (both with experience of child and adolescent inpatient mental health services), district nurses, sexual health nurse, community matron, physiotherapists, governance lead, safeguarding specialist, pharmacist and an expert by experience a person who had used a service or a carer of someone using a service.

Why we carried out this inspection

We previously inspected Leeds Community Healthcare NHS Trust in November 2014 and overall, the trust was rated as requires improvement. We judged the provider to be requires improvement for safe, and responsive and good for effective, caring, and well led. In addition, an inspection of Little Woodhouse Hall was conducted for child and adolescent mental health wards for the safe domain on 9 June 2016. This was given a rating of requires improvement. An inspection of specialist community mental health services for children and young people was also conducted at trust headquarters on 16 June 2016 for safe and responsive domains. Each domain received a rating of good, which reflected the overall rating awarded.

The inspection in January 2017 was a follow up inspection to the comprehensive inspection in November 2014. This inspection was focussed and considered those areas that required improvement. We also inspected sexual health services, which had not been included at the last inspection, and because we had received a whistle blowing concern. We also included an inspection of Hannah House, part of the community services for children, young people and families because we had received concerns regarding medicines management. However, this service has been rated at location level and not as part of the overall provider because we did not inspect the whole of the community children, young people, and families' service.

How we carried out this inspection

We carried out an announced follow-up inspection of this trust between 31 January – 2 February 2017 and an unannounced inspection on 15 February 2017. At this inspection, we assessed the leadership and governance arrangements at the trust and inspected the core services that required improvement at the 2014 inspection. We also included sexual health services at this inspection.

- Community health services for adults;
- Community services for children, young people and families (Hannah House only)
- Community inpatient services
- Sexual Health Services
- Child and Adolescent Mental Health Ward

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:

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

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew. We held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use

Summary of findings

services. We observed how 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 met with people who use services and carers, who shared their views and experiences of the core service.

Information about the provider

Leeds Community Healthcare NHS Trust was established in 2011 and currently employs over 3,000 staff. The trust has ten locations registered with CQC, five of which were previously managed by another provider. The trust serves a population of 850,000 people and staff are based at health centres and community sites across the Leeds area, from Wetherby in the north to Ardsley in the south and from Kippax in the east to Guiseley in the west. The trust's turnover for 2015/16 was £156m from which an adjusted surplus of £3.0m or 1.9% was achieved, retained by the trust for future capital investment.

Leeds Community Healthcare NHS Trust provides the following services:

- Child and adolescent mental health wards
- Community dental services
- Community health inpatient services
- Community health services for adults
- Community health services for children, young people and families
- Sexual Health services
- Community-based mental health services for adults of working age.
- Primary Medical Services

What people who use the provider's services say

Overall, people were very positive about the care and treatment provided by Leeds Community Healthcare NHS Trust. NHS Friends and Family test results trust wide demonstrated that 97% of respondents in September 2016 would recommend the trust's services to their friends and families.

Good practice

- The speech and language therapy team had developed an award-winning choir, which helped patients in their speech and language skills and provide social opportunities.
- Senior therapists saw musculoskeletal (MSK) and rehabilitation patients at the initial assessment. The MSK service in Leeds was trialling alternative models of care both to support increasing demand and support capacity in Primary Care.
- There was a project to improve patient flow. This involved looking at patient pathways and journeys through the inpatient unit, identifying any delays and 'blockages' in the current system which could reduce patient's length of stay and improve patient flow.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Ensure that processes are in place for the safe handling of medicines at Hannah House.

Summary of findings

- Ensure that staff receive appropriate training and development of their competencies, skills and experience at Hannah House.
- Ensure bank and agency staff working in child and adolescent mental health are trained in the use of restraint.
- Ensure staff working in child and adolescent mental health receive specialist training in working with young people, in line with quality standards for this type of service.
- Ensure that governance processes and quality measures are strengthened at Hannah House and the child and adolescent mental health ward.
- Develop a seclusion policy for young people in crisis.
- Ensure that all staff are trained in the appropriate level of safeguarding children and adults for their service.

Action the provider SHOULD take to improve

Community Health Services for Adults

- Ensure systems are consistent to monitor environmental issues in community clinics.

Community Inpatient Services

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- Introduce audits to assure the quality of patient records.
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- Improve patient participation in self-medication at CICU and SLIC.
- Consider improving the variety of food and timings of meals at SLIC.
- Ensure processes are consistent to complete mental capacity assessments for patients who require these.
- Continue to address the recommendations in the Legionella Risk Assessment.

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- Ensure daily checks of the emergency oxygen bag.
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Hannah House

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- 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 by reviewing the reasons for cancellations.

Trust-wide

- Review approach and systems to ensure consistency in meeting the Fit and Proper Person requirements.
- Ensure consistency in recording risks on the risk register in all services.

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 rated safe as requires improvement because:

- Following the last inspection there had been a requirement of having an effective system for recording safeguarding supervision. This was apparent in most areas. However not all staff were clear about the level of safeguarding training undertaken or required particularly staff working with children.
- Staff could access mandatory training however not, all bank and agency staff at Little Woodhouse Hall were trained in restraint. On some shifts there were not enough trained staff to carry out restraint if needed.
- Not all services had consistent methods for monitoring environmental safety checks such as ensuring water temperatures were checked and weekly running of taps to prevent legionella.
- There remained some issues regarding the suitability of premises at Little Woodhouse, although the trust had mitigated a number of risks, not all actions identified in their plans were complete.
- In most services, medicines were managed appropriately. Arrangements for the safe handling of medicines at Hannah House were not consistent and omissions were noted in recording and storage.
- There were high levels of staff sickness at Hannah House, which was affecting areas of the service such as the cancellation of short breaks.

However

- Across community, services staffing levels and skill mix were suitable for staff to provide the necessary support to patients. Recruitment was continuing and additional funding for staffing agreed. Agency staff spend was monitored.
- Cleanliness and infection prevention measures were good.
- The trust had a good incident reporting culture, and there was evidence of improvements following incidents, but systems for sharing information in some areas was not as effective.
- Record keeping was of a good quality. Patient risk assessments particularly for child and adolescent mental health inpatients were completed appropriately.

Requires improvement

Are services safe?

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Our findings

Duty of candour

- There was an appropriate trust policy for duty of candour (DoC). The incident and complaint processes included provision to ensure that DoC requirements were met.
- We looked at ten serious incident investigation reports. The trust Root Cause (RCA) Analysis investigation proformas included a section recording whether DoC was applicable and whether an apology had been given. The RCA proforma included in its recommendations to 'ensure that staff were familiar with duty of candour guidance'.
- Staff had an understanding of the duty of candour. Managers we spoke with were aware of the duty of candour regulations and being open and honest with patients.

Safeguarding

- The safeguarding team sat with the Quality and Professional Development Unit under the Director of Nursing who was the executive board member responsible for safeguarding.
- The Safeguarding Committee, a sub-committee of the Quality Committee met bi-monthly to drive and oversee the safeguarding agenda.
- There were three safeguarding operational groups and outcomes from these groups were shared with Leeds South and East Clinical Commissioning Group through the Children's and Adults advisory groups, Leeds Safeguarding Children's Board (LSCB) and Leeds Safeguarding Adults Board (LSAB).
- There was a Safeguarding Strategy 2016-2019. This set out a range of safeguarding activities and was built around the Care Quality Commission Fundamental Standards 2015. The strategy had six work streams and associated objectives, which were delivered through a safeguarding annual work plan.
- The trust submitted no serious case reviews which they had developed action plans for in the last 12 months. The trust has advised however, they were currently engaged in a serious case review, which was initiated within the timeframe of the request for information (9 February 2016).
- There have been 150 restraint incidents reported between 1 December 2015 and 30 November 2016 effecting 20 different service users, all were attributed to child and adolescent mental health wards. One of the restraints resulted in the use of rapid tranquilisation.
- At the inspection in 2014, we required the trust to ensure they had an effective system to record safeguarding supervision. Records showed safeguarding supervision was a standing agenda item at the team brief, performance, and governance monthly meeting.
- Staff reported having group safeguarding supervision on a quarterly basis. However, 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 indicated that a system was in place and recommendations to improve supervision from the last inspection had been actioned.
- Staff were not always clear of the level of safeguarding training they had or were required to undertake. Data for the trust showed adults safeguarding compliance was 96% and children's safeguarding was 95%. This met the trust target of 90%.
- 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 should have level three safeguarding training.
- At the unannounced inspection an action plan had been commenced which showed all qualified staff were required to attend level three safeguarding training.
- In the child and adolescent mental health wards the process for staff to report safeguarding alerts was unclear. Staff and senior leaders were not aware of which Local Authority to report concerns. The trust agreed that the guidance was unclear and that there had been an over reliance on the social worker within the service to report all incidents.

Medicines

- The trust medicines strategy set out the themes for the next three years detailing the key strategic priorities into the core areas of workforce development, governance, and digitalisation. The medicines management team produced a quarterly dashboard giving a brief overview of safe and effective use of medicines, business work streams and the wider health economy.

Requires improvement

Are services safe?

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- The medicines management team produced bulletins which shared information and learning across the organisation
- The trusts medicine policies were available through the trusts intranet page and regularly reviewed. The medicines governance team received and reviewed the monthly fridge temperature sheets for the medicines fridges within the trust. This had led to flow charts to assist staff with documentation.
- New staff received medicines management training and bespoke training was offered in response to incidents for existing staff. For the neighbourhood teams pharmacy technicians provided support for all staff looking specifically at medicines and competencies.
- There was an audit programme to ensure audits were completed. These were completed on a local level and reviewed by the medicines team; if areas of concern were identified a member of the team would contact the service and work with staff to drive forward improvement. Medicines code assurance checks were completed routinely and audits in missed doses had been completed on the inpatient units.
- The trust used Patient Group Directions (PGDs). PGDs are written instructions, which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. The medical director signed off PGDs. There was a system through the Quality Committee to ensure PGDs were in date and reviewed appropriately.
- The trust had appointed a Medicines Safety Officer (MSO). The MSO was part of the local network and produced reports detailing medicines incidents, which were fed into the appropriate governance groups. A member of the team reviewed individual incidents and after review, findings were reported directly to the investigator.
- There were education sessions in response to risks identified through incidents. Reports were produced for the local controlled drugs intelligence network.
- 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. No actions were in place as part of the review and no follow up review was documented. We identified the same themes during our inspection and brought this to the attention of the management team so action could be taken.
- Following the 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. For example, developing a standard operating policy for checking expiry dates this included reconstituted medications.

Environment and Equipment

- At the inspection in June 2016 there were risks identified with the environment at the child and adolescent mental health ward. The trust had undertaken work on the unit to remove and mitigate some ligature risks. Risk assessments and monthly environmental risk meetings took place. However, we saw that a number of actions on the trust's action plan remained outstanding.
- It was a challenge for the trust to achieve an entirely safe physical environment at Little Woodhouse Hall due to its listed status. This was identified on the trust risk register. The trust was progressing to identify an alternative site. The issues had been flagged to NHS England and a pre-planning application lodged with Leeds City Council.
- During the inspection in June 2016, of Little Woodhouse Hall the trust was not compliant with eliminating same sex accommodation guidance written by the Department of Health, which gives clear guidance on providing accommodation within a hospital setting for mixed-genders. We saw at this inspection, the trust had made changes and was now compliant with this guidance.
- At the South Leeds Independence Centre, the call bell system used was not fit for purpose. Because the falls sensors can break when they are moved, they do not always sound. Since this was identified as an issue the trust have put additional safeguards and regular checks in place to ensure patient safety whilst they look to introduce an alternative system.

Incidents

- Safety incidents were analysed from three sources: incidents reported by the trust to the National Reporting and Learning system (NRLS) and to the Strategic Executive Information System (STEIS) and serious incidents reported by staff to the trust's own incident

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reporting system (SIRI). These three sources were not directly comparable because they used different definitions of severity and type and not all incidents were reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents, or security incidents.

- Overall, incident reporting at the trust was good. The trust was benchmarked in the top 25% of reporters with 91% of incidents categorised with a severity of 'no' or 'low' harm. The NRLS considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture.
- There were delays in reporting incidents above other similar NHS community healthcare organisations with the trust taking an average of 34 days to report 50% of incidents compared to 26 days nationally.
- All major harm, deaths and serious incidents were uploaded to NRLS immediately. These were re-uploaded on closure of the incident to ensure any changes in information and investigation details were captured. All other incidents were uploaded once the incident had been investigated and closed. The trust carried out an additional review each month to capture any outliers.
- The trust data quality response from NRLS was positive showing the trust was achieving the best practice criteria in most areas. The trust was continuing to work on improving this area.
- The top two NRLS incident category were 'implementation of care and ongoing monitoring/ review' (23%) which included incidents such as pressure ulcers, 19% (867) related to 'patient accident', which included patient fall incidents.
- The trust reported a higher percentage of incidents categorised as 'patient accident', 'medication', and 'documentation' when compared to similar organisations between 1 October 2015 and 31 March 2016. However, they reported a lower percentage of incidents categorised as 'implementation of care and ongoing monitoring/review' during this period.
- The trust reported 95 serious incidents between 1 December 2015 and 30 November 2016. None of these were never events, 90% were 'pressure ulcer meeting SI criteria' within community adults. Five more incidents were reported to STEIS than were reported through the trusts internal system as serious incidents requiring investigation. The discrepancy of five incidents related to community adults four of which were pressure ulcers and one being a delay in treatment.
- The trust report to have robust systems and processes to monitor, learn, and disseminate learning with a report submitted to the Clinical Commissioning Group highlighting learning. The trust also identified the need to embed lessons learnt as a risk in the board assurance framework however; this has been rated as 'reasonable' in severity.
- Six of the seven staff survey questions relating to safety were worse than the national average with one scoring similar to other community trusts. In particular, staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months was 10% higher than the national average and 7% higher than the trusts score in 2014. Other questions which were worse than the England average included staff witnessing potentially harmful errors, near misses or incidents; reporting errors, near misses or incidents witnessed in the last month; staff confidence and security in reporting unsafe clinical practice; experiencing harassment, bullying or abuse from staff; and experiencing physical violence from patients, relatives or the public.
- The NHS Safety Thermometer measures a monthly snapshot of areas of harm including falls and pressure ulcers. The trust reported 321 new pressure ulcers between October 2015 and October 2016. November 2015 reported the highest number with 38, prevalence rate of 3.4%. One-hundred and eight falls with harm were reported during this period with the highest monthly number of falls with harm reported in October 2015 with 14 (1.01%). Eleven catheter and new UTI cases were reported and August 2016 reported the highest number of cases with three (0.27%).

Staffing

- The trust had 2,575.9 substantive staff with a 2% turnover, 5.8% vacancy rate and between 5.43 to 6.33% sickness (as at 31 October 2016). In addition, the trust has a 5% vacancy rate for qualified nurses and 8% for nurses' assistants.
- Community health inpatient services had the highest vacancy rate for qualified nurses between 1 November 2015 and 31 October 2016 with 31%, which amounted to

Requires improvement

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13.58 WTE vacancies. This core service also had a nursing assistant vacancy rate above the trust average of 8% with 20%, which amounted to 6.26 WTE vacancies.

- Sexual health services had the highest nursing assistant vacancy rate with 41% but were over staffed by 9% (2 WTE posts) for qualified nurses.
- Child and adolescent mental health wards had vacancy rates higher than the trust average for both qualified nurses and nursing assistants with 16% and 27% respectively.
- The trust risk register contained a risk related to the high turnover of staff within neighbourhood teams. There was a risk of not having enough staff capacity to meet the demands on the service.
- The trusts sickness rates showed an improving downward trend between 1 November 2015 and 31 October to 6% in the final month in the period.
- The trust risk register contained a risk related to current high levels of staff sickness absence across the trust, resulting on greater reliance on agency cover and a risk of remaining staff being under pressure to manage an additional workload.
- Staff fill rates compare the proportion of planned hours worked by staff (Nursing, Midwifery and Care Staff) to actual hours worked by staff (day and night). This is to monitor and in turn ensure staffing levels for patient safety. Because there is no specific standard or guidance for community services, the trust reviewed and monitored safe staffing levels for inpatient settings and community services.
- The trust was guided by the principles set out by the National Quality Board and the Director of Nursing reported this bi-annually to the Board. In November 2016, CICU was operating below the lower fill rates for day and night support staff whilst also being below the 90% threshold for registered nurses covering nights.
- Another ward CNRU operated above planned nursing hours during the day by almost 1.5 times (142.5%) whilst they were slightly below the 90% threshold for support staff on night shifts.
- The same wards (CNRU and CICU) fell below the 90% of shifts filled for support staff in October 2016 with CICU reporting that only 48.4% of planned shifts were filled during the month. The trust risk register/BAF dated 30 November 2016, included four risks relating to staffing.
- The trust was operating within its financial 'cap' for agency expenditure on a year to date basis.

Mandatory Training

- As at 1 December 2016, the trust wide mandatory training compliance figure was around 85% against the trust target of 90%. Whilst all relevant core services achieved over 75% overall, there were pockets of low compliance mainly in the sexual health core service where four of the eleven courses had a compliance rate below the 75% threshold used by CQC as a benchmark. These were relating to moving and handling (63%), CPR (65%), infection control (67%) and fire safety (70%).
- Around 87% of non-medical staff were appraised in the last 12 months (as at 1 December 2016) against the trust's target of 90%. Of the 22 applicable medical staff, 100% had been revalidated during the same period.
- Dementia training was offered as a standalone course and was being considered for inclusion for mandatory training in 2017.

Assessing and Responding to Patient Risk

- In community adult services, patients received a holistic health needs assessment/care plan at their first contact with trust staff. Staff were clear about the process of dealing with a patient whose condition had deteriorated. There was a procedure for escalation.
- In child and adolescent mental health wards records showed in the twelve months prior to inspection, staff had used restraint on 150 occasions; this had reduced to 10 occasions in October to December 2016.
- At the last inspection, there were concerns that risk assessments were not completed. At this inspection, we found that the child and adolescent mental health ward used the Risk Assessment and Risk Management Guideline for Clinicians Assessing Child and Adolescent Mental Health Service patients. Staff completed risk assessments with every young person within 24 hours of admission. Following incidents the multi-disciplinary teams used formulation meetings to reflect on what had happened, why and what changes could be made to prevent or mange an incident more effectively. Young people and sometimes their carers were involved in this process.
- There was a 'Falls Clinical Steering Group', which aimed to enhance shared learning and development from falls incidents to reduce recurrence.

Requires improvement

Are services safe?

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- The October 2016 performance report showed there was a target to reduce falls for inpatient beds by 10% for 2016/2017 compared with 2015/16. The inpatient services were on target to achieve this.
- Inpatient services used the national early warning score (NEWS) to recognise deteriorating patients. NEWS charts showed scores were correctly calculated. The escalation process was documented on charts. Venous thromboembolism (VTE) risk assessments were completed.

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 rated effective as good because:

- At the last inspection, the trust was asked to improve its plans and overall approach to audit, including how it collected and reported patient outcomes in community services. At this inspection, we found improvement in these areas. There was an audit programme and processes to strengthen systems and ensure support for services with audit. Services and the Trust Board measured and monitored patient outcomes.
- There had been improvement in clinical supervision rates in most areas with the implementation of a service specific supervision model. Some further work was required in sexual health services.
- National guidelines were used to treat patients and care pathways were followed. Policies, procedures, assessment tools, and pathways followed recognisable and approved guidelines.
- Multidisciplinary teams worked well together.

However

- There were concerns identified at Hannah House regarding the process for ensuring staff were identified as competent to carry out their role. At the unannounced inspection, the trust had developed an action plan to address this area.
- Not all patient records showed that all community inpatients with a diagnosis of significant dementia had received a mental capacity assessment.

Our findings

Evidence based care and treatment

- There were improvements in the trust's overall approach to audit compared to the last inspection. There was a clinical audit strategy and an annual clinical audit programme. Clinical audit was managed at service level with the support of the quality and professional development directorate.
- At the last inspection, the trust was asked to review how it collected and reported patient outcomes in community services. Outcomes measures were reported through a dashboard. The Quality Committee received reports on progress with development of reporting and improvements in outcomes.
- Three of the seven clinical audits had key findings and trust actions highlighted. Two of the audits related to sexual health services, two for community inpatients, two were children, young people and family services and one related to child and adolescent health wards
- Samples of guidelines inspected were approved by the Clinical and Corporate Policies Group, ratified by the Quality Committee and were in date.

Patient outcomes

- There had been an increase in end of life care patients achieving their wish to die at home. The data for the previous year was 86% against an agreed target with commissioners of 90%.
- Data for the sexual health service for the percentage diagnosed with chlamydia for all ages showed the trust was 9.8% in quarter one and 8.1% in quarter two 2016/2017 against a target of 9% to 11%.
- Data for the provider to promote the benefits of long-acting reversible contraception (LARC) showed sexual health services had achieved 41% against a target of 16%.
- Staff used recognised clinical outcome measures such as the health of the nation outcome scale for child and adolescent mental health, and the children's global assessment scale to record patient outcomes within two weeks of admission.
- Patient outcomes were good for inpatient services. Data provided showed that a higher proportion of patients returned home compared to other community intermediate care (CIC) beds nationally.
- For CICU and SLIC the majority of patients were discharged home rather than into long term care and at CNRC, patient outcome measures were benchmarked against other services providing similar support to patients.

Competent staff

- The trust's compliance rate as at 1 December 2016 for the number of staff who had an appraisal was 87.6%. Of the core services inspected, 85% of staff had an appraisal within the last 12 months. Sexual health had the lowest appraisal compliance rate with 77.8%.

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.

- The trust advised that as at 1 December 2016 100% of their 22 medical staff within the core services inspected had been revalidated.
- There were concerns identified at Hannah House regarding the process for ensuring staff were identified as competent to carry out their role. For example, three competency records we looked at were incomplete. The records were for staff who had worked at Hannah House for over 12 months. For example in one record, 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. A member of staff who had been employed since November 2016 did not have a booklet, and was carrying out some of the skills listed within it.
- The Quality Challenge Improvement Plan from May 2016 had a deadline for competency assessments to be completed by the end of January 2017 however, this target was not met. At the unannounced inspection, the trust had developed an action plan which included staff competencies. A database was being developed to log individual competencies with a completion date of the end of February 2017.
- At the last inspection, action was requested to improve clinical supervision. At this inspection staff working in the child and adolescent mental health ward received regular clinical supervision in relation to their professional practice as well as supervision with a manager or senior staff member. Staff also accessed supervision from a group analyst external to the service.
- Supervision varied per staff group. Between 1 December 2015 and 1 December 2016, the clinical supervision rate for additional clinical services staff was an average of 64% (which was slightly below the trust target of 65%). In the same time, supervision of registered staff was 80%.
- Staff in community adult services received a structured induction and worked four weeks supernumerary whereby they attended meetings and shadowed other staff. Staff said they felt supported and had a better understanding of their role. Staff received regular clinical supervision.

Multidisciplinary working

- Multidisciplinary teamwork was well established and focused on the best outcomes for patients and their families. Staff across all disciplines worked well together for the benefit of patients.
- In the community inpatient service, staff demonstrated good internal multidisciplinary working across all three locations and demonstrated a wider team knowledge, which enabled them to refer patients in a timely manner.
- In the community adult's service, staff reported good access to other services and worked collectively to discuss and meet the needs of service users. Staff liaised closely with each other and we saw discussions of patient information, progress and care planning.
- The palliative care lead was very positive about the relationship with all the local hospitals and hospices. Care planning meetings and discharge information was co-ordinated quickly to meet the needs of patients, their families and the wider care team.
- Staff at Hannah House reported good links with their colleagues in the community nursing teams and GP's. There was close working with the paediatric intensive care unit at the local NHS hospital for children accessing the transition bed.
- The child and adolescent mental health unit had weekly multidisciplinary meetings where staff discussed each patient. These reviews included the unit social worker who facilitated communication between health and social care agencies. Staff gave young people the opportunity to request leave away from the unit at these meetings, and were provided with a written response.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- As at 1 December 2016, the overall compliance rate for Mental Capacity Act (MCA) training across the trust was 89%. The renewal timeframe for this training course was every three years and was mandatory for staff.
- All core services achieved over 75% compliance with MCA training and only community inpatients had a compliance rate below 85%.
- The trust told us in their information return for child and adolescent mental health service wards that they submitted no Deprivation of Liberty Safeguards (DoLS) applications from 1 December 2015 and 30 November 2016. For community in-patients 37 DoLS were submitted between 1 August and 30 November 2016.
- There was one Mental Health Act reviewer visit between 1 January 2016 and 4 January 2017, which was unannounced. From the visit there were six issues found at Little Woodhouse Hall. The highest category for

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issues was 'protecting patients' rights and autonomy with three issues, care support and treatment in hospitals followed with two issues and leaving hospital one issue.

- Staff were aware of the need to make specific decisions with young people in line with assessments of Gillick competence. In the child and adolescent mental health ward we observed staff discussed this at multi-disciplinary team meetings where all young peoples' ability for informed consent was discussed weekly, as well as during the admission process. Staff received training in Gillick competence as part of their Mental Health Act training.
- Mental Capacity Act was one of the prompts on the handover sheets incorporated into the new documentation on adult inpatient wards. Nursing staff carried out capacity assessments. On CICU, there was a spreadsheet showing which patients did not have capacity; this was followed up every week with Leeds City Council. However, on CICU three out of eight (37%) sets of patient records showed patients with a diagnosis of significant dementia had not received a mental capacity assessment.
- There were improvements in the completion of do not attempt cardiopulmonary resuscitation (DNACPR) forms. Discussions around DNACPR were clearly documented in the patient's records.

Good

Are services caring?

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

Summary of findings

We rated as caring as good because:

- Caring and compassionate staff delivered care and treatment. Staff at all grades treated patients with dignity and respect.
- Patients were positive about their interactions with staff. Staff took steps to ensure that patients' dignity and privacy were maintained.
- Patients and those close to them were involved in decisions about their care and treatment.
- Patients were encouraged and supported to manage their own care to develop and maintain their independence. Patients felt supported both physically and emotionally.

Our findings

Compassionate care

- The trust scored better than the England average for recommending the trust as a place to receive care for three of the five months where data was available between April and September 2016 (base sizes were small in some areas).
- The response rate varied over the six month period however the trust reported its highest response rate of 8.9% in the most recent month of September 2016 (5.5% above England average) with 97% of people recommending the trust as a place to receive care and treatment (2% better than the England average).
- The percentage of staff who would recommend the trust as a place to receive care was similar to the England average at 78% (-2 percentage points). The percentage of staff who would not recommend the trust as a place to receive care was similar to England average at 7% (+1 percentage point) however; response rates were much higher for the trust than the England average.
- The integrated sexual health service had a key performance indicator for the percentage of service user feedback on surveys that rated satisfaction as good or excellent. The target was 90% and the service achieved this target in quarter one but were slightly below the target in quarter two at 89.7%.
- PLACE scores for privacy, dignity, and wellbeing at the trust were similar to the England community trust average of 83%.

Understanding and involvement of patients and those close to them

- Patients in all services said they were fully informed about their treatment and were provided with choices about their care and ongoing health needs where appropriate.
- Parents and carers said they called several times a day for an update whilst their child was at Hannah House and fell reassured by the information given.
- Patients accessing community adult services were consulted in their future care plans, involved in their care assessments, and planning. We observed this happened with patients who were at the end of life, patients who had newly accessed the service and for patients visiting the physiotherapy service.

Emotional support

- Meeting people's emotional needs was recognised as important by staff of all grades and disciplines. Staff were sensitive and compassionate in supporting patients and those close to them.
- We heard specialist nurses and community nurses speak of the importance of assessing people's emotional needs as a matter of routine when visiting them at home.
- We saw emotional support being offered to an end of life patient and their relative. Staff took time to listen to relatives anxieties and understood the need to discuss their emotions.
- Healthy lifestyle staff were observed to support patients who had complex emotional needs and wanted to give up smoking.
- Palliative care nurses had referral pathways into local and national bereavement support networks and could refer relatives and carers as required.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as good because:

- The needs of the local population were considered in how community services were planned and delivered. Overall, service provision met the needs of patients.
- The planning and delivery of care had been challenged from the silver command status in the local NHS system. This was a period when there had been unprecedented challenges to capacity and patient demand. Appropriate strategies had been applied.
- Patients were able to access the right care at the right time
- Staff ensured that services met the individual needs of patients and took into account patient preferences in most circumstances. There were some good examples of where staff met the needs of vulnerable people.
- The provider recognised the importance of learning from complaints and concerns and other sources of feedback.

However:

- Reponses to complaints did not always meet trust targets. Learning from complaints was not consistent across all services.

Our findings

Service planning and delivery to meet the needs of local people

- The needs of the local population were considered in how the community services were planned and delivered. Staff worked with local commissioners of services, the local authority, other providers, GPs, and patients to co-ordinate and integrate pathways of care. Commissioners and relevant stakeholders were involved in planning services to provide continuity of care.
- The community adult services had 13 neighbourhood teams who delivered care and treatment to different geographical areas. The teams were multi-professional. Examples of services provided included district nursing, intermediate care, community matron's involvement and domiciliary physiotherapy.
- We saw that the healthy lifestyle service provided individualised care such as smoking cessation which was flexible to community needs and promoted long-term health gains.
- The planning and delivery of care had been challenged from the silver command status in the local NHS system. This was a period when there had been unprecedented challenges to capacity and patient demand. Appropriate strategies had been applied and were in place at the time of inspection.
- 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 pre-determined criteria. All children and young people eligible for continuing care were offered residential health short breaks.
- Sexual health services were delivered to meet contracted outcomes from the clinical commissioning group. The service was required to deliver 60,000 episodes of care to patients and deliver the care within indicated targets. A key performance indicator report supplied by the trust for 2015/2016 showed there were 59,321 attendances between July 2015 and June 2016.

Meeting needs of people in vulnerable circumstances

- Community matrons offered long term conditions management, for people with complex physical health problems. This helped to meet their needs in the community setting and care homes, and avoided hospital admissions.
- There were pathways for patients who lived with dementia and their carers.
- The healthy lifestyle service offered smoking cessation to those patients in vulnerable circumstances who had associated mental health problems, were pregnant and young people.
- The tuberculosis team accessed a number of vulnerable families and were able to signpost them into support networks such as social care.
- There was a palliative care telephone advice line for patients to access out of hours.

Good

Are services responsive to people's needs?

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- Information leaflets for patients were developed according to need. The tuberculosis community team had devised a visual leaflet with country flags on which alerted patients to seek advice on testing if this was their country of origin.
- 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.
- The sexual health service had an outreach team who supported the needs of different groups of service users, for example the LGBT communities and young persons.
- Sexual health services held daily clinics for people under the age of 19 years. The outreach workers also attended schools and colleges to provide health education and advice and to signpost young people into the service.
- The child and adolescent mental health ward had an in-house education service, where specialist teachers delivered the curriculum. The last Ofsted Inspections (2012) rated the school service as 'Outstanding'. The service also supported students not in education, employment, or training, by supporting applications for college or training placements.
- There was a large amount of relevant leaflets and posters on the child and adolescent mental health ward, advising young people of their rights to complain, and seek advocacy. The materials were age appropriate and young people could access further relevant information on mental health treatment, diagnosis, medication.

Access to right care at the right time

- Whilst the average bed occupancy for the trust ranged between 52 – 101%, the Community Neurology Rehabilitation Centre and Community Intermediate Care Unit both had average bed occupancies above 85% over the last twelve months (1 December 2015 to 30 November 2016).
- Little Woodhouse Hall had the highest length of stay for patients, with an average length of stay of 69 days.
- The average waiting times across all of the services during this period were below the 18-week target. Nine patients did not receive treatment within 18 weeks of referral from a total of 10,098 patients, which accounted for less than 0.1%. However, at the end of September 2016, one of the top three complaint categories included appointments. The trust had adopted the same 18-week standard for non-reportable waiting times and had highlighted their own concerns with the following waiting times: continence, urology and colorectal services, diabetes (for Podiatry waits) and children's speech and language therapy.
- There were no re-admissions for community inpatients or child and adolescent mental health services.
- There was a total of 97 delayed discharges between December 2015 and November 2016 for community inpatients and child and adolescent mental health inpatient services.
- The Department of Health Integrated Sexual Health Services, National Service Specification states 98% of patients should have an offer of an appointment within 48-hours of contacting the provider. Data provided demonstrated the service had a local target to see 80% of patients within 48 hours and were meeting this at 81%. The service saw 82% of patients within 48 hours in quarter one of 2016/2017 and saw 80% of patients in quarter 2 of 2016/2017 within two working days of contacting the service.

Learning from complaints and concerns

- The trust received 233 complaints between December 2015 to November 2016 of which 129 (55.4%) related to the core services being inspected. 87.6% of these were for community adults. 42.6% complaints were upheld whilst one was referred to the Parliamentary and Health Service Ombudsman but was not upheld.
- For the first six months of 2016-2017, appointments, access/availability, clinical judgement/treatment, and staff attitude were the top five themes of complaints and concerns.
- The patient experience report to the Board (21 November 2016) showed the actions being taken to address these issues by each business unit.
- The trust recognised the importance of learning from complaints and concerns (and other sources of feedback) and this was captured as a risk on the trust board assurance framework.
- There was a trust Patient Safety and Experience Group chaired by the Director of Nursing, which included

Good

Are services responsive to people's needs?

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

learning from complaints. This reported into the Board's Quality Committee. The trust also made a distinction in reporting between those complaints upheld and those, not upheld.

- We looked at a sample of ten complaint responses. Complaints were investigated appropriately, apologies given where appropriate in letters displaying an appropriate tone and level of detail and signed by the Chief Executive (or nominated deputy in their absence).
- The conclusions reached in the files examined showed clear remedial actions. For example in one file, it was recognised that a standard operating procedure for transcribing medications in Hannah House was required. In another, the need to properly track and log in and log out equipment kept in trust stores and used in domiciliary end of life care was required.
- The trust has recently introduced a regular Patient Experience Board Report, which included numbers of complaints, and concerns, some thematic analysis and some details of lessons and actions but there was no report about whether the actions had been implemented, and whether the actions were effective.
- The central trust team dealing with complaints was reported as having been significantly under-resourced through long-term absence. A restructuring had been undertaken with a view to addressing this and to seek to ensure that there was better capacity and resilience. However, the trust continued to struggle to process and close complaints in a timely fashion. The majority of complaints in the last reporting period were not closed within their 40-day target.

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

We rated well led as good because:

- There was a stable leadership, which appeared cohesive and worked collectively. The leadership were aware of the challenges to provide a good quality service and identify the actions needed to address these. Leaders were visible and accessible.
- Most staff were positive about the open and transparent culture. There were arrangements for staff to raise concerns. Staff were aware of the trust values and strategy which was embedded at recruitment.
- Governance processes were stronger. Staff awareness of governance and risk management was under development.
- There were assurance processes and service performance measures, which were reported and monitored and systems to identify where action should be taken. Progress was evident against the majority of actions identified in the trusts quality improvement plan following the last CQC inspection. Improvements were particularly evident in community inpatient and adult services.
- There were processes to ensure the trust met the Workforce Race Equality Standards and Equality Act 2010.

However:

- Governance and assurance processes required strengthening at Hannah House and in child and adolescent mental health inpatient services.
- There were some inconsistencies in the approach and systems to meet the Fit and Proper Person requirements.
- Staff engagement was variable with morale being lower at Hannah House and Little Woodhouse Hall where there was a feeling amongst staff of disconnect from the rest of the trust.
- Although there were examples of public engagement, this could be stronger in some services.

Our findings

Leadership of the provider

- Since the last inspection in 2014, there has been a stable Trust Board with a few new appointments including a new Director of Nursing appointed in 2015 and two Non-Executive Directors (NEDs) appointed in 2016.
- Executive directors and NEDs indicated that the Board was stronger in terms of accountability and working collectively. NEDs we spoke with described the Board as having 'more appetite' to tackle issues such as service performance, targets and staffing and trust values were now translated into coherent activities at the frontline.
- Most staff told us the senior team were more visible and accessible to staff. The majority of staff knew who the Chief Executive was and were positive about the executive team's role in the improvements at the organisation. However, staff at Hannah House and Little Woodhouse Hall reported feeling disconnected from the rest of the trust.
- The trust scored worse than average in three of the five questions in the NHS Staff Survey 2015 relating to leadership at the trust and about the same as average in the remaining two. Those worse than average were staff recommending the organisation as a place to work or receive treatment, staff experiencing harassment, and bullying and staff suffering from work related stress. There was however a significant improvement (>10%) regarding staff suffering from work related stress in the last 12 months whilst staff experiencing bullying and harassment was 4% worse than 2014.
- In the NHS Staff Survey 2015, 30% of staff felt there was good communication between senior management and staff, which was consistent with the national average for community trusts.

Culture within the provider

- In 2015, the trust worked with staff to review the values and behaviour framework. This work developed the 'Our Eleven, which underpinned the trust approach to services. This was aligned alongside the action plan to deliver the five pillars of quality and safety as set out by the CQC and within the NHS Five Year Forward View Outcomes Framework 5 Domains and the trust's internal Leeds Community Health Care NHS Quality Challenge. The concept of 'Our Eleven' supported the delivery of the trust's quality strategy.
- Staff were passionate about providing good care and treatment to patients and providing support where required.

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.

- Staff in community adult services were positive about the open and transparent culture. They felt supported and valued.
- Staff morale at Hannah House was low amongst some staff due to the recent staffing pressures and gaps in leadership.
- There were arrangements for staff to raise concerns. This included a Freedom to Speak Up Guardian, and approved whistleblowing policy and 'being open'; duty of candour policy.

Vision and strategy

- The trust's vision was to provide the best possible care to every community in Leeds across the ages and to be the key provider of out of hospital care. Staff were aware of the trust's vision and underpinning values and objectives, which were on display in the areas that we visited.
- The trust's vision and values were embedded at recruitment looking closely at how candidates demonstrated the trust behaviours and fit their vision.
- The Board approved the Quality Strategy in February 2016. The strategy set out a programme of work through four key organisational objectives, six quality objectives and six action areas. This was developed into an action and the delivery monitored through the senior management team meetings and relevant board sub committees

Governance, risk management and quality measurement

- Since the last inspection, there was progress made to strengthen risk management and reporting. The risk management strategy was reviewed and an updated policy approved in April 2016. Staff awareness and understanding about effective risk management was under development.
- The senior management team had reviewed processes to measure whether issues and concerns were being escalated quickly. It was decided that current systems were not sufficiently robust and the first phase of a system to provide services with a single integrated source of performance went live in December 2016.
- In most services governance and risk management processes were effective. However, at Hannah House the systems for sharing information, monitoring and identifying risks did not provide assurance. The performance, leadership and governance meeting minutes, were brief. Evidence was lacking to confirm staff reviewed and discussed risks regularly at team meetings. There was a lack of assurance from learning from incidents and complaints and staff were unable to provide any examples of feedback. As a response to the concerns raised at the announced inspection, an action plan was developed. This had ownership by senior staff (Band 6) 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.
- Staff at Little Woodhouse Hall were unclear about key performance indicators and quality targets.
- There were quality boards in a number of services, which provided a visual reminder each day of service data, such as incidents and staffing levels, to ensure teams were focussed on quality and safety in their areas. These were reported to the Quality Committee and Board each month.
- A non-executive director (NED) chaired the Quality and Business Committees. There was overlapping membership by the NEDS to help ensure coordination of committee business, in particular for topics that included the remit of both the Quality and Business Committees.
- The Company Secretary had a key role in ensuring that there was appropriate coordination of business and they personally attended these committees to facilitate this. This was especially important in relation to discussion regarding staffing (a key risk and present issue for the trust) because it was taken under the Business Committee's remit but had clear implications for quality of care.
- There was an appropriate range of executive chaired groups, which reported into the Quality Committee. These covered the clinical quality issues for the trust: Mental Health Act, Clinical Effectiveness, Patient Safety and Experience, Mortality Surveillance and Safeguarding.
- There were 17 risks reported in the board assurance framework and risk register as at November 2016. Out of the 17 identified risks, one was 'extreme', 13 were 'high' and six 'moderate' in severity.

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.

- Three risks related to governance, risk management and quality measurement, there were effective systems and processes for assessing the quality of service delivery, achieving a 'good' CQC rating and income and expenditure.
- The corporate risk register identified two extreme risks relating to difficulties in recruitment and retention of staff within neighbourhood teams and staff sickness rates. Both had controls in place.
- There had been very recent work done on the Board Assurance Framework (BAF) and risk registers and processes following the recruitment of a risk management specialist. The BAF was clear and contained a manageable number of risks. The BAF risks were appropriately strategic and clear and aligned to corporate objectives. Each risk had a named lead and was allocated to a named Board Committee for oversight and assurance.
- We looked at 10-root cause analysis investigations (RCA). Overall, these were thorough. However, in two cases the conclusions and evidence as to how a judgement was made to rate the harm as 'unavoidable' could be stronger. The Director of Nursing agreed to review these.

Fit and proper person requirement

- Leeds Community Healthcare NHS Trust is not a Foundation Trust, therefore it has been required to work with and source NEDs through the Trust Development Authority (TDA).
- We looked at all human resource records for current NEDs and executive directors. There were Disclosure and Barring Service (DBS) checks conducted for all executive directors, including those appointed prior to Fit and Proper Person requirements being introduced.
- The trust had determined, partly on advice from TDA, that DBS checks were not required for NEDs. Given the role of NEDs in visiting clinical areas and meeting and discussing care with patients (including vulnerable patients - with mental health, capacity and sexual health issues) , and their access to personal details in complaints and incident reports there was no risk assessments to determine if DBS checks were required.
- Each of the NED files included a comprehensive Fit and Proper Person checklist. However, those checklists seen appeared to have only been completed in January 2017 not at the time that recent NEDs had been appointed (which was in April 2016). Records showed insolvency checks on all directors.
- For one of the recently appointed NEDs, the Trust Declaration of Interest form had not been completed until October 2016, which was not at the time of appointment. For the other recent NED appointment the Declaration of Interest form was dated for 2015/16; there was not one for 2016/17.

Staff engagement

- The NHS Staff Survey showed that the trust's score of 3.7 for staff engagement was worse than average when compared with trusts of a similar type.
- The trust had regular 'Thanks a Bunch' and annual staff awards (The Thank You Event).
- The 'Our 11' concept was created in partnership with staff and patients, and launched across the trust at three open roadshows led by the CEO. At induction, the CEO introduced 'Our 11' to all new starters. Posters outlining Our 11 were displayed across the trust and were referred to in weekly messages from the CEO and in meetings with the Leaders Network. The behaviours were integrated into the appraisal system and new training programmes.
- Most staff said that they could put forward ideas for improvement with the exception of staff working at Hannah house who said that although they had ideas to improve the service they did not feel these would be implemented, and felt there was no platform to put their ideas forward.
- The CEO had a twitter account, which staff could message. Staff in community adult services confirmed they had tweeted a message and received a response.
- The trust Chair had been out to all neighbourhood teams and listened to staff opinions. There was a positive report on these visits, which was shared with staff.
- The senior leadership team had clinical days when they visited staff teams in the community services.
- Staff in community adult services reported they had met the CEO during their staff induction, the CEO remembered them by name.
- We saw that there was a quarterly group meeting '50 voices' with staff and senior managers. This was to produce a professional strategy across services.

Are services well-led?

Good

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- The trust had local innovation awards. The SALT services were successfully awarded a national award.

Public engagement

- There was some engagement with the public using services at Hannah House. 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. However, most staff at this service said they felt more structured processes were needed 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.
- The sexual health service carried out a number of public engagement events through the outreach team who worked with community groups and third sector organisations to engage with hard to reach groups in the local area. The outreach team delivered sexual health talks too hard to reach groups.
- The CNRC held a 'neuro user and carer forum' (NUCF). The unit had approximately 70 members on an e-mail forum and past and present patients attended service user forums.
- MSK services had a service user group 'membership and involvement group' who considered spinal pathway development and 'did not attend' issues as well as providing a patient reader group to consult on information leaflets.
- The cardiac and neurology services were working at gold involvement standard and were proactively seeking new opportunities for patient, carer and public involvement in individuals own care, service planning and improvement and sharing the results and learning from others.

Equality and Diversity

- The aim of the NHS Equality Delivery System (EDS) is to improve the equality performance of the NHS and embed equality into mainstream business planning processes.
- An annual equality report was presented to the Board in November 2016. This identified the activity and progress that Leeds Community Healthcare NHS Trust had made in meeting the requirement of the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard contract.
- A Board member was identified to lead equality and inclusion and a staff side representative to lead on equality and diversity.
- The trust achieved EDS2 Goal 1 'Better Health Outcomes for All' and Goal 2 'Improved Patient Access and Experience' in September 2016.
- Equality objective 'support the progresses of the Workforce Race Equality (WRES) organise and deliver a BME staff focus group, by 31 March 2016" was met and further work was planned.
- Equality objective "increase by 10% the number of unconscious bias awareness development opportunities in 2016-17 compared to opportunities in 2015-16" was met; an increased number of sessions was scheduled for delivery.
- Equality objective "by 15 September 2016 complete and submit the Stonewall Workplace Equality Index (SWEI17) 2017 The SWEI17" was completed and submitted on 15 September 2016.
- About equality objective "as part of the NHS Learning Disability Employment Pledge, by March 2017 the organisation will increase the number of staff declaring their learning disabilities by 100%." Based on the staff survey and the staff Friends and Family Test feedback the Business Committee concluded that there were a number of actions and outcomes required before progress was made to achieve this objective.
- Equality objective "Conduct an analysis of patient equality data currently held by LCH by 31 May 2016" was achieved, providing LCH with intelligence to indicate the trust was delivering inclusive services, which meet the health needs of local communities.
- Equality and diversity training was mandatory for staff. At the time of inspection, this was 95%.

Innovation, improvement and sustainability

- The Board self-assessed itself using the Well-led Framework for Governance Reviews, There were six priority areas identified; learning and development, accountability and leadership, staff engagement, performance, risk management, and strategy and planning.
- The Board were aware of its areas of challenge. For example, the new models of care in neighbourhood teams, staffing, pressure of resources and the volume of re-tendering work. There were actions to address these areas.

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.

- Progress was evident against the majority of actions identified in the trusts quality improvement plan following the last CQC inspection. Improvements were particularly evident in community inpatient and adult services.
- A high-level summary of performance was presented to the Trust Board. This provided any current concerns relating to contracts and key performance against targets and indicators. The indicators were aligned to CQC domains.
- The December 2016 performance report showed the net surplus and financial deficit remained green for the year to date.
- There were examples of improvement and innovation within a number of services inspected. A speech and language therapy team member had developed an award-winning choir, which helped patients in their speech and language skills and provide social opportunities.
- The MSK service in Leeds was trialling alternative models of care both to support increasing demand and support capacity in Primary Care.
- Staff at CICU had been highly commended during a trust 'Thank You' event held in 2016 and had received a trust award, in November 2016, for having no hospital acquired pressure ulcers for a year.
- The CNRC had won an infection prevention and control award. The CNRC used a quality challenge process based on the CQC key lines of enquiry.
- CICU were completing a project to improve patient flow. This involved looking at patient pathways and journeys through the unit and identifying any delays and 'blockages' in the current system which could potentially reduce patient's length of stay.

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
Nursing care 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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part; (2) Persons employed by the service provider in the provision of a regulated activity must – (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. **How the regulation was not being met:** Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to meet the requirements of the regulation.

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Requirement notices

Staff employed by the provider did not receive such appropriate support, training, professional development, and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

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 17 HSCA (RA) Regulations 2014 Good governance 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. **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 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.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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.

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Regulated activity	Regulation
Nursing care 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. 12 (1) is the failure (2) (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. **How the regulation was not being met:** Care and treatment was not provided in a safe way for patients. Staff providing care or treatment to patients did not have the qualifications, competence, skills and experience to do so safely.
	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. **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.