# Locala Community Partnerships C.I.C.

## Quality Report

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Date of inspection visit: 11-14 October 2016, 27 and 28 October 2016 and 4 November 2016
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| Core services inspected | CQC registered location | CQC location ID |
|---|---|---|
| Services for children, young people and families | Batley Health Centre, WF17 5ED | 1-285685765 |
| | Cleckheaton Health Centre, BD19 5AP | 1-285685809 |
| | Dewsbury Health Centre, WF13 1HN | 1-285685783 |
| | Dewsbury and District Hospital, WF13 4HS | 1-584666529 |
| Community adults services | Batley Health Centre, WF17 5ED | 1-285685765 |
| | Beckside Court, WF17 5PW | 1-285685717 |
| | Cleckheaton Health Centre, BD19 5AP | 1-285685809 |
| | Dewsbury and District Hospital, WF13 4HS | 1-584666529 |
| | Dewsbury Health Centre, WF15 4HN | 1-285685783 |
| | Fartown Health Centre, HD2 2QA | 1-285685995 |
| | Holme Valley Memorial Hospital, HD9 3TS | 1-285685937 |
| | Princess Royal Health Centre, HD1 4EW | 1-285685801 |

# Summary of findings

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|---|---|---|
| Community dental services | Beckside Court, WF17 5PW | 1-285685717 |
| | Holme Valley Memorial Hospital, HD9 3TS | 1-285685937 |
| | Cleckheaton Health Centre, BD19 5AP | 1-285685809 |
| | Batley Health Centre, WF17 5ED | 1-285685765 |
| | Dewsbury and District Hospital, WF13 4HS | 1-58466529 |
| | St John Health Centre, HX1 5NB | 1-285686345 |
| Community inpatient services | Holme Valley Memorial Hospital, HD9 3TS | 1-285685937 |

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

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# Summary of findings

## Overall summary

We inspected Locala Community Partnerships Community Interest Company ("Locala") from 11-14 October 2016. We undertook unannounced inspections on 27 and 28 October 2016 and 4 November 2016. We carried out this inspection as part of the Care Quality Commission's (CQC) comprehensive inspection programme.

We inspected the following core community health services:

- Community adults services
- Community inpatient services
- Community dental services
- Community services for children, young people and families

In relation to each core service that we inspected we asked if the service was safe, effective, caring, responsive and well-led.

We sampled services provided from a range of locations across the Kirklees and Calderdale areas.

We did not inspect GP services, sexual health services or primary dental services provided by Locala during this inspection.

As a result of this inspection, we have rated the four core services that we inspected. We have not rated Locala as a provider for each of the five key questions or given an overall rating because we did not inspect how well-led the organisation was in relation to all the services that it provides.

Our key findings were as follows:

- Locala's systems for identifying, investigating and learning from incidents were not robust. There were several examples of this, including an incident that was not identified as a serious incident until several months after it occurred and that was incorrectly deemed to have been unavoidable.
- The duty of candour requirements were not embedded across the services that we inspected and compliance with the duty of candour requirements had not been monitored by the Board until September 2016.
- The organisation had safeguarding policies and procedures in place for safeguarding vulnerable adults and children. Safeguarding training rates were variable across the core services we inspected. A serious safeguarding adults incident had occurred in June 2016 which highlighted that some staff in the community adults team had not recognised safeguarding concerns that had been raised by patients and subsequently had not known what action to take. This had resulted in a delay in the organisation taking the appropriate action.
- We identified significant concerns regarding assessing and responding to risk on Maple Ward. This included falls and venous thromboembolism risk assessments not being completed and national early warning scores not being calculated when it was clinically appropriate to do so.
- We were not assured that governance and risk management arrangements were robust and we were concerned that there was an insufficient focus on quality within the organisation. Revised governance and risk management arrangements had been introduced shortly before our inspection. However, many of these changes were not fully embedded and it was too early to see whether they would lead to improvements. We saw several examples of serious patient safety issues not being identified or escalated through the governance structures appropriately.
- We found a mixed picture in relation to the culture of the organisation. This was reflected in the variation in responses in the June 2016 staff survey across the four business units.
- Mandatory training compliance rates were variable across the four core services that we inspected.Locala had a trajectory that Nurses in the integrated community care teams were not being provided with individual clinical supervision.
- Appraisal rates were low in the community adults and community inpatient services.
- Staffing levels were appropriate in the majority of services that we inspected. However, staffing shortfalls were a significant issue in the integrated community

# Summary of findings

care teams, which delivered planned and unplanned care to patients. Staffing issues had been particularly acute in these teams in the period August to October 2016.

- A number of the infection prevention and control (IPC) policies and procedures were out of date. There were capacity issues in the infection prevention and control team, which meant that the IPC audit schedule hadn't been followed in all the services that we inspected. We observed staff following IPC practices during the inspection.
- Care and treatment was evidence based across the services that we inspected. Staff had access to policies and procedures and other evidence-based guidance via the organisation's intranet. Policies, procedures, assessment tools and pathways followed recognisable and approved guidelines.
- There was an agreed clinical audit programme in place for 2016/17. Locala had identified that there were gaps in required levels of quality assurance and clinical governance that may lead to poor standards of clinical quality and had commenced a programme of work to address this.
- The services we inspected participated in a number of audits to measure patient outcomes. We generally saw evidence of good patient outcomes in the services that we inspected, with the exception of Maple Ward where national audit data had not been completed during the reporting period for this inspection. In some instances we did not see evidence of action plans in the community dental service to address the outcomes of audits.
- Across the services staff used technology to enhance the service they provided to patients, however there were issues with the connectivity of mobile technology which meant that information was not always available to staff when they needed it..
- Throughout our inspection the majority of patients and relatives informed us they felt involved in care options, decision making and planned treatment. Staff took time to explain the care being administered and to ensure that patients and relatives understood what was happening.
- Patients were generally able to promptly access care and treatment in the services that we inspected. There were waiting lists for patients to access some services in the integrated community care teams and some visits were being delayed as a result of staffing shortfalls.
- There was no dementia or learning disability strategy in place. However, Locala had received an award in 2015 from a local voluntary group specialising in dementia care in recognition of the work to become dementia friendly. We saw some good examples of staff and services responding to the needs of people in vulnerable circumstances.

There were areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that there are robust procedures in place to ensure that incidents, including serious incidents and never events are correctly identified and reported and are comprehensively investigated and reviewed at an appropriate level within the organisation.
- Ensure that learning from incidents and complaints is shared and embedded across the organisation.
- Ensure that the duty of candour process is effective and embedded in practice across the organisation.
- Ensure that at all times there are sufficient numbers of suitably skilled, qualified and experienced staff, taking into account patients' dependency levels.
- Ensure that all staff have completed mandatory training and role specific training.
- Ensure that infection prevention and control policies and procedures are reviewed and in date.
- Ensure that the infection prevention and control audit programme is followed and actions are identified and implemented in a timely manner when issues are identified through the audit programme.
- Ensure that staff are up-to-date with appraisals and staff attend clinical supervision as required.
- Ensure that there are in operation effective governance, reporting and assurance mechanisms.
- Ensure that there are in operation effective risk management systems so that risks can be identified, assessed, escalated and managed.
- The provider must have systems in place, such as regular audits of the services provided, to monitor and improve the quality of the service.
- Ensure that staff have undertaken safeguarding training at the appropriate levels for their role.

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- Ensure that there are appropriate systems in place in the community adults service to ensure that patients are prioritised and seen promptly in accordance with clinical need. In addition, the provider must ensure that the governance and monitoring of such systems is operated effectively to enable the identification of any potential system failures, and to take action so as to protect patients from the risks of inappropriate or unsafe care and treatment.
- Ensure that staff competency is robustly assessed in the community adults service.
- Ensure that timely clinical risk assessments are undertaken and recorded and care plans are developed and recorded that are reflective of the patient's needs for patients on Maple Ward.
- Ensure that clinical risks are promptly identified and appropriately monitored on Maple Ward, including the calculation of National Early Warning Scores, as clinically appropriate.
- Ensure that patients who self-medicate on Maple Ward have been appropriately risk assessed.
- Ensure that patients having venous thromboembolism prophylaxis on Maple Ward are appropriately assessed as per current best practice guidance.
- Ensure that a paediatric nurse is available to provide recovery care for children receiving dental treatment under a general anaesthetic, as recommended by the Royal College of Nursing.

**Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## Our inspection team

Our inspection team was led by:

**Chair:** Carole Panteli, Director of Nursing (retired)

**Team Leader:** Berry Rose, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a safeguarding specialist, a governance specialist, professional lead nurse for children's integrated therapy and nursing service, district nurses, a community matron and an occupational therapist. Additionally, there was an expert by experience who had experience of community health services.

## Why we carried out this inspection

We inspected the following community health services as part of our comprehensive community health services inspection programme:

- Community adults services (including end of life care)
- Community inpatient services
- Community dental services
- Community services for children, young people and families

## How we carried out this inspection

Locala Community Partnerships CIC provides a range of primary care and community services. These are GP services, community health services (as listed below), sexual health services and primary dental care. We didn't inspect all of these services in October and November 2016. In October and November 2016 we inspected the following community health services provided by Locala Community Partnerships CIC:

- Community adults services (including end of life care)
- Community inpatient services
- Community dental services
- Community services for children, young people and families

This report only comments on what we found in relation to the four community health services that we inspected. We have not rated Locala Community Partnerships CIC as a provider for each of the five key questions or given an overall rating because we did not inspect how well-led the organisation was in relation to all the services that it provides.

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 four community health core services that we inspected and asked other organisations to share what they knew. We carried out an announced visit from 11 to 14 October 2016. We carried out unannounced visits on 27 and 28 October 2016 and 4 November 2016. During the announced inspection we held focus groups with a range of staff who worked within services we inspected including nurses, therapists, doctors and support staff. We also interviewed senior staff in each of the core services we inspected and executives. We talked with people who use the services. We observed how people were being cared for, talked with carers and/or family members, and reviewed care or treatment records of people who used the services.

# Summary of findings

## Information about the provider

Locala Community Partnerships CIC ("Locala") was established in 2011 and provides a range of healthcare services predominately in the Kirklees area but also in the Calderdale and Bradford areas. In 2016 the population of Kirklees was 431,000. About 19% (16,000) of children live in low income families in Kirklees and life expectancy for both men and women is lower than the England average.

In the period 1 April 2015 to 31 March 2016, Locala had over 761,000 patient contacts. Locala was registered with the Care Quality Commission to provide services from 28 locations and employed over 1,500 staff.

Locala provides the following services:

- GP services
- Sexual health services
- Primary dental services
- Community adults services (including end of life care)
- Community inpatient services
- Community dental services
- Community services for children, young people and families

We inspected the following services in this inspection:

- Community adults services
- Community inpatient services
- Community dental services
- Community services for children, young people and families

Services were organised into three service business units; Integrated Adults Business Unit, Planned Adults Health and Wellbeing Business Unit and the Integrated Children's Business Unit.

Locala works with the following Clinical Commissioning Groups (CCGs):

· NHS Greater Huddersfield CCG

· NHS North Kirklees CCG

· Bradford CCG

· Calderdale CCG

## What people who use the provider's services say

We spoke with a total of 88 patients, carers and relatives during the inspection. The majority of people spoke positively about the services that they used.

In the service for children and young people we spoke with 38 parents and children over the inspection period and heard many positive comments from families and carers of children and young people about the services provided. Parents told us that they felt respected and treated in a compassionate manner by friendly and caring staff. While on home visits, two mothers with children requiring complex care told us about the importance of the help and support they had received from the community nurses with caring for their children at home. In the immunisation clinic, parents told us that they felt they could ask for advice and trusted the information that they were given.

In the community dental service we spoke with six patients who used the service. All provided positive comments about the service. One patient rated the service as 'perfect'. Friends and family test results showed high levels of respondents would recommend the services.

In the community inpatient service we spoke with eight patients who used the service and with the exception of one, all of them commented positively about experiences of their stay. Comments were positive about the ward environment and the communication with, and availability of, doctors and nurses and volunteers. The only negative comment was that the evening meal was served too early.

In the community adults service we spoke with 28 patients and eight relatives during our inspection. We also reviewed patient feedback information sent to us prior to the inspection. Most patients were happy with the service they received. There had been complaints about the delay in reaching the single point of contact earlier in 2016.

# Summary of findings

## Areas for improvement

### Action the provider MUST or SHOULD take to improve

**Action the provider MUST take to improve:**

- Ensure that there are robust procedures in place to ensure that incidents, including serious incidents and never events are correctly identified and reported and are comprehensively investigated and reviewed at an appropriate level within the organisation.
- Ensure that learning from incidents and complaints is shared and embedded across the organisation.
- Ensure that the duty of candour process is effective and embedded in practice across the organisation.
- Ensure that at all times there are sufficient numbers of suitably skilled, qualified and experienced staff, taking into account patients' dependency levels.
- Ensure that all staff have completed mandatory training and role specific training.
- Ensure that infection prevention and control policies and procedures are reviewed and in date.
- Ensure that the infection prevention and control audit programme is followed and actions are identified and implemented in a timely manner when issues are identified through the audit programme.
- Ensure that staff are up-to-date with appraisals and staff attend clinical supervision as required.
- Ensure that there are in operation effective governance, reporting and assurance mechanisms.
- Ensure that there are in operation effective risk management systems so that risks can be identified, assessed, escalated and managed.
- The provider must have systems in place, such as regular audits of the services provided, to monitor and improve the quality of the service.
- Ensure that staff have undertaken safeguarding training at the appropriate levels for their role.
- Ensure that there are appropriate systems in place in the community adults service to ensure that patients are prioritised and seen promptly in accordance with clinical need. In addition, the provider must ensure that the governance and monitoring of such systems is operated effectively to enable the identification of any potential system failures, and to take action so as to protect patients from the risks of inappropriate or unsafe care and treatment.
- Ensure that staff competency is robustly assessed in the community adults service.
- Ensure that timely clinical risk assessments are undertaken and recorded and care plans are developed and recorded that are reflective of the patients' needs for patients on Maple Ward.
- Ensure that clinical risks are promptly identified and appropriately monitored on Maple Ward, including the calculation of National Early Warning Scores, as clinically appropriate.
- Ensure that patients who self-medicate on Maple Ward have been appropriately risk assessed.
- Ensure that patients having venous thromboembolism prophylaxis on Maple Ward are appropriately assessed as per current best practice guidance.
- Ensure that a paediatric nurse is available to provide recovery care for children receiving dental treatment under a general anaesthetic, as recommended by the Royal College of Nursing.

**Action the provider SHOULD take to improve:**

- Ensure that out of date policies are reviewed and updated.

# Locala Community Partnerships C.I.C.

**Detailed findings**

## 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 were concerned that Locala's systems for identifying, investigating and learning from incidents were not robust. There were several examples of this, including an incident that was not identified as a serious incident until several months after it occurred and that was incorrectly deemed to have been unavoidable. This meant that there was a delay in the organisation identifying and taking action to address patient safety issues on the community inpatient ward, Maple Ward. Incidents were not always investigated in a timely way and in July 2016, the organisation had reported that there were 87 incidents overdue investigation.

Staff were generally aware of the duty of candour regulation. However, there was no robust system to ensure that the organisation met the requirements of the duty of candour regulation. We saw some examples of where the duty of candour requirements had been implemented. We also saw examples of when the duty of candour requirements were not followed in a timely manner and where the application of the duty of candour was appropriate and had not been applied. Board oversight of the organisation's compliance with duty of candour requirements did not begin until September 2016.

The organisation had safeguarding policies and procedures in place for safeguarding vulnerable adults and children. Staff received mandatory training in safeguarding. Safeguarding training rates were variable across the core services we inspected and we found low levels of compliance with safeguarding children training in the community dental and community adults core services. A serious safeguarding adults incident had occurred in June 2016 which highlighted that some staff in the community adults team had not recognised safeguarding concerns that had been raised by patients and subsequently had not known what action to take. This had resulted in a delay in the organisation taking the appropriate action.

Locala's oversight of compliance with health and safety requirements had not been robust and the organisation had commissioned an external review, which had identified a range of areas of non-compliance. Actions had been identified to address these issues but it was

# Are services safe?

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

too early for us to assess how effective these actions had been. There were issues with the safety and security of some of the buildings that we visited. Locala took immediate action to address the issues identified.

We found significant issues with record keeping on Maple Ward. Ward staff were using both paper and electronic systems for record keeping and there was no consistency in where information was documented either in the electronic or paper records. We identified gaps in care plans and risk assessments in all of the records that we reviewed on Maple Ward. We also found gaps in the care plans that we reviewed for palliative care patients.

A number of the infection prevention and control (IPC) policies and procedures were out of date. There were capacity issues in the infection prevention and control team, which meant that the IPC audit schedule hadn't been followed in all the services that we inspected. Locala was taking action to address these issues. We observed staff following IPC practices during the inspection.

We identified significant concerns regarding assessing and responding to risk on Maple Ward. This included falls and venous thromboembolism risk assessments not being completed and national early warning scores not being calculated when it was clinically appropriate to do so. Locala took action to address these issues following the inspection.

Staffing shortfalls were a significant issue in the integrated community care teams, which delivered planned and unplanned care to patients who were housebound, temporarily housebound or were receiving care by a specific care pathway. Staffing issues had been particularly acute in the period August to October 2016. We found that staff were struggling to cope with sometimes large caseload and visits were being passed from one shift to another because of capacity issues.

# Our findings

### Duty of Candour

- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients or other relevant persons of certain notifiable safety incidents and provide reasonable support to that person.
- Within the organisation there was no explicit policy on the duty of candour, this was embedded in the Patient Safety Policy and the Serious Incident Policy.
- It was unclear whether training on duty of candour was classed as mandatory training. Training compliance data provided by Locala did not refer to duty of candour training. However, some staff advised that there was a video on the intranet which was classed as a "mandatory read".
- Staff were generally aware of the requirements of the duty of candour but we found that some staff were less clear on the process to follow to implement the duty of candour.
- There was no robust system to ensure the organisation met the requirements of the duty of candour regulation. We saw some examples of where the duty of candour requirements had been implemented. However, we also saw examples of when the duty of candour requirements were not followed in a timely manner. There were other incidents where the application of the duty of candour was appropriate and had not been applied, such as for category four pressure ulcers.
- Board oversight of the organisation's compliance with duty of candour requirements did not begin until September 2016.

### Safeguarding

- There was an executive lead for safeguarding, an acting head of safeguarding, two named nurses for safeguarding vulnerable adults and two named nurses for safeguarding children.
- The organisation had safeguarding policies and procedures in place for safeguarding vulnerable adults and children.
- There was access to guidelines about female genital mutilation and staff in the childrens services demonstrated awareness of the policy; however, there had been no known notifications. There had been extra local training on child sexual exploitation and staff we spoke with understood their roles and responsibilities in multi-agency planning and activities.
- Staff received training in safeguarding as part of their mandatory training. Safeguarding training rates were

# Are services safe?

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

variable across the core services we inspected and we found low levels of compliance with safeguarding children training in the community dental and community adults core services.

- The organisation's safeguarding team had identified that data on safeguarding children training compliance that had been extracted from the Electronic Staff Record showed lower levels of compliance than there actually was. They had reviewed childrens safeguarding training compliance rates in the childrens services to gain assurance that they were at an appropriate level. However, this exercise had not been repeated in the other core services to ascertain the true level of training compliance.
- Insufficient evidence of safeguarding children training was included in the Board's risk register. However it was not clear how the Board had gained assurance regarding safeguarding training levels within the other core services.
- Staff we spoke with generally demonstrated a good awareness of safeguarding and could describe the actions they would take if they identified a safeguarding concern. However, a serious safeguarding adults incident had occurred earlier in 2016 which highlighted that some staff in the community adults team had not recognised safeguarding concerns that had been raised by patients and subsequently had not known what action to take. This had resulted in a delay in the organisation taking the appropriate action. Subsequently the incident had been investigated through the multiagency process and at the time of inspection an action plan was being developed.
- Staff received safeguarding children supervision in line with Locala policy. Safeguarding supervision rates for teams within the integrated childrens business unit for Quarter One 2016/17 varied between 72% and 100%. We saw that peer auditing occurred in safeguarding and supervision records.

### Incidents

- There was a serious incident policy and a procedure following patient safety (clinical) and non-clinical incidents document in place at the time of inspection. The procedure document was due for review in January 2016 but this had not happened when the document was provided to us prior to the inspection. A new procedure was in the process of being agreed, which would replace the existing policy and procedure.
- According to Locala's staff survey in June 2016, 77% of staff felt secure raising concerns about unsafe clinical or non-clinical practice and 59% of staff were given feedback about changes made in response to reported errors, near misses and incidents.
- There had been no never events in the period 6 July 2015 to 27 June 2016. 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.
- Locala reported 17 serious incidents requiring investigation in the core services that we inspected in the period 6 July 2015 and 27 June 2016. The majority of these incidents occurred in the community adults service and related to grade three or four pressure ulcers.
- We were concerned that systems for identifying serious incidents and were not robust. A serious incident had occurred on the community inpatient ward, Maple Ward, earlier in 2016. The incident was investigated, however it was not identified and declared as a serious incident or as an incident that was reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 until five months later when the incident was brought to the attention of a senior member of staff who had recently joined the organisation. When the incident had initially been investigated it had been found to be unavoidable. The investigation report not been signed off by Locala's falls panel, which included the Head of Quality, who was trained to conduct root cause analyses of incidents. When the incident was investigated again, following being declared as a serious incident, it was found to have been avoidable. We were concerned that this meant that opportunities to learn from the incident and address patient safety concerns had been delayed in the period between the first and second investigation.
- Locala had identified that action was required to reduce the number of medication errors. For example, between 1 November 2015 and 31 October 2016 there had been 27 medicines management incidents relating to errors in the administration of insulin in the community adults service, including the serious insulin administration incident that occurred in April 2016. A review of medicines incidents processes had taken place in June 2016 and Locala had taken a number of actions to

reduce the number of medicines administration errors, including identifying the root causes of the errors and putting in place processes to manage and learn from the incidents. We were not assured that these actions had been effective or were embedded at service level. For example, there had been 14 incidents involving the administration of vaccinations in the service for children, young people and families between September 2015 and August 2016. Two of these incidents occurred in the period April to August 2016. We saw evidence that appropriate actions took place in response to the investigation of these incidents but no root cause analysis had been done to identify any trends around the process for administering vaccinations. There had also been 17 subsequent incidents relating to the administration of insulin since the serious incident in April 2016, with a peak of incidents occurring in September 2016.

- Locala had identified that there was a backlog of incidents awaiting investigation. For example, in the community adults' service at the end of December 2015 there were 77 incidents waiting to be sent to a manager to review, 75 incidents overdue for review by a manager and 137 incidents overdue for final approval by the quality manager. The July 2016 Quality Report identified that there were 87 incidents outstanding. Locala was taking action to improve the incident reporting system to support operational colleagues. There was also a plan to address this situation in the community adults team, however no timescales to resolve the situation had been identified in the plan.

## Medicines Management

- Clinical pharmacy services to most of the organisation were supplied by an in-house team of pharmacists and pharmacy technicians. The medicines supply function was purchased by the organisation from external pharmacies.
- The pharmacy service on the inpatient ward was provided by a local NHS trust. We were provided with a clinical services specification template which detailed the service provision however this covered the period 1 April 2011 to 31 March 2012 and had not been updated since then. Performance measures had not been documented as discussed or agreed and no formal process was in place to ensure the service being provided met the requirements in the specification.
- There were procedures for the safe transport, handling and use of vaccinations. We saw staff following the guidelines appropriately and evidence of good practice in relation to vaccinations, for example, fridge temperature checks were completed and there had been an immediate response when the temperature was found to be above the upper limit.
- Medicines, including controlled drugs, were generally stored securely and there were processes in place to ensure that prescription pads were issued appropriately and stored securely.
- Medicines administration was generally observed to be safe. However, we observed medicines being prepared for several children at once in a school treatment room 'to save time'. This increased the potential for risk of giving a drug to the wrong patient and this had occurred in May 2016 (with no harm caused). We raised this at the time of inspection and Locala took immediate action to resolve this issue during the inspection. On the inpatient ward, patients who were noted on medicine administration charts to have self-administered medicines had no documented assessment of their ability to administer their own medicines recorded.
- The provider completed a two yearly audit programme of compliance with their requirements for medicines management. The results of the audits, including actions, were discussed with the service and evidence of actions taken obtained by the medicines management team.
- The provider 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. A spreadsheet had been developed which listed all available PGDs and their review/expiry dates. We were shown the procedure in place to ensure that teams had received and signed the most up to date PGD and how this was then recorded by the medicines management team. Each service maintained their own 'PGD pack' which was signed by an appropriate professional and authorised. These packs were checked as part of the two yearly audit programme

## Safety of equipment and facilities

- In response to concerns about compliance with health and safety requirements, Locala had commissioned an external audit which took place in August 2016. The audit had identified a number of concerns relating to

the safety of equipment and facilities including that limited equipment safety checking had taken place and that the majority of testing was out of date, an inconsistent approach to fire alarm testing and fire drills and limited security at some locations. Actions had been identified to address these issues but it was too early for us to assess how effective these actions had been.

- There were issues with the safety and security of some of the buildings that we visited.
- In the child development centre the front door lock was not working and there was open access to children and their families in the reception area at the time of inspection. The reception area was not directly monitored or attended by staff. Locala had identified that the premises were not suitable and were working to identify an alternative.
- At the Princess Royal Health Centre we saw that there was an unmanned reception desk and unlocked external doors, meaning staff did not know who was in the building. We also saw that there were unlocked internal doors, which opened directly onto steep concrete stairs. There was signage on the door indicating no entry. However, there was a risk that visitors to the building could walk through the door onto the steep steps. We raised this at the time of inspection and Locala took immediate action to address our concerns. We visited the location as part of our unannounced inspection and saw evidence of this.
- In the dental service, treatment rooms at Princess Royal Health Centre were small which made, for example, treating patients in wheelchairs difficult for staff due to lack of space.
- Locala was aware of the environmental issues at the Princess Royal Health Centre and the Board had considered various options regarding this in July 2016.
- We found that all the equipment in use that we checked was safety tested and serviced where required. Staff were aware of the process for reporting any faulty equipment.
- The majority of equipment that we reviewed was in date. Resuscitation and emergency equipment was available. Checks of resuscitation and emergency equipment took place and equipment was generally observed to be in date as required.
- Staff reported no issues with the availability of equipment and equipment could be accessed quickly if needed. The out of hours' nursing team were able to access equipment for patients, particularly palliative patients, at any time.
- There had been an external audit of compliance with health and safety requirements at four of Locala's operational premises in August 2016. The audit identified that no general assessments of work activities covering office work, display screen equipment (DSE), slip and trip hazards, use of equipment, stress, driving or lone working were available at the premises inspected. An action plan was in place to address these concerns.

### Records management

- The organisation used an electronic record keeping system, called SystmOne, and the majority of patient records were held electronically.
- We reviewed 51 sets of patient records across the community adults services, services for children, young people and families and the community dental services and found they were generally of a good standard. Records were audited and action plans were in place where issues had been identified.
- We found significant issues with record keeping on Maple Ward, which was the community inpatient ward. Ward staff were using both paper and electronic systems for record keeping. This was confusing as information was held in both areas and there was no consistency in where information was documented in either the electronic or paper records. Staff on the ward explained to us that they weren't clear about where to input information into the electronic patient record. This meant there was a risk to patient care as staff did not always have the most up to date information available to them.
- We reviewed patient records on Maple Ward during the announced inspection and during three further unannounced inspections of the ward. We identified gaps in care plans and risk assessments in all of the records that we reviewed. As a result of the issues that we identified with record keeping, Locala audited the clinical records of all patients on the ward in early November 2016. The audit showed gaps in the clinical records of all nine patients on the ward at the time. Locala has developed an action plan to address these concerns. We have seen audit data that now shows that

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all patient records are complete but we were concerned at the length of time that it took following our unannounced inspections for all patients to have a full set of records in place.

- We found gaps in the care plans that we reviewed for palliative care patients. In eight sets of records the patient's palliative care plan, including the patients' preferred place of care, was not completed on the electronic palliative care co-ordination system (EPACCS). We reviewed a further 12 records for patients with end of life care plans. Six of these did not have the care plan fully completed and four had no carer's needs assessment completed. This meant patients who were at the end of life did not have a detailed care plan specific to their needs.
- Staff in the community adults services and services for children, young people and families were mobile workers and accessed patient records via laptops. There were issues with laptop connectivity in both these services which meant that staff were not always able to access patient records at the time of patient contact. Locala had set up a user group to address these connectivity issues and we were provided with a Network Disruption Policy after the inspection that outlined what action staff should take in the event of a connectivity issue. The document had no implementation or review date and it was not clear whether it was in place at the time of inspection.

### Cleanliness and Infection control

- Locala had infection prevention and control polices, however four of these were out of date. The organisation had identified this in the September 2016 infection prevention and control (IPC) update to Board and was prioritising updating the policies.
- The organisation had an IPC annual plan in place, with actions identified against key areas which were red, amber, green risk rated.
- At the time of inspection there was one part-time infection prevention and control nurse in post to undertake all of the audits and training regarding IPC in the organisation. There were IPC link nurses in some of the services that we inspected.
- As a result of a lack of IPC nurse capacity, the IPC audit timetable hadn't been followed in all the services that we inspected. There were high levels of non-submission of IPC audit data in some of the business units, particularly the integrated adults business unit.
- Locala was in the process of recruiting a one whole time equivalent IPC nurse to increase the capacity of the IPC team.
- There had been no cases of hospital acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infections, Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia or Clostridium Difficile (C.Diff) infections for the period April 2015 to March 2016.
- Quarterly hand hygiene audits took place across the services we inspected with scores showing around 97% compliance.
- We saw that action plans were generally in place where issues had been identified in IPC audits, however, the action plans did not always include timeframes for improvement.
- We observed staff during visits to patients in their own homes and in clinic sessions. Staff followed hand hygiene and "bare below the elbow" practices. We saw that gloves and aprons were readily available for staff to use and we observed staff using them appropriately.
- The 2016 Patient Led Assessment of the Care Environment (PLACE) for Maple Ward showed the service scored 99% for infection control in the care environment. This was slightly higher than the national average of 98%.
- We found that some equipment was not in-line with IPC best practice at the Princess Royal Health Centre. For example, we saw that there were couches in the clinical room in the foot health clinic that had torn coverings. Locala ordered new couches in response to our concerns. We also saw that sterile equipment was not stored appropriately and there was no hand gel available for patients in the foot health clinic.

### Mandatory training

- Mandatory training was delivered to staff via eLearning and face-to-face training. There were a number of topics covered in this training including health and safety, equality and diversity, infection prevention and control and safeguarding children and vulnerable adults.
- Moving and handling training was not on the mandatory training schedule supplied to us by the organisation. However, staff told us this was mandatory and was delivered as a practical training session. We were not supplied with information for compliance with this training.

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- In September 2016, overall compliance with mandatory training for the year to date across the organisation was 70.9%, against a target of 100% by 31 March 2017.
- Rates for compliance with mandatory training were variable across the three business units. Compliance rates for the integrated adults business unit was 69.8% and 66.4% in the planned adults and health and well-being business unit. The compliance rate in the integrated childrens business unit was 85% in August 2016.
- The electronic system recording training compliance for each employee could be accessed and monitored by managers. The system had a facility to provide e-mails to staff to highlight when training was due to be completed. Staff told us that they received a reminder e-mail when training was due.

### Assessing and responding to patient risk

- We identified significant concerns regarding assessing and responding to risk on Maple Ward, which was the community inpatient ward.
- We reviewed the investigation of a serious incident involving a patient that fell on Maple Ward earlier in 2016. The investigation showed that falls assessments had not been carried out for the patient as required. Despite the serious incident and rapid improvement plan being implemented in September 2016 we did not see evidence that falls assessments had been completed when we reviewed patient records on the ward during the announced and unannounced inspections in October and November 2016. For example, on 27 October 2016 there was no evidence that six of the nine patients on Maple Ward who had a history of falling had been risk assessed for falls.
- The National Early Warning Score (NEWS) is a clinical assessment tool that is used to identify patients whose clinical condition is deteriorating. We saw several examples of NEWS not being calculated when it was clinically appropriate to do so, meaning that staff could not quickly identify deterioration in the patient's clinical condition. As a result of the concerns that we raised during the inspection, Locala has identified that there is a training need for staff in relation to NEWS.
- We saw other examples of the service not responding appropriately to patient risk on Maple Ward. For example, there was a patient with a history of seizures who had been assessed as requiring a seizure chart on 29 October 2016. A seizure chart is a document that records the date, time, duration and description of seizure behaviour to enable trends to be identified. This can assist with developing an appropriate treatment and management plan. No seizure chart was implemented for this patient until 15 November 2016, despite CQC requesting that the care plans for all patients be reviewed following our unannounced inspections on 28 October and 4 November 2016.
- We found that venous thromboembolism (VTE) risk assessments were not carried out as part of the clerking and medicines re-writing process on Maple Ward meaning that of the 16 medication charts we inspected only four were completed. Eleven patients had VTE prophylaxis prescribed but no indication as to why or for how long it had been in use as it was not recorded on the chart.
- In the community adults service we saw that there was one anaphylaxis kit in the foot health clinic at Princess Royal Health Centre. Some staff were unsure where the kit was stored. During our inspection we found that the kit was out of date. A medicines audit in 2014 had identified that more than one anaphylaxis kit was required at the health centre. There was no evidence this recommendation had been acted on or any further auditing had taken place. We saw evidence on the unannounced inspection that Locala had addressed these concerns.
- In the community dental service we found that the service provided treatment at Dewsbury District Hospital under general anaesthetic to children, but did not provide paediatric nursing staff to support children's recovery from anaesthetic. This was not in line with guidance from the Royal College of Nursing (2013) to ensure safe paediatric care.
- Clinical records that we reviewed in the community adults service, services for children, young people and families and community dental service all showed evidence that risk assessments were completed and care plans developed as appropriate.
- The WHO Surgical Safety Checklist was used in the day surgery service and this was audited for compliance. The dental service used a safer surgery checklist for patients having teeth removed and we saw this in use during the theatre list.

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### Staffing levels and caseload

- There was a workforce strategy for the period 2014-17. This identified three priorities in relation to recruitment, reward and leadership. However, there were no strategies specifically linked to particular staff groups, for example nursing staff.
- Information on staffing was submitted to the Board every two months. This included data on sickness rates and turnover, however the reports did not include any data on overall staff vacancy rates or bank and agency use rates.
- The business units with the highest overall staff turnover rate were the two adults business units with a rolling turnover of 18%. The integrated children's business unit had a turnover rate of 11%. The overall turnover rate for the organisation was 17.9% at the end of March 2016. It was noted that the numbers of staff leaving the organisation was increased because of staff leaving through the NHS Mutually Agreed Resignation Scheme.
- Information provided to the Board showed that overall sickness rates in 2016/15 fell over time from a peak of 6.3% in January to 4.3% in May 2016. Sickness rates across the three business units was variable, with the integrated adults business unit showing the highest overall sickness levels in the organisation (8.6% in September 2016).
- Information provided by Locala in advance of the inspection showed that the vacancy rate at the end of March 2016 was 6.7%, however it was also noted that this figure was approximate as it was based largely on advertised vacancies.
- The organisation was cited on high sickness levels as a result of stress, particularly in the integrated adults business unit which had the highest level of sickness absence due to stress. Sickness absence due to stress in the integrated adults business unit had risen from just under 1.5% in January 2016 to just over 3% in March 2016.
- Staffing shortfalls were a significant issue in the integrated community care teams (ICCTs) which delivered planned and unplanned care to patients who were housebound, temporarily housebound or were receiving care by a specific care pathway. This had been identified as a risk in Locala's Board Assurance Map for August 2016.
- The service assessed the staffing situation in the ICCTs on a daily basis and implemented a resource escalation action plan (REAP) together with a REAP score. The trigger point for a REAP level 3 score was a significant unexpected reduction in staffing of 30 – 35%. The trigger point for REAP 4 was a total staff reduction of 35 – 40%. The trigger point for REAP Level 5 was a staff reduction of 40%.
- We saw staffing levels were consistently causing a high REAP score daily (3 or 4 out of 5) in each locality. This had been the situation since the beginning of August 2016 in all the ICCTs. Two localities were at REAP level 5 during the week of 24 October 2016. We were told by staff, and saw in the information supplied, the reason for the high REAP levels was due to the combination of staff vacancies and sickness absence.
- Staff told us that the number of patient visits for nursing staff was approximately 15 – 20 per shift. Information provided by Locala showed that between 1 July 2016 and 30 September 2016 there were 220 occasions when staff had 20 or more visits in a shift.
- We spoke with 17 district nurses during the inspection. Over 50% of these district nurses told us the current workload was difficult to manage. A notable number of the nurses we spoke with were in tears during the inspection due to the pressure of the workload, which they said had been the situation for several months.
- There were 136 occasions in July 2016, 117 in August and 114 in September 2016 when visits had been passed from the ICCT staff who were working in the evening to staff working in the integrated night service. 82% of these handed over visits were undertaken before 11pm.
- There was no formal acuity and dependency tool in use in the ICCTs to help with planning workloads. There was a colour-coded system for patient visits. The more urgent and more complex patients showed as a different colour to routine or less urgent patients on the system. Work was allocated in the ICCTs by Band 6 clinical leads.
- In response to a serious incident that occurred on the inpatient ward (Maple Ward), Locala had reviewed staffing levels on the ward to ensure that they were in-line with National Institute for Clinical Excellence Guidance and had recently introduced the Safer Nursing Care Tool, which showed a staffing level of one registered nurse to eight patients was needed. The

number of beds had since been reduced to meet the one registered nurse to eight patients ratio and we saw evidence of actual staffing levels meeting planned levels during the inspection.

- Medical cover on Maple Ward was provided by a General Practitioner and Consultant for Elderly Medicine from a nearby NHS Trust.
- We found that caseloads within the health visiting teams were within recommended levels. The teams used a capacity and demand tool to manage caseload allocation.
- Staffing levels within the community dental teams were sufficient to meet the needs of the service.

### Managing anticipated risk

- Foreseeable risks including disruptions to services as a result of bad weather were planned for via business continuity plans.
- Daily calls were taking place between managers in the ICCTs in response to the elevated REAP levels within the service.
- The integrated out of hours nursing team had access to 4x4 vehicles overnight if the weather conditions were bad. These were supplied and driven by local authority staff.
- The organisation implemented daily management calls, clinical records audits and manager support in Maple Ward following the concerns that we identified on inspection.

### Major incident awareness and training

- There were business continuity plans in place and staff could give examples of when these might be instigated.
- There had been an incident earlier in the year when there was a disruption in the telephone power. Action was taken and the situation was addressed.

# Are services effective?

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## Summary of findings

Care and treatment was evidence based across the services that we inspected. Staff had access to policies and procedures and other evidence-based guidance via the organisation's intranet. Policies, procedures, assessment tools and pathways followed recognisable and approved guidelines.

There was an agreed clinical audit programme in place for 2016/17. Locala had identified that there were gaps in required levels of quality assurance and clinical governance that may lead to poor standards of clinical quality and had commenced a programme of work to address this.

Patients had access to pain relief as appropriate. We saw that care plans included an assessment of patient's pain and these had been completed.

We saw nutrition and hydration assessments in all the patient records we reviewed on the community adults nursing caseload. The nationally recognised universal risk assessment for malnutrition (MUST) was being used in the community adults and community inpatients service. We did not see evidence of appropriate action in response to a low MUST score for a patient on Maple Ward. We observed appropriate nutritional advice being given in baby clinics.

Across the services staff used technology to enhance the service they provided to patients. This meant fewer face to face visits were required and specialists could be involved without having to visit the patient. The organisation was committed to developing this service and many staff spoke of the benefits of using it. We found there were significant issues with the connectivity of the mobile technology, resulting in important patient information being unavailable to staff when they needed it.

The services we inspected participated in a number of audits to measure patient outcomes. We generally saw evidence of good patient outcomes in the services that we inspected, with the exception of Maple Ward where national audit data had not been completed during the reporting period for this inspection.

There were arrangements in place for staff competencies to be maintained and assessed, although we found that there were variable rates of appraisals across the business units within the organisation. Staff were generally able to access training, supervision and other professional development. The organisation told us they were introducing the Calderdale Framework for shared competencies. This is a recognised and established process for exploring, understanding and delivering care through competence based roles.

We saw good examples of multi-disciplinary team working across the services that we inspected. Staff worked with colleagues internally and externally and across disciplines to achieve good outcomes for patients.

Staff we spoke with understood the legal requirements of the Mental Capacity Act and we saw that consent was sought from patients or their relatives/representatives as appropriate. We were concerned that some capacity assessments had not been conducted in the community adults service.

## Our findings

### Evidence based care and treatment

- Staff had access to policies and procedures and other evidence-based guidance via the organisation's intranet. Policies, procedures, assessment tools and pathways followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE) and Royal College guidance.
- There was an agreed clinical audit programme in place for 2016/17. Locala had identified that there were gaps in required levels of quality assurance and clinical governance that may lead to poor standards of clinical quality and had commenced a programme of work to address this, including establishing the Clinical Quality Group and implementing the revised business unit meeting structure in August 2016. At the time of inspection it was too early to see evidence that these actions had been effective.
- All health visitors, school nurses and the family nurse partnership nurses we spoke with were aware of the guidelines relevant to their practice. They followed the national initiative called the Healthy Child Programme

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(0-5 years). This is a Department of Health programme of early intervention and prevention for health visitor contacts with babies and children. It offers regular contact with every family and includes a programme of screening tests, immunisations and vaccinations, development reviews and information, guidance and support for parents.

- In the community adults service a recently developed individual care of the dying document had just been implemented. This had been developed in conjunction with the local acute hospital. This incorporated the nationally recognised Gold Standards Framework for end of life care. However, this was not seen to be in use in the palliative care patients that we visited with staff.
- Within community dental services, audits of treatment plans were undertaken twice yearly, to evaluate choice of treatment, however we did not see evidence of action plans to address any concerns identified.

### Pain relief

- Nursing staff were able to access anticipatory medications for patients who were at the end of life. This included medication for pain relief. However, there was no written explanatory leaflet to give to patients or their families in relation to anticipatory medicines in line with best practice guidance. Staff were able to access advice and support from the local hospice 24 hours a day for palliative patients' symptom management.
- We saw care plans included an assessment of patient's pain and these had been completed. However, a specific pain assessment tool was not in use.
- On Maple Ward we reviewed 16 medication administration charts. We saw pain relief had been given to patients at regular intervals. On the first day of our inspection, we were informed by the ward manager and saw staff carry out regular two hourly checks (intentional rounding) on patients. This included making sure they were safe and pain free. However, at the unannounced inspection we found intentional rounding was not always taking place.
- Following the inspection, the provider sent information to say they had reviewed their pain score sheet and replaced it with the Abbey Pain Score. They had also linked the care plan to the pain score sheet.
- Within community dental services we saw that patients were appropriately prescribed local and general anaesthesia for the relief of pain during dental procedures. Patients were provided pain relief through inhalation sedation or general anaesthetic when clinically appropriate. During treatment, we observed the clinician ask the patient if they had any pain in their teeth or mouth.

### Nutrition and Hydration

- Within community adults service we saw nutrition and hydration assessments in all the patient records we reviewed on the nursing caseload. The nationally recognised universal risk assessment for malnutrition (MUST) was being used. However, we were told by staff this was reviewed only if the patient had a high risk of pressure ulcer development when the MUST was undertaken monthly.
- Weighing patients in the community was difficult. Care homes were able to do this with the correct equipment. In patients' own homes, unless they were able to stand on their own bathroom scales, an estimate of the body mass index was done. We found staff had received additional training on how to do this.
- Health visitor care pathways included those to monitor children with faltering growth or obesity. Staff referred children to the appropriate service if support was required such as the GP, dietician and paediatric specialist care.
- We observed baby clinics led by nursery nurses. The information and advice provided followed national guidance, for example, not introducing solid foods until six months of age. Training was also available for staff on the use of feed pumps to support those children who were tube fed.
- On Maple Ward the Patient Led Assessment of the Care Environment showed the service scored 92% for the choice of food. This was higher than the national average of 88%. We asked six patients about the quality and variety of food they received during their stay. Without exception, people told us the food was good and there was plenty of choice.
- At the unannounced inspection on Maple Ward we found for one patient that their MUST score was recorded at 17. There was no information in the care records which indicated that staff had highlighted nutrition as a particular concern for the patient. There was also no consistent monitoring of the patient's diet nor had a care plan been developed to support staff in caring for this patient.

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### Use of technology and telemedicine

- All patient records were managed on an electronic patient record management system. Each member of staff had a laptop to facilitate mobile working. Activity and tasks were managed electronically and staff used electronic meeting software for some meetings to reduce travel and use work time more effectively.
- Across the services staff used technology to enhance the service they provided to patients. This was achieved by using photography, virtual patient contacts and messaging. This meant fewer face to face visits were required and specialists could be involved without having to visit the patient.
- The organisation stated that 10% of direct contacts with patients were undertaken by staff using the telephone or through virtual contacts. The organisation was committed to developing this telemedicine service and many staff spoke of the benefits of using it.
- During the inspection we found there were significant issues with connectivity of the mobile technology resulting in important patient information being unavailable to staff when they needed it. Senior managers were aware of these issues and were taking steps to improve this. However, there was no timescale for these improvements to be made.
- Staff had been advised by managers to contact colleagues at the work bases for information about patients on the occasions they could not access it themselves. We saw this happen on several occasions during our inspection.
- Most staff we spoke with were enthusiastic about the use of, and developments in, technology in the service. They were able to tell us how this improved patient care and was an effective use of resources. However, staff expressed their frustrations about the intermittent connectivity and how this affected their ability to work safely and efficiently.

### Approach to monitoring quality and people's outcomes

- All community adult services contributed to patient reported outcome measures (PROMS) which showed an overall positive outcome on conclusion of a care episode of 96.3% against a target of 80% between 1 March 2016 and 31 August 2016. The service did not supply details of the number of patients who had responded to this.
- We saw 95% of patients demonstrated a maintained or improved level of functioning on transfer or discharge from therapy services in August 2016. In the same month, 86% of patients reported confidence in managing their condition on discharge from therapy services.
- The community dental service reported to NHS England the units of dental activity which measured the level at which the service met targets set by NHS England. The most recent report submitted was for the period April 2015 to March 2016. The report showed the service to have met and over achieved its dental activity target for the period.
- On Maple Ward the physiotherapist team leader set goals with patients and were starting to the use therapy outcome measures assessment tool.
- Prior to inspection, we request providers send CQC completed audits of patient outcomes**.** The information we received from the inpatients service showed that national outcome audits had not been completed during the CQC monitoring period.
- From April 2015 to March 2016, the immunisation rate for the measles mumps and rubella (MMR) diphtheria, tetanus, polio and pertussis in children was 98%. The immunisation team undertook immunisations for looked after children of school age. This has been historically a difficult to reach group of young people. The immunisation rate at the time of inspection was between 84% and 87% (England average rate 87%). The Locala target for this indicator was 95%.
- The number of mothers who received a first face-to-face antenatal contact with a Health Visitor at 28 weeks or above as a percentage of new birth visits was 88%. This was better than the target of 80%.
- The rate for breastfeeding at six to eight weeks from April to June 2016 was 21%, which was worse than the England average of 42.2%. However, the percentage of infants for whom the breastfeeding status was recorded at the visit for the same period was 47%. Team Leaders had started to monitor this being recorded more closely through monthly reports.
- We saw a low rate of the completion of the maternal mental mood review which is completed between six and eight weeks after delivery. The care pathway requires mothers' emotional health to be assessed using three World Health Organisation (WHO) questions and clinical judgement. The percentage of mothers who

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received a maternal mood review in line with local pathway, by the time the infant is aged 8 weeks was an average of 7.5% from July 2015 to June 2016. The Locala target was not clear from the data provided.

- Looked after children receive statutory health reviews to identify health interventions and engage in their own care. The initial review takes place within twenty days of a child coming into the care of the local authority. The number of reviews completed within the twenty day timeframe was between 96% and 100%, which was better than the key performance indicator (95%).
- The number of further review health assessments completed for looked after children ranged between 80% and 100% (Kirklees area had a target of 98%). The catchment area received looked after children from other local authorities. These children had a review completion rate of 70%. This rate was explained by some children being seen by health workers from their own area if within a reasonable distance.

### Competent staff

- During our inspection we found that there were variable rates of appraisals across the business units within the organisation. For example in children's community services most staff groups had appraisal rates of between 90% and 100% and the overall rate for the service was 88%. However on Maple Ward appraisal data showed one person (the manager) had received an appraisal out of 34 staff. The manager who had recently come into post to cover maternity leave had arranged dates for staff to have their appraisal at the time of the inspection.
- New registered nursing staff in the integrated community care teams (ICCTs) had a six-week induction period. During this time, they completed mandatory training and spent time meeting specialist team members such as the tissue viability nurses. However, one new clinical leader told us they had found a number of registered nurses in their team who had been in post for six months who had not had a formal induction. Some staff in the ICCTs told us that their induction had not been good due to staffing levels.
- Band 7 managers and Band 6 clinical leads told us there were a high proportion of newly qualified and inexperienced staff in the ICCTs. Band 6 clinical leads expressed concerns about this, as the more experienced team members did not have sufficient time to support them in their new role.
- On Maple Ward the intermediate care matron attended monthly specialist nursing operational meetings. Information showed staff training, nurse revalidation, staff competencies and appraisal were discussed together with support for staff in meeting compliance. Staff told us they were supported in keeping up to date with professional development and there were opportunities in the organisation for staff to access a range of courses and events.
- The organisation told us they were introducing the Calderdale Framework for shared competencies. This is a recognised and established process for exploring, understanding and delivering care through competence based roles.
- Within children's community services additional training needs were identified through supervision and appraisals. Staff we spoke with were encouraged to seek additional training as necessary to develop their roles and they were supported in doing this by the management team.
- Examples of personal development objectives, which linked to overall service objectives included attaining dual qualifications as school nurse and health visitor to support and prepare for the introduction of the 0-19 service. Four health visitors and four school nurses were applying for dual qualification training. We spoke with a school nurse and health visitor who had already started training and were looking forward to achieving the dual qualification and future opportunities.
- Coaching and mentoring in the childrens services were provided and shadowing opportunities were arranged where there was an identified need. Nurses, therapists and clinical leads told us they received regular formal and informal supervision from line managers and peers. Informal supervision occurred on a daily basis. We saw evidence that appropriate policies were in place concerning clinical supervision and safeguarding children supervision. Staff told us that this was embedded practice and took place at least quarterly. Nurses from the family nurse partnership had weekly supervision meetings with their supervisor.
- The community dental service provided its own simulation training on basic life support and responding to medical emergencies for staff. Staff were also trained in clinical holding, a method of safely holding patients when having treatment to ensure they come to no harm.

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- Dental staff are required to undertake continuous professional development by the British Dental Association. We saw evidence from the clinical director that this was undertaken.

### Multidisciplinary working and co-ordination of care pathways

- A tender had been submitted for operating an integrated 0-19 childrens service. In preparation, the health visiting and school nursing services were in the process of a service redesign and review of care pathways.
- We saw good examples of multi-disciplinary team working (MDT) in the childrens service and with external agencies. For example, nurses who were based in the multi-agency support hub (MASH) worked with social care, sharing information according to clear guidelines in order to safeguard children and young people. We observed them following a family from referral to social care to the decision to hold an immediate strategy meeting to take immediate action to safeguard a child. They could demonstrate links to other agencies such as education, police and the youth offending service.
- The youth offending nurses had developed a pathway with the youth offending psychologist to identify those young people who had unrecognised mental health problems. This was instrumental in young people being diverted from custody to community programmes.
- We saw on the integrated adults business unit key opportunities, risks and successes (KORS) document that there were some identified tasks such as blood tests, wound care and Doppler recordings which were leading to additional demand on the district nurses. Timescales for resolution with local GPs were not identified on the KORS document.
- The ICCTs worked closely with the local authority home care services to provide a seamless service to patients. Staff in the teams and managers told us this was not always achieved due to resource and capacity issues in the local authority.
- There were monthly multidisciplinary meetings with GPs to discuss the Gold Standards framework for end of life care patients. However, staff told us they had not been able to attend due their workload. We saw on the Dewsbury locality team meeting minutes in September 2016 that local GPs had raised concerns with senior managers about this. This is not detailed in the adult business unit KORS.
- Nursing staff and the end of life lead told us there were good professional relationships with the local hospice for palliative care patients. There was a specialist palliative care nurse who staff in the ICCTs could contact for advice and support for patients who were at the end of life. The out of hours integrated nursing team described the working relationship with the hospice as 'excellent'.
- Senior managers were aware there was a less effective provision for palliative and end of life care in the north Kirklees area. New plans with commissioners were being implemented to ensure a more holistic service.
- There was effective and collaborative working across disciplines involved in patient's care and treatment. For example, the dentist would consult with the patient's GP, consultant physician or surgeon, if patients had complex medical conditions.
- The adults service carried out joint general anaesthetic sessions with other specialities, for example podiatry. This reduced the need for repeated general anaesthetics for patients, decreasing the risks associated with frequent exposure to general anaesthetic.
- On Maple Ward the MDT meeting that we observed was patient focused and concerned with all elements of a patient's well-being. For example, risk management, equipment, diet, speech therapy and safety strategies were discussed for when the patient returned home.

### Referral, transfer, discharge and transition

- Most referrals to the integrated adults business unit teams was via the single point of contact (SPOC). This could be from GPs, hospital staff including consultants, social services, the voluntary sector, relatives and patients. The call handlers triaged the referrals and allocated these to the relevant locality ICCT, service or specialist team. In each ICCT an administrator allocated the referrals to the appropriate clinical lead for each zone. The clinical lead (Band 6 district nurse) would then allocate the referral to the most appropriate member of staff in the planned or unplanned teams.
- Specialist services such as the cardiology and respiratory service informed the patient's GP and the hospital consultant when patients were discharged from their service.
- End of life patients were picked up as referrals from the GP multidisciplinary meeting. Existing palliative care patients were also discussed at these meetings. Patients who were at the end of life could be referred to the

unplanned care teams. The out of hour's integrated nursing team told us they left a gap in the allocation of work in order to accept and visit a palliative care patient should there be a need overnight.

- There was 24-hour access to the local hospice. This included 24-hour advice from a palliative care consultant. It was possible to arrange admission into hospice care at any time of day or night if a bed was available and appropriate transport could be obtained. The out of hours integrated service gave an example of when this had happened.
- The community in-reach team worked seven days per week to prevent hospital admissions from the emergency department at the local acute hospitals. Patients on this caseload were discharged after 28 days and referred to other services as required.
- Patients on the intravenous home support caseload were subject to a virtual ward round on a weekly basis with a consultant microbiologist from the acute hospital trust.
- On Maple Ward arrangements were in place for patient transfers to the local hospital trust where ward staff were unable to manage the patient's acute medical condition.
- In childrens community services there were clear policies and pathways documented and in place for referral, transfer, discharge and transition of patients. A review of eight electronic records demonstrated effective pathways for referral to and between services and agencies.
- The family nurse partnership transferred families to the health visitor when the child became two years of age. This was a face-to-face handover in addition to completing electronic information. However, we saw changes to the service which meant a number of children were transferred to the care of the health visitor at an earlier stage and we were unclear as to the criterion used.
- Family nurse partnership staff told us that they could refer to specialist services such as domestic abuse workers and there were no significant waiting times for these referrals.
- Health visitors were informed by midwifery services of pregnant women at the time of initial booking and again at twenty-eight weeks of pregnancy so that they could arrange an antenatal visit. All pregnant women were offered this contact in preparation for the transfer to health visiting services.
- There were clear processes for the transfer of records if a family moved by using the electronic patient records system. If a family was identified as vulnerable, there were additional telephone contacts and occasionally joint visits if the area was not far away. There were specific identified services for children and young people moving if there were safeguarding concerns, a child was on a child protection plan or had become looked after.
- In community dental services there was a referral process in place to refer patients to the service. At the time of inspection, this was under review to ensure the service received appropriate referrals from general dental practitioners. The service had a triage system in place to ensure patients were seen at the appropriate time, by the most appropriate staff and in the best place according to their needs.
- Patients who were seen for single courses of treatment for sedation services or general anaesthesia were discharged back to their referring general dental practitioner. A discharge letter was provided and recorded in patient notes.
- There was no transition service as both children and adults were treated by the community dental team.

### Availability of information

- The intranet was available to all staff and contained links to current guidelines, policies and procedures. This meant staff could access advice and guidance easily. All staff we spoke with knew how to access the intranet and the information contained within.
- All staff had access to their work e-mail and we were shown that they received organisational information on a regular basis including updates and changes to policy and procedures. Some policies such as safeguarding directed staff to inter-agency procedures and information.
- The services used SystmOne which was an electronic patient record. Staff who were mobile told us and we observed this was very problematic due lack of connectivity. All information about patients was stored electronically on this system.
- When there was lack of connectivity, staff were not able to access the information they needed. Staff told us there was no facility to download patient information to

# 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.

allow staff access to patient records when connectivity was lost. We observed staff telephoning colleagues at a base to obtain information they needed about a patient which was time consuming.

- We observed the loss of connectivity was a very frequent occurrence and this impacted on staff being able to use their time effectively because of the number of calls made to colleagues to check patient details and care needs.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff in community adult services we spoke with were able to explain about the need to obtain patients' consent to care and treatment. We saw some examples of this in patient records and in observations of staff interacting with patients.
- In the day surgery service, consent to treatment and procedures was obtained prior to the surgery and patients were able to have a cooling off period. Consent was discussed again on the day of the procedure. We reviewed patient records and found this to be the case.
- Mental capacity act training was mandatory and there was 90.8% compliance with this. Staff we spoke with understood the legal requirements of the mental capacity act.
- However, capacity assessments in four records we reviewed of patients living with dementia had not been completed. The band 6 and band 5 nursing staff told us they did not have the knowledge and skills to be confident to undertake a capacity assessment.
- An internal audit of records of five palliative care patients conducted in October 2016 had showed only one do not attempt cardiopulmonary resuscitation (DNACPR) form present. When we reviewed the records of a palliative care patient who was living with dementia there was no evidence of a capacity assessment to support the DNACPR decision. Senior managers informed us it was the responsibility of the community nurse, community matron or specialist nurse involved with the patient to check the appropriate paperwork was in place and to contact the patient's GP if it was not there.
- Locala had a consent policy, which included specific preferences to children and young people. Staff told us that they were familiar with the policy, understood the principles of the Fraser guidelines and Gillick competencies and applied these in practice. The Fraser guidelines refer to the guidelines set out by Lord Fraser in his judgment of the Gillick case in the House of Lords (1985), which apply specifically to contraceptive advice. Gillick competence is concerned with determining a child's capacity to consent.
- Consent was obtained from parents and children at each stage of their care. We observed a health visitor on a post-natal visit explaining clearly to the mother about consent for immunisations and development checks. We also observed staff using the consent process with parents and children during immunisation clinics and speech and language therapy sessions.
- School nurses worked within the guidelines to make decisions about whether young people had the maturity, capacity and competence to give consent themselves. Staff from all services told us they took in to consideration the voice of children and young people when obtaining consent.
- The community dental service had a consent to examination and treatment policy, however this was not dated.
- There was a system for obtaining consent for patients undergoing general anaesthesia, inhalation sedation and routine dental treatment. We saw evidence of consent in the records we looked at.
- Where adults or children lacked the capacity to make their own decisions, staff sought consent from their family members or representatives. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.

# Are services caring?

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

## Summary of findings

Across the services that we inspected we spoke to 88 patients, relatives and carers. We visited clinical areas and accompanied district nurses and health visitors to observe patients receiving care at home as well as to talk with patients and their relatives about their experience of the service.

We found the approach staff used was consistently appropriate to the setting and demonstrated compassion and consideration for the patient. We saw comments on the Locala patient opinion website indicating staff had demonstrated a professional, kind and caring approach to patient care.

Throughout our inspection the majority of patients and relatives informed us they felt involved in care options, decision making and planned treatment. Staff took time to explain the care being administered and to ensure that patients and relatives understood what was happening.

Throughout our inspection we found that staff understood the importance of emotional support needed when delivering care. We saw staff interact in a supportive way with patients who were anxious and upset.

We saw some very positive interactions between staff and children and their families in particular.

## Our findings

### Compassionate care

- As part of our inspections, we observed care given to patients and observed staff speaking to patients and relatives on the telephone. In order to gain an understanding of people's experiences of care, we talked to patients and their relatives who used services across the trust.
- Patients on the whole told us they were happy with the care they received and the attitude of staff. We observed staff engaging with patients in a caring and respectful manner.
- Friends and Family Test data for the whole organisation showed a declining performance over 2016. In January 2016, 94% of patients would recommend Locala to friends and family. In October 2016 this had reduced to 87%. This was above the Locala target to maintain performance of 70%.
- The Family and Friends test was completed by children and families within each of the services. For health visiting, 98% of mothers were extremely likely or likely to recommend the service. For school nursing this was 91%, for the immunisation service 99% and for community nursing 99%. We were not supplied with response rates for children's services.
- We observed counselling sessions between the school nurse and school children and saw that the approach was caring, with opportunities for talking, listening, silence and reflection.
- We saw children's community nurses interacting in a humorous and compassionate way with school children with complex health needs and the children enjoying and returning banter. We also observed the sensitive manner in which the community nurses interacted with mothers of very young children with complex health needs. The mothers reacted positively to the reassurance and support offered.
- On Maple Ward the service scored 93% in the 2016 ward patient led assessment of the care environment for maintaining the privacy and dignity of patients. This was higher than the national average of 84%.
- We saw comments on the Locala patient opinion website indicating staff had demonstrated a professional, kind and caring approach to patient care.
- We were given an example of outstanding care from a patient who was given a hair wash by staff from the intravenous therapy service. This team had also taken the patient's nebuliser to be cleaned and liaised with the respiratory nurse for the patient's equipment to be reviewed.
- Staff in the community dental service were considerate of people's anxieties, provided them with reassurance, and gave clear explanations about the treatment. They allowed the patient time to respond if they were not happy or in pain. We saw an example of a patient receiving treatment, who was using the service because of their anxiety.
- During care for children undergoing a general anaesthetic, we saw staff care for the needs of the parents, providing them with reassurance and support.
- Friends and Family Test results for April 2016 showed that 88% of patients were extremely likely to

# Are services caring?

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recommend the community dental service, from 15 responses. In June 2016, the rate was 72%, from 28 responses. During August 2016, this had increased to a 100% response for patients recommending the service, however, there were only 3 respondents for that period. There was no data for July 2016.

### Understanding and involvement of patients and those close to them

- Throughout our inspection the majority of patients and relatives informed us they felt involved in care options, decision making and planned treatment.
- Patients on Maple Ward told us that they had plenty of opportunities to ask the nurses, doctor or therapists for updates and information relating to their care.
- In the community dental service we saw good examples of how children were involved in the treatment depending on their age. One member of the dental team used simple magic tricks to help children relax and engage in treatment. Staff provided parents with a range of advice to help them improve their child's dental health.
- Staff were able to provide support and care to patients due to having more time to spend with patients and explain treatments in detail and reduce their fear and anxieties. One member of the dental team was qualified in cognitive behaviour therapy. They used this technique for patients with phobias or who were highly anxious to successfully undertake dental treatments.
- In community children's services we spoke with two fathers who said that they felt involved and valued in planning their child's care.
- A child responding to a survey asking about their appointment with looked after children healthcare staff stated: "It was very informative and I felt safe and confident to ask questions". Three children rated the appointment positively because "She listened to what I said".
- Parents told us that they felt they could ask for advice and trusted the information that they were given. We accompanied health visiting staff on six home visits and community nursing on two home visits. We observed respectful and appropriate communication by the nurses and parents being involved in the future plans for their children.
- Some district nurses had been trained in the verification of patient death. This was for situations where the patient's death was expected. Staff told us this was very much appreciated by families of deceased patients who had died at home, particularly during the night time.
- We saw some examples of patients being consulted in their future care plans and involved in their care planning. We saw this happened with patients who were at end of life and also with patients who had just accessed the service

### Emotional support

- Throughout our inspection we found staff understood the importance of emotional support needed when delivering care. We saw staff interact in a supportive way with patients who were anxious and upset.
- MDT staff discussed the impact that a person's anxiety had an impact on their wellbeing and on those close to them; considering that access to future emotional support may be required.
- In childrens community services we observed staff in clinics and home settings providing emotional support to parents when their child's care was discussed. We saw on a home visit that a mother was struggling with her two young children and that strategies and referrals to other agencies were put in place with the mother's consent to help her.
- The immunisation team received feedback including: "My daughter has severe needle phobia. The nurse was aware in advance and was very calm, re-assuring and patient with her. It didn't matter how long it took to calm her and we got there in the end. Well done".
- Staff telephoned patients the day after their procedure in the day surgery service to provide any advice or support that the patient may require. Patients in this service were also able to come back to the service, in working hours, for any additional support they needed after their procedure.
- The district nurses visited the families of patients on the end of life care plan after the patient had died. They were able to signpost families to agencies for support and had information leaflets with details.

# 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 found that services were planned and delivered to meet people's needs across the service that we inspected.

The services worked to meet the needs of people in vulnerable circumstances and we saw some good examples of Locala working with other organisations to help vulnerable people access other health and social care services.

We found a mixed picture in relation to access to services in the community adults service. There were waiting lists for patients to access some services, such as podiatry and the respiratory service. However, waiting times for these services did not exceed the 18 week referral to treatment national indicator. Other services had no waiting lists. Some assessments and patient visits were being delayed or deferred as a result of capacity issues in the integrated community care teams. Patients were generally able to promptly access care and treatment in the other services that we inspected.

The organisation had a complaints policy and procedure, which staff were generally aware of. There was a complaints closure panel in place to monitor and review complaints and quality assure the complaints management process. There were mechanisms in place to share learning from complaints with staff and we saw examples of changes being made as a result of complaints. We were not able to gain assurance of the quality of the final responses sent to complainants in four of the five files reviewed because the final response documentation was not complete.

## Our findings

### Service planning and delivery to meet the needs of local people

- The care home support team was a multi-disciplinary team in the community adults service that offered advice and support to care home staff to help limit avoidable hospital admissions. The team had been successful in reducing hospital admissions by 19% for patients in care homes.
- The childrens service was working to provide a seamless service for families without the need for transition from health visiting services to school nursing.
- The pupil referral service sought to make contact with young people and partners in education by attending breakfast clubs and assemblies at units to increase visibility and accessibility.
- There were some good examples of services being delivered to meet people's needs in the childrens services. For example, the paediatric diabetes team led clinics in local health centres to provide an accessible service outside of the hospital setting and in North Kirklees, a pilot was underway to provide integrated assessments using Ages & Stages Questionnaires for all two year olds who attend childcare. The assessment involved the child, parents, child care provider and allocated health visitor.
- On Maple Ward a Multi-Disciplinary Team (MDT) commenced at the point of patient referral to assess patients prior to admission to ensure that therapy and nursing staff in the community setting could meet their needs.
- The community dental service was reviewing the referral system that was in place to ensure that the right patients were being referred to the service. The purpose of this review was to reduce waiting times for those most in need of the service.

### Meeting needs of people in vulnerable circumstances

- We saw some good examples of the community adults service meeting the needs of people in vulnerable circumstances. For example, the integrated community care teams (ICCTs) had worked with Age UK to develop a personal independence worker role. Two workers supported isolated patients who had reoccurring hospital attendances and lacked family support. From May to August 2016, these workers had supported 86 socially isolated patients by assisting them in navigating the health and social care system.
- The service had also developed a pilot scheme with a housing association to address the health and well-being needs of people living in this setting and reduce the demand on health and social care services. A housing officer was now part of an ICCT.
- There was no dementia or learning disability strategy in place. However, Locala had received an award in 2015

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from a local voluntary group specialising in dementia care in recognition of the work to become dementia friendly. Dementia training was part of the mandatory training programme.

- On Maple Ward, the service was working towards creating a dementia friendly environment and this included the use of recognised mobility aids and coloured toilet seats.
- Staff on Maple Ward used white boards to assist in communicating with patients who had a hearing impairment.
- In the community childrens service, the family nurse partnership was undergoing significant change. Caseloads were reduced to a maximum of ten mothers and their babies from twenty-five. The family nurses were a source of expertise for other staff working with vulnerable young mothers.
- We observed that the nurses who worked in the multi-agency support hub were able share appropriate information and health advice to other members of the multi-agency team with which to assess and plan care in a timely manner
- We observed that the nurses working in the youth offending team were part of the planning for vulnerable young people and were flexible in their approach.
- The dental service provided domiciliary care for people who may have difficulty accessing clinics, for example, those with a physical or learning disability, or with mental health needs.

### Access to right care at the right time

- We found a mixed picture in relation to access to services in the community adults service.
- There were no waiting lists in some of the community adults teams. For example, the cardiology team were able to see patients within seven days of referral and had developed criteria for urgent patients, who were seen within three days. We saw patients being offered a range of dates and times for appointments in specialist services, so patients were given a choice of a time that suited them.
- However, there were issues with access to other community adults services.
- At the time of inspection, there were almost 500 patients on the waiting list to be seen by the podiatry service. The maximum waiting time for this service was 18 weeks. There was a triage system in place and diabetic patients were seen within 24 hours of referral. At the time of inspection there were 170 non-urgent referrals waiting to be triaged by a clinician.
- There were also waiting lists of around eight weeks in the respiratory service and the Jubilee rehabilitation clinic.
- The flu vaccination programme for autumn 2016 had been delayed due to the lack of staff in the planned ICCTs. Staff were administering vaccinations to housebound people who were not on their caseload and told us the volume of work was difficult to manage.
- There was a waiting list of 355 patients awaiting a long-term condition assessment. This was due short staffing in the ICCTs and community matrons being requested to undertake district nursing tasks to support the ICCTs.
- District nurses in the planned team were not able to offer patients timed visits, which meant patients were waiting for the nurse to arrive all day, into the evening and in some cases overnight.
- Scheduled visits were sometimes deferred because of staffing shortages. A manager in one ICCT told us some routine daily dressing changes may be delayed or passed onto the next day as part of staff prioritising what could be done with the resources available.
- There was a single point of contact (SPOC) for all patients using adult services. This service was introduced in February 2016. There had been some significant issues with the service's capacity to meet demand**.** Performance information showed callers waiting up to 60 minutes for their call to be answered in February 2016. Significant improvements had been made since then, with performance data showing improvements in the call answering times from 12% of calls being answered in 90 seconds in February 2016 to over 80% being answered within 90 seconds and the longest wait being 15 minutes in May 2016
- There were clinicians based in the SPOC who provided advice to call handlers from 7am to 11pm and spoke with patients or carers if required. If advice was required outside this time, the clinical lead in the out of hour's integrated nursing team was able to provide this.
- There were clear algorithms on screen for call handlers in the SPOC to follow to ensure patients were referred to the correct service in a timely manner. These algorithms gave staff the information they required to prioritise the

# Are services responsive to people's needs?

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

call into the response times of either, zero – 2 hours, 2 – 24 hours, up to 3 days and more than 3 days. Performance information that we reviewed showed that these response times were generally met.

- In day surgery services the key performance indicators for referral to treatment times was within 18 weeks and this was consistently met.
- Waiting times in the community dental service were not routinely reported on, other than the waiting times for treatment under general anaesthetic. However, the service monitored waiting times for clinic patients. During April to August 2016, 12 patients had been waiting longer than 18 weeks for treatment. The delays were due to changes and cancellations to appointments.
- Did not attend rates were audited in the community dental service. This had led to a change in the service engagement with patients which had a significant impact in reducing the number of patients failing to attend appointments.
- In the community childrens services, therapy services including physiotherapy, occupational therapy and speech and language therapy achieved 100% of assessments and interventions starting within 18 weeks. Therapists told us that capacity issues meant that follow-up appointments could be delayed. This was being reviewed by the service.
- The health visiting service had recently established a duty system which operated from a base from 17.00 to 20.00 to provide advice and support to families out of hours.
- On Maple Ward, the average length of stay was 25 days. Further information was not available relating to referral, assessment or admission times.

### Learning from complaints and concerns

- The organisation had a complaints policy and procedure, which staff were generally aware of.
- We saw leaflets for patients and carers in a number of the locations we visited advising how to make a complaint. There was also a portal on the organisation's website where patients and their families were able to leave comments. Staff reported that there was an open and honest culture around complaints in the organisation.
- Complaints were risk assessed and logged on the organisation's electronic system on receipt and we saw evidence of this in four of the five complaints files that we reviewed.
- We reviewed five formal complaints files during the inspection. We were not able to confirm the quality of the final responses sent to complainants in four of the five files reviewed because the final response documentation was not complete.
- Complaints reports were provided to the business units on a quarterly basis and complaints had been introduced as a regular item on the business unit governance meeting agendas as part of the revised governance arrangements that were introduced in August 2016. Complaints were reported to Board in the quarterly quality report.
- Each business unit had a customer engagement manager who was responsible for overseeing complaints within their business unit.
- There was a quarterly complaints closure panel that comprised of non-executive and executive directors, other senior staff members and customer engagement managers. The purpose of this panel was to link quality and patient experience as well as provide assurance in relation to the management of complaints.
- Locala had seen a 156% increase in complaints within the 12 months prior to the inspection. The increased complaints were generally in relation to the single point of contact service, the podiatry service and the integrated sexual health service.
- We saw examples of learning from complaints. For example, as a result of complaints about the podiatry service patients were now able to book their next appointment at the same time as their previous appointment. Following a complaint in the childrens service a more robust process for communication was put in place if a child had a problem such as fainting after an immunisation.
- Learning from complaints was shared with staff at team meetings, in business unit governance meetings and via the weekly information email entitled 'Locala Live'.

# 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 of findings

Locala had a vision and strategy in place, together with a set of three core values. Staff knowledge of the values was variable across the services that we inspected. At the time of inspection, the organisation had just implemented a three year quality strategy for 2016-2019. Reporting against this had not yet commenced so we were unable to assess performance against the quality priorities.

The team of executive and non-executive directors had been stable since the organisation became operational in 2011. However, we were concerned that there was a lack of senior clinical leadership in the organisation, as there was no medical director or director of nursing. There was insufficient focus on workforce planning in relation to nursing in particular.

We were not assured that governance and risk management arrangements were robust and we were concerned that there was an insufficient focus on quality within the organisation. Revised governance and risk management arrangements had been introduced shortly before our inspection. However, many of these changes were not fully embedded and it was too early to see whether they would lead to improvements. We saw several examples of serious patient safety issues not being identified or escalated through the governance structures appropriately.

We found a mixed picture in relation to the culture of the organisation. This was reflected in the variation in responses in the June 2016 staff survey across the four business units. Some staff that we spoke with on inspection were obviously distressed. The organisation was taking action to improve this situation.

Locala communicated with staff in a number of ways, however some staff did not always feel this was effective. Staff generally reported that they felt engaged with the organisation and supported by managers. Patient engagement was embedded throughout the organisation and there were some good examples of services being developed as a result of patient feedback. Locala had strong relationships with the third sector.

## Our findings

### Leadership of the provider

- At the time of inspection the Locala Board was comprised of a chair, three non-executive directors, Locala's chief executive and three executive directors.
- The executive leadership team had been stable since the organisation became operational in 2011. The executive directors were the director of strategy, planning and partnerships, the director of finance and the director of quality. There was also an executive lead for care homes and the elderly. A director of operations had recently joined Locala as a result of a decision to split the operations and quality roles, which had previously been part of a single role. However, as a result of sickness, the director of operations was also responsible for quality at the time of the inspection.
- We were concerned that there was no medical director or director of nursing. Responsibility for clinical issues and leadership sat with the director of quality, who was a qualified therapist, although at the time of inspection this role was being covered by the director of operations, who was a qualified nurse. The majority of directors told us that the clinical voice on the Board was provided by a non-executive director. Medical advice to the Board was provided by a part-time medical advisor and Locala had recently recruited a second medical advisor to provide advice in relation to general practice.
- The non-executive directors were aligned to business units. They attended business unit meetings and fed issues back to the Board.
- Most staff were positive about their immediate line managers and felt well-supported. Some staff gave examples of senior managers, including the chief executive, being approachable and responsive. Some staff in the integrated community care teams (ICCTs) reported that senior managers were not visible.
- Locala had started a process called 'Shifting the Focus'. This initiative was aimed at enhancing the organisation's values, delivering social value and improving staff development plans. As part of this process, senior managers were making an effort to be more visible across the organisation.
- We saw reference in the May 2016 Finance, Performance and Quality Committee papers to a leadership strategy that was agreed by Board in January 2016. However, the leadership strategy that we were provided by the

# Are services well-led?

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organisation was in draft form. The associated action plan had no timescales for implementation of any of the actions identified or any indication of who was responsible for monitoring delivery of the actions. However, the May 2016 Finance, Performance and Quality Committee papers reported that a programme of activities aimed to strengthen leadership at business unit level had commenced, which included leadership sessions, coaching conversation workshops and a manager induction programme in the integrated community care teams. Managers that we spoke with confirmed that there was a greater focus on leadership in the organisation.

- The organisation had identified, and we observed, that there was inconsistent practice in relation to lone working within the services that we inspected.
- There was a lone worker procedure but this was past its review date of October 2015. We found different teams in the community adults service had set up their own ways of ensuring that staff were safe. These approaches varied between teams. Some staff said they had bought their own personal alarms. This was of particular concern because, following a serious incident in the community around 6 months prior to the inspection, Locala had identified that they need to review lone working practices and arrangements.
- There were panic alarms on staff laptops. However, this would not work if the laptop had lost connectivity. Managers were looking into trialling a key fob type alarm for staff to use.

## Vision and strategy

- Locala's vision was "Seeing Care Differently" and there were seven key outcomes identified as part of the vision.
- The organisation had three core values that had been in place since May 2012, "Be caring, Be inspirational, Be part of it". Staff knowledge of these values was variable across the services that we inspected and some staff in the community adults services described the values as "just words".
- We saw the organisation's vision and values on display in a number of the locations that we visited.
- There was a five year strategy for the period 2013-2017, which was underpinned by ten strategic objectives. A number of organisation wide objectives had been agreed for 2016/17.
- There was a workforce strategy for the period 2014-17. This identified three priorities in relation to recruitment, reward and leadership. However, there were no strategies specifically linked to particular staff groups, for example nursing staff. This was concerning in light of the staffing issues in the integrated community care teams which we were told was partially attributable to staff retirement and a decision not to recruit to vacant posts within these teams.
- We saw that the integrated childrens business unit and the community dental service both had strategic plans in place. There was no strategy for the integrated adults business unit.
- Locala had developed a three year Quality Strategy for the period 2016-2019, that was considered by the Board in September 2016. The strategy set out five quality objectives which were linked to the five CQC domains of "safe", "effective"," caring", "responsive" and "well-led". A number of priorities had been identified under each quality objective. Locala had asked its members to vote on the shortlist for the 2016/17 quality priorities. Performance against the quality objectives would be reported in the Performance Framework that was being introduced in August 2016 but it was too early for us to see evidence of this on inspection.

## Governance, risk management and quality measurement

- There were three sub-committees of the Board, including a Finance, Performance and Quality Committee, which was chaired by a non-executive director who had a clinical background.
- The services that we inspected were managed within four business units. Each business unit had its own management team covering operations, quality, finance, performance, workforce and customer engagement.
- In June 2016, Locala had introduced revised governance arrangements. In relation to clinical quality, a Clinical Quality Group had been introduced in August 2016 to scrutinise and hold to account the work of a range of sub-committees, including the safeguarding committee, medicines management committee and the audit and effectiveness committee. The Clinical Quality Group was a sub-group of the Finance, Performance and Quality Committee.
- Revised governance and risk management arrangements were also introduced in the business units. From August 2016 monthly meetings took place for three groups at business unit level: Clinical Quality

and Patient Safety, Finance and Performance, and Assurance. These changes were not fully embedded at the time of inspection so we were unable to assess the impact of this new approach during the inspection.

- The organisation had identified five strategic risks. These were, "poor standards of clinical quality and customer service", "failure to sustain financial health", "ineffective workforce, systems and processes", "failing to listen to and understand the needs of our community" and "the external environment getting the better of us".
- We were not assured that the organisation's approach to risk management was robust.
- The risk management policy described how corporate risks were identified by the Executive Management Group (EMG) and the Senior Management Team (SMT) based on their own and collective knowledge of the business, including key risks highlighted from front line services. The policy described how risk should be escalated through team meetings and fed into business unit management team meetings. Risks would be escalated from the business unit management team meetings to the Joint Business Unit Monthly Meetings, the Scrutiny Management Group and the EMG.
- Risks identified in the business units and sub-committees were set out on 'KORS' documents. 'KORS' stands for 'Key Opportunities Risks and Successes'. In around June 2016, the KORS template had been strengthened to ensure that they identified status, ownership and mitigation of risk. This was in line with recommendations made in an internal audit. We reviewed the KORS documents at service level. We were concerned that they were not robust. We saw that they recorded risks, their grading for likelihood and impact, and a brief description of the action to be taken, but did not include the date the risk was first recorded, the responsible officer and a target date for completion or review.
- According to the organisation's risk management policy, corporate risks were captured on two risk registers, the corporate risk log and the corporate issue log. The purpose of the corporate risk log was to capture potential corporate risks . The purpose of the corporate issues log was to capture actual risks i.e. things that had happened that had a negative consequence. Issues could move from the corporate risk log to the corporate issues log and vice versa. The corporate risk log and issues logs were reviewed and updated on a monthly basis by the EMG.
- The Locala Board had a Business Assurance Map in place. The assurance framework was linked to the organisation's strategic objectives and the 18 'pillars' or facets of the organisation. The pillars covered areas such as Clinical Quality, Finance and Performance and corporate enablers, such as workforce. The Business Assurance Map was updated quarterly.
- There was an inconsistent approach to rating risks in the corporate and strategic risk log, the corporate issues log and the Business Assurance Map.
- Risks on the Business Assurance Map were not risk rated according to their likelihood or impact. Risks were red, amber or green rated according to the level of assurance received by the Board. If 40% or more of the assurances in relation to a risk were deemed 'insufficient assurance', then the overall risk rating was 'insufficient assurance'. In August 2016, four risks were rated as having insufficient assurance. These were "risks to people who use the services are not assessed or their safety monitored or maintained", " that services do not take account of the needs of different people including those in vulnerable circumstances", "that patients and staff are not trained adequately before using equipment with which they are unfamiliar" and "that staff are vulnerable when working alone".
- Risks on the strategic and associated corporate risk log were risk rated according to an assessment of their likelihood and impact. It didn't include the date that the risk was identified or any timelines for the actions to address the risks. The two highest rated risks in August 2016 related to a risk of inappropriate estate to deliver the new clinical model and risks around changes in acute and social care provision and the potential impact of demand for Locala's services.
- The corporate issues log contained 11 risks in June 2016. Risks were not rated by their likelihood or impact. They were assigned a high, medium or low priority. There was no description of what a high, medium or low priority risk was on the document or in the risk management policy. Seven of the risks were assigned a high priority, the remainder were medium priority. Actions were not consistently identified in the document to mitigate the risks and there were no

timescales attached to any of the actions. However, Locala did refer to actions plans that were developed in response to issues identified on the corporate issues log.

- We reviewed the corporate issues log dated June 2016. It did not include a number of the key concerns that we identified during the inspection, for example in relation to assessing and responding to patient risk on Maple Ward, with the management of incidents or the staffing issues in the ICCTs. There was only one clinical risk identified, in relation to compliance with National Institute for Health and Care Excellence guidance for staffing levels on Maple Ward.
- According to the risk management policy, the corporate issues log should be updated monthly. Locala told us that no issue logs were available for September or October 2016. As such we saw no evidence that issues that we had identified on inspection, for example, with assessing and responding to patient risk on Maple Ward or the staffing issues in the ICCTs had been identified and escalated as actual corporate risks by the organisation prior to the inspection.
- There was confusion between very senior members of staff about the purpose of the corporate issues log and the corporate risk log. Two senior members of staff explained the purpose of these documents in a contradictory way.
- There were no risk escalation criteria in place to provide a framework for staff to determine what risks should be escalated through the organisation. As a result of this it was not clear what criteria were being applied to escalate risks in the organisation. For example, we saw two Integrated Children's Business Unit Assurance reports written for the Joint Business Unit Assurance Group which identified a number of risks, including recruitment challenges in therapy services, the lack of a formal service commissioned for 16-18 year olds and the possibility of relocating the children's development centre. From the minutes, it was not clear what the Joint Business Unit Assurance Group intended to report as key messages to the Scrutiny Management Group. We did see evidence of children's service risks being presented to the Scrutiny Management Group but saw no criteria being applied to the threshold of risk that was brought to that committee.
- We saw in various documents that the staffing issues in the ICCTs had been escalated through the governance structure and a number of actions had been agreed to address them. However, there was no evidence of a comprehensive review of the situation or a single robust action plan to address the staffing shortfalls or to manage the waiting lists of patients created as a result of the organisation's response to acute staff shortages in these teams over the summer and autumn of 2016.
- We raised our concerns in relation to risk management with Locala and they have advised us of a number of actions that they are taking to strengthen governance and risk management in the organisation.
- There was an agreed clinical audit programme in place for 2016/17. Locala had identified that gaps in required levels of quality assurance and clinical governance may lead to poor standards of clinical quality and had commenced a programme of work to address this, including establishing the Clinical Quality Group and implementing the revised business unit meeting structure in August 2016. At the time of inspection it was too early to see evidence that these actions had been effective.
- The processes for identifying and reviewing serious incident investigations were not robust. For example, an incident that fit the criteria for a serious incident that occurred earlier in 2016 had not been identified as a serious incident until five months later. The initial investigation had found that the incident was unavoidable. This finding was later found to be incorrect following a further investigation and the incident was then classed as avoidable. The delays in identifying and investigating this incident as a serious incident resulted in delays in implementing actions to address patient safety concerns on Maple Ward.
- Incidents were reported to the Finance, Performance and Quality Committee in the organisation's quarterly quality reports. However, from the reports we reviewed, there was no systematic approach to reporting incidents. For example, there were no regular reports on never events or serious incidents and the reports contained limited quantitative information. We were concerned that this would make it difficult for the organisation to recognise trends in incidents. The organisation was in the process of reviewing governance arrangements in relation to incidents at the time of inspection. A combined Performance and Quality report had been implemented in September 2016 and we saw that this contained more detailed analysis of incidents.
- There had been a serious incident earlier in 2016, which highlighted that a new member of staff had not been

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properly supervised or had their competencies checked. The organisation had a guide for managers relating to new starters but this had not been followed. This serious incident also highlighted poor human resources systems, as pre-employment checks had not been carried out prior to a member of staff starting work with the organisation. Locala had taken action to address these issues and gain assurance regarding employment checks on existing members of staff.

- At the time of inspection there had been no Board oversight of the organisation's compliance with the duty of candour regulation, which was introduced in April 2015, until September 2016. Board members confirmed this during the inspection.
- The membership contribute to the governance of Locala through the Members' Council which was made up of 10 staff members covering a wide range of Locala's services, 6 community members, and 4 co-opted members (these include a GP, a Practice Manager and 2 local councillors). They are the link between the members, the community and the board of directors

### Culture within the provider

- We found a mixed picture in relation to the culture of the organisation. Some staff groups were very positive about the organisation, others were less so. This was reflected in the variation in responses in the June 2016 staff survey across the business units. In general, the integrated adults business units showed lower levels of satisfaction than the integrated childrens business unit.
- Generally staff we spoke with reported that they felt supported by their immediate managers and able to raise concerns. The staff survey in June 2016 showed that 77% of staff felt secure raising concerns about unsafe clinical or non-clinical practice (the average in the NHS staff survey is 69%).
- Opportunities were available for professional development and staff generally felt supported in accessing training and development.
- Some staff spoke very positively about the organisation empowering them to make positive changes in their services. This was supported by the June 2016 staff survey results, which showed that only 14% of staff felt unable to make suggestions to improve the work of their department.
- Staff survey data from June 2016 showed that 45% of staff would recommend Locala to friends and family as a place to work. This was down from 63% in January 2015. The organisation thought this was due to the impact of the Care Closer to Home contract in October 2015.
- We spoke with a notable number of tearful staff in the integrated community care teams, who cited an unmanageable workload as the primary reason for feeling upset. Staff at various levels of the organisation were obviously upset when speaking to the inspection team.
- There were high levels of staff absence due to stress, particularly in the integrated adults business unit. The organisation had taken a number of actions to support staff including introducing a wellbeing fund, making health checks available to staff and providing stress workshops. However, it had been noted that not all staff who would benefit from the stress management sessions had attended them. In response to feedback from staff, Locala was working with a local mental health NHS Trust to redesign the stress sessions.
- There was a whistleblowing policy and procedure in place. Locala had signed up to the Nursing Times Speak out Safely Campaign and had recently appointed a Freedom to Speak up Guardian, to support staff in raising concerns. However, some of the staff that we spoke with were not aware of the whistleblowing policy of the Freedom to Speak up Guardian.

### Fit and proper persons

- The organisation had been slow to implement the requirements of the Fit and Proper Persons Regulation (FPPR), which came into force for non-NHS Trusts in April 2015. This regulation ensures that directors of healthcare providers are fit and proper to carry out their roles.
- There was now a comprehensive Fit and Proper Persons Procedure in place. However, the organisation had not commenced the checks required under the FPPR until the FPPR procedure was ratified, which occurred in July 2016.
- Therefore, director level appointments made in the period April 2015 to July 2016 were not in accordance with the FPPR requirements and checks had not been made to ensure existing directors were fit and proper until the summer of 2016.
- We reviewed 12 personnel files for executive and non-executive directors. This showed that the required

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checks had been completed in August 2016, with the exception of occupational health assessments which were not available in four of the files reviewed and references were not available in two of the files reviewed.

### Equality and diversity

- Locala had an equality and diversity strategy and an equality and diversity action plan for 2016/17 had been agreed as part of the strategy. This plan included how the organisation would meet the requirements of the Accessible Information Standard.
- There was an equality and diversity group, which had been meeting bi-monthly since January 2016. Outputs from this group were reported to Board in the workforce report.
- A head of human resources had recently been recruited to provide focus and leadership in relation to equality and diversity, reward and staff engagement.
- The workforce race equality standard (WRES) aims to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.
- Locala had benchmarked itself against the standard and indicators in April 2016. This showed that the experience of BME colleagues was less favourable than of white colleagues in a number of indicators. Locala was doing better or was in-line with national and regional averages in most indicators, with the exception of more BME staff saying they experienced harassment, bullying or abuse from staff in Locala compared to the average community provider. Locala was working to understand the reasons for this.

### Public and staff engagement

- Locala undertook regular staff surveys. The June 2016 staff survey results showed that 73% of staff would recommend Locala has a place to work (against an average of 69% in the NHS staff survey), 51% of staff agreed that Locala's values influenced their working life and 42% of staff agreed that communication was effective across Locala.
- Locala had identified key areas for improvement as a result of the staff survey and action plans to address issues identified in staff surveys were developed by each business unit and progress was monitored by the Scrutiny Management Group.
- The organisation communicated with staff in a number of ways. There was a weekly electronic staff newsletter, Locala Live, which included an article linked to the Locala values. There was also a team brief that was cascaded to staff through the management structure.
- Senior managers visited team meetings on a quarterly basis with a set brief to share with the teams. There were also quarterly or six monthly business unit forums for staff from a range of services to meet to discuss professional or organisational issues.
- Generally staff we spoke with felt engaged with the organisation. However, the June 2016 staff survey results showed only 42% of the staff agreed that communication was effective across the organisation. The most positive themes showed staff liked the communication systems and technology was said to have helped. The lack of time and too much information were reported negatively in the survey.
- Staff we spoke with in the integrated community care teams (ICCTs) generally did not feel engaged with the senior managers of the service. Many staff told us they did not think the senior management understood what they and their teams did. Senior managers told us the amount of change in implementing the care closer to home contract had caused fatigue and apathy amongst staff in the ICCTs. This issue was recognised by senior staff and the organisation was working to improve the way it managed change in relation to anticipated changes to the childrens services.
- Locala was committed to building strong relations with external partners, particularly in the voluntary sector. One of the directors was a trustee of Kirklees Third Sector Leaders. Locala was the Age UK Partner of the Year in 2016.
- There was a customer service and engagement strategy, which was underpinned by a customer engagement plan and service level customer engagement plans. Engagement plans covered areas such as customer concerns, comments, friends and family test and patient surveys. Customer engagement managers supported the business units in delivering their customer engagement plans.
- Locala had engaged with a number of groups, including hard to reach groups, to try to understand and improve their experiences. For example, the organisation had created a Young Peoples' Network. Feedback from this

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network had been used to improve the childrens' immunisation services. Locala was working with this group in relation to service developments in the childrens service.

- There was a customer experience group, which was made up of Locala's staff and community members The group reviewed patient feedback and provided feedback to the organisation.

### Innovation, improvement and sustainability

- Locala was committed to benefitting the communities that it served and was involved in a number of community initiatives. For example, there was a Locala Community Fund, which had helped 18 voluntary organisations over the last 12 months.
- The organisation had worked with Age UK to develop two "personal independence worker" posts. The posts were designed to support isolated patients who had no family support that have recurrent hospital admissions or urgent care intervention.
- Locala had recently successfully piloted a partnership arrangement with Connect Housing to address health and wellbeing needs of housing association residents. The project had been reviewed by a local university, with patients reporting improved health and wellbeing.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Regulation 12 (2) (a) Assessing the risks to the health and safety of service users of receiving the care or treatment<br><br>·Clinical risks on Maple Ward were not robustly assessed, monitored and recorded.<br><br>Regulation 12 (2) (b) Doing all that is reasonably practicable to mitigate any such risks<br><br>How the regulation was not being met<br><br>· An incident was not identified as a serious for five months.<br><br>· There was a backlog of incidents awaiting completion of investigation.<br><br>·A serious incident had been incorrectly determined as unavoidable.<br><br>·Learning from the serious incident on Maple Ward was not embedded in the service.<br><br>·Care plans had not been developed for some patients on Maple Ward. Care plans were not person centred.<br><br>Regulation 12 (2) (c) Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely<br><br>How the regulation was not being met |

This section is primarily information for the provider

# Requirement notices

·There were some staff in the integrated community care teams who were noted in meeting minutes as not meeting competency requirements.

Regulation 12 (2) (h) Assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated

How the regulation was not being met

· Four infection prevention and control policies were out of date.

· The infection prevention and control (IPC) audit timetable hadn't been followed in all the services that we inspected. There were high levels of non-submission of IPC audit data in some of the business units, particularly the integrated adults business unit.

· Some equipment was not in-line with IPC best practice at the Princess Royal Health Centre. At Princess Royal Health Centre sterile equipment was not stored appropriately and there was no hand gel available for patients.

| Regulated activity | Regulation |
| --- | --- |
| Nursing care<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>Regulation 17 (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.<br>How the regulation was not being met<br>·The processes for identifying and reviewing serious incident investigations were not robust.<br>·There was no systematic approach to reporting incidents to the Board.<br>·Action plans were not always comprehensive and their implementation was not always robustly monitored. |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Nursing care<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>Regulation 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part<br><br>How the regulation was not being met<br>·There were significant staffing shortfalls in the integrated community care teams.<br>·Paediatric nurses were not available at Dewsbury District Hospital to provide recovery care for children receiving dental treatment under general anaesthetic.<br><br>Regulation 18 (2) Persons employed by the provider in the provision of a regulated activity must - |
| | Regulation 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<br><br>How the regulation was not being met<br>·Risks were not appropriately escalated and managed within the organisation, for example the impact of acute staffing shortfalls within the integrated community care teams.<br>·Risk management tools were not robust.<br>·There were not always robust and comprehensive action plans in place to mitigate risks.<br>·Audit programmes were not always followed and outcomes were not consistently reported through the governance structure. |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Nursing care<br><br>Treatment of disease, disorder or injury | Regulation 18 (2) (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<br><br>How the regulation was not being met<br><br>·Mandatory training compliance rates were significantly below target in some of the services that we inspected.<br><br>·Staff did not receive individual clinical supervision in the community adults service.<br><br>·Compliance rates for safeguarding children training were low in the community adults and community dental services.<br><br>·Appraisal rates were low in the community adults and community inpatients services. |
| Nursing care<br><br>Treatment of disease, disorder or injury | Regulation 20 HSCA (RA) Regulations 2014 Duty of candour<br>**Regulation 20(1)** Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity<br><br>How the regulation was not being met<br><br>Compliance with the duty of candour requirements was not embedded across the organisation. We saw examples of the duty of candour not being implemented as soon as reasonably practicable and where the application of the duty of candour was appropriate and had not been applied, such as for category four pressure ulcers. |