Leeds Community Healthcare NHS Trust

RY6

Community health inpatient services

Quality Report

CQC Registered Location	CQC Location ID
Community Intermediate Care Unit	RY6Y2
South Leeds Independence Centre	RY6Y1

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

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

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

Summary of findings

Ratings

Overall rating for Inpatient Services	Requires Improvement
Are Inpatient Services safe?	Requires Improvement
Are Inpatient Services effective?	Requires Improvement
Are Inpatient Services caring?	Good
Are Inpatient Services responsive?	Requires Improvement
Are Inpatient Services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service. Requires Improvement

The units we inspected were South Leeds Independence Centre (SLIC) and the Community Intermediate Care Unit (CICU) based at St James's Hospital. Both of the units provided rehabilitation and hospital avoidance services in the community.

In terms of safety, we found there were areas for improvement around staffing levels and skill mix, particularly at SLIC. Other aspects of safety were more positive particularly in terms of incident reporting, records, medicines management and infection control.

The effectiveness of the services provided by the units varied. Care plans were in place for all patients at each unit and care plans on CICU were appropriately patient-centred but those on SLIC were more generic and impersonal. Evidence-based documents were in place at both units but these weren't always fully completed. For example, with some forms, staff signatures and dates were missing and certain sections were blank, such as identified goals, time-frames and outcomes. Such sections should have been completed before moving on to complete later sections of certain documents; this was confirmed by staff we spoke with.

Staff worked together well across the two units and between disciplines and appraisal rates were suitable on CICU at 87% but were slightly lower on SLIC at 73%, although this was recognised by the trust and efforts were being made to increase this figure. There were good examples across both units where consent was gained before treatment but, on SLIC, there were issues with do not attempt cardio pulmonary resuscitation (DNACPR) forms.

We found staff, at both SLIC and CICU, to be caring in their approach to patients and their relatives. We observed numerous interactions between staff and patients and staff showed compassion, respect and understanding.

In terms of responsiveness, there were positive aspects and this included equality and diversity and meeting the needs of vulnerable people. Average length of stay data, on the whole, for both units was encouraging but there were some outliers on SLIC in relation to some long term nursing patients. Both units were able to admit referred patients within acceptable time-frames but there was no formalised process for ensuring patient's needs could be met as judged against the needs of existing patients and available resource. A care needs dependency tool was being piloted in November 2014 to help to clarify and understand the process.

In relation to well led, there were some leadership challenges on SLIC and staffing skill mix was not well balanced and staffing had been struggling to meet the full needs of all patients for a relatively long period. There was however a clear vision and detailed strategy for the services and leadership was seen by many staff as supportive and there was open culture.

Summary of findings

Background to the service

Background to the service

South Leeds Independence Centre (SLIC) was a 40 bedded community rehabilitation unit, with 30 nursing and 10 residential beds which opened in April 2013. The service, integrated health and social care, in order to deliver short term patient centred rehabilitation, recovery and reablement.

The team based at SLIC was made up of nurses, physiotherapists, occupational therapists, care assistants, and medical practitioners with access to other health care professionals such as dieticians, joint care managers and medical practitioners. The majority of the staff on SLIC were employed by Leeds Community Healthcare NHS Trust (LCHT) except for care assistants (CAs) and facilities staff, such as the cooks and cleaners, who were employed by another organisation.

The beds at SLIC were used when a person could not be supported safely in their own home, and when they did not need to go in to, or remain in hospital.

Staff worked with people aged 60 years or over, and people aged under 60 who had complex, multiple health and social care needs, usually associated with old age.

The community intermediate care unit (CICU) was a 24 bedded unit providing care for older people who had become unwell and required a higher level of nursing, therapy and medical care than could be provided at home or in a community intermediate care bed.

The multi-disciplinary team was made up of community geriatricians, a community matron, general nursing staff, occupational therapists and physiotherapists, and clinical support workers. Access to other healthcare professionals such as dieticians, and joint care managers also took place.

Staff worked to stabilise health, optimise independence and enable patients to reach their full potential. The service was for people aged 60 years or over, with older person's needs and provided a person-centred care.

Our inspection team

Our inspection team was led by:

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

Head of Inspection: Adam Brown, Care Quality Commission

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of findings

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

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

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

What people who use the provider say

We spoke with a high proportion of patients at both SLIC and CICU; the vast majority of patients and patient's friends and relatives were happy with the care they received. Patients often said staff were polite, caring and respectful. Patients also felt that staff were approachable and supportive.

Some patients on SLIC said, that on occasion, staff were very busy which meant, in their view, they were not adequately supported and encouraged to do certain things, for example, take a bath, go to the lounge area and/ or have their meal with others in the dining area. Other patients also added that they were bored and not involved in any arranged activities. Some patients on SLIC were aware of the relatively high use of agency staff and recognised how it affected their continuity of care. For example, one patient said they had to prompt an agency worker to review their care plan.

Patients on CICU also spoke positively about their involvement in their care and were, in the main, clear about their care plan and discharge plans.

Good practice

Our inspection team highlighted the following areas of good practice:

N/A

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Ensure staffing levels and skill mix are suitable for staff to effectively provide the necessary support to patients.
- Ensure that resuscitation procedures and practice are reviewed and the use of best practice is implemented for example Resuscitation Council guidance.
- Ensure initial assessments are promptly undertaken and care plans are person centred on all units.
- Develop discharge planning processes and encourage decisions to be more focused and time-stated.
- Ensure DNACPR forms are completed in-line with trust policy.
- Ensure emergency drugs can be accessed quickly in an emergency.
- Ensure drug fridge temperatures are maintained appropriately.
- Ensure equipment is appropriately maintained and fit for use.

Leeds Community Healthcare NHS Trust

Community health inpatient services

Detailed findings from this inspection

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

Requires Improvement

Are services safe?

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

Summary

We judged the safety of services as requiring improvement. Staffing was the main area of concern, particularly in relation to SLIC. Evidence from patients, staff and from our observations demonstrated that staff could not effectively carry out their intended roles and support patients effectively at all times.

There was an open incident reporting culture and changes to practice were implemented in response to any investigations. The management of falls risk was not always managed effectively and there was over-reliance on pressure pads and the patient alert system at SLIC.

Staff were aware of their responsibilities in relation to safeguarding vulnerable people and understood how to escalate any concerns. Equipment, across both units, was, on the whole, appropriate but there were issues with slings and resuscitation equipment on SLIC.

Records on both units were suitably organised and information was straightforward to locate. Infection control standards were good and staff washed their hands when necessary. Mandatory training compliance figures, on the whole, were appropriate.

Detailed findings

Incident reporting, learning and improvement.

We reviewed the number of reported patient-related incidents for SLIC and CICU between 1 September 2013 and 30 November 2014. All incidents, excluding expected and unexpected deaths, were graded under five headings; near miss, no harm, minimal harm, moderate harm and major harm.

For the time period stated above, there were a total of 630 reported patient-related incidents for the 40 bedded SLIC and 231 for the 24 bedded CICU. For SLIC, this equated to just under 17 patient-related incidents per bed, and for CICU, this equated to just under 10 patient-related incidents per bed.

Requires Improvement

Are services safe?

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

Of all the incident totals, for both in-patient areas, no harm incidents were around 60% of all reported patient-related incidents and minimal harm incidents were around 20%. Within SLIC 47 (7.5%) moderate harm patient-related incidents were reported and CICU reported 15 (6.5%) moderate harm patient-related incidents. Finally SLIC reported 5 (0.8%) major harm incidents and CICU reported 1 (0.4%).

For all the reported major harm patient-related incidents, these were reported as serious incidents (SIs) and were fully investigated. We were informed that SI investigations included a root cause analysis (RCA), action plan and implementation of change where necessary.

Of the 630 patient-related incidents reported at SLIC between 1 September 2013 and 30 November 2014, 409 of these were fall incidents, this equated to 60%. For CICU, of the 231 reported incidents, 109 were falls, this equated to 47%. SLIC had a higher percentage of falls incidents in comparison.

The unit managers for both in-patients' units recognised the risks in relation to falls and acknowledged the fine balance between encouraging patients to become more independent and reducing falls/ incident risks.

Each unit had analysed their falls data in detail and compared the number of falls against admission rates. For SLIC, from August 2014 to November 2014, admission rates had significantly increased, yet, the number of falls went down slightly. For CICU, for the same time period, there was more of a mixed picture.

Both SLIC and CICU had falls sensor alert systems in place. However the system on SLIC had greater functionality, with different alert tones for different types of incident and urgency, and the facility to community through the system for alerting staff as to when a patient may have fallen or required assistance. The system was effective but it had replaced some elements of planned general observations and regular checking of patients. Relying on responding to the electronic alerts made responding to patient risk reactive and intentional rounds had stopped during day shifts. We discussed this with the clinical pathway lead and the day time intentional rounds were reintroduced during the inspection to ensure regular formal checks on patients. This was positive because patients on SLIC had their own individual rooms and line-of-sight was not possible until staff entered each room.

The unit manager for SLIC described how both in-patients units were comparatively high reporters of incidents and this reflected a positive and open incident reporting culture.

Both in-patient area unit managers reviewed Datix (computer-based incident reporting system) on a weekly basis and shared data with staff. This was done via team meetings and handovers.

Learning from incidents was also shared between the Leeds community services. For example, from an SI investigation following a patient who fractured their hip, daily checking of falls sensors was introduced; we saw evidence of the daily checks happening in practice.

In relation to CICU, it was recognised, particularly towards the end of 2013, that the number of medication incidents had increased. Analysis of some incidents pointed to a key contributory factor; nurses being distracted during medicine rounds. To help prevent this, practice was changed and nurses were required to wear tabards during medicine rounds to reinforce the fact they should not be disturbed. As a result of this, and an increase in staff awareness of the issue, medication errors reduced.

Duty of Candour

We spoke with the service manager and clinical pathway lead for the in-patient units and they were aware of the recently introduced Duty of Candour regulation for NHS trusts.

They also described how the senior management were aware of the new regulation but felt that a culture of openness with patients and families already existed. A recent example was given where the two members of the executive team visited a patient following a 'no harm' drug prescription incident in order to apologise and openly discussed the issue.

Safeguarding

Across both in-patient areas the unit managers described how they had a positive working relationship with the safeguarding lead for the trust and felt the safeguarding lead was supportive and provided appropriate advice and guidance. The safeguarding lead also conducted teaching sessions on the units for staff and there was a strong emphasis on dignity, communication, honesty and openness.

Requires Improvement

Are services safe?

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

We spoke with numerous staff across the two in-patient units and staff described how to access the trust's safeguarding policy and the correct procedure for escalating safeguarding concerns.

For agency staff, safeguarding and how to report concerns was covered during the brief induction process that agency staff were required to go through before starting work.

We reviewed the safeguarding training figures for SLIC and CICU. In respect of safeguarding children training all staff on the in-patient units were expected to complete this at level 1; this was a mandatory requirement.

The training compliance data provided by the trust after the site visit stated that safeguarding adult's level 1 training was mandatory for all staff; for band 6 level staff and above it was mandatory to complete adult safeguarding level 2 training.

According to figures provided by the trust after the inspection all band 6 staff at SLIC and CICU had completed, and were up-to-date, with their level 2 safeguarding adults training.

Overall compliance with safeguarding adults training was 96% for SLIC and 90% for CICU. Overall compliance with level 1 safeguarding children training was 96% for SLIC and 100% for CICU.

According to the training matrix reviewed during the inspection, at SLIC (26 members of staff listed on the mandatory training record sheet), the percentage compliance for safeguarding adults training was 92%. At CICU (38 staff listed), percentage compliance was 84%, taking into account maternity and extended sick leave.

Prior to CICU relocating to the St James's Hospital site on 17 January 2014 the service was provided at Seacroft Hospital, also in Leeds. Between 25 February and 3 July 2013 five separate safeguarding alerts were referred to the adult social services safeguarding team. The alerts involved five patients who had been admitted to CICU, at the Seacroft location, during that time period. The issues raised related to aspects of patient care and allegations including patients not receiving compassionate care and aspects of care being neglectful; all of the safeguarding investigations were deemed as appropriate and were upheld throughout the course of the investigation.

Contributing factors for the incidents included 'competencies of staff not understanding and implementing Safeguarding Vulnerable Adults Operational Policy and also not implementing the Whistle Blowing Policy. With this in mind, we were concerned to see that safeguarding adults training was not mandatory for the more junior members of staff.

Medicines management

SLIC

There was an appropriate selection of medicines available including opiate-based drugs in a variety of forms. All the medicines we reviewed, including patches, were in date, securely stored and stock records were accurately completed. The medicines stored in the drugs fridge were being stored appropriately and the drugs we observed were in date.

Recording of fridge temperatures was, on the whole, accurate and consistent; we noted two dates from the previous month were two temperature recordings had been missed.

We reviewed five drug charts and they were clearly written and accurately completed.

Emergency medicines were stored in the locked medicines cabinet. During an emergency, the staff member holding the 'drugs keys' needed to be located in order to access the locked cupboard; this would have created unacceptable delays.

CICU

Medicines observed on the resuscitation trolley were stored appropriately in a sealed container in a drawer; the emergency medicines observed were in-date.

There was an appropriate selection of medicines available on the ward including intravenous fluids.

We reviewed five drug charts and, on the whole, they were clearly set-out and accurately completed. On two of the drug charts we noted that the dates for when medicines needed to commence had not been entered.

We checked the contents of all the drug cupboards, including the cupboard for controlled drugs, and all medicines we observed were in-date.

We reviewed the storage of medicines in the fridge and the medicines we checked were in-date.

Requires Improvement

Are services safe?

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Some fridge temperature recordings were higher than 8 degrees Celsius; the recommended temperature range for a medicines fridge is between 2 – 8 degrees Celsius.

Safety of equipment

SLIC

We observed a variety of equipment used on the unit including resuscitation equipment, wheel chairs, walking frames, hoists and hoist slings. The resuscitation equipment included a trolley containing an automated external defibrillator (AED), a box of bandages, suction apparatus and two oral airways; the selection of equipment available was not sufficient and there was no oxygen available.

There was some uncertainty amongst staff about their role in a cardiac arrest situation and what equipment should be used. The skill mix of staff in terms of cardiac arrest management was also variable. These issues were discussed during the inspection with the clinical pathway lead. During the week of the inspection a decision was made by the trust to clarify the expectations of staff during a cardiac arrest. The trust had decided to retain the AED and remove all other resuscitation equipment. The trust intended to ensure staff were clear about when an emergency ambulance needed requesting.

From a previous CQC inspection it was found that the necessary steps to maintain safe resuscitation equipment were not consistently applied. We reviewed and checked this during the inspection. Apart from two occasions in July 2014 resuscitation equipment had been checked as required.

From a previous CQC inspection it was found that the necessary checks for resuscitation equipment were not consistently being completed on a weekly basis; we reviewed this during the inspection and checking frequency had improved. However, there were two occasions in July 2014 where resuscitation equipment had not been checked. The decision to use / have available only an AED had simplified the checking process but the manufacture of the AED recommended to check the AED daily by looking for the 'green tick' on the machine.

Servicing of all wheel chairs had been completed two weeks previously and the hoists and walking frames we observed were in good working order.

We examined three re-usable hoist slings; a small, medium and a large. The label on the small hoist sling had been completely worn away, the label on the medium and large hoist slings were also very worn. When the label on slings becomes worn it is an indication for it to be replaced.

A physiotherapist we spoke with described how it was everyone's responsibility to check slings each time they used one; this process was not effective and there was lack of accountability for ensuring the safety of slings.

CICU

We observed the same variety of equipment at CICU as we did at SLIC including resuscitation equipment, wheel chairs, hoists and slings. The correct type of resuscitation equipment was available and the necessary checks were being completed consistently.

The resuscitation equipment on CICU needed to be managed correctly because in the event of a cardiac arrest, the St James's Hospital cardiac arrest team were called and they would need to use the equipment / emergency medicines available on the unit.

Wheel chairs, walking frame and slings appeared to be in good working order and we also observed equipment being used safely.

We observed two mobile hoists and their servicing dates; one of the hoists had its next service date in January 2015 and the other hoist had a date of June 2014; there was no evidence that the second hoist had been serviced within the necessary timescale.

Records management

During a previous CQC inspection of SLIC, we found that records were not being managed effectively and information was not always easy to locate. The unit manager of SLIC described how the record management system on SLIC had been closely reviewed and significant changes had been made.

We found that, on both in-patient areas, nursing and medical records were effectively organised and it was clear to see which records were medical and which were nursing. It was also relatively straightforward to locate the records of allied healthcare professionals such as physiotherapy and occupational therapy.

The storage of notes was slightly different between the in-patient areas. On SLIC, nursing plans and some nursing

assessments were kept at the end of the bed and on CICU, because there was generally more medical input, care plans and multidisciplinary notes were kept at the end of patient's beds.

In addition, on SLIC, discharge sheets were kept in the nursing noted and on CICU, discharge sheets were kept in the medical notes.

Cleanliness, infection control and hygiene

The patient environment on both in-patient units was visibly clean including surfaces frequently touched by patients including hand rails and equipment.

We observed domestic staff and they were using the appropriate cleaning materials and cleaning products. However, on two occasions we observed a member of cleaning staff clean the bottom of a bed-side cabinet, with the cloth touching the wheels, and then clean the table-top with the same cloth; this had a high potential of cross infection.

On the SLIC unit, in its design, it was evident that infection control staff had been appropriately consulted and the layout and materials used helped support good infection control practice. For example, the wall and floor surfaces were easy to clean and the environment was not cluttered.

On both in-patient units, there was appropriate access to alcohol hand rub, hand wash basins and personal protective equipment (PPE); we observed staff cleaning their hands appropriately and wearing PPE when necessary.

All of the patients on SLIC had their own room which was an ideal situation if any patients required isolation facilities to reduce the likelihood of cross infection. CICU was designed differently and split into bays of four beds; it had four bays in total and three designated side rooms. Staff we spoke with felt that three side rooms, most of the time, was sufficient.

For patients requiring their own room, but where this could not be achieved, staff accurately described how such patients would be 'barrier nursed' in a bay.

Mandatory training

Training, across both in-patient areas was split into 'clinical mandatory training', and 'universal statutory mandatory training'. Clinical mandatory training, only for clinical staff, included safeguarding children (Level 1); safeguarding adults with Mental Capacity Act (2005), conflict resolution and cardio pulmonary resuscitation (CPR).

Universal statutory mandatory training, for all staff, included equality and diversity, fire training, information governance, infection prevention and control, moving and handling and slips trips and falls.

Training was provided via e-learning but some training required face-to-face interaction, for example, moving and handling and CPR. For those staff unable to access e-learning, bespoke face-to-face training sessions were accessible. Although some variation in training levels all were above 80% and a number were at 100%.

Assessing and responding to patient risk

Across both in-patient areas, an early warning score (EWS) assessment was used to help staff assess if patients were deteriorating; Leeds Community Healthcare NHS Trust (LCHT) used NEWS (National Early Warning Score).

Predominantly within the National Health Service (NHS), the EWS assessment is used as part of a 'track-and-trigger' process where an increasing score suggests a patient's health is deteriorating. An increasing score most often requires an escalated response which could include increasing the frequency of patient's observations up to instigating an urgent medical review.

Across both in-patient units, all patients were assessed at admission and given a base-line NEWS score; this was important as any negative variation to the base-line score indicated a potential deterioration in health.

Of the patient records we reviewed, across both in-patient units, all patients had a baseline NEWS and up-to-date on-going NEWS's.

Of the nursing staff we spoke with, they were clear about the NEWS process and how to escalate concerns.

Staffing levels and caseload

SLIC

We discussed staffing levels at SLIC with the clinical pathway lead, service manager for in-patient units, unit manager and support service manager; the unit manager had managerial oversight of all staff irrespective of their employer.

Requires Improvement

Are services safe?

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

The staffing of the two in-patient units was arranged differently; the majority of the staff on SLIC were employed by LCHT accept for care assistants (CAs) and facilities staff, such as the cooks and cleaners, who were employed by another organisation.

SLIC was allocated 426 hours per week for CAs. At the time of the inspection there were around 67 hours per week vacant and 74 hours per week of long term sickness (a total of 141 hours). This meant the unit was down by one third (33%) of the CA work-force.

To compensate for the shortage of CA hours, agency staff were used and SLIC used, on average, 10 hours per day agency staff and 10 hours at night; this was for seven days a week. Agency staff included a combination of external agency staff and a central staff bank service known as CLaSS (clinical and support service).

Both employers regularly used agency CA staff if a patient or patients required one-to-one support and/ or supervision. The service support manager recognised the challenges with using agency staff and requested the same staff, where possible, in order to maintain some continuity. This was not always possible and a significant proportion of shifts were covered by staff who had never worked on the unit before or who had worked only a few shifts on the unit.

Permanent staff we spoke with felt that using agency staff was challenging because, on many occasions, the agency staff member was not familiar with the working environment or working practices. Some agency staff were more competent than others but all required extra support from existing staff; this created extra work and detracted attention from patients.

SLIC was split between two floors with two separate corridors of 10 beds on each floor, this equalled 40 beds. There was one staff nurse overseeing ten patients, this meant a ratio of 1:10 as had been agreed with the trusts commissioners. During the day, each floor of 20 patients had two CAs and there was a third CA that 'floated' between the floors. During the night, there was one CA per floor. The clinical pathway lead, and healthcare staff we spoke with during the inspection, felt that the number of CAs was inadequate.

A business case had been submitted to provide a sixth CA during the day; the decision regarding this had not been made at the time of the inspection. On SLIC, we were informed by the unit manager that activity and patient need at 02.00 / 03.00 in the morning was no different to that during certain periods of the day.

The nurse staffing ratio during the inspection for SLIC was 1:10 (one nurse to ten patients); four nurses in the morning, four in the afternoon and three during the night; this was recognised by the service manager and clinical pathway lead as not being ideal; a more appropriate number was described as being 1:8 (one nurse to eight patients).

Leadership at unit level included a band 7 unit manager and two band 6 nurses, 2 band 6 allied health professionals and a clinical lead nurse who had recently joined the team. The unit manager had a background in physiotherapy and it was a multidisciplinary rehabilitation approach

A band 8a matron had some input into SLIC but their role was as a clinical practitioner which was more medically focused. Their input into leading the service and supporting staff was limited.

There were several examples of the impact the staffing arrangements were having on patient care and they were significant. For example, one patient we spoke with described how they had to prompt an agency CA to read their care plan as they did not seem clear about the patient's needs.

The majority of nursing staff, physiotherapy and occupational staff we spoke with described how staffing levels affected the role they were intended to do. This was because nursing and allied healthcare staff often supported care support staff in their role in order to manage the work-load. This had a knock-on effect and reduced the time available for nurses and allied healthcare staff carry out their roles, for example, conducting occupational and physiotherapy sessions and supporting patients with day-to-day activities.

From our observations, and from speaking with staff, patients and relatives, patients were often in their rooms for long periods of time and patients told us they were often bored. The staffing levels meant that much of the work-load was centred on supporting patients with their personal needs and with meals as opposed to providing that alongside structured rehabilitation sessions and activities.

Requires Improvement

Are services safe?

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

The work was more task focused as opposed to care being provided in-line with care plans and the patient's goals.

CICU

CICU was staffed differently to SLIC and all staff, apart from house-keeping, were employed by Leeds Community Healthcare NHS Trust.

Medical support was provided by two community geriatricians and a non-consultant grade doctor on their general practice training six monthly rotations. Cover was provided between 09.00 – 17.00 Monday to Friday. There was no on-site medical cover out of hours; cover was provided by the GP out of hour's service. .

From our discussions with medical staff and the management team, medical staffing arrangements worked effectively.

The leadership on CICU was under review as part of the ongoing leadership restructure but, at the time of the inspection, there was one whole time equivalent (wte) band 7 operational manager (occupational therapy background) and one band 7 clinical lead/ advanced practitioner (nursing background); at the time of the inspection this person was on long term sick leave.

There were three wte band 6 nursing positions and just over 12 band 5 nurses with one wte band 5 nurse vacancies; this enabled a nurse to patient ratio of 1:8. In addition, there were just over 13 wte band 2 clinical support workers (CSWs) with a low 0.2 wte vacancy.

The band 7 operational manager took up post in August 2013, at which time, there were challenges with staffing including morale, retention, vacancies and increased use of CLaSS agency staff. During August 2013 the vacancy rate was around 30%.

Much progress had been made between August 2013 and November 2014 and, at the time of the inspection, vacancy rates were minimal; between 95% - 100% of nursing and care support staff were substantive and staff retention and morale was much improved.

Managing anticipated risks

We observed the plans in place for both in-patient services in managing anticipated risks. The plans for each in-patient unit were specific to that service and the associated risks.

The business continuity plan for SLIC, in particular, was detailed and included photographs to help guide people in an urgent situation. The SLIC business continuity plan included guidance on how to manage staff shortages, telephone failure, gas leak, water leak, lift failure and robbery.

The business continuity plans for CICU were less detailed but there guidance available, for example, in managing staff shortages and managing a need to perform a full evacuation. The guidance for CICU could be improved to bring it in-line with that of SLIC.

Major incident awareness

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

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

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

Requires Improvement

Are Inpatient Services effective?

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

Summary

The process for introducing evidence based care to practice was effective and we observed evidence based documentation on the units. However, such documents were not always completed or were only partially completed. Patients underwent the necessary assessments in order to determine their care plan but these were often delayed. In some instances, this could have been due to the nature of the MDT processes and associated documentation but in others this was not the case.

Care plans were used across both units to plan care but there were differences in how involved patients felt in the planning phases. Care plans on CICU were appropriately patient-centred but those on SLIC were more generic and impersonal.

Assessment tools were being used across the two units to monitor outcomes of care but compliance rates were relatively low. There were differences in discharge planning across the two units and CICU, on the whole, planned discharge in a clear way and decisions were clear. Discharge planning on SLIC was not as clear and decisions were less focussed and time-stated.

Staff worked together well across the two units and between disciplines but appraisal rates varied and whilst 87% of staff on CICU had received an appraisal only 73% had on SLIC. There were good examples across both units were consent was gained before treatment but, on SLIC, there were concerns with do not attempt cardio pulmonary resuscitation (DNACPR) forms, with some examples where patients and their relatives had not been involved in decisions.

Detailed findings

Evidence based care and treatment

We spoke with the clinical pathway lead about implementation of best practice guidelines, in particular, guidelines produced by the National Institute for Health and Care Excellence (NICE).

We were informed that the library services for LCHT were the initial point at which new NICE guidance was received. Once received library services sent out a brief to the head of medicines management who, in turn, forwarded to the relevant service; this included SLIC and CICU.

The receiving service was required to assess the guidance and produce a compliance statement for when they would be compliant with the new guidance; the head of medicines management and the clinical lead would then follow up with all compliance statements to ensure any required changes had been implemented.

During the inspection, across both in-patient areas, we reviewed patient records and documentation to assess the use of evidence based care and treatment. Across both units, we noted that nationally recognised assessment documents were in place for the planning of, and provision of care.

Assessment and planning documentation was completed to varying standards across the two in-patient units and, with some patients, it wasn't clear what the care/ therapy aims were and/ or what the discharge plans were.

CICU

On CICU, a patient had been admitted to the unit during November 2014 and was reviewed by a physiotherapist four days later. A multidisciplinary team assessment, which included falls risk assessments, was conducted five days after admission; it had been identified that bed transfers were a risk for the patient but plans to address the risks were not documented. The next physiotherapy review was seven working days later and, again; plans to address the bed transfer risks were not documented. There was no evidence of bed transfer activities with the patient to help prepare them for discharge.

With the same patient, an occupational therapy (OT) assessment was conducted four days after the patient's admission and bed transfers were also highlighted as a risk. Some action was taken but this was limited; the action was to liaise with the patient's family about the delivery of a bed to the patient's place of residence after discharge from the unit.

Requires Improvement

Are Inpatient Services effective?

A family member raised concerns about the bed transfer risks and a member of the nursing team was unclear about the plans in place to address the risks. The rehabilitation plans for the patient were unclear and there wasn't a cohesive team approach for the patient's plans for discharge.

Within another set of records we reviewed on CICU the OT assessment had been timely and comprehensive. It was clear from the assessment that the patient's needs were understood and what resources were required to support the patient whilst on the unit and once discharged home.

The care plans on CICU were, on the whole, person-centred and there was reasonable detail as to the individual needs of each patient. This was encouraging because an outcome of the serious incident report in relationship to the safeguarding concerns at the Seacroft site were that evidence was limited in terms of personalised care planning.

SLIC

On SLIC, a patient had been identified as requiring OT input. We noted several aspects of the OT assessment that were incomplete including;

- Unit name
- Dates and signatures of staff
- Identified goals including plan, time-frame and outcome
- Communication section
- Environmental safety
- Leisure activities
- Psychological section

It was written in the notes that the patient's relative wanted them to have support in mobilising with a walking aid to the bathroom. The actual plan of care was to provide the patient/ relative with details of services where a chair could be purchased and 'advise of height'; this differed from what the goals of the patient and relative were. The plan of care for the night staff was different and it was to encourage the patient to use the commode independently.

The above example also showed a lack of clarity in terms of the patient's rehabilitation needs, their goals during their in-patient stay and discharge arrangements. The expectations of the patient's relative, OT and the nursing team varied; this was having a negative impact on the patient's overall rehabilitation needs.

Another set of patient records we reviewed on SLIC had a comprehensive physiotherapy assessment using the elderly mobility scale (EMS) and a personal exercise programme; there was also evidence of appropriate equipment being ordered via the Leeds Community Equipment Service. A falls assessment had also been completed but there was no OT assessment. We spoke with an OT about this who said OT's wouldn't conduct an assessment until the patient's mobility had improved to a point where OT input would be affective.

Wound documentation had been started but the written entries were inconsistent.

The care plans on SLIC were not particularly person-centred, more so for the care plans we reviewed on the bottom floor. Care plans were mostly pre-printed and generic. For example, with one patient, it was described how they preferred a shower and staff were to 'please offer this as able.' The patient had a recent documented fall and required a walking aid to mobilise; the level of support the patient required with showering was not clear.

For the same patient, the night care plan consisted of standardised entries including: -

- Encourage independence with toilet/commode/ personal hygiene
- Call buzzer available
- Record any interventions overnight
- Hourly checks
- Offer urine bottle

There were no specific therapy interventions during the night; this did not promote a 24 hour concept of rehabilitation with a focus on ensuring the patient would be prepared to manage to the best of their ability once discharged.

It was stated in several care plans that the patient preferred a bath and/ or the patient was able to have a bath or shower. However, there was no evidence that patients had been offered/ or had a bath during their time on the unit. Supporting patients with showering also didn't occur as frequently as some patient's care plans stated.

The bathrooms we observed were used for the storage of some equipment, and, during the inspection, we did not observe this being removed to make space for a patient to be bathed or showered.

Requires Improvement

Are Inpatient Services effective?

On SLIC, many of the patients we spoke with described how they were bored and how there were no planned activities. Many also described how they were willing, and felt able, to have a bath/ shower, eat meals in the dining area and visit the lounge area but were not encouraged to do so.

One patient had been in the unit for six days and had been supported to have a strip wash each day. This was positive but the patient described how they felt ready for a bath or shower and they wanted support to be able to do this.

We spoke with a staff nurse about patient's bathing and showering and asked if patients had a bath or shower when they wanted; they felt this was not the case. They felt this was because there was not enough support staff to accommodate patient's needs.

CICU/ SLIC

Across both units we observed other nationally recognised tools being used including occupational therapy outcome measures (TOMs) which are used to assess therapy goals and EQ5D- which is an evidence-based clinical evaluation of healthcare.

The main negative aspect was that these were not consistently completed across the two units and there were variations with the timeliness of patient's initial assessments and the clarity and detail within patients' care/ therapy plans.

There was also variations with discharge planning including goal setting and remaining focused on supporting patients with their rehabilitation needs.

Pain relief

Of the patient records we reviewed across the two in-patient units areas, pain assessment scores were completed in a consistent and accurate way.

Patients we spoke with, across both units, felt comfortable and had discussed their levels of pain with nursing staff. Patients understood that they could speak with staff if they required medication to relieve any pain.

Nutrition and hydration

Of the patient records we reviewed, across both units, nutritional assessments were complete and if necessary, referrals had been made to the dietetics service.

We reviewed several dietetic referral dates and dietetic reviews occurred within acceptable timescales.

Patients we spoke with across both units had no complaints about meals and stated they were offered plenty of drinks.

A patient on SLIC was on a soft diet and they said the food was suitable.

Staff we spoke with felt the support they received from dietetic services was suitable.

Approach to monitoring quality and people's outcomes

An annual activity and performance report was produced; the results of which were presented to the SLIC management board. The aim was to report against the agreed key performance indicators (KPIs) set for SLIC.

The report also provided the board with an understanding of both the activity and performance of SLIC over time as well as presenting corresponding performance information from the major community intermediate care (CIC) nursing bed bases in Leeds.

We reviewed the latest report (October 2014) covering between 1 April 2014 to 30 September 2014. The report was split into specific 'dashboards' including admissions, discharge, length of stay, patient outcomes, service availability and patient satisfaction.

The information was clear and there were specific comments sections provided by an analyst and the 'service.' This helped add context to the data and explain some of the variations, for example, for SLIC, it was commented that increased continuity of medical cover and clearer lines of accountability could have explained the reduction in the figures for mortality.

As briefly discussed earlier, therapy outcome measures (TOMs) were being used and the EQ5D measuring instrument. TOMs were used to assess therapy goals and EQ5D was a tool for use as a measure of health outcome; the results of these were reported on within the annual activity and performance report.

The October 2014 report recognised that the number of completed TOM and EQ5D assessments were not

significantly large enough to present an accurate trend. Improvements were being made with EQ5D and TOM assessments and future data analysis would reveal if the increases were sustained.

The data supports our observations during the inspection; EQ5D and TOM assessments were not routinely being completed.

Competent staff

We spoke with staff across both units about training and the support they received to ensure they were able to perform their role effectively. All staff we spoke with felt well supported by their managers and felt able to access required training.

The appraisal percentage compliance rate for SLIC was 73% and for CICU it was 87%. The figure for SLIC was slightly down but this was recognised and efforts were being made to increase this figure. Staff also felt they could approach their managers with training requests and training needs were discussed at appraisal.

New staff were required to complete a specific induction process and be assessed as competent before formally starting as a new employee.

On CICU, the staffing base was well established and the use of agency staff was very low; this supported appropriate continuity of care and the necessary skill mix.

On SLIC, there were challenges with CAs and staff felt the competence of the agency CAs was variable. The varying competence levels of agency CAs affected the team dynamics and, in varying degrees, negatively impacted on patient care.

The relatively high use of agency staff on SLIC impacted on continuity of care, team morale and skill mix. Staff felt their work-load increased with use of agency staff because they felt it necessary to more closely supervise agency staff than they would permanent care support staff.

Multi-disciplinary working and coordination of care pathways

We observed multi-disciplinary team (MDT) meetings at each in-patient unit and there were monthly meetings attended by several teams including nursing, medical and community staff. Discussions held at the MDT meetings were constructive and each team member had an opportunity to raise any issues.

Overall, between the two in-patient areas, staff we spoke with felt there was good teamwork and the whole MDT was focused on patient safety and welfare. Staff opinion on SLIC was more negative in some aspects because the relatively high use of agency CAs affected the team in terms of morale and continuity of care.

Referral, transfer, discharge and transition

For both in-patient units, referral patterns were monitored and reported on within the annual activity and performance report. For example, the October 2014 report, in comparing referral sources between SLIC and CIC nursing beds, showed minimal year-to-date variations; the majority of referrals were from hospital wards and the lowest percentage of referrals were from accident and emergency departments.

We reviewed discharge planning across both units including information presented in patient records and discussions held at handovers and MDT meetings. On CICU, there was clear focus on discharge planning and we noted a number of clearly outlined discharge plans for patients including discussions held with families and the patient. MDT meetings also discussed patient progress in detail and focused on moving the patient forward in terms of preparedness for discharge.

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

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

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

In relation to referrals and involvement of other services, staff across both units felt, that on the whole, support from services such as dietetics was suitable. However, staff did comment that there was restricted access to speech and language therapy (SLT) and urgent referrals often took two weeks; non-urgent referrals was often much longer.

Requires Improvement

Are Inpatient Services effective?

Availability of information

Across both units, key information about patients and services was available to staff and it was accessible.

Staff on both units could describe how to access information and describe the way in which information was managed.

Both units, in the main, had paper-based records and staff described how there had been 'talk' of introducing a fully electronic database/ notes system. The trust has indicated that it has signed up to an electronic patient record system and has communicated this to staff.

A staff member we spoke with on CICU felt that the existing information recording systems were ineffective. Apparently, this was because there was a mixture of paper-based and electronic records; staff could access SystmOne (a centrally hosted clinical computer system used in healthcare, predominantly by GPs) and review district nursing notes and also add in discharge summaries, but that was about all staff could do.

The service currently used a paper based system as a primary record with access to SystmOne to support communication and sharing of relevant patient information. In addition RIO (an electronic patient information system) was used to record admissions information.

The trust recognised that the current recording systems was complex and, in response to staff feedback and need to improve efficiency and effectiveness, the trust had signed up to an electronic patient record system. The timescales and rollout of this for the CICU and SLIC were to be confirmed.

Staff described how there had been discussions about introducing a single electronic paperless system but definitive decisions never seemed to be made.

On CICU, there were summary sheets at every patient's bed that enabled staff to quickly remind themselves of the main needs and challenges for each patient; this was not used on SLIC.

Consent

We spoke with staff across both units about consent including best interest decisions and mental capacity. On SLIC, we also spoke with the mental capacity and deprivation of liberty lead; we also reviewed patient records.

On SLIC and CICU there was good evidence to support the fact that staff were aware of the need to gain consent and the processes to follow if there were concerns about someone's the abilities to make their own decisions which were in their best interest.

On SLIC, there was one particular example where a patient required a mental capacity assessment as it was considered that the person's dementia was affecting their decision-making. The person's family were fully involved and the necessary healthcare professionals were involved in deciding on the best options available; the discussions and decisions were accurately recorded in the patient's records.

On CICU, there was also a specific example where a patient was being considered for a mental capacity assessment and discussions with family and healthcare professionals had been arranged to discuss the patient's best interests.

During observations on both units, we heard staff on a number of occasions asking for verbal consent before providing direct care to patients.

A more negative aspect to consent related to 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms. On SLIC, we reviewed six DNACPR forms and four on CICU. The DNACPR forms on CICU were completed accurately and discussions with the patient and/ or relative were documented. On SLIC, three of the six DNACPR forms we reviewed were not fully completed and there was no evidence of discussions with the patient and/ or relative. For example, with one form it was acknowledged that the patient had mental capacity but they were deemed not for resuscitation because of their medical condition; no discussions with the patient had been documented.

Good

Are Inpatient Services caring?

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

Summary

We found staff, at both SLIC and CICU, to be caring in their approach to patients and their relatives. We observed numerous interactions between staff and patients and staff showed compassion, respect and understanding.

Patients on CICU felt a little more involved in making decisions about their care and patients on CICU were more involved with discharge planning. Emotional support was provided to patients and information about additional support was available.

Detailed findings

Dignity, respect and compassionate care

Throughout the inspection across both the units we observed medical and nursing staff interacting with patients and providing care and support. We also observed OTs, physiotherapists, care assistants and other allied healthcare professionals working with patients and providing support.

We noted that staff were caring and compassionate and were respectful to patients and their family/ friends. Staff also showed patience in their approach to supporting people and adequately explained their intentions when providing care and support.

Of the patients we spoke with on both units it was felt that staff worked hard and patients felt staff were caring and kind. On SLIC, some patients felt it took too long, on occasion, for their buzzer to be answered.

In addition, on SLIC, some patients felt that agency staff did not fully understand their needs and in one case, a patient described how they needed to remind a member of agency staff to read their care plan. However, there were no negative comments in terms of the attitude of agency staff.

Patient understanding and involvement

From discussions with patients and families on both units, on the whole, people felt adequately involved in discussions about their care.

Patients also understood the reasons why they were on the units and what support they were to expect. On SLIC, some patients were uncertain about discharge arrangements and timescales for discharge.

Emotional support

We observed staff interacting with patients and observed handovers and MDT meetings at both units; it was evident that staff appreciated the impact on patient's emotional well-being from being on the units and emotional support was discussed as part of patient's care.

We observed conversations with families and these also touched on emotional well-being and if extra emotional support was required with some patients.

We also noted that counselling services were clearly displayed on both units and staff understood how to access extra support for patients if necessary.

Promotion of self-care

CICU

Patients were encouraged, where possible, to manage their own health and empowered to become more independent; this was reflected in the care plans and discharge plans. We also observed this during therapy sessions and from interactions with nursing staff.

SLIC

Patients on SLIC were supported to become more independent but opportunities to encourage this were often missed and care plans were not always focused on encouraging independence.

Requires Improvement

Are Inpatient Services responsive to people's needs?

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

Summary

Whilst the dependency levels of patients on CICU were suited to the intended design of the service, the dependency levels of patients on SLIC were relatively high and many patients could not engage in sustained rehabilitation. Average length of stay for long term nursing patients was understandably longer but for some patients this was excessively long. The trust indicated that it recognised the dependency levels of patients and regularly discussed these with commissioners.

On both units staff understood the principles of equality and diversity and were able to meet the needs of the more vulnerable patients, such as those with dementia. Both units were able to admit referred patients within acceptable time-frames but there was no formalised process for ensuring patient's needs could be met as judged against the needs of existing patients and available resource.

Detailed findings

Planning and delivering services which meet people's needs

Across Leeds there were in the region of 161 community intermediate care (CIC) beds and SLIC and CICU were providers of a proportion of the CIC beds.

A key aspect of the services provided at SLIC and CICU were based on the fact that the patient group were different. Patients on CICU were deemed to be more sub-acute whereas patients on SLIC were less dependent. Both units aimed to provide rehabilitation but the needs of the patients were different.

However, from our observations, and from speaking with staff, the dependency levels of the patients being admitted to SLIC had increased and the design of service provision was not accurately geared to meeting the increased dependency levels of people using the service; some patients were increasingly not able to engage in sustained rehabilitation because they were too unwell.

The dependency levels of patients on CICU was more in-line with the intended patient group and staff felt the way in which care was provided suited the patient group and accurately met people's needs.

Year-to-date (YTD) average length of stay (ALS) data for up to September 2014 showed 32.6 days for SLIC and 20.3 for CICU; the national benchmark mean length of stay for 2012/2013 was 26.3 days. However, it is recognised that ALS may be skewed slightly because Leeds has larger numbers of people staying 51 days or more compared to the national picture.

The intermediate care bed ALS for SLIC was around 20 days which is a comparatively good figure. The target for LOS for long term care nursing patients was around 28 days but, often, LOS for such patients was often double that of intermediate care patients.

In an extreme example, on SLIC, a patient admitted in April 2014 was 134 days on the unit. Patients often attended the unit who were non-weight bearing post-operatively for around the first six weeks of their stay which could be extended by another four weeks depending on the patient's progress. Therefore, for such patients, ALS would almost always be above the intended figure of 28 days before any rehabilitation had been started.

ALS figures for CICU were less than SLIC and more in-line with the expectations of the unit.

Staff recognised this as an issue, and as discussed, commented that low staffing levels/ staffing skill mix were a key reason for this.

We spoke with the clinical pathway lead and the provision of CIC beds across Leeds was under review including SLIC and CICU. There was some acknowledgment of the changing needs of patients being admitted to SLIC and this was to be taken in to account during the bed base strategy review.

Equality and diversity

Across both units we observed how patients were cared for and how equality and diversity was ensured.

Requires Improvement

Are Inpatient Services responsive to people's needs?

On both units staff were aware of the need to understand and appreciate the different needs of people and how this should be factored in when providing care. For example, at referral to both units, any patients requiring a special diet would be flagged during the admission process.

On SLIC, the support manager described how a number of patients had been provided Kosher meals and how kitchen staff were able to meet many other dietary requirements including vegan and vegetarian.

During our observations of care, staff were equally respectful and kind to all patients and were respectful to patient's individual needs.

As discussed, care plans on SLIC were not sufficiently patient-centred which also impacted on diversity because the planning of care did not always make specific reference to patient's specific support needs.

Meeting the needs of people in vulnerable services

We spoke with senior staff at both units in terms of meeting the needs of vulnerable people, for SLIC and CICU; this was relatively often people living with dementia.

If people's needs and dependency levels were increasing and/ or a patient had known additional needs, extra staff were used to provide one-to-one support.

Staff we spoke with recognised if the needs of some patients were increasing and how to request additional staffing support if necessary to reduce risk and provide the necessary one-to-one support.

Staff also described how people's friends and family members were often integral to providing the necessary care and support for people who were particularly vulnerable and/or who had additional support needs.

Access to the right care at the right time

The Leeds Community Beds Strategy 2014 – 2019 highlighted referral times and provided comparative data. From the data provided in the above report, only 65% of CIC bed referrals in 2013/ 2014 resulted in actual admissions to a CIC bed. The average waiting time for a Leeds CIC bed (including SLIC and CICU) in 2012/ 2013 was 3.9 days; this was the length of time from referral to the service to being admitted to a bed. The national benchmark in 2012/ 2013 was an average waiting time of 3.4 days; in 2013/2014 the Leeds waiting time went up to 4.2 days. Overall Leeds CIC beds (including SLIC and CICU) operated at 89% occupancy in 2013/ 2014.

The main source of referral for SLIC beds (around 45%) were hospital discharges and for CICU it was from assessment wards (around 35%). CICU also had a relatively high community referral rate, around 25%.

For all CIC beds, there was a single point of urgent referral (SPUR) where all potential admissions were triaged and a decision made as to which service was suitable. SPUR would liaise with a nurse on SLIC or CICU to discuss the patient and check if the referral was appropriate.

The process for assessing the suitability of patients and whether SLIC or CICU could manage to meet the needs of certain patients, and had adequate resources, was not a formalised process and was dependent on the judgements of particular staff. There was no set process whereby the dependency levels of existing patients were taken into account or other factors such as how many patients required hoisting, how many were receiving one-to-one care and the number of agency staff.

We were informed that this had been recognised as an issue by the trust and by commissioners, and that there was a gap in screening and monitoring dependency levels. A pilot was underway using a care needs dependence tool.

Staff felt that, on occasion, some patient referrals, particularly on SLIC, were inappropriate when staffing levels and the existing dependency levels of existing patients was taken in to account. This often added to the pressures of maintaining a safe environment and negatively impacted on the amount of rehabilitation that could take place.

We reviewed the care needs tool and for many of the assessments, including the nursing needs section, most patients would reach the highest dependency score of 9 and above, however as noted the tool was being piloted at the time of the inspection so a final judgement on the effectiveness of the tool could not be made.

Complaints handling and learning from feedback

Between September 2013 and November 2014 there were a total of seven formal complaints between SLIC and CICU; three relating to SLIC and four relating to CICU.

Requires Improvement

Are Inpatient Services responsive to people's needs?

We reviewed two of the complaints and it was evident that the complaints process had been accurately followed and complaints had been responded to appropriately and within the necessary timescales.

All complaints had been investigated and resolved to the satisfaction of all parties involved.

Good

Are Inpatient 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

There was good leadership locally, and an open culture. Staff indicated that managers were supportive, though some were critical of the nature of the move of CICU from Seacroft Hospital to St James and the way it was handled.

There were governance systems in place, though these were changing at the time of the inspection and were still embedding. There was a vision and strategy for the services, including for community beds as a whole in Leeds, and SLIC was seen as a template for future service design.

Plans for sustaining the service were clearly set out and included in the CIC bed service re-design. There was a strong focus on continuing to provide rehabilitation services and enabling patients to regain control of their independence. This was positive but the resources required need to match the needs of the patient and outcome measures need to better implemented and used.

Detailed findings

Service vision and strategy

We spoke with the clinical pathway lead about CIC and the vision/ plans for SLIC and CICU. The services being provided, and how they were to continue to be provided, were under review.

The Leeds Community Beds Strategy 2014 – 2019 provided an analysis of the current provision and of the future requirement for short-stay beds, both in terms of capacity and the expectations of what the beds should provide to meet the needs of the people using them.

The strategy was clear, ambitious and set out a pragmatic approach to meeting the future demands that would be placed on the services, including SLIC and CICU. The main overall vision was for Leeds to have only three types of bed; the person's bed at home, a community bed and a hospital bed. This was a departure from the current model of sub-types of bed and meant that the trust would no longer use the sub-categories of nursing, sub-acute, residential, dementia and extra care. CICU, therefore, would not be seen as sub-acute. Another key vision was to increase the bed base and assess the benefits of new build options within the existing estate.

The strategy was focused on maximising the potential of each service user to remain independent and in control of their care and a focus on older people returning back to their home through recovery, re-ablement or rehabilitation. At the time of the inspection, particularly for SLIC, the focus on rehabilitation and delivery of rehabilitation was limited and opportunities to support people to recover and return home sooner rather than later were missed on a daily basis and staffing levels didn't always allow for regular and consistent rehabilitation to take place, particularly in terms of people being able to manage with activities of daily living, such as bathing, transferring out of bed and managing in the kitchen. However, there was some evidence that SLIC did deliver improved outcomes relative to other CIC bed bases with a higher percentage of patients being discharged home, rather than to long term care.

We were informed that the outcomes for how SLIC operated influenced the model for the future; this was a concern because of the short-falls identified with the service.

Governance, risk management and quality measurement

At the time of the inspection, governance structures and the processes for managing risk and quality assurance processes were changing and many aspects were in the process of becoming embedded.

From discussions with senior staff, including the clinical pathway lead and service manager for in-patient units, the changes being implemented were positive but it was felt that, at the time, there were too many people 'in the system' which affected decision-making, decisiveness and accountabilities.

Good

Are Inpatient Services well-led?

Senior staff described how they felt their senior colleagues were approachable and members of the executive team were 'visible' and contactable. The 'visibility' aspect of the executive team was something which people felt had improved.

There were specific meetings which formed a key part of the governance structure including the bed-base monitoring meeting, bi-monthly SLIC board and operational group meetings. On a positive note, we were informed that the management team had received formal recognition within two annual general meeting (AGM) reports and were awarded the team of the year award for 2012/2013.

Culture within this service

From speaking with staff at both units, the culture, in terms of information and incidents, was described as open and staff felt that they could openly discuss concerns or make requests to their immediate line manager. Staff also felt that the executive team were becoming more open and visible.

On SLIC, the culture was different to that on CICU which was mainly around the fact there were two employers; one for CAs and facilities staff and one for nursing staff and allied healthcare professionals. When SLIC opened the care assistants employed by another organisation were given the choice of working at SLIC or being redeployed to an alternative residential establishment. The unit was delivered in partnership between the two organisations with the trust as the lead provider. This integration of staff, from what we were told, wasn't easy at first because staff were integrating who had different training and experiences. This had improved but the use of agency CAs was affecting morale and holding back the continued development of team building and a positive culture.

Leadership of this service

Leadership staffing arrangements for SLIC and CICU have been set-out earlier in the report. For SLIC, nurse leadership was commented on by several staff as lacking and being 'bottom heavy' with junior nurses. A band 7 nurse had recently started in post two weeks previously, on a secondment, in order to complement the role of the existing band 7 unit manager; this was a temporary solution in response to identified need for additional nursing leadership on the unit and was pending the outcome of the B7 leadership restructure process which was underway at the time of the inspection.

For CICU, as discussed, the staffing structures were different and unit leadership was better balanced and there was appropriate input from therapy and nursing leadership grades. However, the unit manager position was on a secondment basis, so, again, there was some uncertainty about the future leadership of CICU. This was unsettling for staff because, as some commented; the existing unit manager had implemented positive changes and had positively developed the service since leaving the Seacroft site.

In relation to the move from the Seacroft site to St James's Hospital, staff felt the process was not effectively managed and the move was too sudden. Staff weren't clear why the move of patients was so sudden because the environmental concerns about the Seacroft site, especially in relation to infection control, had been raised as a concern for a relatively long period prior to the move.

As discussed above, the relatively high use of agency CA staff was causing some tensions and we were informed that the issue was relatively long-standing; three separate papers had been presented to the appropriate boards during the last 18 months about staffing levels and the short-falls. The active response in relation to the issues raised with staffing had not been effective in ensuring the service could deliver its core objectives.

Fit and proper person requirement

We spoke with the clinical pathway lead and service manager for in-patient units and they were aware of the newly introduced fit and proper person requirement for directors. They also confirmed that their senior colleagues were also aware of the new requirement and were assured that the Trust had the appropriate human resource processes to meet the requirements.

Public and staff engagement

Staff we spoke with felt that communication and staff engagement was reasonable. Staff were clear about the current changes occurring with the services across SLIC and CICU and they described how their unit managers were

Good

Are Inpatient Services well-led?

open and approachable. Both unit managers informed us of tea parties that had recently been hosted with 3rd sector as a way of engaging patients and gathering views of patient experience.

In terms of public engagement, this was achieved, in the main, via a patient satisfaction survey which patients were asked to complete towards the end of their stay on both SLIC and CICU. The survey asked six key questions where answers ranged from agree strongly to don't know, including whether the patient felt they had been treated with dignity and respect and if they were involved in the planning of their care. Three more open-ended questions were asked including what the service did well, what could be done better and if there was anything else the patient wanted to add.

Throughout the inspection, we observed information available to patients and this included guidance on how to make a complaint, comment or compliment about the service; this was done mainly via the patient advice liaison service (PALS). Both unit managers confirmed that they reviewed, often on a weekly basis, any complaints and/or compliments.

Innovation, improvement and sustainability

We spoke with the clinical pathway lead about innovation and SLIC was one of 17 sites recognised as a pioneering site for innovation in relation to its model of care and design of the unit. We spoke with the unit manager about the development of the new unit and much thought went in to its design, especially in terms of the environment and meeting infection control design standards. Plans were in place to continually improve the environment and this included altering some of the colour schemes and 'softening' the décor to help it feel more 'homely'.

It was evident that staff wanted to continually develop the service and sustain high standards of care. However, there were financial constraints and the service was over-spent; this was partly because of the money used on agency staff at SLIC. The desire for there to be a sixth CA on SLIC was an example where financial pressures were conflicting with the need of the service. At the time of the inspection, a revised safer staffing paper was being written and would be presented to relevant board in January. This covered registered nursing, care assistants and administrative support.

The sustainability of the service formed part of the Leeds Community Beds Strategy 2014 – 2019 and the aims for how the service would be sustained were clear. However, the assurances around how well the service was performing in terms of rehabilitation need to be more robust.