Leeds Community Healthcare NHS Trust

RY6

Community health inpatient services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RY686	South Leeds Independence Centre	SLIC	LS11 7DB
RY6X7	Community Intermediate Care Unit (CICU)	CICU	LS9 7TF
RY6X2	Community Rehabilitation Unit	CNRC	LS12 3PE

This report describes our judgement of the quality of care provided within this core service by Leeds Community Healthcare NHS Foundation 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 Foundation Trust and these are brought together to inform our overall judgement of Leeds Community Healthcare NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

When the community inpatients service at Leeds Community Healthcare NHS Trust was last inspected in November 2014, we rated the services as requires improvement overall.

We asked the provider to make the following improvements at that time:-

- Ensure staffing levels and skill mix is suitable for staff to effectively provide the necessary support to patients.
- 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.
- Ensure 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.
- Ensure 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms are completed in-line with trust policy.
- Ensure discharge-planning processes and decisions are more focused and time-stated.

At this inspection, we found the provider had made all of the improvements required.

We visited three locations.

- the South Leeds Independence Centre (SLIC)
- the Community Intermediate Care Unit (CICU)
- the Community Neurological Rehabilitation Centre (CNRC)

We rated community inpatient services as good because:

- Services were planned and delivered to meet the needs of all patients using them. There were systems to ensure patients were protected from avoidable harm and abuse. Safety performance was monitored, incidents were reported and lessons learnt.
- The service managed staffing effectively and services had enough competent staff with the appropriate skills, experience and training to keep patients safe and deliver effective care and treatment. Staff were well motivated and knowledgeable. Staff teams and services worked together effectively to deliver good care.
- Emergency medicines and equipment for use in a medical emergency were fit for use and quickly accessible in an emergency. Medicines management was effective.
- Equipment was appropriately maintained and fit for use.
- Patient care and treatment was planned and delivered in line with current guidance; patients had good outcomes because they received effective care and treatment.
- Consent to care and treatment was obtained in line with current legislation and guidance. Do not attempt cardiopulmonary resuscitation (DNACPR) forms were completed in-line with trust policy.
- Patients were able to access the right care at the right time. Initial assessments and discharge-planning processes were promptly undertaken on all three units.
- New care planning documentation had recently been introduced; care plans were person centred.
- Resuscitation procedures and practice had been reviewed and were in line with best practice.
- Staff involved and treated patients and their families with compassion, kindness, dignity and respect. People and their families understood the care and treatment choices available to them and were involved in making decisions about their care and treatment. Staff supported patients and their families to cope emotionally with their care and treatment.

Summary of findings

- Reasonable adjustments were made to ensure people with disabilities, or those in vulnerable circumstances, could access services on an equal basis.
- The service had a low number of complaints and a high number of compliments; there was a complaints process and the service was proactive in dealing with any complaints received.
- The leadership, governance and culture promoted the delivery of high-quality person-centred care. The new leadership teams, which had been put in place since the last inspection, were making effective changes.
- The services had clear visions, values and strategies and staff in all areas were aware of these.
- There were systems and processes in place for managing governance and risk, with a clear a focus on learning and improving. Appropriate actions had been put in place to mitigate identified risks in the services.

However:-

- There was no internal system to record delayed discharges from the South Leeds Independence Centre and Community Intermediate Care Unit until January 2017. This meant there was no way to know if discharges were timely or the reasons for any delays until this process was put in place.
- Response rates for the friends and family test were low. One of the trust's quality priorities was to increase patient survey response rates.
- At the South Leeds Independence Centre, the call bell system and falls sensors were on a 'linked system'. Senior staff told us the system was not fit for purpose.The falls sensors did not always trigger the audible alarm if patients stood up. This meant patients could be at risk of falling and suffering harm. Managers were aware of this and told us there were plans to replace the system. The call bell system relied on staff carrying a handset around with them. Staff then responded to patients who heard staff on a loudspeaker in their room. Staff told us this method of responding to patients usually caused more anxiety and confusion for patients.
- There was no evidence to show that the recommendations identified in the most recent legionella risk assessments at all three locations had been followed up and appropriate actions taken. This included ensuring staff were appropriately trained in the control and management of legionella.
- Staff caring for patients with dementia did not always have up-to-date appropriate training in dementia care.

Summary of findings

Background to the service

Information about the service

At the time of the inspection, community inpatients provided services from three sites with a total of 72 overnight beds available across the three locations. The largest facility was South Leeds Independence Centre (SLIC), which provided 40 beds. The Community Intermediate Care Unit (CICU) was located within St James' University hospital and provided 27 beds (registered for 24). The Community Neurological Rehabilitation Centre (CNRC) provided five inpatient beds and five day case beds and was located within St Mary's Hospital in South Leeds.

The main purpose of all the units was to provide rehabilitation and re-ablement to patients who were either transferred from an acute hospital, or admitted from the community.

Between January and December 2016, 113 patients were admitted to CNRC and 437 to SLIC. The management of CICU was transferred to the local acute trust between November 2015 and May 2016; it, returned to Leeds Community Healthcare Trust in June 2016, so the trust was unable to provide data for admissions during November 2015 to May 2016. There were 179 inpatient admissions to CICU in the seven months from June to December 2016.

South Leeds Independence Centre

SLIC opened in April 2013. It provides short term integrated health and social care. The team at SLIC compromises of nurses, physiotherapists, occupational therapists and clinical assistants. The services of other health and social care professionals are also available. The centre provides 24-hour care and treatment for people over 60 years of age who cannot be safely supported at home, or those who did not need to remain in an acute hospital. People aged less than 60 years with complex health or social care needs can also receive care. Patients were referred by hospital staff or a community health professional. The referral criteria includes patients with a Leeds GP and those who paid their council tax to Leeds local authority.

Community Intermediate Care Unit

CICU is a rehabilitation unit, based on site at St James's hospital, which provides care for older people who become unwell and unable to remain in their own home and required care and treatment from medical staff, nursing and therapy staff. The team consists of consultant geriatricians, other doctors, nurses, occupational therapists, physiotherapists and clinical support workers. An administration team supports the heath care team. There is also access to other health care professionals such as dietitians, other specialist services, and joint care managers. (Joint care management is a partnership between the trust and Leeds adult social care). The unit provides 24-hour care and works with patients and their families and carers to optimise independence and enable patients to reach their full potential.

Anyone with a Leeds GP can be referred to CICU. Referrals are usually made by GPs, community geriatricians, intermediate care teams, district nurses or hospital staff.

Community Neurological Rehabilitation Centre

CNRC is a regional inpatient unit, which provides multidisciplinary rehabilitation through planned short stay admissions for people with complex needs due to a neurological condition, who are medically stable. The centre also offers a day service for people who need more intensive multidisciplinary care and treatment than is available in the community but who do not require overnight admission.

Our inspection team

Our inspection team was led by:

Chair: Carole Pantelli

Team Leader: Amanda Stanford, Care Quality Commission

The community inpatients inspection team included four CQC inspectors (one for one day and one for two half

days), a specialist advisor, who was a consultant occupational therapist, and an expert by experience (for one half day). The expert by experience was a person who had experience of looking after people accessing services.

Why we carried out this inspection

When Leeds Community Healthcare NHS Trust was last inspected on 24 November 2014, the community inpatients core service was rated as requires improvement overall. The safe, effective, and responsive domains were rated as requires improvement and the caring and well-led domains were rated as good.

Following that inspection, we asked the provider to make the following improvements in community inpatients services:-

- 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 focussed 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.

We went back on this inspection to check whether these improvements had been made. We carried out an announced comprehensive inspection between 31 January and 2 February 2017.

How we carried out this inspection

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?

At the time of the inspection, Leeds Community Healthcare NHS Trust provided community inpatients services from three sites:-

- South Leeds Independence Centre (SLIC)
- Community Intermediate Care Unit (CICU)
- Community Neurological Rehabilitation Centre (CNRC)

We visited all three locations during the inspection.

Before visiting the service, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. These organisations included the local clinical commissioning groups and Healthwatch.

We carried out an announced visit on 31 January, 1 February and 2 February 2017.

During the visit, we held focus groups with a range of staff who worked within the service, such as nurses, doctors

Summary of findings

and therapists. We talked with people who used the services and staff that worked in 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 services.

We spoke with 22 patients and 43 staff including nurses, medical staff, care support workers, allied health professionals and unit and senior managers. We reviewed 28 sets of patient care records and observed the care environment.

We observed two multidisciplinary handovers at SLIC (one on each floor); five members of staff attended one handover and six at the other. We also attended the weekly multidisciplinary team meeting at SLIC on the Thursday morning.

We attended a nursing handover and a patient goal setting multidisciplinary team meeting at CNRC, we held an impromptu focus group with eight staff members a t that unit.

We observed two mealtimes during the visit, one lunchtime meal at SLIC and one evening meal at CNRC.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve:-

- Replace the patient call system at South Leeds Independence Centre, to ensure it meets the needs of the people using the service.
- Replace the patient falls sensor system at South Leeds Independence Centre, to ensure it meets the needs of the people using the service.
- Make sure all patients are assessed in line with the Mental Capacity Act.
- Provide and maintain up-to-date dementia training for staff caring for patients living with dementia.
- Introduce audits to assure the quality of patient records.
- Work to improve response rates for patient feedback through the Friends and Family test.
- Improve patient participation in self-medication at CICU and SLIC.
- Consider improving the variety of food and timings of meals at South Leeds Independence Centre.
- Consider improving the environment/maintenance of the community intermediate care unit.

Leeds Community Healthcare NHS Trust

Community health inpatient services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

When the community inpatients service at Leeds Community Healthcare NHS Trust was last inspected in November 2014, the safe domain was rated as requires improvement. We asked the provider to make the following improvements:-

- Ensure staffing levels and skill mix is suitable for staff to effectively provide the necessary support to patients.
- 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.

At this inspection, we rated safe as good because:

- There were systems in place to ensure patients were protected from avoidable harm and abuse.
- Staffing levels and skill mix were regularly planned and reviewed to keep patients safe.
- Appropriate arrangements were in place for obtaining, recording and handling medicines; emergency medicines and equipment for use in a medical emergency were fit for use and could be accessed quickly in an emergency. Fridge temperatures where medicines were stored were maintained appropriately.
- Equipment was appropriately maintained and fit for use.
- Safety performance was monitored, incidents were reported and lessons learnt.
- Care records on the CNRC were individualised, holistic and completed to a high standard.
- New care planning documentation had recently been introduced on CICU and SLIC; this was individualised and person-centred. This included appropriate risk assessments and new documentation for admissions. Separate medical and nursing records at SLIC and CICU made it difficult to follow documented care plans for some patients. Staff told us there were plans to combine these separate records.

However;

- There was no evidence to show that the recommendations identified in the most recent

legionella risk assessments at all three locations had been followed up and appropriate actions taken. This included ensuring staff were appropriately trained in the control and management of legionella.

- The falls sensors at SLIC did not always trigger the audible alarm if patients stood up. This meant patients could be at risk of falling and suffering harm. Managers were aware of this and told us the falls sensors break easily if they were moved around. There were plans to replace the falls sensors. After our inspection, senior managers told us regular checks were in place to support patient safety while they considered an alternative system.

Detailed findings

Safety performance

- The community inpatient service collected data in line with the NHS Safety Thermometer. The NHS Safety Thermometer is an audit tool that allows organisations to measure and report patient harm in key areas; for example, pressure ulcers, urine infection in patients with catheters, falls and venous thromboembolism (VTE) and the proportion of patients who are 'harm free.' This provided the service with a 'temperature check' on harm that could be used to measure local progress in providing harm free care for patients.
- The England average for harm free care is 95%. We reviewed the percentage of harm free care at the three units over the previous 12 months (January to December 2016). We saw SLIC achieved between 92% and 100% harm free care in 11 months out of 12.; the percentage of harm free care in July 2016 was 79%.
- Data for harm free care at the CICU was only available from June to December 2016; in June and December 2016 there had been 100% harm free care, the percentage of harm free care over the other five months ranged between 91% and 96%.
- Between January and December 2016, CNRC achieved 100% harm free care in seven out of the 11 months reported (there was no figure for June 2016). Two months reported 60% harm-free care and two months reported 75% harm free care. Following our inspection, senior managers told us these figures had been affected by two patients who were admitted to the unit with existing pressure ulcers. The reported harm was not attributable to the unit. The national reported average for harm free care in community rehabilitation units over the same period ranged between 94% and 96%.
- Analysis of data submitted between July and December 2016 showed the numbers of slips, trips, falls, or collisions had increased steadily within community inpatient services from 17 in July 2016 to 37 in December 2016. When we asked staff about the increasing numbers of falls, they explained that a number of these were repeat falls involving two individual patients. The service had a number of initiatives in place to reduce the numbers of falls and the overall trend was decreasing.
- During the same period, there was a slight increase in the number of pressure ulcers reported within community inpatient services, rising from two in July 2016 to nine in December 2016. However, staff on the CICU told us it had been over a year since they had reported grade 3 or grade 4 pressure ulcers.
- We saw all three units had quality boards, which displayed patient safety data and monthly quality indicators. These included the most recent safety thermometer results. In addition, the boards indicated the unit's performance in relation to MRSA and Clostridium difficile.
- Staff on CICU told us they had done improvement work with the NHS Improvement Academy and, as a result of this, carried out daily safety huddles. Staff told us everyone was included in the safety huddles, including housekeepers.
- We observed a safety huddle on CICU, which was an effective and comprehensive review of the units current, and potential patient safety concerns.

Incident reporting, learning and improvement

- There was an incident reporting policy in place and staff described the process of incident reporting and understood their responsibilities to report safety incidents, including near misses. Staff reported incidents using the trust's electronic reporting system; all staff were competent to use this system.
- Staff said they received feedback from incidents they had reported. Lessons learnt from incidents were shared through team meetings, face-to-face feedback from managers and safety briefs.
- Trusts are required to report serious incidents and never events to the Strategic Executive Information System

(StEIS). Between 1 December 2015 and 30 November 2016, community inpatient services reported one serious incident, which required investigation, this incident was categorised as a slips, trips or falls incident and occurred at SLIC.

- There had been no never events reported between 1 December 2015 and 30 November 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.
- From 1 December 2015 to 30 November 2016, there had been 234 patient safety incidents. We saw 62% of these resulted in no injury sustained; 34% resulted in 'minimal' harm to patients; 3.8% (9) incidents resulted in 'moderate' harm. Leeds Community Healthcare NHS Trust did not manage the CICU until June 2016 during this period.
- There were eight incident sub categories reported. The majority (67%) of all incidents were related to slips, trips and falls; the next most frequently reported incidents were pressure ulcers (13%). Staff we spoke with knew their top incidents were falls and pressure ulcers.
- The majority (79%), of the slips, trips, or falls, occurred at SLIC, which had the greatest number of patients.
- There had been five incidents of 'abuse of staff by patient', which all occurred on CICU. We spoke with staff about this, and found staff had appropriately dealt with the incidents.
- The unit manager described the actions taken following a recent medication error on CICU; this was a no harm incident and medical staff reviewed the patient immediately. We saw staff had learned lessons; relevant staff had undertaken retraining, reflective practice and observed medication rounds for four weeks.
- Staff told us they discussed incidents at the CNRC team meetings. In addition, clinical leads discussed clinical risks for specialist service teams at a specialist forum.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- We spoke with staff and they were aware of their responsibilities in relation to duty of candour; they knew about being open and honest with patients and families, and apologising when things went wrong.
- Senior staff at the CNRC explained because there had been no incidents there which required duty of candour to be applied, they used an example from another service to raise awareness and support staff learning on the unit.

Safeguarding

- There was a safeguarding policy in place and all staff received training in safeguarding adults and safeguarding children. The overall training compliance rates for staff working in the three units was 91% for safeguarding adults and 85% for safeguarding children, against the trust target of 90%.
- Staff could describe their role in how to identify and report a safeguarding concern. Staff completed Safeguarding referrals using an electronic system. There had been three safeguarding referrals made to the local authority between November 2015 and November 2016, one at each location.
- Safeguarding information to support staff learning was displayed on the three units. For example, a safeguarding flow chart was displayed in the dining room.
- Staff we spoke with told us the trust safeguarding team were accessible to provide help and support when needed.
- During the multidisciplinary meeting at the CNRC, we heard staff discussing safeguarding concerns and saw these were proactively escalated by staff when necessary.

Medicines

- There was a medicines management policy in place to guide staff. Appropriate arrangements were in place for obtaining, administering, and recording of medicines.
- We checked the arrangements for managing medicines at the three-inpatient services. We spoke with four members of staff and one patient and looked at 16 sets of patients' records.
- The CNRC displayed incidents relating to medications, including medication errors on the quality board.

Good

Are services safe?

- Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely with access restricted to authorised staff. Staff maintained accurate records and performed regular balance checks.
- We checked medicines and equipment for use in a medical emergency and found they were fit for use and a system of checks was in place to ensure this.
- Staff monitored the temperatures of medicine stock cupboards knew who to contact if temperatures exceeded the recommended range. Medicines requiring refrigeration were stored securely and staff recorded the temperatures on a daily basis. We saw however, at SLIC, staff had recorded the same temperatures for 26 days in January 2017. The temperatures were unlikely to have been the same for that length of time. Following our inspection, senior managers told us this appeared to be staff error in taking the temperature readings rather than the thermometers failing to monitor the temperature accurately. There was an alarm fitted to the fridge, so alarm would still sound if the temperature was outside the safe range of two to eight degrees.We reviewed the medicines fridge temperature checks on CICU. Staff checked and recorded the fridge temperature on a daily basis. there was no alarm fitted to the fridge, so staff could not be alerted if the temperature increased to above the safe upper limit of 8 degrees, then dropped again during the 24 hour period. This meant there was a potential risk to the stability of medication inside the fridge.
- A community pharmacy provided the service at SLIC and CICU under a contract. A local NHS trust provided medicines for the CNRC under a service level agreement. The provision covered both dispensing stock control and a clinical service. Staff said that the service was effective and that they could obtain medicines when they needed.
- Patients had their medicines in a timely way as prescribed, including pain relief. There was a system for medicines reconciliation, which involved medical and pharmacy staff. The aim of medicines reconciliation on admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission to hospital. Staff clearly recorded patient allergies in the records we looked at.
- Staff told us patients did not self-medicate, however, there was a self-medicating policy which related to CNRC. This process was not routinely offered to rehabilitation patients. One patient we spoke with told us they looked after their own medicines at home before admission, but were not aware they could do that in hospital. Following our inspection, senior managers told us patients on CNRC can self-medicate, as the centre is not a hospital setting, and that staff follow the current policy. We saw the policy which staff followed was due for review in 2010. This meant staff might not have had the most up to date guidance to follow.
- Staff entered a code for non-administration on the reverse of the medicines chart if any medicines were not given; we saw the code was used on almost all occasions explaining why the medicine was not given.
- During our visit, we saw one patient had received five types of medicines each day from 6 January 2017 and our visit; however, a prescriber had not signed the prescription, and two nurses (as stated in the policy) had not checked the chart. A second patient who had two medicine charts had a regular dose of their pain medicine prescribed on one chart as well as the same medicine being prescribed on the second chart to be given 'when required'. This increased the risk of too much medicine being administered to the patient.
- A third patient had one medicine prescribed as once daily when the patient's own drug label stated this was to be taken twice daily. There was no evidence of an entry in the records to indicate a change of dose. We brought these issues to the attention of the nurse in charge who asked the doctor to correct the dose immediately.

Environment and equipment

- All three units appeared visibly clean, tidy and generally well maintained.
- PLACE assessments (Patient Led Assessments of the Care Environment) took place every year. These are self-assessments undertaken by teams of NHS and independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). The assessment focused on different aspects of the environment as well as supporting non-clinical services such as cleanliness.
- At SLIC, the topic, which received the highest, score of 95%, was 'Condition, Appearance, and Maintenance.' CNRC scored 82% overall in the PLACE assessment. CICU did not have a PLACE inspection carried out in 2016.

Good

Are services safe?

- We checked emergency equipment in all of the areas visited and found it was well maintained and checked regularly. However, the resuscitation trolley on CICU should have been checked every 24 hours and after any emergency use; we saw daily checks had not been recorded on three occasions in January 2017 (the 11th, 22nd and 29th).
- The CICU was located on a ward within the local acute trust; we saw the environment was dated and in need of refurbishment. We noted the flooring in some areas of the unit was cracked and scratched, however, senior member of staff told us that they were awaiting a date for floor replacement. When we spoke with the service manager about the environmental issues at CICU, they acknowledged that the ward layout was not ideal and that some refurbishment was required.
- Staff at CICU said they had enough equipment to meet patient's needs. We saw that bed loops, perching stools, toilet raises, hoists and Zimmer frames were readily available.
- The SLIC was a purpose-built two-storey building with 20 beds on each floor. Downstairs there were 20 beds for patients who required nursing care, and 10 of these upstairs, and there were 10 beds for other patients who had a lower level of needs. The unit was secure and access was via a swipe card, or staff let visitors in. A lift or stairs provided access to the second floor.
- Appropriate equipment was available at SLIC to assist in the evacuation of patients in the event of a fire. The unit ran weekly fire alarm tests.
- The lift was very small and a trolley or a stretcher would not fit in it. For example if a patient were injured or unwell and needed to leave the building on a stretcher. Staff told us in this kind of situation the ambulance crew and they would use appropriate equipment to carry the patient down the stairs.
- All rooms had large emergency buzzers that staff or patients could press in the case of an emergency.
- Leeds City Council owned the building which housed the SLIC service. This meant the community inpatients staff did not have any control over issues with the estate.
- There were well-equipped therapy rooms on each floor at SLIC with rehabilitation equipment such as parallel bars.
- There were lounges and dining rooms on each floor and an outside garden area with tables and chairs. We saw patients accessing the outside areas during the visit.
- Social areas were available for patients to access including a dining room and a lounge area with a television.
- All rooms had ensuite toilets. Each of the four wings of the building had a shower room and a bathroom was available for patients.
- We did not have assurance the falls sensors helped to keep patients safe at SLIC. They did not always trigger the audible alarm if a patient stood up. This meant a patient could be at risk of major harm, as assistance would not be available if staff were unaware they were moving. When we asked service managers and the unit manager about this, they said this was on the risk register and they were getting quotes for a replacement system.
- CNRC was located within a hospital site in South Leeds. The community inpatients service did not own the building and did not have any control over issues with the estate. The manager told us there were frequently problems with the heating and hot water in the unit; they said this was a challenge for them.
- All patient rooms at the CNRC had ceiling track hoists. Maintenance staff serviced these for electrical safety.
- After our inspection, the trust submitted information to provide assurance of equipment maintenance and environmental audit, which they conducted across the three units. Records showed that all equipment maintenance was up-to-date.

Quality of records

- Medical and nursing records were stored securely in all areas we visited. This meant that staff kept patients' confidential records safe.
- Since our previous inspection in November 2014, the trust introduced new admission and care planning documentation in December 2016. Staff and managers explained that the new documentation was still evolving; they told us it was more patient-centred and brought together the MDT records.
- Record audits had previously taken place. Service managers told us these had not been formalised since the introduction of the new paperwork but they planned to introduce audits. The CICU service manager showed us 'spot checks' of admission documentation, which they completed for their own reassurance.
- Following our inspection, we were provided with information to indicate records audits were scheduled to take place from June 2017 to March 2018 on CICU; the

audits were planned to take place from April 2017 to March 2018 for SLIC. The audit for CNRC was completed in March 2017and 74% overall compliance was achieved. There was an improvement plan in place

- Records were all paper based; the unit managers at SLIC and CICU told us electronic patient records (EPR) were being rolled out across the community trust. Community adults neighbourhood teams were already changing onto EPR and community inpatients would be next.
- The trust used an 'intentional rounding' tool. Intentional rounding involves nursing staff using predetermined questions to ask patients on a regular basis, about care needs and checking the patient environment is clean and safe and that everything is in reach of the patient. We saw these checks were in place and completed regularly, for all the records we checked at the three units.
- We found it difficult to follow the documented plans for some patients on CICU. Each patient had medical notes and a set of MDT notes. We found the medical notes did not contain a lot of information. Senior staff explained that the service was predominantly nurse led and therapy focused and they would only go to the doctors if there was a problem. This meant there were fewer entries in medical records.
- Some allied health professionals wrote in either the MDT notes or the medical notes. We saw the dietitian had documented a request in medical notes for a patient to be weighed on 27 January, this had not happened and the request was repeated on 31 January. We spoke with senior staff about this; they told us nurses might miss such entries if they were written in medical notes rather than MDT notes. They told us they would look into this issue.
- There were two signature sheets for each set of patient records, one in the medical notes and one in the MDT notes. Four out of eight (50%) signature sheets in the medical notes were left blank (we were unable to cross check all these with MDT notes as some of those were in use or not available). We spoke with the unit manager about this; they told us they were thinking of combining the two signature sheets.
- We reviewed ten sets of medical and nursing records at SLIC. All records showed patients had been risk assessed for falls, pressure ulcers, moving and handling and malnutrition. In addition, a holistic assessment of each patient's activities of daily living was completed and where needed, an individualised care plan was in place; staff reviewed and evaluated these regularly.
- The records all had a transfer summary from the acute trust. The medical notes were for multidisciplinary use. The records had a comprehensive, patient centred, nursing assessment. On admission patients were asked a number of questions about 'my memory and thinking', 'my breathing', 'my skin', 'my well-being', 'how I eat and drink', 'how I wash and dress' and 'my home, people who help and support me'.
- We looked at the care records of five patients on the CNRC and found staff completed these to a high standard. All notes we looked at showed a comprehensive, holistic assessment of patients' physical, emotional, and psychological needs. We found care plans were individualised for each patient.

Cleanliness, infection control and hygiene

- There was a policy in place for staff to follow on infection prevention and control (IPC). There were effective systems in place to reduce the risk and spread of infection; patients were cared for in a mostly clean and hygienic environment. Cleaning schedules were displayed or available in files kept on the units.
- The trust submitted reports that demonstrated their compliance against IPC requirements and staff carried out hand hygiene audits across all three teams.
- Personal protective equipment (PPE) such as gloves and aprons were available in all areas we visited. Hand sanitiser was also available at the entrances to all wards and outside patient bays and side rooms. We saw staff using appropriate PPE and washing or using hand sanitiser before and after providing care to patients. Staff complied with the arms 'bare below the elbow' requirement.
- Staff correctly segregated and disposed of clinical and domestic waste in accordance with trust policy. Separate bins for clinical and domestic waste were evident throughout all the units we visited.
- Staff cleaned equipment after use and used dated 'I am clean' stickers to indicate it was clean and ready for use.
- The trust's PLACE assessment for 2016 showed at location level, SLIC performed better than average in three out of four areas with the exception of 'cleanliness' (94%).

Good

Are services safe?

- SLIC had reported one case of C. difficile in October 2016.
- Staff carried out MRSA screening at admission on all three of their units. Since January 2016, there had been four positive MRSA admission screens at CICU, four at SLIC and one positive admission screen at CNRC.
- At SLIC, the IPC audit data showed the results for environment were an average of 78%, hand hygiene as 100% and equipment as 89%.
- We were concerned the patient rooms at SLIC did not contain clinical hand basins and there were minimal facilities available for hand washing. Hand sanitiser gel was available on the corridors outside patient rooms but the only clinical hand washing sinks were in the dirty utility rooms.
- CQC inspectors also identified this issue at the previous inspection. We discussed this with the unit manager who said they had spoken with the trust IPC lead who judged this was low risk in that environment.
- In one patient room, we saw the toilet seat was not clean and there was no evidence to show when the room was cleaned. The room had an unpleasant odour.
- At CICU, we saw that labels were attached to most items of equipment to show when it was last cleaned both on the ward and in the rehabilitation gym. However, we saw eight walking sticks in the gym that did not have stickers attached. This meant there was no way for staff to know if the equipment was clean.
- At CICU, we saw some toilets that were visibly soiled; we also saw that the sink areas in the patient toilets had disposable privacy curtains. The frequency for changing disposable curtains was every six months unless they were visibly soiled, which these curtains were. In the female toilets, the curtains were visibly soiled and housekeepers had not changed the curtains since April 2016, nine months prior to our announced inspection. In the male toilets, the curtains appeared to be visibly clean however; these had not been changed since May 2016. We raised all of these concerns with senior staff on the unit at the time of our visit.
- Housekeeping staff from the acute hospital trust were responsible for cleaning on CICU.
- At the CNRC, we found that most items of equipment had stickers to indicate when staff last cleaned them. However, we saw some items for example a shower chair, which appeared visibly clean, but did not have a sticker to indicate when it was last cleaned.
- The service displayed IPC audit data. This showed that the unit had achieved 86% for environmental cleanliness, 100% for staff hand hygiene, and 75% for equipment cleanliness at the time of the last audit.
- We did not receive assurance about water safety at all the three units. Relevant staff had not followed up or taken appropriate actions taken in response to recommendations identified in the most recent legionella risk assessments. The actions that had not been taken included ensuring staff were appropriately trained in the control and management of legionella.
- Water safety involves flushing and running infrequently used taps and showerheads at least weekly, and the cleaning and de-scale of showerheads at least quarterly.
- We asked senior staff about legionella flushing and staff told us the local acute trusts facilities team completed this. We saw files were available on the units, which had details of the service level agreements with the estates team however whilst we saw evidence of environmental cleanliness audits we did not see any evidence that the legionella flushing had been completed.

Mandatory training

- All staff were required to complete a programme of mandatory training appropriate to their role. Mandatory training for staff was a rolling programme across the year. The unit managers received monthly reports, which were informed by the electronic staff record. Staff told us they could access courses required within a maximum of four months.
- Staff said they either could access trust mandatory training by electronic learning or could attend face-to-face training.
- All staff could access their mandatory training record and received alerts to indicate when training was due. The unit managers monitored mandatory training compliance.
- The care support staff at SLIC were employed through the local authority, so they completed separate mandatory training. However, staff told us if a training need was identified, they could complete the community trust's mandatory training modules.
- On 1 December 2016, the training compliance for this core service overall was 89% against the trust target of 90%. None of the three teams had achieved the training compliance target of 90%; SLIC reported 88%, CICU 89% and CNRC achieved 89%.

Good

Are services safe?

- All three teams, with each scoring 100%, achieved compliance with Information Governance training.
- Out of the 11 training courses listed, five topics achieved the trust target of 90%. Cardiopulmonary resuscitation, fire safety, IPC, and safeguarding children were all below 90%; conflict resolution and moving and handling had the lowest (worst) compliance with 79% each. This means all staff were not up to date with essential training for these topics. Six out of the 11 topics achieved the trust target.

Assessing and responding to patient risk

- There were appropriate systems in place at all three sites for assessing and responding to patient risk.
- The trust used a national early warning score tool (NEWS) to recognise a deteriorating patient. We saw these were in use and correctly completed in the care records we reviewed on all three units.
- There was a 'Falls Clinical Steering Group', which aimed to enhance shared learning and development from the incidents to reduce recurrence.
- We looked at the October 2016 performance report, which showed there was a target to reduce falls for inpatient beds by 10% for 2016/2017 compared with 2015/16. We saw from the year to date forecast that the services were on target to achieve this.
- All patients had fall risk assessment tools that indicated if they were at risk of falls. Patients identified as high risk were identified on the staff handover. We reviewed these patients and found they all had fall sensors in use.
- Staff told us they had worked hard to reduce the number of falls and had a daily safety huddle that focused on falls. Staff could also place 'crash mats' by a patient bed or could get additional staff to provide one to one supervision if needed to help keep patients safe.
- A team meeting was planned which would focus on falls, communication and how the team could work together better to prevent falls. Staff told us patients at high risk of falls were cared for in supervised 'cohorts' with adequate, working falls prevention equipment.
- We saw that non-slip 'red socks' were available for patients at CICU and SLIC. These socks were used to help prevent falls. This initiative also identified patients who were at risk of falls to all staff.
- SLIC did not have an emergency resuscitation trolley unit on site. A defibrillator was available and some emergency medication. Staff said in an emergency they would commence basic life support (BLS) and would call for an ambulance. All of the registered nurses had completed BLS training.
- At SLIC, all patients wore a pendant alarm, which they could press if they required assistance from staff. All the nursing staff carried a handset, which connected to the pendant alarm. This meant that if a patient was not near a nurse call buzzer they could request the assistance of staff for example, if they were in a communal area or in the event of a fall. However, staff told us the call bell system was not fit for purpose as it relied on staff carrying a handset around with them. Staff then responded to patients who heard staff on a loudspeaker in their room. Staff told us this method of responding to patients usually caused more anxiety and confusion for patients. When we asked the managers about this, they said they were looking into replacing the system.
- During our visit to CICU, the emergency buzzer system sounded twice, this alerted staff to an emergency incident. During both incidents, we saw that all staff responded immediately.
- We observed a nursing handover at the CNRC. At this meeting, the registered nurses and rehabilitation assistants reviewed each patient and discussed any specific nursing needs in relation to risk or patients care and treatment.
- We saw that at the CNRC, where appropriate, patients were photographed (with their consent) to ensure that all staff were aware of safe and preferred positioning of patients.

Staffing levels and caseload

- The trust used an acuity tool used to determine staffing levels on the three units. Staff considered patients' dependency levels and reviewed staffing levels on a daily basis to try achieve safe staffing levels.
- Senior staff at the CNRC confirmed they used a safer staffing tool and had collated patient dependency and acuity data to establish their baseline nurse staffing.
- The unit managers on CICU and SLIC told us staff from one unit would rarely work at the other; they said they would only do this in order to maintain safe staffing levels.
- We saw the service displayed planned and actual nurse staffing levels in all three locations we visited.
- Information sent to us before the inspection showed within the community inpatients teams in December

2016, there were 8.3 whole time equivalent (WTE) qualified nurse vacancies (20%) and 9.4 WTE nursing assistants vacancies (30%). The trust also had a staff turnover rate of 13% in the 12 months prior to December 2016. This is lower than the national average of around 17.8% for NHS Community trusts.

- Information from the provider showed that in the 12 months leading up to our inspection, sickness rates were high (10.8%) in SLIC. At the time of the inspection, the sickness rate was displayed as 1.5%. At CNRC, we saw staff sickness was 0.1% at the time of our inspection; at CICU, it was displayed as 2.1%. The national average of sickness rates are around 3%.
- Senior staff booked agency and bank staff to cover vacant shifts as required. We asked the trust to provide us with details of bank and agency staff but they were unable to do this as they did not have any standard shifts across the services.
- At SLIC, the planned staffing levels for the whole unit during the day were four registered nurses and six care workers. This meant the plan was for two registered nurses (RNs) and three care workers on each floor.
- The planned staffing levels for the whole unit on a night were three RNs and two carers. The unit manager told us they used regular agency nurses at night in addition to the permanent staff.
- An average fill rate of 100% means that all the planned staff were on duty. The average fill rate for RNs from September to November 2016 was 96.4% on days and 94.6% on nights. For care support staff, the average was 99.7% on days and 98.4% on nights.
- Planned staffing levels for allied health professionals were two physiotherapists, two occupational therapists, and two therapy assistants. At the time of the inspection, there was a vacancy for a physiotherapist; a locum physiotherapist was covering this.
- At CICU, the average fill rate from September to November 2016 for RNs was 95.9% on days and 92.6% on nights. In November 2016, the average fill rate fell to 88.9% at night.
- For care support staff at CICU, the average fill rate on days during this period was 87.4%. In November 2016, this average dropped to 82.1%. The average fill rate for nights was 61.6%. This included the months of October and November when the fill rates were 48.4 % and 73.3% respectively. This meant in October 2016, there were less than half the required numbers of care support staff on night shifts than were planned.
- Bed numbers on CICU were increased from 24 to 27 on a temporary basis to respond to system pressures. The trust had ensured that there were additional nurses and support workers on duty to meet the additional demands and advised that they would continue to have extra support whilst these additional three beds remained open.
- Senior staff told us planned staffing was three RNs and three care support workers during the day for 24 patients. It was the same planned level for the three extra patients. At night, it was three RNs plus one care support worker for 24 patients. there were three RNs plus two support workers planned for 27 patients.
- The unit manager at CICU told us it was difficult to attract staff; they were planning to go to careers fairs in the hope of attracting more candidates.
- We spoke with a trainee-nursing associate on CICU. They told us they were undertaking a foundation degree at the local university and were currently supernumerary at the time. They would be included in the numbers of care support workers when they had completed their competency-based training and clinical experience.
- Patients we spoke with at CICU and SLIC told us there were enough staff and they did not have to wait for anything for too long. One patient told us they did not think there were enough staff, however they said staff tried their best so patients were not waiting too long.
- At CNRC, the average fill rate for RNs on day shifts from September to November 2016 was 141.5%. In October, there had been 160%. This meant extra staff were on duty at those times. The average fill rate for RNs on nights was 83.6% for the three months. Following our inspection, senior managers told us agency or bank nurses had been arranged to cover 16.4% of the night shifts during this period.
- We saw in September 2016, there had only been 56.7% of shifts filled against the planned levels. There had been an average fill rate of 94.3% care support workers on day shifts; this ranged from 65% in September to 125% in November. On nights, from September to November the fill rates of staff ranged from 56% to 88%.

Medical staffing

- On CNRC a Consultant in Rehabilitation Medicine worked Monday 9am-1pm, and Tuesday to Thursday 9am- 5pm.

Good

Are services safe?

- Outside these times and overnight medical cover was provided by the on call Consultant in Rehabilitation Medicine on a one week in five rota.
- During the day, a specialist trainee in rehabilitation medicine was based on the unit Monday morning and Tuesday and Thursday all day. They could be contacted by phone outside these times between 9am and 5pm Monday to Friday.
- CICU had one consultant geriatrician and a junior doctor GP trainee who provided cover Mon-Fri 9am to 5pm.. If medical support was needed outside of these hours, it was provided by the GP out of hours service. In an emergency, a patient would be transferred to A&E.
- SLIC had two consultant geriatricians and a junior doctor GP trainee who provided cover Monday to Friday 9am to 5pm. If medical support was needed outside of these hours, this is provided by the GP out of hour's service. In an emergency, a patient would be transferred to A&E.

Managing anticipated risks

- We saw fire safety equipment was available and information was displayed on the units we visited. In addition to this, we saw evacuation equipment was available on the upper floor at SLIC.

Good

Are services effective?

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

Summary

When community inpatient services at Leeds Community Healthcare NHS Trust were last inspected in November 2014, the effective domain was rated as requires improvement. We asked the provider to make the following improvements:-

- Ensure resuscitation procedures and practice were reviewed and the use of best practice is implemented, for example Resuscitation Council guidance.
- Ensure initial assessments were promptly undertaken and care plans are person centred on all units.
- Ensure 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms were completed in-line with trust policy.

At this inspection, we rated effective as good because:

- Patient care and treatment was planned and delivered in line with current guidance.
- Patients had good outcomes because they received effective care and treatment.
- Staff were qualified and had the skills they needed to carry out their roles effectively.
- There was good evidence of multidisciplinary team working.
- Consent to care and treatment was obtained in line with current legislation and guidance.
- Initial assessments were promptly undertaken and care plans were person centred on all three units.
- Do not attempt cardiopulmonary resuscitation (DNACPR) forms were completed in-line with trust policy.
- Resuscitation procedures and practice were reviewed in line with best practice.
- Falls risk assessment tools were in line with National Institute of Health and Care Excellence (NICE) guidance.

However,

- The service did not collect information for the community inpatients teams relating to delayed transfer of care or delayed discharges for SLIC and CICU until January 2017 This meant the trust did not know if patients were delayed in going home from the units, or by how long, and for what reason until this process was put in place.
- The October 2016 trust performance report showed compliance with NICE guidance within one year was rated as red.
- Staff caring for patients with dementia did not always have up-to-date appropriate training in dementia care.
- Not all patients were assessed in line with the Mental Capacity Act

Detailed findings

Evidence based care and treatment

- Patient's care and treatment was planned and delivered in line with current evidence-based best practice. For example, falls risk assessment tools were in line with National Institute of Health and Care Excellence (NICE) guidelines.
- However, the October 2016 trust performance report showed that compliance with NICE guidance within one year was rated as red. This meant there were actions which needed to be taken to meet the guidance.
- There was participation in relevant national and local audits. The community inpatient team had participated in three of the 14 audits conducted by the trust in 2016; two were national audits and one local. Two were due to be completed in March 2017 and the audit undertaken by SLIC for 'Re-audit Falls Tool' was completed in September 2016.
- The trust provided their latest resuscitation policy and deteriorating patient guidelines. Resuscitation procedures and practice were delivered in line with best practice.
- At SLIC, there were Leeds Community Healthcare (LCH) NHS Trust and Leeds City Council (LCC) policies and procedures; this was because the qualified staff were employed by LCH and the care support staff were employed by LCC.

Good

Are services effective?

- The provider had dashboards and performance reports relating to community inpatient services. These showed that the service regularly monitored key areas such as staffing, training, length of stay, harm free care, admissions and discharges
- Medical staff on CNRC were members of the British Society of Rehabilitation Medicine and used their training programmes. The service clinics were bench marked against another regional district general hospital.
- CNRC used the 'repeatable battery of neurological status' (RBANS) to assess patients' cognitive status in order to make sure that they were able to actively participate and benefit from the planned rehabilitation. The RBANS considered factors such as attention span, language, and memory.
- The CNRC had audited their spasticity service against Royal College guidelines as a measure of effectiveness.
- Medical staff working at the CNRC attended a weekly Yorkshire Region support meeting. The consultants were considering development of a group for young adults attending the unit, to provide help and advice about sexual function difficulties.

Pain relief

- Individual patients' pain was assessed and managed appropriately.
- Pain scores were recorded using the NEWS scoring system. We saw this was being used correctly.
- Patients told us their pain was well managed and they received adequate pain relief in a timely manner.
- We spoke with patients at the CNRC who told us staff responded quickly when they need pain relief.
- Everyone we spoke with on CICU told us their pain relief was given when they needed it.

Nutrition and hydration

- Patients nutrition and drink needs were assessed and care planned accordingly.
- The units had protected mealtimes. This meant that patients were not disturbed during their meals. We saw that patients had access to drinking water at all times and that staff ensured that this was within reach.
- At CNRC, we saw that patients were encouraged to eat in the dining room to prevent social isolation. We observed the evening meal service and found that staff were attentive to patients needs and provided assistance where necessary. Patients we spoke with told us that they enjoyed the food on the unit.
- At SLIC, patients told us that they enjoyed the food and they were offered hot drinks and snacks throughout the day. However, we found the three main meal timings were close together; breakfast was from 8am to 8:30am, lunch from 12-12.30 and tea at 4pm, without a full evening meal later. When we asked the managers about this, they said the kitchen staff made sandwiches and drinks to give patients in the evening.
- Dietary needs were recorded on the staff handover sheet and kitchen staff were aware of patients on a special diet. Patients were encouraged to go to the dining room for meals.
- At CICU, the mealtimes were the same as for the rest of the trust; there was a patient kitchen on the ward where staff could make food and drinks for patients. However, there was no access to hot food outside the normal mealtimes.
- The red tray system was in use; this identified patients that needed assistance with eating and drinking. Where patients had been identified as needing nutritional supplements, a red tray was used to serve meals on as a visual reminder to staff. Special diets were listed on a whiteboard in the kitchen and housekeeping staff took account of these when giving out extra snacks with drinks.
- CICU did not use the Malnutrition Universal Screening Tool (MUST); however an adapted assessment score for assessing patients' nutritional needs was in use.

Patient outcomes

- Patient outcomes were good; we saw patients' length of stay data and outcome measures demonstrated the quality of service. Data provided to us showed that a higher proportion of patients returned home compared to other community intermediate care (CIC) beds nationally.
- For CICU and SLIC the majority of patients were discharged to their own home rather than into long-term care. At CNRC, patient outcome measures were benchmarked against other services providing similar support to patients.
- The CNRC was working with Leeds University in completing an audit to measure the maintenance of patient goals following discharge.

Good

Are services effective?

- The CNRC was piloting and auditing Therapy Outcome Measures (TOMs). These allow professionals working in health and social care to describe the relative abilities and difficulties a patient may have in the four areas of impairment, activity, participation, and wellbeing. The professionals are then able to monitor changes over time.
- In addition, the unit was also considering using the new NHS England Patient Activation Measure (PAMs) outcome measure. Patient activation describes the knowledge, skills and confidence a person has in managing their own health and care.
- The CNRC collated carer outcomes using an outcome measures tool. This was done by gathering information from carers of patients on the unit, when the patient was admitted and again at discharge.
- The unit consultant an outcome measures group that was attended by nursing and therapy staff as well as the clinical psychologist.
- Physiotherapy staff completed physiotherapy assessments using the elderly mobility scale. This outcome measure used to assess a patient's mobility and demonstrate patient's progress.
- We saw there were local quality improvement projects, which had occurred within the last 12 months.

Competent staff

- Between 2 December 2015 and 2 December 2016, clinical supervision for nursing staff working in community inpatients was 64% and for Allied Health Professionals (AHPs) was 67%. The overall trust target for clinical supervision was 65%. Senior staff leads in nursing, occupational therapy and physiotherapy at CNRC told us they did not have time to do any clinical supervision. We saw the rate of clinical supervision was 69% which was slightly higher than the trust target.
- The trust's target rate for appraisal compliance was 92%. On 1 December 2016, the overall appraisal rates for non-medical staff working the three community inpatient teams was 83%. This meant not all permanent non-medical staff had received regular appraisal.
- The units with the highest average appraisal rate were CICU and SLIC wards where 86% who achieved. None of the units achieved the trust's appraisal target, with CNRC scoring lowest with 78%.
- At CICU and SLIC, there were a number of link roles for nurses and support workers. However, it was not clear how involved the staff actually were in those roles, or how much time they had to attend link meetings or update others. Staff who were link workers at CNRC told us they didn't have time to fulfil those aspects of their role.
- The unit managers at CICU and SLIC had both undertaken leadership training
- At CICU and SLIC, we found there was significant proportion of patients who were living with dementia, and staff had not been trained in caring for people with dementia. The quality statement in the National Institute of Health and Care excellence (NICE 2010) guidance on dementia support in health and social care states that people with dementia should receive care from staff appropriately trained in dementia care. There should be evidence of local arrangements to provide and maintain up-to-date dementia training.
- When we asked the service managers about this, they told us dementia awareness was encouraged and they were looking at whether dementia training should be a core competency for staff. Dementia training was not mandatory for staff at the time. Information sent to us after the inspection showed that one member of staff working at SLIC had undertaken dementia training; none of the other staff had received the training. The unit managers were developing a plan.
- At the CNRC, all band 2 (rehabilitation assistants) staff completed nursing and therapy competencies. In addition, all band 2 staff completed competency assessments to enable them to be the second checker of controlled drugs. One of the band 2 rehabilitation assistants was studying to gain a nursing associate post.
- At the CNRC, most of the registered nurses had completed mentor training.
- The lead nurse at the CNRC was a nurse prescriber, other registered nurses had completed additional postgraduate education, for example in Parkinson's disease and neurogenic bladder and bowel conditions, which enabled them to complete advanced assessments.
- Staff at CNRC told us they did not have enough psychology input for patients. Both speech and language therapists (SALT) and psychology were based off site.
- Revalidation within the service highlighted that all medical staff had revalidated in the last 12 months. Revalidation means doctors were up to date and fit to practice

Good

Are services effective?

- Data was provided to us to show medical staff on the three community inpatient wards.received appraisals.

Multi-disciplinary working and coordinated care pathways

- At SLIC, we observe two multidisciplinary handovers between nursing staff, care support workers, and therapy staff. The handover was detailed and highlighted any patient risks. Discharge plans were discussed and there we saw the staff knew the patients well. Staff used a handover sheet which highlighted patients' needs and risks, such as those without mental capacity, or who has special dietary requirements, falls risks, or if the patient was living with dementia.
- Staff we spoke with at CNRC told us that following referral to the CNRC, patients were triaged through a multidisciplinary (MDT) centre. This involved an MDT assessment of the patients' needs to determine if inpatient or community based care was needed. If the patient was deemed appropriate for the inpatient unit, they then attended a full assessment clinic to identify their needs and decide if they would need inpatient or a day care.
- Staff admitted patients to CNRC on a Monday. A full MDT assessment took place with the patient, a rehabilitation nurse, a physiotherapist, and an occupational therapist. On the patients second morning the patient and their family attended an individual goal setting meeting with the MDT.
- The unit held a full MDT on Tuesday afternoons. We attended this meeting during our inspection and found a comprehensive holistic review of each patient and his or her goals were discussed and reviewed. The unit leader, the rehabilitation consultant and the nursing and therapy staff attended this meeting from the unit.
- A patient review meeting took place on the second Thursday of the patient's admission. At this meeting, a further goal review was held and future care needs were determined, this was either a plan for readmission, onward referral for further specialist care or discharge. We observed a patient goal setting MDT meeting (with the patient's permission). It was very structured and done in a way so the patient and their family could understand what was being said. The patient and family were very involved, and able to participate. Staff were genuinely very caring and compassionate towards the patient. We observed the TOMS (therapy outcome measures) being used.
- Staff on CNRC told us that they had close and positive working relationships with community based rehabilitation teams, for example the stroke team, district nurses, the continence team and also with the local authority.

Referral, transfer, discharge and transition

- The service did not collect information for the community inpatients teams relating to delayed transfer of care or delayed discharges for SLIC or CICU until January 2017. This meant the trust did not know if patients were delayed in going home from the units, or by how long, and for what reason until this process was in place. Therefore, specific action could not be taken to address particular reasons for delays before this time..
- At CNRC, the patients were admitted for a fixed two-week period of treatment and were discharged on a Friday, so there were no delayed discharges.
- SLIC collected information to show how many patients were re-admitted to hospital within 72 hours of discharge form the centre.
- Both CICU and SLIC accepted referrals from the community to prevent an admission, or from hospital, in order to support someone's discharge.
- All referrals went through the Single Point of Urgent referral (SPUR) and the Bed Bureau. The unit managers told us the bed bureau held their waiting lists; they were unaware of their current waiting list and told us this changed daily.
- The unit manager on CICU told us the main reason for referral to the service was for rehabilitation. They said they occasionally took other patients who required nursing care, for example patients requiring antibiotics or intravenous fluids.
- Patients were aware of why they were in hospital and one person described the ward as a 'halfway house', people expected to go home. However, two patients (who were alert and orientated) were not aware of a discharge plan. One of these told us they had not had a discussion around discharge. Two patients we spoke with were aware of their discharge plan and one person told us the occupational therapist had done a home visit. Another person we spoke with told us their discharge plan had been fully discussed with them and the physios were working to help them with their mobility.

Good

Are services effective?

- The average length of stay on CICU was 24 to 25 days; the national intermediate care audit recommends the length of stay should be 21 days. At the time of the inspection, two of the patients were 'long stays.' All of the patients at CICU required nursing care.
- Occupational therapy staff carried out home visits to carry out assessments prior to discharge. The majority of patients were discharged to their own home rather than into long-term care.
- At SLIC, the unit aimed for an average length of stay of 21 days for residential patients and 27 days for nursing patients. However, the unit manager told us they were not currently meeting this for all patients.
- Prior to admission to CNRC patients were assessed by a registered nurse from the unit, in their own home and a discussion took place about the aims and outcome goals of their treatment.
- There was a referral pathway for the Community Neurology service for accessing CNRC. Patients were usually admitted to the CNRC from their own home. Patients could be referred by their GP, or by a community rehabilitation team member, or they could self-refer if they had previously been a patient on the unit.
- The consultant at CNRC was leading work for patients transitioning between children's and adult services. The service ran four joint clinics with paediatrics, which linked to the neurological disability team at Leeds General Infirmary.

Access to information

- Discharge summaries from the acute trust were stored in the patients' medical records.
- Staff we spoke with told us they were able to access policies, standard operating procedures and best practice guidance on the trust's intranet system.
- Staff said there were no problems accessing information they required, such as patients test results.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We saw Mental Capacity Act information was on display for staff. We saw when patients lacked capacity that this had been mostly determined through a capacity assessment and best interest process, involving the patient's family where possible. We saw that discussion with patients, or their families, had taken place and that staff documented this clearly in the patient's medical records.
- Mental Capacity Act was one of the prompts on the handover sheets and was incorporated into the new documentation. Nursing staff carried out capacity assessments. On CICU, there was a spreadsheet showing which patients did not have capacity; staff told us this was followed up every week with the local authority social care team who worked with the trust.
- However, when we checked eight sets of patient records on CICU we found three patients with a diagnosis of significant dementia had not had mental capacity assessments carried out. This meant the Mental Capacity Act was not followed in these instances.
- Staff training in the Mental Capacity Act was mandatory, with a renewal timeframe of every three years. On 1 December 2016, the overall compliance rate for the Mental Capacity Act training in the previous 12 months for community inpatient teams was 95%, this was better than the trust target of 90% compliance.
- We saw CICU and SLIC staff made appropriate applications for Deprivation of Liberty Safeguards (DoLS); they also used best interest meetings and independent mental capacity advisors (IMCAs).
- The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom
- The trust provided information around the number of DoLS applications the community inpatients wards had made between 1 September 2016 and 30 November 2016. The services made 37 applications, 22 of which were for the CICU and 15 for SLIC. The trust did not collect this data before June 2016.
- During our inspection, we looked at the do not attempt cardiopulmonary resuscitation (DNACPR) forms for 11 patients, this included four on CICU and seven on SLIC. Staff completed these to a high standard. Discussions around DNACPR were clearly documented in the patient's records. All of the forms were found in the front of the patients' medical records, all were legible and completed in full. Our only concern was that not all of the forms at SLIC were signed by a consultant. We discussed this with the leadership team who addressed this issue immediately.

Good

Are services caring?

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

Summary

When community inpatients at Leeds Community Healthcare NHS Trust were last inspected in November 2014, the caring domain was rated as good.

At this inspection, we rated caring as good because:

- All of the patients we spoke with were happy with their care and treatment. They told us the staff were caring and kind.
- Staff responded compassionately when patients needed help and support; staff treated patients with dignity respect and kindness.
- Staff encouraged patient to be involved in making decisions about their care and treatment.

Detailed findings

Compassionate care

- On all the units we visited, we saw staff were caring and compassionate towards patients. Staff treated patients with kindness, dignity and respect. We found that staff were sensitive to the needs of the patients and their families. This was confirmed by the most recent patient led assessments of the care environment (PLACE).
- SLIC was similar to the England average in relation to PLACE results for privacy, dignity, and wellbeing, at 83%, whilst CNRC fell marginally below at 82%. We acknowledged CNRC was located within St Mary's Hospital, which also provided services related to other services, which were included in the score.
- On all units we visited, we saw that patients looked well cared for; they were well groomed with attention given to their hair and nails.
- During an MDT meeting, we observed a discussion about how staff had managed a situation when a patient or their family had set unrealistic goals and how staff had dealt with this in a caring and compassionate manner.
- We spoke with eight patients on SLIC, all patients spoke positively about the care and treatment they had received. They said staff were attentive and answered buzzers in a timely way.
- One patient told us that the unit was 'absolutely brilliant' and that staff were always having a laugh and joke. Patients said they felt safe and that it was 'really excellent'.
- We observed staff respecting patient's privacy and dignity by knocking on doors before entering and closing patients' doors during care and conversations.
- We spoke with 12 patients at the CICU; one patient told us that they were 'really happy' and that staff look after them very well.
- CICU displayed friends and family feedback data. This showed that in January 2017, the unit had seven responses and that patients were 100% satisfied with the care they had received.
- We observed caring interactions and good rapport between staff and patients. We saw all patients who were sat out of bed were dressed in daytime outdoor clothes as part of their rehabilitation. We spoke with one patient who told us that a member of staff had stayed behind after their shift to paint their fingernails for them.
- All the patients we spoke with were very positive about the staff and felt they were caring. One patient told us the day staff were more caring than the night staff. Another told us 'everyone knows your name; you are not just a woman in the bay.' Patients told us the staff were good and treated them nicely.
- All the patients we spoke with told us they were treated with dignity and their privacy was respected. One person told us their dignity and privacy were respected because staff drew the curtains when they were getting dressed and undressed. (This person was blind).
- Three of the people we spoke with told us of the humour and banter staff employed when delivering personal care that made the atmosphere light and the whole experience as comfortable as is possible.
- We spoke with two patients at the CNRC. One patient had previous experience of the service, this patient told us that the unit was like a 'home from home' and that nothing was too much trouble for the staff and they thought they were outstanding.
- The second patient we spoke with told us that this was their first experience of the unit. They said as soon as they arrived they could feel the 'warmth and empathy' and could tell that staff really want to help. This patient

also said that 'nothing was too much trouble' for the staff and, everyone was willing to help. This patient also said that everyone in the unit spoke kindly to them, including the catering and domestic staff.

Understanding and involvement of patients and those close to them

- On SLIC, we observed staff discussing different methods of communication for a patient who was hard of hearing. Staff used written communication to support their discussions with the patient.
- Nursing records contained 'my goal' sheets, which were individualised and completed with each patient. Information about 'how I will achieve this' and 'you will help me by' was documented in the patient records.
- Patients felt involved in their care and understood why they were on the unit and what their goals were.
- Staff knew patients and their relatives well and were aware of the patients' family circumstances.
- We saw that patients and those close to them were involved in planning their care and setting goals. Patients we spoke with told us that they were involved in setting their own goals but that all members of the MDT supported them with this if needed.
- Three people we spoke with at CICU said they were given enough time to absorb information and ask questions. One of these told us if they did not understand anything, they would ask staff to explain things in simpler terms, which they did.
- All the people we spoke with told us they had a care/ treatment plan and were fully involved in the plan. One person told us their plan was discussed with them and their relative, and that their views were listened to. Another person told us they were informed on a daily basis about their care plan.
- One person told us had three different physiotherapists who had all given them different advice which was confusing.
- Three patients at CICU were not aware of their plan of care. We looked at the care records for one of these patients and found there was evidence of multidisciplinary involvement with clear goals and a discharge plan. We could not tell if the patient had been involved.
- Patients we spoke with did not have any concerns. One person told us if they had any concerns they would discuss them with their relative. Another person told us they would discuss any concerns or worries with their 'regular nurse'.
- We saw that patient and carer information leaflets for were available on the three units we visited. The leaflets covered a wide range of information including those specific to each unit, and generic information such as pressure ulcer prevention, nutrition information and infection prevention and control advice.

Emotional support

- People received the support they needed to cope emotionally with their conditions.
- A patient in CNRC told us that the emotional support received was 'fantastic'. They told us that at home they do not look in the mirror because all they see is their wheelchair, at the unit the staff encouraged them to see 'me'.

Good

Are services responsive to people's needs?

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

Summary

When community inpatients at Leeds Community Healthcare NHS Trust were last inspected in November 2014, the responsive domain was rated as requires improvement. We asked the provider to make the following improvements:-

- Discharge planning processes needed development and decisions needed to be more focused and time-stated.

At this inspection, we rated responsive as good because:

- Services were planned and delivered to meet the needs of all patients using them. All three units were short-stay rehabilitation units. Activities were provided for patients at all three units.
- Reasonable adjustments were made to ensure people with disabilities, or those in vulnerable circumstances, could access services on an equal basis. These included dementia friendly signage and adaptations to the care environment at SLIC and soap dispensers at an appropriate height for people in wheelchairs at CNRC.
- Patients were able to access the right care at the right time. Discharge-planning processes were clear and time-stated
- The service had a low number of complaints and a high number of compliments; there was a robust complaints process and the service was proactive in dealing with any complaints received.

Detailed findings

Planning and delivering services which meet people's needs

- Three local Clinical Commissioning Groups (CCGs) planned services and worked closely with health trusts and the local authority to deliver services for patients.
- The SLIC and CICU had open visiting hours between 8am to 8pm and at the CNRC, there was open visiting, apart from mealtimes and therapy sessions.
- SLIC used to be a residential care home, and had been used for community inpatient (community-intermediate care – CIC) beds since 2013.
- Services at SLIC were jointly commissioned with Leeds City Council; Leeds Community Healthcare NHS Trust was the lead provider. Leeds City Council employed the care support workers.
- CNRC had five inpatient beds and five-day patient beds. Patients with overnight needs were admitted in to an inpatient bed for two weeks of rehabilitation from Monday to Friday. Patients who did not need overnight care came in to the unit for rehabilitation two days per week for four weeks.

Equality and diversity

- All three units were accessible for patients with disabilities and had made reasonable adjustments to ensure disabled people could access services on an equal basis. For example, there was enough moving and handling equipment, such as hoists, available.
- There was access to interpreters. As patients were initially referred to the service from their general practitioner, staff were made aware and could plan for this in advance of patients' being assessed and admitted to the unit. We were also told that there were some staff on the unit who spoke a second language including Polish and Hindu.
- We saw that an equality assessment was completed in all of the patient care records we looked at on the CNRC.
- At CICU, the unit was separated in to male and female areas with separate designated bathrooms, showers, and toilets. During our inspection, we noticed that the first four-bedded bay of the male section of the ward was being used for female patients. We spoke with senior staff about this in terms of mixed sex accommodation. We were told the unit had robust and procedures in place to ensure that there were no mixed sex accommodation breaches. Staff said this included ensuring that female patients were taken to the toilets and bathroom facilities in the appropriate area of the ward.
- At CNRC, the male and female signage on the toilets and bath/shower room doors was interchangeable; this meant these facilities could be assigned according to the patients in residence at the time.
- At the SLIC, each floor was split in to two corridors. However, there was a mixture of female and male

patients on each corridor. Each patient's room had an ensuite toilet and wash hand basin, which meant patients could use their own facilities rather than using ones on the unit. However, male and female patients were located in opposite rooms. This meant that patients might be able to see a patient of the opposite sex in the room opposite them.

Meeting the needs of people in vulnerable circumstances

- At SLIC, the area was better than the England Average was for 'Dementia Friendly' status by six percentage points. We not clear how this was scored as staff at SLIC had not all been trained in dementia care.
- At SLIC, there was 'dementia friendly' signage directing patients to the toilets, dining room and lounge area was visible. We saw patients had dementia friendly equipment in their rooms; for example, brightly coloured raised toilet seats to enable patients to find the toilet more easily. Fixtures and fittings throughout the building supported patients with dementia, these included appropriate floor coverings and handrails on corridors
- All rooms had memory boxes, a large clock, and the date displayed to help patients orientate themselves to their surroundings.
- One patient we spoke with at SLIC told us about their family and life history. However, when we looked at their care record there was no record of this being recorded. Such information enables health and social care professionals to see the patient as an individual and deliver person-centred care that is tailored specifically to that person's needs.
- The CNRC scored better than average in two areas of dementia friendly status. 'Disability', was the highest recorded score relating to the environment in this core service at 98%.
- Senior managers at CICU told us the service subscribed to 'John's campaign;' this is a campaign supporting the rights of people with dementia to be supported by their carers in hospital. They explained there were no family rooms on the unit, but fold up beds were available if family members or carers wanted to stay with the patient.
- The CICU had staff who were dementia champions; these staff attended dementia champions meetings. The aim was to improve care for vulnerable people.
- SLIC held a breakfast club twice a week where patients could attend and make their own breakfast. The therapists offered weekly seated and fall prevention exercise classes for patient who were vulnerable from falls.
- There was a cinema room at SLIC and films were shown on Mondays, Wednesdays, and Fridays; charitable funds had been used to purchase the projector.
- The CICU did not have a separate area for patients to eat meals; meals were served to patients in bed or by the bedside. This meant there was less opportunity for social interaction at mealtimes.
- The units had daily activities patients could participate in during the week, including craft sessions and music groups. These were provided by a local charity called 'Kissing it better'. Some units had visits from therapy dogs.

Access to the right care at the right time

- Patients using the community inpatient services were mostly able to access the right care at the right time; there were delays from referral to treatment times on CNRC.
- Staff told us patients waited three months for an inpatient bed and four months for day case treatment. Staff told us this had improved significantly since the previous January, when waiting lists for an inpatient bed were seven months, and eight months for the day case service. They explained how the unit had changed the working patterns of the therapy and rehabilitation assistants to allow for additional sessions on a Friday and this had reduced the waiting lists significantly.
- Senior staff told us that patients awaiting care and treatment at the CNRC were screened through the triage process and that priority was given to patients who needed occupational rehabilitation so that they could remain in employment.
- Bed occupancy levels were high on the units; however, there was no evidence to show this had detrimentally affected patient care.
- Over the 12-month period, 1 December 2015 to 30 November 2016, the community inpatient service had a bed occupancy ranging from 60% to 101%. The CNRC reported bed occupancies consistently over 85% for 10 of the 12 months, reaching 100% in two months.

Good

Are services responsive to people's needs?

- For seven of the 12 months another trust managed services provided by the CICU. For the last five months, when Leeds Community Healthcare NHS Trust managed the services, the bed occupancy level had been consistently high, reaching 101% in one month.
- Length of stay across the SLIC and the CNRC ranged from seven to 28 days, over the 12-month period from 1 December 2015 to 30 November 2016.
- The CICU only reported five months of data (July-November 2016) as another provider previously managed the unit. The average length of stay over the five months was 27 days.

Learning from complaints and concerns

- The service had a robust complaints process and was proactive in dealing with any complaints received.
- The service received three complaints with one upheld and another partially upheld during the 12 months from 1 December 2015 – 30 November 2016. No complaints were referred to the ombudsman.
- Themes from the three complaints included delay or lack of bed availability, failure to follow agreed procedures and all aspects of clinical treatment.
- We saw from minutes of meetings that actions were taken to prevent recurrence. For example, in the case of a medication error, the unit manager contacted all registered staff on the unit by email and provided them with learning materials.
- The service had received 114 compliments during the 12 months from 1 December 2015 to 30 November 2016. CRNC received the most compliments (88) in the time.
- We saw Patient Advice and Liaison Service (PALS) information displayed on the units we visited and information about how to make a complaint was visible in communal areas.
- At the CNRC we saw that details about the patient experience team and the 'speak up guardian', which was an independent patient advocacy service, were displayed on the quality board.
- Senior staff on the CNRC told us that there had been no complaints about the unit for more than two years however, they were able to tell us how they would deal with a verbal or written complaint if one was made.

Good

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

When community inpatients services at Leeds Community Healthcare NHS Trust were last inspected in November 2014, the well-led domain was rated as good.

At this inspection, we rated well-led as good because:

- The leadership, governance, and culture promoted the delivery of high-quality person-centred care.
- There were new leadership teams in place, which were making effective changes.
- The services had a clear vision, values, and strategies and staff in all areas were aware of these.
- There were systems and processes in place for managing governance and risk, with a clear focus on learning and improvement.
- Appropriate actions had been put in place to mitigate identified risks in the services. For example, regular agency staff were covering gaps in staffing rotas to ensure fill rates were maintained at safe and identified levels.
- The service had a blame free culture where staff felt confident to raise concerns.
- Friends and family test results were consistently positive.

However

- Response rates for the friends and family test were low.

Detailed findings

Leadership of this service

- We saw the service was led and leaders understood the challenges to good quality care and safety.
- At the time of the inspection, there were two operational (senior) managers for the three services, one with responsibility for CICU and SLIC and the other with responsibility for the CNRC. They were in secondment roles and had been in post for approximately six to seven months.
- The CICU unit manager had been in post for seven months and the SLIC unit manager worked on the unit before they were promoted to the post at around the same time (June 2016).
- Since our last inspection, the local acute trust had taken responsibility for the CICU. Management of the unit had changed back to the community trust in May 2016. Senior staff told us this had been an unsettling time for staff.
- Staff at CICU and SLIC told us the new unit managers had made an impact, with lots of positive differences; they said the new unit managers had high standards and expectations. This meant they were feeling much more supported.
- We saw a comment on the 'positivity board' at CICU that said 'We have a really supportive and encouraging manager. Massively helpful and always there when times are stressful.'
- A therapist we spoke with told us that MDT working was good at CICU and it was 'improving all the time', due to the strong leadership.
- At the SLIC, the care support workers were employed by Leeds City Council (LCC) and managed by a separately by a LCC care manager. This manager was based at the SLIC and was also responsible for the upkeep of the building.
- The SLIC unit manager had management responsibility for the qualified staff (nurses and therapists); they told us it would be better if they also managed the care support workers working at the service.
- The CNRC was part of the specialist services business unit, which had a different management structure. The unit manager at CNRC had been in post for about a year; they were line managed by the operational manager for the group.
- Staff at the CNRC told us their senior staff were visible and approachable. Staff at CNRC spoke very highly of their unit manager; they said they were very approachable, visible, forward thinking and willing to listen to suggestions. They told us the unit manager had made improvements since they had been there.
- Junior staff told us the senior staff on all units were engaged, visible, approachable and knowledgeable.
- Staff on all three units told us they had seen the trust senior executive team on their walk rounds; they said they were friendly and approachable.

Good

Are services well-led?

Service vision and strategy

- We saw the trust's vision and values displayed on the units we visited and staff we spoke with could explain these to us.
- The trust provided the 2017- 2018 business plan for the CICU and SLIC and the strategic objectives for CNRC.
- There was a citywide ambition to increase the number of intermediate care beds. Senior staff explained there would be a new specification for community integrated care (CIC) beds across the city soon (expected Spring 2017)) and the service had placed a bid with commissioners to be the lead provider for these.
- Senior managers told us they were looking into how the provision of care for patients requiring nursing and residential care at the SLIC could be improved. This was intended to provide for patients that are more dependent. The unit manager told us they were visiting another residential community intermediate care unit to see what they could learn from them.
- The CNRC had a strategy displayed on the unit. Senior staff we spoke with told us that this was developed through the quarterly strategic meeting. The strategy for CNRC included band 7 nurse development, incorporating early supported discharge into the stroke pathway, reduction of waiting lists for the service and local and national audit participation.
- Senior staff told us there was an increased focus on ensuring plans were aligned with organisation priorities, across all services and corporate teams.

Governance, risk management and quality measurement

- Governance is a term used to describe the framework, which supports the delivery of the strategy and safe, good quality care.
- Governance was established within the services and progress was tracked through the trust's performance reports. The service's governance dashboards tracked patient outcomes, feedback, admissions, discharges, and safety thermometer performance in graphs and data tables.
- Staffing levels, supervision and training at the three locations were also monitored by the use of dashboards.
- We saw governance meeting minutes from August to November 2016 and three sets of ward meeting minutes for each of the three units, from June to November 2016. The minutes included outcome measures, performance, and feedback from incidents and complaints, including actions taken to prevent recurrence and lessons learnt.
- There were two risks on the risk register for community inpatients as of 30 November 2016; they were both for the SLIC. The first risk involved the impact of agency staff on service provision and the second was the risk of the falls sensors at SLIC not always triggering the audible alarm. Managers were aware of these risks and actions were in place.

Culture within this service

- The service had a blame free culture where staff felt confident to raise concerns.
- Staff said they felt supported in their role and able to raise concerns. They felt their local managers were approachable. The managers told us they had an open door policy; staff we spoke with confirmed this.
- We found all staff were positive, enthusiastic, friendly, helpful and approachable in all areas we visited. All of the staff we spoke with were team focused. One member of staff at the CNRC told us they loved working there and that the team were 'fantastic'.
- We saw comments on the positivity board at CICU, which included, 'I am proud of the teamwork', and 'I am proud to work with an outstanding team of professionals from the manager to the housekeeper'.
- We witnessed two emergencies during our inspection. We saw the senior staff on the ward were supportive and visible during these incidents; in addition to this, we saw staff thanked each other for being helpful and supportive. The senior nurse held a debrief session with the staff involved following these incidents.

Public engagement

- The CNRC held a 'neuro user and carer forum' (NUCF). Staff we spoke with said approximately 15 members (active and past patients) regularly attended. In addition to those who attended the forum, the unit had approximately 70 members on an e-mail forum. We saw information about the forum displayed in the unit.
- Staff told us members of the user forum had contributed to changes within the unit, for example, soap dispensers and notice boards had been relocated so that these were more easily accessible for wheelchair users.

Good

Are services well-led?

- The user forum discussed all of the proposed patient information leaflets to gain the views of the forum members. Patients we spoke with told us they were given useful written information and leaflets.
- We saw the units gathered feedback from patients using the friends and family test (FFT); however, the response rates were low. In December 2016, there had been seven responses at CICU and eight at SLIC. The average number of patients admitted to the units in that month was 28 at CICU and 29 at SLIC. The unit managers explained that staff were meant to ask patients for their feedback on discharge, but this did not always happen. The unit managers for the CICU and SLIC agreed it would be easy to improve these response rates. However, these were slightly higher (9.7%) than the trust average response rate of 9.5%.
- The average response rate for CNRC for 2016 was higher than average at around 27%.
- The trust had a plan to increase survey response rates in all areas, to bring about an improved level of understanding of patient experience and satisfaction. However, there was no evidence to show this priority was being effective within inpatient services. Data provided in the bed governance dashboard for December 2016 showed response rates for the three sites overall decreased between April and December 2016. There were 14 responses in April and three responses in December.

Staff engagement

- The service managers told us that following the 2015 staff survey, there was an organisation wide action plan, which aimed to keep staff involved and updated.
- The unit manager on CICU told us they worked with the unit manager on SLIC to produce a joint newsletter for staff. We saw staff meeting minutes on display on the noticeboards.
- We saw that staff on CICU had been involved in creating a 'positivity board.' This displayed positive comments from the staff.
- At CICU and SLIC, staff meetings were held every month. The unit managers held meetings with night staff and with care support workers when they had requested a separate meeting. Staff could contribute to the agendas for the staff meetings, there was an agenda on the noticeboard, or staff could email the unit manager. Staff meetings were open to all grades of staff.
- At SLIC, the unit manager told us they had changed the shift times several times following consultation with, and feedback from, staff.
- At the CNRC, team meetings were held every other month. In addition, there was a quarterly full community neurorehabilitation meeting, involving inpatient and community services. Both of these meetings had minutes produced for staff to access. Staff told us that all members of the team, including the catering and domestic staff (who were not employed by the trust) were invited to the meetings because they were part of the team.

Innovation, improvement and sustainability

- New personalised, patient centred multi-professional assessment documents had been introduced on CICU and SLIC in December 2016. These were still under development at the time of the inspection; staff feedback showed these had been a positive service development however, we saw there was room for some improvement.
- Senior staff at CICU told us about a project they were completing to improve patient flow. This involved looking at patient pathways and journeys through the unit and identifying any delays and blockages in the current system, which could potentially reduce patient's length of stay and therefore improve patient flow.
- Staff at CICU had been highly commended during a trust 'Thank You' event held in 2016 and had received a trust award, in November 2016, for having no hospital acquired pressure ulcers for a year.
- The CNRC had won an infection prevention and control award. The CNRC used a quality challenge process based on the CQC key lines of enquiry.
- Senior staff at the CNRC had reviewed working patterns and activities to ensure the patient's rehabilitation was optimised. This involved changing working practice on a Friday afternoon to ensure therapists and rehabilitation assistants were available.