Requires improvement

Leicestershire Partnership NHS Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT5KF	Bradgate Mental Health Unit	Crisis Service	LE3 9EJ
RT5KF	Bradgate Mental Health Unit	Health based place of safety	LE3 9EJ

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

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

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Not sufficient evidence to rate** 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We gave an overall rating for mental health crisis services and health-based places of safety of **requires improvement** because:

- Some medication was out of date and there was no clear record of medication being logged in or out. There were no recorded regular temperature checks of the medication cupboard.
- The health-based place of safety did not meet some aspects of the guidance of the Royal College of Psychiatrists. For example, furniture was light and portable and could be used as a weapon. Designated staff were not provided by the trust. This meant the police very often had to care for detained patient for the duration of the assessment.
- Information needed to deliver care was not always readily available when people using community mental health teams presented in crisis out of hours.
- People using the service had limited access to psychological therapies and there were no psychologists working within the service.
- Staff had not received any specialist training on crisis intervention. Administrative staff had not received specific mental health awareness training to assist them when taking calls for people who were acutely unwell and in crisis.
- There some gaps in staff receiving regular supervision.
- Target times had been set but the speed of response to referrals was not analysed and used to determine whether they were meeting targets. People using the service may not be able to get the speed of telephone response they needed in a crisis.
- There was no performance data dashboard to gauge the performance of the service. However, the service was collecting data. A dashboard of key performance indicators was being developed.
- Staff knew who the most senior managers were in the organisation but these managers had not visited the service and staff had no contact with them. Staff felt supported by their immediate managers but felt disaffected with trust senior management.
- Staff treated people who used the service with respect, listened to them and were compassionate. They showed a good understanding of peoples' individual needs.
- The trust had set safe staffing levels and these were followed in practice. Cover arrangements for sickness, leave and vacant posts were in place.
- The needs of people who used the service were assessed and care was delivered in line with their individual care plans. Risks to people who used the service and staff were assessed and managed.
- Multi-disciplinary teams and inter-agency working were effective in supporting people who used the service.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because

- Some medication was out of date and there was no clear record of medication being logged in or out. There were no recorded regular temperature checks of the medication cupboard.
- The health-based place of safety did not meet some aspects of the guidance of the Royal College of Psychiatrists. For example, furniture was light and portable and could be used as a weapon. Designated staff were not provided by the trust. This meant the police very often had to care for detained patient for the duration of the assessment.

However:

- The trust had set safe staffing levels and these were followed in practice. Cover arrangements for sickness, leave and vacant posts were in place.
- Staff had been trained and knew how to make safeguarding alerts.
- Risks to people who used the service and staff were assessed and managed.

Are services effective?

Good 

We rated effective as **good** because:

- The needs of people who used the service were assessed and care was delivered in line with their individual care plans. This included a good assessment of people's physical health needs. Interventions included support for housing, employment and benefits.
- Multi-disciplinary teams and inter-agency working were effective in supporting people who used the service.

However:

- Information needed to deliver care was not always readily available when people using community mental health teams presented in crisis out of hours.
- People using the service had limited access to psychological therapies and there were no psychologists working within the service.
- Staff had not received any specialist training on crisis intervention.
- There some gaps in staff receiving regular supervision.

Summary of findings

Are services caring?

Good

We rated caring as **good** because:

- Staff treated people who used the service with respect, listened to them and were compassionate. They showed a good understanding of people's individual needs.
- People were involved in their care and treatment and were aware of their care plans.
- Staff encouraged people to involve relatives and friends in care planning if they wished.
- Advocacy services were available for people who used the services.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** because:

- Target times had been set but the speed of response to referrals was not analysed and used to determine whether they were meeting targets..
- People using the service may not be able to get the speed of telephone response they needed in a crisis.
- Administrative staff had not received specific mental health awareness training to assist them when taking calls for people who were acutely unwell and in crisis.
- Staff took a proactive approach to re-engaging with people where there was a failed visit
- Appointments ran on time and people who used the service were kept informed if there were any unavoidable changes.
- Information leaflets were available in languages spoken by people who used the service and there was access to translation services and interpreters where needed.

Are services well-led?

Not sufficient evidence to rate

We did not rate well-led as the service is too new to rate:

- There was no performance data dashboard to gauge the performance of the service. However, the service was collecting data. A dashboard of key performance indicators was being developed.
- Staff knew who the most senior managers were in the organisation but these managers had not visited the service and staff had no contact with them. Staff felt supported by their immediate managers but felt disaffected with trust senior management.

Summary of findings

- Staff felt the new model of service would improve the consistency and responsiveness of the service and had been involved in its development.
- There was good team working and mutual support.
- The triage car was an example of innovative practice.

Summary of findings

Information about the service

Leicestershire Partnership NHS Trust provides a crisis service whose focus is to meet the needs of people experiencing acute mental health crisis. The service is based at Bradgate Mental Health Unit, is available 24 hours a day, 365 days a year and covers Leicester City, Leicestershire and Rutland.

The health based place of safety is situated at the Bradgate unit in Leicester.

A mental health triage service and deliberate self-harm service is also provided for people who present to the urgent care centre or Leicester Royal Infirmary emergency department.

The trust had developed a new model for the crisis service which was in the third week of operation at the time of this inspection.

We carried out a pilot thematic inspection of mental health crisis care in September 2014. The trust was working with its partners on the recommendations.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, Head of Hospital Inspection (mental health) CQC

Inspection Managers: Lyn Critchley and Yin Naing

The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers and support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team that inspected this core service included CQC inspectors, an expert by experience and a psychiatrist, 2 nurses, a Mental Health Act reviewer and a social worker.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback at focus groups.

During the inspection visit, the inspection team:

Summary of findings

- visited the crisis service and health-based place of safety at Bradgate Mental Health Unit, the triage and deliberate self-harm service based at the emergency department of Leicester Royal Infirmary and the crisis house
- spoke with nine people who were using the service
- spoke with the managers of the service
- spoke with 36 other staff members; including doctors, nurses and social workers
- observed two reviews with the prior permission of those involved
- observed telephone based assessment procedures
- attended and observed three hand-over meetings
- accompanied staff in the triage car
- held discussions with approved mental health professionals.

We also:

- looked at 22 care records of people who used the service
- carried out a specific check of the medication management in the crisis service based at Bradgate Mental Health Unit
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

People spoken with were positive about the support provided to them and praised the staff. They told us staff treated them with respect, listened to them and were compassionate. They said they were involved in their care and treatment and were aware of their care plans.

People told us that appointments ran on time and they were kept informed if there were any unavoidable changes. They told us the service tried to ensure the same person visited them or if not from a small group of staff. Some people said this did not happen in practice

People we spoke with knew how to raise concerns and make a complaint. They felt they would be able to raise a concern should they have one and believed that staff would listen to them.

Good practice

- The introduction of the triage car had improved access to assessments for people who come to the attention of the police and may have mental health needs. A police officer and nurse in an unmarked car attended such incidents. We observed that staff in the triage car undertook assessments in an interview environment that provided dignity and confidentiality within the vehicle. The triage car was called to all incidents where a police officer believed it may be appropriate to detain a person under S136.

Areas for improvement

Action the provider MUST take to improve

- The trust must protect people who use the service against the risks associated with the unsafe management of medicines.
- The trust must address the identified safety concerns in the health-based place of safety.
- The trust must ensure that all staff receive regular managerial supervision in line with their own policy and protocols.
- The trust must develop mechanisms to regularly assess and monitor the quality of the service provided and develop active plans where there are issues.

Summary of findings

Action the provider SHOULD take to improve

- The trust should ensure information needed to deliver care is always readily available when people using community mental health teams present in crisis out of hours.
- The trust should ensure people using the service have access to psychological therapies.
- The trust should ensure staff have the specialist training required for their role.
- The trust should work in partnership with the acute trust so that a more appropriate service is offered to those in the emergency departments.
- The trust should review its procedures for responding to telephone calls from people in crisis to ensure they get the speed of response they need.

Leicestershire Partnership NHS Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Crisis Services	Bradgate Mental Health Unit
Health-based place of safety	Bradgate Mental Health Unit

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Most staff were trained in and appeared knowledgeable about the Mental Health Act and code of practice. They were aware of their responsibilities around the practical application of the Act although staff in the crisis service had little cause to use this as the service was not working with anyone subject to a community treatment order (CTO).

We found that the relevant legal documentation was completed appropriately for those people detained under S136 in the health-based place of safety in those records reviewed. Staff, including approved mental health professionals (AMHP), were clear about the procedure and processes involved if a person required assessment under the Act.

Not all staff in the emergency department were clear under which legal authority they would prevent people with a mental disorder from leaving when this would put them at risk. We also found this in our pilot thematic inspection of mental health crisis care in September 2014.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with were aware of the Mental Capacity Act 2005 and the implications this had for their clinical and professional practice. Most staff had received training on this Act.

We found in a review of records that mental capacity assessments were being completed appropriately. A capacity assessment was completed as part of the initial assessment process developed with University Hospitals of Leicester NHS Trust for use in the Leicester Royal Infirmary emergency department.

Requires improvement

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We rated safe as **requires improvement** because

- Some medication was out of date and there was no clear record of medication being logged in or out. There were no recorded regular temperature checks of the medication cupboard.
- The health-based place of safety did not meet some aspects of the guidance of the Royal College of Psychiatrists. For example, furniture was light and portable and could be used as a weapon. Designated staff were not provided by the trust. This meant the police very often had to care for detained patient for the duration of the assessment.

However:

- The trust had set safe staffing levels and these were followed in practice. Cover arrangements for sickness, leave and vacant posts were in place.
- Staff had been trained and knew how to make safeguarding alerts.
- Risks to people who used the service and staff were assessed and managed.

Our findings

Safe environment

- The trust had identified areas of potential environmental risk in all of the services we visited. A risk had been identified relating to the lack of space and access to and from some rooms in the emergency department used to assess people who may need mental health services. We were told by staff that a redevelopment of the emergency department was planned which included good facilities for people needing mental health services.
- Alarms were available in interview rooms and staff said that when the alarm was used, staff responded quickly.
- The health-based place of safety did not meet some aspects of the guidance of the Royal College of Psychiatrists. Furniture was light and portable and could be used as a weapon. Access to the two small rooms was through one door only which meant that it could be difficult to exit the room quickly if needed. The facility was locked. Resuscitation equipment and emergency medication were available.

Safe staffing

- The trust had carried out a review of staffing as part of its development of a new model for crisis services. This had set staffing levels within the crisis service for each of the trust's localities and was due to be evaluated once the new model had been in place for a few months. We reviewed the staff rotas for the weeks prior to our inspection and saw that staffing levels were in line with the levels and skill mix determined by the trust as safe.
- Managers told us they were able to allocate additional staff to a locality crisis team if more staff were required for some shifts. Staff told us they could respond promptly to the needs of the people who used the service and there were sufficient staff to ensure their safety.
- Cover arrangements for sickness, leave and vacant posts ensured patient safety. Agency staff were on long term placements with the crisis service whilst vacant posts were being recruited to. They were given an induction to the service and provided with written guidance.
- Rapid access to a psychiatrist was available in the crisis service when required.
- The health-based place of safety did not have designated staff provided by the trust. We were told that this meant the police very often had to care for the detained patient for the duration of the assessment. This is contrary to the guidance of the Royal College of Psychiatrists which states there should be a minimum of two mental healthcare professionals immediately available to receive the person from the police. Police had to summon help if the person required medical intervention and ward staff responded in the same way as they would a crisis on another ward.

Assessing and managing risk to patients and staff

Requires improvement

Are services safe?

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

- The case records reviewed showed that staff had undertaken a risk assessment at the initial assessment and then reviewed and updated this when required. Care plans were in place to address the identified risks.
- We observed that staff taking telephone call referrals completed an initial risk assessment and had immediate access to a qualified member of staff if appropriate.
- Risk levels for people who used the service were discussed at handover meetings in order to detect any increases and take prompt action. Staff demonstrated a good understanding of the needs and assessed risks of people who used the service.
- We saw that a joint process had been developed with the University Hospitals of Leicester NHS Trust (UHL) which provided an initial assessment of risk for people experiencing a mental health crisis and presented to the Leicester Royal Infirmary emergency department.
- Staff had received training in safeguarding and staff we spoke with knew how to recognise and report a safeguarding concern. We observed a new safeguarding concern being discussed and identified in a handover meeting and saw that appropriate action had been taken to report this.
- Good personal safety protocols including lone working practice were used to reduce the risks to staff. Principles and practice guidance on worker safety including visits to people in their own home were given to staff. Staff had recently been issued with electronic devices that were able to track their location and communicate remotely to gain assistance if needed. Staff we spoke with were positive about this development which they felt increased their safety.
- Staff had received training in physical interventions to manage violent and challenging behaviour and were aware of de-escalation techniques.
- We were concerned about the storage and recording of medication. The medication cupboard for the crisis service was locked and we were told by staff that medication stored there was for emergency use out of hours. We found that some medication was out of date and there was no clear record of medication being logged in or out. The only record was for how many bottles of one medication was stored and this showed there should have been six bottles whereas we found only four bottles. We found some patient labelled medication in the cupboard but no record of what patient medication was being stored or what had been given. There were no recorded regular temperature checks of the medication cupboard. We informed managers of our findings on the same day. Immediate action was taken by staff to dispose of out of date medication and we were told a plan of regular recorded audits was being put in place.

Track record on safety

- We saw that the trust had commissioned a review into attempted suicides and suicides of which seven took place within the crisis services between May and October 2013. We found that improvements had been made as a result including a new process for actions to be carried out following a failed visit. The findings had also been used to inform the new model for the crisis service.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to report incidents and were able to describe what should be reported.
- An incident that had put staff at risk in a person's home had been reviewed using root cause analysis and as a result lone working procedures were strengthened and staff were issued with electronic devices referred to above in order to improve safety.
- We saw that team meetings were used to feedback to staff from investigations of incidents both internal and external to the service. Some staff felt that such feedback was not consistently given and would have preferred access to such information in written form as well.
- Most staff told us that they were de-briefed and supported after a serious incident. Some staff told us they had been involved in the investigation of incidents and development of service improvements as a result.

Are services effective?

Good

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

Summary of findings

We rated effective as **good** because:

- The needs of people who used the service were assessed and care was delivered in line with their individual care plans. This included a good assessment of people's physical health needs. Interventions included support for housing, employment and benefits.
- Multi-disciplinary teams and inter-agency working were effective in supporting people who used the service.

However:

- Information needed to deliver care was not always readily available when people using community mental health teams presented in crisis out of hours.
- People using the service had limited access to psychological therapies and there were no psychologists working within the service.
- Staff had not received any specialist training on crisis intervention.
- There some gaps in staff receiving regular supervision.

Our findings

Assessment of needs and planning of care

- The needs of people who used the service were assessed and care was delivered in line with their individual care plans. Care plans were regularly reviewed, considered all aspects of the person's circumstances and were centred on them as an individual. People we spoke with gave us examples of how their individual needs were met.
- The trust was in the process of rolling out the electronic patient record system RiO. The crisis service and triage service were using RiO but the community mental health teams were not. This meant that information needed to deliver care was not always readily available when people using community mental health teams presented in crisis out of hours.

Best practice in treatment and care

- Staff we spoke with were aware of NICE guidance in prescribing medication but the crisis service did not audit that staff followed this guidance in practice.
- NICE guidelines on self-harm were used by the triage and deliberate self-harm team. For example a mental health triage scale had been developed with UHL for use in the Leicester Royal Infirmary emergency department by all practitioners.
- People using the service had limited access to psychological therapies and there were no psychologists working within the service.
- We saw that interventions provided by the crisis service included support for housing, employment and benefits and that these issues were considered as part of the assessment and care plans.
- Our review of records showed that people's physical health needs were considered in assessments. Where physical health concerns were identified, care plans were put in place to ensure the person's needs were met.
- The crisis service had a limited number of measures to monitor the effectiveness of the service provided. We were told by managers that recent audits of the quality of risk assessments and care plans had been undertaken but there was no written evidence of the findings and actions arising from these. The new model of service was only in its third week of operation at the time of this inspection and some measures to monitor the effectiveness of the service were being developed.

Skilled staff to deliver care

- The staff working with the crisis service came from a range of professional backgrounds including nursing, medical, occupational therapy, and social work. There were no psychologists working within the service.
- Staff told us they had undertaken training relevant to their role, including record keeping and care planning, infection control and basic life support. Records showed that most staff were up-to-date with statutory and mandatory training. Staff had not received any specialist training on crisis intervention. New staff had a period of induction before being included in the staff numbers. Managers had access to the electronic training records for their service. This allowed them to oversee their progress in completing their training.

Are services effective?

Good

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

- Some staff raised concerns about the amount of formal supervision available but all felt that there was good ad hoc supervision on a daily basis during the shift and in handover meetings. We were told by managers that team leaders were not sending notifications of supervision to the academy within the trust as required and this meant that there was no accurate measure of the level of supervision for the service over time. Managers undertook a manual collection during the inspection using the written log of supervision and told us that 85% of staff in the service were receiving regular supervision.
- There were regular team meetings and staff told us they found these useful to reflect on practice and discuss any issues, concerns or good practice.

Multidisciplinary and inter-agency team work

- Different professionals worked together to assess and plan people's care and treatment. Staff told us there was effective team working within the service. Care plans included advice and input from different professionals involved in people's care. We observed three handover meetings and found they were effective in sharing information about people and reviewing their progress.
- There were some delays in the handover from the crisis to community teams and this was an area that staff hoped to improve with the new crisis model.
- We observed effective inter-agency work, with staff from the triage and deliberate self-harm team and staff from Leicester Royal Infirmary working together on the assessment and provision of care to people presenting in mental health crisis to the emergency department.
- There were good working links between the trust and police which had resulted in the development of the triage car staffed by a nurse from the trust and a specially training police officer. Regular meetings between the trust and police operations were used to discuss for example S136 matters, policies and procedures and any incidents.

Adherence to the MHA and the MHA Code of Practice

- Most staff were trained in and appeared knowledgeable about the Mental Health Act and code of practice. They were aware of their responsibilities around the practical application of the Act.
- We found that the relevant legal documentation was completed appropriately for those people detained under S136 in the health-based place of safety in those records reviewed. Staff, including approved mental health professionals, were clear about the procedure and processes involved if a person required assessment under the Act.
- Not all staff in the emergency department were clear under which legal authority they would prevent people with a mental disorder from leaving when this would put them at risk. We also found this in our pilot thematic inspection of mental health crisis care in September 2014.

Good practice in applying the MCA

- Staff we spoke with were aware of the Mental Capacity Act 2005 and the implications this had for their clinical and professional practice. Most staff had received training on this Act.
- We found in a review of records that mental capacity assessments were being completed appropriately. A capacity assessment was completed as part of the initial assessment process developed with UHL for use in the emergency department.

Good

Are services caring?

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

Summary of findings

We rated caring as **good** because:

- Staff treated people who used the service with respect, listened to them and were compassionate. They showed a good understanding of people's individual needs.
- People were involved in their care and treatment and were aware of their care plans.
- Staff encouraged people to involve relatives and friends in care planning if they wished.
- Advocacy services were available for people who used the services.

Our findings

Kindness, dignity, respect and compassion

- People who used the service told us staff treated them with respect, listened to them and were compassionate. One person told us "everyone knew my history and they were all there for me". Another said "they are not overpowering and they know my needs."
- We observed reviews and telephone based assessments of people. Staff treated people who used the service with respect and communicated effectively with them. They showed the desire to provide high quality and responsive care.
- When staff discussed people who used the service in handover meetings or with us, they discussed them in a respectful manner and showed a good understanding of their individual needs. They were aware of the requirement to maintain confidentiality at all times.

The involvement of people in the care they receive

- People who used the service told us they were involved in their care and treatment and were aware of their care plans. They said they were able to discuss their medication and its use. People were encouraged to involve relatives and friends in care planning if they wished.
- Advocacy services were available for people who used the service and managers told us they hoped to extend the availability of this out of hours.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

We rated responsive as **requires improvement** because:

- Target times had been set but the speed of response to referrals was not analysed and used to determine whether they were meeting targets.
- People using the service may not be able to get the speed of telephone response they needed in a crisis.
- Administrative staff had not received specific mental health awareness training to assist them when taking calls for people who were acutely unwell and in crisis.
- Staff took a proactive approach to re-engaging with people where there was a failed visit
- Appointments ran on time and people who used the service were kept informed if there were any unavoidable changes.
- Information leaflets were available in languages spoken by people who used the service and there was access to translation services and interpreters where needed.

Our findings

Access, discharge and transfer

- The trust had developed a new model for the crisis service which was in the third week of operation at the time of this inspection. Target times and clear criteria had been set:
- assessment within two hours of referral for those people referred from the emergency department or EDU as a result of self-harm and under the care of UHL;
- assessment within four hours of referral for those people referred by their GP or other professional who they assessed as requiring an assessment within four hours;
- assessment within 24 hours of referral for those people referred by their GP or other professional who they assessed as requiring an assessment within twenty four hours.
- We observed that people were given a degree of choice in the times of appointments on the first contact by the service following a referral.
- We heard from staff that they met the target times for assessment but this was not being monitored routinely, save in the triage and deliberate self-harm service. This meant that it was not possible to measure the speed of the crisis service's response to referrals and whether they were meeting their targets. Managers told us that the introduction of RiO had made it difficult to extract this information and plans were being developed to overcome this.
- The crisis service took a proactive approach to re-engaging with people where there was a failed visit. A new systematic and clear process had been developed for staff to use when there was a failed visit using the findings from a review of a serious incident. Staff we spoke with were familiar with this process and were using it in practice.
- People who used the service told us that appointments ran on time and they were kept informed if there were any unavoidable changes. They told us the service tried to ensure the same person visited them or if not from a small group of staff. Some people said this did not happen in practice. One person said "I think they've done pretty well but they need to keep the same person where possible." Managers and staff were aware of this concern from people who used the service and felt the new service model would improve on consistency of care.
- We observed that administrative staff were taking telephone calls meant for the referral lines or for a clinician. These calls were directed back into queue to be answered and we heard that this could be a lengthy wait. No member of staff would be aware if the call had been abandoned by the person using the service and there was no follow up of such calls. This meant that people using the service may not be able to get the speed of telephone response they needed in a crisis. We raised this with managers during the inspection who planned to develop a new process to overcome this risk.
- Administrative staff had not received specific mental health awareness training to assist them when taking calls for people who were acutely unwell and in crisis.

Meeting the needs of all people who use the service

Are services responsive to people's needs?

Requires improvement

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

- Staff had access to translation services and interpreters to help assess and provide for the needs of people using the service. Managers told us they were planning to review the availability of such services out of hours.
- Information leaflets were available in languages spoken by people who used the service.

Listening to and learning from concerns and complaints

- Information about raising concerns and complaints was available to people who used the service and their carers. Information was also available on the trust's website. This information could be made available in different languages.
- People who used the service told us they knew how to raise concerns and make a complaint. They felt they would be able to raise a concern should they have one and believed that staff would listen to them.
- Staff told us they tried to address patients concerns informally as they arose. Staff we spoke with were aware of the formal complaints process. We saw managers had a log of complaints made and we saw that such complaints were investigated and the trust formal process was followed.
- Staff told us and we saw from the minutes that learning from complaints was discussed at team meetings.

Are services well-led?

Not sufficient evidence to rate

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

We did not rate well-led as the service is too new to rate:

- There was no performance data dashboard to gauge the performance of the service. However, the service was collecting data. A dashboard of key performance indicators was being developed.
- Staff knew who the most senior managers were in the organisation but these managers had not visited the service and staff had no contact with them. Staff felt supported by their immediate managers but felt disaffected with trust senior management.
- Staff felt the new model of service would improve the consistency and responsiveness of the service and had been involved in its development.
- There was good team working and mutual support.
- The triage car was an example of innovative practice.

Our findings

Vision and values

- Most staff we spoke with were aware of the trust's vision and values..
- Staff told us they had regular contact with their team managers and occasional contact with the service manager. They knew who the most senior managers were in the organisation but these managers had not visited the service and staff had no contact with them. Doctors told us they were well supported and had regular contact with the Medical Director.

Good governance

- A new model of service delivery for the crisis service had been introduced and was in its third week of operation at the time of the inspection. Staff and stakeholders had been involved in the development of the model. We found that a dashboard of key performance indicators was being developed but there was no reliable performance data, save the number of referrals, to gauge the performance of the service. We were told by managers that the trust had agreed to suspend the interim dashboard, as the data was not reliable, until the implementation of the new model of care and the ability for RiO to populate the dashboard in April 2015.
- There were some systems of governance that enabled managers to monitor some aspects of the service provide information to senior staff in the trust. Examples were the electronic training record and the incident reporting system. However we were told by managers that team leaders were not sending notifications of supervision to the academy within the trust as required and this meant that there was no accurate measure of the level of supervision for the service over time.
- Managers told us that they had enough time and autonomy to manage the service. They also said that, where they had concerns, they could raise them. Where appropriate the concerns could be placed on the trust's risk register.

Leadership, morale and staff engagement

- The service was in a period of change and staff were adjusting to the changes this had meant for them. Staff had been involved in the development of the model. Staff we spoke with felt the new model would improve the consistency and responsiveness of the service.
- All staff we spoke with were very positive about team working and the mutual support they gave one another. They felt supported by their immediate managers but felt disaffected with trust senior management.
- Staff we spoke with knew how to use the whistleblowing process. Some staff did not feel able to raise concerns.

Commitment to quality improvement and innovation

- The trust was participating in the Mental Health Crisis Care Concordat with their partners and had developed an action plan to improve services that was being monitored regularly.
- The introduction of the triage car had improved access to assessments for people who come to the attention of the police and may have mental health needs. A police officer and nurse in an unmarked car attended such incidents. We observed that staff in the triage car undertook assessments in an interview environment that provided dignity and confidentiality within the vehicle. The triage car was called to all incidents where a police officer believed it may be appropriate to detain a person under S136. We were told by managers that the scheme had resulted in a 40% reduction in section 136 admissions and cost savings.

Are services well-led?

Not sufficient evidence to rate

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.

- A new crisis house had recently been opened by the trust working with a voluntary sector provider. This service offered short term placement in conjunction with crisis intervention in an effort to help prevent hospital admission. We visited the service and found the accommodation was of good quality with toiletries and food available for those using the service in crisis. People using the service were very positive about their experience. One person said “this is a step above the care that has traditionally been available”. Another said “I don’t think I would be here if it weren’t for the intervention of the team”.
- General nurses in the emergency decision unit of Leicester Royal Infirmary were responsible for looking after people’s mental health prior to and after being seen by mental health professionals, sometimes for lengthy periods and included dealing with challenging behaviour. Security guards were used to restrain people or stay with people with challenging behaviour. Whilst this is not a Leicestershire Partnership Trust premises, the trust should work in partnership with the acute trust so that a more appropriate service is offered.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The provider did not protect patients against the risks associated with the unsafe management of medicines.** • Some medication was out of date in the crisis service • There was no clear record of medication being logged in or out. • There were no recorded regular temperature checks of the medication cupboard. **The trust had not implemented the requirements of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013** This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The provider had not ensured that patients were protected from the risks associated with unsafe or unsuitable premises by means of suitable design and layout.** • The health-based place of safety at the Bradgate unit did not meet guidance: furniture was light and portable and access arrangements were unsafe. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 10 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The trust had not made suitable arrangements to ensure that staff were appropriately supported in relation to their responsibilities, including receiving appropriate training, professional development, supervision and appraisal. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The trust did not protect people, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the trust to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. There were insufficient mechanisms to regularly assess and monitor the quality of the service provided and develop active plans where there are issues. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.