Care Quality Commission

Leicestershire Partnership NHS Trust

Community-based mental health services for older people

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)
RT5Z1	Bridge Park Plaza	Leicester City East CMHT	LE5 3GH
RT5Z1	Bridge Park Plaza	West Leicestershire CMHT	LE10 0EW
RT5Z1	Bridge Park Plaza	South Leicestershire CMHT	LE5 4PW
RT5Z1	Bridge Park Plaza	Melton, Rutland and Harborough CMHT	LE13 1SJ
RT5Z1	Bridge Park Plaza	City West CMHT	LE3 9DZ

Summary of findings

RT5Z1	Bridge Park Plaza	Charnwood CMHT	LE11 5JY
RT5Z1	Bridge Park Plaza	Memory Services	LE5 4QG

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?	**Requires improvement**
Are services caring?	**Requires improvement**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

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 rated **community based mental health services for older people** as **requires improvement** because:

- When we checked care records, we found variable implementation of the Mental Capacity Act. Staff did not record consent to treatment, and capacity to consent and best interest's decisions when these were needed. Staff received Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Some staff did not demonstrate a good understanding of the Mental Capacity Act.
- Staff did not assess and record the risks posed by medicines stored in patents' homes. For example, for adepot injection,a slow-release slow-acting form of medication. Not all medicine records included allergy information.
- Care plans were generalised, not person centred or recovery focused. Risk assessments were brief, did not always contain sufficient information and were not updated regularly.
- At West Leicestershire there was a lack of psychology input.
- Patients and their carers were not involved in care planning and care programme approach (CPA) reviews. Staff told us they involved patient's carers but there was little evidence of this in care records. Patients told us they did not have access to a copy of their care plan.
- The trust set target times from referral to initial assessment against the national targets of 28 to 42 days. Five of the six services in this core service were in breach of these targets.

  Managers identified the breach in these targets and had plans in place to reduce them and had highlighted this risk on the risk register.
- Staff received supervisions and appraisal. However at South Leicestershire clinical supervision take-up was low at 73%.
- There were not enough registered staff at City West and this was identified as a risk on the service risk register. However, managers had identified funding for two agency nurses to start work the week following the inspection.
- Staff told us there were no service information leaflets available. We saw information in the service reception areas about older people's care. Patients occasionally attended the service. Staff usually met patients in their homes or in the community.
- At Melton, Rutland and Harborough and Charnwood there was a lack of audits and little focus on quality and improvement.

However:

- The waiting areas and interview rooms where patients were seen were clean and well maintained.
- Staff were up to date with mandatory training. Staff had a good knowledge of safeguarding.
- There were appropriate lone working procedures in place.
- There was a duty worker system in place which meant the service was able to respond quickly to escalating risks if necessary.
- Some staff used tools and approaches to rate patient severity and monitor their health.
- Staff received appropriate induction.
- There was good multi-disciplinary working within the teams and good communication with other organisations.
- Staff treated patients with kindness, compassion and respect.We saw staff spend time talking to and their carers. Patients told us that appointments usually run on time and they were kept informed when they do not. Staff provided patients and carers with information in a way that they understood.At City West, City East, and South Leicestershire patients and their carers reported "outstanding" and "good care".

Summary of findings

- There was access to interpreters and staff were aware of how to access them.
- There was good staff morale. Staff felt well supported and were able to raise concerns with their line manager and were listened to.
- At Melton, Rutland and Harborough, City East and City West CMHT's m
- At City West in conjunction with the young onset dementia assessment service staff developed a digital app for younger who were developing dementia.

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:

- Medicine risk assessments were not in place for medicines held in patient's home for example adepot injection,a slow-release slow-acting form of medication. Not all medicine records included allergy information.
- Risk assessments were brief, did not always contain sufficient information and were not updated regularly.
- There were not enough registered staff at City West, and this was identified as a risk on the service risk register. However finances had been arranged for two agency nurses to start work the week following the inspection.

However:

- The waiting areas and interview rooms where patients were seen were clean and well maintained.
- Staff were up to date with mandatory training. Staff had a good knowledge of safeguarding.
- There were appropriate lone working procedures in place.
- There was a duty worker system in place which meant the service was able to respond quickly to escalating risks if necessary.

Are services effective?

Requires improvement

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

- Consent to treatment, capacity to consent and best interest's decisions were not routinely recorded within the care records we saw. Some staff did not demonstrate a good understanding of the Mental Capacity Act.
- Care planning was general, not person centred or recovery focused.
- Staff received regularly supervisions and appraisal. However at South Leicestershire clinical supervision take up was low at 73%.

However:

- Some staff used tools and approaches to rate patient severity and monitor their health.
- Staff received appropriate induction.
- There was good multi-disciplinary working within the teams and good communication with other organisations.

Summary of findings

Are services caring?
We rated caring as **requires improvement** because:

- Patients and their carers were not routinely involved in formulating their care plans, or care programme approach (CPA) reviews. There was little evidence of this in care records.
- Patients told us they did not have access to a copy of their care plan.

However:

- At City West, City East, and South Leicestershire patients and carers reported “outstanding” and “good care”.
- We observed that staff treated patients and their carers with kindness and compassion.

Requires improvement

Are services responsive to people's needs?
We rated responsive as **requires improvement** because:

- The trust set target times from referral to initial assessment against the national targets of 28 to 42 days. Five of the six services in this core service were in breach of these targets.
- The waiting times for patient to commence treatment varied across the different teams from two to 22 weeks.
- Staff and patients told us there were no service information leaflets available.

However:

- Urgent referrals were triaged by a duty worker and the patient would be seen within 24 hours.
- Staff monitored the patients on the waiting list in daily multidisciplinary meetings within each team.
- There was access to interpreters and staff were aware of how to access them.
- Patients told us appointments run on time and they were kept informed when they do not.
- We saw staff spend time talking to patients and their carers. They made sure they received information in a way that they understood.

Requires improvement

Are services well-led?
We rated well-led as **requires improvement** because:

- Teams across the service had carried out care plan audits but these were not effective.
- Staff received mandatory training. However, not all staff demonstrated a good understanding of the Mental Capacity Act.

Requires improvement

Summary of findings

- The West Leicestershire team had a low appraisal rate

However:

- There was good staff morale. Staff felt well supported. They were able to raise concerns with their line manager and were listened to.
- There were clear arrangements for supervision and appraisal. Staff received supervision on a regular basis
- Managers were responsive and demonstrated good leadership and management.
- At City East in conjunction with the memory service, staff developed a digital app for younger patients who were developing dementia.

Summary of findings

Information about the service

The community based mental health services for older people are part of the trust's services for older people. They offer services in locations across Leicestershire. We visited the following teams:

- City East Community Mental Health Team
- West Leicestershire Community Mental Health Team
- South Leicestershire Community Mental Health Team
- Melton, Rutland and Harborough Community Mental Health Team
- City West Community Mental Health Team
- Charnwood Community Mental Health Team
- Memory Services

The service provides mental health treatment for patients with functional mental health issues over the age of 65 years and treatment for patients with organic mental health issues both over 65 years and under 65 years where appropriate**.** The majority of patients seen by the teams had dementia.

Teams included psychiatrists, psychologists, community psychiatric nurses, occupational therapists, health care support workers and administrative staff.

Leicestershire Partnership NHS Trust underwent a full comprehensive inspection of its services between 09 and 13 March 2015. This core service was given an overall rating of good. However, the effective domain was rated as requires improvement. This led service to being served a requirement notice for Regulation 18, Consent to care and treatment. Staff had not followed procedures required under the Mental Capacity Act and not all patients had recorded assessments of capacity. We reviewed the services practice in this area during this inspection and found that these requirements were still not being met.

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 Manager: Sarah Duncanson, Inspection Manager (mental health) CQC.

The team that inspected community based mental health services for older people comprised: three inspectors, one nurse, one psychologist, one social worker and one expert by experience.

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.

Summary of findings

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 from patients at focus groups.

During the inspection visit, the inspection team:

- visited six teams within community mental health services for older people and observed how staff were caring for patients
- spoke with 18 patients
- spoke with 23 relatives/carers of patients
- spoke with four team leads and two community managers, one psychology manager, one occupational therapist manager and one community manager for memory services
- spoke with thirty other staff members, including psychiatrists, nurses, occupational therapists, and health care support workers
- attended and observed a multi-disciplinary meeting and a clinical network meeting
- looked at the care and treatment records of patients
- carried out a specific check of the medication management at six services
- 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

We spoke with eighteen patients and twenty three carers. We visited some patients in their homes, and spoke with some carers on the telephone.

Patients were happy with the care they received. They said staff were caring and respectful. They felt well supported and happy with their treatment. At City West, City East and South Leicestershire patients and carers reported "outstanding" and "good care".

Carers spoke very positively about the service they received. They said that they were signposted to extra support where appropriate. Carers said that staff were polite, responsive and treated them with dignity and respect.

Patients and carers told us they were not given information about the service or information on how to complain. They were not involved in writing care plans or reviews and did not have opportunities to feedback about the service.

Good practice

At City West in conjunction with the young onset dementia assessment service staff developed a digital app for younger patients who have developed dementia. The app could be downloaded free of charge onto a mobile phone, or tablet computer. The app brought together up to date information, advice and inspiration from others who have the condition. The app was highly commended in the Innovation Support Service Development category of the Care Coordination Association 2016 awards.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that consent to treatment is properly sought and recorded.
- The trust must ensure that formal capacity assessments and best interest's decisions are properly recorded.
- The trust must ensure proper and safe medicines management. This includes ensuring medicine risk assessments are in place for medicines kept in the patient's home and
- The trust must ensure that referrals and waiting list risks
- The trust must ensure that care plans detail the care and treatment patients need to manage risks appropriately for their health and safety.

Action the provider SHOULD take to improve

- The trust should involve patients and their carers in care programme approach (CPA) reviews.
- The trust should ensure patients have access to service information about the service, and information on how to complain.
- The trust should ensure that staff fully understand the requirements of Mental Capacity Act training.

Care Quality Commission

Leicestershire Partnership NHS Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
City East Older People's Community Mental Health Team	Bridge Park Plaza
West Leicestershire Older People's Community Mental Health Team	Bridge Park Plaza
South Leicestershire Older People's Community Mental Health Team	Bridge Park Plaza
Melton, Rutland and Harborough Older People's Community Mental Health Team	Bridge Park Plaza
City West Older People's Community Mental Health Team	Bridge Park Plaza
Charnwood Older People's Community Mental Health Team	Bridge Park Plaza
Memory Services	Bridge Park Plaza

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.

Detailed findings

- Mental Health Act was covered in the induction training and as part of the trust's mandatory training on consent. 94% of staff had received training in the Mental Health Act.
- Staff were able to access psychiatrists and approved mental health professionals to undertake Mental Health Act assessments if required.
- Patients had access to independent mental health act advocacy services where appropriate. Staff knew how to access these services. There were posters displayed in some locations.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to treatment was not routinely recorded in care records.
- The Mental Capacity Act was part of the trust's mandatory consent to treatment training. The compliance rate was 90%.
- Staff had received training regarding the MCA and this was evidenced in the training records. However some staff did not demonstrate a good understanding of the principles of the Act.
- The partnership trust had a policy on the MCA and staff were aware of this. They could access an electronic version of the policy as and when required.

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

Our findings

Safe and clean environment

- The waiting areas and interview rooms where patients and carers were seen were clean and well maintained. Staff worked to infection control principles. We saw posters and signs promoting hand washing. At South Leicestershire, alarms were fitted in patient areas.

Safe staffing

- Staffing in August 2016:
  - Total number of substantive staff143
  - Total number of substantive staff leavers in the last 12 months12
  - Total turnover of ALL substantive staff leavers in last 12 months8.4%
  - Total permanent staff sickness overall7.5%
  - Establishment levels qualified nurses (WTE)150
  - Establishment levels nursing assistants (WTE)43
  - Number of WTE vacancies qualified nurses 5.1
  - Number of WTE vacancies nursing assistants0
  - Qualified nurse vacancy rate3.4%
  - Nursing assistant vacancy rate0%
  - Shifts filled by bank staff to cover sickness, absence or vacancies19
  - Shifts have filled by agency staff to cover sickness, absence or vacancies280
  - Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies28
- Overall the core service had a lower vacancy rate for qualified nurses than the trust average of 11.9% and had no vacancies for nursing assistants. Establishment and vacancy levels remained stable over a three month period.
- City east, city west, countrywide memory service and west Leicestershire were the only teams to record any bank or agency usage over the reporting period June to August 2016. City East community mental health team had one agency nurse who had been in post since January 2016 and covered a permanent staff member on long-term sick leave. The agency staff member knew the service. Five shifts were not filled by bank or agency staff where there was sickness, absence or vacancies.
- The core service had a sickness rate above the trust's average at 7.5%. Melton Rutland and Harborough had the highest sickness rate at 17%, which is higher than the trust average of 5.1%.
- Four teams, the south Leicestershire, Charnwood, and Melton & Rutland teams had a turnover rate above the trust's average of 9.1% at between 15 to 17%.
- The six community mental health teams operated Monday to Friday 9 to 5pm. Outside of the weekday hours there was a psychiatrist on-call rota to ensure continuous access. The teams had input from two consultant psychiatrists Monday to Friday 9 to 5pm. Psychologists were available approximately one day a week at each team. A team of eleven occupational therapists supported the six teams as required. Administration staff supported the teams with some staff working across teams. Managers used suitably skilled bank and agency staff to cover any gaps. The teams had an adequate number of staff to provide safe care.
- Care coordinator caseloads varied between teams and were from 30 to 40 per care coordinator. The managers reviewed the caseloads of staff during supervisions and team meetings to ensure they were fair and manageable. Most teams had a deputy, qualified staff member who dealt with the day to day running of the teams.
- The overall staff training compliance rate for the six teams was 91%. Staff told us mandatory training took place regularly with classroom and trust online training. Some of the topics included were safeguarding adults and children, Mental Health Act, information governance, adult basic life support and medicines management.

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

- We reviewed 36 care records and the quality of the risk assessments was variable. These covered risks in terms of the patient's physical and mental health. Risk assessments were completed using a standard format in the patient electronic system and covered physical and mental health. However, not all risks were reflected in care plans and were brief and lacked detail to help staff and patients manage their risks... Some risk assessments were not updated in response to ongoing issues in a timely manner.
- At South Leicestershire, one patient had used services for 15 months and their risk assessments had not been reviewed since January 2016.
- The psychology manager held monthly speciality meetings with colleagues to identify patients on the waiting list who needed to be seen urgently. Team psychologists saw patients outside of their patch if required.
- Managers and the occupational therapist manager monitored the patients on the waiting list to detect increases in level of risk.
- The teams had a dedicated duty worker that allowed staff to respond quickly to deterioration in the mental health of patients. Named duty managers and deputies were available to support staff when needed.
- The waiting time from referral to treatment varied in different teams. The time for referral to treatment averaged 4 weeks. The manager at South Leicestershire had a waiting list of 60 patients and did not manage risks effectively. The waiting list was not identified as a risk on the risk register. The manager told us brief details of how they would manage the waiting list with no set timescales.
- At Melton, Rutland and Harborough there was a waiting list of 20 patients. At Charnwood there was a waiting list of 18 patients. Both these teams managed risks well.
- Staff had received training in safeguarding adults and children. The staff training completion rate was 92%. Staff knew how to recognise possible abuse and alert as needed. The teams worked closely with the local authorities when there were safeguarding concerns raised. Charnwood team staff told us the trust safeguarding team were not available after 3pm each day. This arrangement impacted on the older people's mental health team, not being able to seek advice and support from the safeguarding team in a timely way.
- We reviewed medicines management practice, including the transport, storage and dispensing of medicines. We found medicine risk assessments were not in place for medicines held in the patient's home. For example adepot injection,a slow-release slow-acting form of medication. Not all medicine records included the patient's allergy information. Five out of six teams did not have a dedicated clinic room. At Melton, Rutland and Harborough the room where adrenaline was stored, was unlocked and the key to the medicine cabinet was in an unlocked drawer. This was raised with the manager and action was taken. When administrating medicines, the nurse ensured correct medicine and doses, and medicine signing in and out systems were in place.

Track record on safety

- There were five serious incidents reported between 1 July 2015 and 30 June 2016 requiring investigation for the older people's mental health community teams. Seven serious incidents were reported between 1st October 2015 and 30 September 2016. Staff told us incidents across the six teams were discussed at business and clinical network meetings, including lessons learnt. We saw serious incidents were a permanent item on the business meeting agenda.

Reporting incidents and learning from when things go wrong

- Managers were confident that staff knew how to report incidents and reported appropriately. Staff described incidents that had occurred in the teams recently. Individual staff would be spoken to where they were involved. Incidents were investigated and feedback was shared across the six teams, with lessons learnt. Changes were made because of feedback to reduce the risk of the same type of incident happening again.
- Staff were given support after incidents and there were staff debriefing sessions with multi-disciplinary input if needed. Staff said they felt well supported after serious incidents by their manager and other members of their team.

Requires improvement

Are services safe?

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

- Staff at City East told us about lessons learnt from a recent incident and changes made. The team now writes to patients to tell them if the care coordinator is not available and confirm who will be visiting them. At Charnwood, one serous incident was still under investigation from the summer of 2016.

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.

Our findings

Assessment of needs and planning of care

- Assessments were carried out following referrals, for all urgent and routine referrals. Assessments were undertaken daily and at weekly multi-disciplinary meetings. These were recorded on trust electronic records.
- We reviewed 36 care plans on the electronic records system. Across the six services we found care plans were generic and basic in their content, and were not always holistic. Consent of people who use the service was not sought or consistently recorded. This aspect was identified at the last inspection and was a breach in regulations. Risk assessments were brief and not updated regularly.

Best practice in treatment and care

- Staff told us that the National Institute for Health and Care Excellence (NICE) guidance was available at the team bases and they were supported to follow best practice. The teams offered psychological therapies recommended by NICE guidance, which included cognitive behavioural therapy.
- Occupational therapists within teams visited patients and offered support and advice in relation to community resources, housing and benefits.
- Some of the health care support workers were falls champions within the teams and followed NICE guidance in relation to falls in older people. They shared best practice with their teams.
- Staff used a variety of recognised rating scales and assessment tools when assessing for potential cognitive impairment. These included theHamilton anxietyratingscalea psychologicalquestionnaireused by staff to rate the severity of a patient'sanxiety. TheBeck depressioninventory, a commonly used tool for quantifying levels of depression.In addition staff used the mini mental state examination and the geriatric depression scale. Staff at South Leicestershire team told us they had iPads and were looking into uploading some assessment tools onto the iPad and these could be completed with patients in their home. The occupational therapist manager was developing a standardised outcome tool that would potentially be compatible with the trust's electronic systems.
- Staff considered people's physical health needs as part of the assessment. These included checks for smoking, alcohol and a detailed last GP check. If teams were concerned about a patient's physical health, they would liaise with the patients GP.
- Some team managers told us they audited five sets of care plans per week. This covered risk assessments, care plan quality and review. Despite the weekly audits, care planning was not at a satisfactory standard. The audit did not include Mental Capacity Act recordings. City East had a carried out an audit for long acting antipsychotic injection prescribing practice. Another audit carried out was cardiovascular monitoring of people with cognitive enhancers.

Skilled staff to deliver care

- Teams were made up of a range of disciplines including psychiatrists, psychologists, nurses, health care support workers, occupational therapists and pharmacist input.
- The health care support worker worked under the supervision of the care coordinator (nurse). The nurse would carry out the first initial assessment with the patient, and the health care support worker, depending on the patient's care and treatment plan, may carry out follow up work.
- Younger with suspected cognitive impairment were referred to specialist services for further investigation. However some of the City East team were particularly experienced with this service user group. One staff member was invited to a dementia carer support group for younger people as a speaker, to talk about the community mental health team service.
- The teams average appraisal rate was 83 %. The West Leicestershire team had the lowest appraisal rate of 72%.
- Teams had arrangements in place for regular clinical and managerial supervision and staff knew the name of their supervisor.
- Information from the trust 1 August 2015 to 31 July 2016 showed City West's clinical supervision rate was 87%.

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.

The trust target was 85%. The other five teams had clinical supervision rates between 56% to 73%. All team managers showed us local data to confirm 100 % compliance with clinical supervisions rates.Staff told us electronic training records did not always capture accurate supervision and appraisal dates.

- There were support and development groups for staff groups. Monthly peer supervisions for health care support workers. Occupational therapists had monthly development meetings. The deputy manager was a new role within older people mental health teams and had monthly peer group meetings.
- At City East an agency nurse had been in post since January 2016. The nurse told us they received the same training and supervision as permanent staff, and felt well supported.
- Staff had access to additional specialist training. For example at Melton, Rutland and Harborough a health care support worker had received training in providing ECG tests. An electrocardiogram (ECG) is a simple test that can be used to check the heart's rhythm and electrical activity. Most staff attended the suicide and self-harm training for older people in October 2016 and praised the course content and trainer. Staff had also attended recent care plan training. Staff identified further training needs in their annual appraisal and supervisions.
- Health care support workers told us when starting work they had received the care certificate standards induction one day a week for four weeks. The care certificate aims to equip staff with the knowledge and skills which they need to provide safe compassionate care.

Multi-disciplinary and inter-agency team work

- The older people's community mental health teams held weekly multi-disciplinary meetings. The meetings enabled staff to work together to review existing patients, new referrals and allocations. The psychology manager based at City West team told us they attended multi-disciplinary meetings once a month due to low staffing in their team.
- West Leicestershire held two weekly multi-disciplinary meetings. At West Leicestershire, the two worked differently and attended one multi-disciplinary meeting a month. One The staff team told us this arrangement did not ensure consistent working practice.
- The and psychologist told us they visited patients on inpatient wards at the Evington and Bennion Centre, when necessary and helped to facilitate home visits from the ward. The attended ward rounds in the inpatient wards to ensure that discharges could be made in a timely manner.
- There was joint working with the third sector. Teams worked closely with the Alzheimer's Society, Age UK, Side by Side a befriending scheme for young patients with dementia and LAMPan independent voluntary organisation working to promote good mental health for everyone living inLeicester,Leicestershireand Rutland.
- The older people's community mental health teams worked closely with social services for example completing joint visits with social workers and receiving input from the dietician service.
- Community mental health teams and the memory service worked closely with GPs, to keep them updated with patient's progress and to discuss memory service assessments.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- At City East, team one patient was subject to a community treatment order (CTO). There was a community treatment order care plan on the electronic records. Staff we spoke with y had basic knowledge of the person's treatment plan. Staff told us these were held by the Mental Health Act administration office. The Mental Health Act reviewer checked this care plan and found overall, the community treatment order paperwork was in order. We found at other teams some staff were unsure which patients were subject to community treatment orders.
- As of 1 September 2016 94% of staff had received training in the Mental Health Act training. This was 14 % higher that the trust average. However, we found staff were less confident with the principles of the Mental Health Act.

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.

- Consultants and some junior doctors had completed the training to be an approved clinician and carry out the functions under section 12 of the Mental Health Act as having special experience in the diagnosis or treatment of patients with mental health issues.
- Staff were able to access psychiatrists and approved mental health professionals to undertake Mental Health Act assessments if required.
- Some staff we spoke with did not know about their Mental Health Act administration office, to offer support in making sure the Act is followed.

Good practice in applying the Mental Capacity Act

- Mental capacity assessments and best interest decisions were not consistently documented in care records where they were required. The electronic part of the care plan for mental capacity assessments or best interest decisions was often left blank. This aspect was identified at the last inspection and was a breach of regulations. However at the Melton, Rutland and Harborough team we saw mental capacity assessments had taken place, recorded on the care plan and staff knew about least restrictive options.
- The compliance rates for Mental Capacity Act training was 90%. Staff had received training regarding the Mental Capacity Act and this was evidenced in the training records. However, we found staff were less confident with understanding of the Mental Capacity Act.
- Staff were aware of the Mental Capacity Act policy and how they could access it. They could access an electronic version of the policy as and when required.

Requires improvement

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Patients and carers gave positive feedback for all six teams. They described staff as helpful, friendly, caring and respectful. At City West, City East and South Leicestershire team's patients and carers reported "outstanding" and "good care."
- We observed positive interactions between staff and patients that were respectful, kind and compassionate. They were professional, caring and were understanding of individual's needs.

The involvement of people in the care that they receive

- Patients and their carers told us they were not involved in care planning and had no opportunities to participate in care programme approach (CPA) reviews. We saw little evidence of involvement in care plan records. Staff told us if a care programme approach review was due, they met with the patient and compiled information to take to the multi-disciplinary team, where the patients care was discussed. Patients and their carers were not aware of care programme approach (CPA) reviews. This issue was identified at the last inspection.
- We did not see any evidence of patients or carers being involved in care planning or reviews. This issue was identified at the last inspection. This was confirmed when we spoke to 23 carers.
- Staff told us they did not routinely provide care plans for patients, unless specifically asked. Some staff told us the care plan may not be understood by the individual, or could be upsetting to read. Consultants did not consistently send out letters to patients and their carers outlining their treatment plan. At West Leicestershire, one patient was offered a care plan, but declined. At South Leicestershire, one patient told us they had asked for a care plan but not received one.
- The teams did not offer carer assessments. When staff identified that patient's carers and families required support they would refer them to social services. Patients had access to support from independent advocates when needed.
- Patients told us they were unable to give feedback on the care they received. Some managers told us a staff member took out an iPad each day and patients were asked for feedback. However, this was not consistent practice, some teams did not have iPads or iPads were not working. However, staff told us when patients were leaving the service they were given a paper questionnaire. Either the patient or their carer could complete this. Questionnaires were evaluated and managers received monthly feedback.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- The mental health older people's hub received referrals. These were generally from GPs and hospitals. The referrals were risk assessed and sign posted to the correct service within one day. Team managers and the occupational therapist manager prioritised referrals to ensure urgent referrals were followed up quickly and discussed at weekly multi-disciplinary meetings.
- Fifty per cent of new referrals were signposted to the memory service. The memory service clinics were held at the Evington and Bennion Centre and at satellite clinics around Leicestershire.
- The trust set target times from referral to initial assessment against the national targets of 28 and 42 days. Five of the six services in this core service were in breach of these targets. Data provided by the trust showed that two teams did not meet their target of 28 days. City East teams average waiting time was 117 days and City West was 45 days. However, two teams did meet the target of 28 days, in the West Leicestershire team the average wait was seven days. The Charnwood team the average wait was one day. Three teams did not meet the 42 day target for referral to initial assessment. The City East team average waiting time was 151 days, South East Leicestershire was 47 days and the City Wests team was 63 days. Although three teams did meet the 42 day target. The West Leicestershire team average wait was 42 days, Charnwood team was 35 days and Melton Rutland and Harborough team was 28 days.
- The waiting times for patient to commence treatment varied across the different teams. Staff prioritised the need of patients who were waiting for treatment in order to ensure that the higher risked patients were prioritised. West Leicestershire and Melton, Rutland and Harborough teams waiting times to start treatment were from two to eight weeks. South Leicestershire patients had to wait up to 10 weeks to start treatment. City East team had a waiting time of between 18 weeks and 22 weeks.
- At West Leicestershire staff told us there was a waiting list for psychology input.
- Staff reported that if an urgent referral comes into the service this would be picked up duty worker and the patient would be seen within 24 hours. The duty worker system meant that a member of the team was always available within 9 to 5 hours to respond to urgent referrals and telephone calls.
- Staff monitored the patients on the waiting list in daily multidisciplinary meetings within each team.These meeting reviewed all patients' risks, and individual need to determine if they needed to move up the waiting list in order to access services sooner.In addition to this a manager within the hub held daily board rounds to discuss all urgent referrals received by the unscheduled care service to ensure that all patients on the waiting list were reviewed regularly within individual teams and risks had been monitored effectively.
- The occupational therapist manager told us that referral rates had gone down as there was an occupational therapist based in the hub to triage cases. As a result they worked through the team list and identified cases that were more appropriate to be seen by the occupational therapist, rather than nursing staff.
- Managers were aware there were breaches in waiting times for patients to be assessed or commence treatment and had plans in place to reduce them. This issue was highlighted on this risk register.
- The older people's community mental health teams had a clear criterion for which people will be offered a service. Services for patients with functional mental health issues over the age of 65 years and treatment for patients with organic mental health issues both over 65 years and under 65 years where appropriate**.** The majority of patients seen by the teams had dementia.
- Teams took a proactive approach to re-engage with patients and did not attend appointments. Staff told us they called patients or carers prior to appointments to remind them. If a patient did not attend an appointment, the doctor or nurse would contact the patient and re-arrange to see them.
- Patients told us appointments usually run on time and they were kept informed when they do not.
- Patients were encouraged to move on from the community teams, when ready for discharge. However,

staff were flexible and responsive to patient's needs. They recognised that some patients needed to be supported for extended periods to prevent relapse and admission to hospital.

- Sometimes there were delays in discharging patients from the service. Delays were usually caused by difficulties in finding appropriate accommodation for patients to move onto.
- At City West, we saw one patients care plan referred to section 117 after care services to be provided. Section 117 When we spoke with staff about how they were meeting this patient's needs, they were unsure.At West Leicestershire, we saw one joint care plan section 117 and staff were also unclear about the details within care plan. However, at Melton, Rutland, and Harborough we saw one

The facilities promote recovery, comfort, dignity and confidentiality

- Teams had different arrangements for rooms and equipment to support treatment and care. For example at South Leicestershire there were a large waiting area, four clinic rooms with equipment, and two rooms with couches. At City West there was an office base only. Interview rooms could be booked on site at the Glenfield hospital.
- Information leaflets on a range of relevant topics for patients were displayed in waiting areas (where waiting areas were available). These supported patients to make decisions about their care and treatment. Some patients and carers told us they felt they had been given enough information about their treatment.
- The six older people's community mental health teams did not provide any information about the service, or about how to complain.

Meeting the needs of all people who use the service

- At Melton Rutland, and Harborough patients, carers and staff told us most clinics were held the Neville Centre at Leicester General hospital site 20 miles away. They felt this was far for patients to travel.
- Clinic sites were both accessible and had bathroom facilities appropriate for patients who used a wheelchair.
- Staff said that where needed interpreters could be booked to support patients. This would be assessed and arranged upon referral. Some teams used interpreters weekly to meet the needs of patients. Information we saw displayed was only available in English, staff were unclear how to access information in other languages.

Listening to and learning from concerns and complaints

- Patients told us they did not know how to complain. Information about how to complain had not been given to them.
- The information from the trust showed the core service received 40 compliments during the period 3 August 2015 to 28 July 2016. Managers told us they received mainly verbal compliments from patients and carers. However, at Melton, Rutland, and Harborough service we saw thank you cards to staff.
- The service received seven formal from 3 August 2015 to 28 July 2016. City West had two complaints for the reporting period and one complaint was upheld. Charnwood team had one complaint which was upheld. South Leicestershire had two complaints and one complaint was upheld. The other complaint was referred to the Ombudsman. Hinckley had one complaint, which was upheld. City West team had one complaint which was upheld.
- Staff told us that complaints, comments and other feedback from patients was discussed in team meetings to ensure that learning, where possible could be facilitated.

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.

Our findings

Vision and values

- Staff were aware of the trust vision and values, and told us the trust values was the approach they took when working with patients and carers. Managers told us that senior managers in the trust were accessible and visited their teams and attended local meetings.
- Staff gave feedback on services to their line manager and senior managers and felt they were taken seriously and treated with respect.

Good governance

- There were performance key performance indicators (KPI) but these did not always help staff focus on areas for improvement. Managers held information on the performance of their service. This included information lifted from the electronic record system. Such as referral times and waiting lists, discharge, training data, information on incidents, complaints, patient feedback and data provided by the manager on supervision and appraisals. The information was not routinely used to monitor performance. At Managers told us this caused stress for some staff and they were concerned about the impact this would have on patients waiting for a service.
- Most managers had systems in place to submit items to the service risk register. At City East the manager had identified a financial risk to delivering sustainable quality care and finances were eventually agreed. South Leicestershire had an item of concern of a waiting list of 60, which was not identified as a risk on the risk register. Risks and issues were not always dealt with quickly.
- Teams across the service had carried out care plan audits but these had not been effective. Care plans detailing patient care and treatment were not person centred and did not manage risks appropriately. Managers told us a care programme approach (CPA) tool was being developed.
- We saw managers had implemented self-regulation (time to shine) meetings, with the issues identified from the last CQC inspection repeatedly raised with staff, but had not been acted on. consent to treatment, formal capacity assessments and best interest's decisions, and i. Lessons were not learnt and improvements had not been made.
- Some medicines were held at some locations. We found at City West, medicine risks were not identified and acted on
- Mandatory training was available on line and as classroom based. Staff had received mandatory training including the Mental Capacity Act. Not all staff
- There were clear arrangements for supervision and appraisal. Staff received supervisions on a regular basis. The exception was
- The managers we met felt they had sufficient authority and information to make decisions at their service level. Each team had their own administrator.

Leadership, morale and staff engagement

- Staff felt well supported. They were able to raise concerns with their line manager and were listened to.
- At Melton, Rutland and Harborough, City East and City West m
- There were no reported cases of bullying or harassment in any of the teams. Staff were aware of how to use the whistleblowing process.
- Teams described morale as good across the six teams. Staff said they enjoyed their jobs and they worked well as a team.
- Managers told us there were opportunities for leadership development in the trust.
- Managers told us they used the duty of candour and explained to people when things went wrong. They supported staff to report incidents and mistakes.

Commitment to quality improvement and innovation

- At City West in conjunction with the young onset dementia assessment service staff developed a digital app for younger patients who have developed dementia. The app could be downloaded free of charge onto a mobile phone, or tablet computer. The app brought together up to date information, advice and inspiration from others who have the condition. The app was highly commended in the Innovation Support Service Development category of the Care Coordination Association 2016 awards.

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 11 HSCA (RA) Regulations 2014 Need for consent • Consent to treatment was not properly sought and recorded. • Formal capacity assessments and best interest's decisions were not properly recorded within the care records. This was in breach of Regulation 11

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 12 HSCA (RA) Regulations 2014 Safe care and treatment • Medicine risk assessments were not in place for medicines kept in the patient's home. Not all medicine records included allergy information. • The care plans did not detail the care and treatment the patient needed, to manage risks appropriately for their health and safety. • Assessing risks for referrals and waiting lists risks were not always managed effectively. This was in breach of Regulation 12