CareQuality Commission

Requires improvement 🟠

Leicestershire Partnership NHS Trust

Community-based mental health services for adults of working age

Quality Report

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Date of inspection visit: 14-18 November 2016
Date of publication: 08/02/2017

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	City West Community Mental Health Team (CMHT)	LE3 1HN
RT5Z1	Bridge Park Plaza	City Central CMHT	LE2 OTA
RT5Z1	Bridge Park Plaza	West Leicestershire CMHT	LE10 1DS
RT5Z1	Bridge Park Plaza	Charnwood CMHT	LE11 5JY
RT5Z1	Bridge Park Plaza	South Leicestershire CMHT	LE18 2LA
RT5Z1	Bridge Park Plaza	City East CMHT	LE5 3GH

Summary of findings

RT5Z1	Bridge Park Plaza	North West Leicestershire CMHT	LE67 4DE
RT5Z1	Bridge Park Plaza	Assertive Outreach Team	LE19 1XU
RT5Z1	Bridge Park Plaza	Psychosis Intervention and Early Recovery Team (PIER)	LE2 0TA
RT5Z1	Bridge Park Plaza	East Leicestershire CMHT	LE13 1SJ

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

Contents

Summary of findings

Overall summary

We rated community based mental health services for adults of working age as requires improvement because:

- Access to the service was delayed due to variable caseloads and waiting times.

- There was no medicines management input from pharmacy within the community based mental health services for adults of working age.

- A dual paper and electronic recording system meant that some information was not accessible to all of the staff that might need it.

- 56% of individual care plans were not up to date, personalised or holistic.

- The patients did not consistently have their physical healthcare monitored or recorded, unless there were identified problems.

- Not all of the patients felt involved in their care planning and not all had a copy of their care plans.

- Staff were not meeting targets for the assessment and assessment to treatment of urgent referrals and six week routine referrals.

- There were waiting lists of up to 18 months for psychology and up to 40 weeks for other treatment within the personality disorder service.

- Staff were not meeting the trust's target compliance rate for annual appraisals and mandatory training.

However:

- Lessons were learned from feedback and complaints from patients. Managers changed practice because of this.

- Staff reported incidents, which were discussed and reviewed by line managers within the teams. Incidents were on the agenda at the clinical governance meetings. Staff were adequately supported and debriefed following incidents and could access further support if required.

- Staff held multidisciplinary team meetings weekly and these were attended by a range of mental health professionals. There was detailed discussion and consideration of patients and carers' needs. Staff routinely referred patients to access additional support for employment, housing, benefits and independent mental health advocacy.

- Some patients told us that staff were polite and respectful and willing to go the extra mile in supporting them.

- There was evidence of leadership at local and senior level. Staff told us their managers were supportive and senior managers were visible within the service.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- We were unable to verify that medicines were stored within safe temperature ranges.
- There was no medicines management input from pharmacy within the community based mental health services for adults of working age.
- Staff did not record patients' allergy status on medication administration charts.
- Staff did not consistently complete risk assessments, and update them as required.
- Variable caseloads and waiting times were delaying access for the patients.
- Staff were not meeting the mandatory training compliance rates.

However:

- There was a lone working policy and measurements were in place to ensure that staff followed this and were safe.
- Staff added items to the risk register. Cover arrangements were in place to try to mitigate risks arising from the demand for services outweighing staffing capacity.
- Lessons were learned from feedback and complaints from patients. Practice was changed because of this.
- Staff reported incidents, which were discussed and reviewed by line managers within the teams. Incidents were on the agenda at the clinical governance meetings. Staff were adequately supported and debriefed following incidents and could access further support if required.

Requires improvement ●

Are services effective?

We rated effective as requires improvement because:

- Record keeping was inconsistent because staff used both a paper and electronic system. Less than half of all of the comprehensive initial assessments were in place within the care records reviewed. 78% of patients had care plans but 56% of these were not up to date, personalised or holistic.
- There was delayed access to the psychology service across the teams with the exception of the early intervention in psychosis service team.
- There was delayed access to the personality disorder service across the teams.

Requires improvement ●

Summary of findings

- The patients did not have their healthcare monitored or recorded consistently.

However:

- Staff held multidisciplinary team meetings weekly and attended by a range of mental health professionals. There was detailed discussion and consideration of patients and carers' needs, including capacity issues.
- Staff used outcome measures to assess the effectiveness of interventions within patient care.
- Staff routinely referred patients to access additional support for employment, housing, benefits and independent mental health advocacy.
- Staff were qualified and experienced to carry out their role and they could access further training as and when required.

Are services caring?

We rated caring as requires improvement because:

- Staff did not protect patients' privacy and dignity in the depot clinic because curtains were not closed always when staff were giving injections.
- Not all of the patients said that they felt involved in their care planning.
- Staff did not routinely give the patients a copy of their care plan.

Requires improvement ●

However:

- Some patients that we spoke to told us that staff were polite, respectful, and willing to go the extra mile in supporting them. If their own community psychiatric nurse was unavailable, other staff would assist.
- Staff requested consent from the patients before involving their carers. During assessments, staff were supportive, empathetic and aware of the needs of the patients. Staff considered the needs of the carers as well as the patients.
- Staff routinely referred the patients to the independent mental health advocacy services.
- Staff had asked patients about their views on the service. Some had completed the friends and family test.

Are services responsive to people's needs?

We rated responsive as requires improvement because:

- Teams were not meeting targets for urgent five day referrals and six week routine referrals.

Requires improvement ●

Summary of findings

- There were waiting lists for treatment. Up to 18 months for psychology and up to 40 weeks for the personality disorder service.
- The service had received a number of complaints, some of which were about staff attitude. During the interviews with the patients, we received a mixed response about staff. Appointments did not always run on time and occasionally staff had to cancel appointments due to not having the staff available.

However:

- The teams followed up people who did not attend their appointment by telephone or letter. Patients told us that there was some flexibility in appointment times. Staff used a text reminder to assist patients with appointments service.
- The teams regularly reviewed the referrals at the allocations meeting and prioritised according to the needs of the patients.
- People knew how to make a complaint. There were posters and leaflets displayed. Staff received feedback from complaints and changed practices because of the feedback.

Are services well-led?

We rated well-led as requires improvement because:

- Compliance with annual appraisal was low.
- Staff morale was affected by the high caseloads and waiting lists across the community mental health teams with the exception of the psychosis intervention and early recovery team and the assertive outreach team.

However:

- Staff were familiar with the trust's vision and values.Team objectives were in line with these.
- There was leadership at local and senior level. Staff felt supported by their managers. Senior managers were visible throughout the services and staff knew who they were.
- Staff were able to make suggestions about the service via listening events that senior managers attended.
- There were governance systems in place which enabled effective monitoring and learning from incidents.
- Staff felt able to raise concerns and were aware of the whistle-blowing policy. Staff said they regularly spoke with their managers and that they were approachable and supportive.
- Staff added items to the trust risk register, which was reviewed regularly and contained mitigation against identified risks.

Requires improvement ●

Summary of findings

Information about the service

The community based mental health services for adults of working age provide services to clients across the county of Leicestershire. The teams consist of consultant psychiatrists, psychiatric nurses, psychologists and occupational therapists, providing a range of treatments and support to adults aged 16-65 and aged 14-65 within the psychosis intervention and recovery service.

Services are provided to people who have experienced mental health issues and referrals are made by their GP or other mental health professional involved in their care. People are seen by healthcare professionals at outpatient clinics, team bases or in their own home. An assessment is carried out to establish the level of need and determine the most appropriate treatment or intervention.

The psychosis intervention and recovery service supports people aged 14 to 64 years who have experienced a first episode of psychosis. Staff work with individuals to aid recovery, and to minimise the chance of potential future relapse. Support is also provided to families.

People who use the service benefit from a range of individual and group work depending upon their needs. Individuals will have a named worker who will coordinate their care.

The assertive outreach team provides support for people with an enduring mental illness. The service aims to develop meaningful engagement in order to improve the quality of life for people who have a history of severe persistent mental illness.

The service has a multidisciplinary team approach, including nurses, occupational therapists, social Workers, psychologists, doctors and support workers where all staff can be involved in a person's care package.

The Care Quality Commission last inspected the community mental health services for adults of working age in 2015. At that inspection, the trust identified the following actions that the provider must take:

- To protect patients against the risks of unsafe or inappropriate care and treatment through the availability of accurate information and documents relating to the care and treatment provided.

- To ensure that there are sufficient numbers of staff to safely meet patient need.

- To ensure that staff are appropriately supported by the provision of appropriate training, professional development, supervision and appraisal.

- To address the delayed access to psychological therapy and occupational therapy.

We checked these actions on this inspection, details can be found later in the report.

Our inspection team

Our inspection team was led by:

The Chair: Peter Jarrett

Team Leader: Julie Meikle, Head of Hospital Inspection (mental health) Care Quality Commission

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

The team that inspected the community based mental health services for adults of working age comprised of two inspectors, one expert by experience, one pharmacist, three nurses, a social worker and a psychiatrist.

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.

Summary of findings

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 patients, 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 over the phone and at outpatient clinics.

During the inspection visit, the inspection team:

- visited all eight of the Community Mental Health Team bases, looked at the quality of the environment and observed how staff were caring for the patients
- visited the assertive outreach team base
- visited the psychosis intervention and early recovery service (PIER)
- spoke with 18 patients
- interviewed the managers or acting managers for each of the teams
- interviewed 36 other staff members; including doctors, nurses and occupational therapists
- attended and observed three multi-disciplinary meetings and an allocations meeting.

What people who use the provider's services say

- We spoke to 17 patients. Most told us that they could contact and access their community psychiatric nurse (CPN) without any difficulty. Patients described staff as kind, helpful and genuinely interested in them.

- Some patients that we spoke to said that they had a copy of their care plan and they had been actively involved in developing it.
- Patients had been able to discuss different treatment options with their CPN and the team.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure the proper and safe management of medicines.
- The trust must ensure that the healthcare records of the patients are available to all of the staff who may need to access them.

- The trust must ensure that there is sufficient staffing to meet the demands of the service and that caseloads of individual staff members are managed safely.
- The trust must ensure staff are adequately supervised, appraised and trained.
- The trust must ensure the privacy and dignity of patients is protected.

Summary of findings

Action the provider SHOULD take to improve

- The trust should ensure that core assessments and crisis plans are documented in the records of the patients.

- The trust should ensure that staff are compliant with targets for Mental Capacity Act training.

- The trust should ensure patients' privacy and dignity is protected at all times.

Leicestershire Partnership NHS Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
City west Community Mental Health Team (CMHT)	Trust Headquarters
West Leicestershire CMHT	Trust Headquarters
City East CMHT	Trust Headquarters
East Leicestershire CMHT	Trust Headquarters
South Leicestershire CMHT	Trust Headquarters
Assertive Outreach Team	Trust Headquarters
Psychosis intervention and Early Recovery Team (PIER)	Trust Headquarters
City Central CMHT	Trust Headquarters
North West Leicestershire CMHT	Trust Headquarters
Charnwood CMHT	Trust Headquarters

Detailed findings

Mental Health Act responsibilities

- As of 1st September 2016, 72% of staff across the service were compliant in Mental Health Act training. Staff demonstrated a good understanding of the Mental Health Act.

- Staff sought advice from senior staff or the Mental Health Act administrator if needed.Staff scanned all paperwork onto the electronic system and sent it to Mental Health Act administrators.

- Staff referred the patients to the independent mental health advocacy service. Staff were able to tell us how to access the service and what sort of support was offered.

- A small number of patients were detained under a community treatment order (CTO).Staff received training on CTO within the Mental Health Act training although not all services were compliant with the 75% target for training.

Mental Capacity Act and Deprivation of Liberty Safeguards

- 87% of staff had received training on the Mental Capacity Act. This was above the trust average.

- Staff were able to tell us the five statutory principles of the Act, and were able to give us examples of capacity issues which had been discussed.

- The trust had a policy on the Mental Capacity Act that staff are aware of and could refer to.

- Staff discussed capacity on an individual basis for patients at the regular multidisciplinary meetings.

- A Mental Capacity Act clinical forum fed into the clinical governance meeting. There had also been a Mental Capacity Act champion's event earlier on in the year and staff were planning a further event.

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

- Alarms were available in some of the interview rooms at the bases. All staff had access to personal safety alarms. This meant that staff could summon help if needed.

- There was no emergency equipment available in some clinic rooms such as oxygen cylinders defibrillators, airways and suctions and the adrenaline for depot was out of date. Staff interviewed were unclear on what to do in the event of a medical emergency. The sharps boxes were not signed or dated and in some cases, they were very full which placed staff at risk of needle stick injury or infection.

- We did not see evidence of cleaning records in the clinic rooms. However, staff informed us that the environment was regularly cleaned. All other rooms and corridors were clean and well maintained with new furniture and décor at some of the locations

- There were adequate hand washing facilities and we observed staff following infection control practices.

- We did not observe visible and in date clean stickers in the clinic rooms.

Safe staffing

- Data for the 12 months prior to the inspection showed the establishment levels for whole time equivalent (WTE) qualified nurses were 115 and for whole time equivalent (WTE) nursing assistants were 19. The number of vacancies for qualified nurses was five and for nursing assistants it was two. The qualified nurse vacancy rate was 5% and the nursing assistant vacancy rate was 8%. The number of shifts filled by bank staff to cover sickness, absence or vacancies was 42. No agency staff were used to cover sickness absence or vacancies.

- Caseloads across the service varied at between 35 and 57, and varied in size across the teams. We saw that

patients referred to the service were awaiting allocation of a care coordinator, as the high demand for services outweighed the ability of staff to provide a timely response.

- Staff reviewed referrals daily and prioritised cases based on risk of individual patients. Staff also monitored the number of referrals weekly.

- Patients had access to a psychiatrist when required.

- Staff received mandatory training. However, staff at community team east fell below the compliance rate of 75% in management of aggression disengagement skills (58%), adult life support (74%), safeguarding adults (74%) and Mental Capacity Act (74%) Staff at community team west fell below the compliance rate of 75% in Mental Health Act for nurses (40%), adult basic life support (58%), disengagement skills (58%) fire safety awareness (66%), information governance (72%), Mental Capacity Act (74%). Staff at community team city fell below the compliance rate of 75% in Mental Health Act for nurses (55%), information governance (67%), and disengagement skills (71%).

Assessing and managing risk to patients and staff

- We reviewed 45 risk assessments. We found staff had not completed risk assessments for five patients and 16 assessments were out of date.

- Staff had completed only 27 out of the 40 crisis plans on the case records we reviewed.

- Staff monitored people on the waiting list. However, we could not be assured risks were managed effectively.

- Staff knew how to make a safeguarding alert. In the community team east 74% of staff were trained in safeguarding adults, 84% in community team west and 91% in city community team. All services had safeguarding posters on the walls in the reception areas, which gave phone numbers of where to ring to report a safeguarding.

Are services safe?

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

- There was a lone working policy, which staff followed. Staff used mobile phones, a buddy system and electronic diaries to maintain personal safety. This enabled colleagues to know their whereabouts.

- There were issues with the safe management of medicines. We examined 39 medication charts at one location. We found that staff had not documented the allergy status on these. This meant that staff could administer medication that patients were allergic to, placing them at risk.

- There was no medicines management input within the community mental health teams, which could have resulted in an increased risk of incorrect safe and secure handling of medicines and unsafe practice in relation to the administration and prescribing of medication. In the mental health team east prescriptions were stored in a filing cabinet and the key held with the medical secretary. They were removed from the filing cabinet at the doctor's request to be printed and signed by the doctor at that time. There was no record of prescription numbers at the point of placing in the filing cabinet or removal for printing to be sent to the patient. If prescriptions went missing in transit, there was no record of which numbered prescription it was. There were no pharmacist or pharmacy technician visits at community mental health team east. Charts were held in files in the main office, injections were stored in the clinic room. Staff administered medication usually on site, but occasionally at the patient's home.

- There was inconsistent monitoring of the fridge temperatures that were used to store medication. At community mental health team east the temperature of the fridge was monitored only 39 times out of a possible 214 occasions.

Track record on safety

- Between 1 July 2015 and 30 June 2016, trust staff reported 15 serious incidents concerning this core service. Of these, 14 were 'apparent/actual/suspected self-inflicted harm' meeting the criteria and 12 were related to unexpected patient deaths.
- Managers ensured that these were fully investigated. All serious incidents and lessons learned were identified and cascaded to staff at team meetings.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents to report and reported them using the electronic reporting system.

- Staff discussed incidents with their managers who reviewed and monitored the incidents. Staff at the clinical governance meeting also discussed incidents.

- Staff were aware of the duty of candour and were able to explain this to us.

- Senior staff discussed incidents at the multidisciplinary team meetings and team meetings, including lessons learned.

- Senior staff debriefed the teams and supported them after a serious incident. Staff reported that they could also access additional support if required.

Are services effective?

Requires improvement 🟠

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

- We reviewed 45 care records and found that less than half of all initial comprehensive assessments were in place.

- Of the 45 records examined, staff had completed only 78% of care plans of which 44% of them were up to date, personalised and holistic.

- Record keeping was inconsistent due to staff using both a paper and electronic system. The information needed to deliver care and treatment effectively was stored electronically or in paper based records. This meant that staff might not have been able to access all of the information about the people using the service.

Best practice in treatment and care

- Care and treatment records demonstrated that doctors followed the National Institute for Health and Care Excellence (NICE) guidelines when prescribing anti-psychotic medication.

- Patients had access to psychological therapies including family therapy, dialectical behavioural therapy and cognitive behavioural therapy. However, waiting lists for therapy varied between three and eighteen months.

- Interventions included support for employment, housing and benefits. Staff referred patients to the citizens advice bureau for welfare rights and tenant support workers. Staff also had links with university welfare rights workers.

- There was inconsistency in the monitoring of physical healthcare. Staff completed physical healthcare checks if specific monitoring was required for the side effects of medication, or if there was an identified health problem.

- Staff used the Health of the Nation Outcome Scale (HoNOS) for measuring outcomes of those who used the service.

Skilled staff to deliver care

- The range of staff to deliver care included psychologists, occupational therapists, registered mental health nurses and psychiatrists. However there was no input from pharmacy across the teams and social workers were not employed by the trust although had input into patient care.

- The percentage of non-medical staff that had an appraisal in the last 12 months was variable across the teams, averaging at 77%. The lowest appraisal rate was in city east team at 44%, whereas in the psychosis intervention and early recovery team they achieved 95%. The percentage of staff who had received clinical supervision as of 1st November 2016 was 50% at City Central, 53% at City East and 52% at City West. However, the psychosis intervention and early recovery team had an 86% compliance rate for supervision.

- Senior nurses provided supervision. Staff received a local induction and a trust wide induction. Some staff received training specific to their role and psychologists gave the example of psychologically informed practitioner training.

- Managers addressed concerns with staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

- Staff held multidisciplinary team meetings weekly and the full range of staff attended.

- Managers held weekly team meetings. Minutes were recorded and sent to those staff who could not attend.

- A regular allocations meeting was also held across the team, which enabled staff to review referrals and establish the most urgent referrals.

- Social workers were based in the same building as the community based mental health services for adults of working age in some areas. Teams had effective links with social services, GPs and other external organisations.

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

- As of 1st September 2016, 72% of staff across the service were compliant in Mental Health Act training. Staff demonstrated a good understanding of the Mental Health Act.

Are services effective?

Requires improvement 🟠

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.

- Staff sought advice from senior staff or the Mental Health Act administrator if needed.Staff scanned all paperwork onto the electronic system and sent it to the Mental Health Act administrators.

- Staff referred patients to the independent mental health advocacy service. Staff were able to tell us how to access the service and what sort of support was offered.

- A small number of patients were detained under a community treatment order (CTO). Staff had received training on CTO within the Mental Health Act training and explained people's rights under this section of the Mental Health Act to them.

Good practice in applying the Mental Capacity Act

- 87% of staff had received training on the Mental Capacity Act. This was above the trust average.

- Staff were able to tell us the five statutory principles of the Act, and were able to give us examples of capacity issues which had been discussed.

- The trust had a policy on the Mental Capacity Act that staff are aware of and could refer to.

- Staff discussed capacity on an individual basis for people who used the service at the regular multi-disciplinary meetings.

- A Mental Capacity Act clinical forum fed into the clinical governance meeting. There had also been a Mental Capacity Act champion's event earlier on in the year and staff were planning a further event.

Are services caring?

Requires improvement 🟠

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

Our findings

Kindness, dignity, respect and support

- Some of the patients that we spoke to told us that staff were polite and respectful and that the staff went the extra mile. One patient we spoke with said that if their community psychiatric nurse was not available, then other staff had time for them and responded to their needs.

- We observed staff were supportive, empathetic and aware of the patients' needs during face to face assessments and considered the needs of their carers.

- However, staff did not protect patients' privacy and dignity in the depot clinic because curtains were not closed always when staff were giving injections.

The involvement of people in the care that they receive

- Staff ran carers groups at different locations across the service monthly. The purpose of this was to provide support and advice to carers as well as to promote involvement in care planning and services.

- Advocacy leaflets were displayed and patients told us they had access to an advocacy service.

- Some patients told us that they felt involved in their care planning. One patient said that they had been asked if they agreed to their family being involved in their care and treatment. Care records were not inclusive of the views of the people using the service across the community mental health teams. Staff did not routinely give a copy of the care plans to the people using the service. However, staff in the psychosis intervention and early recovery service and the assertive outreach team routinely gave out copies of care plans and they were inclusive of patients views

- There were leaflets displayed in different languages in the patient areas which covered how to complain, how to access support with benefits, how to access support with domestic violence and how to access a number of voluntary sector organisations.

- Patients confirmed that they had been asked about their views on the service and had completed the friends and family test.

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

- Targets times for urgent patients were five days from referral to triage/ assessment and then a further five days from assessment to treatment. Target times for routine assessments were six weeks. All referrals were risk assessed. Data for the 12 months prior to inspection showed that at Charnwood community mental health team there were 40 breaches of the six week referral and seven breaches of the five day urgent referral. Community mental health teams did not meet the national referral to assessment time target of five working days. The actual mean number of days from referral to initial assessment was nine.

- The early intervention in psychosis team had a target of 50% for patients to commence a National Institute for Health and Care Excellence (NICE) concordant package of care within two weeks of referral, 76% of referrals were within the target.

- The community mental health teams reviewed all referrals and prioritised the urgent cases.

- There were waiting lists for the personality disorder services with 42 patients outside of the 13 week target for treatment, some of whom waited up to 40 weeks. There were waiting lists for the psychology service ranging from three to 18 months.

- Staff followed clear criteria for patients who would be offered a service. The exclusions were dementia and organic mental health issues.

- Staff carried out home visits to engage with patients who found it difficult or were reluctant to engage with the service. Staff followed up people who did not attend appointments and an alternative appointment was offered.

- Patients told us that there was some flexibility in the times of appointments. Appointments did not always run on time. Staff informed people by telephone when they did not. Staff phoned patients when appointments were cancelled and offered an explanation and apology.

- Care plans referred to identified section 117 aftercare services, which were provided for those who had been subject to section 3 or equivalent under the Mental Health Act.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a full range of rooms available in which to see patients, including interview rooms, larger meeting rooms and clinic rooms.

- Interview rooms had adequate sound proofing to ensure patient confidentiality.

- The service had accessible information including leaflets on treatment and care, local services, patients' rights and posters and leaflets on how to complain.

Meeting the needs of all people who use the service

- The service was accessible for people requiring disabled access.

- Across the service, there was a provision of accessible information on treatments, local services, patients' rights and how to complain. This information was available in the languages spoken by patients.

- Staff provided access to interpreters and signers as and when required.

Listening to and learning from concerns and complaints

- The service had 80 complaints in the 12 months prior to the inspection, 48 of these complaints were upheld. One complaint was referred to the ombudsman, which was not upheld.

- Nine out of 11 complaints were upheld at South Leicestershire CMHT, eight out of nine at Charnwood CMHT, five out of six at City West CMHT and all four at Melton Rutland and Harborough CMHT. Most of the complaints were about poor staff attitude, appointment times and cancellations of appointments.

- Staff gave complaints leaflets out to the patients. We saw complaints posters and leaflets displayed in patient areas

Are services responsive to people's needs?

Requires improvement ●

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

- Patients told us that they knew how to make a complaint and received feedback from concerns raised. Staff knew how to handle complaints and followed the complaints policy.

- Managers explained how practice had been changed because of the learning from a complaint.

- Managers shared feedback on the outcome of complaints with staff in monthly business meetings.

Are services well-led?

Requires improvement ●

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 able to tell us what the organisations vision and values were and we saw these displayed across the service.

- We saw evidence of effective team working and team objectives were linked to the organisations values and objectives.

- Staff told us who the most senior managers were within the team and said that they were visible and supportive. Senior managers had visited the services and held listening events at which staff had the opportunity to make suggestions.

Good governance

- Staff received mandatory training and managers had access to records electronically which highlighted when training was due. However, compliance was low in some areas.

- Managers did not ensure that all staff had regular supervision and annual appraisals. Managers reviewed incidents and shared the outcome of incidents and lessons learnt with staff across the service.

- Senior nurses participated in clinical audits.

- Managers shared lessons learnt and outcomes of complaints to staff in monthly meetings. This was also discussed in staff supervision.

- Safeguarding issues were managed appropriately. Managers ensured staff followed Mental Health Act and Mental Capacity Act procedures.

- Managers had the ability to submit items to the trust risk register. Managers attended a clinical governance group monthly. Minutes of the meetings showed that staff discussed the risk register, incident reporting, Mental Health Act and Mental Capacity Act compliance.

- Managers used key performance indicators to gauge the performance of teams.

Leadership, morale and staff engagement

- The results from a recent staff survey showed that staff morale was low. Sickness rates ranged from 0% to 29% across the teams.

- Staff were familiar with the whistle blowing policy and knew how to use it.

- Staff reported that the high caseloads and waiting lists were affecting morale. Managers had submitted this as a risk on the risk register and actions were being taken to mitigate the risk by the use of bank staff.

- There were opportunities for leadership development. Staff said that senior managers were supportive of this.

- Teams were cohesive and professional. They were mutually supportive of each other.

- Staff had been open and honest with patients when things had gone wrong.

- The trust facilitated listening into action events for staff to attend. This enabled staff to give feedback to senior managers on suggestions for service improvement.

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 10 HSCA (RA) Regulations 2014 Dignity and respect • The trust did not ensure the privacy and dignity of patients was protected due to not using the curtains when patients received treatment. This was in breach of regulation 10

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 • The trust had not ensured that medicines prescribed to the patients were stored, administered, recorded and disposed of safely. • The trust had not implemented a recording system to track all medications. • The trust had not ensured that the patients had their allergy status recorded to prevent allergic reactions. • The trust had not ensured that waiting times between assessment and treatment were kept to a minimum. • The trust had not ensured that waiting times for access to psychology were kept to a minimum. This was a breach of Regulation 12

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 17 HSCA (RA) Regulations 2014 Good governance • The trust had not ensured that the healthcare records of the patients were available to all relevant staff.

Requirement notices

This was a breach of Regulation 17

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 18 HSCA (RA) Regulations 2014 Staffing • The trust had not ensured that staff received annual appraisals. • The trust had not ensured there was sufficient staff so that caseloads were manageable. This was a breach of Regulation 18