Requires improvement

Leicestershire Partnership NHS Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT5KF	Bradgate Mental Health Unit	Health Based Place of Safety	LE3 9EJ
RT5KF	Bradgate Mental Health Unit	Crisis Resolution and Home Treatment Teams	LE3 9EJ
RT5KF	Bradgate Mental Health Unit	Liaison Psychiatry Services	LE3 9EJ
RT5KF	Bradgate Mental Health Unit	Liaison mental health triage service	LE3 9EJ
RT5KF	Bradgate Mental Health Unit	Criminal Justice and Liaison Services	LE3 9EJ

Summary of findings

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**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 Leicestershire Partnership NHS trust as requires improvement because:

- Environmental risks in the Health Based Place of Safety (HBPoS) identified in our previous inspection remained.
- The HBPoS had no designated resuscitation equipment and emergency medication and shared equipment with acute wards. We found out of date and non-calibrated equipment located within a cupboard in the health-based place of safety. The HBPoS did not have access to a dedicated clinic room.
- The HBPoS had poor visibility for observing patients.
- HBPoS and crisis resolution and home treatment (CRHT) team toilets were not visibly clean
- The HBPoS did not have designated staff provided by the trust.
- Risk assessments were completed during the initial assessment at the CRHT team. However, they were not updated regularly or following an incident.
- In all instances police transported the patient to the HBPoS. This does not comply with the guidance from the Royal College of Psychiatrists.
- The CRHT team did not have lockable bags to transport medication to patients' homes; staff told us they transported medication in their handbags.
- Patients using the CRHT team had limited access to psychological therapies and there were no psychologists working within the CRHT team.
- Care records for patients using the CRHT teams were not holistic or personalised.
- Staff did not document physical health checks for patients detained under section 136 in the HBPoS.
- Records in the HBPoS did not clearly indicate if patients had their rights explained to them.
- Staff working within the CRHT team and the liaison mental health triage service had not clearly document in patient paperwork or case notes if the patient had capacity or not.
- With the exception of the liaison psychiatry service and the mental health triage car, managers were not supervising or appraising staff within the trust's supervision policy.
- A new quality dashboard had been introduced in September 2016 after it was established that the previous system was incorrect, meaning all data submitted prior to September 2016 was incorrect.
- Mandatory training that fell below 75% included adult immediate life support, adult basic life support, safeguarding children level 3 and fire safety awareness.

However:

- Mental health crisis services and health-based places of safety had an overall mandatory training compliance rate of 82%.
- Lone working policies and procedures were in place for staff to follow to ensure patient and staff safety.
- Staff were de-briefed and supported after a serious incident; we saw that incidents were a standing agenda item for team meetings and were discussed with staff.
- Teams met assessment target times.
- Trust staff working within the had remote access to electronic systems used by the trust.
- Staff considered and supported patients with their physical health needs in CRHT and the liaison mental health triage service.
- Patients who accessed the CRHT team told us that they felt their wishes and needs were taken in to consideration, staff could be accessed quickly and they felt safe when visiting the Bradgate Mental Health unit.
- Carers told us they had regular contact with the CRHT team and they were kept involved with their loved one's care.
- Staff were passionate about their roles and enjoyed working with the client group.

Summary of findings

- Staff followed up on all people seen in by phone, post or face to face to help with any ongoing issues such as housing or benefits.
- We saw evidence of discharge planning in care plans written by CRHT staff.
- Staff working within criminal justice and liaison services and triage teams had good morale and worked well with internal and external colleagues.

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:

- Environmental risks in the HBPoS identified in our previous inspection remained.
- The HBPoS had no designated resuscitation equipment and emergency medication and shared equipment with acute wards. We found out of date and non-calibrated equipment located within a cupboard in the health-based place of safety. The HBPoS did not have access to a dedicated clinic room.
- The HBPoS had poor visibility for observing patients.
- The HBPoS and CRHT toilets were not visibly clean
- The HBPoS did not have designated staff provided by the trust.
- Risk assessments were completed during the initial assessment. However, they were not updated regularly or following an incident. In all instances police conveyed the patient to the HBPoS. This does not comply with the guidance from the Royal College of Psychiatrists.
- Clinical case notes for patients using the HBPoS lacked detail. Clinicians did not consistently record information around risks.
- The CRHT team did not have lockable bags to transport medication to patient's homes; staff told us they transported medication in their handbags.

However:

- Mental health crisis services and health-based places of safety had an overall mandatory training compliance rate of 82%.
- Lone working policies and procedures were in place for staff to follow to ensure patient and staff safety.
- Staff were de-briefed and supported after a serious incident. We saw that incidents were a standing agenda item for team meetings and were discussed with staff.

Are services effective?

Good

We rated effective as requires improvement because:

- Patients accessing CRHT had limited access to psychological therapies and there were no psychologists working within the CRHT team.
- Care records for patients at CRHT were not holistic or personalised.
- Staff had not documented any physical health checks for patients detained under section 136 in the HBPoS.
- Staff allocated to the HBPoS had not received specialised or specific training.

Summary of findings

- Staff appraisal and supervision rates were low, with the exception of liaison mental health triage and the mental health triage car. Staff in these areas were supervised regularly.
- Records in the HBPoS did not clearly indicate if patients had their rights explained to them.
- Patients did not have access to an independent mental health advocate (IMHA) in the HBPoS.
- Staff working within CRHT and the liaison mental health triage service did not clearly document in patient paperwork or case notes if the patient had capacity or not.

However:

- Teams were meeting assessment target times.
- Care plans for patients using the liaison mental health triage service were personalised, holistic and recovery orientated.
- Trust staff working within the criminal justice and liaison service had remote access to electronic systems used by the trust.
- Staff considered and supported patients with their physical health needs in the CRHT team and the liaison mental health triage service.
- Staff received appropriate induction.
- We saw good joint working other professionals and clinicians in all teams.

Are services caring?

Good

We rated caring as good because:

- Patients in CRHT told us that they felt their wishes and needs were taken in to consideration by staff, staff could be accessed quickly and they felt safe when visiting the Bradgate Mental Health unit.
- Carers told us they had regular contact with CRHT and they were kept involved with their loved ones care.
- Staff were passionate about their roles and enjoyed working with the client group.

However:

- Patients in CRHT told us that appointments did not run on time and they were not kept informed if there were any unavoidable changes. Appointment times were not specific; patients were told their appointments would be before or after 3pm.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

Summary of findings

- Staff reported delays in patients being accepted into an acute hospital setting due to lack of bed space.
- Case records for patients in HBPoS did not detail if the patient had been offered food or refreshments and if the patient had been given clean clothing or had attended to their personal hygiene.
- Patients we spoke to were not aware how to make a complaint if they were not satisfied with the care they received.

However:

- Staff followed up on all patients seen in criminal justice and liaison services by phone, post or face to face to help with any ongoing issues such as housing or benefits.
- We saw evidence of discharge planning in care plans written by CRHT.
- Frontline staff told us they received feedback from complaints or investigations during team meetings. We saw that this was a standing item on the CRHT meeting agenda.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff we spoke to were unable to recall the trust's visions and values without being prompted.
- Senior managers in the trust rarely visited the premises.
- Managers did not supervise or appraise staff within the trust's supervision policy, with the exception of the liaison psychiatry service and the mental health triage car
- A new quality dashboard had been introduced in September 2016 after it was established that the previous system was incorrect, meaning all data submitted prior to September 2016 was incorrect
- Managers were not completing any audits or outcome measures to show the effectiveness of the health-based place of safety.

However:

- Overall, the average compliance rate for mandatory training was 82%.
- Staff working within criminal justice and liaison services and triage teams had good morale and worked well with internal and external colleagues.

Summary of findings

Information about the service

The crisis resolution and home treatment teams (CRHT) and health based place of safety (HBPoS) services provided by Leicestershire Partnership NHS Trust also incorporate liaison psychiatry services, liaison mental health triage services and criminal justice and liaison services.

CRHT teams provide emergency and urgent assessment and home treatment for adults who present with a mental health need that require a specialist mental health service. Their primary function is to undertake an assessment of needs, whilst providing a range of short-term treatment as an alternative to hospital admission. The team are also gatekeepers so have the ability to admit patients to an inpatient unit if this is required. This service is available 24 hours a day, 365 days a year and covers Leicester City, Leicestershire and Rutland. The service is based at the Bradgate Mental Health Unit.

A mental health triage and deliberate self-harm service is provided for people who present to the urgent care centre or Leicester Royal Infirmary emergency department. This team aim to provide prompt assessment of a service user's needs and signpost care appropriately.

Liaison mental health triage services work from a custody suite within Leicester city. Here, mental health nurses are able to assess people within the custody suite. Further nurses are based with a paramedic or police officer and are available to respond to 999 calls which the call handler had identified that a mental health intervention may be required.

There is one health-based places of safety (HBPoS) in Leicester. A HBPoS is a place where someone who may be suffering from a mental health problem can be taken by police officers, using the Mental Health Act, in order to be assessed by a team of mental health professionals.

Leicestershire Partnership NHS trust was last inspected in March 2015 by the CQC. During the last inspection, we told the trust that it must take the following actions:

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

At the current inspection, the safety concerns identified in the health-based place of safety had not been addressed and staff were still not being supervised regularly in line with the trust's supervision policy. We noted that medicines management had improved.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Head of Inspection: Julie Meikle, Head of Hospital Inspection, mental health hospitals, CQC.

Inspection Manager: Sarah Duncanson, inspection manager mental health hospitals, CQC

The team that inspected mental health crisis services and health-based places of safety consisted of two inspectors, five specialist advisors 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.

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 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 three focus groups.

During the inspection visit, the inspection team:

- visited the crisis resolution and home treatment team (CRHT) based at the Bradgate Mental Health unit and the crisis house
- visited the health based place of safety at the Bradgate Mental Health Unit
- visited the liaison mental health triage team at Leicester Royal Infirmary
- visited the criminal justice and liaison services
- spoke with 43 staff members; including doctors, nurses, support workers, social workers, administrators and managers
- spoke with 17 people who used the service or who had recently been discharged from the service and three carers
- attended and observed one handover and one assessment
- looked at 31 treatment records of people using the service
- looked at 21 Section 136 documents
- carried out a specific check of the medication management across the sites, and
- 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

Patients we spoke with gave mixed opinions about the support provided to them during their treatment. The majority of patients using the service told us staff treated them with respect, listened to them and were compassionate. However, some people using the service said that staff in CRHT teams were inconsistent with their attitude towards them.

We spoke with 17 people who used the service. The majority of those we spoke with were under the care of the CRHT team. Of those 17, nine told us they were offered a copy of their care plan and six told us they felt involved in developing their care plan.

Patients told us that appointments in the CRHT team did not run on time and they were not kept informed if there were any unavoidable changes.

Patients we spoke with said they did not know how to raise concerns or make a complaint.

Carers told us they were offered a carers assessment and they felt involved in their loved one's care.

Summary of findings

Good practice

The triage car and Criminal Justice and Liaison Services, launched in 2014, had improved access to assessments for people who come to the attention of the police and may have mental health needs. A police officer and nurse in an unmarked car attended such incidents. Staff undertook assessments in an interview environment that provided dignity and confidentiality within the vehicle. The triage car was called to all incidents where a police officer believed it may be appropriate to detain a person under S136.

This service ensured that individuals were able to access appropriate interventions by utilising a multi-disciplinary team.

Areas for improvement

Action the provider MUST take to improve

- The trust must address the identified safety concerns in the health-based place of safety.
- The trust must ensure that staff are supervised and appraised in line with trust policy.
- The trust must ensure that out of date medication and equipment is disposed of correctly.
- The trust must ensure that risk assessments are reviewed and updated regularly and following an incident.
- The trust must ensure that all environments are cleaned regularly.
- The trust must ensure that medication is transported in suitable transportation bags.

Action the provider SHOULD take to improve

- The trust should ensure that care plans are holistic and personalised.
- The trust should ensure patients accessing CRHT teams have access to psychological therapies.
- The trust should ensure that staff allocated to the health-based place of safety have adequate training.
- The trust should ensure that staff document physical health checks for patients detained under section 136 in the health based place of safety.

Leicestershire Partnership NHS Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Health-based Place of Safety	Bradgate Mental Health Unit
Crisis Resolution and Home Treatment Teams	Bradgate Mental Health Unit
Liaison Psychiatry Services	Bradgate Mental Health Unit
Liaison mental health triage service	Bradgate Mental Health Unit
Criminal Justice and Liaison Services	Bradgate Mental Health Unit

Mental Health Act responsibilities

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

Overall, 76% of staff had completed Mental Health Act training.

Staff working within Mental health crisis services and health-based places of safety demonstrated a good understanding of the Mental Health Act, additional training had also been offered to teams working in joint partnership with Criminal Justice and Liaison Services

We did not monitor responsibilities under the MHA 1983 within this core service as none of the patients using services were detained.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Overall, 90% of staff had attended training in the Mental Capacity Act 2005. The staff we spoke with demonstrated a clear understanding of their responsibilities in relation to the Mental Capacity Act 2005. Staff stated they would seek advice from a senior staff member if they were unsure of the correct action to take.

Capacity assessments were not routinely completed in care records we looked at within CRHT or the liaison mental health triage service.

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

Crisis resolution and home treatment

Safe and clean environment

- Staff from all areas had access to pin point alarms. Staff said there was a quick response when an alarm was used. Interview rooms at the liaison mental health triage service were fitted with alarms. However, they were not connected to security so staff told us that response to an alarm was variable.
- We saw no evidence of cleaning rotas; the toilets at the CRHT team for use by patients and staff were visibly dirty.
- The trust had an infection control link nurse. Overall, 96% of staff working within CRHT team had completed hand hygiene training.

Safe staffing

- Trust data showed the total number of substantive staff across mental health crisis services was 120, which included 65 whole time equivalent (WTE) qualified nursing staff and 14.6 WTE support workers.
- Mental health crisis services reported 29% vacancy rate for qualified nurses and 14% vacancy rate for support workers in August 2016. This equated to 19 whole time equivalent qualified nursing positions and two whole time equivalent support worker positions. CRHT had the highest qualified nurse vacancy rate at 37%.
- The provider did not use a recognised tool to reach the agreed numbers, but instead determined staffing requirements by considering service need and patient safety. Staffing within CRHT had been added to the trust's risk register due to ongoing issues with recruitment.
- Staffing levels within the and liaison mental health triage service were adequate.
- CRHT teams used bank and agency staff to cover sickness, absence or vacancies. Between June and August 2016, 724 shifts were filled by bank or agency staff, 55 shifts were unfilled. The highest usage of bank and agency staff was at the CRHT.
- Managers were able to allocate additional staff if more staff were required for some shifts. Bank and agency staff were contracted on three to six month contracts to ensure consistency.
- Managers in CRHT assessed caseloads with clinicians on a regular basis.
- Rapid access to a psychiatrist was available when required in all locations. Outside of core time on-call arrangements were in place.
- The trust did not provide a compliance target for mandatory training. Mental health crisis services had an overall average compliance rate of 82%. Mandatory training that fell below 75% included adult immediate life support, adult basic life support, safeguarding children level 3 and fire safety awareness.

Assessing and managing risk to patients and staff

- We looked at 23 care records for patients accessing CRHT and eight records for patients using the liaison mental health triage service. All records showed that staff had completed a risk assessment at the initial assessment. However, they had not been updated regularly or following an incident.
- Crisis plans were not in place for patients at the CRHT team. Staff told us crisis plans were incorporated in to risk assessments and care plans. All patients who accessed the service were given information of who they could contact in a crisis, this included information on how to contact the team inside and outside of core business hours.
- The CRHT team had no waiting list. The service contacted patients within four hours of referrals and put arrangements in place to visit them.
- Risk levels for patients accessing the CRHT team were discussed at handover meetings in order to detect any increase in risk and took prompt action.

Requires improvement

Are services safe?

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

- Lone working policies and procedures were in place for staff to follow to ensure safety. This included pin point alarms and a lone working device when facilitating home visits which allowed staff to log their location, staff were also required to sign in and out. Staff we spoke with were aware of the trust's lone working policy and said they felt safe using it.
- Overall, 88**%** of staff had received training in adult safeguarding, 86% of staff had completed Safeguarding Children Level 2 and 71% had completed safeguarding level 3 training. We spoke with 43 members of staff and they knew how to recognise and report a safeguarding concern. The trust had a safeguarding lead in place who staff could contact for further advice.
- There was no pharmacy input to CRHT. Patient group directives (PGD's) were used to prescribe medicines. Patient Group Directives. Staff who were assessed as competent administered PGD medication to patients.
- The service did not have lockable bags to transport medication to patient's homes; staff working within CRHT told us they transported medication in their handbags.

Track record on safety

- Between 1 July 2015 and 30 June 2016 mental health crisis services and health-based places of safety reported six serious incidents. Four involved the death of a patient. Staff told us that learning from incidents was fed back in team meetings.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and could describe what should be reported. The trust used an electronic system to record all incidents.
- Staff were able to describe duty of candour as the need to be open and honest with patients when things go wrong.

Health based place of safety (HBPoS)

Safe and clean environment

- There was no alarm system in place for the health-based place of safety (HBPoS).
- Environmental risks in the HBPoS identified in our previous inspection remained. Access to the two small rooms was through one door only which meant that it could be difficult to exit the room quickly if needed. The doors were not anti-barricade. There was no clock visible to the person in the suite. Furniture was weighted; however, patients were unable to lie down.
- The HBPoS had poor visibility for observing detained patients. There were blind spots from both standing outside of the room and on the closed circuit television (CCTV), meaning that staff would need to be present both outside of the room and also observing CCTV. There were no mirrors in use to mitigate visibility risk.
- Resuscitation equipment and emergency medication were not available in the HBPoS and were shared with other areas of Bradgate Mental Health unit.
- We found out of date syringes, plasters and drug testing kits located within a cupboard in the HBPoS. The blood pressure machine was last calibrated in 2008.
- The HBPoS was not visibly clean and did not have access to a dedicated clinic room. There were no cleaning rotas available to show when the HBPoS was last cleaned.

Safe staffing

- The HBPoS did not have designated staff provided by the trust. We were told that this meant the police very often had to care for the detained patient for the duration of the assessment. This is contrary to the guidance of the Royal College of Psychiatrists which states there should be a minimum of two mental healthcare professionals immediately available to receive the person from the police.

Assessing and managing risk to patients and staff

- We looked at 21 section 136 documents for the HBPoS. In all instances police transported the patient. This does not comply with the guidance from the Royal College of Psychiatrists.
- There was no medicine storage in the HBPoS as recommended in then guidance from the Royal College of Psychiatrists.

Track record on safety

Requires improvement

Are services safe?

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

- Between 01 July 2015 and 30 June 2016 mental health crisis services and health-based places of safety reported six serious incidents. Four involved the death of a patient. Staff told us that learning from incidents was fed back in team meetings.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and could describe what should be reported. The trust used an electronic system to record all incidents.
- Staff were able to describe duty of candour as the need to be open and honest with patients when things go wrong.

Are services effective?

Good

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

Our findings

Crisis resolution and home treatment

Assessment of needs and planning of care

- CRHT completed an assessment of a patient within 24 hours of a referral being made and the liaison mental health triage service completed all referrals from the wards within four hours, accident and emergency within one hour and urgent care within one hour. Assessments completed by the CRHT team included medication, side effects, physical health care needs, offending history and family history.
- Care plans for patients accessing CRHT teams were not holistic or personalised. Care plans included short term goals and were not recovery-focussed.
- We reviewed eight care plans for patients using the liaison mental health triage service, care plans were personalised, holistic and recovery orientated.
- Records were stored securely via electronic records. Trust staff working within the had remote access to electronic systems used by the trust.
- Staff working at the liaison mental health triage service used paper forms; these were then securely transported to the Bradgate Mental Health Unit where they could upload them to the electronic recording system.
- Letters sent to GPs were located within the patient's electronic file.

Best practice in treatment and care

- Staff demonstrated an awareness of the National Institute for Health and Care Excellence (NICE) guidelines in their practice and in prescribing medicines. We looked at prescription charts and medicines management within CRHT and found them to be satisfactory in line with NICE guidelines.
- Patients accessing CRHT teams had limited access to psychological therapies and there were no psychologists working at CRHT.
- CRHT teams had designated social workers within the teams to support patients with housing, benefits and employment.
- Our review of 31 records showed that patients' physical health needs were considered and discussed at the point of assessment and CRHT teams worked closely with the olanzapine and clozapine clinic staff. If a physical health need was raised during assessment then patients.
- Managers at the CRHT team were completing clinical audits including care plans, record keeping, physical health monitoring and inappropriate referrals.

Skilled staff to deliver care

- CRHT consisted of nurses, support workers, psychiatrists, social workers and occupational therapists.
- The criminal justice and liaison service and liaison mental health triage service consisted of a range of qualified and experienced nurses with access to other professionals and clinicians.
- Staff received appropriate induction. All staff received the trust induction which included reading relevant policies and shadowing experienced staff.
- Overall, 86.4% of staff working within mental health crisis services and health-based places of safety had received an annual appraisal in the 12 months to 1 September 2016.
- Overall, 60% of staff working within CRHT received regular supervision, 100% of staff working within the liaison mental health triage service were receiving regular supervision, 80% of staff working within the mental health triage car and 50% of staff working within the were receiving regular supervision. Staff working within CRHT had the opportunity to access fortnightly group supervision.
- We saw evidence in individual supervision files that managers were addressing poor staff performance.

Multi-disciplinary and inter-agency team work

- CRHT had two daily handovers which were attended by all available staff, new cases and any ongoing issues were discussed. However, staff reported that clinicians led these meetings and there was minimal input from other staff attending the handovers. Risk assessments were not discussed or reviewed.

Are services effective?

Good

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

- Staff working within CRHT completed a daily face to face handover with staff working at the crisis house. Staff at the crisis house reported good relationships with CRHT.
- CRHT, the liaison mental health triage service had a range of multi-disciplinary team meetings which were well attended by staff. These included a mental health partnership group, crisis resolution and home treatment operations meeting, team meetings and daily debrief meetings.
- The criminal justice service and liaison service and the liaison mental health triage service showed good joint working with other professionals and clinicians.

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

- Overall, 76% of staff had completed Mental Health Act (MHA) training.
- Mental Health Act advice was readily available during working hours from the mental health legislation office.

Good practice in applying the Mental Capacity Act

- Overall, 90% of staff working with crisis services and health-based place of safety had completed Mental Capacity Act training. Staff that attended Mental Capacity Act 2005 (MCA) training were aware of their responsibilities under the Act.
- Staff working within CRHT did not clearly document in patient paperwork or case notes if the patient had capacity or not.
- Staff working in the liaison mental health triage service told us that they had been told to assume capacity and therefore had not documented this in paperwork or case notes.
- An audit on the application of the MCA was undertaken during 2016.

Health based place of safety

Assessment of needs and planning of care

- We looked at 21 records of patients detained under section 136 in the HBPoS; all assessments had been completed within the required timescale. There was no record of physical health checks.

Best practice in treatment and care

- Staff demonstrated an awareness of the National Institute for Health and Care Excellence (NICE) guidelines in their practice.
- Staff had not documented any physical health checks for patients detained under section 136 in the HBPoS.
- We saw no evidence of clinical audits taking place to show the effectiveness of the health-based place of safety.

Skilled staff to delver care

- All staff allocated to the HBPoS had accessed the expected mandatory training to their appropriate designation which included all necessary competencies for working in the HBPoS.

Multidisciplinary and inter-agency work

- Leicestershire Police staff reported that they had a productive and positive relationship with staff working within the HBPoS.
- The Manager allocated to the HBPoS attended a quarterly multi-agency meeting to discuss any ongoing issues and developments.

Adherence to MHA and MHA code of practice

- We looked at 21 records of patients detained under section 136 in the HBPoS Overall, 16 records did not clearly indicate if patients had their rights explained to them. It is a requirement under the MHA code of practice for staff to advise all detained patient of their rights when detained.
- Patients did not have access to an independent mental health advocate (IMHA) in the HBPoS.
- We looked at 21 records of patients detained under section 136; all were transported to the HBPoS by police rather than by ambulance. This does not comply with guidelines set out in the MHA Code of Practice.

Good practice in applying MCA

- Overall, 90% of staff working with crisis services and health-based place of safety had completed Mental Capacity Act training. Staff that attended Mental Capacity Act 2005 (MCA) training were aware of their responsibilities under the Act.
- An audit on the application of the MCA was undertaken during 2016.

Good

Are services caring?

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

Our findings

Crisis resolution and home treatment

Kindness, dignity, respect and support

- We observed staff interacting with a patient in a kind, considerate and compassionate way.
- The CRHT team used the friends and family test as an opportunity for patients to provide feedback.
- Patients accessing the CRHT team told us that they felt their wishes and needs were taken in to consideration by staff, staff could be accessed quickly and they felt safe when visiting the Bradgate Mental Health unit. However, two people who accessed CRHT said that some staff were not as friendly and welcoming as others.
- Patients accessing CRHT teams told us that when they were visited at home, they were not given precise times, staff advised them if their appointment would be before or after 3pm, which could interrupt any plans they had that day.
- Patients we spoke to were aware of who their care coordinator was.
- Criminal justice and liaison services completed information sharing agreements to ensure patient confidentiality was maintained.

The involvement of people in the care that they receive

- We spoke with 17 people who used the services, of those 17, nine told us they were offered a copy of their care plan and six told us they felt involved in developing their care plan.
- We reviewed 31 care records across the locations we visited and did not find evidence to show that staff routinely offered copies of care plans to patients. However, we spoke with 17 patients and nine told us they had been offered a copy of their care plan.
- Carers told us they had regular contact with the CRHT team and they were kept involved with their loved one's care.
- It was not always clear from documentation that families and carers were involved in patients' care and treatment. However, patient and carer feedback confirmed that patients and carers were involved.
- Patients had access to advocacy services to seek independent advice.

Health based place of safety

Kindness, dignity, respect and support

- At the time of inspection the HBPoS was not in use due to an issue with the heating system, therefore we were unable to see any staff and patient interactions.

The involvement of people in the care that they receive

- Staff told us patients detained under section 136 did not have access to an independent mental health advocate (IMHA).
- Patients detained under section 136 in the HBPoS were not able to offer feedback on the service they received.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Crisis resolution and home treatment

Access and discharge

- The target response time for CRHT from referral to initial contact was four hours. The trust provided data for September 2016 which showed that 13 referrals required a four hour response and 12 of those referrals were contacted within the four hours.
- Urgent referrals were seen quickly by skilled professionals in all the teams we visited. Non-urgent referrals were seen within an acceptable time.
- CRHT and the crisis house had clear exclusion criteria in place. However, CRHT had added inappropriate referrals to the trust's risk register and were looking in to ways of reducing inappropriate referrals to the service.
- CRHT teams took a proactive approach to engaging with patients who found it difficult or were reluctant to engage with mental health services. This included re-engaging with patients who did not attend their appointments.
- Staff carrying out home visits in CRHT teams told patients that they would be seen before or after 3pm, patients told us they found this disruptive as it meant they would have to ensure they were home for a large part of the day.
- CRHT team phone line data from September 2016 showed that people phoning in to CRHT had their call answered on an average time of one minute eleven seconds. However, community mental health teams said that they could be waiting for up to 30 minutes to speak to the CRHT teams.
- Staff followed up on all people seen in by phone, post or face to face to help with any ongoing issues such as housing or benefits.
- We saw evidence of discharge planning in the care plans for CRHT teams.

The facilities promote recovery, comfort, dignity and confidentiality

- CRHT saw most patients at home; they also had facilities to see patients in their premises. Interview rooms had adequate soundproofing.
- Facilities to see patients at the criminal justice and liaison site were adequate.
- Posters were seen around custody advertising that a mental health nurse was available for to speak to.
- The had access to a police van which had a table and chairs located within the van, meaning people could be interviewed quickly and privately.
- Information on local services was available at all sites visited.
- Every patient assessed by CRHT was given an information booklet, which included information on crisis treatment, the complaints process and local advocacy.

Meeting the needs of all people who use the service

- All locations we visited were accessible for people with a disability.
- Information available was written in English. Staff said they could request literature in different languages if there was a need to do so.
- Staff had access to translation services and interpreters to help assess and provide for the needs of people using the service.

Listening to and learning from concerns and complaints

- Between 3 August 2015 and 28 July 2016 mental health crisis services received 24 complaints, 11 of these complaints were upheld and no complaints were referred to the ombudsman. All complaints were in relation CRHT. Complaints included delivery of service received or concern at the treatment received, staff attitude, and the discharge process.
- We spoke to 17 patients, none of the patients we spoke to were aware how to make a complaint if they were not satisfied with the care they received.

Are services responsive to people's needs?

Requires improvement

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

- Frontline staff told us they received feedback from complaints or investigations during team meetings. We saw that this was a standing item on the CRHT meeting agenda.

Health based place of safety

Access and discharge

- Staff reported delays in patients being accepted into an acute hospital setting due to lack of bed space. Between April 2016 and September 2016 there were 16 occasions where patients being held in custody suites were assessed as requiring care under the Mental Health Act in a healthcare setting. Seven of these occasions resulted in police transportation being used due to a lack of appropriate transportation; eight occasions resulted in patients being held in custody in breach of the Police and Criminal Evidence Act (PACE). On these 16 occasions the average time that an individual was kept in a police cell, after the person was deemed to require care under the Mental Health Act was 16 hours.

The facilities promote recovery, comfort, dignity and confidentiality

- Case records for patients in the HBPoS did not detail if the patient had been offered food or refreshments and if the patient had been given clean clothing or had attended to their personal hygiene.
- Clinical case notes for patients using the HBPoS lacked detail. Clinicians did not consistently record information around risks.

Meeting the needs of all people who use the service

- All locations we visited were accessible for people with a disability.
- Information available was written in English. Staff said they could request literature in different languages if there was a need to do so.
- Staff had access to translation services and interpreters to help assess and provide for the needs of people using the service.

Listening to and learning from concerns and complaints

- Between 3 August 2015 and 28 July 2016 the HBPoS did not receive any complaints.

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

Crisis resolution and home treatment

Vision and values

- Staff we spoke with were unable to recall the trust's visions and values without being prompted.
- Staff were aware of senior managers in the trust, but they said they rarely visited the premises.
- Staff had regular contact with their immediate managers. Most staff reported that their immediate managers supported them to carry out their roles and they felt able to raise concerns with their manager. However, some staff told us that they did not feel their managers understood their roles and they would not feel comfortable raising any issues with them.

Good governance

- Overall, the average compliance rate for mandatory training was 82%.
- The trust did not provided a compliance target for staff appraisals. Overall, 86.4% of staff working within mental health crisis services and health-based places of safety had received an annual appraisal in the 12 months to 1 September 2016.
- Managers were not supervising staff regularly, although steps had been put in place to ensure supervision was taking place. Overall, 60% of staff working within CRHT received regular supervision, 100% of staff working within the liaison psychiatry service were receiving regular supervision, 80% of staff working within the mental health triage car and 50% of staff working within the were receiving regular supervision.
- Staff learnt from incidents, complaints and any patient feedback during team meetings, we saw that incidents and complaints were a standing agenda item.
- The CRHT used key performance indicators (KPI's) to measure the responsiveness of the teams in areas such as numbers referred to the service, time taken to first contact following a referral and discharge destination. A new quality dashboard had been introduced in September 2016 after it was established that the previous system was incorrect, meaning we could only view KPI achievements for September 2016.
- Managers told us they had sufficient authority and administrative support to carry out their roles.
- Managers told us that they could submit items to the risk register where appropriate.

Leadership, morale and staff engagement

- Managers told us that they had enough autonomy to manage the service. They also said that where they had concerns they felt able to raise them.
- Staff we spoke with knew how to use the whistleblowing process.
- Staff were aware of the duty of candour.
- Staff working within CRHT generally had good morale, but said they felt stressed due to there being several vacancies and high referral numbers.
- Staff working within CRHT said they felt supported to take part in further training and felt that they could give ideas in service development.
- Staff working within criminal justice and liaison services and triage teams had good morale and said they worked well as a team both with internal and eternal colleagues.
- There were ongoing no bullying or harassment cases at the time of the inspection.
- All staff felt able to raise concerns without fear of victimisation from their immediate manager. However, staff said they did not feel listened to by senior members of the trust.
- Some staff we spoke with did not feel supported by senior managers as they did not feel senior managers understood their roles.
- Staff were able to progress within the service. We saw evidence of internal recruitment and promotion.

Commitment to quality improvement and innovation

- The Criminal Justice and Liaison Services was part of a pilot set up in 2014. Funding for mental health nurses and other mental health professionals was awarded to work with police stations and courts so that people with mental health problems get the right treatment, Leicester was one of the areas to be awarded with this funding.

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.

Health based place of safety

Vision and values

- Staff we spoke with were unable to recall the trust's visions and values without being prompted.
- Staff were aware of senior managers in the trust, but they said they rarely visited the premises.

Good governance

- Overall, the average compliance rate for mandatory training was 82%.
- Managers were not completing any audits or outcome measures to show the effectiveness of the HBPoS.
- Managers told us they had sufficient authority and administrative support to carry out their roles.
- Managers told us that they could submit items to the risk register where appropriate.

Leadership, morale and staff engagement

- Managers told us that they had enough autonomy to manage the service. They also said that where they had concerns they felt able to raise them.
- Staff we spoke with knew how to use the whistleblowing process.
- Staff were aware of the duty of candour.

Commitment to quality improvement and innovation

- The health based place of safety was not taking part in any innovative practice or improvement methodologies.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found out of date medication and equipment located in the health-based place of safety. Staff in the crisis resolution and home treatment team were not reviewing and updated risk assessments regularly or following an incident. Staff in the crisis resolution and home treatment team were transporting medication to patient's homes in their handbags. **This was a breach of regulation 12**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The environment in the health based place of safety and the crisis resolution and home treatment team were visibly unclean. The health-based place of safety at the Bradgate unit did not meet guidance, access arrangements were unsafe, doors were not anti-barricade and patients were unable to lie down. **This was a breach of regulation 15**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Not all staff received supervision on a regular basis. **This was a breach of 18**