Good

Leicestershire Partnership NHS Trust

Community-based mental health services for adults of working age

Quality Report

Trust Headquarters,
Lakeside House
4 Smith Way
Grove Park
Enderby
Leicester LE19 1SX
Tel: 0116 225 6000
Website: www.leicspart.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT5Z1	Bridge Park Plaza	Charnwood Community Mental health Team (CMHT)	LE11 3EB
RT5Z1	Bridge Park Plaza	North West CMHT	LE67 4DE
RT5Z1	Bridge Park Plaza	East Leicestershire CMHT	LE16 7PH
RT5Z1	Bridge Park Plaza	Rutland CMHT	LE15 6RB
RT5Z1	Bridge Park Plaza	West Leicestershire CMHT	LE18 2PE
RT5Z1	Bridge Park Plaza	Assertive Outreach Team	LE19 1XU
RT5Z1	Bridge Park Plaza	South Leicestershire CMHT	LE18 2LA

Summary of findings

RT5Z1	Bridge Park Plaza	East Leicester CMHT	LE13 1SJ
RT5Z1	Bridge Park Plaza	City Central CMHT	LE2 0TA
RT5Z1	Bridge Park Plaza	City West CMHT	LE3 1 HN
RT5Z1	Bridge Park Plaza	City East CMHT	LE5 3GH
RT5Z1	Bridge Park Plaza	Increasing Access to Psychological Therapies (IAPT)	LE5 4QF

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	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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 gave an overall rating for community based mental health teams for adults of working age as **good** because:

- There were risk assessments and plans in place to keep people and staff safe.
- Staffing skill mix was appropriate to need overall.
- There were safe lone working practices embedded in practice.
- There was good multi-disciplinary working within the teams.
- There were effective methods for obtaining feedback from service users and carers and feedback was acted upon.
- Staff were caring and committed to providing high quality care and showed a person-centred approach.
- Staff received regular supervision and most had received an appraisal in the last 12 months.
- The local managers monitored the environment for staff, carried out local audits and checked performance of staff on a regular basis.
- People we spoke with said they had received a good service.

However:

- Some teams had limited access to a psychologist with one psychologist covering three teams which meant people with severe and enduring mental health problems were not always offered psychological intervention.
- There were different recording systems in place, for example paper records and electronic records, different professional kept separate files. Staff told us they will move to a new electronic system in July 2015 which will be the same as other areas in the trust. Until then there is a danger information is not shared or fully available to all staff seeing a person.
- The IAPT service was not meeting the Key Performance Indicators (KPIs) set by commissioners in relation to 'access targets' - meaning they were not getting the expected quota of referrals per population head.
- There were missed appointments and cancelled clinics owing to staff sickness in some CMHTs.

Summary of findings

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

Are services safe?

Good

We rated these services as **good** for safe because:

- Individual risk assessments and plans were in place and updated regularly.
- Staffing skill mix met people's need overall.
- Staff were aware of the safeguarding process and used it when necessary. Safeguarding was discussed as part of supervision and team meetings.
- All staff were aware of the incident reporting process and learning was shared within the teams.
- There were safe lone working practices used in all teams.

However

- Local managers monitored the environment for staff and reported any repairs needed, but minor repairs and maintenance requests were not responded to quickly. At the Orchard Resource Centre we saw walls where plaster had fallen off and the paint was chipped. The flooring in the toilet at the assertive outreach team base was in a poor state.
- At the Orchard Centre, the public toilet was through into the staff area and there was the potential for people to be unsupervised in this area having been let through to use the toilet. Staff were aware of this but could be distracted from monitoring the person's whereabouts.
- The use of locums led to inconsistency in the service meaning people were not seen by the same psychiatrist at every appointment.

Are services effective?

Requires improvement

We rated these services as **requires improvement** for effective because:

- There was a lack of knowledge about the use of Community Treatment Orders (CTO) and assessing someone's capacity in some teams.
- Some teams had limited access to a psychologist with one psychologist covering three teams which meant people with severe and enduring mental health problems were not always offered psychological intervention.
- Some teams reported a lack of senior professional leadership for psychologists and occupational therapists which meant a lack of professional supervision.

Summary of findings

- There were different recording systems in place, for example paper records and electronic records, different professional kept separate files. Staff told us they will move to a new electronic system in July 2015 which will be the same as other areas in the trust. Until then there is a danger information is not shared or fully available to all staff seeing a person.
- The building where the assertive outreach team was based had poor connectivity for staff to access electronic systems, meaning limited access to these.
- Communication was not always consistent between community teams and other services, including the crisis team and in-patient services.

However

- Full assessments were carried out involving all relevant staff.
- Outcome measures were used to assess effectiveness of interventions.
- Staff were able to access specific training when required to meet people's need.
- There were trust wide and local audits to monitor effectiveness.
- Staff received supervision and an annual appraisal.

Are services caring?

Good

We rated these services as **good** for caring because:

- Staff were kind and respectful to people and recognised their individual needs.
- Staff actively involved people in developing and reviewing their care plan.
- Staff also made sure families and carers were involved when this was appropriate.
- People who used the service told us staff were caring.

Are services responsive to people's needs?

Good

We rated these services as **good** for responsive because:

- There was good involvement with families and or carers.
- Diverse needs were considered, information was readily available for staff.
- There was access to interpretation services when required.
- Staff felt they could raise any issues with the local manager and they would be addressed.
- Feedback was acted upon quickly. There were effective ways to obtain feedback from people and carers.
- Teams had a plan in place for any major event such as adverse weather and loss of power in their base.

Summary of findings

However

- There was a lack of knowledge of the Greenlight initiative which promotes equal access to mental health services for people with learning disabilities.
- The IAPT service was not meeting the Key Performance Indicators (KPIs) set by commissioners in relation to 'access targets' - meaning they were not meeting the assessed demand for the service.
- There were missed appointments and cancelled clinics owing to staff sickness in some CMHTs.
- One team building had no disabled access to upstairs; plans were shared with us about a move to another site.
- Information on how to complain was not easily visible in waiting areas.

Are services well-led?

Good

We rated these services as **good** for well-led because:

- Staff felt supported by local and senior managers.
- Staff told us they received regular supervision and appraisal. We saw staff records to confirm this.
- Local managers monitored the standard of care, environment and staff performance.
- Staff were aware of the "listening into action" events which the trust ran to gain feedback from staff on how to improve services.
- There were regular meetings for the team managers to share information and provide support to each other.

Summary of findings

Information about the service

- The community mental health teams (CMHTs) provide services across the county. They are made up of consultant psychiatrists, psychiatric nurses, occupational therapists and psychologists providing a range of treatments, interventions and assistance to adults aged 16-65.
- The service is for people who have difficulty with their mental health who have been referred by their general practitioner or other health professional. People are seen in clinics, team bases, and through home visits.
- An assessment is completed either in out-patients or by the community team to determine the level of need and subsequent intervention. Close links are needed with both the trust's in-patient facilities and the crisis teams.
- The teams have not been inspected by the Care Quality Commission previously.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

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

Inspection Managers: Lyn Critchley and Yin Naing

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

The team that inspected the community-based mental health teams consisted of a CQC inspection manager, CQC inspector, Mental Health Act reviewer and a variety of specialist professional advisors: a nurse, psychologist, and social worker, occupational therapist, all of whom had recent mental health service experience and an expert by experience that had experience of using mental health services.

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

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of the experience of people who use services, we always ask the following five questions of every service and trust:

- 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 we held about these services and asked a range of other organisations for information.

We carried out an announced visit between 09 and 13 March 2015.

Summary of findings

During the inspection visit, the inspection team:

- Visited 12 community services, looked at the quality of the care provided and how staff were caring for people.
- Spoke with 48 people who were using the service, in person and via telephone calls.
- Spoke with the managers for each of the services.
- Spoke with 86 other staff members; including nurses, care workers, psychologists.
- Interviewed the services manager with responsibility for these services.
- Attended and observed a referral management meeting, an allocation meeting, a multi-disciplinary team (MDT) meeting, group supervision and one out-patient appointment.
- Attended and observed six home visits.

We also:

- Looked at 66 care records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- People who used the service told us they were happy with the care and service received.
- They said staff were respectful towards them.
- They said they were kept informed and involved in planning care.
- They said staff had provided good care and had responded quickly to changing need.

Good practice

- Safety alarm devices were given to staff following incidents which had put staff in potential danger. This showed learning from incidents and improved practice.
- The use of tele-psychiatry in some teams enabled people to be contacted using technology if they couldn't attend for an appointment.
- One team had laptops and remote access to enable them to update the system with the latest information if they weren't returning to base at the end of the day.
- Teams ran nurse led clinics and there were some non-medical prescribers.
- Discharge training for community staff was being developed to ensure people were discharged appropriately.

Areas for improvement

Action the provider MUST take to improve

Action the trust MUST take to improve

- The trust must ensure consistency and accuracy of records across all teams which are available to all relevant staff providing care and treatment for each individual.
- The trust must ensure sufficient numbers of suitably qualified, competent and skilled staff to provide care and treatment.
- The trust must review its procedures for maintaining records, storage and accessibility including out of hours provision.

Action the provider SHOULD take to improve

Action the trust SHOULD take to improve

- The trust should ensure the contracted service meets the requirements for maintaining the environment and décor.
- The trust should ensure recruitment to vacancies is prioritised to reduce the need for locum psychiatrist cover and inconsistency in the service.
- The trust should ensure all staff have a good working knowledge of the Mental Health Act and the use of Community Treatment Orders.

Summary of findings

- The trust should work with commissioners to review the provision of the IAPT service to ensure that this meets the assessed demand for this service.
- The trust should review its communication with people in out of area placements to ensure consistency of service.
- The trust should review the interface between community teams and the trust's in-patient and crisis services.
- The trust should review the professional leadership of the different professions to ensure the correct level of leadership.

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
Charnwood Community Mental health Team (CMHT)	Trust Headquarters
North West CMHT	Trust Headquarters
East Leicestershire CMHT	Trust Headquarters
Rutland CMHT	Trust Headquarters
West Leicestershire CMHT	Trust Headquarters
Assertive Outreach Team	Trust Headquarters
South Leicestershire CMHT	Trust Headquarters
East Leicester CMHT	Trust Headquarters
City Central CMHT	Trust Headquarters
City West CMHT	Trust Headquarters
City East CMHT	Trust Headquarters
Increasing Access to Psychological Therapies (IAPT)	Trust Headquarters

Detailed findings

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 Trust.

- Most staff had received Mental Health Act training.
- When required staff said they could contact the approved mental health professional (AMHP) service to co-ordinate assessments under the Mental Health Act (1983/2007), the response rate to this was reported as variable.
- Staff knowledge of the use of Community Treatment Orders (CTOs) was variable and some staff required further training to understand the implications for community teams. For example in relation to consent to treatment forms.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they had received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Trust wide compliance was 90%.
- Most staff said they would seek advice from seniors when needed.
- There was information on display about advocacy in most team bases.
- Staff boards displayed contact details for Deprivation of Liberty Safeguards referrals for staff to refer to in their work.

However

- The practical knowledge of the application of the Mental Capacity Act training was poor in some teams. This meant they were not able to tell us about the process for assessing someone's capacity and where this should be documented.

Good

Are services safe?

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

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

Summary of findings

We rated these services as **good** for safe because:

- Individual risk assessments and plans were in place and updated regularly.
- Staffing skill mix met people's need overall.
- Staff were aware of the safeguarding process and used it when necessary. Safeguarding was covered as part of supervision and team meetings.
- All staff were aware of the incident reporting process and learning was shared within the teams.
- There were safe lone working practices used in all teams.

However

- Local managers monitored the environment for staff and reported any repairs needed, but minor repairs and maintenance requests were not responded to quickly. At the Orchard Resource Centre we saw walls where plaster had fallen off and the paint was chipped. In this base the public toilet was through into the staff area and there was the potential for people to be unsupervised in this area having been let through to use the toilet. Staff were aware of this but could be distracted from monitoring the person's whereabouts. The flooring in the toilet at the assertive outreach team base was in a poor state.
- The use of locums led to inconsistency in the service meaning people were not seen by the same doctor.

Our findings

Safe environment

- The environment was safe but not always well maintained. We saw walls where plaster had fallen off and the paint was chipped at the Orchard Resource Centre, and flooring in the toilet at the assertive outreach team base was in a poor state.
- There was a lone working policy and all staff we spoke with knew about it and could describe what was done in relation to staff safety.
- Teams had alarms for use in interview rooms when needed, although staff reported they didn't always work, this meant there was a potential risk to staff. We were told the trust was looking at alternatives.
- Not all clinic rooms (where medicines were stored) had hand washing facilities which could increase the risk of infection or cross contamination.

Safe staffing

- Staffing skill mix overall was sufficient to meet need and showed a range of different professions, including nurses, care assistants, occupational therapists, psychologists and doctors.
- Caseload numbers were in the range of 30-40 people per professional and numbers were monitored in supervision.
- The use of locums led to inconsistency in the service, meaning patients were not seen by the same psychiatrist at every appointment and the psychiatrist would not be familiar with the patient.
- There were cover arrangements in place for staff sickness but sickness impacted on capacity to keep appointments in some teams.
- Staff had access to advice quickly, when required, from a psychiatrist or senior staff.

Assessing and managing risks to people and staff

- Individual risk assessments had been completed for people. Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was managed. Most risk assessments had been regularly updated but this was not consistent across the teams. We found one record which had no risk assessment.
- Individual risk assessments we reviewed took account of people's previous history, as well as their current situation.
- Staff had received training in safeguarding vulnerable adults and children and most staff we spoke with knew how to recognise a safeguarding concern. They knew who to inform if they had safeguarding concerns. Trust wide compliance was at 90%. Safeguarding was discussed as part of supervision and in team meetings.

Good

Are services safe?

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

- Safeguarding was discussed at team meetings and it was a standing item on the agenda for meetings. Safeguarding discussions with staff also took place during supervision, to ensure staff had sufficient awareness and understanding of safeguarding procedures.
- Medicines were managed well and were stored safely. Not all teams used syringes with safe retractable needles which is recognised as best practice.

Track record on safety

- In the period January to December 2014 there had been 12 suicides by a patient in receipt of community services, seven suspected suicides and 21 attempted suicides. All were investigated by the trust and actions or lessons identified. Information and learning was shared at team meetings.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to recognise and report incidents on the trust's electronic incident recording system. All incidents were reviewed by the manager and forwarded to the trust's clinical governance team, who maintained oversight.
- Staff we spoke with were aware of the duty of candour responsibility.
- The system ensured senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response.
- Staff told us, after a serious incident, they were given the opportunity to have a formal de-brief and they could access additional support if needed.
- Managers told us how they maintained an overview of all incidents reported in their teams and could identify any themes. Incidents were investigated and some managers told us they were made aware of incidents that had occurred in other areas through team meetings.

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.

Summary of findings

We rated these services as **requires improvement** for effective because:

- There was a lack of knowledge about the use of Community Treatment Orders (CTO) and assessing someone's capacity in some teams.
- Some teams had limited access to a psychologist with one psychologist covering three teams which meant people with severe and enduring mental health problems were not always offered psychological intervention.
- Some teams reported a lack of senior professional leadership for psychologists and occupational therapists which meant a lack of professional supervision.
- There were different recording systems in place, for example paper records and electronic records, different professional kept separate files. Staff told us they will move to a new electronic system in July 2015 which will be the same as other areas in the trust. Until then there is a danger information is not shared or fully available to all staff seeing a person.
- The building where the assertive outreach team was based had poor connectivity for staff to access electronic systems, meaning limited access to these.
- Communication was not always consistent between community teams and other services, including the crisis team and in-patient services.

However

- Full assessments were carried out involving all relevant staff.
- Outcome measures were used to assess effectiveness of interventions.
- Staff were able to access specific training when required to meet people's need.
- There were trust wide and local audits to monitor effectiveness.
- Staff received supervision and an annual appraisal.

Our findings

Assessment of needs and planning of care

- Peoples' needs were assessed and care was delivered in line with their individual care plans. Records showed risks to physical health were identified and managed effectively.
- Care plans were in place that addressed peoples' needs. We saw these were reviewed on a regular basis and updated or discontinued as appropriate. Involvement from people and family was included wherever possible.
- Most records showed people who used the service and carers were involved in care planning. The care plans reflected people's individual needs. Some records contained advance decisions about what the person wanted if they became ill again.
- Most staff updated care plans and risk assessments at regular intervals and when any change took place.
- The approach to record keeping was not consistent across all teams resulting in differing standards of record keeping. Some of the paper records were not always signed and dated, risk assessments were not always updated regularly. The building where the assertive outreach team was based had poor connectivity for staff to access electronic systems, meaning limited access to these.

Best practice in treatment and care

- The trust audited against National Institute for Health and Care Excellence (NICE) guidelines to monitor compliance, for example schizophrenia and severe depression.
- Staff assessed people using the Health of the Nation Outcome Scales (HoNOS) for clustering. These covered 12 health and social domains and enabled the clinicians to build up a picture over time of the person's responses to interventions. Other outcome measures were in use also.
- Occupational therapists were using evidence based assessment tools and measures.
- Local managers we spoke with carried out regular audits of care records and results were fed back to the team during team meetings with actions identified. Record keeping was discussed in supervision. We saw team meeting minutes and records to confirm this.
- Outcome measures were used to assess effectiveness of interventions.

Skilled staff to deliver care

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 came from a range of professional backgrounds including nursing, medical, occupational therapy, and psychology and administration staff. The team at Loughborough had limited access to occupational therapy staff. The team at the Hawthorne Centre and the Orchard Centre had limited access to a psychologist. The psychologist at Melton Mowbray was covering three teams which meant people with severe and enduring mental health problems were not always offered psychological intervention.
- Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training relevant to their role, including safeguarding children and adults. Records showed most staff were up-to-date with mandatory training. New staff had a period of induction to introduce them into the team in addition to the trust wide induction.
- There was a lack of knowledge about the use of Community Treatment Orders (CTO) and assessing someone's capacity in some teams.
- Some staff received specific training to meet people's needs. For example psychological intervention training and psychologically informed practitioner training (PIP). We saw training slides used for staff supervision on psychological awareness.
- Nurses in some teams had trained as medication prescribers.
- Staff told us they received clinical and managerial supervision every month, where they were able to reflect on their practice and any incidents that had occurred. The assertive outreach team was maintaining the trust standard of four supervision sessions per year.
- However, some teams reported a lack of senior professional leadership for psychologists and occupational therapists which meant a lack of professional supervision.
- We saw an example of how poor staff performance had been addressed using the relevant trust policy.
- Three teams had one psychologist covering the three teams which meant some people were not able to access psychology quickly. Some teams had limited access to an occupational therapist which meant people were not always offered this intervention.

Multi-disciplinary and inter-agency team work

- Care records showed there was effective multidisciplinary team (MDT) working taking place in some areas, but others had very limited multi-disciplinary approach.
- There were regular team meetings and staff felt well supported by their manager and colleagues. Many staff mentioned good team work as one of the best things about their job.
- We attended an allocation and a MDT meeting where care was discussed and reviewed. Changes were made to the care plan if required.
- Contact was not always maintained with people who had been placed out of area due to bed shortages within the trust.
- Discharge planning was inconsistent across all teams with some records showing no record of discharge planning.
- Social care staff were based in the same building in most teams but they kept separate files and were not employed by the trust. This meant relevant information could be missed as it was not recorded in the same file and social care input was separate not integrated.
- Communication was not always consistent between community teams and other services, including the crisis team and in-patient services.

Adherence to the MHA and MHA Code of Practice

- Staff told us they had received training on the Mental Health Act 1983/2007. However, there was a lack of knowledge in some teams on the use of community treatment orders (CTOs). Some staff were not aware of the requirements for consent to medication.
- Staff reported access to approved mental health professionals (AMHPs) was variable with some referrals taking a couple of hours for a response.

Good practice in applying the MCA

- Staff said they had received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Some staff showed an excellent understanding of capacity and the requirements of the Mental Capacity Act (2005), recording consideration of capacity. Other staff had limited knowledge of the practical application of this training, although most staff said they could seek advice if needed.

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.

- Some records showed consideration of mental capacity and appropriate assessment when required.

Good

Are services caring?

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

Summary of findings

We rated these services as **good** for caring because:

- Staff were kind and respectful to people and recognised their individual needs.
- Staff actively involved people in developing and reviewing their care plan.
- Staff also made sure families and carers were involved when this was appropriate.
- People who used the service told us staff were caring.

Our findings

Kindness, dignity, respect and support

- We observed staff interacting with people in a caring and compassionate way. Staff appeared interested and engaged in providing good quality care to people.
- When staff spoke with us about people, they discussed them in a respectful manner and showed a good understanding of their individual needs. Records showed a person-centred approach throughout care.

The involvement of people in the care they receive

- People said they were involved in their care and they or their relatives were given a copy of their care plan to comment on and agree or disagree. Involvement from people who used the service and family was recorded in some records but not all.
- The views of people who used the service and family using the service were gathered through the use of the friends and family test (FFT) which asked if they would recommend the service to friends and family, it also included space for comments. Responses to this were fed back to staff at team meetings, to enable them to make changes where needed.
- There were leaflets on display in some team bases on advocacy and how to access the advocacy service.

Are services responsive to people's needs?

Good

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

Summary of findings

We rated these services as **good** for responsive because:

- There was good involvement with families and or carers.
- Diverse needs were considered, information was readily available for staff.
- There was access to interpretation services when required.
- Staff felt they could raise any issues with the local manager and they would be addressed.
- Feedback was acted upon quickly. There were effective ways to obtain feedback from people and carers.
- Teams had a plan in place for any major event such as adverse weather and loss of power in their base.

However

- There was a lack of knowledge of the Greenlight initiative which promotes equal access to mental health services for people with learning disabilities.
- The IAPT service was not meeting the Key Performance Indicators (KPIs) set by commissioners in relation to 'access targets' - meaning they were not meeting the assessed demand for the service.
- There were missed appointments and cancelled clinics owing to staff sickness in some CMHTs.
- The team building at Loughborough had no disabled access to upstairs; plans were shared with us about a move to another site.
- Information on how to complain was not easily visible in waiting areas.

Our findings

Access, discharge

- For teams covering the county areas there was a duty clinician rota (a member of the team), to respond to urgent referrals and possible Mental Health Act assessment needs.
- For the city teams there was a referral management service (RMS) which picked up the referrals for assessment and then took to the team for allocation or transfer.
- Recent changes to the crisis team meant the community mental health teams were adjusting to new ways of working and one of the managers was monitoring the impact of the changes on their referral rates.
- There was an assertive outreach team (AOT) that saw people who find it difficult to engage.
- There was a protocol in place telling staff how to respond to people who missed appointments.
- Caseloads were mostly 30-40 cases per professional, most staff felt this was manageable but some said the intensity of input had changed which impacted on their capacity to respond as quickly.
- The IAPT service was not meeting the Key Performance Indicators (KPIs) set by commissioners in relation to 'access targets' - meaning they were not meeting the assessed demand for this service.
- Staff said there was long wait for psychotherapy (about 24 months) this impacted on community staff who continued to see the person until transferred.

The facilities promote recovery, dignity and confidentiality

- Most environments were clean, safe and confidential. However, at the City Central team we saw an open plan office in which people's care records had been left on desks; potentially other agencies could access these.
- The teams had the full range of rooms and equipment available to provide confidential treatments where appropriate.

Meeting the needs of all people who use the service

- People's individual needs were met, including cultural, language and religious needs.
- A variety of groups were run by staff. For example anxiety management, hearing voices group, wellbeing group.
- Staff told us about the interpretation services they used which helped them speak with people whose first language was not English.
- The team building at Loughborough had no disabled access to upstairs; plans were shared with us about a move to another site.

Listening to and learning from concerns and complaints

Are services responsive to people's needs?

Good

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

- Staff were able to describe the complaints process and how they would handle any complaints.
- There had been 31 complaints about the CMHTs in 2014 with just under half being upheld. Themes included cancelled out-patient appointments and people having to move teams owing to changes in services.
- Managers described the process they followed with complaints and how practice had changed as a result of some of the feedback received.
- Staff knew how to respond to anyone wishing to complain and the managers demonstrated how positive and negative feedback was used to improve services.
- Information on how to complain was not easily visible in waiting areas.

Are services well-led?

Good

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

Summary of findings

We rated these services as **good** for well-led because:

- Staff felt supported by local and senior managers.
- Staff told us they received regular supervision and appraisal. We saw staff records to confirm this.
- Local managers monitored the standard of care, environment and staff performance.
- Staff were aware of the "listening into action" events which the trust ran to gain feedback from staff on how to improve services.
- There were regular meetings for the team managers to share information and provide support to each other.

Our findings

Vision and values

- Staff considered they understood the vision and direction of the trust and were able to explain them. The trust vision was on display in some team bases.
- Some staff, but not all, knew who the chief executive and executive directors were. Some had had direct contact with the chief executive through the "ask the boss" initiative and all had received a response.
- Team managers said they received good support from senior managers.

Good governance

- The teams had access to systems of governance that enabled them to monitor and manage the team and provide information to senior staff in the trust. One example of this was the electronic staff record that monitored the training staff had received and informed staff and their managers when training needed to take place.
- The managers told us where they had concerns, they could raise them. Where appropriate the concerns could be placed on the trust's risk register. We were shown examples of issues which had been placed on the risk register for community teams. There was a local risk register.
- Staff told us they received regular supervision and appraisal. We saw staff records to confirm this.
- Local managers monitored the standard of care, environment and staff performance.

Leadership, morale and staff engagement

- There was evidence of clear leadership at a local level. Team managers were accessible to staff and they were proactive in providing support. The culture was open and encouraged staff to bring forward ideas for improving care. There were regular meetings for the team managers to share information and provide support to each other.
- Staff told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line manager.
- Sickness rate for CMHTs in the last 12 months had been about 4.5% across the teams and included some long term sickness. Managers explained the policy for managing attendance and gave examples of when this had been followed. Two teams we visited had three members of staff off sick at the same time and this was being covered within the team.
- At the time of our inspection there were no grievance procedures being pursued within the teams, and there were no allegations of bullying or harassment. Staff were aware of the whistleblowing process and said they would use it if they needed to.
- Team managers told us they had access to leadership training and development. They felt supported by their immediate line manager.
- Staff were aware of the "listening into action" events which the trust ran to gain feedback from staff on how to improve services.

Commitment to quality improvement and innovation

- Staff demonstrated a commitment to providing high quality care and talked to us about plans for improving services. For example there were nurse led clinics, non-medical prescribers and the use of tele-psychiatry to reach people who could not come to the team base for their appointment.
- One team had negotiated so they could receive laptops and remote access to improve recording of interventions when away from their base.

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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Regulations 20 HSCA 2008 (Regulated activities) Regulations 2010** **Records** The trust did not ensure that services users were protected against the risks of unsafe or inappropriate care and treatment through availability of accurate information and documents in relation to the care and treatment provided. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Regulation 22 HSCA 2008 (Regulated activities)** **Regulations 2010** **Staffing** The trust did not take appropriate steps to ensure there were sufficient numbers of staff. Not all community teams had sufficient staffing to safely meet patient need.

This section is primarily information for the provider

Requirement notices

This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulations 9 HSCA 2008 (Regulated activities) Regulations 2010** **Care and welfare of service users** People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of planning and delivering care to meet individual service user's needs.

This section is primarily information for the provider

Requirement notices

- There was limited and delayed access to psychological therapy.
- There was limited access to occupational therapy.

This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.