Leicestershire Partnership NHS Trust

Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix: .

NOTE: This report is an updated version of one originally published on 29 January 2018, correcting errors.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

Summary of findings

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Background to the trust

The trust was created in 2002 to provide mental health, learning disability and substance misuse services. In April 2011 the trust merged with Leicester City and Leicestershire County and Rutland Community Health Services as a result of the national transforming community services agenda. This has enabled joined up mental health and physical health care pathways to advance health and wellbeing for the people and communities of Leicester, Leicestershire and Rutland. The trust no longer provides substance misuse services. The trust has 16 active locations registered with CQC.

We inspected community health services for adults, acute wards for adults of working age and psychiatric intensive care unit, community based mental health services for adults of working age, mental health crisis services and health based place of safety and specialist community mental health services for children and young people.

The trust has 628 inpatient beds across 39 wards, 10 of which are children's mental health beds. The trust also has 73 outpatient clinics a week and 436 community clinics a week.

The trust serves a population of approximately one million people across Leicester, Leicestershire and Rutland, has a budget in excess of £250 million and employs over 5,500 staff in a wide variety of roles. The trust obtained a £1.6m surplus year ending March 2017.

Services are commissioned through local clinical commissioning groups and specialised commissioning within NHS England.

CQC undertook a comprehensive inspection of the trust in March 2015 with the inspection report published 10 July 2015. The overall rating was requires improvement. The trust was rated inadequate for safe, requires improvement for effective, responsive and well led, and good for caring.

The last comprehensive inspection was 14 to18 November 2016. Reports were published 2 February 2017. The overall rating was requires Improvement. The service was rated as requires Improvement for safe, effective, and well led, inadequate for responsive and good for caring.

The areas of non-compliance were:

Regulation 10 HSCA Regulated Activities Regulations 2014 Dignity and respect.

- The trust had not ensured the privacy and dignity of patients was protected at all times.
- Shower rooms on one ward did not have shower curtains for the privacy and dignity of patients.
- The trust admitted males to female areas. The trust must ensure that it complies with Department of Health guidance in relation to mixed sex accommodation.

Regulation 12 HSCA Regulated Activities Regulations 2014 Safe care and treatment.

- The trust had not completed work to remove ligature risks on acute wards. The trust must ensure that ligature risks are removed, as far as is practical to ensure a safe environment for patient care.
- Wards continued to have ligature risks, including door handles, soap and towel dispensers and window closers.
- The trust had hydraulic beds in use. These beds posed a risk of ligature and barricade for patients.
- Wards had areas where staff could not easily observe patients.

Summary of findings

- One ward had nurse call alarms that were not in working order.
- Staff were not always recording room and fridge temperatures in clinical rooms. The trust must consistently maintain medication at correct temperatures in all areas.
- Staff had not ensured that out of date medication was disposed of appropriately.

Regulation 15 HSCA Regulated Activities Regulations 2014 Premises and equipment.

- The trust had not ensured that all equipment within the patient area was free from damage and suitable for use.
- One ward had a damaged shower fitting and toilet roll holder that posed a risk to patient safety.

Regulation 18 HSCA Regulated Activities Regulations 2014 Staffing.

- The trust did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons.
- The trust had not ensured there were sufficient registered nurses for safe care and treatment.
- The trust had not ensured all staff were in receipt of regular supervision. The trust could not be sure staff were appropriately supported for their role.
- The trust had not ensured that patients could access psychological input, in accordance with National Institute for Health and Care Excellence guidelines.
- The trust had not ensured all staff were up to date with mandatory training requirements. The trust reported low levels of compliance with immediate life support training. The trust was required to address this following the CQC inspection in 2015.

Overall summary

Our rating of this trust stayed the same . We rated it as Requires improvement

What this trust does

Leicestershire Partnership NHS Trust provides mental health and community health services across 16 locations throughout Leicester, Leicestershire and Rutland. The trust delivers the following mental health services:

- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- Community mental health services for people with learning disabilities or autism
- Community-based mental health services for adults of working age
- Community-based mental health services for older people
- Forensic inpatient/secure wards
- Long stay/rehabilitation mental health wards for working age adults
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Wards for older people with mental health problems

Summary of findings

- Wards for people with learning disabilities or autism

In addition, the trust provides the following community health services:

- Community health services inpatient services
- Community health services for adults
- Community health services for children, young people and families
- Community health services for end of life care

The trust serves a population of approximately one million people across Leicester, Leicestershire and Rutland, has a budget in excess of £250 million and employs over 5,500 staff in a wide variety of roles.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected five complete services which we previously rated as inadequate or requires improvement or which we risk assessed as requiring an inspection this time. These were:

- Acute wards for adults of working age and psychiatric intensive care units
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Community Health services for adults.

We did not inspect the other 10 core services during this inspection because the risk based assessment did not indicate these services required an inspection this time or they were rated as good in previous inspection.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed Is this organisation well-led?

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

Summary of findings

- We rated safe, effective, responsive and well led as requires improvement and caring as good. We rated the four mental health core services as requires improvement and community health services for adults as good. In rating the trust, we took into account the previous ratings of the core services we did not inspect on this occasion.
- We rated the trust as requires improvement for well led.
- The environment in some services was poor, not well maintained and not kept clean. The acute mental health wards had broken facilities which had not been repaired in a timely manner and we found dirt in some areas on one ward. The environment in specialist community mental health services for children and young people, and community based mental health services for adults of working age was not suitable, did not promote safe practice and was not well maintained. The environment in the crisis service did not ensure confidentiality as rooms were not sound proofed and conversations could be heard outside the room.
- Staffing levels did not meet requirement in some community teams. There was a high vacancy rate of 12.9% for band 5 and 6 nurses in community based mental health services for adults of working age, 18.9% for band 5 and 6 nurses in crisis service and 17.3% across community health services for adults.
- Patients were not always safeguarded. Patients waiting for their appointment in community based mental health services for adults of working age had access to a room unsupervised which held items which could cause harm. Patients waiting for their appointment in the specialist community mental health services for children and young people used a shared waiting room with the learning disabilities adults' services. This could pose a risk as patients were unsupervised in this area.
- We identified medicines management issues, including out of date medication in the acute mental health wards and fridge temperatures were not monitored in community based mental health services for adults. The policy for rapid tranquillisation was not in line with national guidance.
- Staff held high caseloads in community based mental health services for adults of working age, an issue which had been recognised by the trust and placed on the risk register. Waiting times and lists remained of concern, and this had been identified in the previous inspection. There were a high number of patients on the waiting list for treatment in the specialist community mental health services for children and young people. The waiting times in community based mental health services for adults of working age were long and breached targets. A high number of outpatient appointments were cancelled. The psychiatric outpatients was responsible for 2094 of the breaches, with city east reporting the highest of these breaches at 429.2
- Not all patient records showed a full assessment of need, including physical health needs or up to date care plans. Care plans were not always holistic and person centred.
- Staff were not always recording their supervision on the electronic system so we could not be assured they were receiving it regularly.
- The acute mental health wards had two and four bedded dormitories which did not promote privacy and dignity. Patients returning from leave from the acute mental health wards were not assured of returning to their original ward. This reduced continuity of care.
- The governance processes had not picked up the issues around repairs, medicines and cleanliness.
- The quality of some of the data was poor. Staff could not rely on performance reports being accurate. Some local managers were keeping their own records to ensure performance was monitored.

However:

- The trust had addressed the issues regarding the health based place of safety identified in the previous inspection.

Summary of findings

- The process for monitoring patients on the waiting list in specialist community mental health services for children and young people had been strengthened since the last inspection.
- Care planning had improved in the crisis service.
- There was an effective incident reporting process which investigated and identified lessons from incidents which were shared in most teams.
- Patients and carers knew how to complain and complaints were investigated and lessons identified.
- Staff were kind, caring and respectful towards patients. Most patients spoke positively about their care and said they were involved. Patients had access to advocacy.

Are services safe?

Our rating of safe stayed the same. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- The environment in some services was poor, not well maintained and not kept clean. The acute mental health wards had broken facilities which had not been repaired in a timely manner and we found dirt in some areas on one ward. The environment in some community teams was not suitable, did not promote safe practice and was not well maintained.
- Staffing levels did not meet requirement in some community teams. There was a high vacancy rate of 12.9% for nurses in community based mental health services for adults of working age, 18.9% in crisis service and 17.3% in community health services for adults, resulting in high caseloads and cancelled appointments.
- Patients were not always safeguarded. Patients waiting for their appointment in one community mental health base had access to a room unsupervised which held items which could cause harm. Patients waiting for their appointment in the specialist community mental health services for children and young people used a shared waiting room with the learning disabilities adults' services. This could pose a risk as patients were unsupervised in this area.
- We identified medicines management issues including out of date medication in the acute mental health wards and fridge temperatures were not monitored in community based mental health services for adults. The policy for rapid tranquillisation was not in line with national guidance.

However:

- The health based place of safety met requirements. Most services completed timely risk assessments and updated them regularly. The trust had improved the monitoring of young people waiting for treatment.
- The trust tried to book regular bank and agency staff to provide continuity of care.
- Staff were aware of the Duty of candour and reported incidents using the electronic system. Incidents were investigated and actions identified.

Are services effective?

Our rating of effective stayed the same. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- There were data quality issues. The reports for community health services for adults were not accurate as they didn't capture all visits. Performance reports were not an accurate reflection of work completed because the system did not allow corrections to be made.
- Not all patient records showed a full assessment of need, including physical health needs or up to date care plans. Care plans were not always holistic and person centred.

Summary of findings

- Staff were not always recording their supervision on the electronic system, although some managers were keeping local records.

However:

There was effective multidisciplinary working across all services.

- The trust provided specific training for staff.
- The trust had a comprehensive audit programme.

Are services caring?

Our rating of caring stayed the same. We took into account the current ratings of services not inspected this time. We rated it as good because:

- Staff were kind, caring and respectful towards patients.
- Most patients spoke positively about their care and said they were involved.
- Patients had access to advocacy.

However:

- The involvement of patients and carers in care was not always documented.

Are services responsive?

Our rating of responsive stayed the same. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- There were 323 patients on the waiting list for assessment in the specialist community mental health services for children and young people. There were 622 waiting for individual interventions or second opinions within the services, for example waiting for family therapy, primary mental health, eating disorder services and learning disabilities. Of these 569 were waiting for specific treatment within the community teams.
- The waiting times in community based mental health services for adults of working age were long and breached targets. A high number of outpatient appointments were cancelled.
- The environment in the specialist community mental health services for children and young people did not ensure confidentiality as rooms were not sound proofed and conversations could be heard outside the room.
- Three of the acute mental health wards had two and four bedded dormitories which did not promote privacy and dignity.
- Patients returning from leave from the acute mental health wards were not assured of returning to their original ward. This reduced continuity of care.
- The crisis service was not meeting its targets for seeing patients referred to them.

However:

- The process for monitoring young people on the waiting list had been strengthened since the last inspection. The service met the target for seeing referrals within 13 weeks of referral. There were no patients waiting for more than a year which was an improvement since the last inspection.
- Patients and carers knew how to complain and the trust investigated complaints and identified actions.

Summary of findings

Are services well-led?

Our rating of well-led stayed the same. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- The governance processes in place had not picked up the issues around waits for repairs, medicines management and cleanliness.
- Waiting times and lists remained of concern, and this had been identified in the previous inspection.
- The quality of some of the data was poor. Staff could not rely on performance reports being accurate. Some local managers were keeping their own records to ensure performance was monitored. The trust acknowledged this and was working towards improving the data quality.

However:

- The trust had a clear vision and values which were displayed in all services and staff were able to tell us about them.
- Staff told us they felt supported by the managers and knew who senior managers were.
- The trust was aware of the issues in relation to waits and data quality and was working towards addressing them.

Community health services

Our overall rating of community health services stayed the same. We took into account the current ratings of services not inspected this time. We rated community health services as requires improvement because:

- We rated safe, caring, and responsive as good and effective and well led as requires improvement.
- We rated three of the four core services as good overall.

Community health service for adults

Our overall rating of community health service for adults improved. We rated services as good because:

- We rated safe, effective, caring and responsive as good and well led as requires improvement
- Patients were protected from avoidable harm and abuse, systems were in place to investigate incidents and concerns and staff received suitable training in safety systems. Risk assessments were completed and care plans implemented to keep patients safe and promote wellbeing. The service had plans in place to manage service disruption and major incidents.
- The service used evidence based, best practice guidance throughout its policies and procedures and ways of working. Clinical audit was taking place and learning was shared across the service. Staff were suitably trained with the relevant knowledge and skills to carry out their work, had regular appraisals and had access to the information they needed to perform their duties. Multidisciplinary team work both internal and external to the service was effective and patients were supported to make informed decisions about their care.
- Patients were supported, treated with dignity and respect and involved as partners in their care. They told us that staff were kind and caring.
- Services and care were planned with the local population in mind and to address the individual needs of patients. Facilities had been adapted to improve access and systems were in place to support the most vulnerable. Patients knew how to make a complaint or raise a concern and complaints were taken seriously.

Summary of findings

- A new leadership structure had been introduced since the last inspection and had not yet fully embedded in the service. Leaders were motivated and developing their skills to address the current challenges to the service. Staff support systems were in place and there was a drive to engage with staff. Governance structures were in place and risks registers were reviewed regularly.

However:

- The service still had challenges in recruiting sufficient staff which meant that the service, in particular community nursing, was understaffed at times impacting on staff satisfaction and compromising patient care.
- Staff did not always have time to attend clinical supervision sessions and patient information systems were inconsistently utilised and did not always enable effective working.
- Patient outcomes were not routinely collected so the quality of the clinical care being delivered could not be measured or benchmarked.
- There were long waiting times from initial referral to being seen in some clinics and services although these had improved in some areas since the last inspection.
- The community nursing service could not measure its performance in relation to response times for unplanned care.
- The leadership, governance and culture did not always support the delivery of high quality person centred care.
- Staff satisfaction varied greatly across the service with some staff feeling devalued.

Mental health services

Our overall rating of mental health services stayed the same. We took into account the current ratings of services not inspected this time. We rated services as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement, and caring as good.
- We rated four of the 11 core services as good and seven as requires improvement.
- The quality and safety of the environment was poor in some of the areas we visited. The trust did not ensure repairs were completed in a timely manner. Wards had two and four bedded rooms which did not promote privacy and dignity. There were issues with medicines management. Patients were not always safeguarded when waiting for the appointments in clinics.
- Staff held high caseloads in community based mental health services for working age adults and a high number of appointments were cancelled. There were high numbers waiting for treatment in specialist community mental health services for children and young people.
- Data quality remained an issue which resulted in inaccurate reports and managers keeping local records to ensure correct monitoring. Staff were not always able to keep their electronic supervision records up to date and kept local records.

However:

- The trust had addressed the issues identified in the previous inspection in relation to the health based place of safety.
- The trust was using regular bank and agency nurses where possible to maintain continuity of care.
- Care planning had improved in crisis services.
- The trust had strengthened the monitoring of patients waiting to be seen in specialist community mental health services for children and young people

Summary of findings

Acute wards for adults of working age and psychiatric intensive care units

We rated services as requires improvement because:

- We rated safe, responsive and well led as requires improvement and effective and caring as good.
- There were issues with the environment at the Bradgate unit. The older wards had blind spots which had not been completely mitigated. Repairs were not carried out in a timely manner and we found two areas on one ward which had gathered dust and this had not been picked up by the cleaning staff.
- Vacancy rates were high with the highest being on Ashby ward at 50%.
- We found out of date medications in the clinic rooms on several wards. The processes for checking had not picked these up.
- Bed occupancy meant that patients returning from leave may not return to their original ward, meaning a lack of continuity of care.
- The older wards still had dormitories of two and four beds, which reduced the ability to maintain privacy and dignity for patients.
- Staff were not always recording their supervision on the electronic system.

However:

- The wards tried to book regular bank and agency staff so they knew the ward and patients, to provide continuity of care.
- Staff kept risk assessments up to date and carried out comprehensive assessments which were holistic and recovery focused.
- Staff were kind, compassionate and respectful towards patients.

Community-based mental health services for adults of working age

We rated services as requires improvement because:

- We rated safe, effective and responsive as requires improvement, and caring and well led as good.
- The vacancy rate was 12.9% for band 5 and 6 nurses. Staff held high caseloads and there were breaches of waiting times. This issue was on the risk register.
- In one of the waiting areas patients were able to access a room unsupervised which contained items which could cause harm.
- Staff did not review care plans regularly, we found 45% were not up to date. Staff did not always carry out physical health assessments, 52% did not have an assessment.

However:

- Staff treated patients with respect and maintained dignity.
- Staff felt supported by their managers and received regular supervision and annual appraisals.
- There was effective multidisciplinary working. Staff monitored those patients on the waiting list regarding risk levels.
- Staff had been given lone worker safety devices to ensure their safety.

Mental health crisis services and health-based places of safety

We rated services as requires improvement because:

Summary of findings

- We rated responsive and well led as requires improvement, and safe, effective and caring as good.
- Interview rooms were unsafe. They did not have alarms or vision panels in the door. They contained items which could pose a danger to staff and patients.
- Staffing levels were below the expected level. The vacancy rate for the service was 12.9% and for band 5 and 6 nurses was 18.9%.
- The quality of the data produced was poor and staff needed to correct the data when reports were produced.
- The service was not meeting its performance targets.

However:

- The trust had addressed the issues previously identified with the health based place of safety.
- Care plans were up to date and holistic.
- There was effective communication between the service and other healthcare professionals.
- Staff received regular managerial and group supervision.

Specialist community mental health services for children and young people

We rated services as requires improvement because:

- We rated responsive, effective and well led as requires improvement and safe and caring as good.
- There were still a high number on a waiting list for treatment. Data provided showed 945 patients on the waiting list for treatment, this included waiting for services outside of this core service such as family therapy, young people's team, primary mental health, eating disorders, home treatment, and learning disability services. The inspection that took place in November 2016, found 647 children waiting for a specific treatment within community out-patient teams following their initial access assessment and whilst this had reduced to 569 children, it was still a high number waiting. Some patients said the long waiting times had made them feel more anxious. Some patients, parents and carers felt there was poor communication between agencies, autism outreach, schools, and children and adolescent mental health services.
- We found issues with the environment. Not all sites where community child and adolescent mental health services were delivered were well designed, visibly clean, well maintained and met the needs of the patient. At Loughborough county team, there were no alarms fitted or personal alarms available; staff would call out if they needed assistance. At Valentine Centre county and Westcotes House city there were no alarms in treatment rooms although, staff held personal alarms. At Westcotes House the soundproofing between the corridors and interview rooms was poor. We could hear conversations between patients and staff. The environment was not visibly clean. The family therapy interview rooms did not have vision panels to keep patients safe.
- We found out of date equipment at the Valentine Centre in the video family therapy room. We found some issues at Valentine Centre and Westcotes House clinic rooms where the service did not have all the equipment to carry out physical health observations. The crisis service waiting area was shared with the adult learning disability community team. This was a safeguarding risk for children and young people waiting for their appointments.
- Record keeping was poor in some areas. Not all patients had a care plan and risk assessment. At Loughborough capacity and competence was not always recorded and managed well. Teams at a local level had not changed to the new systems. New care plan templates were set up but not consistently used. Care plans were not written in a holistic and personalised manner; and not focused on outcomes strengths, or age appropriate. Staff told us 924 care plans had been completed, we found 179 patients still did not have care plans in place.

Summary of findings

- Some staff had large caseloads of up to 40. Staff told us managers reviewed caseloads with staff during management supervision. Not all staff had manageable caseloads to be able to respond to patient needs.

However:

- The rating had improved from the November 2016 inadequate rating. Managers had introduced a specialist child and adolescent mental health traffic light system, a red, amber and green rating tool for managing risk. In addition to this, risk assessments were comprehensive and reviewed as per the trust policy, six monthly or after risk incidents. Staff reviewed young people's risk at every appointment and recorded this in the case notes. Managers had introduced a duty clinician to manage caseload sizes and reduce patients' risks. The service was meeting the target for initial assessment within 13 weeks of referral with a compliance of 99%. However, 323 were waiting for their first appointment through the access team, to complete a core mental health assessment. There were no children who had waited more than a year for treatment.
- The clinic rooms across sites had all the equipment calibrated. Therefore, staff could ensure accurate measures of blood pressure were being recorded. Across the teams, we found up to date ligature audits in place. At the Valentine Centre improvements had been made to the storage of cleaning materials.
- Since the last inspection the service now had a Section 136 suite that met the standards set out in the Royal College Standards. The 136 suite is a place of safety for those who have been detained under Section 136 of the Mental Health Act. A children's adolescent mental health crisis service had been developed and commenced in April 2017.
- We observed clinicians working with young people were skilled and very positive. There was regular and effective multidisciplinary working. Staff provided psychological therapies as recommended by NICE such as group work and cognitive behavioural therapy. Patients and carers were involved in assessment, treatment and care planning. There were clear treatment pathways.

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account, for example, the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Areas for improvement

We found areas for improvement including six breaches of legal requirements that the trust must put right. We found 23 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information see the Areas for improvement section later in this report.

Action we have taken

We issued six requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of six legal requirements at a trust wide level and in the five core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

Summary of findings

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Areas for improvement

Action the trust MUST take to improve:

Action a trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

We told the trust it must take action to bring services into line with six legal requirements. This action related to the five services.

Community health services

Community health services for adults

- The trust must improve its performance in collecting information about patient outcomes in order to assure itself of the quality of the services being delivered.
- The trust must ensure that staff are able to complete their workload within their working hours.

Mental health services

Acute wards for adults of a working age and psychiatric intensive care units

- The trust must ensure that staff record their supervision in line with trust policy.
- The trust must ensure the proper and safe management of medicines.
- The trust must ensure that blind spots are managed fully to enable staff to observe patients.
- The trust must ensure that wards are clean and that equipment and facilities are maintained in a timely way.

Community based mental health services for adults of working age

- The trust must ensure that there is sufficient staffing to meet the demands of the service and caseloads of individual staff members are managed safely.
- The trust must ensure the proper and safe management of medicines and medical equipment.
- The trust must ensure they mitigate against identified environmental risks to keep patients and staff safe.
- The trust must ensure that all patients have an up to date care plan, risk assessment and physical health assessment.
- The trust must ensure that patients subject to Mental Health Act community treatment orders have their rights explained to them at regular intervals and that this is documented.
- The trust must ensure work continues to reduce caseloads in community teams.

Mental health crisis services and health-based places of safety

- The trust must ensure interview rooms in the crisis team are safe and fit for purpose.

Summary of findings

- The trust must ensure systems support reliable recording of data in order to have oversight of key performance indicators and safeguarding referrals
- The trust must ensure teams are able to meet targets for referral to assessment and treatment within the crisis, mental health triage, and psychiatric liaison teams.

Specialist community mental health services for children and young people

- The trust must ensure care plans are personalised and holistic, and patients are involved in care planning.
- The trust must ensure that caseloads of individual staff are manageable.
- The trust must ensure sites where services for children and young people are delivered are safe, clean, and meet the needs of the patients.
- The trust must ensure work continues to reduce the number waiting for assessment and work to reduce those waiting for treatment within the service.

Action the trust SHOULD take to improve:

We told the trust it should take action either to comply with a minor breach that did not justify regulatory action, to avoid breaching a legal requirement in future or to improve services. These 23 actions related to the whole trust and the five core services.

Community health services

Community health services for adults

- The trust should promote the lone working policy and carry out audits to check if staff understand and are following the policy. This is required as part of regulation 12 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall in this service.
- The trust should ensure that all bank and agency staff have the appropriate skills to care for patients. This is required as part of regulation 18 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall at the service.
- The trust should review their policies for record keeping in the patient's home to ensure there is consistency across the patch. This is required as part of regulation 17 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall at the service.

The provider is not currently doing the following, that we have identified as an area for improvement but which does not link directly to a regulation.

- The trust should continue its work to ensure daily caseload levels for community nursing staff are manageable and staff are able to access clinical supervision and meetings relevant to their role.
- The trust should review the information captured on the community nurse daily reports to ensure it captures all planned, unplanned and cancelled visits. The trust should produce validated data on response times for unplanned care and share this information widely.
- The trust should review the use of the tough books and ensure they are being used consistently across the patch and that patient records are completed in a timely manner.
- The trust should ensure patients know the name of the community staff member who is responsible for their care.

Summary of findings

- The trust should review the waiting times at some clinics and identify ways to reduce lengthy waits to improve the patient experience.
- The trust should work towards improving perceptions between staff working in the city and staff working in the county. The trust should ensure managers engage with staff in the areas that have not been directly involved in the transformation programme.
- The trust should expedite the developments in the electronic record system in order that it can produce meaningful data on response times for unplanned care.

Mental health services

Acute wards for adults of a working age and psychiatric intensive care units

- The trust should ensure that wards are clean and maintenance issues are dealt with in a timely way. This is required as part of regulation 12 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall at the service.

The provider is not currently doing the following that we have identified as an area for improvement but which does not link directly to a regulation.

- The trust should ensure that patients have access to a bed on their admitting ward when returning from leave.
- The trust should consider working towards providing single rooms for patients and removing two and four bedded dormitories.
- The trust should consider how to follow best practice in the implementation of the smoke free policy.

Community based mental health services for adults of working age

These are required as part of regulations 9 and 17 but we considered that it would be disproportionate for one finding to result in a judgement of a breach of the regulation overall at the service.

- The trust should ensure that patients' views are included in care plans.
- The trust should ensure that the electronic patient record system is fit for purpose.
- The trust should review the level of required social work input across the teams.
- The trust should ensure that performance data provided to managers is accurate.
- The trust should review how patients and carers could be further engaged in service developments.

Mental health crisis services and health-based places of safety

- The trust should ensure that shifts are covered with the required numbers of appropriately trained and skilled staff. This is required as part of regulation 18 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall at the service.
- The trust should ensure all staff are in receipt of appraisals in line with their policy. This is required as part of regulation 18 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall at the service.

Specialist community mental health services for children and young people

- The trust should ensure that interview rooms are fitted with alarms and staff have access to personal alarms. This is required as part of regulation 12 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall at the service.

Summary of findings

- The trust should ensure patients' mental capacity assessments are recorded. This is required as part of regulation 17 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall at the service.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as requires improvement because:

- Whilst we acknowledge improvements had been made in terms of processes and structures. This assessment focused on well-led at trust level, and drew on our wider knowledge of quality in the trust at all levels. We rated well led as requires improvement for four of the five core services we inspected. Eight of the 15 core services are rated as requires improvement. The overall rating for specialist community mental health services for children and young people and for community health services for adults improved and eight of the 25 key questions, across the five core services we inspected had improved.
- We identified that improvements were required in relation to the environment in acute wards for adults of working age, community based services mental health services for working age adults, and in specialist community mental health services for children and young people. Whilst governance processes had identified some of the issues we found in relation to cleanliness, maintenance, medicines management, and record keeping, these had not been resolved.
- Waiting times remained high in community based services mental health services for working age adults, and in specialist community mental health services for children and young people.
- Staff across the trust were not always clear or fully informed of the trust's development plans. In order to address this, the trust had shared information via email, newsletters and bulletins. However, there were teams in which staff felt unsure of the trust's plans.
- Data quality remained an issue despite the ongoing work to cleanse data and improve systems. Some local managers kept their own records to ensure local monitoring was in place.
- There was limited reporting to board on physical healthcare provision within mental health services.

However:

- The trust had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services. They recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation.
- The board and senior leadership team had set a clear vision and values that were at the heart of all the work within the organisation. They worked hard to make sure staff at all levels understood them in relation to their daily roles.
- The trust strategy was directly linked to the vision and values of the trust. The trust involved clinicians, patients and groups from the local community in the development of the strategy and from this had a clear plan to provide high-quality care with financial stability.

Summary of findings

- Senior leaders made sure they visited all parts of the trust and fed back to the board to discuss challenges staff and the services faced. The executive team carried out boardwalks, visiting services to speak with patients and staff. The patient voice was heard at the beginning of every board meeting. Staff presented at every board meeting.
- The trust had a clear structure for overseeing performance, quality and risk, with board members represented across the divisions. This gave them greater oversight of issues facing the service and they responded when services needed more support. The board reviewed performance reports that included data about the services, which divisional leads could challenge. Work was in progress to cleanse data inaccuracies and reduce caseloads. The trust recognised the risks created by the introduction of new information technology and business systems in the services. This was identified as a significant risk to the efficiency of services, in the absence of sufficient capital funding. Early identification of this risk allowed the trust to prioritise funding to manage this potential future risk to ensure the systems are maintained and able to provide effective care to patients.
- The leadership team worked well with the clinical leads and encouraged divisions to share learning across the trust. Services were encouraged to develop innovative ways of filling vacant roles to address the nursing shortfall where appropriate. The trust was committed to continuously looking at how it could improve services through projects, research and audit.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. It had developed a more outward facing approach to learn from good performing trusts.
- Board members were sighted on the issues of high caseloads and staffing. The board was supportive of the planned measures to review caseloads, implement auto planning for daily visits in the community nursing services and the review of roles in teams.
- Board members had recognised that they had work to do to improve diversity and equality across the trust and at board level and implemented plans to address.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Jan 2018	Requires improvement →← Jan 2018	Good →← Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018
Mental health	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Good ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018
Overall trust	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Good ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ↑ Jan 2018	Requires improvement ➔➔ Jan 2018	Good ↑ Jan 2018
Community health services for children and young people	Good Nov 2016	Good Nov 2016	Outstanding Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Community health inpatient services	Requires improvement Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016
Community end of life care	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Overall*	Good ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ➔➔ Jan 2018	Good ↑ Jan 2018	Good ➔➔ Jan 2018	Requires improvement ↑ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016
Forensic inpatient or secure wards	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Child and adolescent mental health wards	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Wards for older people with mental health problems	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Wards for people with a learning disability or autism	Requires improvement Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016
Community-based mental health services for adults of working age	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Good ↑ Jan 2018	Requires improvement ➔➔ Jan 2018	Good ↑ Jan 2018	Requires improvement ➔➔ Jan 2018
Mental health crisis services and health-based places of safety	Requires improvement ➔➔ Jan 2018	Good ↑ Jan 2018	Good ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018
Specialist community mental health services for children and young people	Requires improvement ↑ Jan 2018	Requires improvement ➔➔ Jan 2018	Good ➔➔ Jan 2018	Requires improvement ↑ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ↑ Jan 2018
Community-based mental health services for older people	Requires improvement Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016
Community mental health services for people with a learning disability or autism	Good Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016
Overall	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Good ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Community health services

Background to community health services

The trust was created in 2002 to provide mental health, learning disability and substance misuse services. In April 2011 the trust merged with Leicester City and Leicestershire County and Rutland Community Health Services as a result of the national transforming community services agenda. This has enabled joined up mental health and physical health care pathways to advance health and wellbeing for the people and communities of Leicester, Leicestershire and Rutland.

The trust provides the following community health services:

- Community health services inpatient services
- Community health services for adults
- Community health services for children and young people
- Community health services for end of life care

We inspected community health services for adults in October 2017.

Summary of community health services

Requires improvement

Our rating of these services stayed the same. We took into account the current ratings of services not inspected this time. We rated them as requires improvement because:

- We rated safe, caring and responsive as good and effective and well led as requires improvement.
- We rated three of the core services as good and one as requires improvement.

Community health services for adults

Good ↑

Key facts and figures

Leicester Partnership Trust (LPT) provides community health services to over one million people across Leicester City, Leicestershire and Rutland. Just under one third live in Leicester City and approximately four percent live in Rutland.

The community health services for adults, is part of the community health services directorate and provides community nursing services, including specialist respiratory and heart failure nurses, community therapy services including rehabilitation and a falls prevention service. These are provided by teams of occupational therapy and physiotherapists, a county wide podiatry service and speech and language therapy are also available.

Referrals to the service are mainly made through the single point of access, a small contact centre were calls are assessed by a team of specially trained staff.

The majority of patients cared for by community health services for adults are over 65 years of age. Services provide care and support to help patients stay well and prevent future problems, support them to live at home and provide treatment when they are ill to help them recover.

Community health services for adults are delivered from a wide range of locations including trust premises and third party locations delivering services to local communities. In Rutland, health services are delivered in partnership with the local authority where an integrated model of health and social care is being delivered.

Community nursing teams are located throughout the city and county areas with the three main areas being the city, the east and the west. Each area has planned visit teams which provide scheduled care and unscheduled care. The intensive community support teams provide care in 256 virtual beds across the whole LPT area. This team provides up to 10 days (in principal) of intensive community nursing care and rehabilitation often for patients discharged from hospital who are not yet fully independent.

In conjunction with these teams is a Leicester, Leicestershire and Rutland night service unit, this is centrally coordinated from a city location.

Primary care coordinators employed by the trust are located in local trust hospitals to identify, assess and where appropriate facilitate the timely discharge of patients back into their own home with community support or to a local community hospital.

This service had been previously inspected as part of a comprehensive inspection in November 2016, when we rated the community health service for adults as requires improvement. This inspection was part of a wider trust follow up inspection.

As part of the inspection we visited locations where community nursing teams were based including health centres and community hospitals. We accompanied nurses on visits to patient homes and observed patients attending clinics. We spoke with 13 patients, six relatives and 57 members of staff. We reviewed 10 sets of patient records and listened to four calls made to the single point of access centre.

Summary of this service

Our rating of this service improved. We rated it as good because:

- We rated safe, effective, caring and responsive as good and well led as requires improvement

Community health services for adults

- Patients were protected from avoidable harm and abuse, systems were in place to investigate incidents and concerns and staff received suitable training in safety systems. Risk assessments were completed and care plans implemented to keep patients safe and promote wellbeing. The service had plans in place to manage service disruption and major incidents.
- The service used evidence based, best practice guidance throughout its policies and procedures and ways of working. Clinical audit was taking place and learning was shared across the service. Staff were suitably trained with the relevant knowledge and skills to carry out their work, had regular appraisals and had access to the information they needed to perform their duties. Multidisciplinary team work both internal and external to the service was effective and patients were supported to make informed decisions about their care.
- Patients were supported, treated with dignity and respect and involved as partners in their care. They told us that staff were kind and caring.
- Services and care were planned with the local population in mind and to address the individual needs of patients. Facilities had been adapted to improve access and systems were in place to support the most vulnerable. Patients knew how to make a complaint or raise a concern and complaints were taken seriously.
- A new leadership structure had been introduced since the last inspection and had not yet fully embedded in the service. Leaders were motivated and developing their skills to address the current challenges to the service. Staff support systems were in place and there was a drive to engage with staff. Governance structures were in place and risks registers were reviewed regularly.

However:

- The service still had challenges in recruiting sufficient staff which meant that the service, in particular community nursing, was understaffed at times impacting on staff satisfaction and compromising patient care.
- Staff did not always have time to attend clinical supervision sessions and patient information systems were inconsistently utilised and did not always enable effective working.
- Patient outcomes were not routinely collected so the quality of the clinical care being delivered could not be measured or benchmarked.
- There were long waiting times from initial referral to being seen in some clinics and services although these had improved in some areas since the last inspection.
- The community nursing service could not measure its performance in relation to response times for unplanned care.
- The leadership, governance and culture did not always support the delivery of high quality person centred care.
- Staff satisfaction varied greatly across the service with some staff feeling devalued.

Is the service safe?

Good  

Our rating of safe stayed the same. We rated it as good because:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Incidents were thoroughly investigated and lessons were learnt and communicated widely to support improvement.

- Staff had received up to date training on all safety systems. Sufficient priority was given to safeguarding vulnerable adults and children and there was active engagement in local safeguarding procedures and work with other relevant organisations.
- Risks to patients who used services were assessed monitored and managed on a day to day basis including signs of deteriorating health and medical emergencies. Risk assessments were person centred, proportionate and reviewed regularly.
- Plans were in place to respond to emergencies and major incidents. Anticipated changes in demand and disruption were assessed, planned for and managed effectively.

However:

- There were periods of understaffing or inappropriate skill mix which had not been addressed particularly in community nursing services and more noticeably in the city teams.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Patients' care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. Patients had comprehensive assessments of their needs.
- There was participation in local audits, results were shared with staff and the information was used to improve care and treatment.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Staff were supported to maintain and further develop their skills and experience.
- Staff were supported through regular appraisals. Processes were in place for managing staff when their performance was poor or variable.
- Patient care was coordinated across different staff, teams and services. Staff worked collaboratively to understand and meet the range and complexity of patients' needs. Patients were discharged at an appropriate time and when all necessary care arrangement were in place
- Staff could access the information they needed to assess, plan and deliver care to patients in a timely way.
- Patients were supported to make decisions and where appropriate their mental capacity was assessed and recorded. The process of seeking consent from patients was understood by staff.

However:

- The outcomes of patients' care and treatment were not always monitored regularly or robustly. Participation in external audits and benchmarking was limited.
- There were gaps for management and support of clinical supervision. Rates of attendance at clinical supervision sessions were generally poor.
- Systems to manage and share care records and information were cumbersome and uncoordinated. Patients did not always have a copy of the information that was shared about them.

Community health services for adults

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Feedback from patients who use the service and those that are close to them was positive about the way staff treated patients.
- Patients understood their care, treatment and condition. Patients and staff worked together to plan care and there was shared decision making about care and treatment.
- Staff responded compassionately when patients needed help and support. Patients' privacy and confidentiality was respected at all times.
- Staff helped patients and those close to them to cope emotionally with their care and treatment. Patients were enabled to manage their own health and care when they could to maintain independence.

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good because:

- Services were planned and delivered in a way that met the needs of the local population. Care and treatment was coordinated with other services and other providers.
- Facilities and premises were appropriate for the services being delivered and reasonable adjustments were made when patients found it hard to access services.
- Access to care was managed to take account of patients' needs including those with urgent needs.
- It was easy for patients to complain or raise a concern. Complaints and concerns were always taken seriously. Improvements were made to the quality of care as a result of complaints and concerns.

However:

- Some patients were not able to access services for assessment, diagnosis or treatment when they needed to. In some services there were long waiting times, delays or cancellations. Action to address this was not effective.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The service did not have robust processes in place to measure patient outcomes so could not assure itself of the quality of care being delivered
- Staff satisfaction was mixed. Staff did not always feel actively engaged or empowered. There were teams working in silos, management and clinicians did not always work cohesively.

- Information to drive service improvement was not robust.

However:

- There was a clear statement of vision and values in place.
- Governance meetings were taking place at team and hub levels and interacted with each other appropriately. Quality received sufficient coverage in meetings.
- The leadership team were knowledgeable about quality issues and priorities, understood what the challenges were and took some action to address them.

There was a positive culture of candour, openness and honesty.

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

Mental health services

Background to mental health services

The trust was created in 2002 to provide mental health, learning disability and substance misuse services. In April 2011 the trust merged with Leicester City and Leicestershire County and Rutland Community Health Services as a result of the national transforming community services agenda. This has enabled joined up mental health and physical health care pathways to advance health and wellbeing for the people and communities of Leicester, Leicestershire and Rutland.

The trust delivers the following mental health services:

- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- Community mental health services for people with learning disabilities or autism
- Community-based mental health services for adults of working age
- Community-based mental health services for older people
- Forensic inpatient/secure wards
- Long stay/rehabilitation mental health wards for working age adults
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Wards for older people with mental health problems
- Wards for people with learning disabilities or autism

We inspected the following core services in October 2017:

- Acute wards for adults of working age and psychiatric intensive care units
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people.

Summary of mental health services

Requires improvement  

Our rating of these services stayed the same. We took into account the current ratings of services not inspected this time. We rated them as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement and caring as good.

Summary of findings

- We rated four of the 11 core services as good and seven as requires improvement.

Community-based mental health services for adults of working age

Requires improvement 

Key facts and figures

The community based mental health services for adults of working age provide services to patients across the county of Leicestershire. The teams consist of consultant psychiatrists, mental health nurses, psychologists and occupational therapists, providing a range of treatments and support to adults aged 16 to 65. The psychosis intervention and recovery service provides services to patient's aged14 to 65.

Services are provided to patients who have experienced mental health issues and referrals are made by their GP or other mental health professional involved in their care. Qualified staff conduct an assessment to establish the level of need and determine the most appropriate treatment or intervention. Healthcare professionals see patients at outpatient clinics, team bases or in their own home.

The psychosis intervention and recovery service supports people aged 14 to 65 years who have experienced a first episode of psychosis. Staff work with individuals to aid recovery, and to minimise the chance of potential future relapse. Staff also provide support to families.

Patients benefit from a range of individual and group work depending upon their needs. Individuals have a named worker who coordinates their care.

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

We inspected the following locations and looked at all five key questions:

- Assertive outreach team
- City Central community mental health team
- City East community mental health team
- City West community mental health team
- Charnwood community mental health team.

The Care Quality Commission completed a whole trust comprehensive inspection in November 2016. Community-based mental health services for adults of working age received an overall rating of 'requires improvement '. The trust had not ensured the proper and safe management of medicines. The trust was required to make improvements including ensuring access to patient records for all staff, ensuring sufficient staffing to meet the demands of the service, ensuring staff are adequately supervised, appraised and trained and ensuring the privacy and dignity of patients is protected. Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. Before the inspection visit we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- visited five of the teams, looked at the quality of the and observed how staff were caring for patients
- spoke with 19 patients who were using the service
- spoke with one carer of patients who were using the service

Community-based mental health services for adults of working age

- spoke with seven managers including team managers, service managers and head of service
- interviewed 34 staff including nurses, occupational therapists, psychiatrists, psychologists, pharmacists, health care support workers, administration managers and medical secretaries.
- reviewed 36 care records of patients
- reviewed 15 patient medication charts
- attended and observed 13 meetings and activities including outpatient reviews, home visits and multi-disciplinary meetings
- carried out a specific check of the medication management in all teams
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- We rated safe, effective and responsive as requires improvement, and caring and well led as good.
- The vacancy rate was 12.9% for band 5 and 6 nurses. Staff held high caseloads and there were breaches of waiting times. This issue was on the risk register.
- In one of the waiting areas patients were able to access a room unsupervised which contained items which could cause harm.
- Staff did not review care plans regularly, we found 45% were not up to date. Staff did not always carry out physical health assessments, 52% did not have an assessment.

However:

- Staff treated patients with respect and maintained dignity.
- Staff felt supported by their managers and received regular supervision and annual appraisals.
- There was effective multidisciplinary working. Staff monitored those patients on the waiting list regarding risk levels.
- Staff had been given lone worker safety devices to ensure their safety.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The vacancy rate was 12.9% for band 5 and 6 nurses. Staff held high caseloads and there were breaches of waiting times. This issue was on the risk register. Managers and staff told us caseloads were high. Nursing staff in the community mental health teams reported caseloads of between 40 and 60 patients. Consultants reported high caseloads; one consultant had a caseload of 600 patients.

Community-based mental health services for adults of working age

- At city central, staff had assessed the waiting area as medium risk. Despite this, inspection team members observed a patient sitting for 20 minutes in the waiting area without staff supervision. There was a blind spot and an unlocked room filled with items that could potentially cause harm, for example parasols, a water dispenser, plugs, cables and small tables.

However:

- Staff monitored waiting lists and responded to increases in risk levels. The trust had introduced a patient tracker tool to support managers to monitor waiting lists. Staff met weekly or fortnightly to review the patient tracker list and took appropriate action, such as bringing forward an assessment to respond to changing levels of risk.
- The service had introduced a new lone worker safety device for staff. This device was discreet and enabled staff to summon help quickly if needed.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- We reviewed 36 care records during the inspection. Staff had not completed and regularly reviewed care plans for 45% of patient records checked.
- Staff had not completed physical health assessments for 52% of patient records reviewed.
- Teams no longer had dedicated social worker roles. Social worker input was provided by the relevant local authority.
- Staff reported that this had been challenging, had increased caseloads and resulted in a lack of joint working."
- Staff used an electronic records system for the majority of records. Staff told us that the system was not always accessible. Staff spoken with reported that a feature of the system, whereby records written off line would automatically upload, did not work.
- We did not find any evidence in records checked that staff had explained rights to patients subject to community treatment orders.

However:

- Managers provided staff with regular supervisions and appraisals. Psychologists provided weekly group supervisions to some teams.
- The teams held weekly multi-disciplinary meetings. All members of the multi-disciplinary team attended these. We observed a multi-disciplinary meeting. Team members discussed patients in detail and participants were encouraged to share their clinical view.

Is the service caring?

Good 

Our rating of caring improved. We rated it as good because:

- We observed staff treating patients with dignity and respect. Staff were empathic, kind, non-judgemental and supportive.

Community-based mental health services for adults of working age

- Patients told us that staff involved their families and carers with their permission. We observed staff involving carers during home visits.
- We observed staff using paraphrasing and reflection to ensure patients understood their care and treatment.
- Of 11 patients asked 82% were aware of how to access advocacy.

However:

- The involvement of patients in care planning and risk assessment was variable across the service. Of 13 patients asked, 85% said they were involved in their care and 54% said staff had offered them a copy of their care plan. In care records reviewed, 50% included patients' views.
- Patients and staff told us that there were no opportunities for patients to be involved in decision about the service, for example, recruitment of staff.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Consultants told us that scheduled appointments had to be cancelled. At city central, 705 outpatients' appointments had to be rescheduled. The trust had identified this on the risk register. The trust reported 2891 breaches of waiting times from October 2016 to September 2017. Psychiatric outpatients were responsible for 2094 of the breaches, with city east reporting the highest of these breaches at 429. Charnwood reported that a patient referred in April 2017 would not get an appointment until February 2018. City central reported that a patient referred in July 2017 would not get an appointment until February 2018.

However:

- Except for outpatient appointments, staff rarely cancelled patient appointments and if they did, they would explain and apologise to the patient and re schedule for as soon as possible.
- Team managers used a patient tracking tool to monitor patients on the waiting list. The multidisciplinary team reviewed this every two weeks.
- Staff in the assertive outreach team applied to a charity for funds to provide activities for patients based upon their needs.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good because:

- Team managers we met with demonstrated that they had the skills, knowledge and experience to perform in their roles. They had a good understanding of their service and many of them had worked as nurses in their teams before promotion to their current role. Team managers were visible in their services and staff told us that they were approachable.
- Staff spoken with told us they felt respected and supported by their team managers and were proud to work for their teams. There was some impact on staff morale due to high caseloads.

Community-based mental health services for adults of working age

- All staff asked told us they felt able to raise concerns without fear of retribution and knew about the whistle blowing process.
- Senior managers were implementing plans to reduce caseloads.
- The trust recognised staff success and contribution through awards schemes. We saw one staff award displayed in the reception area. Another staff member told us about a long service award they had received.

However:

- Managers and staff told us that a recent productivity exercise had resulted in a reduction of staffing levels which had left the service struggling. The impact was higher caseloads. Staff told us they were struggling to keep patient records up to date, but that they prioritised direct contact with patients. Staff in the team were not aware of the trust's plans to address this.
- Staff told us that the electronic system used for patient records was not always accessible and would crash, meaning staff could not update records. Across the teams, there was work on going to provide staff with the technology they needed to work more flexibly. For staff that did not have this technology, the systems did not work well.
- Team managers showed us monthly performance reports they received from the trust. Managers told us that the data was often incorrect and they would then have to spend time finding the correct information and feeding this back to the trust.

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

Specialist community mental health services for children and young people

Requires improvement 

Key facts and figures

The child and adolescent mental health teams are provided by Leicestershire Partnership NHS Trust are part of the Families Young People and Children's division. The service is made up of a number of services. The three teams we inspected are set in Leicester City and Leicestershire.

We visited:

- Valentine Centre-county community adolescent mental health team
- Loughborough Hospital - county community adolescent mental health team
- Westcotes House - city community adolescent mental health team.
- Child and adolescent mental health crisis service
- 136 suite

The trust is registered for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The Care Quality Commission completed a whole trust comprehensive inspection in November 2016. The specialist community mental health services for children and young people received an overall rating of 'Inadequate.' There were requirement notices in relation to Regulations 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The trust had addressed storage of cleaning materials and maintenance of equipment. The trust was required to make improvements to ensure that treatments were delivered in a timely manner and care plans were in place or updated whilst patients were waiting for treatment. These two items remained unmet. At the last inspection we rated four key questions were either inadequate or requires improvement so we re- inspected all five questions.

Our inspection was announced (so staff knew were coming) to ensure that everyone we needed to talk to was available. Before the inspection visit, we reviewed the information that was held about these services and information requested from the trust. We inspected the service looking at all five key questions.

The inspection teams visited these services on the 10 and 11 October 2017. During the inspection, the team:

- visited three child and adolescent mental health service teams. We looked at the quality of the care environment, and observed how staff cared for patients
- spoke with eight patients who were using the service
- spoke with 15 parent carers of patients who were using the service
- spoke with the team managers for each of the services
- spoke with three members of the recovery and improvement team and the head of service

Specialist community mental health services for children and young people

- interviewed 22 staff including, nurses, occupational therapists, psychiatrists, psychologists, assistant psychologists and psychotherapist
- reviewed 17 care records of patients
- attended and observed one multidisciplinary meeting and seven patient activities
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of these services improved. We rated services as requires improvement because:

- We rated responsive, effective and well led as requires improvement and safe and caring as good.
- There were still a high number on a waiting list for treatment. Data provided showed 945 patients on the waiting list for treatment, this included waiting for services outside of this core service such as family therapy, young people's team, primary mental health, eating disorders, home treatment, and learning disability services. The inspection that took place in November 2016, found 647 children waiting for a specific treatment within community out-patient teams following their initial access assessment and whilst this had reduced to 569 children, it was still a high number waiting. Some patients said the long waiting times had made them feel more anxious. Some patients, parents and carers felt there was poor communication between agencies, autism outreach, schools, and children and adolescent mental health services.
- We found issues with the environment. Not all sites where community child and adolescent mental health services were delivered were well designed, visibly clean, well maintained and met the needs of the patient. At Loughborough county team, there were no alarms fitted or personal alarms available; staff would call out if they needed assistance. At Valentine Centre county and Westcotes House city there were no alarms in treatment rooms although, staff held personal alarms. At Westcotes House the soundproofing between the corridors and interview rooms was poor. We could hear conversations between patients and staff. The environment was not visibly clean. The family therapy interview rooms did not have vision panels to keep patients safe.
- We found out of date equipment at the Valentine Centre in the video family therapy room. We found some issues at Valentine Centre and Westcotes House clinic rooms where the service did not have all the equipment to carry out physical health observations. The crisis service waiting area was shared with the adult learning disability community team. This was a safeguarding risk for children and young people waiting for their appointments.
- Record keeping was poor in some areas. Not all patients had a care plan and risk assessment. At Loughborough capacity and competence was not always recorded and managed well. Teams at a local level had not changed to the new systems. New care plan templates were set up but not consistently used. Care plans were not written in a holistic and personalised manner; and not focused on outcomes strengths, or age appropriate. Staff told us 924 care plans had been completed, we found 179 patients still did not have care plans in place.
- Some staff had large caseloads of up to 40. Staff told us managers reviewed caseloads with staff during management supervision. Not all staff had manageable caseloads to be able to respond to patient needs.

However:

- The rating had improved from the November 2016 inadequate rating. Managers had introduced a specialist child and adolescent mental health traffic light system, a red, amber and green rating tool for managing risk. In addition to this, risk assessments were comprehensive and reviewed as per the trust policy, six monthly or after risk incidents. Staff

reviewed young people's risk at every appointment and recorded this in the case notes. Managers had introduced a duty clinician to manage caseload sizes and reduce patients' risks. The service was meeting the target for initial assessment within 13 weeks of referral with a compliance of 99%. However, 323 were waiting for their first appointment through the access team, to complete a core mental health assessment. There were no children who had waited more than a year for treatment.

- The clinic rooms across sites had all the equipment calibrated. Therefore, staff could ensure accurate measures of blood pressure were being recorded. Across the teams, we found up to date ligature audits in place. At the Valentine Centre improvements had been made to the storage of cleaning materials.
- Since the last inspection the service now had a Section 136 suite that met the standards set out in the Royal College Standards. The 136 suite is a place of safety for those who have been detained under Section 136 of the Mental Health Act. A children's adolescent mental health crisis service had been developed and commenced in April 2017.
- We observed clinicians working with young people were skilled and very positive. There was regular and effective multidisciplinary working. Staff provided psychological therapies as recommended by NICE such as group work and cognitive behavioural therapy. Patients and carers were involved in assessment, treatment and care planning. There were clear treatment pathways.

Is the service safe?

Requires improvement 

Our rating of safe improved. We rated it as requires improvement because:

- Managers provided up to date information, which showed 1180 patient risk assessments had been completed with 46 patients without risk assessments. Some staff had large caseloads of up to 40. Staff told us managers reviewed caseloads with staff during management supervision.
- One staff team did not have access to alarms in interview rooms or personal alarms available to them; staff would call out if they needed assistance. Two teams had personal alarms.
- General maintenance of two of the buildings was poor. The environment was not visibly clean; rooms were smelly, carpets, woodwork and paint work was marked and grubby. Not all electrical equipment items had an up to date safety test. In another building the soundproofing between the corridors and interview rooms was poor. During the inspection we could hear conversation between staff and patients in communal areas. The family therapy interview rooms did not have vision panels to keep patients safe.
- We found two clinic rooms that did not have equipment for staff to carry out physical health observations.
- Managers did not discuss or record learning from incidents in minutes of the team meetings we reviewed.
- The crisis service waiting area was shared with the adult learning disability community team. This was a safeguarding risk for children and young people waiting for their appointments.

However:

- Managers had introduced a specialist child and adolescent mental health traffic light system, red, amber and green rating tool for managing risk. In addition to this, risk assessments were comprehensive and reviewed as per the trust policy, six monthly or after risk incidents. Staff reviewed young people's risk at every appointment in recorded this in the case notes.
- Managers had introduced a duty clinician to manage caseload sizes and reduce patient's risks.

Specialist community mental health services for children and young people

- Since the last inspection the service now had a 136 suite that met the standards set out in the Royal College Standards. The 136 suite is a place of safety for those who have been detained under Section 136 of the Mental Health Act. A children's adolescent mental health crisis service had been developed and commenced in April 2017.
- Across the teams, we found up to date ligature audits in place.
- Staff ensured that they stored cleaning materials safely and in line with guidance.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated is as requires improvement because:

- Staff had completed 924 care plans, although 179 patients still did not have care plans in place. Managers had devised a new care plan templates but staff were not consistently using it. Care plans were generally up to date but not written in a holistic and personalised manner; and not focused on outcomes strengths, or age appropriate.
- Staff had not recorded mental capacity assessments for patients in one out of the three services.

However:

- We observed clinicians working with young people were skilled and very positive.
- The service had started a pilot scheme initiative for Neurodevelopment team developing new pathways.
- There was regular and effective multidisciplinary working.
- The service had ensured all staff were trained in the Mental Health Act.
- Staff were supervised and appraised and had access to regular meetings.
- Staff provided psychological therapies as recommended by the national institute for health and care excellence, such as group work and cognitive behavioural therapy.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with respect and kindness. We observed two core assessments. Staff spoke in a balanced and focused way, brought humour, and had a child centred approach.
- Patients and carers spoke positively about staff knowledge, and skills of staff and their trustworthiness.
- We observed consistently positive and caring interactions between staff and patients.
- Parents and carers reported that the staff were professional, kept their boundaries and provided treatment and advice.

However:

- Some patients said the long waiting times had made them feel more anxious.

Specialist community mental health services for children and young people

- Some patients, parents and carers felt there was poor communications between agencies, autism outreach, schools, and children and adolescent mental health services.

Is the service responsive?

Requires improvement 

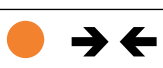
Our rating of responsive improved. We rated it as requires improvement because:

- The service had taken steps to reduce long waiting lists but at the time of the inspection there were 569 patients waiting to access specific specialist treatment. The longest wait was between 181-365 days for 89 patients. We found that those patients could be on the waiting list for more than one treatment due to the patients' co morbidity. (When two disorders or illnesses occur in the same person, simultaneously or sequentially, they are described as comorbid). In addition, 323 patients were waiting for their initial assessment through the access team, to complete a core mental health assessment
- Some patients, parents and carers told us their concerns were around long waiting times, and lack of communications between community adolescent mental health services and schools.
- The lift was not working in one service patients, families and carers only had access to the ground floor if they had mobility issues. Some of the buildings did not have child friendly décor and we found that the equipment used to enhance the patients' treatment were unclean and broken.

However:

- The service encouraged patients and parents /carers to complain and receive feedback. Staff knew how to handle complaints appropriately.
- The service was meeting the target for initial assessment within 13 weeks of referral with a compliance of 99%. There were no patients who had waited more than a year for treatment.
- Staff had responded to a specific need quickly. One patient told us they lived in a remote area and had requested a prescription but had difficulties travelling; the prescription had been sent to their local pharmacy. The service had ensured the patient received prompt care according to their individual need.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The service had made some improvements and set up a recovery and improvement team. Waiting lists monitoring took place and arrangements were in place to manage unmet need and risks. However, there were still long waiting lists.
- Record keeping was poor in some areas. Not all patients had a care plan and risk assessment. Staff did not always record capacity assessments.
- Not all staff had manageable caseloads or able to respond to patient needs.
- Not all sites where community child and adolescent mental health services were delivered were well designed, visible clean, and met the needs of the patient.

Specialist community mental health services for children and young people

- Senior managers had clear vision on how to improve the service that had been shared with teams. However, teams at a local level had not changed to the new systems.

However:

- Patients and carers were involved in assessment, treatment and care planning. There were clear treatment pathways.
- This core service was learning from other trusts. Managers had established links with other community child and adolescent services and shared learning.
- Staff were supervised and appraised and had access to regular meetings
- Staff morale had improved. Most staff had enthusiasm to make the changes needed.
- Staff had been trained in the Mental Health Act and Mental Capacity Act.
- As part of the recovery, improvement and transformation phase, staff were working towards a new model of care for this core service. The THRIVE framework had been identified as a way to meet the vision of improvements to children and young people's mental health services. Events and seminars were planned from December 2017.

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement 

Key facts and figures

The acute wards for adults of working age and the psychiatric intensive care unit (PICU) provided by Leicestershire Partnership NHS Trust are part of the trust's acute division. The wards are situated at the Bradgate Mental Health Unit in Glenfield, Leicestershire.

The Bradgate Mental Health Unit has seven acute wards for adults of working age, these are;

- Beaumont, 22 bedded male ward
- Watermead, 20 bedded male ward
- Bosworth, 20 bedded male ward
- Thornton, 24 bedded male ward
- Ashby ward, 21 bedded female ward
- Heather, 18 bedded female ward
- Aston, 23 bedded female ward

The psychiatric intensive care unit, Belvoir ward, is also located at the Bradgate Mental Health Unit and has 10 beds. The trust admits patients to the psychiatric intensive care unit if their needs cannot be safely met within the acute environment. Belvoir ward accepts only male patients. The trust currently has no intensive care facilities for females; however a female intensive care unit is due to open in November 2017.

All wards accept patients detained under the Mental Health Act 1983 (MHA).

The trust is registered for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The Care Quality Commission completed a whole trust comprehensive inspection in November 2016. The acute wards for adults of working age and the psychiatric intensive care unit (PICU) received an overall rating of 'requires improvement '. The trust had not ensured all clinical areas were safe for patient use. The trust was required to make improvements to make the clinical environments safer, including reducing ligatures; ensuring patient alarms are in working order, improving lines of sight and ensuring the safety and dignity of patients. The trust was also required to ensure that wards are appropriately staffed and that staff are adequately trained, receive regular supervision and are up to date with mandatory training.

At the last inspection we rated three or more key questions either inadequate or requires improvement so we re-inspected all five key questions.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. Before the inspection visit we reviewed information that we held about these services and information requested from the trust.

Acute wards for adults of working age and psychiatric intensive care units

The inspection team visited all seven acute wards and the psychiatric intensive care ward on 10 and 11 October 2017. During the visit the inspection team:

- spoke with 31 patients who were using the service
- spoke with 28 staff and eight managers or acting managers for each of the wards
- spoke with four senior managers
- observed one handover and two multidisciplinary meetings
- reviewed 34 patient records relating to physical health, risk assessments and care plans
- reviewed 25 medication charts.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- We rated safe, responsive and well led as requires improvement and effective and caring as good.
- There were issues with the environment at the Bradgate unit. The older wards had blind spots which had not been completely mitigated. Repairs were not carried out in a timely manner and we found two areas on one ward which had gathered dust and this had not been picked up by the cleaning staff.
- Vacancy rates were high with the highest being on Ashby ward at 50%.
- We found out of date medications in the clinic rooms on several wards. The processes for checking had not picked these up.
- Bed occupancy meant that patients returning from leave may not return to their original ward, meaning a lack of continuity of care.
- The older wards still had dormitories of two and four beds, which reduced the ability to maintain privacy and dignity for patients.
- Staff were not always recording their supervision on the electronic system.

However:

- The wards tried to book regular bank and agency staff so they knew the ward and patients, to provide continuity of care.
- Staff kept risk assessments up to date and carried out comprehensive assessments which were holistic and recovery focused.
- Staff were kind, compassionate and respectful towards patients.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

Acute wards for adults of working age and psychiatric intensive care units

- Ward areas were visibly clean except on Ashby ward where we found dust and dirt in the clinic room and on the floor near the ward kitchen door. A shower had been out of order for four weeks, staff had reported this to the maintenance department, and however at the time of inspection it had not been repaired. This meant there was only one shower and one bathroom for 20 patients. The cold water fountain on Aston ward had been out of order for four weeks. This had also been reported to the maintenance department and had not been repaired at the time of the inspection.
- Staff vacancy rates were variable across the service. The overall vacancy rate was 23.4%. Ashby ward reported the highest qualified nurse vacancy rate at 50% and Aston ward the lowest with no vacancies.
- Staff did not adhere to best practice in implementing the smoke free policy on all wards. We saw evidence that patients were smoking in the garden area on Thornton and Watermead wards.
- Staff did not follow good practice in medicines management. We found out of date medication on Watermead and Thornton wards and out of date urinalysis testing equipment on Thornton and Belvoir wards. Staff said they had reported one out of date controlled medication to the pharmacy department in September; however, at the time of the inspection the medication had not been removed.

However:

- Staffing levels allowed for patients to have regular one to one time with their named nurse, patients we spoke with said that one to one time, activities or escorted leave was rarely cancelled but sometimes was rearranged due to staffing issues.
- We reviewed 34 care records. Each patient had an individualised risk assessment which was completed on admission and updated on a regular basis.
- Staff were aware of, and demonstrated the Duty of candour placed on them to inform patients who use the services of any incident affecting them. Staff discussed incidents and learning points in team meetings. We saw minutes of these meetings where staff had discussed changes that needed to be made to prevent incidents.

Is the service effective?

Good 

Our rating of effective improved. We rated it as good because:

- Staff completed comprehensive mental health assessments for patients on admission. We looked at 34 care plans, they were up to date, personalised, holistic, recovery orientated and included physical health checks.
- Staff said they were given opportunities to develop their skills and knowledge by attending both internal and external training, for example personality disorder and leadership training.
- The trust had processes for identifying and managing poor staff performance, including involvement from occupational health and the human resources (HR) departments. Managers said they had good support to manage poor staff performance.
- Staff completed MHA paperwork correctly. There was administrative support to ensure paperwork was up to date and regular audits took place. Staff scanned MHA paperwork onto the electronic record for staff reference.
- Occupational therapists and therapeutic liaison workers worked as part of the ward team and we saw that they worked closely with patients. The patient's we talked with spoke positively about the support they received.

However:

Acute wards for adults of working age and psychiatric intensive care units

- Between 31 July 2016 and 30 June 2017 the average supervision rate across all eight teams in this core service was 42% against the trust's target of 85%.
- The service had one psychologist in post. Patients were referred for interventions, but staff said there was a waiting list of about four weeks for assessment. On all wards, staff (doctors and nurses) told us there was a limited amount of psychology input. No evidence was recorded as to how care was being provided in line with relevant NICE (National Institute for Health and Care Excellence) guidance, particularly relating to the provision of psychological therapies for patients. However, we were informed that four psychologists had been appointed and three were due to commence work in October 2017.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with kindness, compassion and respect. We observed interactions between staff and patients during the inspection and saw that staff were responsive to patient's needs, discreet and respectful. Staff treated patients with dignity and remained interested when engaging patients in meaningful activities. Staff interacted with patients in a timely way and at a level that was appropriate to individual needs.
- We spoke with 31 patients who told us that staff were generally kind and caring. Three patients said that staff helped them to access services to find accommodation in the community.
- Patients had access to advocacy services on the wards and information and contact details were contained in patient admission packs and on posters and leaflets available on the wards. Wards had information boards detailing the staff on duty and staffing levels. This informed patients of the staff available for care and treatment for that day.
- We spoke with nursing staff who described how they took patient's personal, cultural, social and religious needs into account when care planning.

Is the service responsive?

Requires improvement 

Our rating of responsive improved. We rated it as requires improvement because:

- Staff reported that when patients went on leave their beds were regularly used for patients needing admission to hospital. This meant that patients returning from leave would not have access to their bed and would be nursed on a different ward which led to inconsistency of care.
- Staff told us that three rooms intended as single bedrooms on Thornton ward were used as two bedded rooms, we looked at these rooms which were cramped and patients had very little access to private space.
- On Ashby, Bosworth and Thornton wards, we found inadequate numbers of rooms for care and treatment of patients. Wards did not have sufficient rooms for patients to access 1-1 time with nursing staff, to receive visitors or to participate in ward based activities. Patients had difficulty having confidential and private conversations with staff and visitors.
- The trust provided a choice of food to meet differing dietary needs and choices. However, patients told us that halal options were limited.

However:

- Patients had access to information on how to make a complaint. Wards had information on the complaints process available to patients on ward notice boards and in leaflets. Staff supported patients to raise concerns when needed. The trust had systems for the recording and management of complaints. We saw minutes of team meetings where the outcomes and learning from complaints was discussed.
- Staff could access information leaflets in a variety of languages for patients whose first language was not English. The trust had a specific email address and contact telephone number to ensure information was available quickly when needed. We found these details contained in patient admission packs.
- Patients were able to personalise their bedrooms, for example with artwork and photographs. Patients accommodated in bed bays and dormitories had less space; however, we observed personal items in these areas.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Managers and staff reported that supervision was taking place, however the data submitted by the trust did not reflect this. Compliance rates for acute wards and PICU was 42% which was below the trust target of 85%. Staff sickness for the service was 7% which was above the trust target of 4.5%.
- Managers did not ensure clinical areas were clean and that equipment and facilities were maintained in a timely way.
- Staff vacancy rates were variable across the service. Ashby ward reported the highest qualified nurse vacancy rate at 50% and Aston ward the lowest with no vacancies.

However:

- Managers used a standard agenda for ward meetings, items covered at the meeting included safeguarding, feedback and actions following incidents and performance data.
- Managers supported staff to work in collaboration with community teams and external agencies such as, housing and the criminal justice service to meet the need of patients.
- The ward matrons were able to provide us with an up to date picture of how the wards were performing and had a good understanding of where improvements were required.
- The trust held two weekly discharge meetings which included other agencies and commissioners to address the delayed discharges.

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

Mental health crisis services and health-based places of safety

Requires improvement 

Key facts and figures

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

Crisis 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 place of safety in Leicester. A health based place of safety 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.

The psychiatric liaison service provides assessment and treatment for adults between the ages of 16 to 65, who experience mental health problems in the context of physical illness. The team see people on inpatient wards at the three acute hospital sites. The psychiatric liaison service also provides outpatient clinics and a specialist chronic fatigue syndrome service.

Leicestershire Partnership NHS trust was last inspected in November 2016 by the CQC. During the last inspection, we rated the trust as 'requires improvement' because:

- 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 updating 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.
- 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 Royal College of Psychiatry guidance, access arrangements were unsafe, doors were not anti-barricade and patients were unable to lie down.

The trust is registered for the following regulated activities:

Mental health crisis services and health-based places of safety

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury.

At the last inspection we rated three or more key questions as requires improvement so we re-inspected all five key questions.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. Before the inspection visit we reviewed information that we held about these services and information requested from the trust.

The inspection team visited the crisis team, the mental health triage team and the psychiatric liaison team on 10 and 11 October 2017. During the visit the inspection team:

- visited the crisis resolution and home treatment team based at the Bradgate Mental Health unit
- 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 liaison psychiatry service at the Glenfield Hospital
- spoke with 12 patients who were using the service
- spoke with 5 managers or acting managers for the three teams we visited.
- spoke with 23 other members of the multidisciplinary team
- spoke with four senior managers
- observed three multidisciplinary meetings and a governance meeting
- reviewed 36 patient records relating to physical health, risk assessments and care plans
- carried out a specific check of the medication management at the crisis and home treatment teams, and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- We rated responsive and well led as requires improvement, and safe, effective and caring as good.
- Interview rooms were unsafe. They did not have alarms or vision panels in the door. They contained items which could pose a danger to staff and patients.
- Staffing levels were below the expected level. The vacancy rate for the service was 12.9% and for band 5 and 6 nurses was 18.9%.
- The quality of the data produced was poor and staff needed to correct the data when reports were produced.
- The service was not meeting its performance targets.

However:

- The trust had addressed the issues previously identified with the health based place of safety.

- Care plans were up to date and holistic.
- There was effective communication between the service and other healthcare professionals.
- Staff received regular managerial and group supervision.

Is the service safe?

Requires improvement  

Our rating of safe stayed the same. We rated it as requires improvement because:

- The crisis team had access to three assessment rooms in which they saw the most challenging patients. We considered these rooms to be unsafe as they did not have anti-barricade doors and the room only had one exit. There was lightweight furniture and office equipment which could have been used as a weapon or to barricade the door. It was not possible for staff to be visible whilst assessing in these rooms as glass panels in the doors were frosted. However staff carried working alarms.
- All areas were clean, however the décor, furniture and carpets at the crisis resolution home treatment team were stained and in need of updating.
- Between 1 July 2016 and 30 June 2017, bank staff filled 1494 shifts to cover sickness, absence or vacancy for qualified and unqualified nurses. The vacancy rate for the whole service was 12.9% and 18.9% for band 5 and 6 nurses.
- The trust did not ensure sufficient staff were available on all shifts for the safe care and treatment of patients. The trust covered 1834 vacant shifts with agency staff between 1 July 2016 and 30 June 2017. However, 321 (15%) of shifts were not filled. On these occasions, teams worked below established staffing levels,
- Staff we spoke with told us that sickness was rarely covered within the team. When staff left the team there was insufficient staffing to assess patients within the 4 hour target.
- A number of teams were below 75% for some of the mandatory training. The crisis team was below 75% training compliance for one out of 23 modules (4% of all modules). The psychiatric liaison team was below 75% training compliance for five out of 23 modules (22% of all modules). Across the service medical staff fell below 75% training compliance for six out of 18 modules (33% of all modules).

However:

- The trust had addressed environmental concerns within the health based place of safety identified during our last inspection. The environment had been refurbished and now met the Royal College of Psychiatry guidance.
- The trust stored and managed medication appropriately at each location. At the Bradgate Unit crisis team there was no clinic room, however there was a locked cupboard with stock of regularly prescribed medications secured to the wall of the team office. The health based place of safety had a fully equipped resuscitation trolley and small supply of stock medication in a locked cupboard in the nursing office.
- Staff completed a risk assessment for every patient at telephone triage and then conducted a further more detailed risk assessment which was updated regularly, including after any incident.
- The trust had devised a risk assessment tool for use across the crisis resolution home treatment team. A similar core assessment was used by the mental health triage teams and health based place of safety.
- Staff created and made good use of crisis plans with patients taking the lead in the planning of their care. However, in the records we reviewed, advance decisions were rarely used.

Mental health crisis services and health-based places of safety

- The trust had improved staffing in the health based place of safety. Designated staff were allocated to support patients on arrival and throughout their admission. When the unit was not in use, these staff worked within the acute admission wards.
- The trust had developed good personal safety protocols, including lone working practices, and there was evidence that staff followed them.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- We reviewed 36 care records across the teams we visited. Records showed that staff completed a comprehensive mental health assessment of each patient. In the crisis team patients would receive a triage assessment over the telephone, a subsequent appointment would then be booked to complete a detailed assessment and care plan.
- Staff developed care plans that met the needs identified during assessment. Care plans were personalised, holistic and recovery-oriented. Staff updated care plans when necessary. Care plans were written in a way that suggested the patient was engaged in their care and had the opportunity to set goals with their key worker.
- Staff maintained communication with other healthcare professionals and GPs to ensure patients' physical healthcare needs were met, and updated the records accordingly.
- Staff we spoke with told us they received monthly managerial and group supervision as well as informal supervision within the team on a daily basis.
- Managers dealt with poor staff performance promptly and effectively.
- Staff in all teams held effective multidisciplinary team meetings. We observed two meetings with the crisis and psychiatric liaison teams and found that staff shared information about appointment allocation, risks and case formulation within these meetings.
- Staff shared information about patients at effective handover meetings.
- The community teams had good working links, including effective handovers, with primary care, social services, and other teams external to the organisation. Staff spoke about good links with GP practices and a crisis house run by an external organisation. Amongst other services several patients gave positive feedback about a local mindfulness group which had aided their recovery.
- Staff were trained in and had a good understanding of the Mental Health Act (1983) and the Mental Capacity Act (2005).
- Staff had easy access to Mental Health Act policies and procedures and to the Code of Practice on the trust internet.
- We saw evidence in patient records that if the team worked with patients who were detained under the Mental Health Act or subject to a Community Treatment Order, staff explained to patients their rights in a way that they could understand. Patients were given a leaflet explaining their rights.
- Staff had completed Community Treatment Order paperwork correctly and it was up to date and stored appropriately.
- Managers conducted audits of three case notes each on a weekly basis and any issues were addressed in supervision with staff.

- The trust's target rate for appraisal compliance was 80%. As at 30 June 2017, the overall appraisal rates for non-medical staff within this core service was 94%.

However:

- The Liaison Psychiatry Service failed to meet the trust's appraisal target of 80% with only 67% of staff having had an annual appraisal.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff were respectful and responsive to patients' needs providing patients with help, emotional support and advice when they needed it.
- Staff spoke positively about patients and were passionate about their work.
- Staff supported patients to understand and manage their care, treatment or condition. Patients we spoke with were positive about the care they received and told us staff treated them well and they put their needs and wishes at the centre of the care plan.
- Staff referred patients to other services when appropriate. For example, if patients in crisis needed support away from their usual home environment they were referred to a local crisis house provided by another organisation.
- Staff understood the individual needs of patients, including their personal, cultural, social and religious needs and were able to access additional support to meet the needs of the diverse patient group.
- Staff understood and maintained the boundary of patient confidentiality.
- Patients we spoke with told us they were involved their care planning and risk assessments, and were offered copies of their care plans. We found evidence of this in patient records.
- Staff involved patients when appropriate in decisions about the service. For example, patients and carers sat on the recruitment panel and interviewed new staff.
- The trust had recently devised a patient feedback survey in addition to the friends and family test. This was available electronically as well as in paper form.
- Staff ensured that patients could access advocacy, both within the trust and from an independent advocacy service.
- Carers were provided with information on how to access a carer's assessment. Some carers we spoke to had accessed this service.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The provider had set a target for time from referral to triage/assessment and from assessment to treatment. The target time for referral to assessment for the mental health triage team was 2 hours and 4 hours. For the Crisis team the referral to assessment target was 4 hours for urgent assessments and 24 hours for other referrals. The trust was

not meeting targets for referral to assessment. The mental health triage team were not compliant with the 2 hour or 4 hour target for referral to assessment for approximately 30% of referrals. Managers told us this was due to low staffing levels and increasing patient demand. Data for the past 2 months showed an average of 25% of referrals had not met the target for 2 hour and 4 hour assessments.

- The crisis team were not compliant with the target for 4 hour or 24 hour assessments. A subsequent data request revealed that for the period April to August 2017 an average of only 32.5% of all referrals were assessed within 4 hours. The average number of referrals seen within a 24 hour period for April to August 2017 was 75%. There was however rapid access to psychiatrists should a patient need to be assessed in an emergency.
- The psychiatric liaison team, which provides assessment and treatment for adults between the ages of 16 to 65, who experience mental health problems in the context of physical illness, were not meeting their target of 13 weeks from referral to assessment. Data showed some patients had waited between 14 and 39 weeks to see the consultant psychiatrist. The trust included failure to meet agreed waiting time targets as a risk to patient safety and experience on the trust risk register.
- This core service received 20 complaints between 1 July 2016 and 30 June 2017. Seven of these were related to attitude of staff and seven regarding all aspects of clinical treatment.

However:

- The trust had clear criteria for patients to access the service. There was no waiting list for crisis and mental health triage teams.
- The trust responded promptly and adequately when patients telephoned the service. In all teams there were designated staff available to take calls and triage patients over the telephone.
- The teams engaged with patients who found it difficult or were reluctant to engage with mental health services.
- We saw evidence in patient records that the team made follow-up contact with patients who did not attend appointments.
- Staff offered patients flexibility in the times of appointments whenever possible.
- Staff cancelled appointments only when necessary. When this was necessary, staff assisted patients to access treatment as soon as possible.
- This core service received seven compliments during the last 12 months from 1 July 2016 and 30 June 2017. All of these compliments were attributed to the Crisis Resolution Team.
- Patients we spoke with told us they knew how to complain or raise concerns. Staff protected patients who raised concerns or complaints from discrimination and harassment
- Staff knew how to handle complaints appropriately. Staff we spoke with told us that they tried to resolve as many issues as possible within the team.
- Staff received feedback on the outcome of investigation of complaints and acted on the findings. We saw evidence of learning from complaints in team meeting minutes.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

Mental health crisis services and health-based places of safety

- Data provided by the quality dashboard was unreliable. Senior staff advised that the quality dashboard did not accurately record the team activity; therefore administration staff were required to cleanse all data to show mitigation when target times were not met.
- Managers did not have oversight of the numbers of safeguarding referrals submitted to the local authority.
- Managers and staff reported that supervision was taking place. However, the data submitted by the trust did not reflect this. Data provided showed an overall compliance rate of 60% which was below the trust target of 85%. Managers kept local records to evidence compliance with supervision for their staff.

However:

- Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.
- Staff we spoke with told us that leaders were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff could explain how they were working to deliver high quality care within the budgets available; by linking in with other agencies in the local community, providing mutual aid and support groups.
- Leadership development opportunities were available, including opportunities for staff below team manager level.
- Staff undertook or participated in clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.
- Staff understood arrangements for working with other teams, both within the trust and external organisations, to meet the needs of the patients.

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Julie Meikle, Head of Hospital Inspection, CQC and Margaret Henderson, Inspection Manager, CQC led this inspection. Two specialist professional advisors with board experience and a knowledge of governance supported our inspection of well-led for the trust overall.

The team for the core services included four inspection managers, eight further inspectors, 11 specialist advisers, and two experts by experience.

Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.