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.

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?	**Inadequate**

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.

Summary of findings

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 15 active locations registered with CQC.

The trust has 614 inpatient beds across 40 wards, 10 of which are children's mental health beds.

The trust serves a population of approximately one million people across Leicester, Leicestershire and Rutland, has a budget of £270,000,000 and employs over 5,500 staff in a wide variety of roles. The trust obtained a £4.65m surplus year ending March 2018, compared to £2.24m year ending March 2017. The trust predicts a surplus of £3.27m year ending March 2019.

Services are commissioned through three local clinical commissioning groups and specialised commissioning within NHS England. The trust's key stakeholders include Leicestershire County and City Council, Rutland County Council, police and ambulance services, Healthwatch, primary care and mental health partners and local universities.

CQC undertook a comprehensive inspection of the trust in October and November 2017 with the inspection report published 30 April 2018. The overall rating was requires improvement. The trust was rated requires improvement for safe, effective, responsive and well led, and good for caring.

The areas of non-compliance were:

- Regulation 9: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care
- Regulation 12: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment
- Regulation 13: Health and Social Care Act 2008 (Regulated Activites) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 15: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment- premises not properly maintained
- Regulation 17: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance
- Regulation 18: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

At this inspection, we found that the trust continued to show they did not meet the requirements of five of these regulations and one additional regulation. However, the trust had met the requirement for Regulation 13.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement

What this trust does

Leicestershire Partnership NHS Trust provides mental health and community health services across 15 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

Summary of findings

- 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

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 of £270,000,000 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 patient's 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 inspected five complete services which we previously rated as 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 older people
- Specialist community mental health services for children and young people
- Long stay / rehabilitation mental health wards for working age adults
- Wards for people with a learning disability or autism.

Summary of findings

We did not inspect the other four community health services or six mental health 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 a 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?

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

What we found

Overall trust

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

- We rated well-led as inadequate, safe, effective, and responsive as requires improvement and caring, as good. In rating the trust, we took into account the previous ratings of the ten core services not inspected this time. We rated the trust overall for well-led as inadequate. At this inspection, we rated two core services as inadequate, two core services as requires improvement, and one core service as good. Therefore, overall, eight of the trust's 15 services are now rated as good, five as requires improvement and two as inadequate.
- We found a high number of concerns not addressed from the previous inspections. We found significant issues with trust level governance, oversight of environments, a failure to address keys issues and a lack of pace with delivering essential improvements. Overall, the pace of change in planning and converting plans into action across the trust was disappointingly slow.
- The trust had not fully articulated their vision for how they operated as a trust. The trust had several strategies, a vision and corporate objectives, but they did not underpin all policies and practices. The trust lacked an overarching strategy which everyone within the trust knew. Staff and senior leaders could not articulate the trust's direction of travel and how this was co-ordinated. There was a lack of understanding in teams how their own plans, visions and objectives connected with the trust's vision.
- We were not assured that the trust risk register clearly documented action taken or progress of action, within agreed timescales. Many of the actions listed included plans to review process, establish an approach, or to develop areas. We felt this contributed to senior staff views that pace of change in the trust was slow. The trust's Board Assurance Framework (BAF) was lengthy, was combined with a corporate risk register and had overdue actions. Due to the lack of a trust overarching strategy, the BAF did not provide an effective oversight against strategic objectives, gaps in control and assurance.
- We had serious concerns about the trust's oversight of ward environments and safety of patients within those areas. Since our 2017 inspection, the trust had not fully ensured that clinical premises where patients received care where safe, clean well equipped, well maintained and fit for purpose. We found concerns with the environment in all five core services we inspected.
- Medication management across four of the five services we inspected was poor, despite reported trust oversight and audit. We found serious concerns with medication disposal, storage, labelling and management of controlled drugs.
- Staff did not record seclusion well. Considerable numbers of records we reviewed during our inspection, were of a poor standard, with substantial and important clinical reviews missing, as recommended by the Mental Health Act Code of Practice.

Summary of findings

- Risk management in services required improvement. Staff did not effectively complete risk assessments for patients, manage a smoke free environment, or share information about incidents or share learning from incidents within teams, across services or between services in the trust.
- In most services, we were concerned with the lack of evidence in care plans which showed patients and carers had been consulted and involved in their care. Staff did not routinely complete detailed, person centred, individualised or holistic care plans about or with patients. Staff in four of the five services we inspected did not document patient involvement in their care. Staff had not routinely recorded whether they had given patients copies of their care plans and we saw this in a considerable number of patient records we sampled. Patients and carers confirmed in most services they had not received copies of care plans. Community meetings and patient involvement in the services did not always take place. Therefore, patients were not always actively engaged in decisions about service provision or their care.
- We found concerning evidence of long waiting times for assessment in specialist community mental health services for children and young people. Whilst staff monitored patient's risk on the waiting lists, the length of time to wait was of concern, in addition to the services' lack of oversight and management of this issue. This left patients without access to treatment when they needed it most.
- The dignity and privacy of patients across three services we visited was compromised. The trust did not always manage the admission of patients into mixed sex environments well. Staff used strategies to maintain patient's safety which had an adverse effect on their dignity and privacy. Staff carried out physical observations in public areas in one service, and staff did not always record or explain why some observations of patients were required.
- Staff did not always feel connected to the wider trust. Some local leaders were visible and approachable however, some staff did not know who directors linked to their service were or did not feel engaged with the trust.
- The trust lacked a framework for co-ordinating, endorsing and therefore learning from the very many positive quality projects taking place. The teams we spoke with, felt the trust board did not set clear timescales or direction on how to move their projects forward.
- The trust had a limited approach to patient involvement. We found this across core services and within senior teams. We would expect patient involvement to be embedded at all levels of the trust, across as many departments as possible, in planning, review, evaluation and delivery. The trust mostly used surveys to gain feedback and we saw limited evidence of face to face engagement with patients about service delivery and improvement.
- There were issues within the trust of a bullying culture despite evidence that staff knew the trust values. Some teams told us about a lack of teamwork, best practice was not shared amongst services and regular meetings did not take place in some services.
- The trust's pace for implementing equality and diversity initiatives across the organisation needed improvement. This was particularly relevant to protected characteristics. The trust supported a BAME network (black and minority ethnic) however, given the diversity of the geographical area of the trust, they had not significantly developed its agenda or work streams since our last inspection.
- Supervision and appraisal compliance of three teams fell below 75%. The trust did not provide data to demonstrate medical staff appraisal compliance.

However:

- Despite the issues we found with storage, disposal, labelling and controlled drugs, the trust had made improvements to prescribing of medication and had successfully implemented e-prescribing processes trust wide. Services had supplies of emergency medication available and this was accessible to staff. Staff in some services completed care plans with detailed information on allergies, and risks around medication.

Summary of findings

- The number of incidents reported by the trust had decreased since the last inspection and serious incident figures remained comparable. The trust had robust systems in place which allowed staff to effectively report incidents. The patient incident team carried out a review of serious incident reporting and made changes to improve the reporting process, categorise incidents in a better way and improved reporting of safeguarding. The group established a deliberate self harm and suicide group in the last year to oversee specific incidents of this nature.
- Mandatory training compliance for trust wide services was 91% against the trust target of 85%.
- We heard from most teams, positive examples of teamwork and multidisciplinary working within teams and services, and with external agencies and key stakeholders.
- Many staff we spoke with knew who their chief executive was and mentioned them by name. Staff gave examples of initiatives such as the chief executives' blog and the presentation of the valued star award. We were pleased to hear about the trust's investment in well-being events and initiatives for staff, such as 'valued star award', choir, yoga and time out days.
- Detention paperwork for those detained under the Mental Health Act was detailed and followed procedures. Staff knew and understood their role in compliance with the Mental Health Act and Mental Capacity Act.
- Staff showed caring attitudes towards their patients. We saw numerous interactions between staff and patients with very complex needs and staff managed extremely challenging situations with knowledge and compassion. Staff demonstrated a respectful manner when working with patients, carers, within teams and showed kindness in their interactions. Patients and carers gave positive feedback about the caring nature and kindness of staff and made positive comments about the positive therapeutic relationships they had with their loved ones.
- The trust had robust governance structures and they had assured any potential gaps or overlaps had been considered. The trust had a variety of measures in place to ensure that processes and reporting to board were not delayed. Every team we spoke with knew who they reported to and what to report.
- We heard positive reports of senior staff feeling able to approach the executive team and the board. Local leaders were visible and had the skills and knowledge to perform their roles. The trust delivered programmes for staff to develop into senior roles and had a clear career development programme for nursing staff.
- Engagement and joint planning between departments was well developed. The trust encouraged staff at most levels of the organisation to develop and deliver ideas for service delivery, improvement and innovation. We heard many examples of interesting innovation projects and work that staff groups had done which impacted on and improved patient care.
- The trust had made progress in oversight of data systems and collection. Staff were aligned to services to manage data and we have seen improvements in recording and monitoring of supervision and appraisal, improvement in managing risks of those on waiting lists in specialist community mental health services for children and young people and in training data.

Are services safe?

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

- The trust had not fully ensured since our 2017 inspection that clinical premises where patients received care were safe, clean well equipped, well maintained and fit for purpose. We found concerns with the environment in all five core services we inspected. Staff had not identified ligature risks in two of the five services, and where risks had been identified staff had not fully recorded or were aware of mitigation to manage such risks. Two seclusion rooms were not free from hazards. Services inconsistently completed environmental risk assessments. The trust did not respond promptly to repairs needed in four of the services inspected. This ranged from broken windows, cracked walls,

blocked toilets, poor lighting and broken furniture. Services inconsistently completed environmental risk assessments. We had concerns about fire safety in the Bradgate Unit, where staff did not complete regular fire checks or document patient fire evacuation plans, and a fire door required repair. These issues caused concern given that 14 incidents of fire setting had occurred in the last year.

- The management of seclusion documentation was poor. Despite seclusion audits taking place, the standard of documentation fell below the standard expected by the Mental Health Act Code of Practice, in relation to medical reviews, nursing reviews and care plans for those who required the intervention of seclusion. We reviewed 58 seclusion records, 34 did not record a medical review within one hour of the start of seclusion; forty did not record a nursing review by two nurses every two hours throughout seclusion. Twenty-four did not record continuing medical reviews every four hours until the first multidisciplinary review. Ten of 15 records did not record an independent multidisciplinary team review after eight consecutive hours of seclusion. Sixty-one records did not record in a care plan how de-escalation attempts would continue or how risks would be managed.
- Medicines management within four of five services inspected, was unsafe and raised serious concerns, despite trust oversight, reports to board and audits. We found issues with medication disposal, storage of medication, medicines labelling and management of controlled drugs. Medicines management was raised as an issue at our inspection in 2017.
- We were not assured the trust had full oversight of risks within core services. Staff did not consistently and effectively manage patient risk in three services. Staff at the Bradgate Unit did not safely manage the smoke free environment. Patients frequently secreted lighters onto the wards and smoked in bedrooms, gardens and close to the buildings. This continued to take place despite recent fire setting incidents. Staff inconsistently recorded safeguarding incidents in the Specialist community mental health services for children and young people. Staff did not regularly complete or update patient risk assessments in long stay / rehabilitation mental health wards.
- The trust did not comply with guidance on eliminating mixed sex accommodation in some services. Two wards in the long stay / rehabilitation mental health wards for working age adults service had unlocked doors between male and female areas, and no single sex lounges. We were not assured the trust reported mixed sex breaches accurately. Staff told us on acute mental health wards, patients were admitted in to 'breach beds', and Short Breaks Units recorded 37 occasions where breaches had occurred. This was despite data submitted from the trust prior to inspection which showed no breaches had occurred.
- Four services had ineffective processes to share learning from incidents. There was limited evidence to show how ward teams shared information about incidents with their own staff, between wards or across services within the trust. We saw limited evidence of how learning from incidents had been shared and embedded into practice to prevent reoccurrence.
- Staffing shortages, sickness and use of agency presented issues for three services we visited. Patients waited for long periods to see staff in specialist community mental health services for children and young people and within community based mental health services for older people; high use of agency in acute mental health wards reduced consistency for patients and impacted on therapeutic relationships.
- Staff did not ensure infection control measures were effective in two services we inspected. This included toy cleaning, play equipment and handwashing facilities in specialist community mental health services for children and young people, and unlabelled hairbrushes at Rubicon Close.

However:

- The trust had plans in place to re-provide environments for specialist community services for children and young people services. Plans for the Bradgate Unit were a vision for 2023. Clinical areas in two of the five services we inspected were of good quality, clean and well maintained.

Summary of findings

- Staff completed thorough risk assessments for patients in community based mental health services for older peoples and on wards for people with a learning disability or autism. Staff managed the risks of patients on waiting lists well. Significant improvements had been made since our last inspection to manage the risks of those who waited for assessment or treatment in specialist community mental health services for children and young people and in community mental health services for older people. Robust systems had been put in place to oversee these patients.
- The trust had made improvements to prescribing of medication and successfully implemented e-prescribing processes. Services had supplies of emergency medication available and this was accessible to staff. Staff in some services completed care plans with detailed information on allergies, and risks around medication.
- Staff rarely used seclusion at the Agnes Unit. Staff had completed restrictive practice training and used positive behaviour support plans and de-escalation techniques to reduce restraints and seclusion.
- The number of incidents reported by the trust had decreased since the last inspection and serious incident figures remained comparable. The trust had robust systems in place which allowed staff to effectively report incidents. The patient incident team carried out a review of serious incident reporting and made changes to improve the reporting process, categorise incidents in a better way and improved reporting of safeguarding. The group established a deliberate self harm and suicide group in the last year to oversee specific incidents of this nature.
- Mandatory training compliance for trust wide services was 91% against the trust target of 85%.

Are services effective?

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

- Staff did not routinely complete individualised, person centred and holistic care plans for or with patients. A significant number of care plans sampled across long stay rehabilitation mental health wards for working age adults and acute wards for adults of working age demonstrated this. Ward staff often used templates for care plans which generated generic wording and statements. Some care plans did not identify patient strengths or demonstrate a recovery focus. There was limited evidence of patient involvement in care plans, or that staff recorded whether patients were offered, accepted or declined care plans.
- Staff supervision and appraisal compliance on wards for people with learning disability or autism, specialist community mental health services for children and young people, long stay rehabilitation mental health wards for adults of working age teams fell below 75%. The trust did not provide data to demonstrate medical staff appraisal compliance.
- Not all teams had access to a full range of skilled staff to deliver treatment under best practice guidance. The Bradgate Unit had a vacancy for a clinical psychologist which impacted on therapy offered to patients. Not all units there, had access to therapeutic liaison workers who provided activity for patients. We heard how Accident and Emergency liaison triage staff had experience of working with adults and not children and young people in crisis. There was little evidence of how staff in acute wards for adults of working age and the psychiatric intensive care unit services recorded care delivery in line with best practice guidance.
- Staff did not routinely complete or record physical health checks on admission in long stay rehabilitation mental health wards for working age adults or annually within specialist community mental health services for children and young people.
- Staff and managers in acute wards for adults of working age and the psychiatric intensive care units did not demonstrate evidence of collaborative working between wards, learning from incidents and sharing of best practise. Some wards had good initiatives underway such as healthy eating and seclusion recording, but these positive outcomes were not shared.

However:

Summary of findings

- Staff across three services we inspected showed effective care planning and physical health monitoring.
- Services had made significant improvement with recording compliance with staff supervision and appraisal since our last inspection.
- Staff knew and understood their role in compliance with the Mental Health Act and Mental Capacity Act. Staff routinely carried out capacity assessments where necessary and consent to treatment was recorded for patients in most services. The trust provided effective support and governance to ward staff with Mental Health Act compliance, and paperwork showed correctly completed documentation.
- We saw evidence of effective collaboration amongst some teams and with external stakeholders.
- The trust engaged with national accreditation schemes and carried out frequent audits.

Are services caring?

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

- Staff showed caring attitudes towards their patients. We saw numerous positive interactions between staff and patients with very complex needs and staff managed extremely challenging situations with knowledge and compassion. Staff demonstrated a respectful manner when working with patients, carers, within teams and showed kindness in their interactions.
- Patients and carers gave positive feedback about the caring nature and kindness of staff and made positive comments about the positive therapeutic relationships they had with their loved ones.
- Patients had access to advocacy services.

However:

- Staff in four of the five services we inspected did not document patient involvement in their care. Staff had not routinely recorded whether they had given patients copies of their care plans and we saw this in a considerable number of patient records we sampled. Patients and carers confirmed in most services they had not received copies of care plans.
- The dignity and privacy of patients across three services we visited was compromised. The trust did not always manage the admission of patients into mixed sex environments well. Staff used strategies to maintain patient's safety, although these had an adverse effect on their dignity and privacy. Staff carried out physical observations in public areas in one service, and staff did not always record or explain why some observations of patients were required.

Are services responsive?

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

- Trust oversight in regard to access to care and treatment within four services we inspected was below expectation. Patients waited for long period to access community services, bed occupancy within inpatient wards was high. The trust used out of areas beds for acute wards for adults of working age, waiting lists were considerable for specialist community mental health services for children and young people, children and young people in crisis had difficulty accessing help urgently, and carers had difficulty accessing beds in short breaks units. At times, some patients were admitted into rehabilitation settings when acutely unwell and not appropriate for rehabilitation at the time.
- At all five services we visited, there were facilities that did not promote comfort, dignity and privacy. These issues included soundproofing of rooms, privacy to meet patients and carers in a confidential setting, and insufficient space for therapy and meetings. Some patients shared bedroom space at the Bradgate Unit because dormitory accommodation continued to exist within the trust and patient toilets at Stewart House were not lockable.

Summary of findings

- At times, services did not meet the diverse needs of those patients who used services. For example, we saw limited evidence of how specialist community mental health services for children and young people met the needs of a black and ethnic minority population. Patients in three services told us food was over processed or lacked variety and quality and snacks were provided at set times only.

However:

- Services planned discharges well. Staff engaged community teams, relevant services and health and care professions to facilitate effective placements and discharges. Discharge co-ordinators in several services were in post and had made improvements to discharges for patients. Staff completed detailed discharge plans in most services we visited.
- Despite long waiting times for assessment or treatment, the trust had taken proactive steps to monitor the risk of those patients on the waiting lists more effectively since our last inspection. Staff maintained contact with patients who waited and monitored their risks regularly. The trust told us of further steps they planned to make to review access to treatment pathways.
- Staff made information available to patients in a variety of languages, facilitated patient's access to interpreters and provided information on and supported patients and carers how to make a complaint where necessary. The trust held a very comprehensive data base which collated all information regarding complaints and we were assured of trust oversight for complaints.

Are services well-led?

Our rating of well-led went down. We rated it as inadequate because:

- We found a high number of concerns not addressed from the previous inspections. We found significant issues with trust level governance, oversight of environments, a failure to address keys issues and a lack of pace with delivering essential improvements. Overall, the pace of change in planning and converting plans into action across the trust was disappointingly slow.
- The trust had not fully articulated their vision for how they operated as a trust. The trust had several strategies, a vision and corporate objectives, but these did not underpin all policies and practices. The trust lacked an overarching strategy which everyone within the trust knew. Staff and senior leaders could not articulate the trust's direction of travel and how this was co-ordinated. There was a lack of understanding in teams how their own plans, visions and objectives connected with the trust's vision.
- Although the trust had a defined reporting structure to the board, the governance of the trust was poor. The trust did not have robust governance procedures to ensure that they could identify and address issues across the trust in a timely way. These issues with governance procedures had been reported at the last inspection in 2017.
- We were not assured that the trust risk register clearly documented action taken or progress of action, within agreed timescales. Many of the actions listed included plans to review process, establish an approach, or to develop areas. We felt this contributed to senior staff views that pace of change in the trust was slow. The trust's Board Assurance Framework (BAF) was lengthy, was combined with a corporate risk register and had overdue actions. Due to the lack of a trust overarching strategy, the BAF did not provide an effective oversight against strategic objectives, gaps in control and assurance.
- Frontline staff did not always feel connected to the wider trust and did not know who directors linked to their service were or did not feel engaged with the trust.
- The trust leadership and local service leadership lacked oversight and responded slowly to issues of risk and performance that affected safe delivery of patient care. Oversight of medication management, environments, seclusion documentation, staffing, waiting lists, care planning and patient involvement was variable, and in some services limited.

Summary of findings

- The trust lacked a framework for co-ordinating, endorsing and therefore learning from the positive quality projects taking place. The teams we spoke with, felt the trust board did not set clear timescales or direction on how to move their projects forward.
- There were issues within the trust of a bullying culture despite evidence that staff knew the trust values. Some teams told us about a lack of teamwork, best practice was not shared amongst services and regular meetings did not take place in some services.
- The trust had a limited approach to patient involvement. We found this across core services and within senior teams. We would expect patient involvement to be embedded at all levels of the trust, across as many departments as possible, in planning, review, evaluation and delivery. The trust used numerous surveys to seek views but this does not always replace face to face engagement.
- The trust's pace for implementing equality and diversity initiatives across the organisation needed improvement. This was particularly relevant to protected characteristics. The trust supported a BAME network (black and minority ethnic) however, given the diversity of the geographical area of the trust, they had not significantly developed its agenda or work streams since our last inspection.
- Overall, the pace of change in planning and converting plans into action across the trust was disappointingly slow. There was a lack of both grip and pace in the movement of the plans to secure resources to re-provide outdated environments.

However:

- The trust had a variety of measures in place to ensure that processes and reporting to board were not delayed. Every senior team we spoke with knew who they reported to and what to report.
- Some local leaders were visible and had the skills and knowledge to perform their roles. The trust delivered programmes for staff to develop into senior roles and had a clear career development programme for nursing staff.
- The trust encouraged staff to develop and implement ideas for service delivery, improvement and innovation. We heard many examples of interesting innovation projects and work that groups had done which impacted on and improved patient care.
- The trust had made progress in oversight of data systems and collection. The trust aligned staff to services to manage data and we saw improvements in recording and monitoring of supervision and appraisal, improvement in monitoring of waiting lists in specialist community mental health services for children and young people, and in trust wide training data. All managers in services had access to key performance data and knew how to interpret it and escalate concerns when necessary.
- The trust was proactive and promoted staff health and well-being. We heard many positive stories to support the health and well-being of staff across the trust. This included mindfulness, yoga, staff choirs, corporate events, training courses through local colleges (such as mental health first aid), physiotherapy and counselling. The trust had a health and well-being calendar for events, and health and well-being champions to promote events.

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

Our rating of this service went down. We rated it as inadequate because:

- Staff on the wards did not manage a range a safety related issues well. In particular, medicines management, implementation of the smoke free policy, lack of clarity and understanding around the requirements of same sex

accommodation, and environmental risks particularly relating to fire. Managers did not always share lessons learned effectively. Managers did not identify themes from incidents and did not address issues quickly. Patients in seclusion did not always have access to the appropriate reviews of their treatment, or the appropriate staff to maintain their dignity. Documentation relating to seclusion was poor.

- High usage of bank and agency staff on some wards had an impact on the development of person-centred therapeutic relationships. There was no dedicated staffing for the Section 136 place of safety and staff left the acute wards to staff the 136 suite when a patient was admitted. This had an impact on ward staffing and consistency of staffing.
- Wards that were built some time ago were poorly maintained and did not promote privacy, dignity and recovery. They lacked private space for patients to meet visitors or to have physical health checks. We observed patients having blood pressure and weight checks in full view of other patients and staff on three wards. Four wards had dormitory style accommodation and five wards did not have enough seating for all patients to eat together. We observed broken windows, poor lighting, stained furnishings and broken furniture in bedrooms. Staff reported a lack of responsiveness from maintenance services. Windows identified as urgently requiring replacement in September 2017 had not been fixed. Ward staff were not aware of refurbishment plans scheduled for 2019 and were pessimistic about work starting on time.
- Patients were at risk of not receiving individualised, person-centred care. Staff did not involve all patients in their care. Care plans used generic wording and statements with a lack of patient voice. 11 out of 26 patients we spoke with were either not aware of what a care plan was or did not feel involved or been given a copy of their care plan.
- There was little record of mental capacity and consent to treatment being assessed on a regular basis.
- There was insufficient opportunity for some patients to access psychological therapy. This was not in line with National Institute for Health and Care Excellence (NICE) guidance. On all acute wards, doctors and nurses told us there was a limited amount of psychology input.
- Staff across the unit did not demonstrate collaborative working. Senior managers did not encourage the sharing of best practise, innovative working and learning from incidents. Four ward managers expressed frustration that their views and concerns about patients being admitted on to their wards were not always considered. We observed staff from one ward struggling to get urgent assistance from other wards to help deal with a difficult incident.
- Staff did not feel always feel connected to the wider trust. They described visible local leadership to service manager level but felt above that role there was a lack of visibility and understanding of their service's needs. We heard examples where local leaders felt there was a lack of response from the trust regarding issues significant to their wards. Some staff members knew who the executive team were, in particular the chief executive, but were not able to name who the director was linked to the service or had seen them on a board walk.

However:

- Local ward staff and managers demonstrated passion and commitment to their roles. Staff worked hard to mitigate against the challenges of a poor physical environment.
- Staff were largely aware of the risks within the environment and permanent staff had good knowledge of their patients and their risks. The trust had implemented some environmental improvements, for example reduced ligature door frames.
- There were some examples of good initiatives taking place on wards. For example, a member of staff on one ward was assisting patients to make healthy snacks rather than ordering take-aways. Seven wards had therapeutic liaison workers employed to engage patients pro-actively in activities both on and off the ward.

Summary of findings

- Staff had the right qualifications and experience to support patients. Compliance with mandatory training and supervision had improved since the last inspection. We observed staff dealing well with a very difficult incident. Staff documented this appropriately, and at the earliest opportunity. We observed positive and caring interactions between staff and patients on the wards.

Long stay or rehabilitation mental health wards for working age adults

Our rating of this service went down. We rated it as inadequate because:

- Managers had not ensured safe and well-maintained care environments. We found unidentified ligature risks and ligature risks that were not safely managed on two wards. At Stewart House, managers had not ensured that the occupational therapy kitchen was safe and doors were in a state of disrepair. On Maple ward patients and staff told us that the toilets were continually blocked. Two wards were not compliant with mixed sex guidance, there were no locked doors between male and female areas and no single sex lounges. Two toilet doors at Stewart House could not be locked.
- Managers had not ensured compliance with the Mental Health Act Code of Practice. The seclusion rooms on two wards were not free from hazards, including blind spots. Staff had not completed the required reviews for a patient in seclusion a seclusion care plan and were using out of date seclusion documentation.
- Staff did not always complete and review the required assessments for patients. Staff had not completed a physical health examination for patients on admission in 14 out of 30 records. On Maple ward staff had not completed and updated patient risk assessments in six out of eight records.
- Staff did not follow good practice in medicines management. On two wards we found medicines that staff should have disposed of, sharps bins used to dispose of medicines, unlabelled medicines, medicated creams stored in an unlocked cupboard, loose tablets (unboxed in their foils) in the medicines trolley, two out of eight patient's medicines not reconciled on admission and staff not reviewing PRN (as required) medicines in line with national guidance.
- Staff did not always involve patients. In 20 out of 30 records there was no evidence that staff had involved patients in their care planning and there was no evidence in any records that patients had been offered a copy of their care plan. Staff had not completed care plans that were personalised, holistic or recovery orientated in 19 out of 30 records. Sycamore ward did not hold regular meetings for patients.
- The care records did not provide evidence this service provided care that would be considered best practice in a rehabilitation unit. The care plans did not indicate that people received the range of services a rehabilitation should provide.
- Staff did not always treat patients with dignity and respect when providing care and treatment. We found issues on four wards with intrusive observations of a patient, patients having to walk past bedrooms and bathrooms of the opposite sex and patient toilets unable to be locked. Patients were not happy with the quality and variety of food available. Patients had made repeated requests for more salads, vegetarian dishes and a greater choice of food. There was no evidence that staff had met these requests.
- Governance systems and processes had not ensured safety and environmental issues were addressed, that staff adhered to the Mental Health Act Code of Practice, that patient involvement was evidenced in records and that patient's requests were responded to in a timely manner. Leaders had not ensured a clear model of service. Managers did not feedback learning from incidents across the trust to staff.

However:

Summary of findings

- Staff and managers worked to keep the use of restrictive interventions to a minimum. They participated in the provider's restrictive interventions reduction programme. Staff made every attempt to avoid using restraint by using de-escalation techniques and only restrained patients when these failed and when necessary to keep the patient or others safe.
- All staff received training in safeguarding that was appropriate for their role. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.
- The team included or had access to the full range of specialists required to meet the needs of patients on the ward. Staff worked well as a multidisciplinary team. Ward teams had effective working relationships with other teams in the trust and external teams and other organisations.
- Despite a lack of recording in patient records, staff supported, informed and involved families or carers. Carers were provided with a welcome pack. We spoke with four carers. Carers told us that staff were brilliant, helpful and polite and looked after their relative well. Carers were invited to meetings about their relative's care and were kept updated. Staff helped families to give feedback on the service.
- The service had low numbers of delayed discharges (three in the past year). The service employed discharge nurses to enable a smooth transition for patients being discharged. Managers and staff ensured they did not discharge patients before they were ready. Staff had completed detailed discharge plans that were regularly reviewed in 26 of the 30 records reviewed.

Wards for people with a learning disability or autism

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

- The short breaks services did not comply with mixed-sex accommodation guidance. Services planned male and female only weeks at all the services to avoid breaching the guidelines but admitted patients when families required support at short notice. This had happened 37 times in the last 12 months. Carers and staff told us this gave carers less flexibility to book breaks.
- Staff did not always comply with the Mental Health Act code of practice when secluding patients and did not complete seclusion paperwork appropriately. Records did not contain seclusion care plans. In three records, there was no medical review within one hour and in two cases no regular nursing reviews throughout the seclusion. Managers had not retained oversight of this.
- There were hazards in the short breaks services which could compromise the safety of patients. These included broken items of garden furniture and uneven pathways. The keys to the 'Control of Substances Hazardous to Health (COSHH) cupboard had been left in the door and the door had been left open. Staff did not always manage medicines safely or adhere to infection control principles. Managers did not have sufficient oversight of these issues.
- Managers did not have clear oversight of data and information gathering processes. Managers did not have a robust system to ensure that essential information, such as learning from incidents and complaints, was shared and discussed with all staff, including healthcare assistants. The trust could not provide data relating to staffing on the Agnes unit prior to the inspection. We did not find clear systems in place to gather feedback from patients and carers and use it to make improvements to the service. Staff had not routinely recorded whether they had given copies of care plans to patients or to their carers where appropriate.
- Patients could not make or have access to snacks when they wanted them. Although patients could ask for a drink at any time, the patient booklet stated that snacks were at set times only.
- Some of the nursing offices at the Agnes unit were very small and could not support handovers. Staff held handovers in other rooms such as a staff kitchen.

Summary of findings

- Managers and staff at the short breaks services said they felt isolated from the trust and from each other with little sense of a shared identity. The three units showed limited joined up working. Managers spent more time in some units than others.

However:

- Internally the wards were clean and well maintained. Furnishings were generally of good quality. The Agnes unit had access to a full range of rooms to support treatment and care. There was a separate activity area and smaller rooms where staff could speak to patients privately. The clinic room was clean and well organised.
- There were enough staff deployed to keep patients safe. Mandatory training rates were high across the services. Managers at the Agnes unit provided staff with regular appraisals and supervision and new staff received an induction which was based on care certificate standards. Staff completed restrictive practice training which taught them to use positive behaviour support plans and de-escalation techniques to reduce restraints and seclusions.
- Staff completed comprehensive risk assessments and kept these updated. Staff completed ligature risk assessments which addressed all the ligature risks on the wards. The Agnes unit had been fitted with anti-ligature fittings. Staff used enhanced levels of observations based on individual risk assessments to ensure patients were safe.
- Staff managed medicines safely at the Agnes unit. The provider ensured staff stored medication at appropriate temperatures and used an electronic prescribing system to ensure they administered medicines safely. Doctors followed national institute for health and care excellence when prescribing medication for patients.
- Staff completed and updated comprehensive mental health assessments regularly. Staff completed physical health checks for patients on admission and monitored this during their stay. Patients had good access to physical healthcare services; staff referred to specialist services and procured specialist equipment when necessary. Staff completed holistic and person-centred care plans and positive behaviour support plans. Staff applied the Mental Capacity Act appropriately. Mental capacity assessments and DoLS applications were of good quality, decision specific and correctly submitted.
- Staff treated patients with kindness and compassion and were focused helping them get better by providing high quality care. We observed staff interacting with patients in a kind, caring and respectful manner. Staff involved patients in planning their care. Staff reflected this in care plans and patients confirmed it. Staff supported and involved carers and families in their relatives' care and treatment. Staff understood patient's needs and helped patients to understand why they were in hospital and how to move on.
- There were good interagency working arrangements in place to support the needs of patients. Multidisciplinary team members worked with their community colleagues to ensure smooth transitions and discharges. Staff at the Agnes unit supported moves to placements and liaised with community teams to ensure a smooth transition.
- Staff provided information in an accessible format and displayed it across the services in several different languages. Patients had access to interpreters when needed. Speech and language therapists worked with patients and staff to ensure they met patient's specific communication needs.
- Systems were in place to measure the performance of the team. Managers received regular information to help them ensure staff received training and supervision when they required it. Staff had access to equipment and information technology to do their work. The patient information system was easy to use and staff found it easy to update patient records.
- Staff teams supported each other well and said they felt respected, supported and valued. Staff felt able to raise concerns without fear of consequences and knew how to do this.

Specialist community mental health services for children and young people

Summary of findings

Our rating of specialist community mental health services for children and young people stayed the same. We rated it as requires improvement because:

- The trust had not ensured adequate higher management leadership and governance to address all actions from our previous inspections. Some issues particularly relating to the management of staff resources, waiting lists and the environments for example, infection control procedures, still posed a risk for the service. The CQC had found some of these risks since 2015. Whilst we noted the trust had made changes to the service, we had concerns about the slow pace of change as patients still faced long waits for assessment and treatment.
- As of 19 November 2018, 498 patients waited for a routine assessment at city or county teams, 136 patients waited over 30 weeks across services for assessment. There were 969 patients waiting for treatment. Staff including managers told us there was a 34 week wait for patients with 'medium' and 'low' risks who needed a 'routine' assessment.
- The trust did not meet the needs of patients with neurodevelopment issues in a timely way as patients often faced the longest waits for this service. As of 19 November 2018, 454 patients with attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) waited for either further specialist assessment or treatment, 161 patients waited one to two years. The crisis team supported a lot of these patients who presented in crisis.
- The trust had taken remedial action to make changes to decrease the waiting times including a 'a demand capacity review'. However, at the time of the inspection this work had not addressed the current issues in regard to the length of time patients remained on the waiting list and not in receipt of care and treatment.
- The trust had not ensured there were enough staff to meet the needs of the service. Many patients still faced long waits for assessment and treatment. Seventeen out of 35 staff we spoke to raised concerns about this. Sickness rates for county and crisis teams were at times above the national average (of 4.2%) for NHS mental health and learning disability services at 5.7%. The trust had not ensured that all managers had access to data systems to assess and monitor risks in their services.
- The trust had not fully ensured since our 2017 inspection that clinical premises where patients received care were safe, clean, well equipped, well maintained and fit for purpose. The trust's infection control processes were not robust as most sites did not have cleaning rotas for treatment rooms and toys. The trust had not ensured that Westcotes House reception was fully private and confidential as visitors could overhear the receptionist conversations and trust information.
- The trust staff gave limited examples of how they met the diverse needs of patients. Twenty out of 26 patient's records checked held limited information about patients protected characteristics for example race, religion or belief or sexual orientation. This was despite Leicester black and minority ethnic population being significantly greater (49.5%) when compared against the England average. (Joint Strategic Needs Assessment). The trust did not have a system in place to regularly engage with patients and carers and involve them in the service delivery. Whilst staff showed they were considering patients physical health needs, they did not routinely or annually assess patient's them and instead relied on the patient's GP to do so.
- The service did not follow the process for reporting safeguarding incidents on the trust's electronic record.

However:

- Staff contributed to discussions about the service's strategy and changes to the service. Managers said their access to data had improved and they were more confident they knew who was waiting for assessment and treatment and why.

Summary of findings

- The trust had made improvements to ensure staff completed clear comprehensive and holistic care plans which showed patient's needs, the care required and involved them in the development of them. The trust had ensured since our last inspection that staff documented, where required, assessments a of patient's mental capacity and their consent to treatment.
- Managers showed compassion and understanding when explaining how they supported their staff when they had been unwell. The trust more actively promoted staff wellbeing through events. Staff developed their skills and competencies through managers giving regular supervision and appraisal.
- The trust had a range of specialist services. These included a young peoples' team which worked with vulnerable young people in care and those who are involved with the youth offending service; a specialist perinatal outreach mental health service and other teams to support patients with an eating disorder or with psychosis.
- Staff provided a range of care and treatment interventions that were recommended by and were delivered in line with National Institute for Health and Care Excellence guidance. The trust gave staff some time and support to consider opportunities for improvements. Staff had effective multidisciplinary working with internal and external teams such as primary care and education. Specialist community mental health services for children and young people, staff had effective working relationships, including good handovers, with other teams within the organisation (for example, community to crisis team).

Community-based mental health services for older people

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

- Safety was a sufficient priority for the service. Staff managed and assessed medicines risks safely. This was an improvement since the last inspection. Staff ensured all depot injection cards and care plans contained allergy information. Staff ensured all care plans contained individual patient risks with medication and how risks had been reduced.
- The service improved the monitoring of waiting lists and patient risk. Team managers reviewed waiting lists weekly and breaches of waiting times were minimal. Team managers called patients on the waiting list to assess risk and referred them to the unscheduled care team for urgent assessments. Staff risk assessed all patients regularly and responded appropriately to changes in risks. Staff understood how to protect people from harm and abuse and had good working knowledge of safeguarding adults and children. Staff had all completed their mandatory training.
- Patients received individualised treatment. We reviewed 27 care plans that were up to date, person centred and involved patients. Staff developed care plans collaboratively with patients and patients could identify their goals and objective. Staff discussed care plans with carers and family members with the patient's consent and involved them in meetings, which was evidenced in the care records we reviewed.The service had positive multi-disciplinary team relationships across which enabled staff to refer patients to other professionals easily. Individual teams had good relationships with local third sector organisations such as; the advocacy service and veteran charities who staff regularly referred patients to.
- We observed staff to be compassionate, respectful and responsive to the needs of patients and carers. Feedback from patients and carers was positive. Staff were aware of the demographics within the county and understood the individual, cultural needs of patients. For example, we saw interpreters were used to facilitate appointments where English was not the first language of the patient to ensure the patient had the opportunity to talk to staff alone if required. Carers and family members informed us that they felt supported by staff in understanding how to care for the patient. Carers and family members felt their concerns were always taken on board and resolved and support was always provided to them as well as the patient. The service held recovery cafes with carers, patients and staff to ensure the service delivered was person centred.

Summary of findings

- Staff adhered to the principles of the Mental Capacity Act 2005. The trust had changed the delivery of training to be face-to-face and prioritised mental capacity training within learning lunches. Staff evidenced consideration of mental capacity in care records. Staff obtained consent to treatment and conducted mental capacity assessments and best interest decisions. Team managers conducted weekly audits on care records, risk assessments and progress notes. Staff self-audited their records using a document filled monthly and discussed this within supervision.
- The leadership, governance and culture of the service actively encouraged the delivery of person-centred care. Staff received regular supervisions, appraisals and training relevant to their role. Managers allowed staff, within working hours, to focus on their well-being and encouraged team building through activities like bowling and yoga. The trust held a well-being week for staff to try and reduce sickness rates. Managers provided individual feedback to staff members who reported incidents and lessons were shared across the service in team meetings.
- The service had positive multi-disciplinary team relationships across all teams. Multi-disciplinary members felt included in the service and individual teams had good relationships with third sector organisations such as the advocacy service and veteran charities.

However:

- There were environmental issues in two of the team locations. In one location, staff had not conducted a ligature risk assessment for patient areas. In a second location, staff did not have access to personal alarms. The rooms in one location lacked soundproofing and privacy glass in areas where staff met with patients.
- Staff felt disconnected from the executive team.
- Staff did not always give care plans to patients and this was confirmed by the patients we spoke to.
- Staff and managers highlighted issues with the electronic recording system and reported a loss of data such as care plans which had already been entered by staff. This increased staff workloads as they had to re-enter information onto the system.
- The service recalled a patient on a Community Treatment Order twice to extend the period of detention, which was not in line with the Mental Health Act 1983.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, 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 factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in in two core services we inspected. For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including six breaches of legal requirements that the trust must put right. We found 29 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 of this report.

Summary of findings

Action we have taken

We issued six requirement notices to the trust and took three enforcement actions. Our action related to breaches of six legal requirements at a trust-wide level and in four core services.

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

What happens next

We will check 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.

Outstanding practice

We found examples of outstanding practice in two core services.

In community-based services for older people, managers provided staff with time during working hours to focus on their well-being and prioritised staff needs. Staff could feedback activities they enjoyed to managers such as yoga, bowling, massages and sports. Managers then provided staff with protected time during working hours to conduct those activities, which provided staff time to focus on well-being and team building. Staff responded positively to us when discussing this and felt it was a good initiative to minimise sickness.

Also, staff were aware of the county demographics and diversity. Staff adapted their practice to help breakdown any barriers by speaking to patients and family members in a culturally appropriate way. Staff would bring interpreters regardless of family members being present, to allow patients to have the opportunity to voice any concerns separate to their family if required.

Staff prepared patients if they were leaving the trust or if they were due to be on annual leave, giving specific plans of what would happen in their absence which reduced anxiety for patients.

Staff wrote comprehensive notes, detailing their visits, for families and carers who could not attend meetings, so they would receive an update on the same day. Staff followed this up with a phone call the following day to clarify any issues. Both carers and patients were extremely positive about this.

In specialist community mental health services for children and young people staff at Westcotes House had greatly improved the visual decoration of their site. Westcotes house was an older style building that previously not been decorated in a child or young people friendly. Staff had gained money from the trust's charity and had worked with another local charity to 'brighten lives as well as walls'. They had decorated the building with a range of stimulating, fun and friendly artworks in differing colours, shapes, sizes and textures. For example, there were small pictures of well-known animation characters for children (and adults) to point out and count around various points and heights of the corridors, walls and rooms. Large pictures/posters included a whale and mythical characters. They had involved patients, carers and staff in the development of this to create a range of pieces loosely themed around 'diversity' and difference. The overall effect helped create a welcoming and non- threatening environment for patients and carers, particularly if this was their first visit to a mental health service. This was also despite the limitations of their building environment. The trust held a formal celebration event for this work and invited senior trust staff, stakeholders and the CQC inspection team.

Summary of findings

Areas for improvement

Action the 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.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with six legal requirements. This action related to the whole trust and four core services.

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

- The trust must ensure all environmental risks are identified and mitigated against. The trust must ensure that ligature risk assessments contain appropriate actions detailing plans to update, replace or remove identified ligature risks. Regulation 12 (1) (2)(a)(b).
- The trust must ensure the safe management of medicines, to include storage, labelling and disposal. Regulation 12 (1) (2)(g).
- The trust must ensure that medical equipment used by staff is regularly and accurately checked. Regulation 12 (1) (2)(e).
- The trust must ensure that staff consistently apply and record appropriate elements of the seclusion policy in line with the Mental Health Act Code of Practice. Regulation 12 (1).
- The trust must ensure that lessons from incidents and complaints are shared with staff. Regulation 17 (1).
- The trust must ensure all staff are aware of the Department of Health's guidance on eliminating mixed sex accommodation to ensure appropriate and accurate reporting. Regulation 12 (1).
- The trust must ensure it reviews arrangements of dormitory accommodation with a view to eliminating this in line with national guidance. Regulation 10 (1).
- The trust must ensure staff involve patients in their care planning and their views are recorded appropriately. Regulation 9 (1)(c) 3(b).
- The trust must ensure that the privacy and dignity of patients is protected. Regulation 10 (1).
- The trust must ensure that sufficient facilities are available to meet the needs of all patients. Regulation 15 (1)(e).
- The trust must ensure that environments are regularly maintained and updated to ensure they provide a safe environment for patient care. Regulation 12 (1) (2)(a)(b)(d).
- The trust must ensure effective governance systems are in place to monitor the service. Regulation 17 (1) (2)(a)(b).
- The trust must ensure patients have personal fire evacuation plans in place where necessary and weekly fire checks of environments are completed. Regulation 12 (1).

Long stay or rehabilitation mental health wards for working age adults:

- The trust must ensure all environmental risks are identified and mitigated against. The trust must ensure that ligature risk assessments contain appropriate actions detailing plans to update, replace or remove identified ligature risks. Regulation 12 (1) (2)(a)(b).

Summary of findings

- The trust must ensure that environments are regularly maintained and updated to ensure they provide a safe environment for patient care. Regulation 12 (1) (2)(a)(b)(d).
- The trust must ensure that all wards comply with guidance on the elimination of mixed sex accommodation. Regulation 12 (1).
- The trust must ensure that staff consistently apply and record appropriate elements of the seclusion policy in line with the Mental Health Act Code of Practice. Regulation 12 (1).
- The trust must ensure seclusion rooms comply with the Mental Health Act Code of Practice. Regulation 12 (1) (2)(d).
- The trust must ensure staff assess and care plan patient's physical health needs. Regulation 12 (1) (2)(a).
- The trust must ensure staff update risk assessments following incidents. Regulation 12 (1) (2) (a).
- The trust must ensure the safe management of medication, to include storage, labelling and disposal. Regulation 12 (1) (2)(g).
- The trust must ensure care plans are personalised and holistic. Regulation 9 (1)(a)(b)(c).
- The trust must ensure staff involve patients in their care planning and their views are recorded appropriately. Regulation 9 (1)(c) 3(b).
- The trust must ensure that the privacy and dignity of patients is protected. Regulation 10 (1).
- The trust must ensure effective governance systems are in place to monitor the service. Regulation 17 (1) (2)(a)(b).

Wards for people with a learning disability or autism:

- The trust must ensure that staff consistently apply and record appropriate elements of the seclusion policy in line with the Mental Health Code of Practice. Regulation 12 (1).
- The trust must ensure that all wards comply with guidance on the elimination of mixed-sex accommodation. Regulation 12 (1).
- The trust must ensure that staff adhere to infection control principles and that items such as hairbrushes are not used for different patients. Regulation 12 (2)(h).
- The trust must ensure effective governance systems are in place to monitor the service. Regulation 17 (1) (2)(a)(b).

Specialist community mental health services for children and young people

- The trust must ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people. Regulation 9 (1)(a)(b)(c).
- The trust must review their service provision for patients with attention deficit hyperactivity and autism spectrum disorders and reduce service waiting times in the children and young people's service. Regulation 9 (1)(a)(b)(c).
- The trust must ensure children and young people's service staff follow the trust's infection control procedures and processes. Regulation 12 (1) (2)(a)(b)(h).
- The trust must ensure there is effective leadership of the children and young people's service across the trust. Regulation 17 (1) (2)(a)(b)(e)(f).
- The trust must ensure effective governance systems are in place to monitor the service. Regulation 17 (1).
- The trust must ensure they have accessible and comprehensive data/systems for the children and young people's service to measure their performance and risks. Regulation 17 (1).

Summary of findings

- The trust must review their recruitment processes and ensure there is adequate staff available to reduce the patient waiting lists for assessment and treatment in the children and young people's service. Regulation 18 (1).

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 29 actions related to the whole trust and the five core services.

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

- The trust should ensure staffing requirements of 136 services do not adversely affect those of acute wards for adults of working age.
- The trust should ensure the use of bank staff does not impact on the delivery of consistent patient care.
- The trust should ensure patients have access to psychological therapy and this is delivered and recorded in line with best practice guidance.
- The trust should ensure that staff have access to regular team meetings.
- The trust should ensure a review of the management and implementation of its smoke free policy at the Bradgate Unit.
- The trust should ensure bed management arrangements are more robust in order that patients have access to an acute bed within their area.
- The trust should ensure best practice and innovation within the service is shared.
- The trust should ensure that the senior executive team are present and visible to staff.

Long stay or rehabilitation mental health wards for working age adults:

- The trust should ensure staff support patients to make advanced decisions.
- The trust should ensure there is clear criteria for admittance to the service.
- The trust should ensure there is a clear model for the service.
- The trust should ensure patients are provided with food of their choice.
- The trust should ensure all staff are supported to raise concerns about bullying.

Wards for people with a learning disability or autism:

- The trust should ensure that medication errors, where electronic prescribing has not been introduced, are reported as incidents.
- The trust should ensure that learning from incidents and complaints is discussed with all staff, including health care assistants.
- The trust should ensure there are clear systems to gather feedback from patients and carers and use it to make improvements to the service.

Specialist community mental health services for children and young people

- The trust should review how they assess and monitor patient's physical health needs in the children and young people's service.

Summary of findings

- The trust should review and improve their systems for engaging patients and carers in development of the children and young people's service.
- The trust should review their safeguarding children and incident reporting policies to reflect staff practice.
- The trust should review their processes for meeting patient's diverse needs.
- The trust should ensure that premises are suitable for purpose in the children and young people's service, such as at Westcotes House.

Community-based mental health services for older people

- The trust should ensure that staffing levels meet the needs of the service.
- The trust should ensure that environments are effectively alarmed and environmental risk assessments are completed.
- The trust should ensure effective disposal of out of date needles.
- The trust should ensure that the senior executive team are present and visible to staff.
- The trust should ensure that staff knowledge and training on Community Treatment Orders is improved.
- The trust should ensure that every patient is provided a copy of their care plan and that this is documented. The trust should ensure care plans are provided in accessible formats for patients.
- The trust should ensure that all environments respect privacy, dignity and safety by introducing privacy glass in rooms where patients are seen and alarm systems for staff.

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.

Our rating of well-led at the trust went down. We rated well-led as inadequate because:

- We found a high number of concerns not addressed from the previous inspections. We found significant issues with trust level governance, oversight of environments,a failure to address keys issues and a lack of pace with delivering essential improvements. Overall, the pace of change in planning and converting plans into action across the trust was disappointingly slow.
- The trust had not fully articulated their vision for how they operated as a trust. The trust had several strategies, a vision and corporate objectives, but these did not underpin all policies and practices. The trust lacked an overarching strategy which everyone within the trust knew. Staff and senior leaders could not articulate the trust's direction of travel and how this was co-ordinated. There was a lack of understanding in teams how their own plans, visions and objectives connected with the trust's vision.
- Although the trust had a defined reporting structure to the board, the governance of the trust was poor. The trust did not have robust governance procedures to ensure that they could identify and address issues across the trust in a timely way. These issues with governance procedures had been reported at the last inspection in 2017.

Summary of findings

- We were not assured that the trust risk register clearly documented action taken or progress of action, within agreed timescales. Many of the actions listed included plans to review process, establish an approach, or to develop areas. We felt this contributed to senior staff views that pace of change in the trust was slow. The trust's Board Assurance Framework (BAF) was lengthy, was combined with a corporate risk register and had overdue actions. Due to the lack of a trust overarching strategy, the BAF did not provide an effective oversight against strategic objectives, gaps in control and assurance.
- Frontline staff did not always feel connected to the wider trust and did not know who directors linked to their service were or did not feel engaged with the trust.
- The trust leadership and local service leadership lacked oversight and responded slowly to issues of risk and performance that affected safe delivery of patient care. Oversight of medication management, environments, seclusion documentation, staffing, waiting lists, care planning and patient involvement was variable, and in some services limited.
- The trust lacked a framework for co-ordinating, endorsing and therefore learning from the positive quality projects taking place. The teams we spoke with, felt the trust board did not set clear timescales or direction on how to move their projects forward.
- There were issues within the trust of a bullying culture despite evidence that staff knew the trust values. Some teams told us about a lack of teamwork, best practice was not shared amongst services and regular meetings did not take place in some services.
- The trust had a limited approach to patient involvement. We found this across core services and within senior teams. We would expect patient involvement to be embedded at all levels of the trust, across as many departments as possible, in planning, review, evaluation and delivery. The trust used numerous surveys to seek views but this does not always replace face to face engagement.
- The trust's pace for implementing equality and diversity initiatives across the organisation needed improvement. This was particularly relevant to protected characteristics. The trust supported a BAME network (black and minority ethnic) however, given the diversity of the geographical area of the trust, they had not significantly developed its agenda or workstreams since our last inspection.
- Overall, the pace of change in planning and converting plans into action across the trust was disappointingly slow. There was a lack of both grip and pace in the movement of the plans to secure resources to re-provide outdated environments.

However:

- The trust had a variety of measures in place to ensure that processes and reporting to board were not delayed. Every senior team we spoke with knew who they reported to and what to report.
- Some local leaders were visible and had the skills and knowledge to perform their roles. The trust delivered programmes for staff to develop into senior roles and had a clear career development programme for nursing staff.
- The trust encouraged staff to develop and implement ideas for service delivery, improvement and innovation. We heard many examples of interesting innovation projects and work that groups had done which impacted on and improved patient care.
- The trust had made progress in oversight of data systems and collection. The trust aligned staff to services to manage data and we saw improvements in recording and monitoring of supervision and appraisal, improvement in monitoring of waiting lists in specialist community mental health services for children and young people, and in trust wide training data. All managers in services had access to key performance data and knew how to interpret it and escalate concerns when necessary.

Summary of findings

- The trust was proactive and promoted staff health and well-being. We heard many positive stories to support the health and well-being of staff across the trust. This included mindfulness, yoga, staff choirs, corporate events, training courses through local colleges (such as mental health first aid), physiotherapy and counselling. The trust had a health and well-being calendar for events, and health and well-being champions to promote events.

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 ➔➔ Feb 2019	Requires improvement ➔➔ Feb 2019	Good ➔➔ Feb 2019	Requires improvement ➔➔ Feb 2019	Inadequate ↓ Feb 2019	Requires improvement ➔➔ Feb 2019

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 →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement →← Feb 2019
Overall trust	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement →← Feb 2019

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	Inadequate ↓ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement →← Feb 2019	Inadequate ↓ Feb 2019	Inadequate ↓ Feb 2019
Long-stay or rehabilitation mental health wards for working age adults	Inadequate ↓ Feb 2019	Inadequate ↓ Feb 2019	Requires improvement ↓ Feb 2019	Good ↑ Feb 2019	Inadequate ↓ Feb 2019	Inadequate ↓ Feb 2019
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 →← Feb 2019	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019
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 →← Feb 2019	Good ↑ Feb 2019	Good →← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019
Community-based mental health services for older people	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
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 →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement →← Feb 2019

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.

Long stay or rehabilitation mental health wards for working age adults

Inadequate 

Key facts and figures

Leicestershire Partnership NHS Trust provides long stay or rehabilitation mental health wards for working age adults from two locations:

The Willows is located in Leicester and comprises of four wards;

- Maple, an eight bedded male high dependency rehabilitation unit
- Acacia, a ten bedded mixed sex community rehabilitation unit
- Cedars, a ten bedded mixed sex community rehabilitation unit
- Sycamore, a ten bedded male community rehabilitation unit.

Stewart House is located in Leicester and comprises of two units;

- Arran, a 15 bedded female community rehabilitation unit
- Skye, a 15 bedded male community rehabilitation unit.

The service provides treatment and recovery for adults over 18 with a complex and enduring mental illness.

The service was rated as requires improvement following the comprehensive inspection in November 2016. The caring key question was rated as good. The safe, effective, responsive and well led key questions were rated as requires improvement. We found breaches of the following regulations:

- Regulation 11: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent
- Regulation 12: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment
- Regulation 17: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance
- Regulation 18: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing.

We identified areas for improvement and told the trust to take the following actions:

- The trust must ensure the environment is safe, clean and well maintained and there is sufficient storage to safely store equipment and patients' belongings.
- The trust must ensure the safe management of medicines, including storage, disposal and patients' consent to treatment is documented clearly and accurately.
- The trust must ensure staffing skill mix meets patient need.
- The trust must ensure patient records are organised clear and contain the necessary information to provide a safe and effective service.
- The trust should ensure all patients prescribed high doses of anti-psychotics are identified and appropriate physical health monitoring completed.
- The trust should ensure managers follow the trust's policy on managing attendance.

We have identified the issues which remain in this report. The trust had completed some but not all of the actions from the November 2016 inspection.

Long stay or rehabilitation mental health wards for working age adults

Our inspection, carried out between 19 to 23 November 2018, was comprehensive and announced at short notice (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 this core service and information we had requested from the trust.

During the inspection visit, the inspection team:

- visited all six wards
- spoke with 13 patients who were using the service
- spoke with four carers of patients who were using the service
- spoke with the managers or deputies for each of the wards
- spoke with 29 other staff members; including doctors, nurses, occupational therapists, psychologists, discharge nurses and domestic staff
- observed five episodes of care
- reviewed 30 patient records relating to physical health
- reviewed 30 records relating to patient risk assessments and care plans
- reviewed 31 medication records.

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- Managers had not ensured safe and well maintained care environments. This was raised at the inspection in 2016. We found unidentified ligature risks on Maple ward and ligature risks that were not safely managed at Stewart House. Managers had not ensured that the occupational therapy kitchen at Stewart House was safe.The gas cooker had not been serviced and cooker dials were worn. We observed a tile falling off the wall whilst a patient was cooking. At Stewart House the door from the female lounge to the garden was in a state of disrepair and could not be closed. On Maple ward patients and staff told us that the toilets were continually blocked and at Stewart House, two toilets could not be locked.
- Two wards were not compliant with guidance on elimintating mixed sex accommodation. There were no locked doors between male and female areas and no single sex lounges on Cedar and Acacia wards.
- Managers had not ensured compliance with the Mental Health Act Code of Practice. The seclusion rooms on Maple and Acacia were not free from hazards. There was a blind spot in the en suite area of Maple's seclusion room. Staff had not completed the required reviews for a patient in seclusion. Staff had not completed a seclusion care plan and were using out of date seclusion documentation.

- Staff on Maple ward were not completing or updating patient risk assessments. We reviewed eight patient records and six had risk assessments that staff had not updated. Managers did not feedback learning from incidents to staff. We reviewed 14 team meeting minutes and found brief references made to incidents that had occurred on that ward but no evidence of wider learning across the service or from other incidents in the trust.
- Staff did not follow good practice in medicines management. This issue was raised in the inspection in 2016. At Stewart House we found medicines that staff should have disposed of and staff using sharps bins to dispose of medicines. Staff had not labelled one in use medicine with the date of expiry. Staff had stored two medicated creams in an unlocked cupboard in the clinic room. We found loose tablets (unboxed in their foils) in the medicines trolley. On Maple ward, staff had not reconciled two out of eight patient's medicines on admission. Staff were not reviewing PRN (as required) medicines in line with national guidance.

However:

- The service had enough staff with the right skills, qualifications and experience for each shift. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. At Stewart House additional nursing staff were employed for three days a week to cover meetings and ward rounds.
- Staff and managers worked to keep the use of restrictive interventions to a minimum. Staff participated in the provider's restrictive interventions reduction programme. Staff made every attempt to avoid using restraint by using de-escalation techniques and only restrained patients when these failed and when necessary to keep the patient or others safe.
- Staff had completed and were up to date with their mandatory training. The mandatory training programme met the needs of staff and patients in the service. Managers kept track of staff and their mandatory training and staff received alerts so they knew when to update or complete training modules.
- All staff received training in safeguarding that was appropriate for their role. Staff knew how to recognise adults and children at risk of, or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Is the service effective?

Inadequate  

Our rating of effective went down. We rated it as inadequate because:

- Staff had not completed a physical health examination for patients on admission in 14 out of 30 records. Staff had not developed care plans to meet patient specific physical health needs for four patients. Staff had completed a physical health examination on admission for another patient at Stewart House over a year ago and indicated that the patient required an electro cardiogram. We were unable to find a record that this had been done.
- Staff had not completed care plans that were personalised, holistic or recovery orientated in 19 out of 30 records. Ten of these records were at Stewart House, four on Maple ward, three on Sycamore ward and two on Cedar ward.

However:

- The team included or had access to the full range of specialists required to meet the needs of patients on the ward. As well as doctors and nurses, teams included occupational therapists, clinical psychologists, substance misuse workers, discharge nurses, activities leads and pharmacists. Staff were able to refer patients to social workers, speech and language therapists, dieticians and physiotherapists.

Long stay or rehabilitation mental health wards for working age adults

- Staff worked well as a multidisciplinary team. Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed two care programme approach meetings and a discharge meeting which evidenced this. Staff made sure they shared clear information about patients and any changes in their care during handover meetings. Ward teams had effective working relationships with other teams in the organisation and external teams and organisations.
- Managers provided staff with supervision and appraisal. Apprasial compliance was at 82% and superivison compliance was between 78% and 100%.

Is the service caring?

Requires improvement 

Our rating of caring went down. We rated it as requires improvement because:

- Staff did not always involve patients and give them access to their care planning and risk assessments. In 20 out of 30 records checked there was no evidence that staff had involved patients in their care planning and there was no evidence in any records that patients had been offered a copy of their care plan. Managers told us that they were working with staff to ensure they improved how they evidenced patient involvement in care planning. Community meetings on Sycamore had not taken place regularly, in the past 12 months there had only been four meetings.
- Staff did not always treat patients with dignity and respect when providing care and treatment. A patient on one to one observations told us he had complained that staff were observing him when he used the toilet and had a shower. We reviewed this patients care records and found evidence in staff observation records that they were observing the patient in these situations. The trust observation policy stated that any decision regarding observations during personal care would be recorded by the doctor in the patients' care records. We did not find evidence that this had been done. On Cedar and Acacia wards staff escorted male patients past female bedrooms and bathrooms to access the laundry room.
- Staff did not always support patients to make advanced decisions on their care. In 20 out of 30 records staff had not supported patients to do this.

However:

- Patients said staff treated them well and behaved kindly. Patients told us that staff were brilliant, really caring and supportive. Staff introduced patients to the ward and the services as part of their admission. Staff provided patients with a welcome pack on admission.
- Staff supported patients to produce a newsletter at the Willows that was shared with patients and staff across the service. We observed an occupational therapy session where patients were in the process of producing the latest newsletter. One patient had produced a video of his recovery journey.
- Staff supported, informed and involved families or carers. Carers were provided with a welcome pack. We spoke with four carers. Carers told us that staff were brilliant, helpful and polite and looked after their relative well. Carers were invited to meetings about their relative's care and were kept updated. Staff helped families to give feedback on the service. The service had recently implemented carers meetings and was planning a carers event. Staff gave carers information on how to find the carer's assessment. One carer told us that they were in the process of accessing a carer's assessment.

Long stay or rehabilitation mental health wards for working age adults

Is the service responsive?

Good ↑

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

- The service had low numbers of delayed discharges (three in the past year). The service employed discharge nurses to enable a smooth transition for patients being discharged. Managers and staff ensured they did not discharge patients before they were ready. Staff had completed detailed discharge plans that were regularly reviewed in 26 of the 30 records reviewed.
- Each patient had their own bedroom, which they could personalise. Staff risk assessed patients before giving them their own room key. Patients had a secure place to store personal possessions. Patients could make their own hot drinks and had access to snacks. Each ward had a hot drink making 'station' that patients could access freely. We observed staff responding promptly to patients requests for snacks.
- The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. The occupational therapy kitchen at the Willows and the patient kitchens at Stewart House had been refurbished. The service had quiet areas and a room where patients could meet with visitors in private. The service had an outside space that patients could access easily.
- Staff made sure patients could access information on treatment, local services, their rights and how to complain. The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get hold of interpreters or signers when needed. We observed a member of staff communicating with a patient using Makaton.

However:

- Managers told us they were receiving referrals for patients who were acutely unwell and were reviewing the service criteria. The number of patients requiring one to one observations had increased over recent months. Managers had escalated this issue within the trust as a potential service gap.
- Patients were not happy with the quality and variety of food available. Patients had made repeated requests for more salads, vegetarian dishes and a greater choice of food. There was no evidence that staff had met these requests.
- We found that two patient toilets at Stewart House were not able to be locked. This impacted on patients' privacy and dignity.

Is the service well-led?

Inadequate ↓

Our rating of well-led went down. We rated it as inadequate because:

- Governance systems and processes had not ensured safety and environmental issues were addressed, that staff adhered to the Mental Health Act Code of Practice, that patient involvement was evidenced in records and that patients' requests were responded to in a timely manner.
- Leaders had not ensured that staff were fully informed about the new model of service. Most leaders at the service were new in post. Leaders were working on a transformation programme for the service but this was not yet embedded or communicated to all ward staff.

Long stay or rehabilitation mental health wards for working age adults

- The care records did not provide evidence this service provided care that would be considered best practice in a rehabilitation unit. The care plans did not indicate that people received the range of services a rehabilitation should provide.
- Managers did not feedback learning from incidents to staff. We reviewed 14 team meeting minutes and found brief references made to incidents that had occurred on that ward but no evidence of wider learning across the service or from other incidents in the trust.
- Three staff raised concerns related to bullying and feeling overloaded and pressurised. Two staff told us that communication could be better between the trust and staff.

However:

- The majority of staff (14 out of 16) understood the whistle-blowing policy and were aware of who the speak up guardian was. One staff member, who had started recently, had been given a card with details of the speak up guardian.
- Staff knew and understood the trust's visions and values and could describe how they applied to their work. Out of 16 staff asked, all of them were able to describe the trust's vision and values. Staff told us vision and values were discussed in induction, supervision and appraisal.
- The trust gave opportunity for leaders to develop their skills and for other staff to develop leadership skills. Leaders told us they had accessed leadership courses through the trust, including a 'building leaders' course. One staff member told us they were completing a course in line management as part of a leadership pathway. The trust had an agreement in place with the local university enabling staff to access some of their courses.

Areas for improvement

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

Wards for people with a learning disability or autism

Requires improvement 

Key facts and figures

The Agnes unit is a 12-bed assessment and treatment unit for adults with learning disabilities. The unit provides an inpatient service for individuals living in Leicestershire who require to be supported in a hospital setting because of their mental health, behaviour and levels of risk posed to themselves or others.

The short breaks services provide support for adults with learning disabilities and associated physical and sensory disabilities, challenging behaviour or autistic spectrum disorders. The services plan regular short breaks with families and carers. In addition, the services will provide breaks for families at short notice where this is possible. There were three units, The Grange and Gillivers, which were next door to each other, and 3 Rubicon Close. All three units admitted male and female patients. Since the last inspection, the service planned male and female only weeks to comply with mixed-sex accommodation guidelines. Patients at the Agnes unit may be voluntary/informal, detained under the Mental Health Act 1983 or subject to Deprivation of Liberty Safeguards (DoLS). The short stay units do not admit patients under the Mental Health Act.

The Care Quality Commission last inspected this location in November 2016 as part of a comprehensive inspection of Leicestershire Partnership NHS Trust. At that inspection we found that this service had breached the following regulations:

- Regulation 10: Health and Social care Act 2008 (Regulated Activities) Regulations 2014 dignity and respect – the short stay services did not comply with mixed-sex accommodation guidelines. There were no separate areas for male and female bedrooms. There were no separate male and female bathrooms and toilets.
- Regulation 11: Health and Social care Act 2008 (Regulated Activities) Regulations 2014 need for consent – staff were assessing for capacity to consent to admission after admission had taken place and after they had made a Deprivation of Liberty Safeguards (DoLS) application. Capacity assessments were not decision specific.
- Regulation 18: Health and Social care Act 2008 (Regulated Activities) Regulations 2014 staffing – staff did not receive regular supervision in line with the trust policy.

At this inspection, the trust had addressed the findings of the inspection in November 2016 and was no longer in breach of regulation 11 and regulation 18 but continued to be in breach of regulation 10.

This was an announced comprehensive inspection at short notice (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 the Agnes unit and three short breaks services to look at the environment and observe the care being given to patients
- spoke with eight patients who were using the service
- spoke with eight carers of patients who were using the service
- interviewed the managers for each of the wards
- spoke with 20 nurses, healthcare assistants and other members of the multidisciplinary team
- observed two multi-disciplinary meeting, one care and treatment review and observed four episodes of care

Wards for people with a learning disability or autism

- reviewed 13 patient care and treatment records relating to physical healthcare, risk assessments and care plans
- reviewed staff meeting minutes and staff rotas
- carried out a specific check of the medication management and viewed 14 prescription charts
- reviewed a range of policies, procedures and other documents related to the running of the service.

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Requires improvement 

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

- Staff did not always comply with the Mental Health Act code of practice when secluding patients and did not complete seclusion paperwork appropriately. We looked at four seclusion records. None of the notes contained a seclusion care plan. In three cases, there was no medical review within one hour and in two cases no regular nursing reviews throughout the seclusion. In one of the four notes we looked at there was also no evidence of four-hourly medical reviews taking place.
- The short breaks services did not comply with guidance on eliminating mixed-sex accommodation. Services planned male and female only weeks at all the services in order to avoid breaching the guidelines. However, managers told us that breaches happened regularly because they would admit patients when families were in need and required support at short notice. Data from the trust stated that in the last 12 months, the service admitted men and women at the same time on 16 occasions at The Grange, 12 occasions at Gillivers and on nine occasions at Rubicon Close.
- The short breaks service did not always adhere to infection control principles. We found a jug on the edge of the bath at Rubicon Close containing several used hair brushes, labelled with the name of the service.
- Staff did not always manage medicines safely in the short breaks services. At Gillivers and 3 Rubicon Close, staff used a paper system to record the administration of medication. At 3 Rubicon Close, it was not clear on one of the charts whether the patient had received their medication or not. The Agnes Unit did not have facilities to dispose of medicines on the ward.
- There was no system in place to ensure that learning from incidents, complaints and concerns was effectively communicated to non-registered staff.
- There were hazards in the short breaks services which could compromise the safety of patients. We saw broken items of garden furniture and uneven pathways. At one of the services the keys to the cleaning cupboard, containing 'Control of Substances Hazardous to Health (COSHH) materials, had been left in the door and the door had been left open.

However:

- Internally the wards were clean and well maintained. Cleaning scheduled showed that the wards were cleaned daily. Furnishings were generally of good quality.

Wards for people with a learning disability or autism

- Staff completed comprehensive risk assessments and kept these updated. Staff completed ligature risk assessments which addressed all the ligature risks on the wards. The Agnes unit had been fitted with anti-ligature fittings. Staff used enhanced levels of observations based on individual risk assessments to ensure patients were safe.
- There were enough staff deployed to keep patients safe.
- Mandatory training rates were high across the services.
- The Agnes unit had low rates of seclusion. Staff completed restrictive practice training which taught them to use positive behaviour support plans and de-escalation techniques to reduce restraints and seclusions.
- Staff managed medicines safely at the Agnes unit. The provider ensured staff stored medication at appropriate temperatures which were monitored electronically. Emergency medications, appropriate for the service, were stocked and managed in accordance with trust policy and Resuscitation Council guidance. The provider used an electronic prescribing system to ensure staff administered medicines safely and in line with prescriber's instructions. Doctors prescribed medicines in line with national institute for health and care excellence. The electronic prescribing system reduced the possibility of medication errors and allowed easy access to historical prescribing.

Is the service effective?

Good ↑

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

- Staff completed comprehensive mental health assessments at the Agnes unit on or shortly after admission. Short breaks units updated assessments on new admission dates or before if needed. Staff completed holistic and person-centred care plans and positive behaviour support plans.
- Staff at the Agnes unit completed physical health checks for patients on admission and ensured monitored this during their stay. The short breaks services updated physical health check on each new admission or prior to this if they received information from families or GPs.
- Patients had access to physical healthcare services. We saw examples of patients managed with chest infections and pressure sores. Staff referred to specialist services when necessary and procured specialist equipment to address patient need, for example, an air bed. Staff at the short breaks services liaised with patients' families and GPs. A number of the patients they supported had profound physical needs and required specialist care.
- Doctors followed national institute for health and care excellence when prescribing medication for patients.
- Managers at the Agnes unit provided staff with regular appraisals and supervision. Compliance with appraisal was 94% and Agnes Unit supervision compliance was 92%.
- There was a full range of multi-disciplinary staff at the Agnes unit. Staff were experienced, appropriately qualified and attended regular multi-disciplinary meetings for patients including Care Programme Approach meetings and Care and Treatment Reviews. Staff undertook specialist training to ensure they had the relevant skills to undertake their role. New staff received an induction which was based on care certificate standards.
- Staff applied the Mental Capacity Act appropriately. In the short breaks units, staff completed mental capacity assessments and DoLS applications; these were of good quality, decision specific and correctly submitted.

However:

- Supervision compliance in the short breaks units was lower than the trust average and target at 70%.

Wards for people with a learning disability or autism

Is the service caring?

Good 

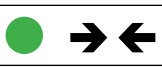
Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with kindness and compassion and focused on recovery by providing high quality care. We observed staff interacting with patients in a kind, caring and respectful manner.
- Staff involved patients in planning their care. Staff reflected this in care plans and patients confirmed it. Staff understood patients' needs and helped patients to understand why they were in hospital and how to move on.
- Staff supported and involved carers and families in their relatives' care and treatment. Carers were positive about the way staff had supported them and their relative.

However:

- Staff had not routinely recorded whether they had given copies of care plans to patients or to their carers where appropriate.
- The dignity and privacy of patients was compromised. The trust could not comply with mixed-sex accommodation guidance when they admitted males and females into short breaks units at the same time. On some occasions, patients were placed on enhanced observations to keep them safe which they would not have needed had they been in single sex accommodation.

Is the service responsive?

Good 

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

- Beds were available when needed for people living in the catchment area. Patients on home leave did not return to a different bed and patients were not moved from one pod to another during an admission unless there were clinical grounds to do so.
- Staff at the Agnes unit supported moves to placements and liaised with community teams to ensure a smooth transition. The average length of stay over the previous six months varied from 4.5 days in August 2018 to 157 days in October 2018. The Agnes unit's discharge co-ordinator liaised with professionals and families to ensure discharges were planned and patients were discharged in the most appropriate way.
- Community treatment reviews were person centred, compassionate and discharge focused. The meeting we attended identified progress and future plans, working in partnership with the patient.
- The Agnes unit had access to a full range of rooms to support treatment and care. There was a separate activity area and smaller rooms where staff could speak to patients privately.
- Staff provided information in an accessible format and displayed this across the services. There were posters on the ward and in information booklets. These were written in several different languages offering information on request, including how to complain, an information booklet about the Agnes unit, information on treatments and access to advocacy. Information was in simple language and in an easy-read form.

- Patients had access to interpreters when needed. Speech and language therapists worked with patients and staff to ensure they met patients' specific communication needs.

However:

- In the short breaks services, carers and staff told us that it was more difficult for some carers to book into because of the policy to offer male and female only weeks.
- Patients could not make or have access to snacks when they wanted them. Although patients could ask for a drink at any time, the patient booklet stated that snacks were at set times only.
- Some of the nursing offices at the Agnes unit were very small and could not support handovers. We attended one handover in a staff kitchen, which contained information on the walls about patients' needs, including some personal information.

Is the service well-led?

Requires improvement 

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

- The trust had not ensured that wards for people with a learning disability or autism were compliant with mixed sex accommodation guidelines. The trust was in breach of this guidance but these breaches were unavoidable to meet the needs of the people and families that used this service. Carers felt passionate about the accommodation being mixed sex.
- Managers had not ensured that seclusion took place in accordance with the Mental Health Act code of practice and that staff completed seclusion paperwork correctly.
- Managers and staff at the short breaks services said they felt isolated from the trust and from each other with little sense of a shared identity.
- Managers did not have oversight of some issues affecting the short breaks services, for example medication errors and infection control issues. Managers did not have a robust system to ensure that essential information, such as learning from incidents and complaints, was shared and discussed with all staff, including healthcare assistants.
- We did not find clear systems in place to gather feedback from patients and carers and use it to make improvements to the service. The trust could not provide data relating to staffing on the Agnes unit prior to the inspection.

However:

- Systems were in place to measure the performance of the team. Local managers received regular information in relation to the performance of the service, staffing and patient care. Information was easy to understand and help managers ensure staff received training and supervision when they required it. Managers had a good understanding of the services they managed. The ward manager was frequently on the unit and available to staff. Staff knew who were the senior managers in the service and they visited the ward on occasions.
- Staff had access to equipment and information technology to do their work. The patient information system was easy to use and staff found it easy to update patient records.
- There were good interagency working arrangements in place to support the needs of patients. Multidisciplinary team members worked with their community colleagues to ensure smooth transitions and discharges.

Wards for people with a learning disability or autism

- Staff felt positive about working in their teams. Staff teams supported each other well and staff said they felt respected, supported and valued for their work and were proud to work for the team. Staff felt able to raise concerns without fear of consequences and knew how to do this.

Areas for improvement

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

Community-based mental health services for older people

Good  

Key facts and figures

The community-based mental health teams (CMHT) for older adults in Leicestershire provide, multidisciplinary assessment and intervention for patients of any age, with a complex presentation of dementia or those over 65 with a complex functional illness.

We inspected six community-based mental health teams for older adults. These were Charnwood CMHT, Leicester City East CMHT, Leicester City West CMHT, Melton, Rutland and Harborough CMHT, South Leicester CMHT and West Leicester CMHT.

This core service was last inspected in November 2016. Following that inspection, we rated this core service as requires improvement overall, with a rating of requires improvement for safe, effective, caring, responsive and well-led. We issued the trust with two requirement notices which related to:

- Regulation 11: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Consent - consent to treatment not being routinely sought, a lack of capacity assessments and best interest decisions not properly recorded within care records
- Regulation 12: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment - medicine risk assessments were not in place for medication kept in patient homes, medicine records did not include allergy information, care plans did not detail the care and treatment the patient needed to manage risks appropriately for their health and safety and assessing risks for referrals and waiting lists were not managed effectively.

We found the service had met these requirements at this inspection.

Before the inspection visit, we reviewed information that we held about these services. Our inspection was announced at short notice (staff knew we were coming) to ensure that everyone we needed to talk to was available. This was in line with CQC guidance.

During the inspection visit, the inspection team:

- interviewed 29 staff including nurses, consultant psychiatrists, occupational therapists, clinical psychologists, administrators and healthcare workers
- interviewed three team managers and two community managers.
- spoke with 15 patients
- spoke with 11 carers
- attended three home visits
- reviewed 27 patient care and treatment records
- toured the premises of each service we visited and conducted a check of the clinic rooms, medication and clinical equipment where appropriate
- reviewed a range of other documentation, policies and procedures related to the services we visited.

Community-based mental health services for older people

Summary of this service

The summary of this service appears in the overall summary of this report.

Is the service safe?

Good  

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

- Staff completed risk assessments of patients at initial assessment and reviewed individual patient risk regularly. Patients were also provided with numbers to call if they needed to speak to a duty worker whilst on the waiting list. Where risks increased managers referred patients to the unscheduled care service who arranged urgent assessments
- The service improved on medicine risk assessments. Staff added allergy information on depot cards and individual risk assessments. Care plans contained individual patient risks with medication and how risks had been reduced.
- All areas were clean and well maintained and we observed staff adhering to infection control principles including handwashing.
- The service improved monitoring of waiting lists. Team managers checked waiting lists weekly. The number of patients on the caseload of the teams, and of individual members of staff, was appropriate. The service had introduced a case complexity tool which to ensure caseloads were manageable.
- Staff received safeguarding training which included how to recognise and report abuse and/or exploitation and had a good working knowledge of safeguarding.
- Managers debriefed staff after incidents and ensured regular team meetings took place to discuss lessons learned from incidents.
- The trust had a lone working policy and managers in each team implemented their own local lone working procedure that was location specific. Staff spoken with had knowledge of it.
- Patients had rapid access to a psychiatrist when required.

However:

- There were three fulltime vacancies across three teams for qualified nurses. The vacancy for a consultant psychiatrist was filled with a locum. Prior to the locum consultant being in post and the nurse vacancies had impacted on the waiting lists. As a result, the team were put on the trust risk register. However, managers had a plan to recruit vacant posts and used staff from other teams to ensure there were minimal breaches and a short waiting list.
- Not all interview rooms within the service were fitted with alarms in West Leicester and staff did not have access to personal alarms.
- In the City East team, managers failed to undertake an environmental risk assessment of rooms where patients were seen by staff.
- City East staff had failed to dispose of needles that were out of date.

Community-based mental health services for older people

Is the service effective?

Good ↑

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

- During this inspection staff knowledge and understanding of the Mental Capacity Act 2005 had improved. Staff followed the Mental Capacity Act principles and assumed capacity unless there was a reason to doubt this. Staff assessed capacity appropriately, in a time and decision specific way when appropriate. Staff informed us that delivery of training changed from being online to face-to-face which was better and mental capacity was always discussed at learning lunches.
- We reviewed 27 care plans and all of them were up to date, person centred and involved patients. Staff developed support plans which were kept by patients at home to help patients with coping techniques in crisis.
- Staff received regular appraisals and both clinical and management supervisions. Staff told us they were supported and felt valued by team and community managers. New staff, including agency staff, received a trust-wide and local induction.
- The service offered psychological therapies which were delivered in line with national institute for health and care excellence guidance such as cognitive behavioural therapy and dialectical behaviour therapy. Staff used recognised rating scales to assess and record severity and outcomes.
- The multidisciplinary team worked together as a team to benefit patients. They supported each other to make sure that patients received the right care for them. Staff had good working relationships with third sector organisations specialising in help for: housing, veteran support, advocacy and benefits. The service also specialised in helping patients with an early onset of dementia with employment support.
- Staff considered physical healthcare checks and worked closely with GPs and psychiatrists to monitor physical health.
- Staff participated in audits, benchmarking and quality improvement initiatives. Staff self-audited their records using a template which was discussed in supervision. Team and community managers also performed random audit checks on records.

However:

- Managers recognised that staff knowledge on Community Treatment Orders was lacking. We checked four Community Treatment Orders and found that the responsible clinician had recalled a patient on a Community Treatment Order twice, to extend the 72-hour holding period which is not in line with the Mental Health Act 1983.

Is the service caring?

Good ↑

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

- Patients and carers gave positive feedback about their experiences of using the services. They made positive comments about their relationships with staff and how compassionate and supportive staff were. Staff involved patients in decisions about their care and treatment. The service held recovery cafes which involved patients and carers who could provide feedback on their care.

Community-based mental health services for older people

- Staff were aware of demographics within the county and provided interpreters for patients where English was not their first language. This ensured the patient was involved in all aspects of their care.
- Staff signposted patients to other services including day centres and third sector organisations that met their needs. Staff also signposted carers for support.
- We observed staff interacting with patients in a caring and kind manner. Staff demonstrated that they were aware of patients' needs and understood how best to support them.

However:

- Staff did not provide all patients and carers with a copy of their care plan. We reviewed 27 records and 11 records showed that patients had not been given a copy of their care plan. Patients and carers confirmed this.

Is the service responsive?

Good 

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

- The service improved monitoring of waiting lists. Team managers checked waiting lists weekly and breaches of waiting time targets were minimal.
- Staff were able to send patient referrals to the unscheduled care team or the crisis team if the patient was in crisis. Teams had a duty worker to respond to calls from patients and had capacity to conduct visits if required.
- Staff only cancelled appointments when necessary. Patients informed us that appointments were only cancelled to be brought forward if staff had capacity, so patients could be seen quicker.
- The teams met the needs of all people who use the service – including those with a protected characteristic. Staff supported patients with communication, advocacy and cultural needs and preferences.
- All teams demonstrated good working relationships with external organisations and teams displayed leaflets within all bases for patients.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- At Leicester West CMHT, staff saw patients in rooms that lacked soundproofing and privacy glass, compromising patient privacy and confidentiality.

Is the service well-led?

Good 

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

Community-based mental health services for older people

- Leaders had the skills, knowledge and experience to perform their roles, a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Managers supervised staff regularly and appraised their work yearly. Team and community managers had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and 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.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect such as updated guidance on clinical practice.
- Managers shared lessons learned in team meetings and during supervisions, this included learning from complaints.
- The service used KPIs and other indicators to gauge team performance. This included waiting list time, breaches and care records.
- Staff engaged actively in local and national quality improvement activities.

However:

- Staff felt disconnected from the executive team and felt they were not listened to.

Outstanding practice

We found areas of outstanding practice in this service. See outstanding practice section above.

Areas for improvement

We found these areas for improvement in this service. See areas of improvement section above.

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

Inadequate 

Key facts and figures

The acute wards for adults of working age and the psychiatric intensive care units (PICUs) 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 mixed sex ward

• Watermead, 20 bedded mixed sex ward

• Bosworth, 20 bedded male ward

• Thornton, 21 bedded male ward

• Ashby ward, 21 bedded male ward

• Heather, 18 bedded female ward

• Aston, 19 bedded female ward.

The Trust admits patients to a psychiatric intensive care unit (PICU) if their needs cannot be safely met within the acute environment. There are two PICUs at Glenfield:

- Belvoir PICU is also located at the Bradgate Mental Health Unit and has 10 beds for acutely unwell male patients.
- Griffin PICU is located at the Herschel Prins Centre and has 6 beds for acutely unwell female patients. This service opened in October 2017.

This was an announced comprehensive inspection at short notice (staff knew we were coming) to ensure that everyone we needed to talk to was available.

The service was last inspected in November 2017 with reports published in April 2018. The overall rating for the Trust was 'Requires Improvement' and a warning notice was issued to the Trust following this inspection for the following regulatory breaches:

- Regulation 9: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care
- Regulation 12: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment
- Regulation 13: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 15: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safety and suitability of premises
- Regulation 17: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

At this inspection we found the trust had addressed issues relating to Regulation 13 and 15, but remained in breach of the other regulations and one further regulation.

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

During the inspection visit, the inspection team:

- spoke with 26 patients who were using the service and five carers
- spoke with the managers/leaders for each of the wards
- spoke with 27 other staff members; including doctors, nurses, healthcare assistants, occupational therapists, psychologists and members of the bed management team
- observed one bed management meeting and one ward round
- observed nine episodes of care and one meal time
- reviewed documentation relating to the service, including meeting minutes, incident forms, policies and procedures and ward complaints and compliments.
- reviewed 43 care records and 48 patient medication records
- reviewed records relating to 58 episodes of seclusion
- reviewed the Mental Health Act 1983 (MHA) detention paperwork of 43 patients.

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- Safety was not a sufficient priority. Ward environments were poor, and managers did not address issues relating to safety quickly. Windows identified as an urgent safety risk in 2017 had not been replaced. Lighting on some wards was poor and affected the visibility of the area. Staff did not identify all ligature risks on the ligature risk assessments or record how to mitigate against them. Staff did not update ward risk assessments when new environmental risks presented. This included broken fixtures and fittings, protruding screws and fractured Perspex. We were concerned about fire safety. Patients with disabilities did not have personal evacuation plans. Staff did not complete fire warden checks regularly on Watermead ward. Over 24 months staff completed less than 50% of the required weekly checks. Staff did not store and manage medicines and equipment safely. We identified a breach of regulation for medicines management at our last inspection and issues remained. This included; inappropriate management of controlled drugs, storage of medication, disposal of medication and the calibration of equipment to ensure it was working correctly.
- The trust did not support staff to safely manage a smoke free environment. Managers and staff did not uphold the smoke free policy. We observed patients smoking in the gardens and saw evidence of smoking in seven out of nine ward gardens. One ward smelt of cigarette smoke. Staff did not feel supported by senior leaders in addressing the difficulties of implementing the policy. Additionally, staff reported that they did not feel confident to challenge patients who had lighters in their property on or their person and remove the lighters to maintain the safety of the ward, patients, staff and visitors.

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

- There was no evidence of learning from events or action taken to improve safety. Senior managers did not share lessons learned from incidents effectively across the wards. Staff were not aware of incidents on other wards. For example, there was a recent fire on Beaumont ward set by a patient with a contraband lighter. The trust did not initially report this fire as a serious incident. Although the trust was still awaiting the final report, there was no evidence of immediate lessons being shared.
- Substantial and frequent use of agency and bank staff increased the risk to people using the service. Despite attempts to use regular bank staff, three managers described a lack of consistency for patients, impacting on their ability to form therapeutic relationships with staff and understand the risks posed to or by individual patients. Regular staff were often moved to cover absences on other wards. Six patients told us they did not always know the staff on duty and experienced delays in responding to requests due to staff numbers. In October 2018 the average number of shifts filled by bank and agency staff was 43.6%.
- Staff did not always assess, monitor or manage risks to people who use the services appropriately. Staff missed opportunities to prevent or minimise harm. We reviewed 58 episodes of seclusion. In 72% of records there was no medical entry to demonstrate a doctor completed a medical review within an hour, or without delay. In 76% of records it was not clear patients had access to appropriate nursing reviews of their care. No records contained a care plan detailing the ways in which seclusion could be ended at the earliest opportunity. On two wards that accommodated patients of both sexes staff could not describe what resulted in a breach of mixed sex accommodation guidance. Managers could not assure us they understood what resulted in a breach and how this would be reported. Therefore, we were not assured that the data provided showing no mixed sex breaches in 12 months was accurate.
- The trust did not have dedicated staffing for the health-based place of safety. Staff were taken from the acute wards to staff the 136 suite when required. Senior staff told us that there had been a significant increase in patients admitted over the past year.
- A more senior nurse, rostered on a management day, was on call to staff the place of safety. However, they were frequently needed to cover shortfalls on the wards and therefore not always available. In these instances, one of the duty managers attended. This had an impact on duty cover for the wards, as well as staff consistency in the place of safety.

However:

- Staff administered medicines in accordance with the prescribers' intentions and we saw evidence of the pharmacy team input to patients e-prescribing records.
- The electronic prescribing system alerted staff when medicines were due. When staff omitted medications, reasons were recorded. Staff described awareness of schedules for medicines requiring non-standard times for administration We saw emergency medicines and equipment were available, appropriate to each setting and were accessible to staff.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- Staff did not complete individualised, person centred care plans with patients. Wards used templates for care plans which contained generic wording and statements. They consistently showed no evidence of patient involvement, no patient voice, views or wishes. Care plans appeared holistic, in that they covered many areas, but they did not identify patient strengths and did not demonstrate a recovery focus.

- There was insufficient opportunity for some patients to access psychological therapy and therefore the range of treatment offered was not in line with best practice guidance and National Institute for Health and Care Excellence guidance. There was a vacancy in the psychology team which impacted on patient's ability to access psychology input. Some wards employed therapeutic liaison workers to develop activities for patients but not all wards had this resource.
- Staff and managers did not demonstrate evidence of collaborative working between wards, learning from incidents and sharing of best practise. Some wards had good initiatives underway such as healthy eating and seclusion recording. These positive outcomes were not shared.

However:

- Staff were given opportunities to develop their skills and knowledge by attending both internal and external training. Supervision and appraisal rates had improved since the last inspection. During October 2018 five wards had supervision rates of over 90% with two wards achieving 100% supervision attendance.
- 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.

Is the service caring?

Requires improvement 

Our rating of caring went down. We rated it as requires improvement because:

- Staff did not involve patients in care plans. None of the patients we spoke to could describe the contents of their care plan. Staff wrote care plans in formal language and plans lacked the patients' voice. Staff did not record whether patients were offered and had accepted, or declined, a copy of their care plan. Only two patients had a simplified version called 'My Care Plan'. Staff told us that paper copies of these were completed with patients. There was no evidence of these being uploaded onto their electronic files. Five patients told us they had 'no idea' what a care plan was.
- On three acute wards, we observed staff undertaking physical observations in public areas of the ward which compromised their dignity and privacy. Two patients reported having blood pressure and blood sugar monitoring daily despite there being nothing in their care plans to indicate a need for this frequency of checks.

However:

- Staff treated patients with kindness, compassion and respect. We observed interactions between staff and patients during the inspection and saw that staff were respectful and responsive to patient's. We spoke with 26 patients who told us that staff were generally kind and caring. During the inspection, we observed staff dealing with a very unwell patient in a respectful and caring way with an emphasis on maintaining the patient's safety and dignity throughout.
- Staff gave patients opportunities to provide feedback via community meetings. Patients had access to advocacy services on the wards. Staff gave contact details to patients upon admission routinely. We also saw posters and leaflets available on the wards. Wards had information boards detailing the staff on duty, planned activities and times of ward rounds. These informed patients of the staff available for care and treatment for that day.
- Four out of five of the carers we spoke to were happy with their involvement, information shared with them and the level of care provided to their loved ones on the wards.

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

Is the service responsive?

Requires improvement 

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

- On Aston, Ashby, Bosworth and Thornton wards there was an inadequate number of rooms for care and treatment of patients. There were not sufficient rooms for patients to access one to one 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.
- Aston, Ashby, Bosworth and Thornton wards still had four bed dormitory accommodation. Patients disliked these because of the lack of privacy and private space. We observed one room intended as a single bedroom on Thornton ward used as a two-bedded room. This room was very cramped, and patients had very little access to private space.
- High bed occupancy across the wards meant that bed management was challenging. Some patients had to be sent out of area or moved to a rehabilitation ward. At the time of the inspection, 18 patients had been admitted to beds out of area because of lack of acute beds. A member of staff told us that very occasionally seclusion rooms were used when patients needed to be admitted in an emergency.

However:

- The trust provided a choice of food to meet differing dietary needs and choices.
- Discharge planning was done well. Staff worked pro-actively from admission to prevent barriers to discharge, despite the difficulties with social care and housing resources in the community.
- 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.
- The Unit had an Involvement Centre which offered a range of activities and resources for patients. Where occupational therapists and therapeutic liaison workers worked as part of the ward team we saw that they worked closely with patients to pro-actively engage them. The patient's we talked with spoke positively about the support they received.
- Four patients told us that the food was over-processed with poor consistency, quality and flavour.

Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate because:

- There remained significant concerns relating to the proper and safe management of medicines which were raised at the last inspection.
- Requirements relating to maintenance issues being dealt with in a timely way, consideration of removing dormitories, and implementation of the smoke free policy, raised as concerns at the previous inspection had not been addressed.

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

- The trust did not identify, investigate and attempt to reduce significant issues that threatened the delivery of safe care and treatment. We found serious incidents and risks relating to the environment, fire and management of the smoke free policy. The trust had not identified links between incidents to identify wider trust learning. Staff were not always aware of incidents that had occurred within the service.
- There was a lack of cohesion across the unit and staff talked about lack of teamwork between individual wards and between wards and the bed management team. Best practise and innovation were not shared. Staff talked about how it could be difficult to get support from colleagues on other wards during difficult incidents. High vacancy rates and usage of bank and agency staff was negatively impacting on patient care.
- Not all ward teams were having regular team meetings and minutes were not always up to date nor comprehensive. There was little evidence of how information from minutes was shared with non-attendees.
- Staff did not feel always feel connected to the wider trust. They described visible local leadership to service manager level but felt above that role there was a lack of visibility and understanding of their service's needs. We heard examples where local leaders felt there was a lack of response from the trust regarding issues significant to their wards. Some staff members knew who the executive team were, in particular the chief executive, but were not able to name who the director was linked to the service or had seen them on a board walk.

However:

- Ward managers demonstrated commitment and passion and had a good understanding of the services they managed. They could explain clearly how the teams were working towards high quality care. Staff on all wards spoke highly of their ward managers and felt well supported and listened to.
- Senior managers were visible on the wards and accessible to staff. A range of wellbeing initiatives, including protected time off the wards, yoga and free fruit, were offered to all staff to improve staff wellbeing and morale.
- Supervision and appraisal rates had improved significantly since the last inspection and staff spoke positively about supervision, as well as the learning and development opportunities that were available to them.

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

Leicestershire Partnership NHS Trust provides specialist community mental health services for children and young people for patients aged 0 to 18 years under one registered location: Bridge Park Plaza.

The service sits within the Families, Young People and Children's services within Leicestershire Partnership NHS Trust. Specialist child and adolescent mental health service (CAMHS) provides specialist mental health services for children and young people experiencing moderate to severe mental health problems and disorders up to the age of 18 years living in and registered with a GP in Leicester Leicestershire and Rutland.

Specialist community mental health services for children and young people comprises several teams. These include outpatients' teams, access team, eating disorder team, group work team, paediatric psychology team, learning disability team, young people's team, inpatient unit, crisis team and the primary mental health team.

We inspected teams to look at those parts of the service that did not meet legal requirements and as we received information giving us concerns about the safety and quality of the services.

- City outpatients team: Based at Westcotes House, Westcotes Drive, Leicester LE3 0QU.
- CAMHS access team: Based at The Valentine Centre, Gorse Hill Hospital Site, Anstey Lane, Leicester LE7 7GX.
- County outpatients team: Based at The Valentine Centre, Gorse Hill Hospital Site, Anstey Lane, Leicester LE7 7GX and Loughborough Hospital, Hospital Way, Loughborough, Leicestershire, LE11 5JY.
- CAMHS crisis home treatment team: Based at the Agnes Unit, Gorse Hill Hospital Site, Anstey Lane Leicester LE7 7GX.
- Young people's team: Based at Westcotes House, Westcotes Drive, Leicester LE3 0QU.

We did not inspect all other specialist community mental health services for children and young people previously rated as 'requires improvement'. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

At this inspection we found that this core service had not fully addressed actions from our 2017 inspection. We found breaches of:

- Regulation 9: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Patient centred care
- Regulation 12: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and Treatment
- Regulation 17: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance
- Regulation 18: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

The trust had addressed some findings of the inspection in 2017 and was no longer in breach of:

- Regulation 13: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 15:Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safety and suitability of premises.

Specialist community mental health services for children and young people

Our inspection of this core service in November 2018 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 teams to look at the environment
- spoke with two patients who were using the service
- spoke with 24 carers of patients who were using the service
- spoke with six managers, including managers for the teams and the service group manager
- spoke with 35 staff including nurses, support workers, doctors, occupational therapists, psychologists, social workers and administration staff
- observed six staff meetings or contacts with patients including a multi-disciplinary team meeting, a professional leads meeting, observation of access and duty staff and staff appointments with patients
- reviewed 26 patient care and treatment records including, referral information, risk assessments and care plans
- reviewed two staff records relating to appraisals
- reviewed a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Requires improvement 

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

- The trust had not ensured there were enough staff to meet the needs of the service. Many patients still faced long waits for assessment and treatment. Seventeen out of 35 staff (excluding managers) we spoke to raised concerns about this. Staff said this was due to having two consultant psychiatrist, one clinical psychologist and 1.4 band 6 mental health practitioner post vacancies, short term and long-term sickness and parental leave. Sickness rates for county and crisis teams were at times above the national average of 4.2% at 5.7%. Examples of how this had affected the service included crisis team staff held on to patients longer than they had intended to help manage risks. Staff had challenges arranging urgent appointments for patients with doctors due to their availability.
- The trust had not fully ensured since our 2017 inspection that clinical premises where patients received care were safe, clean, well equipped, well maintained and fit for purpose. For example, Westcotes House building was old and not built for purpose. There was a large crack both sides of an archway and it had taken the trust five weeks to get a civil engineer assessment. In addition, some window catches had decayed.

Specialist community mental health services for children and young people

- Staff did not always follow the trust's policy for infection control as they had not ensured that toy and clinic cleaning rotas were available or routinely completed across all sites. Fabric beanbags in Westcotes House's group room had stains. Loughborough House clinic room had no handwashing facilities or gloves for staff in the room.
- The trust's safeguarding and incident policies did not clearly state the process for staff to report safeguarding incidents on the trust's electronic system. Two out of three city team meeting minutes did not capture how managers were sharing learning from incidents.

However:

- Staff reported that they received support to reduce their caseloads. Managers had arranged for some locum staff to assist with managing workloads and were reviewed what resources they had and needed to deliver a service. The trust had systems to risk assess and manage patients referred or waiting for a service.
- The trust stated Westcotes House was on their disposal list and they were looking for alternative premises. The trust had developed a protocol with staff to reduce risks for patients visiting the crisis team using the same entrance and reception as adults with learning disabilities. The trust had ensured that staff had access to personal alarms to use in case of emergency.
- Staff's compliance with role essential training was above 80%. Managers had systems in place to monitor when staff attended training and had systems to prompt and remind them when they did not.

Is the service effective?

Good ↑

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

- The trust had made improvements to ensure staff completed clear comprehensive and holistic care plans which identified patients' needs and the care required. The trust audited records to check they were up to date. Staff gave a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with National Institute for Health and Care Excellence guidance. Staff used recognised rating scales and other approaches to rate severity and to monitor outcomes. Staff used technology to support patients effectively for example, giving online access to therapies and other resources.
- The trust had ensured since our last inspection that staff documented assessments as relevant of patients' mental capacity and their consent to treatment. Staff had considered patients capacity in the 26 records we checked.
- Staff had effective multidisciplinary working with internal and external teams such as primary care, social services, education, paediatrics, police, and other community teams – including adult services. CAMHS staff had effective working relationships, including good handovers, with other teams within the organisation (for example, community to crisis team).
- Managers delivered regular supervision and appraisal to staff and gave staff opportunity to develop their skills and competencies. As of October 2018, the percentage of staff that had had an appraisal was 91%. The percentage of staff that received regular supervision was 79%. Staff additionally said they had access to reflective practice and case discussions.

Is the service caring?

Good →←

Specialist community mental health services for children and young people

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

- The trust had involved patients in their care plans. Staff offered them and carers a copy of their care plan. The trust audited care records to check that staff had involved patients and care plans had a recovery focus.
- Two patients and 18 of 24 carers we spoke with, gave positive feedback about staff, and stated they treated them with kindness dignity and respect. We saw this in our observations of care and treatment delivered. Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Family and friends test results for October 2018 showed 100% would recommend the service to others.
- Staff informed and involved families and carers appropriately and provided them with support when needed.

However:

- The trust did not have a system in place to regularly engage with patients and carers and involve them in the service delivery.
- Six carers gave negative feedback stating staff could be more responsive.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate because:

- Since our inspections from 2015 onwards, the trust had not taken adequate action to ensure that all patients received the service they needed in a timely way. A number of patients waited longer than expected for assessment and treatment. Staff could not always respond as quickly as they wanted to patient referrals due to a lack of resources. As of 19 November 2018, 498 patients waited for a routine assessment at city or county teams, 136 patients waited over 30 weeks across services for assessment. There were 969 patients waiting for treatment 654 for county and 315 for the city team. This was an increase from our last inspection in 2017 (945); of these approximately 230 children were waited 1-2 years for treatment. Fourteen of 24 carers we spoke with, said there were difficulties accessing the service and they had to wait a long time.
- Managers said the crisis team was not always able to meet their commissioned target to telephone patients within two hours and assess them within 24 hours. Staff including managers told us there was a 34 week wait for patients with 'medium' and 'low' risks to receive a 'routine' assessment despite the NHS constitution recommending no more than an 18 week wait for treatment. The trust did not meet commissioned targets for assessment of routine of children within 13 weeks.
- The trust did not meet the needs of patients with neurodevelopment issues in a timely way as patients often faced the longest waits for a service. As of 19 November 2018, 454 patients with attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) waited for either further specialist assessment or treatment, 161 patients waited one to two years. The crisis team said that approximately 50% of patients on their caseload had ASD.
- The trust staff gave limited examples of how they met the diverse needs of patients. Twenty out of 26 patient's records checked held limited information about patients protected characteristics for example race, religion or belief or sexual orientation. This was despite Leicester black and minority ethnic population being significantly greater (49.5%) when compared against the England average. (Joint Strategic Needs Assessment). Twenty out of 26 patients' records checked held limited information about patients protected characteristics for example race, religion or belief or sexual orientation.

- The trust had not ensured that Westcotes House reception was fully private and confidential as visitors could overhear receptionist conversations and trust information.

However:

- The trust had a range of specialist services. These included a young people's team which worked with vulnerable young people in care and those who are involved with the youth offending service; a specialist perinatal outreach mental health service and other teams such as to support patients with an eating disorder or with psychosis.
- The trust had developed a pathway and process for staff to follow to meet the national children and young people transitions commissioning for quality and innovation.

Is the service well-led?

Requires improvement 

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

- The trust had not ensured adequate higher management leadership and governance to address all actions from our previous inspections. This included management of staff resources, waiting lists and the environmental infection control procedures, still posed a risk for the service. The CQC had identified some of these risks since 2015. Not all managers gave clear timeframes or assurance for when patient's waiting times for assessment and treatment would reduce. Whilst we noted the trust made changes to the service, we had concerns about the slow pace of change as patients continued to face long waits for assessment and treatment.
- The trust had not ensured that all managers had access to data systems to assess and monitor risks in their services, for example waiting list times and staff sickness despite these areas being risks for service delivery. Prior to our inspection the trust had not sent us data about waiting times, despite our request. We requested further data from the trust after our site visit. However, some data provided conflicted with what we found at our site visit and therefore we were not assured that the trust had systems to effectively assess, monitor and mitigate risk to patients who waited for a service.
- Administrative staff morale was mixed. Some staff reported they did not feel part of the clinical teams and had equal opportunities for development.

However:

- Staff contributed to discussions about the service's strategy and changes to the service. Managers said their access to data had improved and they were more confident they knew who was waiting for assessment and treatment and why.
- Managers said their access to data had improved and they were more confident they knew who was waiting for assessment and treatment and why. Staff maintained and had access to the risk register either at a team or directorate level and could escalate concerns when required from a team level.
- Managers showed compassion and understanding when explaining how they supported their staff when they had been unwell. The trust more actively promoted staff wellbeing though events such as mindfulness, massage or yoga. Administrative staff said they met with therapists to confidentially discuss workplace pressures or issues. Staff said their immediate line managers were approachable and supportive.
- The trust gave staff some time and support to consider opportunities for improvements. For example, teams were incorporating 'iTHRIVE' into their work. This was an integrated, person centred and needs led approach to delivering mental health services for children, young people and families which conceptualises need in four categories: 'getting advice and signposting'; 'getting help'; 'getting more help' and 'getting risk support'.

Specialist community mental health services for children and young people

Outstanding practice

We found areas of outstanding practice in this service. See the Outstanding Practice section above.

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 10 HSCA (RA) Regulations 2014 Dignity and respect

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 15 HSCA (RA) Regulations 2014 Premises and equipment

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
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

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 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Julie Meikle, head of hospital inspection, mental health, chaired this inspection and Tracy Newton, inspection manager, mental health led it. Two governance specialist advisors, supported our inspection of well-led for the trust overall.

The team included three further inspection managers, 13 inspectors, nine specialist advisers, and one expert by experience.

Governance specialist advisors are senior healthcare managers who support our inspections of the leadership of trusts. 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.