Leicestershire Partnership NHS Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	The Bradgate Mental Health Unit	RT5KF
Community-based mental health services for adults of working age	Trust Headquarters - Lakeside House	RT5X1
Community-based substance misuse services for adults of working age	Trust Headquarters - Lakeside House	RT5X1
Child and adolescent mental health wards	Oakham House	RT5FD
Community mental health services for children and young people	Trust Headquarters - Lakeside House	RT5X1
Community-based mental health services for older people	Trust Headquarters - Lakeside House	RT5X1
Community mental health services for people with learning disabilities or autism	Trust Headquarters - Lakeside House	RT5X1
Forensic inpatient / secure wards	The Bradgate Mental Health Unit	RT5KF

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Mental health crisis services and health-based places of safety	Trust Headquarters - Lakeside House	RT5X1
Mental health crisis services and health-based places of safety	The Bradgate Mental Health Unit	RT5KF
Long stay/rehabilitation mental health wards for working age adults	Stewart House (Narborough)	RT5KE
Long stay/rehabilitation mental health wards for working age adults	The Willows	RT5FK
Wards for older people with mental health problems	Evington Centre	RT5KT
Wards for older people with mental health problems	The Bradgate Mental Health Unit	RT5KF
Wards for people with learning disabilities and autism	The Agnes Unit	RT5NH
Wards for people with learning disabilities and autism	Short Breaks – Farm Drive	RT5FP
Wards for people with learning disabilities and autism	Short Breaks – Rubicon Close	RT5FM
Community health services for adults	Ashby and District Community Hospital	RT5YC
Community health services for adults	Coalville Community Hospital	RT5YD
Community health services for adults	Hinckley and Bosworth Community Hospital	RT5YF
Community health services for adults	Loughborough Hospital	RT5YG
Community health services for adults	Melton Mowbray Hospital	RT596
Community health services for children, young people and families	Melton Mowbray Hospital	RT596
Community health services for children, young people and families	Loughborough Hospital	RT5YG
Community health services for children, young people and families	Hinckley and Bosworth Community Hospital	RT5YF
Community health services for children, young people and families	Ashby and District Hospital	RT5YC

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Community health inpatient services	Feilding Palmer Community Hospital	RT5YE
Community health inpatient services	Coalville Community Hospital	RT5YD
Community health inpatient services	Melton Mowbray Community Hospital	RT596
Community health inpatient services	Hinckley and Bosworth Community Hospital	RT5YF
Community health inpatient services	Rutland Memorial Hospital	RT5YJ
Community health inpatient services	Evington Centre Leicester General Hospital	RT5KT
Community End of Life Care	Loughborough Hospital	RT5YG
Community End of Life Care	Coalville Community Hospital	RT5YD
Community End of Life Care	St Luke's Hospital	RT5YL
Community End of Life Care	Feilding Palmer Community Hospital	RT5YE
Community End of Life Care	Charnwood Mill	RT5YE

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

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

Overall rating for services at this Provider	Requires improvement 
Are Services safe?	**Inadequate** 
Are Services effective?	**Requires improvement** 
Are Services caring?	**Good** 
Are Services responsive?	**Requires improvement** 
Are Services well-led?	**Requires improvement** 

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

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

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

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

We rated Leicestershire Partnership NHS Trust as Requires Improvement overall because:

- Not all services were safe, effective or responsive and the board needs to take urgent action to address areas of improvement.
- While the board and senior management had a vision with strategic objectives in place, staff did not feel fully engaged in the improvement agenda of the trust.
- Morale was found to be poor in some areas and some staff told us that they did not feel engaged by the trust.
- We found that while performance improvement tools and governance structures were in place these had not always brought about improvement to practices.
- We had a number of concerns about the safety of this trust. These included unsafe environments that did not promote the dignity of patients; insufficient staffing levels to safely meet patient's needs; inadequate arrangements for medication management; concerns regarding seclusion and restraint practice: insufficient clinical risk management.
- We were concerned that information management systems did not always ensure the safe management of people's risks and needs.
- Some staff had not received their mandatory training, supervision or appraisal.
- A lack of availability of beds meant that people did not always receive the right care at the right time and sometimes people were moved, discharged early or managed within an inappropriate service.
- We were concerned that the trust was not meeting all of its obligations under the Mental Health Act.

However:

- Overall we saw good multidisciplinary working and generally people's needs, including physical health needs, were assessed and care and treatment was planned to meet them.
- Staff showed us that they wanted to provide high quality care, despite the challenges of staffing levels and some poor ward environments. We observed some very positive examples of staff providing emotional support to people.
- Procedures for incident management and safeguarding where in place and well used.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Inadequate 

We rated Leicestershire Partnership NHS Trust as inadequate overall for this domain because:

- We found a number of environmental safety concerns. We found potential ligature risks and that the layout of some wards did not facilitate the necessary observation and safety of patients. We were concerned about the design of seclusion facilities at some units.
- We found concerns about incidents of restraint and seclusion at the trust. We found that the policies and procedures did not meet guidance. We found restrictive practices that amounted to seclusion that were not safeguarded appropriately.
- We were concerned that staffing levels were not sufficient at a number of inpatient wards and community teams across the trust.
- There was a heavy reliance on bank staff particularly in the acute services and the end of life care service.
- Not all clinical risk assessments had been undertaken or reviewed meaning patients risks and needs were not always known or addressed.
- Arrangements were not adequate for the safe and effective administration, management and storage of medication across the trust.
- Levels of mandatory training in life support were not good across the trust and not all emergency resuscitation equipment had been checked.
- We found a large number of concerns about information management systems. Some had resulted in potential harm to patients.

However:

- The trust had policies and processes in place to report and investigate any safeguarding or whistleblowing concerns. Most staff told us that they were able to raise any concerns that they had and were clear that improvement would occur as a result of their concern.
- The trust had systems in place to report and investigate incidents, usually these would result in learning and changes to practice.
- The trust had processes in place for the safety of lone workers.

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Are services effective?

Requires improvement

We rated Leicestershire Partnership NHS Trust as requiring improvement overall for this domain because:

- Care plans and risk assessment were not always in place or updated were people's needs changed in the forensic and substance misuse services. Peoples' involvement in their care plans varied across the services.
- Staff did not always respond to the needs of patients in community inpatient services.
- Not all services used evidence based models of treatment.
- There was limited access to psychological therapy and there were some issues with accessing physical healthcare.
- Not all staff had received an appraisal or mandatory training. Delays in induction training could place some staff and patients at risk.
- Systems were not robust to ensure compliance with the Mental Health Act (MHA) and the guiding principles of the MHA Code of Practice. There were insufficient processes for the scrutiny of MHA documentation. Patients had not always received their rights, and capacity and consent procedures were not always well managed. Leave was not always granted in line with the MHA requirements. Staff did not always recognise and manage people's seclusion within the safeguards set out in the MHA Code of Practice.
- Procedures were not always followed in the application of the Mental Capacity Act. However, there were good levels of training and understanding of the Mental Capacity Act.

However:

- Generally people received care based on a comprehensive assessment of individual need.
- People's needs, including physical health needs, were usually assessed and care and treatment was planned to meet them.
- Overall we saw good multidisciplinary working.

Are services caring?

Good

We rated Leicestershire Partnership NHS Trust as good overall for this domain because:

- Staff showed us that they wanted to provide high quality care, despite the challenges of staffing levels and some poor ward environments. We observed some very positive examples of staff providing emotional support to people.
- Most people we spoke with told us they were involved in decisions about their care and treatment and that they and

Summary of findings

their relatives received the support that they needed. We saw some very good examples of care plans being person centred however, not all care plans indicated the involvement of the service user.
- We heard that patients were well supported during admission to wards and found a range of information available for service users regarding their care and treatment.
- The trust has a user engagement strategy which set out the trust's commitment to working in partnership with service users. The trust told us about a number of initiatives to engage more effectively with users and carers.
- Results from the friends and family test indicated a good level of satisfaction with the service.
- Advocacy services were available and promoted.

However:

- Arrangements for visits from families were not always appropriate, particularly in respect of children visiting mental health units.

Are services responsive to people's needs?

Requires improvement

We rated Leicestershire Partnership NHS Trust as requiring improvement overall for this domain because:

- The trust was not meeting all of its targets in respect of the delivery of community services. Some teams had significant waiting lists.
- We were told that there was a shortage of beds in acute, PICU and CAMHS services.
- Out of area placements were high for acute services and the PICU was unavailable to female patients as it did not meet the guidance on mixed sex accommodation.
- A lack of available beds meant that people may have been discharged early or managed within an inappropriate service. However, staff worked well with other services to make arrangements to transfer or discharge patients.
- We were also concerned about the operation of the referral line for the crisis service. Performance information had also not been available this service.
- We found that the environment in a number of units did not reflect good practice guidance and had an impact on people's dignity or treatment.
- Within three acute wards and the PICU there were no female only lounges as required by the Mental Health Act Code of Practice and Department of Health guidance.

However:

Summary of findings

- We found a range of information available for service users regarding their care and treatment and many of the leaflets were available in other languages.
- A process in place to address peoples' complaints. However, improvement is required to ensure all complaints are captured at trust level and learned from.
- Most units that we visited had access to grounds or outside spaces and generally had environments that promoted recovery and activities.
- Interpreters were available and we observed some very good examples of staff meeting the cultural needs of their patients.

Are services well-led?

Requires improvement

We rated Leicestershire Partnership NHS Trust as requiring improvement overall for this domain because:

- We reviewed the risk registers for the trust and directorates and noted that while some of the concerns we found had been highlighted others had not been flagged.
- The trust had not met all its strategic objectives.
- The trust had failed to ensure all required improvements were made and sustained at the acute services at the Bradgate Unit following compliance actions made in 2013.
- We were concerned that the trust had not always delivered safe and quality care despite a well organised governance structure and quality system. Our findings indicate that that there is room for improvement to ensure that lessons are learned from quality and safety information and that actions are embedded in to practice.

However:

- The trust board had developed a vision statement and values for the trust and most staff were aware of this.
- The trust had undertaken positive engagement action with service users and carers.

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Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

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

Team Leaders: Lyn Critchley, Inspection Manager (mental health) CQC and Nin Yaing, Inspection Manager (acute and community) CQC

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

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about Leicestershire Partnership NHS Trust and asked other organisations to share what they knew.

We carried out an announced visit between 9 March and 13 March 2015. Unannounced inspections were also carried out on 19 March and during the night of 23 March 2015. We also conducted an unannounced MHA visit on 25 March 2015.

Prior to and during the visit the team:

- Held service user focus groups and met with local user forums.
- Held focus groups with different staff groups.
- Talked with patients, carers and family members.
- Attended community treatment appointments.
- Looked at the personal care or treatment records of a sample of patients and service users.
- Looked at patients' legal documentation including the records of people subject to community treatment.
- Observed how staff were caring for people.
- Interviewed staff members.
- Interviewed senior and middle managers.
- Attended an executive team meeting and leadership conference.
- Met with the MHA assurance group and Hospital Managers
- Reviewed information we had asked the trust to provide.
- Attended multi-disciplinary team meetings.
- Met with local stakeholders and user groups.
- Collected feedback using comment cards.

We visited all of the trust's hospital locations and sampled a large number of community healthcare and community mental health services.

We inspected all wards across the trust including adult acute services, psychiatric intensive care units (PICUs), secure wards, older people's wards, and specialist wards for people with learning disabilities and children and adolescents. We also inspected all the wards providing physical healthcare treatment to adults. We looked at the trust's place of safety under section 136 of the Mental Health Act. We inspected community services including all of the trust's crisis services, integrated delivery teams

Summary of findings

and older peoples' teams, and a sample of teams for people with a learning disability, children and adolescents and physical healthcare teams providing community treatment and end of life care.

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

Information about the provider

The trust was created in 2002 to provide mental health, learning disability and substance misuse services. In April 2011 it merged with Leicester City and Leicestershire County and Rutland Community Health Services as a result of the national Transforming Community Services agenda. The merger resulted in the full integration of physical, mental health and learning disability services. The trust operates in three divisions: adult mental health and learning disability, community health services, and families, children and young people.

The trust is aiming to become a Foundation Trust during 2015/16.

The trust works closely with the three local authorities: Leicestershire County Council, Rutland County Council and Leicester City Council. The Trust is commissioned by three local Clinical Commissioning Groups: West Leicestershire, East Leicestershire and Rutland, and Leicester City.

The trust provides services for adults and children with mental health needs, a learning disability or substance misuse needs, and people with some physical healthcare needs who live in the city of Leicester and the neighbouring counties of Leicestershire and Rutland. They also provide secure mental health services across the region and work with the criminal justice system. A number of specialist services were also delivered including a community based eating disorder service and community based support, in partnership with other agencies, to those whose needs relate to drug or alcohol dependency.

The trust serves a population of approximately one million and employs over 5,500 staff including nursing, medical, psychology, occupational therapy, social care, administrative and management staff. It had a revenue income of £280 million for the period of April 2013 to March 2014. In 2012/13, the trust staff saw over 60,000 individuals. The trust services are delivered from almost 200 different buildings.

Leicestershire Partnership NHS Trust has a total of 21 locations registered with CQC and has been inspected 26 times since registration in April 2010. At the time of our visit there were two locations were compliance actions were in place following previous visits. These were at HMP Leicester and the Bradgate Mental Health Unit.

We had last visited the Bradgate Mental Health Unit in November 2013 and it was found to be non-compliant in five areas. These were: care and welfare, cooperating with other providers, management of medicines, staffing and assessing and monitoring service provision. These issues were looked at as part of this inspection.

What people who use the provider's services say

The Care Quality Commission community mental health survey 2014 was sent to people who received community mental health services from the trust to find out about their experiences of care and treatment. Those who were eligible for the survey where people receiving community care or treatment between September and November 2013. There were a total of 260 responses, which was a response rate of 31%. Overall, the trust was performing about the same as other trusts across most areas.

However, respondents stated that the trust was performing worse than other trusts in relation to crisis care and other areas of care. This specifically related to questions about the response people received in a crisis or in relation to information provided about other support services.

A review of people's comments placed on the 'patient opinion' and 'NHS choices' websites was conducted ahead of the inspection. 26 comments were noted on

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NHS choices of which 6 were partly of wholly positive. Positive comments included that staff were kind, compassionate and helpful, and that Loughborough Hospital was excellent. Issues raised were about access and response in a crisis, staff attitude, misdiagnosis, ward conditions, support for carers and CAMHS services. Both positive and negative opinions were also noted on the patient opinion website.

The trust launched the Friends and Family Test in 2013. The Friends and Family Test seeks to find out whether people who have used the service would recommend their care to friends and family. At February 2015 there had been almost 6000 responses. Of these 91% have been positive about the trust services.

Prior to the inspection we spoke with services users and their carers across the trust. This included meetings with independent user led local organisations and attendance at user and carer groups linked to the trust. We also facilitated focus groups at three inpatient services. During these sessions we heard both positive and negative comments about the trust services. Generally people stated that staff were caring. However, a number of people stated that access to services, particularly in a crisis, was difficult. People told us of a shortage of beds and that staffing could be limited and effect treatment, leave and activities.

During our inspection we received comment cards completed by service users or carers. We also received a large number of phone calls and emails directly to CQC from service users, carers and voluntary agencies supporting service users. Throughout the inspection we spoke with over 300 people who had used inpatient services or were in receipt of community treatment.

People who use inpatient services generally felt safe and supported. However, at some units people told us that staff shortages could impinge on the availability of activities and access to leave. People also told us that access to inpatient care close to home was not always possible.

Most people who use community services told us that staff were good and supportive. A number told us that there had been significant changes within the teams and that this had caused uncertainty and poor communication. Some people told us that they did not always know what to do in a crisis and others reported a poor response from crisis teams. Most welcomed changes to the operational model of the crisis team.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that medicines prescribed to patients who use the service are stored, administered, recorded and disposed of safely.
- The trust must ensure that the use of syringes and needles meet the Health and Safety Executive regulations.
- The trust must ensure that action is taken so that the environment does not increase the risks to patients' safety.
- The trust must ensure that action is taken to remove identified ligature risks and to mitigate where there are poor lines of sight.
- The trust must ensure that all mixed sex accommodation meets guidance and promotes safety and dignity.
- The trust must ensure that staff and patients have a means to raise an alarm in an emergency.
- The trust must ensure that emergency equipment is checked on a regular basis.
- The trust must ensure that seclusion facilities are safe and appropriate and that seclusion and restraint are managed within the safeguards of the MHA Code of Practice and national guidance. The trust should ensure it meets the guidance on restraint practice set out in Department of Health guidance.
- The trust must ensure there are sufficient and appropriately qualified staff at all times to provide care to meet patients' needs.
- The trust must ensure that there is appropriate access to medical staff where required.

Summary of findings

- The trust must ensure that people receive the right care at the right time by placing them in suitable placements that meet their needs.
- The trust must ensure that there are not significant delays in treatment.
- The trust must ensure that all risk assessments and care plans are updated consistently in line with changes to patients' needs or risks.
- The trust must carry out assessments of capacity and record these in the care records.
- The trust must ensure all staff including bank and agency staff have completed statutory, mandatory and, where relevant, specialist training
- The trust must ensure all staff receive regular supervision and annual appraisals.
- The trust must ensure that proper procedures are followed for detention under the Mental Health Act and that the required records relating to patient's detention are in order.
- The trust must ensure that arrangements for patients taking section 17 leave are clear and in line with the Mental Health Act for their safety and that of others.
- The trust must ensure that patients who are detained under the Mental Health Act have information on how to contact the CQC.
- The trust must ensure that procedures required under the Mental Capacity Act are followed.
- The trust must ensure access is facilitated to psychological therapy in a timely way.
- The trust must ensure that there are systems in place to monitor quality and performance and that governance processes lead to required and sustained improvement.
- The trust must review its procedures for maintaining records, storage and accessibility.

Action the provider SHOULD take to improve

- The trust should ensure that all complaints are recorded and that themes from informal complaints are reviewed to ensure appropriate learning.

Leicestershire Partnership NHS Trust

Detailed findings

Mental Health Act responsibilities

Reporting to the quality assurance committee the mental health act assurance group (MHAAG) has overall responsibility for the application of the Mental Health Act (MHA) and the Mental Capacity Act (MCA). An annual report is presented to the board, to inform the executive of performance and required actions across this area. This group also carries out the role of the 'hospital managers' as required by the MHA.

We attended a meeting with the hospital managers and were informed that the hospital managers receive a rigorous induction with training on the MHA and MCA and an induction shadowing other hospital managers.

The MHAAG provides a forum for reviewing and ensuring compliance with the legal and statutory requirements of the MHA. It performs a number of key functions, including:

• monitoring all aspects of MHA performance,

• receiving MHA reviewer reports,

• monitoring actions and responses,

• escalating any outstanding issues and raising issues of concern for resolution to the quality assurance committee (QAC).

There was some confusion regarding whether Mental Health Act (MHA) training was mandatory at the trust. The quality assurance committee (QAC) agreed MHA training was mandatory in April 2014 and a module was planned to begin in September 2014. Training was available but, we found varying levels of understanding across the MHA and different services where unclear regarding whether this training was mandatory. For example, we noted that staff in the crisis services were trained and knowledgeable but staff in acute services had no specific training.

The process for scrutinising and checking the receipt of documentation was not clear. MHA administrators have recently started a new system in order to scrutinise documentation but not all of the documents we looked at had been scrutinised and, whilst the majority of documents were in place and accurate, we identified concerns.

On the wards the MHA documentation relating to the patients' detention was generally available for review and appeared to be in order. However, some documents were missing from some files. In the rehabilitation service there were incomplete photocopies of MHA documents on files and some renewal papers were not available. Reports carried out by the approved mental health professional (AMHP) were not always available in the ward files or the MHA administration files. We could find no record of action taken to obtain the reports.

Patients were usually provided with information about their legal status and rights under section132 at the time of their detention or soon afterwards. The forms used to record the information were brief and we saw many examples where they were incomplete. For example, patients' understanding of their rights was not always recorded. In four of the core services, where detained patients were being treated, patients' understanding of their rights was not reassessed. We also found that, irrespective of their understanding, patients were not reminded of their rights on a regular basis. A patient on one

of the secure wards had only had their rights explained once in twelve months. Files at the MHA office did not routinely include details about whether a person had been provided with their rights under the MHA.

Most of the wards displayed posters about the independent mental health advocate (IMHA) service. However, across all services there were examples where patients had not been informed of, or did not understand, their right to access an IMHA. The exception was the older person's service, where patients were automatically referred to an IMHA if they were unable to understand their rights.

Assessment and recording of patients' capacity to consent at the start of their treatment varied across the core services. There were limited records of discussions between patients and their responsible clinicians (RC) to show patients' understanding of their prescribed medicines and their consent or refusal to take it.

On some of the wards we found treatment was not being given in line with the MHA Code of Practice. On two wards we found T2 certificates, to evidence patients' consent to taking their medication, were not signed by the current RC. On two wards not all prescribed medicines were included on the T2 certificate, which meant patients were being given medication they had not consented to. Similarly, we found examples of medication being given which had not been approved by a second opinion appointed doctor (SOAD) if the patient lacked capacity, or refused to consent to taking medication.

The system for recording section 17 leave did not adhere to the MHA Code of Practice in any of the core services. There were a number of incomplete leave forms. There was a lack of records to show patients were provided with copies of the forms. Several of the wards did not record risk assessments prior to patients going on leave. The outcome of the leave, including the patient's view, was not always recorded in the clinical notes. On one of the wards the leave authorisation was not signed by the patient's current responsible clinician. In the rehabilitation service we saw some leave forms were completed up to twelve months in advance, which meant leave was not being reviewed regularly.

Seclusion was practiced at a number of the services we visited. Generally seclusion paperwork was not fully completed in accordance within the Mental Health Act Code of Practice. We looked at the process of seclusion, including a review of the environment and paperwork in the acute service. We found overall that the record keeping and scrutiny was poor.

We found good practice with regard to seclusion on the wards for people with learning disabilities and autism. On other wards we found seclusion practices did not always follow the Code of Practice or trust policy. For example, on one ward we found a patient was being nursed in a low stimulus area on constant observations. The doors were locked and the patient was prevented from leaving. However, the seclusion safeguards, such as regular reviews, were not taking place.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust has a policy in place on the application of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). Reporting to the quality assurance committee the mental health act assurance group (MHAAG) has overall responsibility for the application of the Mental Capacity Act (MCA). An annual report is presented to the board, to inform the executive of performance and required actions across this area.

The trust told us that training rates for staff in the Mental Capacity Act were good with just over 90% of staff trained at the end of December 2014. Staff confirmed that they had received this training and updates were provided as part of ongoing safeguarding training. Generally most staff had an awareness of the Mental Capacity Act and the Deprivation of Liberty Safeguards. However, this was not the case within the forensic service or the older people's community teams.

At a number of mental health services, particularly learning disability, forensic and older people's services mental capacity assessments and best interest decisions had not always been carried out where applicable.

Deprivation of Liberty Safeguards applications had usually been made when required. However, records were inconsistent in recording these and staff were not always aware of when an authorisation was in place.

Inadequate

Are services safe?

Staff had a clear understanding of their responsibilities in relation to the Mental Capacity Act in community healthcare services. They were able to differentiate between ensuring decisions were made in the best interests of people who lacked capacity for a particular decision and the right of a person with capacity to make an unwise decision.

In end of life care services we looked at "do not resuscitate cardio pulmonary resuscitation" (DNACPR) forms in use in the trust. We saw that the trust was proactive in arranging these forms to be completed early in a patient's care. We reviewed five forms and saw all of these had been completed in full. However, we noticed that the form the trust used did not have an area for staff to document that a multidisciplinary discussion had taken place. This meant that it was not clear as to which professionals contributed to the discussion around DNACPR for the patients.

Inadequate

Are services safe?

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

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

Summary of findings

We rated Leicestershire Partnership NHS Trust as inadequate overall for this domain because:

- We found a number of environmental safety concerns. We found potential ligature risks and that the layout of some wards did not facilitate the necessary observation and safety of patients. We were concerned about the design of seclusion facilities at some units.
- We found concerns about incidents of restraint and seclusion at the trust. We found that the policies and procedures did not meet guidance. We found restrictive practices that amounted to seclusion that were not safeguarded appropriately.
- We were concerned that staffing levels were not sufficient at a number of inpatient wards and community teams across the trust.
- There was a heavy reliance on bank staff particularly in the acute services and the end of life care service.
- Not all clinical risk assessments had been undertaken or reviewed meaning patients risks and needs were not always known or addressed.
- Arrangements were not adequate for the safe and effective administration, management and storage of medication across the trust.
- Levels of mandatory training in life support were not good across the trust and not all emergency resuscitation equipment had been checked.
- We found a large number of concerns about information management systems. Some had resulted in potential harm to patients.

However:

- The trust had policies and processes in place to report and investigate any safeguarding or whistleblowing concerns. Most staff told us that they were able to raise any concerns that they had and were clear that improvement would occur as a result of their concern.
- The trust had systems in place to report and investigate incidents, usually these would result in learning and changes to practice.
- The trust had processes in place for the safety of lone workers.

Inadequate

Are services safe?

Our findings

Track record on safety

We reviewed all information available to us about the trust including information regarding incidents prior to the inspection. A serious incident known as a 'never event' is where it is so serious that it should never happen. The trust had reported one 'never event' in August 2014. In this case a patient was prescribed a daily dose of the drug methotrexate that should be administered weekly. We found the trust had investigated the never event, actions regarding medicines management and prescribing had been implemented and learning had been disseminated to staff throughout the directorate. We did not find any other incidents that should have been classified as never events during our inspection.

Since 2004, trusts have been encouraged to report all patient safety incidents to the National Reporting and Learning System (NRLS). During 2014 the trust had reported 7199 incidents to the NRLS. There were 29 incidents categorized as death during the period and a further eight had resulted in severe harm.

Since 2010, it has been mandatory for trusts to report all death or severe harm incidents to the CQC via the NRLS. There were 190 serious incidents reported by the trust between January 2014 and December 2014. The largest number of these reports had related to unexpected death including suicide or suspected suicide at 37%. Pressure ulcers were the second largest category equating to almost 33%. There were also two homicides reported during this period. This was within the expected range of incidents for a trust of this type and size. Overall, the trust had improved its reporting rates and had been a good reporter of incidents during 2014 when compared to trusts of a similar size.

The National Safety Thermometer is a national prevalence audit which allows the trust to establish a baseline against which they can track improvement. During the 12 months to October 2014 it was noted that there was large fluctuation in the rates of falls resulting in harm, and catheter and new urinary tract infection rates.

Every six months, the Ministry of Justice published a summary of Schedule 5 recommendations which had been made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. A concern was raised about the trust in 2014 in relation to housing for those with severe mental illness who have been evicted from a care placement.

Learning from incidents

Arrangements for reporting safety incidents and allegations of abuse were in place. Staff had access to an online electronic system to report and record incidents and near misses. Most staff had received mandatory safety training which included incident reporting and generally were able to describe their role in the reporting process. Staff were encouraged to report incidents and near misses and most felt supported by their manager following any incidents or near misses. Some staff told us that the trust encouraged openness and there was clear guidance on incident reporting.

We were told that all serious incidents are reviewed by the patient safety group which reports to the quality assurance committee. Meeting minutes confirmed that the board also receive regular updates about actions undertaken as a result of serious incidents.

Where serious incidents had happened we saw that investigations were carried out. The trust had trained a large group of staff to undertake incident investigations. Most investigations were carried out within the timescales required.

Team managers confirmed clinical and other incidents were reviewed and monitored through trust-wide and local governance meetings and shared with front line staff through team meetings. Most were able to describe learning as a result of past incidents and how this had informed improvements or service provision. We saw some particularly good examples of positive change following incidents within the community health care services. However, we heard of some occasions within mental health services were incidents had not led to changes in practice.

Staff received email bulletins and alerts following learning from incidents in other parts of the trust. Generally staff knew of relevant incidents, and were able to describe learning as a result of these. The majority of staff felt that they got feedback following incidents they had reported. However, in the end of life care teams and the child and adolescent mental health community teams' staff told us that they did not always receive feedback.

Inadequate

Are services safe?

In 2014 a CQC regulation was introduced requiring NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong. The trust had undertaken an audit to understand any improvements required to meet this duty of candour. Following this a number of actions were undertaken including duty of candour considerations being incorporated into the serious investigation framework and report. Minutes of directorate and locality governance groups evidenced frequent discussion about the duty of candour. Most staff were aware of the duty of candour requirements. However, not all staff across community health care services were fully aware of duty of candour in relation to their roles.

Safeguarding

The trust had clear policies in place relating to safeguarding and whistleblowing procedures. Additional safeguarding guidance was available to staff via the trust's intranet, and a trust run safeguarding helpline was available to staff for additional advice.

Training requirements were set out in line with the specific role undertaken by staff. We found that almost all staff had received their mandatory safeguarding training and knew about the relevant trust-wide policies relating to safeguarding. In some services we found that safeguarding supervision provided opportunities to discuss any individual cases. Most staff were able to describe situations that would constitute abuse and could demonstrate how to report concerns.

A governance process was in place that looked at safeguarding issues at both a trust and at directorate levels on a regular basis.

Assessing and monitoring safety and risk

The trust had an assurance framework and risk register in place. The risk register identified the responsible owner and the timescales for completion of identified actions. Board meeting and quality assurance committee minutes confirmed that corporate and any high level or emerging risks are discussed on an ongoing basis. Risk registers were also in place at service and directorate level. These were monitored through the directorate assurance groups.

We looked at the quality of individual risk assessments across all the services we inspected. In community healthcare inpatient services these were in place and addressed people's risks.

However, we were concerned that five patients under the care of the community child and adolescent mental health team did not have risk assessments. At the secure services we found that some patients were being managed through the use of risk assessments undertaken on previous wards. Other patients within this service did not have clear risk management plans. We also found that within some mental health and learning disability services risk assessments were not always being updated for people following incidents of concern or changes to an individual's needs. Risk assessments had not always been undertaken prior to leave being commenced.

Risk assessments were completed across all community health care services. For example in end of life care at Loughborough hospital we were shown the variety of risk assessments in place for patients in the ward. These included moving and handling, skin integrity, nutrition, falls, and bed rails. These risk assessments were used as the basis for planning care for people and ensuring that people were safe. The unscheduled care team for community services for adults told us they could provide an initial risk assessment via a home visit within two hours of referral.

The trust has an observation policy in place which was updated in line with recommendations made following a series of inpatient deaths in 2012. Generally staff were aware of the procedures for observing patients. Ward managers indicated that they were able to request additional staff to undertake observations. However, both staff and patients told us that increased observation levels could impact on activities and leave.

Safe and clean environments and equipment

The trust undertakes an annual programme of environmental health and safety checks.

Ligature risk assessments are reviewed as part of this programme. The trust told us that all wards had been reviewed in the previous 12 months and that all keys risks had been addressed.

However, we were concerned that ligature risks at some acute wards at the Bradgate Unit, the secure service at the

Inadequate

Are services safe?

Herschel Prins unit and the Agnes Unit had been highlighted through the risk assessments but were not being adequately addressed. At the Belvoir PICU some redevelopment work was being undertaken to address ligature risks. However, we found additional risks that were not being addressed by the building programme. This raises concerns about the trust's ability to risk assess in a proactive rather than reactive manner.

We found that lines of sight were not clear at some acute and secure wards meaning staff could not always observe patients. We were particularly concerned to find areas of some acute and secure wards that could not easily be observed where there was a presence of potential ligature points.

On four acute wards and the PICU there were not clear arrangements for ensuring that there was single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice, to protect the safety of patients.

Within the learning disability service space was limited within the communal areas at the Gillivers and Rubicon Close due to mobility and healthcare equipment. This meant that the environment could be unsafe. There were also unsafe areas in the lounge in Rubicon Close for patients who had epilepsy.

The health-based place of safety at the Bradgate unit did not meet the guidance of the Royal College of Psychiatrists. Furniture was light and portable and could be used as a weapon. Access to the two small rooms was through one door which meant that it could be difficult to exit the room quickly if needed.

The hospitals we visited within community inpatient services were not purpose built. Some hospitals had spread out wards and patients were not easily visible. This meant there could be an increased risk of patients falling, especially during the night when staffing levels were reduced.

Fire procedures and equipment were in place at most services. Most staff had received fire safety training. However, in the community child and adolescent service based at Loughborough Hospital we had some concerns about the frequency of fire drills and systems for recording when people were in the building. Only 63% of staff had updated fire safety training and they had not received training to use of the evacuation chair for people with mobility difficulties. Fire tests had not been recorded at the child and adolescent learning disability service at Rothesay.

Most units that we visited had a clinic room available and were equipped for the physical examination of patients. All clinic rooms we visited appeared clean. However, we were concerned that the clinic room on Phoenix ward at the Herschel Prins unit had severe drainage problems with sewage flowing into the room from the sink on a couple of occasions. The room was cleaned and signed off as fit to use by the health and safety team and the infection control nurse. The trusts estate contractor was coming to survey pipes in the grounds that were said to be the source of the problem. However, this had taken longer than should be expected.

Not all clinic rooms in community adult mental health team bases (where medicines were stored) had hand washing facilities which could increase the risk of infection or cross contamination.

Most inpatient services were found to have hand-washing facilities readily available and we observed staff adhering to the trust's 'bare below the elbow' policy where appropriate. Hand hygiene audits undertaken between October and December 2014 showed that all staff demonstrated good hand hygiene.

In community services we observed staff following best practice relating to hand hygiene and using personal protective equipment (PPE) appropriately. We were told by numerous staff that there were plentiful supplies of PPE at all times.

Regular trust-wide cleanliness audits were undertaken. Most services were clean and well maintained. Patients were mainly happy with the standards of cleanliness. However, we found that the seclusion room at Watermead ward was not clean. Staff told us that that the cleaning service was usually good for general cleaning but there could be difficulties in ensuring a deep clean where required.

In community inpatient services we found the cleaning contract with the service provider was inflexible at the Evington Centre. There were no cleaners on the ward after 4 pm so if patients were discharged and new patients arrived, nurses did the cleaning. Staff across all community health

care services told us the cleaning contract with the external provider did not always repair or maintain a clean environment as quickly as staff wished. Staff completed incident forms to expedite the completion of these tasks.

Most inpatient areas were well maintained and free from clutter. However, staff at a number of services told us that there could be significant delays in repairs being carried out. On three wards in the acute service we found bath/ shower rooms out of order. Staff had not been aware of all of these issues. At Herschel Prins unit a patient had a hole in their bathroom wall which prevented them using their shower. This hole had been there for two months and had not been fixed.

Inpatient services had systems in place to ensure equipment was serviced and electrically tested. Equipment was labelled with testing dates which were current. Staff told us about the procedure in place to clean equipment between patients.

Not all community mental health team bases had emergency alarms where required. We heard about two incidents were staff had been unable to raise the alarm in an emergency situation. We also heard there could be delays in alarms being repaired where required. In acute services we did not see call bells throughout any of the wards to enable patients to request assistance when required. We were particularly concerned that some bathrooms did not have call bells.

Emergency resuscitation equipment was not regularly checked in some community services. At Belvoir PICU the resuscitation trolley was clean and checked on a daily basis but was not sealed and so could be tampered with.

Most staff could describe how they would use the emergency equipment and what the local procedures were for calling for assistance in medical emergencies. However, levels of mandatory training in life support were not good across the trust. The trust provided training information ahead of the inspection. This stated that 73% of relevant staff had received immediate life support and 78% of relevant staff had received adult and paediatric basic life support. We were particularly concerned that only 47% of staff at the child and adolescent inpatient service at Oakham House and 65% of staff in acute services had received training in intermediate life support training.

Community inpatients staff had been trained in intermediate life support, and informed us that if a patient deteriorated or had a cardiac arrest at the community hospital, they would start resuscitation and call the emergency services through 999.

Potential risks

Systems were in place to maintain staff safety in the community. The trust had lone working policies and arrangements and most staff in community teams told us that they felt safe in the delivery of their role. For example the community end of life care service had a “buddy system” where they check in with their buddy at the end of their shift. If staff were worried about a particular visit they will call their buddy before and after the visit so their whereabouts were known.

The trust had necessary emergency and service continuity plans in place and most staff we spoke with were aware of the trust’s emergency and contingency procedures. Staff told us that they knew what to do in an emergency within their specific service. For example community health care services had policies in place to deal with expected risks, such as deep snow or flooding, which were known to all staff.

Restrictive practice, seclusion and restraint

The trust has an executive lead for security management. Policies and procedures were in place covering the management of aggression, physical intervention and seclusion. The trust was also in the process of forming a policy on the use of mechanical restraint.

We reviewed existing policies regarding management of aggression and physical intervention. These did not reference the safe management of patients in a prone position or address specialist needs of children or people with a learning disability, autism or a physical condition in line with guidance.

A briefing had been submitted to the trust’s patient safety committee in January 2015 outlining the trust’s response to the Department of Health’s ‘Positive and Proactive Care: reducing the need for restrictive interventions’. A working group had been set up to look at restrictive practice. However, the trust was yet to comply with all requirements of the Department of Health's guidance by the target date

of September 2014 as it was yet to formalise a reduction strategy or decide on future training options. The trust acknowledged in the briefing that they were behind the timescales set for immediate improvement in this policy.

The use of restraint and seclusion were defined as reportable incidents at the trust and arrangements were in place to monitor such incidents. Incidents were recorded on a database and would be discussed and monitored at the violence reduction group and patient safety meetings.

Prior to the visit we asked the trust for restraint and seclusion figures. Restraint was used 327 occasions in the six months to January 2015. Of these face down (prone) restraint was used on 38 occasions. This equated to almost 12% of all restraints. At the PICU there had been 47 incidents of restraint. Of these prone restraint was used on 8 occasions equating to 17%. Seclusion was used on 144 occasions. The majority of seclusion episodes were used at acute and PICU services. However, other services such as the secure and forensic services had used this practice on a limited basis. The trust stated that there had been no use of long term segregation.

We reviewed seclusion practice across the trust and we had a number of concerns about restrictive practice and seclusion. These include:

- In the child and adolescent service we found a patient was being nursed in a low stimulus area on constant observations. The doors were locked and the patient was prevented from leaving. However, the seclusion safeguards, such as regular reviews, were not taking place.
- In the acute service we found a 17 year old patient being nursed in seclusion as there was no appropriate service available within an open environment.
- Overall seclusion paperwork was not fully completed in accordance with the Mental Health Act Code of Practice. This was particularly of concern in the acute services.
- In the acute service we reviewed the records of a patient who was being nursed in seclusion. A contemporaneous record was documented however the records lacked any details as to the amount of food and fluid that the patient had taken.
- In the acute service the seclusion rooms did not have intercoms. Therefore patients needed to communicate with staff through a thick wooden door. There were ligature risks within the area. There was no deep clean support available for the wards following seclusion of a patient.
- In the secure service the layout of the seclusion rooms meant that staff could not observe patients at all times to ensure they are safe. Staff had to enter the seclusion room to open the toilet for patients to use. The bed in the seclusion room on Phoenix ward was too high and had been used to climb up to windows and to block the viewing panel.

We observed a number of examples of staff effectively managing patient's aggressive behaviour with an emphasis on de-escalation techniques. Generally we found that staff did not restrict patients' freedom and that informal patients understood their status and knew how to, and were assisted, to leave the wards. However, at Herschel Prins unit the level of security applied to patients and visitors was higher than might be expected for a low secure unit. For example, all patients returning from either escorted or unescorted leave are subjected to a search before entering the wards. In the acute services there were some blanket restrictions. For example lockers were managed by staff and access to the garden was only permitted after midnight, on a one patient basis with an escorting member of staff. At the PICU smoking was only permitted in the garden at designated times.

Safe staffing

In 2014 the trust reviewed and set staffing levels for all teams. Since April 2014 the trust has implemented an online staffing record and has published both the planned and actual staffing levels on their website.

The trust acknowledged challenges regarding recruitment and retention and maintaining safe staffing levels and told us that they are working hard to address this issue. We saw positive information about recruitment initiatives and some teams were improving.

Figures provided indicated that during February 2015 there had been a number of times when actual staffing fell below the planned level. The trust confirmed that they had a vacancy rate of over 7% and that staff turnover stood at over 11 % in February 2015. During February 2015 over 27%

of shifts within inpatient services were covered by agency or bank staff. Acute services had particularly high use of agency or bank staff which ranged between 32 and 62% per ward.

There were not any specific dependency tools used to evaluate the number of staff required to ensure the service was safely staffed at a number of services including the end of life care team, community children, young people and families' services, secure and acute services. The trust confirmed that inpatient services' staffing levels had been set on an 8:1 patient to qualified nurse ratio. We received other documentation that stated that staffing levels had been set in line with actual budget. The trust had also set a target 60:40 split between qualified and unqualified ward staff. At the time of our inspection the trust was not meeting this target but was utilising bank and agency staff to meet this standard. They explained that depending on acuity levels unqualified staff levels were sometimes higher.

The trust told us that processes to request additional staff had been streamlined to aid easier requests and to allow improved monitoring of the use of bank and agency staff. Ward and team managers confirmed that processes were in place to request additional staff where required. However, we found that staffing levels were not always sufficient, particularly in child and adolescent teams. This meant that staff were managing very high caseloads and there were some delays in treatment.

At some acute, forensic and learning disability inpatient units we found that staffing was also insufficient. This meant that staff were unable to take breaks, worked additional hours or were unable to complete necessary tasks. This also meant that patients' leave and activities programmes could be affected. In rehabilitation units there was not always a qualified staff member on duty per unit.

At the health based place of safety at Bradgate unit there was not specific staff to manage the service. This meant when it was in use staff were redeployed from acute services.

Staffing levels across community health care services had been risk assessed and action plans put in place because some services were short staffed. For example, the staffing levels at St Luke's Hospital were not safe prior to our inspection. As a result the trust merged two wards into one. This meant that the service provided at St Luke's Hospital was not sustainable.

Medical cover was generally acceptable. However, we were told that out of hours' medical cover could be an issue in community mental health teams, end of life teams, and secure services. Some older people's community teams had limited or no dedicated medical cover.

Medicines management

The trust used an electronic prescribing and medication administration record system for patients which facilitated the safe administration of medicines. Medicines reconciliation by a pharmacist was recorded on the electronic prescribing and medication administration record system.

Medicines, including those requiring cool storage, were not always stored appropriately as records showed that they were not always kept at the correct temperature, and may not be fit for use. We saw controlled drugs were stored and managed appropriately.

The "cold chain" processes to ensure optimal conditions during the transport, storage, and handling of vaccines were outstanding.

Emergency medicines were available for use and there was evidence that these were regularly checked. However, none of the emergency trolleys were sealed and so could be tampered with.

Following a recent never event, the trust has put in place systems to help prevent this happening again and was extending it to other high risk medicines in the interests of protecting patients

We were concerned about arrangements for medication management within the substance misuse service. There was no system to monitor and manage prescriptions within the service. This meant there was a risk that prescriptions could be lost or stolen. Prescriptions were not securely locked away overnight and were stored in an open office. Staff also took prescriptions home overnight to allow easier travel to neighbourhood services the following day. Naloxone medication was being given to people as a take home dose. This was being given without a Patient Group

Inadequate

Are services safe?

Direction (PGD) in place. PGD's are the legal framework that allows medication to be dispensed to people without the need to see a doctor, without compromising a person's safety.

We found that some medication was out of date in the crisis service and there was no clear record of medication being logged in or out.

At the rehabilitation service we found two patients were necessary medical checks had not been undertaken following administration of high dose anti-psychotic medication.

The rapid tranquilisation policy confirmed that the trust defines rapid tranquilisation as only injectable treatments not oral. This means that some patients could receive additional doses of psychotropic oral medication with no automatic physical monitoring.

Safety syringes and needles were not available on the wards in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. During the inspection we witnessed staff on older people's ward administer insulin using a pen with no safety needle.

Records and management

The trust operates a number of electronic records systems as well as paper records in some services. The trust acknowledged this issue and data sharing was placed on the corporate risk register. The trust is in the process of rolling out a new system to mental health services, which will be in place later in 2015. Improvements are also being planned for community healthcare services.

Across services we found a large number of issues relating to record keeping and to difficulties in sharing information.

In community health care services specialist palliative care nurses told us that some general practitioners (GPs) do not have access to the same system. This caused issues with data sharing. For example, the trust uses paper forms for "do not attempt to resuscitate" (DNACPR) as some GPs could not access this information from the system.

The last six serious incidents at Evington Centre for community inpatient services identified a common theme around record keeping. As a result, staff had been provided with informal training looking at records, such as those used in patient care, and record keeping had improved as a result. The paperwork used for identifying and recording pain was also changed. Staff told us they would like to change systems because the paperwork was not easily available when the medicines round was done.

In community mental health teams there were different paper and electronic recording systems in place. Different professionals kept separate files. The services will move to a new electronic system in July 2015 which will be the same as other areas in the trust. Until then there is a danger information is not shared or fully available to all staff seeing a person.

Out of hours staff, who use an electronic records system, did not have access to relevant CAMHS paper records even if a young person was high risk. Staff said there could be delays in receiving this information. This could pose a risk to both staff and the patient.

In the community learning disability teams some records were over more than one database/system which made locating information a problem. There were also inconsistencies in record-keeping for the autism outreach services and some records were missing.

Requires improvement

Are services effective?

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

Summary of findings

We rated Leicestershire Partnership NHS Trust as requiring improvement overall for this domain because:

- Care plans and risk assessment were not always in place or updated were people's needs changed in the forensic and substance misuse services. Peoples' involvement in their care plans varied across the services.
- Staff did not always respond to the needs of patients in community inpatient services.
- Not all services used evidence based models of treatment.
- There was limited access to psychological therapy and there were some issues with accessing physical healthcare.
- Not all staff had received an appraisal or mandatory training. Delays in induction training could place some staff and patients at risk.
- Systems were not robust to ensure compliance with the Mental Health Act (MHA) and the guiding principles of the MHA Code of Practice. There were insufficient processes for the scrutiny of MHA documentation. Patients had not always received their rights, and capacity and consent procedures were not always well managed. Leave was not always granted in line with the MHA requirements. Staff did not always recognise and manage people's seclusion within the safeguards set out in the MHA Code of Practice.
- Procedures were not always followed in the application of the Mental Capacity Act. However, there were good levels of training and understanding of the Mental Capacity Act.

However:

- Generally people received care based on a comprehensive assessment of individual need.
- People's needs, including physical health needs, were usually assessed and care and treatment was planned to meet them.
- Overall we saw good multidisciplinary working.

Our findings

Assessment of needs and planning of care

The Care Quality Commission community mental health survey 2014 found that overall the trust was performing about the same as other trusts in the areas of involving people in care planning and care reviews. Almost 8 out of 10 respondents stated that they had been involved in their care plan, while only 6 out of 10 said they had received a review of their care in the last 12 months.

In the majority of mental health services people's care needs and risks were assessed and care plans had been put in place. However, this was not the case at the forensic and learning disability services where we found significant gaps in care plans and risk assessments. In addition, at these services, and acute and substance misuse services, we found that the quality of care plans varied and some lacked sufficient detail to ensure that staff were aware of patients individual needs and risks. Not all services had reviewed care plans following changes to people's needs, and risk assessments had not always been updated. Not all care plans reviewed indicated the involvement of the patient. This was a particular issue within older people's services.

In community healthcare services we found that people were appropriately assessed and that relevant treatment and care plans had been put in place. For example in community inpatients services we found that nutrition and hydration assessments were completed on all appropriate patients. These assessments were detailed and used the nutritional screening tool (NST). We saw that appropriate follow up actions were taken when a risk was identified to ensure patients received sufficient nutrition and fluid to promote their recovery. We looked at food and fluid records and found these were complete, accurate and current.

Requires improvement

Are services effective?

In end of life care, the hospice at home team used the electronic system to record where people prefer to be cared for and if this is achieved. The team have a target of 80% in facilitating people to be cared for in their preferred place, and met this with 92% of patients.

We found staff did not always respond to the needs of patients in community inpatient services. Several patients told us staff did not respond to call bells. This caused acute anxiety for one patient. Another patient told us staff sometimes put the call bell on their weak side, meaning it was difficult for them to use the bell.

The trust used a number of different IT care records systems. Some services did not have access to electronic systems so used paper based systems. Additional services used a combination of computerised and paper copies for the recording of care. This made it difficult to follow information and meant that the trust could not ensure that people's records were accurate, complete and up to date. We were particularly concerned about gaps in records within the learning disability, substance misuse and forensic services. Staff in community inpatients and end of life care services told us electronic systems for recording patient information were not always accessible to all staff throughout these services.

In community services for children, young people and families we found some effective use of technology to communicate with children and their families, for example a texting service and the virtual clinic in a rural secondary school.

Best practice in treatment and care

Most services were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) guidelines. Generally people received care based on a comprehensive assessment of individual need and that outcome measures were considered using the Health of the Nation Outcome Score (HoNOS) or other relevant measures.

We saw evidence that NICE guidance, such as the clinical guidance on the prevention and management of pressure ulcers, was followed in community services for adults and inpatients. However, within the older peoples' mental health services and acute services we found limited awareness of evidence based guidance from NICE. In substance misuse services we found that NICE guidance was not followed in relation to physical health checks.

Community services for adults were proactive in monitoring the quality of outcomes for patients and using the information to drive improvements. The service showed that it routinely monitored patient outcomes and could demonstrate that some of the trust services provided better patient outcomes than other similar or alternative services. The hand clinic was a good example of this. However, in older peoples' community teams we found that there was no use of outcome measures.

In 2014 the trust participated in the National Audit of Psychological Therapies. This indicated that the trust had not considered whether psychological therapies were delivered in line with NICE guidance or had looked at outcomes from the therapy. Within mental health services we found a shortage of psychology staff meaning that not all services were able to offer psychological therapies in line with NICE guidance. The IAPT service was not meeting the key performance indicators (KPIs) set by commissioners in relation to 'access targets'. There was a long wait for psychotherapy (about 24 months) this impacted on community staff who continued to see the person until transferred.

The trust told us that improving the physical healthcare of those with mental health issues or a learning disability was a key priority. Across mental health services most patients' physical health care needs were assessed and most care plans viewed included reference to physical health needs. However, we found that within a number of inpatient services access to GPs was an issue which meant that physical healthcare treatment was not always readily available. We also found some specific examples of concern within substance misuse and rehabilitation services where necessary physical health checks were not undertaken in line with prescribed medication.

The trust had participated in some but not all applicable Royal College of Psychiatrists' quality improvement programmes. The ECT suite at the Bradgate unit held accreditation at the excellent service level. The Agnes unit learning disability service had held accreditation since 2012 but was awaiting confirmation of reaccreditation at the time of our visit. The trust told us that some actions had been required to meet this standard but they had been completed.

The trust has a research strategy and had participated in a wide range of clinical research. The trust also undertook a wide range of clinical effectiveness and quality audits.

Requires improvement

Are services effective?

These included safeguarding practice, medicines management, prescribing, compliance with NICE guidance, medical devices, suicide prevention, clinical outcomes, physical healthcare, care planning, record keeping, pressure ulcer management, consent and capacity, Mental Health Act administration and patient satisfaction.

During 2014 the trust also participated in two national clinical audits: the National audit of psychological therapies (NAPT) and the National audit of schizophrenia (NAS).

The trust had undertaken a trust-wide audit using the Green Light Toolkit in 2009. This audit aims to assess whether services are appropriate for people with a learning disability. The trust told us that this had not been re-audited since but would be looked at through the service development improvement plan which was commenced in January 2015.

Skilled staff to deliver care

In the 2014 NHS Staff Survey, the trust scored better than average for staff receiving relevant training and development and for receiving an appraisal. However, the quality of appraisal was indicated to require improvement with just 41% staff saying it was well structured. The trust was also ranked below average in relation to support from immediate managers. Overall the trust had improved its position across relevant indicators against the 2013 survey results.

Staff told us that supervision was usually available and used to manage performance issues and development. However, a number of staff, particularly those within CAMHS services, told us that a lack of staffing and service pressures meant that they did not always receive supervision and therefore had little feedback on their performance.

The staff survey had found that the percentage of staff suffering work-related stress in the last 12 months had been worse than average and the trust was within the worst 20% of trusts for staff feeling pressure to attend work when feeling unwell. Sickness absence rates had fallen slightly since the staff survey was completed but remained slightly above target at 4.9% in February 2015.

The trust had collected information regarding staff undertaking induction training within the first 3 weeks within their new role. At December 2014 the trust had not met its target with only 86% of new starters undertaking the training within time. At rehabilitation services we were concerned to find staff who were unable to access their induction training for up to four months after their start date. This was of particular concern in respect of management of aggression training. However, we were also told of very good practice for induction at Loughborough Hospital were newly qualified nurses complete induction training for a year. During this year nurses completed training in various competencies including administering intravenous medications, venepuncture, cannulation, syringe driver and catheterisation training.

The trust supplied details of their set mandatory training requirements and uptake. At March 2015 this indicated that 92.7% of staff were compliant with core mandatory training. However, this also stated that not all staff were in date with fire safety, information governance or other mandatory training. We were concerned that only 73% of relevant staff had received immediate life support training, only 68% of staff had received training in strategies for crisis intervention and prevention (SCIP), only 78% of staff had undertaken management of aggression training and only 81% of staff had received medicines management training.

We were concerned that in end of life care services advanced nursing practitioners had no mandatory training in end of life care, pain management, or other areas relating to this service. Staff within acute, rehabilitation and CAMHS had not all received required life support training. In addition we found poor compliance with mandatory training in information governance, moving and handling, and fire safety within CAMHS services.

Staff told us that they usually do have access to mandatory training but there was minimal resource to access specialist training to meet the needs of their client group. Issues of travel and time were stated as barriers to accessing some training. In a training analysis undertaken in January 2015 staff had stated their difficulty in accessing training was due to the pressures of their clinical work increasing alongside a reduction in experienced staff in the teams.

The trust had undertaken a number of initiatives to improve staff engagement and support. The 'listening to and engaging our staff' programme included a leading together initiative for all managers, listening in to action (LiA) which involved staff in service improvement initiatives, 'ask the boss', board and directors' service visits, staff equality champions and staff support groups.

Requires improvement

Are services effective?

The trust uses the Friends and Family Test on a quarterly basis to consider staff's views. At March 2015 this indicated that there had been a slight increase in staffs' level of satisfaction.

The trust confirmed that they were working hard to improve access to training and annual appraisal. From December 2014 incremental pay had been linked to completion of an appraisal. This trust had also implemented on-line training and records systems to improve access to training and data quality.

Multi-disciplinary and inter-agency team work

We found a strong commitment to multi-disciplinary team working across all services. On the wards we visited we usually saw good multidisciplinary working, including ward meetings and regular multi-disciplinary meetings to discuss patient care and treatment.

At most mental health units we saw input from occupational therapists, psychologists and pharmacy. However, in a number of mental health and learning disability services we were told that there was limited access to psychology and occupational therapy.

Community inpatients held ward round meetings which took place each week day and each patient was discussed. We saw documentary evidence of a multi-disciplinary approach to discharge planning. In community services for adults the older persons unit (OPU) provided an excellent example of multi-disciplinary working that resulted in admission avoidance for many elderly people.

Medical cover was a matter of concern in a number of areas. Non-medical prescribers in the substance misuse service were not in receipt of medical supervision to monitor and develop their prescribing practice. The staff in the end of life care services had limited support from doctors who had a specialism in palliative care. At Loughborough hospital there were plans to fully remove medical input in to this service. We observed a very slow response from the on call doctors while inspecting the forensic service. At community mental health teams the use of locums led to inconsistency in the service meaning people were not seen by the same doctor. In CAMHS services a doctor was not always on site so staff would use the on call service out of hours meaning the doctor may not have CAMHS experience.

At most wards there were effective handovers with the ward team at the beginning of each shift. These helped to ensure that people's care and treatment was co-ordinated and the expected outcomes were achieved.

Physiotherapists and occupational therapists in community services for children, young people and families met and discussed issues raised by cases. Team meetings every other month enabled working through case studies and learning from when things had not gone well. Information about new research or developments was shared.

We saw that community teams usually attended discharge planning meetings making the process of leaving the wards more effective. Generally we saw that the community teams worked well with inpatient teams to meet people's needs.

Adherence to the MHA and MHA Code of Practice

Reporting to the quality assurance committee the mental health act assurance group (MHAAG) has overall responsibility for the application of the Mental Health Act (MHA) and the Mental Capacity Act (MCA). An annual report was presented to the board, to inform the executive of performance and required actions across this area. This group also carried out the role of the 'hospital managers' as required by the MHA.

We attended a meeting with the hospital managers and were informed that the hospital managers receive a rigorous induction with training on the MHA and MCA and an induction shadowing other hospital managers.

The MHAAG provides a forum for reviewing and ensuring compliance with the legal and statutory requirements of the MHA. It performed a number of key functions, including:

- monitoring all aspects of MHA performance,
- receiving MHA reviewer reports,
- monitoring actions and responses,
- escalating any outstanding issues and raising issues of concern for resolution to the quality assurance committee and (QAC).

There was some confusion regarding whether MHA training was mandatory at the trust. The quality assurance committee (QAC) agreed MHA training was mandatory in April 2014 and a module was planned to begin in September 2014. We found varying levels of understanding across the trust and different services were unclear

regarding whether this training was mandatory. For example, we noted that staff in the crisis service were trained and knowledgeable but staff in acute services had no specific training.

We visited wards at the trust where detained patients were being treated and reviewed the records of people subject to community treatment. We also looked at procedures for the assessment of people under the MHA. In addition we reviewed a random sample of 20 sets of files within the MHA administration office, covering a variety of sections of the MHA, across several locations for detention. There was not a clear process for scrutinising and checking the receipt of documentation. MHA administrators had recently started a new system in order to scrutinise documentation but not all of the documents we looked at had been scrutinised and, whilst the majority of documents were in place and accurate we identified concerns.

There were some examples of MHA documents missing from files. In the rehabilitation and acute services there were incomplete sets of MHA documents on files and some renewal papers were not available. Reports carried out by the approved mental health professional (AMHP) were not always available in the ward files or the MHA administration files. We could find no record of action taken to obtain the reports.

Patients were usually provided with information about their legal status and rights under section 132, at the time of their detention or soon afterwards. At the forensic and learning disability services we found some exceptions to this. The forms used to record the information were brief and we saw many examples where they were incomplete. For example, patients' understanding of their rights was not always recorded. In four of the core services, where detained patients were being treated, patients' understanding of their rights was not reassessed. We also found that, irrespective of their understanding, patients were not reminded of their rights on a regular basis. A patient on one of the secure wards had only had their rights explained once in twelve months. Files at the MHA office did not routinely include details about whether a person had been provided with their rights under the MHA.

Most of the wards displayed posters about the independent mental health advocate (IMHA) service. However, across all services there were examples where patients had not been informed of, or did not understand, their right to access an IMHA. The exception was the older person's service, where patients were automatically referred to an IMHA if they were unable to understand their rights.

Assessment and recording of patients' capacity to consent at the start of their treatment varied across the core services. There were limited records of discussions between patients and their responsible clinicians (RC) to show patients' understanding of their prescribed medicines and their consent or refusal to take it.

On some of the wards we found treatment was not being given in line with the MHA Code of Practice. On two wards we found T2 certificates, to evidence patients' consent to taking their medication, were not signed by the current RC. On two wards not all prescribed medicines were included on the T2 certificate, which meant patients were being given medication they had not consented to. Similarly, we found examples of medication being given which had not been approved by a second opinion appointed doctor (SOAD) if the patient lacked capacity, or refused to consent to taking medication.

The system for recording section 17 leave did not adhere to the MHA Code of Practice in any of the core services. There were a number of incomplete leave forms. There was a lack of records to show patients were provided with copies of the forms. Several of the wards did not record risk assessments prior to patients going on leave. The outcome of the leave, including the patient's view, was not always recorded in the clinical notes. On one of the wards the leave authorisation was not signed by the patient's current responsible clinician. In the rehabilitation service we saw some leave forms were completed up to twelve months in advance, which meant leave was not being reviewed regularly.

Seclusion was practiced at a number of the services we visited. Generally seclusion paperwork was not fully completed in accordance within the Mental Health Act Code of Practice. We looked at the process of seclusion, including a review of the environment and paperwork in the acute service. We found overall that the record keeping and scrutiny was poor. We found seclusion practices did not always follow the Code of Practice or trust policy. For example, on one ward we found a patient was being nursed in a low stimulus area on constant observations. The doors were locked and the patient was prevented from

leaving. The seclusion safeguards, such as regular reviews, were not taking place. We found good practice with regard to seclusion on the wards for people with learning disabilities and autism.

Good practice in applying the MCA

The trust has a policy in place on the application of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). Reporting to the quality assurance committee the mental health act assurance group (MHAAG) has overall responsibility for the application of the Mental Capacity Act (MCA). An annual report is presented to the board, to inform the executive of performance and required actions across this area.

The trust told us that training rates for staff in the Mental Capacity Act were good with just over 90% of staff trained at the end of December 2014. Staff confirmed that they had received this training and updates were provided as part of ongoing safeguarding training. Generally most staff had an awareness of the Mental Capacity Act and the Deprivation of Liberty Safeguards. Deprivation of Liberty safeguards applications had usually been made when required. However, records were inconsistent in recording these and staff where not always aware of when an authorisation was in place. At a number of mental health services, particularly learning disability, forensic and older people's services mental capacity assessments and best interest decisions had not always been carried out where applicable

In community healthcare services staff had a clear understanding of their responsibilities in relation to the Mental Capacity Act. They were able to differentiate between ensuring decisions were made in the best interests of people who lacked capacity for a particular decision and the right of a person with capacity to make an unwise decision.

In end of life care services we looked at "do not resuscitate cardio pulmonary resuscitation" (DNACPR) forms in use in the trust. We saw that the trust was proactive in arranging these forms to be completed early in a patient's care. We reviewed five forms and saw all of these had been completed fully. , we noticed that the form the trust used did not have an area for staff to document that a multidisciplinary discussion had taken place. This meant that it was not clear which professionals contributed to the discussion around DNACPR for the patients.

Good

Are services caring?

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

Summary of findings

We rated Leicestershire Partnership NHS Trust as good overall for this domain because:

- Staff showed us that they wanted to provide high quality care, despite the challenges of staffing levels and some poor ward environments. We observed some very positive examples of staff providing emotional support to people.
- Most people we spoke with told us they were involved in decisions about their care and treatment and that they and their relatives received the support that they needed. We saw some very good examples of care plans being person centred however, not all care plans indicated the involvement of the service user.
- We heard that patients were well supported during admission to wards and found a range of information available for service users regarding their care and treatment.
- The trust has a user engagement strategy which set out the trust's commitment to working in partnership with service users. The trust told us about a number of initiatives to engage more effectively with users and carers.
- Results from the friends and family test indicated a good level of satisfaction with the service.
- Advocacy services were available and promoted.

However:

- Arrangements for visits from families were not always appropriate, particularly in respect of children visiting mental health units.

Our findings

Kindness, dignity, respect and support

Assessments undertaken under the Patient-Led Assessment of the Care Environment (PLACE) reviews in 2014 identified that the trust scored worse than average at 82% for the privacy, dignity and well-being element of the assessment against an England average of 89%. Particular services of concern were Loughborough, Coalville, Feilding Palmer and Ashby community hospitals, and mental health units at Oakham House, the Willows and Mill Lodge. Stewart House rehabilitation unit scored just 53% for this assessment.

We saw that staff were kind, caring and responsive to people and were skilled in the delivery of care. We observed many instances of staff treating patients with respect and communicating effectively with them. Staff showed us that they wanted to provide high quality care. We observed some positive examples of staff providing emotional support to people. However, we observed two occasions in community inpatient services at Feilding Palmer Community and Coalville Community Hospitals where patients' dignity was not always preserved during their treatment.

Generally people told us that staff were kind and supportive, and that they were treated with respect. People we spoke with were mainly positive about the staff and felt they made a positive impact on their care.

Generally staff were knowledgeable about the history, possible risks and support needs of the people they cared for.

We were told that staff respected people's personal, cultural and religious needs. We saw some very good examples of this. For example, the end of life care services team who attend to care for people in their own home, often remove shoes before entering and follow cultural wishes such as wearing head scarves to cover their hair when attending patients.

The involvement of people in the care they receive

At most inpatient services we found welcome packs that included detailed information about the ward and a range of information leaflets about the service. This was not the case at the mental health inpatient wards for children and adolescents. Staff explained this was due to the impending move of the service. Most patients we spoke with told us

that they were given good information when they were admitted to the wards. Some patients at the rehabilitation service told us that they had not received any information at admission.

Community services for adults reported good patient involvement in their care. For example, patients that we spoke with were very positive about the musculoskeletal (MSK) service they received and reported being very involved and well informed about their treatment plan.

Community services for children, young people and families provided support for young people to manage their own treatment and had achieved positive results, such as improving their self-esteem so that they started attending school or college.

Community services for adults' podiatry service was pro-active in promoting self-care and had recently developed protocols for the risk assessment and self-management of warts using silver nitrate sticks. The podiatry service also encouraged people to self-treat using over the counter remedies where it was felt appropriate following assessment.

Within a number of mental health inpatient and community services, substance misuse services, learning disability and community inpatient wards people told us they were usually informed about their care and treatment. However we found that not all care plans and records demonstrated the person's involvement. In addition, within community mental health teams for older people we found that there was not an opportunity for patients to attend care planning meetings. In child and adolescent services we found that care plans were not written in an age appropriate format to be accessible to the patients.

Patients within mental health and learning disability services had access to advocacy including an independent mental health advocate (IMHA) and there was information on the notice boards at most wards on how to access this service. Arrangements were also in place to access independent mental capacity advocates (IMCA) and we saw examples of where this was actively promoted.

Within community healthcare we observed that where a patient was unable to be actively involved in the planning of their care, or where they wanted additional support, staff involved family members with the patients' consent.

In community inpatients we received mixed feedback regarding family involvement but received positive feedback from one family who described the changes staff at Melton Mowbray Community Hospital made to accommodate their preferences for the care of their relative.

Generally within mental health and learning disability services we found some good examples of involving patient's families and carers where appropriate. However, within the short breaks learning disability service we found some examples of staff sharing information with families without the expressed consent of the person.

We found some issues within mental health services in relation to families visiting their loved ones. In forensic services all visits were closely observed, which patients were very unhappy about. At the acute wards there was a specific area for visits involving children. However, this was not available to patients who were admitted to the PICU. Also within acute services there was limited space on wards for visits not involving children.

The trust has a service user and carer involvement strategy which sets out the trust's commitment to working in partnership with service users and carers. This is underpinned by the 'changing your experience for the better programme' which included initiatives to engage more effectively with users and carers. This work is overseen by a trust wide user and carer reference group. Work has included development of a dedicated patient experience team and divisional patient experience committees, public engagement events regarding service reconfiguration, promotion of advocacy and advance statements, increased partnerships with voluntary and community groups and service user involvement in training, recruitment and audit. Other initiatives developed included the use of the 'triangle of care' toolkit which provides an accredited framework to develop carer involvement within local services.

Prior to the inspection we spoke with a large number of user groups, community support organisations and advocacy services. Generally we heard of positive relationships with the trust and of opportunities to be involved in providing feedback on how services are run or planned.

Most inpatient services had community meetings or forums to engage patients in the planning of the service and to

Good

Are services caring?

capture feedback. Patients told us they felt able to raise concerns in the community meetings and that they usually felt listened to. We saw that there was information available throughout the trust and via its website about how to provide feedback on the specific services received by people.

The trust had been a pilot site for the Friends and Families Test (FFT) in 2013 and had fully implemented this across the trust in April 2014. In the 12 months prior to our visit there had been almost 6000 responses to this survey. At March 2015 the results indicated that 96% of respondents were likely or extremely likely to recommend the trust services.

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

We rated Leicestershire Partnership NHS Trust as requiring improvement overall for this domain because:

- The trust was not meeting all of its targets in respect of the delivery of community services. Some teams had significant waiting lists.
- We were told that there was a shortage of beds in acute, PICU and CAMHS services.
- Out of area placements were high for acute services and the PICU was unavailable to female patients as it did not meet the guidance on mixed sex accommodation.
- A lack of available beds meant that people may have been discharged early or managed within an inappropriate service. However, staff worked well with other services to make arrangements to transfer or discharge patients.
- We were also concerned about the operation of the referral line for the crisis service. Performance information had also not been available this service.
- We found that the environment in a number of units did not reflect good practice guidance and had an impact on people's dignity or treatment.
- Within three acute wards and the PICU there were no female only lounges as required by the Mental Health Act Code of Practice and Department of Health guidance.

However:

- We found a range of information available for service users regarding their care and treatment and many of the leaflets were available in other languages.
- A process in place to address peoples' complaints. However, improvement is required to ensure all complaints are captured at trust level and learned from.
- Most units that we visited had access to grounds or outside spaces and generally had environments that promoted recovery and activities.
- Interpreters were available and we observed some very good examples of staff meeting the cultural needs of their patients.

Our findings

Access, discharge and bed management

The trust was asked for information ahead of our inspection regarding the days from initial assessment to onset of treatment but could not supply this as they did not currently collect this information. The trust has met just 65% of its targets for the average number of days from referral to initial treatment. Particular areas of concern were highlighted as ADHD services, community mental health teams, domiciliary therapy, dietetics, continence services, older people's mental health services and memory clinics, and psychological therapies. At March 2015 the trust had almost met its target for percentage of patients on CPA followed up within 7 days of discharge at 94.7%.

The trust monitors both bed occupancy rates and delayed transfers of care. At the time of the inspection the number of delayed transfers of care was 8.7% against a target of 5.9% for mental health services and at 1.06% against a target of 2.12% for community inpatient care. At March 2015 bed occupancy rates at the trust stood at 89.5% across all mental health services and 94.0% for community inpatient services which is above the England average. We also analysed the data for bed occupancy this was at 99% occupancy for adult mental health and learning disability services. The trust told us that the average length of stay for mental health wards was 53 days.

Throughout this inspection we were consistently told there was a shortage of beds for acute mental health and psychiatric intensive care. We observed during the inspection that there was often a problem finding beds for patients who needed an admission. We were shown supporting data which gave the bed occupancy on the wards as very often above 100% capacity. Community and crisis team members told us that they spent a lot of time trying to find appropriate inpatient beds for people. It was

frequently necessary to admit other patients into the beds of patients who were on short term leave. We observed that one patient had returned from leave on Bosworth ward. A bed was not immediately available for this patient, so they had been asked to wait in the lounge until a bed became available. We also observed a 17 year old female patient being nursed in a seclusion room on an adult ward due to no appropriate bed.

Staff told us there could be delays if patients needed to be transferred to more appropriate care facilities, such as a psychiatric intensive care unit (PICU) as there were no beds available there.

We found that there were waiting times for rehabilitation and child and adolescent inpatient services. We were particularly concerned that there is currently no PICU available to female patients as the single PICU is designed in a way that cannot accommodate patients of both genders. This meant the trust either breaching single sex accommodation guidance or placing female patients out of area.

The trust had a bed management system for mental health services. During the day a bed management team co-ordinated admissions whereas at night this responsibility fell to the night co-ordinator. During our unannounced visit, the night co-ordinator explained that a patient who did not need a substance misuse service was being admitted to a detoxification bed usually for patients with substance misuse problems. There was no other bed available within the trust. The alternative was to find a bed out of area.

The trust told us that they are trying to reduce the out of area admissions. Staff and patients also reported concerns about the high level of out of area admissions. This also usually meant that patients were subsequently transferred or repatriated, which was sometimes disruptive to the continuity of their care. At the time of our inspection there were 19 patients in out of area acute beds (that is, beds which are not within the trust's catchment area). Of these patients, we noted that one patient had been out of area for 144 days, although the overall average was 38 days.

We observed that at all inpatient services' staff worked with other services to make arrangements to transfer or discharge patients. However, staff told us that bed availability in the acute, intensive care unit and CAMHS services meant that there had been delays on occasion in transferring a patient. We found that generally there was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services.

The mental health ward teams told us that they worked closely with both crisis services and community teams to ensure continuity of care when patients were discharged from hospital. At most wards we found that arrangements for discharge were discussed and planned with the care co-ordinators and other involved care providers and many people told us that they were fully involved in their discharge planning.

In community inpatient services we found that home assessments were completed with the patient and carers by a member of the multidisciplinary team before discharge. This ensured equipment or further community support was provided once the patient was discharged home. The end of life care services and MacMillan nurses told us they worked closely with other members of the multidisciplinary team, for example GPs and district nurses, in order to ensure patients received timely access to and discharge from services. We were told about the rapid discharge system that could enable the discharge of a patient within four hours by arranging relevant care packages at their home and equipment.

The trust had developed a new model for the crisis service which was in the third week of operation at the time of this inspection. Target times and clear criteria had been set but the trust had not yet been able to measure performance. It therefore was not possible to measure the speed of the crisis service's response to referrals and whether they were meeting their targets. Information available following the inspection indicated that the service had met the 24 hour target but had not met the targets for 2 hour, 4 hour and 72 hour assessments. We were concerned about the crisis referral line which was staffed by untrained administrators rather than clinicians. We also heard of delays in response to this line and found that there was no way of gauging unanswered calls. We found that people were mainly positive about the reorganisation of the service

Across community mental health, learning disability and physical healthcare teams we heard about a number of unacceptable waiting times. These included community

teams for paediatrics and child and adolescent mental health, older peoples' teams, learning disability teams, adult ADHD teams, liaison services, substance misuse services and psychology services.

The service environment optimises recovery, comfort and dignity

Since 2013 'Patient-Led Assessments of the Care Environment' (PLACE) visits had taken place to a number of inpatient services. This is a self-assessment process undertaken by teams including service users and representatives of Healthwatch. The results indicated that the trust overall scored above average for the standard of cleanliness, but below average for food, facilities, and privacy, dignity and wellbeing.

Facilities were rated low in a number of services. The national average score was 92.5%. The trust only met or bettered this score for four of the 17 inpatient services reviewed.

Scores for privacy, dignity and wellbeing were also rated very low in a number of services. The national average score was 89.6%. Only three of the 17 services reviewed met this score. Of these, Mill Lodge, Oakham House and Stewart House scored less than 65%.

We noted some units required updating and staff at a number of services told us that there could be significant delays in repairs being carried out. On three wards in the acute service and one ward in the older peoples' mental health service we found bath/shower rooms out of order. Within older peoples mental health wards we found that Coleman ward was not dementia friendly. At the forensic service we had some concerns about space for people to meet visitors. Not all facilities had a space for children to visit. We found limited space within the learning disability short breaks services for activities and for people with physical health needs to manoeuvre. Generally we found that inpatient services were clean and had environments that promoted recovery. Most had room for activities, space for quiet and a place to meet visitors

On a number of units we found arrangements that did not promote people's dignity.

We were very concerned about sleeping arrangements within the acute services at the Bradgate Unit which was predominantly dormitory style, with up to four patients sleeping in one dormitory. Curtains were provided between the beds but this did not provide the privacy required. Male and female dormitories were adjacent or opposite each other. During our visit we noted dormitory doors open and we were able to observe patients within. Bathroom facilities were allocated as single gender but due to repairs and there location we noted members of the opposite gender using the facilities.

Within three acute wards and the PICU there were no female only lounges as required by the Mental Health Act Code of Practice and Department of Health guidance.

Most units that we visited had a clinic room available and were equipped for the physical examination of patients.

We found that most services had access to grounds or outside spaces, but most garden areas did not have a shelter for use in inclement weather.

Most inpatient services had lockable storage available to patients. Whilst patients had access to a lockable storage space at the acute wards, they did not have the keys for the storage and had to approach a member of staff. In longer stay services we found that people were able to personalise their bedroom space.

Wards we visited had a telephone available for patient use. However, within acute, PICU and forensic services these were not sited in a private area and patients complained about their calls being overheard. At Thornton ward the payphone was out of order and patients told us this was a frequent issue.

Most patients were happy with the choice and quality of food available to them. However, some patients at the forensic service, older peoples' services at the Bennion Centre and in the learning disability service were unhappy with the choice available and the repetitiveness of the menu. Most wards had facilities for drinks and snacks outside of meal times. In the majority of cases these were open to patients as appropriate. At the forensic service patients did not have access to a fridge meaning milk and other perishables were not adequately stored.

Meeting the needs of all people who use the service

Inpatient and community services were provided from facilities that were equipped for disability access.

We found a range of information available for service users regarding their care and treatment both within services and via the trust website. Many of the leaflets viewed were

available in other languages and formats. However, we found that in the end of life service care plans and information was not available in an appropriate format for people with dementia or a learning disability. We found limited information available to people within the crisis services.

In community services for adults staff used a 'getting to know me' booklet which identified person centred information around the person's preferred routines and information that was important to patients living with dementia. However, this information had not been consistently filled out within the records we reviewed at Feilding Palmer Hospital. Community services for adult heart failure patients could access advice via an email helpline with a guaranteed response within 72 hours.

Staff told us that interpreters were available via a central request line and were used to assist in assessing patients' needs and explaining their care and treatment. We observed some very good examples of staff conversing with patients in their own language were English was not the patients first language. In community services we heard about some good practice were staff had asked patients about their preferences were interpretation was required. This meant a patient could choose between an independent translator or family support for their translation needs.

At most inpatient services we saw that multi-faith rooms were available for patients to use and that spiritual care and chaplaincy was provided when requested. We saw there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.

End of life care palliative care nurses told us they aimed to find out patients' wishes and religious beliefs early in their care so they can document this and ensure their wishes can be carried out. Staff told us that they have been able to assist a family in the early release of a body so that burial times were adhered to.

Listening to and learning from concerns and complaints

The trust provided details of all complaints received during 2014. There had been 322 formal complaints. The largest number of these related to nursing and health visiting. The analysis of this highlighted key themes as clinical treatment, staff attitudes, delays to appointments, admission and discharge, and communication. The trust informed us that during the period 53% of complaints had been upheld. During the period 3 complaints had been referred to the Parliamentary and Health Service Ombudsman (PHSO) as the complainant remained unhappy with the outcome. These had not been upheld by the PHSO. The trust also provided information about the complaint issues and the actions they had taken as a result of the findings. We reviewed this information and saw some good examples of learning from complaints.

The trust provided details of their formal complaints process. This set out arrangements for response, investigation and ensuring lessons are learned and shared. All formal complaints are reviewed by the divisional director responsible for the service and responses are signed by the chief executive. Complaints information was discussed at local governance meetings and is reviewed by the quality assurance committee. The board receive the report from the quality assurance committee which includes details of complaints received and any relevant actions.

Ongoing training regarding the complaints process is not currently available. This had been recognised as an area for development by the trust. Staff told us they that were aware of complaints raised in the service and usually heard of the outcome and any learning this raised. Staff were generally aware of the complaints process and received information about the complaints process as part of induction training.

At the inpatient services most patients told us that they were given information about how to complain about the service. This was usually contained within the ward information and included information about how to contact the patients advice and liaison service (PALS). Information about the complaints process was usually displayed at the wards. Most patients knew how to complain and felt they would be listened to.

In some but not all community teams we found that complaints information was displayed and that additional information was available. Most community patients knew how to complain.

Complaints information was also looked at some of the services we visited. Reports usually detailed the nature of complaints and a summary of actions taken in response.

Requires improvement

Are services responsive to people's needs?

Generally complaints had been appropriately investigated and included recommendations for learning. At some units we saw actions that had occurred as the result of complaints.

The trust told us that they are actively trying to manage complaints on an informal basis. In a number of community and inpatient services verbal complaints were managed at service level and the findings were usually acted upon. However, we found a number of services including CAMHS, substance misuse services, forensic and end of life services were these were not logged or notified to the trust complaints team. This meant some issues may not be tracked and resolved by the trust as there was no auditing system in place for verbal complaints. This also may mean that the trust does not have a clear understanding of themes emerging from complaints.

Requires improvement

Are services well-led?

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

Summary of findings

We rated Leicestershire Partnership NHS Trust as requiring improvement overall for this domain because:

- We reviewed the risk registers for the trust and directorates and noted that while some of the concerns we found had been highlighted others had not been flagged.
- The trust had not met all its strategic objectives.
- The trust had failed to ensure all required improvements were made and sustained at the acute services at the Bradgate Unit following compliance actions made in 2013.
- We were concerned that the trust had not always delivered safe and quality care despite a well organised governance structure and quality system. Our findings indicate that that there is room for improvement to ensure that lessons are learned from quality and safety information and that actions are embedded in to practice.

However:

- The trust board had developed a vision statement and values for the trust and most staff were aware of this.
- The trust had undertaken positive engagement action with service users and carers.

Our findings

Vision, values and strategy

While the board and senior management had a vision with strategic objectives in place, staff did not feel fully engaged in the improvement agenda of the trust.

The trust board had developed a vision statement and values for the trust in 2013. The vision was stated as: 'To improve the health and wellbeing of the people of Leicester, Leicestershire and Rutland by providing high quality, integrated physical and mental health care pathways'. The trust values were confirmed as: respect, compassion, trust and integrity.

The trust gave us a copy of their quality strategy for 2013 to 2016. This included the overarching trust objectives. These were: 'to deliver safe, effective, patient-centred care in the top 20% of our peers; to partner with others to deliver the right care in the right place at the right time; staff will be proud to work here, and we will attract and retain the best people; and ensure sustainability'. The strategy also sets out more detailed objectives to meet this plan, as well as arrangements to monitor progress.

Additional annual objectives were also set out in the annual quality account. For 2014/15 the objectives included better physical health care for older people, the 'changing your experience for the better' programme, a review of acute mental health bed usage, initiatives to improve transitions for young people and improved crisis care. The integrated business plan underpins the quality strategy and quality account objectives and sets out the trust's financial plans for 2013 to 2016.

The trust board, executive team and quality assurance committee review performance against the strategy on a monthly basis via a business performance report and dashboard approach known as the 'Integrated quality and performance report' (IQPR). Performance against annual objectives is also published within the quality account.

The trust board members we spoke with were clear about the vision and strategy and were able to articulate their specific areas for improvement. Senior management were aware of the strengths and improvement needs of the trust and the specific objectives of their own service areas.

We were told that the vision and strategy were developed following detailed engagement with service users, staff and commissioners. Across all directorates we found an inconsistent level of staff knowledge and awareness of the trust's vision and strategy. Some staff confirmed that they had received a copy of the vision and values on a wallet sized card. Some staff told us that they had received further

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information about the vision and strategy as part of a self-evaluation package given to teams in advance of our inspection. Other staff had a clearer understanding of the vision, values and strategy. Staff demonstrated that they usually had a better understanding of directorate and service level objectives than of the trust wide objectives.

Good governance

We found that while performance improvement tools and governance structures were in place these had not always brought about improvement to practices. Our findings indicate that that there is room for improvement to ensure that lessons are learned from quality and safety information and actions are imbedded in to practice.

The trust has a board of directors who are accountable for the delivery of services and seek assurance through its governance structure for the quality and safety of the trust. Reporting to this are committees for quality assurance, workforce and organisational development, finance and performance, and audit and assurance. The trust manages all quality governance through the quality assurance committee. Reporting to this are sub-committees for clinical effectiveness, patient safety, safeguarding, health and safety, infection control, patient and carer experience, medicines management and medical devices. These committees had terms of reference, defined membership and decision making powers.

The trust operates an enterprise risk management risk escalation methodology compliant with ISO 31000. This is described within both the trusts board assurance and escalation framework document and the risk management strategy.The trust had an integrated board assurance framework and risk register which is reviewed monthly by the board. Risk registers were also in place held at different levels of the organisation which were reviewed at directorate meetings. We saw that there was a clear disconnect between the risks identified at grass roots level and those recognized by board.

The integrated quality and performance report (IQPR) acts as a performance report against key indicators and an early warning system for identifying risks to the quality of services. This includes measures of organisational delivery, workforce effectiveness and quality and safety. These include: complaints, serious incidents, access and waiting time targets, delayed transfers of care, bed occupancy, average length of stay, as well as staffing measures such as vacancies, sickness, turnover and training rates.

A Mental Health Act assurance group had overall responsibility for the application of the Mental Health Act and the Mental Capacity Act. We met with the hospital managers and found that they provided a regular annual report to the board, to inform of performance in this area. The board also received further information and assurance regarding the Mental Health Act through the board committee structure. There are a large number of concerns about the application of the Mental Health Act and there was a disconnect between board level awareness of these and practices at ground level. We reviewed the annual Mental Health Act report and MHA assurance group minutes and noted that a number of these issues had been raised by the hospital managers since April 2014 and were still outstanding. These included mandatory MHA training for staff, a more robust audit process and better organisation of legal documentation.

The trust publishes a leaflet, 'Clinical Governance: What does it mean for us all in our trust?' This leaflet makes explicit the reasons that sound governance systems are important and the responsibilities of individual staff members. Staff demonstrated they were aware of their responsibilities in relation to governance. Most staff told us that they were aware of the governance structure and had access to performance information and meeting minutes. Most staff told us they would escalate risks they were aware of.

Team managers confirmed that they were involved in governance groups and that they were able to raise issues through the risk register and operational groups. We reviewed the risk registers for the trust and directorates and noted that while some of the concerns we found had been highlighted others, such as ligature and environmental issues, mixed gender accommodation, medication management and clinical risk management, had not been flagged. This shows a poor grasp by the board of these serious failings.

We found a large number of practices and resources that required improvement. Issues of concern included poor

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environments and ligature risks, single sex accommodation issues, under compliance of mandatory training, supervision and appraisal, demand for beds, staffing issues, restrictive practices and medicines management.

In July 2013 we had inspected the Bradgate mental health unit. We were concerned about the care and welfare of patients and co-operation with other providers and issued warning notices. We returned in November 2013 and found some improvement. At this inspection we found that some issues of care and welfare such as care planning and seclusion practice had not been fully met or sustained. This is a serious breach and shows a disconnect with board understanding of the performance of the trust.

We reviewed the performance reports for the previous year's objectives. We noted that while some progress had been made some objectives had not been fully met or sustained such as improvements to record keeping, clinical supervision and physical healthcare for mental health inpatient services. Objectives for 2014/15 had included improvements to bed management and care planning in acute services. We found these remained issues in the acute services.

We were concerned that despite a well organised governance structure and quality system the trust did not always deliver safe and good quality care. Improvement is necessary to ensure that lessons are learned from quality and safety information and are embedded in to practice.

Leadership and culture

Morale was found to be poor in some areas and some staff told us that they did not feel engaged by the trust although managers and leaders were visible. Staff in the CAMHs services, forensic services and older peoples' teams stated that morale was poor and that they did not feel engaged by the trust. The board was not always sighted on these issues.

In the 2014 NHS Staff Survey, the trust was ranked about average overall. The trust was below average in relation to 13 measures including support from immediate managers, feeling valued, job satisfaction and being able to contribute to development. Overall the trust had slightly improved its position across relevant indicators against the 2013 survey results. The staff survey had found that the percentage of staff suffering work-related stress in the last 12 months had been worse than average and the trust was within the worst 20% of trusts for staff feeling pressure to attend work when feeling unwell.

We looked at data available about staffing. The trust confirmed that they had a vacancy rate of over 7% and that staff turnover stood at over 11 % in February 2015. During February 2015 over 27% of shifts within inpatient services were covered by agency or bank staff. Acute services had particularly high use of agency or bank staff which ranged between 32 and 62% per ward. Sickness absence rates had fallen slightly since the staff survey was completed and remained slightly above target at 4.9% in February 2015.

The trust told that they had undertaken a range of initiatives to engage staff. The 'listening to and engaging our staff' programme included a leading together initiative for all managers, listening in to action (LiA) which involved staff in service improvement initiatives, 'ask the boss', board and directors' service visits, staff equality champions and staff support groups.

The trust uses the Friends and Family Test on a quarterly basis to consider staff's views. At March 2015 this indicated that there had been a slight increase in staffs' level of satisfaction. We found that staff were very committed to ensuring that they provided a good and effective service for people who used the services. Most, but not all, staff felt able to influence change within the organisation. However, staff in the end of life service and the CAMHs services told us that they did not know the long term plans from the trust and could not influence change.

Most staff told us they knew their immediate management team well and most felt they had a good working relationship with them. Most staff were aware of, and felt supported by, the trust's directorate management structures. Most staff were aware of who the senior management team were at the trust. Some staff stated that they had met with or seen senior managers at their service and felt supported by this.

Staff were aware of their role in monitoring concerns and assessing risks. They knew how to report concerns to their line manager and most felt they would be supported if they did. We found some good examples of staff feeling that learning from past incidents was informing planning of services or service provision. However, a small number of

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staff in children, young people and families services told us they had not been supported by their managers and they felt unable to raise concerns, or if they did raise concerns these would not be appropriately dealt with.

Some staff at a Black and Minority Ethnic staff focus group from across the trust told us they did not always feel supported or engaged as trust staff members.

In 2014 a CQC regulation was introduced requiring NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong. The trust had undertaken an audit to understand any improvements required to meet this duty of candour. Following this a number of actions were undertaken including duty of candour considerations being incorporated into the serious investigation framework and report and complaints process. Minutes of directorate and locality governance groups evidenced frequent discussion about the duty of candour. Whilst most staff were aware of the duty of candour requirements not all staff across community health care services were fully aware of duty of candour in relation to their roles.

Engagement with the public and with people who use services

The trust has a user engagement and carers' strategy that sets out the trust's commitment to working in partnership with service users and carers. Underpinning this is an improvement programme called 'changing your experience for the better'. Through this they had undertaken a number of initiatives to engage more effectively with users and carers. These included the development of patients' experience workers, ensuring that all divisional patient safety and experience groups had involvement plans, involving service users in recruitment, training and service planning, promotion of advocacy and advance statements, and increased partnerships with voluntary and community groups. Other initiatives developed included the use of the 'triangle of care' toolkit which provides an accredited framework to develop carer involvement within local services.

The trust had been a pilot site for the Friends and Families Test (FFT) in 2013 and had fully implemented this across the trust in April 2014. In the 12 months prior to our visit there had been almost 6000 responses to this survey. At March 2015 the results indicated that 96% of respondents were likely or extremely likely to recommend the trust services.

Since 2013 'Patient-Led Assessments of the Care Environment' (PLACE) visits had taken place to a number of inpatient services. This is a self-assessment process undertaken by teams including service users and representatives of Healthwatch.

Most inpatient services had community meetings or forums to engage patients in the planning of the service and to capture feedback. Patients told us they felt able to raise concerns in the community meetings and that they usually felt listened to. Patients and their families or carers were engaged by staff in community health care groups using a variety of methods. We saw that there was information available throughout the trust and via its website about how to provide feedback on the specific services received by people.

Many patients told us that they felt listened to and their requests were usually acted upon.

Not all care plans reviewed in mental health services indicated involvement of the patient. Not all patients were aware of the content of their care plans. In addition, within community mental health teams for older people we found that there was not an opportunity for patients to attend care planning meetings. In child and adolescent services we found that care plans were not written in an age appropriate format to be accessible to the patients. We also found significant issues in relation to patients being treated without clear consent. In community healthcare services patients stated that they were usually involved in their care

Prior to the inspection we spoke with a large number of user groups, community support organisations and advocacy services. Generally we heard of positive relationships with the trust and of opportunities to be involved in providing feedback on how services are run or planned.

Quality improvement, innovation and sustainability

The trust had participated in some but not all mechanisms for quality improvement.

The trust participated in some accreditation schemes and service networks open to them. The ECT services at the

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Bradgate Unit were accredited with ECTAS (Royal College of Psychiatrist's accreditation for ECT). The Agnes Unit learning disability service had held accreditation since 2012 but was awaiting confirmation of reaccreditation at the time of our visit. The trust told us that some actions had been required to meet this standard but they had been completed. However, the trust had not participated in all relevant accreditation schemes, for example the acute service was not accredited by the AIMS (Royal College of Psychiatrist's accreditation for inpatient services) programme and the forensic services was not part of the quality network for forensic services.

The trust has a research strategy and had participated in a wide range of clinical research.

The trust also undertook a wide range of clinical effectiveness and quality audits. These included safeguarding practice, medicines management, prescribing, compliance with NICE guidance, medical devices, suicide prevention, clinical outcomes, physical healthcare, care planning, record keeping, pressure ulcer management, consent and capacity, Mental Health Act administration and patient satisfaction.

During 2014 the trust also participated in two national clinical audits: the National audit of psychological therapies (NAPT) and the National audit of schizophrenia (NAS). The National Audit of Psychological Therapies indicated that the trust had not considered whether psychological therapies were delivered in line with NICE guidance or had looked at outcomes from the therapy. The trust had participated in the National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) in 2012.

Community services for adults had initiated innovative practice. This speech and language therapy team (SALT) had initiated a pilot where they worked with the dieticians and staff from local care homes to identify training needs. The team then provided the training for the care homes and improved the care patients received. The team had been awarded a Leicestershire Partnership Trust excellence award for this project.

The trust heart failure team had started an initiative to 'grow their own' nurse specialists. There were three Band 6 nurses on a three month induction. A competency framework was being put in place to support these nurses in developing the necessary skills for their specialist roles.

In end of life care services at St Luke's Hospital, a project called 'sisters act' had been implemented which encouraged staff to give feedback about the service and encouraged them to think about how it could be improved. This had been rewarded by an award from the trust.

A new model of service delivery for the crisis service had been introduced and was in its third week of operation at the time of the inspection. Staff and stakeholders had been involved in the development of the model. We found that a dashboard of key performance indicators was being developed but there was no reliable performance data, other than the number of referrals, to gauge the performance of the service. We were told by managers that the trust had agreed to suspend the interim dashboard, as the data was not reliable, until there was the ability for the electronic system to populate the dashboard in April 2015.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The provider did not protect patients against the risks associated with the unsafe management of medicines.** • Arrangements for medication management within the substance misuse service were not robust. • Some medication was out of date In the crisis service. • At the rehabilitation service we found two patients were necessary medical checks had not been undertaken following administration of high dose anti-psychotic medication. • The rapid tranquilisation policy did not cover oral treatment. • Fridge temperatures in the acute service were not monitored meaning medicines may not be safe. • The trust had not implemented the requirements of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

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Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The provider had not ensured that patients were protected from the risks associated with unsafe or unsuitable premises by means of suitable design and layout. • Not all wards at the acute service at the Bradgate unit, and the PICU complied with guidance on same sex accommodation. • Some wards at the acute and forensic services, and the PICU had potential ligature points that had not been fully managed or mitigated. • Observation was not clear within some of the acute and forensic wards. • Not all seclusion facilities had safe and appropriate environments. • Repairs had not always been completed in a timely way. • Sluice doors were not always kept locked to prevent patients and visitors having potential access to harmful products. • The health-based place of safety at the Bradgate unit did not meet guidance: furniture was light and portable and access arrangements were unsafe. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 10 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The provider did not make suitable arrangements to protect patients and staff from the risk of harm during an emergency by providing and maintaining necessary equipment. • Not all community and inpatient service had a means to raise an alarm in an emergency.

This section is primarily information for the provider

Requirement notices

• Not all emergency equipment was checked on a regular basis.

This was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

The trust did not take appropriate steps to ensure there were sufficient numbers of staff.

• Not all community and inpatient services had sufficient staffing to safely meet patient need.

• Not all services had access to specialist medical support in a timely way.

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe.

• A lack of availability of beds meant that people did not always receive the right care at the right time and sometimes people were moved, discharged early or managed within an inappropriate service.

This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe. • Not all seclusion facilities met the guidance of the Mental Health Act Code of practice. • Not all seclusion was recognised and managed within the required safeguards. • The trust was yet to fully implement guidance from the Department of Health regarding restrictive practice. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe. • Not all patients within the forensic and substance misuse services had a risk assessment in place. • Not all risk assessments and care plans were updated consistently in line with changes to patients' needs or risks. • Peoples' involvement in their care plans varied across the services. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of planning and delivering care to meet individual service user's needs. • There was limited and delayed access to psychological therapy. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The trust did not make appropriate arrangements to ensure the consent to care and treatment of all services users. • Not all patients had recorded assessments of capacity. • Procedures required under the Mental Capacity Act were not always followed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The trust did not ensure that services users were protected against the risks of unsafe or inappropriate care and treatment due to a lack of accurate records being made and held securely.

This section is primarily information for the provider

Requirement notices

• Procedures were not always followed for detention under the Mental Health Act and records relating to patient's detention were not always in order.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of planning and delivering care in a way that ensures the welfare and safety of the patient.

• Arrangements for patients taking section 17 leave were not clear and in line with the Mental Health Act.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of planning and delivering care in line with Mental health Act Code of practice.

• Not all patients who were detained under the Mental Health Act had information on how to contact the CQC.

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

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Requirement notices

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The trust did not ensure that services users were protected against the risks of unsafe or inappropriate care and treatment through availability of accurate information and documents in relation to the care and treatment provided. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The trust did not protect people, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the trust to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.