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 -Riverside House	RT5X1
Child and adolescent mental health wards	Coalville Community Hospital	RT5TD
Community mental health services for children and young people	Trust Headquarters -Riverside House	RT5X1
Community-based mental health services for older people	Trust Headquarters -Riverside House	RT5X1
Community mental health services for people with learning disabilities or autism	Trust Headquarters -Riverside House	RT5X1
Forensic inpatient / secure wards	The Bradgate Mental Health Unit	RT5KF
Mental health crisis services and health-based places of safety	Trust Headquarters - Lakeside House The Bradgate Mental Health Unit	RT5X1 RT5KF

Summary of findings

Long stay/rehabilitation mental health wards for working age adults	Stewart House (Narborough) The Willows	RT5KE RT5FK
Wards for older people with mental health problems	Evington Centre The Bradgate Mental Health Unit	RT5KT RT5KF
Wards for people with learning disabilities and autism	The Agnes Unit Short Breaks – Farm Drive Short Breaks – Rubicon Close	RT5NH RT5FP RT5FM
Community health services for adults	Coalville Community Hospital Hinckley and Bosworth Community Hospital Loughborough Hospital Melton Mowbray Hospital	RT5YD RT5YF RT5YG RT596
Community health services for children, young people and families	Melton Mowbray Hospital Loughborough Hospital Hinckley and Bosworth Community Hospital Rutland Memorial Hospital	RT596 RT5YG RT5YF RT5YJ
Community Health Services for community inpatient services	St Luke's Community Hospital	RT5YL
Community End of Life Care	Rutland Memorial Hospital Loughborough Hospital Hinkley and Bosworth Community Hospital Coalville Hospital Evington Centre Trust Headquarters (Community Services, Diana, Hospice @ Home and Macmillian CNS Team)	RT5YJ RT5YG RT5YF RT5YD RT5KT RT5

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?	**Requires improvement** 
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.

Summary of findings

Contents

Summary of findings

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.

The trust needs to take steps to improve the quality of their services and we found that they were in breach of seven regulations. We have issued seven requirement notices which outline the breaches and require the trust to take action to address. We will be working with them to agree an action plan to improve the standards of care and treatment.

We rated the trust as requires improvement overall:

- Whilst there had been some progress since the last inspection in 2015, the trust was not yet safe, fully effective or responsive.
- We had concerns about the safety of some of the facilities where care was delivered. The environmental risks in the health based place of safety identified in our previous inspection remained. The trust had not met all the required actions to reduce and mitigate ligature points across wards following the previous inspection in March 2015. The trust had not fully addressed the issues of poor lines of sight in wards. Due to this staff could not observe all parts of wards due to their lay out and the risk had not been mitigated. The trust was not fully compliant with same sex accommodation guidance in two acute wards, the short stay learning disability service and rehabilitation services.
- Some facilities lacked essential emergency equipment. In the health based place of safety resuscitation equipment and emergency medication were not available and staff had not calibrated equipment to monitor patient's physical health. The community therapy rehabilitation unit at Hinckley did not have a defibrillator in the unit for staff to use in an emergency despite staff having been trained how to use one.
- Some wards and community teams did not store or manage medicines safely. There were no pharmacy services within the community mental health teams or crisis team. This could have resulted in an increased risk of incorrect safe and secure handling of medicines and unsafe practice in relation to the administration and prescribing of medicines. We identified concerns around the storage of medicines in community hospitals, with missing opened or expiry dates across all hospitals. Patients' own controlled drugs were not always managed and destroyed appropriately. We identified that in community mental health teams, wards and community inpatient hospitals, fridge temperatures were not recorded correctly; either single daily temperature readings were recorded rather than maximum and minimum levels or temperatures were not recorded on a daily basis. This did not demonstrate a consistent temperature, had been maintained to assure the safety and efficacy of the medicines.
- Some wards and community teams had low staffing levels, or an absence of specialist staff, and this had an impact on care.Staffing levels remained low at the Bradgate mental health unit. To ensure that safer staffing levels were met they used regular bank or agency staff to achieve the required amount number of staff for the wards to meet the needs of the patients. However, they did not always meet the required skill mix for the nursing teams. Despite considerable effort with recruiting new members of staff for community inpatient areas, staffing was the top concern for all senior nurses and there was still a significant reliance on agency staff to fill shifts which could not be covered internally. The majority of community mental health teams did not meet the referral to initial assessment and assessment to treatment times. The child and adolescent mental health (CAMHS) community team's caseloads were above the nationally recommended amount, although young people had a care co-ordinator. The community adult team caseloads varied. People that were referred to the service were waiting for a care co-ordinator to be allocated. Due to the large caseloads in community health service, the number of visits that were required was not always manageable. The trust had identified the lack of psychological therapies for patients, and support

and training for staff, on their risk register. This had been identified during the last Care Quality Commission inspection in 2015. We remain concerned that a significant period had passed and the trust had not improved access to psychology for patients and staff. At our last inspection we raised concerns that an insufficient number of nursing staff in community health services for adults had received appropriate statutory and mandatory training. At this inspection we found compliance levels with this type of training were still below the trust's target.

- The trust was not meeting its target rate of 85% for clinical supervision. Sixty per cent of staff working in the mental health services had attended supervision and 64% of staff working in community health inpatient services.
- Record keeping was poor in some services. Within mental health services the quality of care plans was variable. Some care plans were not holistic, for example they did not include the full range of patients' problems and needs. Care plans did not always consider the patient views, and were generic did and not all were recovery focussed. Patients in four services across the trust reported that they had not been involved in the planning of their care and had not received copies of care plans. Within the end of life service there were inconsistencies in the quality of completion for do not attempt cardiopulmonary resuscitation (DNACPR) forms, in the quality of admission paperwork within medical records and in the use of the 'Last Days of Life' care plans. This had been raised as a concern in the March 2015 inspection and had not been sufficiently addressed.
- Staff demonstrated poor understanding of some aspects of the Mental Capacity Act. We found that there were still errors within the staff's application of the Mental Capacity Act. Staff did not ensure that mental capacity assessments and best interest decisions were consistently documented in care records. When staff deemed a patient lacked capacity there was no evidence that the best interest decision-making process was applied. There was little evidence that staff supported patients to understand the process, no involvement of family or independent mental capacity advocate in most mental capacity assessments. This meant that patients could have been deprived of their liberties without a relevant legal framework. Managers did not have oversight of these issues. Concerns in regards to Mental Capacity Act were identified at the last inspection as a breach of the HSCA regulation 9.
- Staff did not always maintain the privacy and dignity of patients. Staff in the community adult mental health teams did not protect patients' dignity or privacy. During the depot clinic staff did not close privacy curtains when patients were receiving depot injections. On Bosworth ward patient privacy was compromised when staff and patients entered the clinic room during examinations because there was no privacy curtain in place. On Ashby ward, the shower rooms did not have curtains fitted. This was a breach of the patients' privacy and dignity to patients as staff might be required to enter the shower rooms to check patients were safe. The trust confirmed that these were reinstalled after the inspection had taken place.
- The trust could not always provide a bed locally for patients who required admissions to its mental health wards. Bed occupancy rates were above 85% for community health inpatient wards. Beds were not always available for people living in the trust's catchment area. This meant patients had been placed outside of the trust's area. We saw that patient numbers exceeded the number of beds available on wards. Therefore there were no beds available if patients returned from leave. To address this deficit the trust moved patients that required an acute bed to a rehabilitation bed which was not clinically justified or met the needs of the patients. The trust was not commissioned to provide female psychiatric intensive care beds. Therefore, if a female needed a psychiatric intensive care unit they were sent out of area.
- The trust did not ensure that they meet set target times for referral to initial assessment, and assessment to treatment in the majority of teams. This impacted on patients requiring care. Adult community health patients did not always have timely access to routine appointments. We found a total 40 breaches of the six week referral and seven breaches of the five day urgent referral. At the time of

inspection, there were a total of 647 children and young people currently waiting to be seen in specialised treatment pathways. 87 of the total patients had been waiting over a year to begin treatment. The longest wait was 108 weeks for four patients to access group work or outpatients. In community based mental health teams for older people five of six services breached national targets from referral to assessment. The learning disability community team had not met the six week target for initial assessment on average it was six days over. The adult community therapy team did not meet agreed waiting time targets. Between August 2015 and July 2016 the trust had a total of 372 delayed discharges.

- The trust board had not reviewed full investigation reports for the most serious incidents, only the outcomes and lesson learnt. This meant board members were not able to monitor the trust's assertions that there were strong systems and processes in place for identifying and reporting serious incidents, including deaths, or monitoring whether reviews and investigations were completed fully.

However:

- We rated the caring domain for the community health families, young people and children service as outstanding due to staff approaches to family and patient care utilising or creating tools to assist children to understand their condition or prepare for treatment. Feedback from those who used the families, young people and children services was consistently positive.
- The trust had made some improvements in response to the previous CQC inspection undertaken in March 2015.This included removing some ligature anchor points in the acute mental health wards.
- Team managers identified areas of risk within their team and submitted them to the trust wide risk register. Serious incidents were thoroughly investigated and outcomes and lesson learnt were discussed in a variety of clinical governance meetings. Managers shared the outcomes and lessons learnt from incidents, complaints and service user feedback at regular staff meetings, where meetings took place. Emails and the trust intranet also provided staff with this information. Lessons learnt were shared across the organisation via emails and the intranet. Staff had been trained with regards to duty of candour and in line with the trust policy. The trust had a major incident policy to deal with any major incidents or breakdown in service provisions. Potential risks were taken into account when planning community health services.
- In CAMHS community teams waiting times from referral to initial assessment was less than 13 weeks. The service was meeting its target in this area. This had improved since the last inspection in March 2015.
- Overall, the trusts compliance rates for mandatory training was 87%.
- We reviewed 267 case records and found that, generally, staff completed detailed individualised risk assessments for patients on admission. Care records showed that physical health examinations were completed upon admission and there was ongoing monitoring of physical health across the trust. The majority of care plans were up to date. Care and treatment was mostly planned and delivered in line with current evidence.
- Staff actively participated in clinical audits. The services used recognised outcome measures and monitoring measures to help assess the level of support and treatment required. The trust had well-developed audits in place to monitor the quality of the service. The trust used key performance indicators/dashboards to gauge the performance of the team. These reports were presented in an accessible format.
- Nursing staff interacted with patients in a caring and respectful manner. They remained positive when engaging patients in meaningful activities. Staff responded to patients' needs discreetly and respectfully. Patients were positive about their care and treatment and said staff were caring and understanding and respectful. Patients told us that staff listened and empathised with them. Patients reported that they felt safe on the wards.
- The trust provided patients with accessible information on treatments, local services, patients'

Summary of findings

rights and how to complain across all services. Patients we spoke with knew how to complain. Staff supported patients to raise concerns when needed.

Staff received feedback on the outcomes on investigation of complaints via their managers. Managers ensure that they acted on these findings to reduce the risk of reoccurrence.

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?

Requires improvement

We rated Leicestershire Partnership NHS Trust as requires improvement for safe because:

- We found a number of environmental safety concerns. Whilst some work had taken place or had been planned, we were concerned that some issues had not been addressed at all. The health based place of safety and the acute wards were not visibly clean or well maintained. Environmental risks in the health based place of safety identified in our previous inspection had not been addressed. The trust had not met all the required actions to reduce and mitigate ligature points across services following the previous inspection in March 2015. We also found that the layout of some wards did not facilitate the necessary observations of patients due to poor lines of sight. The trust had not ensured that all mixed sex accommodation met guidance on the elimination of mixed sex accommodation in two acute wards; the short stay learning disability service and rehabilitation services.
- Some facilities lacked essential emergency equipment. In the health based place of safety resuscitation equipment and emergency medication were not available and staff had not calibrated equipment to monitor patient's physical health. The community therapy rehabilitation unit at Hinckley did not have a defibrillator in the unit for staff to use in an emergency despite staff having been trained how to use one.
- Practices did not meet the required standard for the safe and effective, management and storage of medication across the trust. There were no pharmacy services within the community mental health teams or crisis team which could increase the risk of incorrect safe and secure handling of medicines and unsafe practice in relation to the administration and prescribing of medicines. We found concerns around the storage of medicines in community hospitals, with missing opened or expiry dates across all hospitals. Patients' own controlled drugs were not always managed and destroyed appropriately. The trust had not consistently maintained medication at correct temperatures in all areas or ensured action was taken if it was found to be outside correct range. This did not demonstrate a consistent temperature, had been

maintained to assure the safety and efficacy of the medicines. The monitoring of patients vital signs post rapid tranquilisation, as recommended by NICE guidelines NG10, was not carried out as per the trust's own policy document.

- We were concerned that staff levels were not sufficient at the Bradgate Unit and in some community teams across the trust. Whilst the trust met that required safer staffing levels they achieved this by using regular bank or agency staff. However, they did not always meet the required skill mix for the nursing teams. . We found that staffing levels were not always sufficient in the community teams, particularly the CAMHS, and community adult teams. This meant that staff were managing very high caseloads and there were some delays in treatment. We remain concerned that a significant period had passed and the trust had not improved access to psychology for patients and staff. This had been identified during the last Care Quality Commission inspection report in 2015. At our last inspection we raised concerns that an insufficient number of nursing staff in community health services for adults had received appropriate statutory and mandatory training. At this inspection we found compliance levels with this type of training were still below the trust's target.
- In order to meet the Code of Practice guidelines for seclusion rooms the trust had closed some seclusion rooms within the acute wards and completed work on the ones that remained to bring them up to the required standard. However, we found that staff transferred patients requiring seclusion between ward to access suitable rooms. This could pose a risk to patients and staff.
- Whilst the trust had system in place to report incidents and carried out investigation to learn from them, the trust board did not review full investigation reports for serious incidents, only the outcomes and lesson learnt. This meant board members were not able to monitor the trust's assertions that there were strong systems and processes in place for identifying and reporting serious incidents, including deaths, or monitoring whether reviews and investigations were completed fully.

However:

- With the exception of those mentioned above, the majority of the mental health wards and buildings were clean and well maintained. The trust had carried some improvement works which included removing some ligature anchor points in the acute wards. Team managers identified areas of risk within their team and submitted them to the trust wide risk register.

Summary of findings

- Incidents were reported and investigated. Managers shared the outcomes and lessons learnt from incidents, complaints and service user feedback at regular staff meetings, where meetings took place. Emails and the trust intranet also provided staff with this information. Lessons learnt were shared across the organisation via emails and the intranet.
- The trust was meeting its obligation under the Duty of Candour regulations. Staff had been trained with regards to duty of candour and in line with the trust policy. The trust completed an audit in July 2016 to provide the board with assurance that the duty of candour process is being followed. The trust had a major incident policy to deal with any major incidents or breakdown in service provisions. Potential risks were taken into account when planning community health services.
- Trust wide mandatory training compliance rate was 87%. However, many of the core services were not achieving the required compliance rate for individual courses.
- The trust had an effective safeguarding process in place. Staff were able to describe what constituted a safeguarding issue. There were regular safeguarding reviews within each service.
- We reviewed 267 case records and found that staff completed detailed individualised risk assessments for patients on admission. For the majority of services staff updated these regularly and after incidents.

Are services effective?

Requires improvement

We rated Leicestershire Partnership NHS Trust as requires improvement for effective because:

- Managers failed to ensure that staff received regular supervision. On average 60% of staff in mental health service and 64% in community health services had received regular clinical supervision. This did not meet the trust target of 85%. Whilst the trust acknowledged there were issues with the systems used for recording supervision attendance and addressed this there had been no significant improvement noted in this area.
- Record keeping was poor in some services. Within mental health services, the quality of care plans was variable. Some care plans were not holistic, for example they did not include the full range of patients' problems and needs. Care plans did not always consider the patient views, and were generic did and not all were recovery focussed. Patients in four services across the trust reported that they had not been involved in the planning of their care and had not received copies of care plans. Within the end of life service there were inconsistencies

in the quality of completion for do not attempt cardiopulmonary resuscitation (DNACPR) forms, in the quality of admission paperwork within medical records and in the use of the 'Last Days of Life' care plans for adults. This had been raised as a concern in the March 2015 inspection and had not been sufficiently addressed.

- Procedures were not always followed in the application of the Mental Capacity Act. Staff did not ensure that mental capacity assessments and best interest decisions were consistently documented in care records. When staff deemed a patient lacked capacity there was no evidence that the best interest decision-making process was applied. There was little evidence that staff supported patients to understand the process, no involvement of family or independent mental capacity advocate in the most mental capacity assessments. This meant that patients could have been deprived of their liberty without a relevant legal framework. Within community health inpatients services staff did not always complete a Deprivation of Liberty Safeguards for patients who had sensor cushions. Despite being aware they should complete one as they were restricting the movement of these patients. Managers did not have oversight of these issues. Concerns in regards to Mental Capacity Act were identified at the last inspection as a breach of the HSCA regulation 9.

However:

- We reviewed 267 case records and found care records showed that, generally, physical health examinations were completed upon admission and there was ongoing monitoring of physical health across the trust. The majority of care plans were up to date. Care and treatment was mostly planned and delivered in line with current evidence.
- The trust had participated in a range of clinical audits in which staff actively participated. These were well-developed and supported the trust to monitor the quality of the service provided to patients. The trust used recognised outcome measures and monitoring measures to help assess the level of support and treatment that patients required. The trust used key performance indicators/dashboards to gauge the performance of the team. These reports were presented in an accessible format.
- The trust provided a formal induction period for new permanent staff. This involved attending a corporate induction, a period of shadowing existing staff before working alone. Newly registered staff completed a period of preceptorship.

Summary of findings

- The trust had arrangements in place for the receipt and scrutiny of detention paperwork. Each ward matron completed a monthly Mental Health Act census. This captured relevant information which fed into the Mental Health Act dashboard which was shared with the board. The trust ensured that consent to treatment and capacity requirements were adhered to in the majority of cases. Staff referred all detained patients to the IMHA service. Thereafter, patients could choose whether they wished to see an IMHA.

Are services caring?

Good

We rated Leicestershire Partnership NHS Trust as requires good for caring because:

- We rated the caring domain for the community health families, young people and children service as outstanding for caring due to staff approaches to family and patient care using or creating tools to assist children to understand their condition or prepare for treatment. Feedback from those who used the families, young people and children services was consistently positive.
- We saw that nursing staff interacted with patients in a caring and respectful manner. They remained positive when engaging patients in meaningful activities. Staff responded to patients' needs discreetly and respectfully.
- Patients were positive about their care and treatment and said staff were caring and understanding and respectful. Patients told us that that staff listened and empathised with them. Patients reported that the felt safe on the wards.
- Carers spoke positively about the services they received and that they had been offered carers assessments and signposted to extra support if required.

However:

- Staff in the community adult teams did not protect dignity or privacy. During the depot clinic staff did not close privacy curtains when patients were receiving depot injections. On Bosworth ward patient privacy was compromised when staff and patients entered the clinic room during examinations as there was no privacy curtain in place. On Ashby ward, the shower rooms did not have curtains fitted. This was a breach of the privacy and dignity to patients as staff might be required to enter the shower rooms to check patients were safe.
- Patients in seven core services across the trust reported that they had not been involved in the planning of their care and had not received copies of care plans.

Summary of findings

Are services responsive to people's needs?

Requires improvement 

We rated Leicestershire Partnership NHS Trust as requires improvement for responsive because:

- There remained a shortage of beds across the trust and this had impaired patient safety and treatment at times. We found that due to the lack of available beds patient numbers exceeded the number of available beds which meant that if a patient returned from leave they did not have a bed. To address this deficit the trust placed patients out of area or moved patients that required an acute bed to rehabilitation bed which was not clinically justified nor did this meet the needs of the patients.
- The trust was not commissioned to provide female psychiatric intensive care beds. Therefore, if a female needed a psychiatric intensive care bed they were sent out of area. This made visiting difficult for families and did not promote re-integration into the community for those patients.
- The trust did not ensure that they meet set target times for referral to initial assessment, and assessment to treatment in the majority of teams. This impacted on patients requiring care.Adult community health patients did not always have timely access to routine appointments. We found a total 40 breaches of the six week referral and seven breaches of the five day urgent referral. At the time of inspection, there were a total of 647 children and young people currently waiting to be seen in specialised treatment pathways. 87 of the total patients had been waiting over a year to begin treatment. The longest wait was 108 weeks for four patients to access group work or outpatients. In community based mental health teams for older people five of six services breached national targets from referral to assessment.The learning disability community team had not met the six week target for initial assessment on average it was six days over. The adult community therapy team did not meet agreed waiting time targets. Between August 2015 and July 2016 the trust had a total of 372 delayed discharges.

However:

- Services were mostly planned and delivered in a way that met the current and changing needs of the local population and included access to end of life services by people in vulnerable circumstances.
- The average bed occupancy was 85%. Amongst the trust learning disability wards this was 61% and for mental health wards 87%. Across twenty-nine of 54 wards at the trust were reported as having an average bed occupancy of below 85%, with 28 of these operating below 70%.

Summary of findings

- We recognised the improvement the trust had made with regards to the children's' and adolescents' services community teams waiting times from referral to initial assessment since the last inspection. The waiting time had fallen to less than 13 weeks and met the required target.
- The trust recorded 97% of patients on the care programme approach were followed up within seven days of their discharge from inpatient services in from April to June 2016. This was above the England average of 96%.
- We found a range of information that was accessible to patients on treatments, local services, patients' rights and how to complain across all services. These were available in other languages and in easy read format.

Are services well-led?

Requires improvement

We rated Leicestershire Partnership NHS Trust as requires improvement for well led because:

- Whilst there had been some progress since the last inspection in 2015, the trust was not yet safe, fully effective or responsive.
- We had a number of concerns about the safety of this trust. These included unsafe environments; poor arrangements for medication management and lack of essential emergency equipment; the reliance on bank and agency staff to reach the required numbers of staff on wards to meet the needs of the patients and waiting times for patients to access the treatment they required.
- The trust had reorganised its governance processes and embedded their key values which were under pinned by self-regulation.The information gathered from investigations, key performance indicators, audits were used to gauge the trust's performance. However, the board needed to ensure that had access to all the required information and their decisions were implemented in order to make positive improvements.
- We reviewed the risk registers for the trust and directorates and saw that the majority of risks we identified through this inspection had been included in the risk register. However, the trust had not shared across the wards and teams the actions that they were going to implement to reduce these risks. This highlighted that further work was required to ensure that all risk were fully captured and that board shared the plans to mitigate the identified risks across the trust.
- Following on from the last inspection the trust acknowledged that work was required to ensure that the application of the Mental Capacity Act was followed. Whilst the trust provided

clinical forums for staff to discuss Mental Capacity Act, Mental Capacity Act champions had been identified on wards and in team and Mental Capacity Act principles had been embedded into all training courses we found that there were still errors within the staffs' application of the Mental Capacity Act across the trust.

- Managers failed to ensure that staff received regular supervision. On average 60% of staff in mental health service and 64% in community health services had received regular clinical supervision. This did not meet the trust target of 85%. Whilst the trust acknowledged there were issues with the systems used for recording supervision attendance and addressed this there had been no significant improvement noted in this area.
- Whilst compliance rates for mandatory training across the trust was 87%. We found that managers had not addressed individual training topics that fell below 75% for individual training subjects within core services.
- The board had not discussed the most serious incidents at board meetings. Whilst they reviewed the outcomes and lessons learnt we could not be sure they had a firm grip on the quality and safety issues that challenge the trust without debate at board level.
- We did not have assurance that service leads for end of life care had good oversight of the risks relating to this service as staff were not always recording incidents, the service was unable to identify incidents specific to patients at the end of life and concerns relating to the out of hours GP service were not formally recorded
- Staff morale on Griffin ward was extremely low due to the announcement of the ward's closure upon the completion of works on Phoenix ward in early December 2016.

However:

- The trust's vision was to improve the health and wellbeing of the people of Leicester, Leicestershire and Rutland by providing high quality, integrated physical and mental healthcare pathways. The majority of the staff were aware of these and applied them in their roles.
- Managers shared the outcomes and lessons learnt from incidents, complaints and service user feedback at regular staff meetings, where meetings took place. Emails and the trust intranet also provided staff with this information.
- The trust actively promoted staff utilising least restrictive practice and reducing the need to seclude patients. Staff had been trained to utilise de-escalation processes effectively.

Summary of findings

Seclusion recorded was completed accurately and in line with the Mental Health Act Code of Practice and the trusts policy including medical reviews which was a concern from the last inspection.

- The trust board encouraged candour, openness and honesty from staff. Staff knew how to use whistle-blowing process and the majority of staff felt able to raise concerns without fear of victimisation. Staff we spoke with were aware of their responsibilities to be open and honest with patients and families when things went wrong.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Peter Jarrett

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

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

Inspection Manager: Helen Vine, Inspection Manager, community health services, CQC

The team included five inspection managers, 19 inspectors, two Mental Health Act reviewers, two pharmacy inspectors, support staff and a variety of specialists. The specialists included consultant psychiatrists, specialist nurses in mental health, learning disabilities, children's nursing, oncology nurses, a physiotherapist, a speech and language therapist, psychologists, occupational therapists, social workers and a dietician and eight experts by experience who have either used a service or have been a carer of someone using a service.

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

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health and community 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 spoke with commissioners, local healthwatch, Leicestershire police and local service user groups. We reviewed information received form service users and carers and members of the public who had contacted the CQC about the trust.

Prior to and during the visit the team:

- Held focus groups with 16 different staff groups.
- Spoke with 236 patients and 88 carers and family members.
- Collected feedback using comment cards.
- Attended 19 multidisciplinary meetings, nine handover meetings and four community meetings.
- Observed community treatment appointments, home visits and six clinics.
- Reviewed the personal care or treatment records of 267 patients and service users, which included over 114 medication cards.
- Looked at patients' legal documentation including the records of people subject to a community treatment order.
- Observed how staff were caring for people.
- Interviewed more than 499 staff members.

Summary of findings

- Looked at six staff records.
- Interviewed senior and middle managers.
- Reviewed information we asked the trust to provide.

We visited a sample of the trust's hospital locations and community health services.

We inspected most wards across the trust including adult acute services, the psychiatric intensive care unit, rehabilitation wards, learning disabilities, forensic and older people's wards. We looked at the trust's place of safety under section 136 of the Mental Health Act. We inspected learning disability, children and adolescent mental health services, adult mental health and older people's community services and the trust's crisis services. We visited a sample of adult community mental health services.

For the community health services of the trust we visited a sample of services provided in the community adult in patient service, community adult service, end of life care, children and young people and families.

We carried out an unannounced visit on 24 November 2016 to the Bradgate Mental Health Unit.

Information about the provider

Leicestershire Partnership NHS Trust has a total of 19 registered locations serving mental health and learning disability needs, including 9 hospitals sites: the Bradgate Mental Health Unit, Coalville Community Hospital, Hinckley and Bosworth Community Hospital, Loughborough Hospital, Melton Mowbray Hospital, Rutland Memorial Hospital, St Luke's Hospital, Feilding Palmer Community Hospital and The Evington Centre. Two of these locations provide mental health services and six provides community health services.

The trust delivers the following mental health services:

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

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

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

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

The trust serve a population of one million people across Leicester, Leicestershire and Rutland, have a budget in excess of £250 million and employ over 5,500 staff in a wide variety of roles. The trust has 19 active locations registered with CQC.

Leicestershire Partnership NHS Trust has been inspected once under the new methodology of inspection the date of the published report was 10 July 2015. That inspection took place between 9 and 13 March 2015, 15 core services were inspected. We issued 33 requirement notices against

Summary of findings

eight core services, acute wards for adults of working age and psychiatric intensive care, child and adolescent mental health wards, community health inpatient service, forensic inpatient/secure wards, long stay/ rehabilitation mental health wards for working age adults, mental health crisis services and health based paces of safety, specialist community mental health services for children and young people, wards for people with learning disabilities or autism and end of life care. We issued seven requirement notices against the provider level to breaches of the following regulations:

- Regulation nine -person-centered care.
- Regulation 11 - needs for consent.
- Regulation 12 - safe care and treatment.
- Regulation 13 - safeguarding service users from abuse and improper treatment.
- Regulation 15 - premises and equipment.
- Regulation 17 – good governance.
- Regulation 18 – staffing.

There have been 22 Mental Health Act monitoring visits since 22 October 2015 until 4 November 2016, all unannounced. In total, over the 22 visits, there were 126 issues found at locations across the trust.

What people who use the provider's services say

We spoke with 236 patients and 88 carers.

- Patients were positive about their care and treatment and said staff were caring, understanding and respectful. Patients told us that that staff listened and empathised with them. Patients reported that the felt safe on the wards.
- The majority of patients told us that they knew how to complain and that staff were supportive when this happened. There was information across the trust available for patients who wanted to raise concerns which included advocacy and the patient advocacy and liaison service to get information and give feedback about the trusts services.
- Carers spoke positively about the service they received and that they had been offered carers assessments and signposted to extra support if required.
- Families told us that waiting times to gain access to treatment in the child and adolescent mental health community services were long, but once treatment started, it was very good.
- Some patients we spoke with were positive about their involvement with staffing planning their care and treatment. They had copies of their care plans. Carers told us that they had been included in care planning. However, other patients reported that they had not been involved in the planning of their care and had not received copies of care plans.
- The feedback about food was variable. Some patients reported that food was of good quality and there were lots of options available. Others reported that the food was not offered at an acceptable standard and the portions were small.

Good practice

In mental health:

- The triage car and had improved access to assessments for people who came to the attention of the police and may have mental health needs. A police officer and nurse in an unmarked car attended such incidents. Staff undertook assessments in an interview environment that provided dignity and confidentiality within the vehicle. The triage car was called to all incidents where a police officer believed it may be appropriate to detain a person under Section 136 of the Mental Health Act.
- Within the learning disability service we saw that staff had developed care plans for patients that explained their treatment in pictures as well as words
- At City West in conjunction with the young onset dementia service staff developed a digital app for

Summary of findings

younger people who have developed dementia. The app could be downloaded free of charge onto a mobile phone, or tablet computer. The app brought together up to date information, advice and inspiration from others who have the condition. The app was highly commended in the Innovation Support Service Development category of the Care Coordination Association 2016 awards.

- The primary mental health team had a professional's consultation line and responded to questions from children and adolescents who accessed a health app called education, health and care app. The use of social media had been developed to help engage young people in asking questions and to seek help and advice about mental health issues.

In community health services for adults

- There was a six week pilot of joint working between the trust's intensive community support team and the local authority's home care assessment enablement team (HART). A HART team had been co located with an intensive community support team at Loughborough Hospital team base. This had enabled the HART team, who helped to coordinate social care services to be more involved in the discharge planning of patient care.

In community health inpatient services

- Coalville hospital had introduced activity co-ordinators to the inpatient wards (known as the pink ladies). This improved the patient's experience and increased the activities that were conducted on a day to day basis.
- Rutland Ward had gone the extra mile to locate a husband and wife together on the ward whilst both required the inpatient services. Staff on this ward also facilitated a group of patients to have a socialised lunch with prescribed alcoholic beverages.
- The electronic prescribing system which was introduced in all community health hospitals supported the safe administration of medicines as there were additional features which alerted users to actions required.

In the community children and young peoples' service:

- The web based health, text service and web Chat service for young people was proven a successful way to communicate with youngsters and provide appropriate information. The planned health visitor inclusion for mothers and families provided further support for all.
- The flexibility and empathy demonstrated by the looked after children teams was unyielding during challenging times.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that where appropriate, patients are involved in care planning and that this is recorded.
- The trust must review the provision of staffing in the multidisciplinary teams, specifically in relation to psychological input.
- The trust must ensure the privacy and dignity of patients is protected.
- The trust must ensure that staff adhere to the trust's policy and must act in accordance with the requirements of the Mental Capacity Act and associated code of practice when assessing patient's capacity.
- The trust must address the identified safety concerns in the health-based place of safety and in relation to ligature risks, blind spots and mixed sex accommodation.
- The trust must ensure the safe management of medication.
- The trust must ensure the monitoring of vital signs of patients are completed as detailed in the NICE guidelines [NG10] on-Violence and aggression: short-term management in mental health, health and community settings.
- The trust must ensure they have systems and processes that enable them to identify and assess risks

to the health, safety and/or welfare of people who are waiting to receive treatment and have accurate records of all decisions taken in relation to care and treatment of patients.

- The trust must ensure that they have sufficient numbers of suitably qualified, competent, skilled, experienced and supervised staff to make sure that they can meet people's care and treatment needs of patients.

Action the provider SHOULD take to improve

- The trust should ensure that care plans are holistic and personalised.
- The trust should ensure that emergency resuscitation equipment is made immediately available for when needed.
- The trust should ensure that people receive the right care by placing them in suitable placements that meet their needs.
- The trust should ensure that patient areas are clean and well maintained and that there is sufficient furniture available.

Leicestershire Partnership NHS Trust

Detailed findings

Mental Health Act responsibilities

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

- Mental Health Act training was a mandatory training course at the trust and compliance was based on a three year cycle for qualified nurses and a two year cycle for senior doctors. Overall from 808 eligible staff 80 % were up to date.
- The trust ensured that consent to treatment and capacity requirements were adhered to in the majority of cases. However, there were four instances across the trust where patients

  received medication without legal authorisation in place. Additionally, one patient had treatment delayed, under section 58, as the second opinion appointed doctor could not consult with a statutory consultee. However, the consultant prescribed medication under Section 62 of the Mental Health Act so that the patient received treatment.
- The trust had recently implemented a new electronic system for the recording of patients' rights under section 132. There were separate forms for staff to record the explaining of patients' rights on detention, on regrade of a section and for monthly reminders. In the

  majority of cases, staff provided patients with information about their legal status and rights under Section 132 as soon as possible after their detention. The information staff gave to patients was as recommended in the Code of Practice and the patient's understanding was recorded on the electronic system. Staff provided patients with regular reminders about their rights.
- We met with the trust's senior staff, responsible for administration of the Mental Health Act. The trust had arrangements in place for the receipt and scrutiny of detention paperwork. Each ward matron completed a monthly Mental Health Act census. A comprehensive audit programme was in place, including the audit of Section 17, Section 132 and Section 58 (treatment requiring consent or a second opinion).
- We reviewed the detention paperwork for 60 patients, covering 64 periods of detention under the Mental Health Act. We also reviewed seven patients' records relating to their community treatment orders (CTO). A CTO allows a patient to receive treatment, with certain conditions, in the community rather than in hospital. Copies of detention paperwork, including reports by approved mental health professionals (AMHP), were available for inspection and were satisfactory. The one exception to this was Sycamore ward, where one Section 19 – authority for transfer from one hospital to another under different managers' form was not immediately available for inspection.
- The trust produced a Mental Health Act dashboard which included information about the use of the Act across the trust, and provided a month-by-month comparison. This information supported the Mental Health Act assurance committee and the board of directors to be aware of, and address, inconsistencies in practice across the wards. These included the recording of Section 17 leave (leave of absence from hospital) and

reading of Section 132 (the duty of managers of hospital to give information to detained patients) rights, and the recording of a patient's capacity at the start of their treatment. Clinical and managerial staff discussed Mental Health Act issues in a quarterly quality improvement collaborative meeting.

- Staff referred all detained patients to the independent mental health advocacy (IMHA) service. Thereafter, patients could choose whether they wished to see an IMHA. The IMHA service confirmed this arrangement. They also provided feedback that, overall, the IMHA service was welcomed and supported across the trust, and had encountered very few obstacles in providing the service. The Mental Health Act assurance committee representatives spoke of the good working relationships with the (IMHA) service, the robust scrutiny processes in place, and high levels of staff attendance at Mental Health Act training.
- Staff on the adolescent unit and in community teams had a good understanding of the Gillick competence and Fraser guidance and routinely sought consent to share information and consent to treatment from the young people in these services.
- In the last thirteen months leading up to the inspection the Care Quality Commission carried out 22 Mental Health Act reviewer visits. In total, there were 125 issues identified. The trust had an action plan to address this. However, the trust reported there was still work to be completed and they continued to work with staff to ensure that the changes in practice and knowledge base of staff was improved and embedded in to practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

CQC have made a public commitment to reviewing provider adherence to MCA and DoLS.

- Mental Capacity Act training was a mandatory training course at the trust and compliance was based on a three year cycle. Overall from 2,903 eligible staff, 83.7% were up to date. Ahead of the previous inspection in March 2015, the trust reported a compliance rate for Mental Capacity Act of 90%, which was 6.3% higher than the current reporting period.
- Over the six month period the trust made 142 Deprivation of Liberty Safeguarding Applications (DoLS) applications. The trust has not informed the CQC of how many of these applications were approved.
- The trust had implemented Mental Capacity Act clinical forums to discuss any issues or areas of concerns. This led to a flow chart for staff being developed to aid staff understanding in relation to Mental Capacity Act and the difference between Mental Capacity Act and Mental Health Act. All services had Mental Capacity Act champions to support them on the wards and community teams. However, we found the application of the Mental Capacity Act and the understanding of the staff remained poor.
- Mental capacity assessments and best interest assessments were not consistently documented in care records. The electronic part of the care plan for mental capacity assessments or best interest decisions was often left blank. There was no evidence that patients were supported to make decisions for themselves when the assessment was carried out. Where a patient was deemed to lack capacity there was no evidence that the best interest decision-making process was applied. We found evidence that patients were deprived of their liberties without the without the relevant legal framework.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated Leicestershire Partnership NHS Trust as requires improvement for safe because:

- We found a number of environmental safety concerns. Whilst some work had taken place or had been planned, we were concerned that some issues had not been addressed at all.The health based place of safety and the acute wards were not visibly clean or well maintained. Environmental risks in the health based place of safety identified in our previous inspection had not been addressed. The trust had not met all the required actions to reduce and mitigate ligature points across services following the previous inspection in March 2015. We also found that the layout of some wards did not facilitate the necessary observations of patients due to poor lines of sight. The trust had not ensured that all mixed sex accommodation met guidance on the elimination of mixed sex accommodation in two acute wards; the short stay learning disability service and rehabilitation services.
- Some facilities lacked essential emergency equipment. In the health based place of safety resuscitation equipment and emergency medication were not available and staff had not calibrated equipment to monitor patient's physical health. The community therapy rehabilitation unit at Hinckley did not have a defibrillator in the unit for staff to use in an emergency despite staff having been trained how to use one.
- Practices did not meet the required standard for the safe and effective, management and storage of medication across the trust. There were no pharmacy services within the community mental health teams or crisis team which could increase the risk of incorrect safe and secure handling of medicines and unsafe practice in relation to the administration and prescribing of medicines. We found concerns around the storage of medicines in community hospitals, with missing opened or expiry dates across all hospitals. Patients' own controlled drugs were not always managed and destroyed appropriately. The trust had not consistently maintained medication at correct temperatures in all areas or ensured action was taken if it was found to be outside correct range. This did not demonstrate a consistent temperature, had been maintained to assure the safety and efficacy of the medicines. The monitoring of patients vital signs post rapid tranquilisation, as recommended by NICE guidelines NG10, was not carried out as per the trust's own policy document.
- We were concerned that staff levels were not sufficient at the Bradgate Unit and in some community teams across the trust. Whilst the trust met that required safer staffing levels they achieved this by using regular bank or agency staff. However, they did not always meet the required skill mix for the nursing teams. . We found that staffing levels were not always sufficient in the community teams, particularly the CAMHS, and community adult teams. This meant that staff were managing very high caseloads and there were some delays in treatment. We remain concerned that a significant period had passed and the trust had not improved access to psychology for patients and staff. This had been identified during the last Care Quality Commission inspection report in 2015. At our last inspection we raised concerns that an insufficient number of nursing staff in community health services for adults had received appropriate statutory and mandatory training. At this inspection we found compliance levels with this type of training were still below the trust's target.
- In order to meet the Code of Practice guidelines for seclusion rooms the trust had closed some seclusion rooms within the acute wards and completed work on the ones that remained to bring them up to the

Requires improvement

Are services safe?

required standard. However, we found that staff transferred patients requiring seclusion between ward to access suitable rooms. This could pose a risk to patients and staff.

- Whilst the trust had system in place to report incidents and carried out investigation to learn from them, the trust board did not review full investigation reports for serious incidents, only the outcomes and lesson learnt. This meant board members were not able to monitor the trust's assertions that there were strong systems and processes in place for identifying and reporting serious incidents, including deaths, or monitoring whether reviews and investigations were completed fully.

However:

- With the exception of those mentioned above, the majority of the mental health wards and buildings were clean and well maintained. The trust had carried some improvement works which included removing some ligature anchor points in the acute wards. Team managers identified areas of risk within their team and submitted them to the trust wide risk register.
- Incidents were reported and investigated. Managers shared the outcomes and lessons learnt from incidents, complaints and service user feedback at regular staff meetings, where meetings took place. Emails and the trust intranet also provided staff with this information. Lessons learnt were shared across the organisation via emails and the intranet.
- The trust was meeting its obligation under the Duty of Candour regulations. Staff had been trained with regards to duty of candour and in line with the trust policy. The trust completed an audit in July 2016 to provide the board with assurance that the duty of candour process is being followed. The trust had a major incident policy to deal with any major incidents or breakdown in service provisions. Potential risks were taken into account when planning community health services.
- Trust wide mandatory training compliance rate was 87%. However, many of the core services were not achieving the required compliance rate for individual courses.
- The trust had an effective safeguarding process in place. Staff were able to describe what constituted a safeguarding issue. There were regular safeguarding reviews within each service.
- We reviewed 267 case records and found that staff completed detailed individualised risk assessments for patients on admission. For the majority of services staff updated these regularly and after incidents.

Our findings

Safe and clean environment

- The majority of the mental health wards and community buildings were clean and well maintained. However, the health based place of safety and the acute wards were not visibly clean. For example, two bedrooms on Ashby wards had dirty floor and bed areas, with old food left on bedside cabinets and the garden on Beaumont ward was littered.
- Community health inpatient wards were visibly clean and clinic environments were suitable for the purpose for which they were used.
- We found that the some environmental risks in the health based place of safety identified in our previous inspection remained. Access to the two small rooms was through one door only which meant that it could be difficult to exit the room quickly if needed. The doors were not anti-barricade. There was no clock visible to the person in the suite. We noted that the furniture had been replaced with weighted furniture so it was more difficult to use as barricades or weapons. However, patients were unable to lie down because there was no bed.
- The trust had not met all the required actions to reduce and mitigate ligature points across services following the previous inspection in March 2015. The trust had carried out some improvement works which included removing some ligature anchor points in the acute

wards. Some ligature points remained. However, the trust had plans in place to mitigate or remove these. Managers within each core service had completed ligature audits to identify ligature points throughout the wards. These audits were reviewed and updated annually or after an incident of patients ligating had taken place. They also recorded actions and timescales for work to be completed to mitigate the risk. Within the acute wards we were also provided with additional risks assessments undertaken by staff. These were displayed prominently in the ward offices so that all staff were aware of potential ligature points throughout the service.

- The trust had not fully addressed the issues of poor lines of sight in services. Due to this staff could not observe all parts of wards due to their lay out and the risk had not been mitigated. This was evident in the seclusion room on Maple ward, the health place of safety, and the acute wards.
- When we inspected in 2015, we raised concerns about arrangements to eliminate mixed gender accommodation on a large number of wards'. These wards did not meet guidance set by the Department of Health or within the Mental Health Act code of practice. Whilst the trust was not fully complaint with the elimination of same sex accommodation guidance, it was evident that the trust had completed some work to address this. They had converted Ashby, Aston, Bosworth and Thornton wards at the Bradgate Mental Health unit to provide same sex accommodation, although two wards remained non complaint. The short stay, learning disabilities services were not compliant as there were no separate female bedroom areas and no gender specific toilets or bathrooms. In the rehabilitation services there was no door to lock separating female and male areas of the ward and men had to pass females bathroom and bedrooms to access the laundry.
- Following on from the previous inspection and in order to meet the Code of Practice guidelines for seclusion rooms the trust had closed some seclusion rooms within the acute wards and completed work on the ones that remained to bring them up to the required standard. However, we found that staff transferred patients requiring seclusion between ward to access suitable rooms. This could pose a risk to patients and staff.
- The trust had ensured that the majority of clinic rooms were equipped with accessible resuscitation equipment and emergency drugs. Staff checked this regularly to ensure that medication was fully stocked, in date and equipment was working effectively. However, the health based place of safety did not have access to a dedicated clinic room. Resuscitation equipment and emergency medication were not available in the health based place of safety. Staff had not calibrated equipment to ensure accuracy.
- The community therapy rehabilitation unit at Hinckley did not have a defibrillator in the unit for staff to use in an emergency, despite staff having been trained how to use one. The environment at the community therapy rehabilitation unit at Hinckley posed a potential infection control hazard as peeling paint had exposed bricks which made it difficult to keep clean.
- Staff in mental health and community health services complied with infection prevention and control procedures. Hand washing signs were present in all ward areas. Wards and community teams ensured that waste was managed appropriately. The trust ensured that staff had access to protective personal equipment, such as gloves and aprons, in accordance with infection control practice.
- There was sufficient provision of specialist equipment for community health services including an appropriate supply of syringe drivers for the administration of continuous pain relief for patients at the end of their lives. Staff cleaned and stored reusable equipment appropriately after use. However, some emergency lifesaving equipment was out of date on community inpatient wards.
- PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which care was provided, as well as supporting non-clinical services. In relation to cleanliness, the trust scored lower than the national average of 98.1% with 94.7% in 2016.
- Staff in the mental health services carried personal alarms to summon help in an emergency. Across the trust there were call systems in patients' bedrooms for

patients to call for help if needed. However, on Ashby ward a number of nurse call buttons were broken. We discussed this with staff during the inspection and they were unclear whether the system was in working order.

Safe staffing

- Data received from the trust in August 2016 showed:
- Total number of substantive staff was 5467
- Total number of substantive staff leavers in the last 12 month was 654
- Total turnover of all substantive leavers in the last 12 months9.1%
- Total vacancies overall (excluding seconded staff) was 11.9%
- Total permanent staff sickness overallwas 5.1%
- Establishment levels qualified nurses (WTE) in post was 1559
- Qualified nurse vacancy rate was 12.9%
- Establishment levels nursing assistants (WTE)in post was 1031
- Nursing assistant vacancy rate was 20.4%
- Number of WTE vacancies qualified nurses was 189
- Number of WTE vacancies nursing assistants was 209
- Shifts filled by bank or agency staff to cover sickness, absence or vacancies, in the last three months was 14,183
- Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies in the last three months totalled 1450.
- The percentage of trust wide vacancies for qualified nurses had risen each month from around 10% to almost 13%. The teams with the highest vacancy rate for qualified nurse was crisis and health based place of safety, older people's wards and forensic wards which was 29% to 31%. The highest vacancy rate was 15.5% for community health service inpatients.
- The board acknowledged that recruitment and retention of staff had been a key issue andthe impact that staffing levels had across all services. This had been placed on the risk register. The trust had set safer staffing levels in 2013. Since April 2014, the trust had published both the planned and actual staffing levels on their website. Every six months, the trust board received an 'inpatient staffing establishment review' report which provided an overview of the work being taken to ensure safer staffing standards were met across all inpatient wards. A safer staffing dashboard is produced each month to provide an overview of staffing during the period in review. In addition to this managers provided further information to identify particular 'hot spots', the risks they posed and the mitigating actions and longer term plans which were put into place to ensure the wards remain safe.
- To ensure that safer staffing levels were met the trust used regular bank or agency staff to achieve the required amount of staff for the wards to meet the needs of the patients. However, they did not always meet the required skill mix for the nursing teams. The Bradgate Unit had high use of bank staff to due to the highs levels of increased nursing observations required.
- Despite the community inpatient team's effort with recruiting new members of staff, staffing was the top concern for all senior nurses and there was still a significant reliance on agency staff to fill shifts which could not be covered internally. Senior nurses mitigated risk where they could which included switching an agency staff member with a trust member of staff if two agency staff worked together, however, we saw evidence this was not always achieved.
- August 2016 showed that 1,450 shifts were not filled by bank or agency staff and 15,534 shifts were filled by bank or agency staff; in the last three months. Mental health acute wards and the psychiatric intensive care unit had the highest number of shifts filled by bank with2,199 bank shifts and 484 agency shifts and the highest number of shifts not filled by bank was 427. In the community health services the inpatient wards had the highest number of shifts filled by banks with 1,042 and 1,268 by agency shifts, 88 shifts had not been filled.
- Sickness rates for the trust between August 2015 and August 2016 were 4.8 to 5.7%. Mental health long stay / rehabilitation wards had the highest staff sickness rate of 16.4% over the 12-month period.
- From August 2015 to August 2016 community mental health adult services had the highest staff leavers in at

19.2%, which was 79 staff. The community health services' highest leavers was end of life at 18.2%, 16 staff. The team with the lowest staff leavers was mental health forensic wards with no staff leaving.

- The trust had an integrated risk register and board assurance framework dated 7 July 2016. We found that the trust had identified the staffing recruitment as a risk because without recruiting adequate staff they would not be able to run services safely and efficiently. In order to reduce the risk the trust had a recruitment strategy in place to actively recruit staff.
- We observed that staff maintained a constant presence in the communal areas of the wards. There was enough staff to allow patients to have regular one to one time with staff, although this did not happen as regular as patients said they would like as staff were busy. Escorted leave or ward activities were rarely cancelled due to staffing levels although at times they were delayed.

Assessing and managing risk to patients and staff

- Prior to the inspection we asked the trust for details of restraint, seclusion and rapid tranquilisation figures.Restraint was used on 584 occasions and there were 280 incidents of seclusion between 1 February and 31 July 2016. There were ten incidents of prone restraint which accounted for 1.7% of the restraint incidents, of which none resulted in rapid tranquilisation. The trust figures show no use of long term segregation for any of the wards. Acute and psychiatric intensive care wards show the highest number incidents of restraint and seclusion use.
- The trust trained staff who participated in seclusion in seclusion competencies. This increased staff knowledge and clinical practice in relation to seclusion in order to follow best practice and to support patients. The trust provided data which showed an active programme of reducing the need for seclusion of patients, by promoting least restrictive practice and training staff to utilise de-escalation processes effectively. The trust had a "Seclusion and Restrictive Practices Policy" dated December 2015. From the records of seclusion we reviewed, we saw a high level of recording. The use of seclusion was in line with the Code of Practice and the trust's policy. Each seclusion form was quality checked by the ward matron or team leader and service manager following the episode of seclusion. When staff had to use restrictive practices such as physical restraint, rapid tranquilisation and seclusion they did so in line with best practice and guidance.
- From 1 October 2015 to 30 September 2016, the trust made 81 notifications to the CQC. 71 (88%) were Deprivation of Liberty Safeguards notifications. Six notifications regarded the admission of a child (under 18) to an adult ward. All were aged 16-17, three moved in one day, one was a duplicate, one unknown and one moved from the adult to a child's ward in nine days.
- The short breaks service at Rubicon Close had the highest number of notifications with 29 (36% of total notifications) followed by short breaks at Farm Drive with 27 (33%).
- The trust submitted 17 safeguarding notifications to the CQC between 1 October 2015 to 30 September 2016. The Bradgate mental health unit had the highest number with 5 (29%). All have now been closed.
- The trust submitted three serious case reviews for which they had developed action plans in the 12 months preceding the inspection. All related to community health services for children and young people safeguarding. Common themes emerged from these case reviews. The trust acknowledged the impact of the increased safeguarding issues had on clinical and safeguarding teams and that there was a risk they will not learn lesson identified. To monitor this the trust added this to their integrated risk register and board assurance framework.
- The trust had an effective safeguarding process in place. Additional safeguarding guidance was available to staff via the trust intranet. Staff we spoke with were able to describe situations that would constitute abuse and could demonstrate how to report concerns. We saw examples of safeguarding documents which were completed accurately. A governance process was in place that looked at safeguarding issues at both a trust and directorate level on a regular basis.
- Compliance with safeguarding training in community health services was high and staff understood their responsibilities to keep vulnerable adults, children and

young people safe. Not all nurses had completed training on adult safeguarding, although in many cases, managers had planned their training before the end of the financial year.

- We looked at the quality of individual risk assessments across all the services we inspected. We reviewed 267 case records and found that staff completed detailed individualised risk assessments for patients on admission. For the majority of services staff updated these regularly and after incidents. However, we found that risk assessments were not always updated for patients following incidents of concern or changes to an individual's needs within the forensic service and the crisis team.
- The trust had made some changes to the pharmacy provision in order to make improvements across the services. We saw that the trust pharmacy department carried out a 24 hour service to all teams across the trust. The trust had achieved full rollout of an electronic prescribing and medicines administration system within inpatient areas. We found that all 192 electronic prescriptions reviewed included information about allergies, admission date, and date of birth. Appropriate codes were used to note medicines refusals and medicines for physical health were, prescribed and monitored appropriately. We saw that venous thromboembolism risk assessments were recorded for all patients electronically.
- Pharmacy staff had access to patient summary care records that meant that pharmacists were able to provide quality advice about medicines. We saw evidence that medicines reconciliation occurred for each patient admitted to a ward. However, the restriction of access to the summary care records of pharmacy only, potentially increased the risk to patients regarding the accuracy of medicine reconciliation available out of hours.
- Pharmacy technicians visited inpatient services to provide stock, assess patients' own medication or remove unwanted medication. Ward staff were very positive about clinical pharmacist's visits to the ward for clinical meetings when they did occur. However, they stated that this did not happen as often as they would like. Several staff members commented that the visits were cancelled at the last minute due to other more pressing tasks. There was no pharmacy service within the community mental health teams or crisis team. This could have resulted in an increased risk of incorrect safe and secure handling of medicines and unsafe practice in relation to the administration and prescribing of medicines.
- Medicines in community services for adults were appropriately stored, prescribed and administered with some staff qualified as non-medical prescribers. Staff in community health services for families, children and young people and those in end of life care services were also qualified as non-medical prescribers. Patient group directives were in place to supply and administer specified medicines to a pre-defined of patients without them having to see a doctor.
- Anticipatory medicines were appropriately available for patients at the end of their lives both in inpatient and community settings.
- However, we found that some practices did not meet the required standard for the safe and effective management and storage of medication across the trust. We had concerns around the storage of medicines in community hospitals, with missing opened or expiry dates across all hospitals. Patients' own controlled drugs were not always managed and destroyed appropriately. We identified that in community mental health teams and community inpatient hospitals, fridge temperatures were not recorded correctly; either single daily temperature readings were recorded rather than maximum and minimum levels or temperatures were not recorded on a daily basis. This did not demonstrate a consistent temperature had been maintained to assure the safety and efficacy of the medicines. There was no available trust audit data on the community mental health teams' medicine storage at the time of the inspection.
- An up to date policy covering rapid tranquilisation, based on the current NICE guidance NG10 dated May 2015, was available. It advised on how to treat patients in order to manage episodes of agitation, when other calming or distraction techniques had failed to work. We found the prescribing at the trust to be in line with the policy and NICE guidelines.In addition, we found that the monitoring of patients vital signs post rapid tranquilisation, as recommended by NICE guidelines **NG10, was not always documented in the patient records.**

Requires improvement

Are services safe?

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 no 'never events' between 01 October 2015 and 30 September 2016 through STEIS (Strategic Executive Information System). 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). Since 2010, it has been mandatory for trusts to report all death or severe harm incidents to the CQC via the NRLS. Between 1 October 2015 and 30 September 2016 the trust reported 9,321 incidents to NRLS. The trust reported 4794 (87%) of incidents as low or no harm. 37 (0.4%) incidents as moderate harm, 4 (0.04%) incidents as severe harm, 38 (0.4%) incidents were deaths and 1122 (12%) incidents were reported as abuse. The most common incident type was "patient accident" with 2050 (22% of total incidents). Consent, communication and confidentiality had a total of 675 (7.2%) reported in the year.
- When benchmarked, the trust was in the top 25% of reporters. The NRLS considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture.
- Providers are encouraged to report all patient safety incidents of any severity to the NRLS at least once a month. The most recent patient safety incident report covering incidents from 1 October 2015 and 31 March 2016 stated, that for all mental health organisations, 50% of all incidents were submitted to the NRLS more than 17 days after the incident occurred. The data provided showed the trust was outside of this timeframe as they submitted, 50% of incidents more than 26 days after the incident occurred.
- Mental health services had the highest number of incidents with 4623 (50%). 35 (92% of total deaths) deaths occurred in mental health services. In total the community health services had a total of 2612 (28%) incidents.
- Trusts are required to report serious incidents to STEIS. These include never events (serious patient safety incidents that are wholly preventable). The trust reported 78 serious incidents between 1 October 2015 and 30 September 2016. None of these were never events, 46% were 'apparent, actual or suspected self-inflicted harm' incidents, 13% were incidents relating to 'abuse or alleged abuse of child patient' and 9% were 'slips, trips or falls'. 30 were 'unexpected / potentially avoidable deaths'. Twelve (40%) of which related to community health services for adults.
- The core service with the highest number of STEIS incidents was community health services for adults with 17 (22%). The community health services for adults reported 17 incidents, community services for children and young people reported 11, acute mental health wards for adults and psychiatric intensive care reported 10 and mental health crisis services and health based places of safety reported 10.
- The incident type with the highest number logged was, 'Apparent/Actual/suspected self-inflicted harm' at 36 incidents (46%). Abuse/alleged abuse of child patient by third party was the second highest with 10 incidents (13%) reported.
- Between 1 July 2015 and 30 June 2016, trust staff reported 69 serious incidents. Of these 15 (22%) involved community based mental health services for working age adults services. The type of incidents with the highest number was, 'apparent/actual/suspected self-inflicted harm' with 31(45%) and slips trips and falls with 9 (13%).
- We saw evidence that the trust held separate directorate meetings to discuss and review all serious incidents to ensure that the incident had been fully investigated. However, we found the board did not review the full investigation reports, only the outcomes and lesson learnt. This meant board members were not able to monitor the trust's assertions that there were strong systems and processes in place for identifying and reporting serious incidents, including deaths, or monitoring whether reviews and investigations were completed fully.
- The National Safety Thermometer is a national prevalence audit which allows the trust to establish a baseline against which they can track improvement. The

harms that are relevant for the trust include rates for falls resulting in harm, and new pressure ulcers and new cases of catheter and urinary tract infections, acquired whilst under the trust's care. The trust reported 286 new pressure ulcers during the time specified above (average of 23.83 per month). The highest monthly prevalence rate was in October 2015 at 1.2%.

- The trust reported 40 falls with harm during the time specified. The highest prevalence rate reported was 0.3% which occurred in March 2016. The prevalence rate was at its lowest in April 2016 at 0%.
- The trust reported 58 catheter and new urinary tract infection cases in the time specified. The highest prevalence rate recorded was in May 2016 with 0.4%.
- For the same date range, the trust also recorded 27,294 cases of 'Harm Free' care, with a mean of 2327 cases per month. The trust saw their best performance in July 2016 recording a prevalence rate for harm free care of 97%.
- The Chief Coroner's Office publishes all 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. In the period 20 October 2015 to 5 May 2016, there were six concerns regarding the trust following reports to Prevent Future Deaths. Six of these reports were provided by the trust. We reviewed the action plans that and saw that the trust had agreed actions that need to be completed to ensure that the likelihood of similar event reoccurring where mitigated against. A person responsible had been identified to ensure that work was completed by a set date and how the trust will evidence that the work action has been completed.

Reporting incidents and learning from when things go wrong

- Arrangements for reporting safety incidents and allegations of abuse were in place. We saw that staff had access to an online electronic system to report and record incidents and near misses. The trust used an electronic system for reporting incidents. In mental health services staff knew what incidents needed to be reported and how to report them. Managers ensured that they monitored the reporting and recording on incidents. They provided feedback to staff through monthly staff meetings, multidisciplinary meetings, supervision and handovers.
- Serious incidents were investigated and outcomes and lesson learnt were discussed in a variety of clinical governance meetings. Lesson learnt were shared across the organisation via emails and the intranet. However, the trust board did not review full investigation reports for serious incidents, only the outcomes and lesson learnt. This meant board members were not able to monitor the trust's assertions that there were strong systems and processes in place for identifying and reporting serious incidents, including deaths, or monitoring whether reviews and investigations were completed fully. During the inspection and following the inspection interview, the chair undertook to change this and had placed a standing agenda item at every board meeting to consider the reports from investigations into the most serious incidents.
- There was a positive incident reporting culture amongst the staff in community health services and they were able to give examples of where they had received feedback and lessons learnt from incidents. However, the trust was unable to supply data relating to the number of incidents for patients at the end of life. We found end of life care staff did not report all incidents using the electronic reporting system therefore we could not be assured all incidents relating to end of life care were identified and reported.
- Staff reported that managers were supportive when incidents occurred and held debriefs quickly for the benefit of staff and patients following incidents.
- Staff described how they would be open and transparent regarding any incidents. Staff demonstrated their understanding of how to raise concerns and report incidents and near misses. They said they were fully supported when they did so. All staff received a training manual on how to complete incidents electronically.
- The trust had appointed a medicine safety officer who had the responsibility to oversee medication error incident reporting. This was in response to the NHS England and medicines and healthcare products regulatory agency patient safety alert: Improving medication error incident reporting and learning (March

2014). Staff we spoke with discussed the process for reporting and investigating medicine incidents and described awareness of recent incidents within the trust demonstrating that learning from incidents was shared.

Duty of Candour

- In November 2014 the CQC introduced a requirement for 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 duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The trust had a policy in place for duty of candour since 2015. The policy defined what was expected by staff regarding openness when involved in the management of incidents and the sharing of information with carers and relatives. Action, as required by the Duty of Candour legislation, was taken after a notifiable safety incident had taken place. The trust trained staff with regards to duty of candour and in line with the trust policy.
- The trust had introduced a serious incident duty of candour assurance from. This form was used to capture information in regards to the incident and what action the trust had taken to ensure that they followed their regulatory duty. This included what contact they had with patients and families, confirmation that an apology had been given and the outcome of the investigation and that people were given the opportunity to give feedback to the trust. In addition to this the trust completed an audit in July 2016 to provide the board with assurance that the duty of candour process was being followed. The finding of the audit reported that the trust were 100% complaint with their duty candour process. They achieved this by insuring relatives and carers had been contacted, involved or supported through the process and that this was evidenced within the serious incidents reports. However, there was a 70% compliance with ensuring that that the duty of candour assurance template was completed and embedded in the action plan. In order to address this, the trust had actions plans in place to provide staff with more training in this area. No date had been set for this training to take place at the time of the inspection.
- Within the community mental health services there were varying degrees of knowledge about the term duty of candour. However, all staff had a good understanding of the principles of being open and honest when something went wrong. Some staff had received information about duty of candour as part of mandatory training they had attended but not all staff had received duty of candour training.

Anticipation and planning of risk

- The trust had a major incident policy to deal with any major incidents or breakdown in service provisions.
- Potential risks were taken into account when planning community health services, for example seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing. A business continuity plan was in place across community health services.
- The trust ensured there was a good understanding amongst staff with regards to their roles and responsibilities during a major incident. The trust offered training to all staff which included emergency preparedness resilience response training for on call directors. Staff were able to signpost us to the trust wide policy which was located on the trust intranet.
- Checks of fire extinguishers and emergency lighting had taken place at regular intervals. We also saw records of recent fire drills and fire training within the last 12 months. We saw the fire evacuation procedure was clearly posted on the walls throughout the locations.
- The children's and adolescent mental health community team's caseloads were above the nationally recommended amount, although young people had a care co-ordinator. The community adult team caseloads varied. Patients that were referred to the service were waiting for a care co-ordinator to be allocated. Due to the large caseloads in community adult team, the number of visits that were required was not always manageable. However, the learning disability team and older people community teams managed their caseloads effectively, monitored and discussed them in supervision and during.

Requires improvement

Are services safe?

- The trust provided adequate medical cover day and night. This ensured a doctor could attend the wards quickly in an emergency. Community mental health staff said that they could easily access the psychiatrist via telephone when required, this included out of hours.
- Medical cover in community inpatient areas was provided by advanced nurse practitioners (ANPs) working Monday to Friday between 9am and 5.30pm with an on call ANP covering 8pm to 9am. Out of hours medical cover was provided by the GP out of hour's service covering Leicestershire, Leicester city and Rutland.
- The trust provided a breakdown of mandatory training for staff which included the following courses:

- SCIP-UK (Strategies for Crisis Intervention and Prevention)
- Fire Safety Awareness
- Mental Health Act for Nurses
- MAPA Disengagement Skills
- MAPA Holding Skills (Medium Risk)
- Adult Immediate Life Support
- Adult and Paediatric Basic Life Support
- Mental Health Act for Doctors
- Mental Capacity Act
- Adult Basic Life Support
- MAPA Holding Skills (High Risk)
- Safeguarding Children Level 2
- Information Governance
- Medicines Management
- Safeguarding Adults
- Dementia Capable Care
- Record Keeping and Care Planning
- Infection Control
- Core Mandatory Training - 3 Years
- Moving & Handling Level 2
- Safeguarding Children Level 3
- Hand Hygiene

- As at 1 September 2016, the training compliance trust wide was 87%. The trust did not provide the target compliance rate.However, not all core services achieved a compliance rate of above 75% for individual training subjects. Community health service inpatients, end of life, mental health long stay rehabilitation wards, community older people and wards for older people had the highest compliance rate at 91%. The team with the lowest compliance rates were learning disability and autism wards and children's and adolescent mental health community team at 81% and 82%.
- Across the trust the highest rates of compliance for individual training sessions were hand hygiene at 96%, safeguarding children level three at 93% and infection control at 92%. The lowest rate of compliance was for SCIP-UK at 59%.
- Mandatory training was incorporated into agency staff contracts. This meant that regular agency staff were fully trained alongside permanent staff.
- At our last inspection we raised concerns that an insufficient number of nursing staff in community health services for adults had received appropriate statutory and mandatory training. At this inspection we found compliance levels with this type of training were still below the trust's target, especially for bank staff and this meant staff may not have received training necessary for them to carry out their duties.

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 requires improvement for effective because:

- Managers failed to ensure that staff received regular supervision. On average 60% of staff in mental health service and 64% in community health services had received regular clinical supervision. This did not meet the trust target of 85%. Whilst the trust acknowledged there were issues with the systems used for recording supervision attendance and addressed this there had been no significant improvement noted in this area.
- Record keeping was poor in some services. Within mental health services, the quality of care plans was variable. Some care plans were not holistic, for example they did not include the full range of patients' problems and needs. Care plans did not always consider the patient views, and were generic did and not all were recovery focussed. Patients in four services across the trust reported that they had not been involved in the planning of their care and had not received copies of care plans. Within the end of life service there were inconsistencies in the quality of completion for do not attempt cardiopulmonary resuscitation (DNACPR) forms, in the quality of admission paperwork within medical records and in the use of the 'Last Days of Life' care plans. This had been raised as a concern in the March 2015 inspection and had not been sufficiently addressed.
- Procedures were not always followed in the application of the Mental Capacity Act. Staff did not ensure that mental capacity assessments and best interest decisions were consistently documented in care records. When staff deemed a patient lacked capacity there was no evidence that the best interest decision-making process was applied. There was little evidence that staff supported patients to understand the process, no involvement of family or independent mental capacity advocate in the most mental capacity assessments. This meant that patients could have been deprived of their liberty without a relevant legal framework. Within community health inpatients services staff did not always complete a Deprivation of Liberty Safeguards for patients who had sensor cushions. Despite being aware they should complete one as they were restricting the movement of these patients. Managers did not have oversight of these issues. Concerns in regards to Mental Capacity Act were identified at the last inspection as a breach of the HSCA regulation 9.

However:

- We reviewed 267 case records and found care records showed that, generally, physical health examinations were completed upon admission and there was ongoing monitoring of physical health across the trust. The majority of care plans were up to date. Care and treatment was mostly planned and delivered in line with current evidence.
- The trust had participated in a range of clinical audits in which staff actively participated. These were well-developed and supported the trust to monitor the quality of the service provided to patients. The trust used recognised outcome measures and monitoring measures to help assess the level of support and treatment that patients required. The trust used key performance indicators/dashboards to gauge the performance of the team. These reports were presented in an accessible format.
- The trust provided a formal induction period for new permanent staff. This involved attending a corporate induction, a period of shadowing existing staff before working alone. Newly registered staff completed a period of preceptorship.
- The trust had arrangements in place for the receipt and scrutiny of detention paperwork. Each ward matron completed a monthly Mental Health Act census. This captured relevant information which fed

Are services effective?

into the Mental Health Act dashboard which was shared with the board. The trust ensured that consent to treatment and capacity requirements were adhered to in the majority of cases. Staff referred all detained patients to the Independent Mental Health Advocacy service. Thereafter, patients could choose whether they wished to see an Independent Mental Health Advocate.

Our findings

Assessment and delivery of care and treatment

- The trust ensured that care and treatment was mostly planned and delivered in line with current evidence based guidelines, standards, best practice and legislation.
- Within mental health wards and community teams the quality of care plans was variable. Some care plans were not holistic, for example they did not include the full range of patients' problems and needs. Care plans did not always consider the patient views and were generic not all were recovery focussed. Although, the majority of care plans were up to date.
- Within the end of life service there were inconsistencies in the quality of completion for do not attempt cardiopulmonary resuscitation (DNACPR) forms, in the quality of admission paperwork within medical records and in the use of the 'Last Days of Life' care plans. This had been raised as a concern in the March 2015 inspection and had not been sufficiently addressed.
- Within services patients' physical health needs were usually identified. Patients had a physical healthcare check completed by the doctor on admission and their physical healthcare needs were being met. Physical health examinations and assessments were usually documented by medical staff following the patients' admission to the ward. Ongoing monitoring of physical health problems was taking place. Within the acute mental health wards the trust employed registered nurses to assist with assessment and management of physical healthcare needs for patients. Community mental health teams considered people's physical health needs as part of the assessment and would liaise with general practitioner when required.
- The trust used three different computerised records systems to store information needed to deliver care. Some services also held paper based records. However, the two computerised records did not work together. This was a particular issue with CAMHS services. For example if a young person was turning 18 adult services would not be able to access their records. The community hospital also had access to mobile devices to access records when away from their base.

Best practice in treatment and care

- In the services we inspected, most teams were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) guidelines.
- The trust also undertook a wide range of clinical effectiveness and quality audits which staff actively participated in clinical audits. Services used recognised outcome measures and monitoring measures to help patients access the level of support and treatment they required. Staff used health of the nation outcome scales to assess and record severity and outcomes for all patients.
- There was a planned programme of audits in the community health services for adults, which monitored outcomes and highlighted areas for improvement. Findings were shared and re audits conducted to monitor change. Therapy services routinely reviewed patients' outcomes using a patient self-assessment process.
- The trust provided details of 17 national audits undertaken since 2013. The trust had taken part in four national audits in 2016. The trust completed 34 clinical audits between January 2016 and June 2016. These included adults in community health services as well as mental health. Audits of compliance with National Institute for Health and Care Excellence (NICE) guidance and medication audits were carried out as part of this programme.
- The trust carried out an audit in 2013 to 2014 and again in 2016 to 2017 to ascertain the proportion of admission to acute wards gate kept by the crisis response and home treatment team. In five of the 12 quarters the trust fell below the target of 95% for the proportion of

admissions being gate kept by the CRHT team. Although the trust fell below the England average in five of the twelve quarters, they have exceeded this figure in each of the most recent five quarters.

- Whilst the trust were committed to participation in the Gold Standards Framework (GSF) for community hospitals training programme in support of a local Commissioning for Quality and Innovation (CQUIN) around end of life care, they did not participate in the National Care of the Dying Audit.
- The trusts electronic prescribing and medicines administration system was being used, to provide in house reporting on a range of monitoring and audit reports for the trust using the electronic prescription data. These included audits of antimicrobial prescribing in inpatient setting, medicines reconciliation, prescription of antipsychotics above the maximum recommended dose by the British National Formulary (BNF), safe storage of medicines in inpatients and controlled drugs in inpatients.
- We found positive examples of evidence-based practice used throughout the community hospitals. However, there was minimal data on patient outcomes being collected which made it difficult to identify if patients were improving following the care they received.

Skilled staff to deliver care

- Teams across the trust had a range of disciplines to provide care and treatment. The multidisciplinary team consisted of consultants, doctors, qualified nurses, healthcare support workers, occupational therapists and psychologists. However, there was only one psychologist in post in the acute wards. The trust had identified the lack of psychological therapies for patients, and support and training for staff, on their risk register. The trust detailed plans to advertise for posts with a target date of February 2017. However, the trust was required to address this deficit following the Care Quality Commission inspection in 2015. We were concerned that a significant period had passed and the trust had not improved access to psychology for patients and staff.
- The trust provided a formal induction period for new permanent staff. This involved attending a corporate induction, a period of shadowing existing staff before working alone. Newly registered staff completed a period of preceptorship.
- The trust had implemented a 'Grow your own programme'. This included apprenticeships, a pathway for health care assistant to nurse qualification which was due to start in January 2017.
- We were concerned about the supervision rates; the trust had not met its target for clinical supervision of 85%. On average 60% of staff in the mental health wards and community teams had attended supervision from 1 August 2015 to 31 July 2016.The trust were aware of the low levels of supervision recorded and believed the process took place but was not always accurately recorded. The trust had identified that there were issues with their recording systems for supervision. Whilst they had amended the system staffs reported in was time consuming and they did not always update their supervision records due to this.
- The trust's target rate for appraisal compliance was not provided by the trust when requested.As of 1 September 2016, the overall appraisal rates for non-medical staff was 83%.Of the core services with more than 20 staff, child and adolescent mental health wards had the highest appraisal rate of 97%, 14% higher than the trust average. Long stay/rehabilitation wards for working age adults had the lowest appraisal rate of 65%, 18% lower than the trust average.
- The trust had provided details of medical appraisals. At 30 June 2016, there were 139 doctors with a prescribed connection to the trust, 130 of these (93%) had been appraised in the 12 months to this date, and 25 appraisals had been missed or were incomplete. However, the trust provided an audit and a quality assurance audit of appraisal inputs and outputs that will aim to ensure that all are completed or a reason for non-completion as defined with the definition provided by NHS England.
- The trust are in the third year (running from April 2015 – March 2016) of a five year cycle in regards medical revalidation. In year three the trust made the following recommendations for revalidation, 52 recommendations were completed on time, 45 were positive recommendations. There had been 21 revalidation deferrals, eight appraisal records not submitted on time, five no multi source feedback, three insufficient quality improvement activity, two retirement pending, two sickness absence and one performance process on going.

Requires improvement

Are services effective?

Multi-disciplinary and inter-agency team work

- On the wards we visited we saw good multidisciplinary working, including ward meetings and regular multidisciplinary meetings care reviews and care programme approach meetings to monitor and review patients' progress. The multidisciplinary teams worked well together to achieve good outcome for the patients.
- Wards held effective handovers with the ward team at the beginning of each shift. We observed nine of these and found that they were well structured and informative and ensured that people's care and treatment was co-ordinated and the expected outcomes achieved.
- Teams had links with other organisations. Crisis teams linked well with partner agencies. The trust held mental health partnership group meetings which consisted of police, and clinical commissioning group members.
- Community health services teams worked effectively with agencies external to the trust. We saw evidence of effective multidisciplinary team working across and within teams and also work in partnership with external organisations to deliver effective care and treatment.

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

- Mental Health Act training was a mandatory training course at the trust and compliance was based on a three year cycle for qualified nurses and a two year cycle for senior doctors. Overall from 808 eligible staff 80 % were up to date.
- The trust ensured that consent to treatment and capacity requirements were adhered to in the majority of cases. However, there were four instances across the trust where patients were receiving medication without legal authorisation in place. Additionally, one patient had treatment delayed, under section 58, as the second opinion appointed doctor could not consult with a statutory consultee.Although the consultant prescribed medication under Section 62 of the Mental Health Act so the patient received treatment.
- The trust had recently implemented a new electronic system for the recording of patients' rights under section 132. There were separate forms for staff to record the reading of patients' rights on detention, on regrade of a section and for monthly reminders. In the majority of cases, staff provided patients with information about their legal status and rights under Section 132 as soon as possible after their detention. The information staff gave to patients was as recommended in the Code of Practice and the patient's understanding was recorded on the electronic system. Staff provided patients with regular reminders about their rights.
- We met with the trust's senior staff, responsible for administration of the Mental Health Act. The trust had arrangements in place for the receipt and scrutiny of detention paperwork. Each ward matron completed a monthly Mental Health Act census. A comprehensive audit programme was in place, including the audit of Section 17, Section 132 and Section 58 (treatment requiring consent or a second opinion).
- We met four hospital managers (members of a committee authorised to consider the discharge of patients detained under certain Sections of the Mental Health Act. The hospital managers provided positive feedback in relation to the induction, training, supervision and appraisal they received. They told us the Mental Health Act administration team were very responsive, a great resource and offered professional expertise.
- We reviewed the detention paperwork for 60 patients, covering 84 periods of detention under the Mental Health Act. We also reviewed seven patients' records relating to their community treatment orders (CTO). A CTO allows a patient to receive treatment, with certain conditions, in the community rather than in hospital. Copies of detention paperwork, including reports by approved mental health professionals (AMHP), were available for inspection and were satisfactory. The one exception to this was Sycamore ward, where one Section 19 – authority for transfer from one hospital to another under different managers' form was not immediately available for inspection.
- Staff referred all detained patients to the independent mental health advocacy (IMHA) service. Thereafter, patients could choose whether they wished to see an IMHA. The IMHA service confirmed this arrangement. They also provided feedback that, overall, the IMHA service was welcomed and supported across the trust, and had encountered very few obstacles in providing the service. The Mental Health Act assurance committee

representatives spoke of the good working relationships with the IMHA service, the robust scrutiny processes in place, and high levels of staff attendance at Mental Health Act training.

- Staff on the adolescent unit and in community teams had a good understanding of the Gillick competence and Fraser guidance and routinely sought consent to share information and consent to treatment from the young people in these services.
- In the thirteen months leading up to the inspection the Care Quality Commission carried out 22 Mental Health Act reviewer visits. In total, there were 125 issues identified. The trust had an action plan to address this. However, the trust reported there was still work to be completed and they continued to work with staff to ensure that the changes in practice and knowledge base of staff was improved and embedded into practice.

Good practice in applying the Mental Capacity Act

- Mental Capacity Act training is a mandatory training course at the trust and compliance is based on a three year cycle. Overall from 2,903 eligible staff 83.7% were up to date. Ahead of the previous inspection in March 2015, the trust reported a compliance rate for Mental Capacity Act of 90%, which was 6.3% higher than the current reporting period.
- Over the six month period the trust made 142 Deprivation of Liberty Safeguarding Applications (DoLS) applications. The trust has not informed the CQC of how many of these applications were approved. Wards for older people with mental health problems made the most DoLS applications during the period at 74.
- Ahead of the previous inspection in March 2015, the trust reported that over a six month period 104 DoLS applications were made, thus meaning an increase of 38 applications during the current reporting period.
- The trust held Mental Capacity Act clinical forae to discuss any issues or areas of concerns. This led to a flow chart for staff being developed to aid staff understanding in relation to Mental Capacity Act and the difference between Mental Capacity Act and the Mental Health Act. All services had Mental Capacity Act champions to support them on the wards and community teams.
- Whilst it was evident that staff had received training in Mental Capacity Act staffs understanding and application of Mental Capacity Act was a concern. In the older peoples' community teams, mental capacity assessments and best interest decisions were not consistently documented in care records when they were required. The electronic part of the care plan for mental capacity assessments or best interest decisions was often left blank. This aspect was identified at the last inspection and was a breach of regulations.
- On wards for older adults we found that Mental Capacity Act assessments were completed upon admission for every patient. However, there was no evidence of patients being supported to make decisions for themselves at the point of assessment. Where a patient was deemed to lack capacity there was no evidence that the best interest decision-making process was applied. There was no documentation of the person's wishes, feelings, culture, or history. There was little evidence that staff supported patients to understand the process, no involvement of family or independent mental capacity act advocate in most mental capacity assessments. On Welford ward at the Bennion Centre one patient managed under DoLS after they had been assessed as having capacity two weeks previously; therefore they had been deprived they were liberties without a relevant legal framework in place. We informed the manager of this on inspection who took appropriate action. One patient's mental capacity had been assessed without a decision specific question. A third patient had been assessed as having capacity to consent to admission and treatment and reassessed one day later as lacking capacity; there was no evidence that the patient's presentation had changed.
- Within wards for people with learning disabilities staff were not adhering to the Mental Capacity Act. Patients with impaired capacity did not always have their consent assessed and recorded appropriately. At the short stay services, we found two patients who had not had a mental capacity assessment for consent to admission. Staff did not always complete capacity assessments on a decision specific basis. We found staff had completed capacity assessments for three patients, which stated the assessment was for all decisions and not decision specific. At the short stay services we also found that Deprivation of Liberty Safeguards applications were made at the start of every patient's

admission, regardless of whether a mental capacity assessment had been completed. Staff had not followed procedures to identify whether DoLS were necessary, and did not take all practicable and reasonable steps to avoid DoLS. This could lead to patients being deprived of their liberty unnecessarily.

- Staff in community inpatient services did not always understand the requirements of the Mental Capacity Act 2005 in relation to their roles and responsibilities and patients' capacity was not always suitably assessed.
- Staff did not always complete a Deprivation of Liberty Safeguard for community inpatients who had sensor cushions despite being aware they should complete one as they were restricting the movement of these 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 requires good for caring because:

- We rated the caring domain for the community health families, young people and children service as outstanding for caring due to staff approaches to family and patient care using or creating tools to assist children to understand their condition or prepare for treatment. Feedback from those who used the families, young people and children services was consistently positive.
- We saw that nursing staff interacted with patients in a caring and respectful manner. They remained positive when engaging patients in meaningful activities. Staff responded to patients' needs discreetly and respectfully.
- Patients were positive about their care and treatment and said staff were caring and understanding and respectful. Patients told us that that staff listened and empathised with them. Patients reported that the felt safe on the wards.
- Carers spoke positively about the services they received and that they had been offered carers assessments and signposted to extra support if required.

However:

- Staff in the community adult teams did not protect dignity or privacy. During the depot clinic staff did not close privacy curtains when patients were receiving depot injections. On Bosworth ward patient privacy was compromised when staff and patients entered the clinic room during examinations as there was no privacy curtain in place. On Ashby ward, the shower rooms did not have curtains fitted. This was a breach of the privacy and dignity to patients as staff might be required to enter the shower rooms to check patients were safe.
- Patients in seven core services across the trust reported that they had not been involved in the planning of their care and had not received copies of care plans.

Our findings

Kindness, dignity, respect and support

- We observed some positive examples of staff providing emotional support to patients across the services we visited. We saw that nursing staff interacted with patients in a caring and respectful manner. They remained positive when engaging patients in meaningful activities. Staff responded to patient's needs discreetly and respectfully. Staff approached all patients differently in order to meet their individual needs. Staff demonstrated that they wanted to provide high quality care and were knowledgeable about the history, possible risks and support needs of the patients they cared for. There was a strong person-centred culture in end of life care services.
- Patients were positive about their care and treatment and said staff were caring and understanding and respectful. Patients told us that that staff listened and empathised with them. Patients reported that the felt safe on the wards.
- Patients in community health services told us staff treated them with dignity and respect and praised them for their kind ways of treating them, using words such as 'marvellous', 'wonderful' and 'excellent'. Young people told us they were listened to in a non-judgmental way and they felt respected
- PLACE assessments are self-assessments undertaken by NHS and private/ independent health care providers, and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services. In relation to privacy / dignity and wellbeing the trust overall score was around 4% lower than the national average of 84.2%% at 80.3%.

Good

Are services caring?

- The following sites scored lower than the trust national average:
- St Luke's Hospital (79%)
- The Willows (76%)
- Stewart House (70.6%)
- Melton Mowbray Hospital (77.6%)
- Rutland Memorial Hospital (76.7%)
- Loughborough Community Hospital (69.4%)
- Fielding Palmer Hospital (72.7%)
- The following sites scored higher than the national average:
- Herschel Prins Centre (91.3%)
- Bennion Centre (88.2%).

The involvement of people in the care they receive

- The trust had developed a positive re-enforcement approach to involving patients in their care. Community inpatients on Rutland Ward were awarded with a trophy if they were identified as the most improved for rehabilitation
- We rated the caring domain for the community health families, young people and children service as outstanding due to staff approaches to family and patient care utilising or creating tools to assist children to understand their condition or prepare for treatment. Feedback from those who used the family, children and young people services was consistently positive.
- We saw some very good examples of care plans being person centred and some patients we spoke with were positive about their involvement with staff in planning their care and treatment. They had copies of their care plans. Carers told us that they had been included in care planning. However, patients in the older people inpatients and community, rehabilitation wards for adults, community learning disability and adult teams, reported that they had not been involved in the planning of their care and had not received copies of care plans.
- Carers spoke positively about the services they received and that they had been offered carers assessments and signposted to extra support if required.
- Adult patients in the community health services, and their relatives were included in the planning and delivery of care. Staff listened to patients and encouraged them to be involved in their care. Families and children health services were actively involved in care planning.
- Patients at the end of their lives and their relatives felt involved in the care provided.
- The trust provided access to advocacy services for patients and contact details displayed across the services for patient reference.
- The friends and family test (FFT) was launched in April 2013. It asks people who use services whether they would recommend the services they have used; giving the opportunity to feedback on their experiences of care and treatment. The trust were using the FTT although they had a low response rate of 1%, which was 1.4% lower than the national average. However, 93% of respondents for the trust said they were either 'Extremely likely' or 'likely' to recommend the trust as a place to receive care, 5% higher than the 87% England average.
- At the start of 2015, a questionnaire was sent to 850 people who received community mental health services. Responses were received from 258 people at Leicester Partnership NHS Trust. The trust scored 'about the same' as other mental health trusts in all questions apart from 'Planning Care' and 'Other Areas of Life' where the trust scored worse than average.

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 requires improvement for responsive because:

- There remained a shortage of beds across the trust and this had impaired patient safety and treatment at times. We found that due to the lack of available beds patient numbers exceeded the number of available beds which meant that if a patient returned from leave they did not have a bed. To address this deficit the trust placed patients out of area or moved patients that required an acute bed to rehabilitation bed which was not clinically justified nor did this meet the needs of the patients.
- The trust was not commissioned to provide female psychiatric intensive care beds. Therefore, if a female needed a psychiatric intensive care bed they were sent out of area. This made visiting difficult for families and did not promote re-integration into the community for those patients.
- The trust did not ensure that they meet set target times for referral to initial assessment, and assessment to treatment in the majority of teams. This impacted on patients requiring care.Adult community health patients did not always have timely access to routine appointments. We found a total 40 breaches of the six week referral and seven breaches of the five day urgent referral. At the time of inspection, there were a total of 647 children and young people currently waiting to be seen in specialised treatment pathways. 87 of the total patients had been waiting over a year to begin treatment. The longest wait was 108 weeks for four patients to access group work or outpatients. In community based mental health teams for older people five of six services breached national targets from referral to assessment.The learning disability community team had not met the six week target for initial assessment on average it was six days over.

The adult community therapy team did not meet agreed waiting time targets. Between August 2015 and July 2016 the trust had a total of 372 delayed discharges.

However:

- Services were mostly planned and delivered in a way that met the current and changing needs of the local population and included access to end of life services by people in vulnerable circumstances.
- The average bed occupancy was 85%. Amongst the trust learning disability wards this was 61% and for mental health wards 87%. Across twenty-nine of 54 wards at the trust were reported as having an average bed occupancy of below 85%, with 28 of these operating below 70%.
- We recognised the improvement the trust had made with regards to the children's' and adolescents' services community teams waiting times from referral to initial assessment since the last inspection. The waiting time had fallen to less than 13 weeks and met the required target.
- The trust recorded 97% of patients on the care programme approach were followed up within seven days of their discharge from inpatient services in from April to June 2016. This was above the England average of 96%.
- We found a range of information that was accessible to patients on treatments, local services, patients' rights and how to complain across all services. These were available in other languages and in easy read format.

Our findings

Service planning

- The trust worked with three main clinical commissioning groups to plan and deliver community inpatient services to the population of Leicestershire, Leicester and Rutland.

Requires improvement

Are services responsive to people's needs?

- The families, young people and children's service worked with external partners including local authorities to plan and deliver services to meet the needs of the local and migrant population.
- Services were planned and delivered in a way that met the current and changing needs of the local population and included access to end of life services by people in vulnerable circumstances.
- Adult community health services worked well in partnership with other organisations to provide choice and locally based services for patients. However, provision was not planned to meet local demand in a systematic way and local community adults' area teams were developing approaches to better manage this.
- The trust used information about the local population when planning service developments and delivering services. The trust had effective working relationships with commissioners and other stakeholders. There were close links with the commissioners and ongoing discussions about developments to improve services. However, feedback we received from stakeholders was that they felt the trust did not always provide enough detail in their information.

Access and discharge

- The trust did not provide the overall trust figures on bed occupancy. Although ahead of the previous inspection in March 2015, in quarter two of 2014/15 the trust reported an average bed occupancy of 85%; amongst the trust learning disability wards this was 61% and for mental health wards it was 87%.Twenty-nine of 54 wards at the trust were reported as having an average bed occupancy of below 85%, with 28 of these operating below 70%.
- Community inpatient wards were above 85% for their mean bed occupancy rates between August 2015 and July 2016. Swithland Ward had the highest mean occupancy rate of 94% and Rutland Ward had the lowest mean bed occupancy rate of 90%. National data had shown when bed occupancy rates reach above 85%, there was an increased risk of regular bed shortages and an increase in healthcare associated infections.
- The trust monitored the length of stay for discharged patients during the 12 month period. Overall the trust reported length of stay data for 43 wards trust wide. Maple Ward, (long stay ward) had the highest length of stay for discharged patients with 1,281.3 days. The ward or team with the lowest length of stay was 1 The Grange at Farm Drive 9 (learning disability ward) with 4.3 days.
- The trust were aware that they needed to reduce the amount of out of areas placements. However, beds were not always available for people living in the trust catchment area. At the time of the inspection there were 53 patients who were put in placements outside of the trust area in 15 different locations between 1 February 2016 and 31 July 2016. These were all for patients from acute wards for adults of working age and psychiatric intensive care units. The trust did not provide any data on the length of these placements.
- The trust identified on their risk register that bed demand was high and there was a delay in identifying and assessing a bed in acute services. This meant that the trust were aware of the issue and monitoring it at a senior level. However, during the inspection we noted on Thornton ward at the Bradgate mental health unit there were 24 beds, however, during the inspection there were 24 patients on the ward and four more on leave. One patient was receiving care at Stewart House as no beds were available within the acute service. This meant if a patient returned from leave they did not have a bed.
- We found that the trust was not ensuring continuity of for care patients. Patients were moved from the acute services to rehabilitation wards to free beds for admission; this was not always clinically justified on the grounds of those patients' clinical needs. Since May 2016, staff transferred 39 patients between acute wards and rehabilitation wards during episodes of care. The trust advised 18 patients were transferred back to acute beds and 17 were assessed and found suitable to remain within the rehabilitation service. Staff transferred eight patients back to the acute wards within three days and ten remained on rehabilitation wards for between five and 57 days.
- The trust was not commissioned to provide female psychiatric intensive care beds. Therefore, if a female needed a psychiatric intensive care bed they were sent out of area. This made visiting difficult for families and did not promote re-integration into the community for those patients.

Requires improvement

Are services responsive to people's needs?

- From April 2016 to September 2016 there were seven occasions when the trust used a police vehicle to transport patients due to a lack of appropriate transport. There were eight occasions where due to a lack of beds, or appropriate transport, patients had to be held in custody which was in breach of police and criminal evidence act 1984. Within the last six months 16 patients had to remain in custody due to lack of beds or lack of transport.
- The trust did not ensure that patients who required the use health based place of safety had timely access to the crisis team. Police took patients to the health based place of safety and had to wait for the crisis team to arrive. Whilst the crisis team, responded within the required three hour timeframe it meant that patients were not in receipt of care from a mental health professional.
- Since the introduction of the street triage in 2012 the admission to the health based place of safety had reduced to 5.6%. The main reasons for this reduction was the positive working relationship between the trust and the police resulting in patients receiving the appropriate care and treatment.
- The trust reported no readmissions within 90 days between August 2015 and August 2016.
- The trust monitored delayed transfers of care. Between August 2015 and July 2016 there were a total of 372 delayed discharges. The service with the highest numbers of delayed discharges was community inpatient services with 175, (47% of discharges). The lowest was long stay rehabilitation mental health wards for working age adults with 8 (2% of discharges). There were 7,860 delayed days between August 2015 and July 2016. The reasons for the highest number were as follows: 2001 (25%) were due to 'patient choice', 1200 (15%) were due to 'completion of assessment' and 817 (14.2%) were due to 'awaiting nursing home placement or availability.'
- The trust provided data on referral to initial assessment times for 66 teams across the trust. Out of these 66 services, 44 assessed patients within the set national target. However, 22 of these services did not meet the national target. In children's and adolescent mental health community teams, waiting times from referral to initial assessment was less than 13 weeks which met their target.
- Throughout the inspection we found that people had to wait to receive treatment. Whilst the trust were aware of these issues it was not clear what action was being taken to address them. Adult community health patients did not always have timely access to routine appointments. For routine musculoskeletal physiotherapy patients had to wait up to 26 weeks, the continence clinic up to 46 weeks and 18 weeks for respiratory clinics. Physiotherapists told us that demand exceeded capacity for routine patient appointments.
- Adult community health patients did not always have access to community nurse care within the expected timescale. Unscheduled (reactive) community nursing services had a target to attend these calls within two hours. In August, September and October 2016 they attended 58%, 55% and 55% respectively of calls within two hours, so many patients waited longer than two hours.
- Community mental health adults' teams had a total 40 breaches of the six week referral and seven breaches of the five day urgent referral.Community mental health teams did not meet the national referral to assessment time target of five working days. The early intervention in psychosis team had a target of 50% for people using the service to commence a National Institute for Health and Care Excellence (NICE) concordant package of care within two weeks of referral, 76% of referrals were within the target.
- At the time of inspection, in children's and adolescent mental health community teams there were a total of 647 children and young people currently waiting to be seen in a specialised treatment pathways. 87 of the total patients had been waiting over a year to begin treatment. The longest wait was 108 weeks for four patients to access group work or outpatients.
- In community based services for older people the trust set target times from referral to initial assessment against the national targets of 28 to 42 days. Five of the six services in this core service were in breach of these targets.

Requires improvement

Are services responsive to people's needs?

- The learning disability community team had not met the six week target for initial assessment on average it was six days over.
- The adult community services therapy team did not meet agreed waiting time targets. They did not achieve the three day, 10 day or 20 day targets in September 2016, or the previous month. In September they saw 73%, 42% and 66% of patients respectively within the three, 10, and 20 working days targets. This meant non-urgent patients could wait longer than the agreed standard. One board report showed this could be up to 33 weeks.
- Children's health visiting services monitored compliance with national targets for visits and child development checks. Between July 2016 and September 2016, 93% of babies received a face-to-face new born visit within 14 days. This was slightly worse than the national average of 97%. The number of children receiving a 12 month check was 88%. This was similar to the national average of 91%.
- Looked after children initial health assessments varied, this was in part due to delays in communication with the looked after children team regarding children entitled to this service. The key performance indicator for initial health assessments was 28 days and once referred to the team they were able to meet this target 93% of the time. However, due to delays in referral by local authorities some children were not assessed up to 170 days from being placed into care, this reduced the overall compliance to 44%. A spreadsheet of all referrals received in September 2016 showed 19 of 37 referrals were delayed. Senior staff had raised this with the social services team. The looked after children team received 29 to 45 requests for initial health assessments each month.
- Data provided by the trust following our inspection showed 100% of children and young people referred for end of life care were seen by specialist nurses working within the Diana team within 24 hours Monday to Friday.

  The trust provided data for average speed of response to referrals for the Hospice at Home team for the period November 2015 to December 2016. The service had three timescale targets for response to referral, dependant on the urgency of the referral; 'planned appointment', 'attend within two hours' and 'attend within 48 hours'. Visits were monitored and recorded as to whether the referral was responded to within 24 hours or 48 hours. The data showed 83% of 'planned appointments', 99% of 'within two hours' and 93% of 'within 48 hours' were made within the 24 hour period. The response to referral rate within 48 hours was over 96% for all categories.

  The trust provided response to referrals data for the same period for the Macmillan service. The data showed 12% of 'planned appointments', 26% of 'within 48 hours' and 10% of 'within five days' had been made within the 24 hour period. The rate of response within 48 hours was 18%, 44% and 20% respectively. The trust did not provide a target response time.
- Data provided by the trust showed from 30 November 2015 until 1 November 2016 the end of life care service received 107 referrals for Rapid Discharge home to the patients preferred place of death. Staff working across the trust in all care settings told us of concerns regarding the fast track process. A fast track process was where a patient had a rapidly deteriorating condition, and may be entering the final stages of their life and where additional arrangements need to be put in place to facilitate a discharge home. Staff on the community inpatient wards told us of concerns some patients were admitted to hospital that could have been managed at home with an appropriate package of care. We also learned of concerns patients fast tracked for discharge home were not discharged in a timely way due to delays with the fast track system.
- Staff provided some flexibility in the times of appointment. Appointments did not always run to times. However, staff informed patients or carers by telephone when they did not. Staff phoned patients and carers when appointments were cancelled and offered an explanation and apology.
- Sometimes community nurses missed appointments. Staff told us when this happened; they rang the patient to explain and to re-schedule the appointment. We requested details about how many appointments were missed and rescheduled but the trust did not provide this. If there was a staff shortage, the night service warned local area hubs and prioritised calls in order of clinical need.

Requires improvement

Are services responsive to people's needs?

- The Care Programme Approach is a way that services are assessed, planned, and co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. The trust recorded 97% of patients on the care programme approach were followed up within seven days of their discharge from inpatient services in from April to June 2016. This was above the England average of 96%.
- We spoke with two approved mental health professional (AMHP) leads. They expressed some concerns about inappropriate referrals from the crisis team and difficulties in obtaining responsible clinicians to attend Mental Health Act assessments and lack of beds particularly at the Bradgate Mental Health Unit.

The facilities promote recovery, comfort, dignity and confidentiality

- The majority of wards and community buildings we visited had a range of rooms and equipment to support care and treatment. For example, rooms to patients to participate in therapeutic activities, have one to one sessions with staff and therapy kitchens. However, the learning disability, short stay services and the acute wards did not have sufficient space.One rehabilitation ward kitchen was not fit for purpose and poorly equipped but was being used by occupational therapy. The ovens were old and the dials were not visible and cupboards were broken. There were no vision panels on patient bedrooms. On Aston and Ashby wards we found insufficient chairs for all patients to use.
- We had some concerns about patients' privacy and dignity being protected. We observed a clinic in the community mental health adult team where staff did not provide dignity or privacy. During the depot clinic staff did not close privacy curtains when patients were receiving depot injections. On Bosworth and Ashby we noted there were no privacy curtains in the clinic or shower room which could compromise people's privacy.
- There was a provision of accessible information on treatments, local services, patients' rights and how to complain across all services.
- Patients had access to quiet areas on wards and access to outside space. The quality of the food was variable across the trust. Patients had the ability to make drinks for themselves 24 hours a day or staff would facilitate this for them. Secure storage was available, although this was not always provided within patient areas; staff would lock valuables in ward offices. Patients could personalise their bedroom areas if they wished.
- The PLACE assessment relating to food scores show that the trust scored lower than the national average of 88.2% for food with 85%. The Evington Centre scored the lowest out of the trust sites for food with 77.3%. This was 7.7% percentage points lower than the average trust score and 10.9% percentage points lower than the national average.
- The following sites scored lower than the trust average of 85%:
  - St Luke's Hospital (81.6%)
  - Stewart House (83%)
  - Melton Mowbray Hospital (84.6%)
  - Coalville Community Hospital (83.7%)
  - The Willows (78.7%)
  - The Evington Centre (77.3%)
  - Feilding Palmer Hospital (79.8%)
  - Hinckley (83.1%)
  - Loughborough (79.4)
- Two sites scored higher than the national average of 88.2% for food, the Agnes Unit with 90.6% and the Bradgate Unit with 93.9%.

Meeting the needs of all people who use the service

- The trust did not ensure that all nurses had access to training on dementia, or learning disabilities within the community health services for adults in order to meet the needs of patients. The care was not always planned, delivered and coordinated to take into account people with complex needs. There were no nurse champions for patients living with dementia.
- The End of life team would liaise closely with the trust learning disabilities team and the carers of any patient with learning disabilities who was at the end of life to ensure they meet their needs. Although, there was no pathway specific to end of life care for patients with learning disabilities or living with dementia.

Requires improvement

Are services responsive to people's needs?

- Information leaflets were available in easy read formats and in different languages for people whose first language was not English.
- The families, young people and children's service employed care navigators who helped families negotiate their way through the complexities of services available to them.
- The trust had access to interpreters and signers. Staff arranged for interpreters to attend clinical meetings where appropriate. We saw evidence in patients' records where this had happened. There were posters displaying "your rights to an interpreter" written in different languages detailing what inpatients who required interpretation services could expect. All wards had clear pictorial signage to aid patients living with dementia or who had cognitive impairments.
- The trust catered for specific dietary and religious requirements.
- Spiritual support was available to patients for a range of faiths. Information was displayed on notice boards.
- Wards and community team buildings were suitable for people who required disabled access.

Learning to and learning from concerns and complaints

- The trust provided details of complaints received between from 3 August 2015 to 28 July 2016 the trust received 354 complaints. The trust informed us that during the period, 218 complaints were upheld; seven complaints were referred to the ombudsman, of which none were upheld. 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.
- Most complaints made were against the mental health community adults core service (80 complaints made with 55% upheld and two referred to the ombudsman).
- The Bradgate Unit had the highest number of complaints with 72; 37 of these were upheld.
- There were 22 complaints for the community inpatient service of which 16 were upheld. Information about how to complain was displayed in the service and staff understood their responsibilities to help people make a complaint. Community inpatient staff received feedback about complaints and lessons learnt. Adult community services received 21% of trust complaints between August 2015 and July 2016.
- For the period January to August 2016 there were 28 formal complaints about the families, young people and children's services. Of these 71% (20) were upheld locally and one was referred to the health service ombudsman, which was not upheld.
- Data provided by the trust showed the end of life care service did not receive any complaints between August 2015 and July 2016.
- The patient experience and improvement lead led on complaints work to ensure an integrated approach to patient experience information.The trust developed the complaints process and made some changes. This included additional dedicated staff, a centralised recording process, clearer guidance and training for staff and governance oversight.
- The trust received 1441 compliments during the last 12 months (1 August 2015 – 31 July 2016). Ellistown Ward at Coalville Hospital received the most compliments during this period with16.
- The trust ensured that patients had access to information on how to make a complaint by displaying information on how to make complaints. The patients we spoke with knew how to complain. Staff supported patients to raise concerns when needed.
- Staff received feedback on the outcomes on investigation of complaints via their managers. Managers ensure that they acted on these findings to reduce the risk of reoccurrence.

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 requires improvement for well led because:

- Whilst there had been some progress since the last inspection in 2015, the trust was not yet safe, fully effective or responsive.
- We had a number of concerns about the safety of this trust. These included unsafe environments; poor arrangements for medication management and lack of essential emergency equipment; the reliance on bank and agency staff to reach the required numbers of staff on wards to meet the needs of the patients and waiting times for patients to access the treatment they required.
- The trust had reorganised its governance processes and embedded their key values which were under pinned by self-regulation.The information gathered from investigations, key performance indicators, audits were used to gauge the trust's performance. However, the board needed to ensure that had access to all the required information and their decisions were implemented in order to make positive improvements.
- We reviewed the risk registers for the trust and directorates and saw that the majority of risks we identified through this inspection had been included in the risk register. However, the trust had not shared across the wards and teams the actions that they were going to implement to reduce these risks. This highlighted that further work was required to ensure that all risk were fully captured and that board shared the plans to mitigate the identified risks across the trust.
- Following on from the last inspection the trust acknowledged that work was required to ensure that the application of the Mental Capacity Act was followed. Whilst the trust provided clinical forums for staff to discuss Mental Capacity Act, Mental Capacity Act champions had been identified on wards and in team and Mental Capacity Act principles had been embedded into all training courses we found that there were still errors within the staffs' application of the Mental Capacity Act across the trust.
- Managers failed to ensure that staff received regular supervision. On average 60% of staff in mental health service and 64% in community health services had received regular clinical supervision. This did not meet the trust target of 85%. Whilst the trust acknowledged there were issues with the systems used for recording supervision attendance and addressed this there had been no significant improvement noted in this area.
- Whilst compliance rates for mandatory training across the trust was 87%. We found that managers had not addressed individual training topics that fell below 75% for individual training subjects within core services.
- The board had not discussed the most serious incidents at board meetings. Whilst they reviewed the outcomes and lessons learnt we could not be sure they had a firm grip on the quality and safety issues that challenge the trust without debate at board level.
- We did not have assurance that service leads for end of life care had good oversight of the risks relating to this service as staff were not always recording incidents, the service was unable to identify incidents specific to patients at the end of life and concerns relating to the out of hours GP service were not formally recorded
- Staff morale on Griffin ward was extremely low due to the announcement of the ward's closure upon the completion of works on Phoenix ward in early December 2016.

However:

- The trust's vision was to improve the health and wellbeing of the people of Leicester, Leicestershire

Requires improvement

Are services well-led?

and Rutland by providing high quality, integrated physical and mental healthcare pathways. The majority of the staff were aware of these and applied them in their roles.

- Managers shared the outcomes and lessons learnt from incidents, complaints and service user feedback at regular staff meetings, where meetings took place. Emails and the trust intranet also provided staff with this information.
- The trust actively promoted staff utilising least restrictive practice and reducing the need to seclude patients. Staff had been trained to utilise de-escalation processes effectively. Seclusion recorded was completed accurately and in line with the Mental Health Act Code of Practice and the trusts policy including medical reviews which was a concern from the last inspection.
- The trust board encouraged candour, openness and honesty from staff. Staff knew how to use whistle-blowing process and the majority of staff felt able to raise concerns without fear of victimisation. Staff we spoke with were aware of their responsibilities to be open and honest with patients and families when things went wrong.

Our findings

Vision, values and strategy

- The trust's vision was to improve the health and wellbeing of the people of Leicester, Leicestershire and Rutland by providing high quality, integrated physical and mental healthcare pathways.
- The trust involved all staff during 2014 to create a set of key values. The trust then set the following key values:
- Following the last Care Quality Commission inspection of end of life care provision at the trust in March 2015, a number of improvement actions were identified which included the need to develop an end of life care strategy. The trust had introduced an end of life steering group and developed a quality improvement plan as an intermediate strategy. The Leicester, Leicestershire and Rutland strategic case for change was approved by the Board and approved at the trusts quality assurance committee on 15th November 2016. Service leads told us there were further plans to implement a new end of life strategy by April 2017.
- Respect
- Integrity
- Compassion
- Trust
- The trust's board developed strategic objectives 2014 to 2016 and discussed these with shadow governors and the trust top 100 leaders and divisional management teams as summarised below:
  - Deliver safe, effective, patient centred care in the top 20% of our peers
  - 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
  - Ensure sustainability
- The trust's quality strategy (2013/2016) articulated a three-year vision for continuous quality improvement and was reviewed during 2016. It was based on three key pillars of quality and underpinned by self-regulation. Together these set out more detailed objectives to meet this plan as well as arrangements to monitor progress. The trust confirmed that the 'We are LPT' programme and listening in to action programmes had helped inform the development of the objectives.
- The senior leaders in the trust engaged with leaders in the partner trusts, local authority and other organisations across the area in a number of groups and discussions including developing the sustainability and transformation plans.
- The strategy reflects the trust's financial situation. The trust has been tightly managed and were in segment 2 of the single oversight framework segmentation. The trust has not declared a deficit. There is an ambitious financial plan to deliver the trust's objectives. Cost improvement plans are signed off clinically and these vary by needs driven by the operational services.
- Most staff across the trust told us that since the last CQC inspection trust communication and engagement with

staff for the planning and delivery of trust services had improved. Almost all staff were aware of the trust's vision and values and could describe them. Posters describing the trust's vision were on display in services.

- Following the last Care Quality Commission inspection of end of life care provision at the trust in March 2015, a number of improvement actions were identified which included the need to develop an end of life care strategy. The trust had introduced an end of life steering group and developed a quality improvement plan as an intermediate strategy. The Leicester, Leicestershire and Rutland strategic case for change was approved by the Board and approved at the trusts quality assurance committee on 15th November 2016. Service leads told us there were further plans to implement a new end of life strategy by April 2017.

Good governance

- The trust provided their board assurance integrated risk register and board assurance framework dated 7 July 2016, which detailed 29 corporate risks, 16 of which were rated as high risk (risk level of 16 or higher) and 13 as moderate risks. The higher rated risks relating to 'good governance' are summarised below:

- Delivery of financial plan may not be achieved
- Financial viability
- Accuracy and validity of patient information
- Failure to address the 2015 CQC Comprehensive Inspection Actions
- Delivery of our strategic objectives could be jeopardised if planned capital funding was not available
- Risk of contribution loss
- Overall risk of population growth costs, inflation costs and volume increases exceeding current resources
- Risk of not having sufficient non recurrent funds to support transformation
- Efficiency savings are an integral part of our Service Development

  Initiatives.
- Risk to the trusts financial position of Local Health Economy financial failure

- Since the last inspection in March 2015 the trust had put in place well-developed audits to monitor the quality of the service. The trust used key performance indicators/ dashboards to gauge the performance of the team. These reports were presented in an accessible format.
- The trust had an integrated board assurance framework and risk register which was reviewed monthly by the board. Risk registers were also in place, held at different levels of the organisation which were reviewed at directorate and locality meetings. Most key risks that had been highlighted following our last inspection were reflected within the risk registers. Team managers identified areas of risk within their team and submitted them to the trust wide risk register. However, we found that full details were not always reported within the teams risk register which meant that some risks might not be mitigated. For example, within the acute services the use of hydraulic beds was identified on the ligature audit as a risk. However, on the risk register the hydraulic beds were only highlighted as a risk of barricade not as a ligature point.
- The trust produced a Mental Health Act dashboard which included information about the use of the Mental Health Act across the trust, and provided a month-by-month comparison. This information supported the Mental Health Act assurance committee and the board of directors to be aware of, and address, inconsistencies in practice across the wards. These included the recording of Section 17 leave (leave of absence from hospital) and reading of Section 132 (the duty of managers of hospital to give information to detained patients) rights, and the recording of a patient's capacity at the start of their treatment. Clinical and managerial staff discussed Mental Health Act issues in a monthly quality improvement collaborative meeting.
- Whilst the trust wide mandatory training compliance was 87%. Many of the core services were not achieving the required compliance rate for individual courses. It was not clear what action was being taken to address this corporately.
- After the inspection in March 2015 the trust was found to be in breach of regulation 18, in relation to supporting staff in relation to providing clinical supervision. We found that the trust had again failed to ensure that staff received regular supervision. On average 60% of staff in mental health service and 64% in community health

services had received regular clinical supervision. This did not meet the trust target of 85%. Whilst the trust acknowledged there were issues with the systems used for recording supervision attendance and had addressed this there had been no significant improvement noted in this area. The trust acknowledged that they needed to do better in this area.

- The trust had systems and processes in place to ensure that an average of 83% of staff had received an annual appraisal.
- In the 2015 staff survey, the percentage of staff saying they had received an appraisal in the 2015, was 91%, this was a one percent increase on the 2014 staff survey. This figure compares to the trust's reporting of 83% of staff having had an appraisal in the 12 months to September 2016. The score matched the average of combined mental health, learning disability and community health trusts. The trust's score of 3.09 for the quality of their appraisals is 0.04 higher than the average for combined mental health, learning disability and community health trusts putting it in the average range.
- Since 1 August 2015 there have been 27 cases where staff have been either suspended or placed under supervision. Ten staff were suspended and 17 staff placed under supervised practice. Three of these occurred at the Evington Centre.
- Whilst the trust had a recruitment plan in place, it lacked imagination or originality to recruit staff. The trust continued to have high levels of vacant posts particularly in the Bradgate Mental Health Unit.
- Mental health wards and community teams and the majority of community health teams ensured that incidents were reported. However, we did not have assurance that service leads for end of life care had good oversight of the risks relating to this service as staff were not always recording incidents, the service was unable to identify incidents specific to patients at the end of life and concerns relating to the out of hours GP service were not formally recorded.
- Managers shared the outcomes and lessons learnt from incidents, complaints and service user feedback at regular staff meetings, where meetings took place. Emails and the trust intranet also provided staff with this information.
- The trust actively promoted staff utilising least restrictive practice and reducing the need to seclude patients. Staff had been trained to use de-escalation processes effectively. Seclusion records were completed accurately and in line with the Mental Health Act, Code of Practice and the trust's policy. This included medical reviews which was a concern from the last inspection.
- The trust had processes for the identification and reporting of safeguarding alerts and concerns. Staff had received safeguarding training and demonstrated a good understanding of processes.
- Following on from the last inspection the trust acknowledged that work was required to ensure that the application Mental Capacity Act was followed.Whilst the trust provided clinical forums for staff to discuss Mental Capacity Act, Mental Capacity Act champions had been identified on wards and in team and Mental Capacity Act principles had been embedded into all training courses we found that there were still errors within the application of the Mental Capacity Act by staff across the trust. The CQC highlighted this as a concern and a breach of regulations following its inspection in March 2015. The trust had an action place to address this issue but were aware that there was still more work needed to ensure practices were embedded and applied correctly.
- The trust complied with the Equality Act 2010 and had a clear approach to equality and diversity for both patients and staff. The trust understood the diverse needs of its workforce and proactively sought to promote equality and diversity. It achieved this through training and feedback from staff.
- There were effective governance arrangements in place in community inpatient wards to monitor quality, performance and patient safety. There were well-developed audits in place to monitor the quality of the services provided. Team managers shared the results in team meetings if improvements were needed and developed action plans to monitor progress. Staff we spoke with confirmed that they provided outcomes of audits from the boards to senior managers and ward staff.However, we were told and saw from minutes that the board did not discuss the most serious incidents at board meetings. We wondered how the board had a full understanding of the quality and safety issues challenging the trust without debate at that level. The

chair reflected on this throughout the week and undertook to implement an agenda item to provide assurance that the most serious incidents were fully discussed and mitigations and improvement actions were sought as necessary.

- There was a system of governance meetings to ensure that leaders of community services for adults discussed complaints, quality and incidents. However, performance and risk management arrangements were not robust enough to ensure leaders always took timely action. There were clear governance structures within the families, young people and children's service with systems and processes for escalation.
- We did not have assurance service leads for end of life care had good oversight of the risks relating to this service as staff were not always recording incidents, the service was unable to identify incidents specific to patients at the end of life and concerns relating to the out of hours GP service were not formally recorded.
- The trust had effective working arrangements with commissioners, local authorities and other partners, including the police.
- Staff morale on Griffin ward was extremely low due to the announcement of the ward's closure upon the completion of works on Phoenix ward in early December 2016. Staffs' concerns included dissatisfaction with how the trust had communicated the closure to them and lack of consultation, as not all staff were directly informed of this by their managers. The trust confirmed to us the ward was temporarily closed, whilst it reviewed the low secure contract with commissioners, and considered other options for the longer term functionality of the unit.

Fit and Proper Person Requirement

- The trust had ensured that relevant policies and procedures included the requirement to check all future senior staff had the met this standard. They had also developed guidance and an annual fit and proper persons test checklist to be signed off as part of performance appraisal. The trust provided documents which detailed their policy and procedures relating to fit and proper person's requirement checks. We reviewed the files for six directors and the trust had met these requirements and had ongoing monitoring for regular reviews of fit and proper person's requirement.

Leadership and culture

- We found in last inspection in March 2015 that morale was poor in some areas and staff told us that they did not feel engaged by the trust although managers and leaders were visible. However, during this inspection staff morale appeared to have improved. Staff were positive about the leadership and culture of the trust. They felt listened to and supported to be involved in the trusts visions and values. Many of the staff we spoke with spoke highly of the chief executive and chair. The chief executive had been in post for three years and the chair was relatively new to the trust. They were seen by staff to be positive role models and promoters of positive change.
- In the 2015 NHS Staff Survey the trust was in the middle of 20% of combined mental health, learning disability and community health trusts nationally against any of the questions in the 2015 NHS staff survey.
- The trust scored above the national average against the following question, reporting good communication between senior management and staff. However the trust scored below the national average against the following questions:
  - believing that their role makes a difference to service users/patients
  - able to contribute towards improvements at work
  - suffering work related stress in the last 12 months
  - feeling pressure to attend work in the last 3 months when feeling unwell.
  - reporting most recent experience of violence
  - reporting most recent experience of bullying, harassment or abuse
  - reporting potentially harmful errors, incidents or near misses in the last month
  - The NHS staff survey also highlighted the trust improved its score since 2014 against the following metrics:
  - staff recommendation of the organisation as a place to work or receive treatment, percentage of staff reporting good communication between senior management and staff percentage of staff reporting errors, near misses or incidents in the last month

Requires improvement

Are services well-led?

- percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
- percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
- percentage of staff experiencing physical violence from staff in last 12 months
- percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

- The board had raised their visibility through a programme of executive and non-executive visits to wards and community teams, opportunities for staff to shadow executive team members and managers, senior management engagement forums.
- The majority of staff reported that the leaders of the trust were visible and approachable to front line staff. 'Board walks' promoted the visibility of the trust leaders. The trust ran a variety of 'listening in to action programmes'. These are listening events that staff can attend to provide feedback to the trust on a range of topics. The trust then develop action plans to address the issues discussed and support their implementation.
- Teams in community health services for adults felt connected to their local hub but not always to the rest of the division. The trust was starting to invest in leadership. We heard from local leaders across the county that some of them had received trust funded leadership training. The trust launched the 'WeNurture' talent management programme in August 2016, with 29 staff taking part in the initiative.
- During this inspection we also looked at the trust application of the Workforce Race Equality Standard (WRES). This requires all NHS organisations to demonstrate progress against a number of indicators of workforce equality. The trust had reported that as of March 2016, ethnicity was known for 98% of the substantive workforce. The trust's workforce was 5574 substantive staff, of which 20% came from a minority group.
- To improve the self-reporting rate of staff across the trust by ethnicity, in November and December 2015 a 'Listening into Action' roadshow was launched across the trust to gather information on barriers to providing equality monitoring information. The trust followed this up with a request to employees in March 2016 to update their equality monitoring information on the electronic staff record.
- We looked at data available about staffing. The trust managed staff sickness and absence rates with human resource support. Sickness and absence rates were 5%. Staff told us they enjoyed working for the trust and many had been in the service for a number of years.
- The trust confirmed that they have an overall vacancy rate of over 11% and that staff turnover stood at 9% as of August 2016.
- Poor staff performance including senior staff members was addressed promptly and effectively with the support of human resources
- The trust had various different methods of sharing their appreciation for the work that staff carried out. For example, the valued star and celebrating excellence.Staff told us that this made then feel valued and encouraged them to get their work recognised across the trust.
- The trust board encouraged candour, openness and honesty from staff. Staff knew how to use whistle-blowing process and the majority of staff felt able to raise concerns without fear of victimisation. Staff we spoke with were aware of their responsibilities to be open and honest with patients and families if things went wrong.
- 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 local management structures. Most staff were clear about who the senior management team were at the trust. Many staff stated that they had met with or seen senior managers at their service.
- We saw friendly and open engagement between all staff groups. Nurses, doctors, health care professionals and health care assistants we spoke with were proud of the

care and the services they provided to patients, children and young people. They were clear that they placed the patients, families and carers at the heart of everything they did.

- The staff friends and family test was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their service as a place to receive care, and whether they would recommend their service as a place of work.
- In Q1, Q2 and Q4 of April 2015 to March 2016 the trust had a higher response rate than England. In Q4 the trust reported 62% of the staff being 'extremely likely' or 'likely' to recommend the trust as a place to work. This figure for Q4 was similar to the average figure for England. The trust reported 17% of staff as being 'extremely unlikely' or 'unlikely' to recommend the trust as a place to work in Q4. This was 2% lower than the average figure for England.

Engaging with the public and with people who use services

- The trust participated in national surveys such as the community mental health community survey and the friends and family test.
- The trust had a number of user and carers forums and inpatient service had community meetings to engage patients in the planning of services and to capture feedback. The trust had launched an evolving minds group, which was a service user led group for children's and adolescent mental health community to support the co-design of the new crisis model. Patients and staff had a monthly voice at the board meetings to provide feedback about their experiences of care and working for the trust. Patents were asked for their feedback on a regular basis in most teams via community meetings.
- The trust gathered views and experiences from the public people who used services such as healthwatch and community patient panels. Feedback from a community panel was positive when we spoke with them. They told us that senior staff were responsive to the issues they raised and looked into them and provide feedback as to what action he trust had taken to address them.
- The ward managers at St Luke's Hospital had started public engagement sessions where relatives and community inpatients (past or present) were invited in to discuss care and treatment with the ward manager. Any pertinent points raised were displayed on the ward with details on how they planned to overcome them.
- Leaders prioritised the participation of people who used services. The trust board in October 2016 recognised the community health services team's work in rolling out the use of iPads to increase the amount of people who were responding to the friends and family test.

Quality improvement, innovation and sustainability

- At the previous inspection in March 2015 the trust had two services that had been accredited, accreditation for inpatient mental health services (AIMS). During this inspection we saw three more services had been accredited, Langley ward for AIMS, and community of communities for Langley and Francis Dixon lodge.
- The trust had implemented the use of apps for patient's phones and on line resources, health for kids, nerve centre and electroconvulsive therapy, information aimed at patients and carers. These resources provided information relating to a range of subjects to support children and young people.
- At City West community mental health team in conjunction with the young onset dementia assessement service, staff developed a digital app for younger patients who have developed dementia. The app could be downloaded free of charge onto a mobile phone, or tablet computer. The app brought together up to date information, advice and inspiration from others who have the condition. The app was highly commended in the Innovation Support Service Development category of the Care Coordination Association 2016 awards.
- The ward manager on Snibston Ward, Coalville Hospital had improved the way community health inpatients were engaged in activities through the introduction of the first activities co-ordinator. Due to budget restraints, the ward manger had adapted the role of one of the unregistered positions so the duties they performed were centred on providing a meaningful activities programme for inpatients.

Requires improvement

Are services well-led?

- The service had implemented the use of the 'Salford Swan' logo on the trust's intranet and paperwork relating to end of life care. This was a nationally recognised logo and was used so people can easily identify information relating to end of life care.

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 9 HSCA (RA) Regulations 2014 Person-centred care • The trust had not ensured that where appropriate, patients were involved in care planning and that this is recorded. • The trust had not ensured that care plans were holistic and personalised. • The trust did not ensure that patients' care and treatment needs were assessed by people with the required level of skills and knowledge, specifically in relation to psychological input. This was in breach of regulation 9

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • The trust did not ensure the privacy and dignity of patients was protected due to lack of privacy curtains or not using the curtains when patients received treatment. This was in breach of regulation 10

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent • The trust did not ensure that staff adhered to the Mental Capacity Act Code of Practice and to the

This section is primarily information for the provider

Requirement notices

principles of the Act specifically in regards to formal capacity, best interest decisions and Mental Capacity Act when completing Do Not Attempt Cardio-Respiratory Resuscitation forms.

This was in beach of regulation 11

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The trust had not addressed the identified safety concerns in the health-based place of safety. • The trust did not ensure that all mixed sex accommodation met guidance and promoted safety and dignity. • The trust did not ensure that all ligature risks were identified on the ligature risk audit and had not done all that is reasonably practicable to mitigate any such risks. • The trust had not ensured that blind spots on ward areas were managed to ensure staff can easily observe patients. • The trust had not ensured that people received the right care at the right time by placing them in suitable placements that met their needs. • The trust did not ensure that medication was consistently at correct temperatures in all areas and did not take action if temperatures were outside of the correct range. • The trust did not ensure that staff adhered to the NICE guidelines [NG10] on-Violence and aggression: short-term management in mental health, health and community settings. This was in breach of regulation 12

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	• The trust had not ensured that emergency resuscitation equipment was made immediately available for patients when receiving care and treatment. • The trust had not ensured that patient areas were clean and well maintained and that there was sufficient furniture available. This was in breach of regulation 15

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The trust did not ensure that staff recorded in patient notes the explaining of patients' rights under Section 132 of the Mental Health Act. • The trust did not ensure that actions were taken to address the failure to meet the targets for delivery of services, in particular the two hour response target for unscheduled care, and referrals for continence services, musculoskeletal physiotherapy and community therapy. • The trust did have system in place to provided treatment in care without significant delays in regards to assessment and treatment of patients in the community and patients on internal waiting list were not regularly reviewed. This was in breach of regulation 17

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The trust did not ensure that staff were supervised and appraised in line with trust policy. • The trust had not ensured that staffing skill mix and that staff were adequately qualified and experienced to meets patient need.

This section is primarily information for the provider

Requirement notices

- The trust did not ensure staff within community health services received appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform.

This was in breach of regulation 18