# Leicestershire Partnership NHS Trust

## Evidence appendix

Bridge Park Plaza,

Bridge Park Road,

Leicester

LE4 8PQ

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Date of inspection visit:

9 to 12 October 2017

14 to 16 November 2017

20 to 21 November 2017

Date of publication:

xxxx> 2018

This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

## Facts and data about this trust

| Registered location | Code | Local authority |
|---|---|---|
| **Bridge Park Plaza** | RT5Z1 | Leicestershire |
| **Coalville Community Hospital** | RT5PE | Leicestershire |
| **Evington Centre** | RT5KT | Leicester |
| **Feilding Palmer Community Hospital** | RT5PH | Leicestershire |
| **HMP Leicester** | RT5Y1 | Leicester |
| **Hinckley and Bosworth Community Hospital** | RT5YF | Leicestershire |
| **Loughborough Hospital** | RT5YG | Leicestershire |
| **Melton Mowbray Hospital** | RT596 | Leicestershire |
| **Rutland Memorial Hospital** | RT5PC | Rutland |
| **Short Breaks - Farm Drive** | RT5FP | Leicester |
| **Short Breaks - Rubicon Close** | RT5FM | Leicestershire |
| **St Luke's Hospital** | RT5YL | Leicestershire |
| **The Agnes Unit** | RT5NH | Leicester |
| **The Bradgate Mental Health Unit** | RT5KF | Leicester |
| **The Rise** | RT5KE | Leicestershire |
| **The Willows** | RT5FK | Leicester |

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

| | |
|---|---|
| **Total number of inpatient beds** | 628 |
| **Total number of inpatient wards** | 39 |
| **Total number of day case beds** | Not provided |
| **Total number of children's beds (MH setting)** | 10 |
| **Total number of children's beds (CHS setting)** | Not provided |
| **Total number of outpatient clinics a week** | 73 |
| **Total number of community clinics a week** | 436 |

# Is this organisation well-led?

## Leadership

The trust board and senior leadership team had the appropriate range of skills, knowledge and experience to perform its role. Leads were identified for children and young people services, mental health and community health services. The directors of these services were an executive board member.

Fit and Proper Person checks were in place. When senior leadership vacancies arose the recruitment team reviewed capacity and capability needs. Non-executive directors had been recruited with board level experience and a range of relevant skills and knowledge.

The trust had a leadership development programme for different levels in the organisation, to develop clinical and non clinical staff into leadership roles.

There was a programme of board visits to services and staff fed back that senior managers were approachable.

Succession planning was in place throughout the trust. We were given examples of how consideration for filling vacancies included talent management within the organisation.

Data provided prior to the inspection showed the executive board had 14% black and minority ethnic (BME) members and 43% women. The non-executive board had one BME member and 43% women.

| | BME % | Women % |
|---|---|---|
| Executive | 14% | 43% |
| Non-executive | 1 | 43% |
| **Total** | 14% | 43% |

## Vision and strategy

The board and senior leadership team had set a clear vision and values for the trust that were at the heart of all work within the organisation. They worked hard to make sure staff at all levels understood them in relation to their role. Senior managers referred to the values in supervision and in meetings with staff. Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team.

There was a robust and realistic strategy for achieving the priorities and developing good quality, sustainable care. Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. Local providers and people who use services had been involved in developing the strategy.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans.

The trust had planned services to take into account the needs of the local population. The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans.

However, the trust did not have a strategy for meeting the physical healthcare needs of patients in adult mental health services. Although there was an executive lead for physical healthcare, reports to board level did not include specific physical healthcare performance reporting.

## Culture

Staff said the culture of the organisation had changed positively over the last two years, with executive directors, non-executive directors, and senior managers demonstrating being open and transparent about services and when things went wrong. Most staff felt respected, supported and valued. The trust's strategy, vision and values underpinned a culture which was patient centred.

Staff felt positive and proud about working for the trust and their team. The trust recognised staff success by staff awards and through feedback. Senior managers ensured staff received individual "thank you" cards for good work.

The trust worked appropriately with trade unions. Managers addressed poor staff performance where needed. Teams had positive relationships, worked well together and addressed any conflict appropriately.

The trust had appointed a freedom to speak up guardian and provided them with sufficient resources and support to help staff to raise concerns. Staff reported that this had been positively received. Staff knew how to use the whistle-blowing process and some teams knew about the role of the speak up guardian. This was identified as an area for further work to increase staff awareness of this across the organisation.

The handling of concerns raised by staff was met with best practice. Most staff felt able to raise concerns without fear of retribution. There were various methods for staff to raise concerns in the organisation.

The trust applied the Duty of candour appropriately. The trust took appropriate learning and action as a result of concerns raised. We reviewed a sample of five cases where the patient had died. The trust followed a robust process when investigating deaths. The trust policy complied with the national guidance on learning from deaths. We saw that the trust contacted families and carers for their views and kept them informed, if that was what they requested. The investigations were carried out by trained staff independent of the service in which the death occurred. The reports detailed a means to share learning.

All staff had the opportunity to discuss their learning and career development needs at appraisal. This included agency and locum staff. The trust had recently ensured that bank and agency staff had the same access to mandatory training as permanent staff.

Staff had access to support for their own physical and emotional health needs through occupational health and staff wellbeing service.

Staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression. Staff networks were in place promoting the diversity of staff. However, this was an area the trust had identified as requiring further work.

In the 2016 NHS Staff Survey the trust had better results than other similar trusts in five key areas:

| Key finding | Trust score | Similar trusts average |
|---|---|---|
| **KF 11. Percentage of staff appraised in last 12 months** | 94% | 92% |
| **KF 12. Quality of appraisals** | 3.19 | 3.10 |
| **KF 15. Percentage of staff satisfied with the opportunities for flexible working patterns** | 60% | 58% |
| **KF 6. Percentage of staff reporting good communication between senior management and staff** | 38% | 35% |

| | | |
|---|---|---|
| **KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months** | 26% | 28% |

In the 2016 NHS Staff Survey: the trust had worse results than other similar trusts in 15 key areas

| Key finding | Trust score | Similar trusts average |
|---|---|---|
| **KF 13. Quality of non-mandatory training, learning or development** | 3.99 | 4.08 |
| **KF 20. Percentage of staff experiencing discrimination at work in the last 12 months** | 12% | 11% |
| **KF 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents** | 3.71 | 3.77 |
| **KF 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves** | 62% | 55% |
| **KF 1. Staff recommendation of the organisation as a place to work or receive treatment** | 3.61 | 3.71 |
| **KF 4. Staff motivation at work** | 3.90 | 3.94 |
| **KF 7. Percentage of staff able to contribute towards improvements at work** | 71% | 74% |
| **KF 9. Effective team working** | 3.80 | 3.87 |
| **KF 14. Staff satisfaction with resourcing and support** | 3.26 | 3.33 |
| **KF 5. Recognition and value of staff by managers and the organisation** | 3.50 | 3.55 |
| **KF 10. Support from immediate managers** | 3.80 | 3.88 |
| **KF 2. Staff satisfaction with the quality of work and care they are able to deliver** | 3.68 | 3.89 |
| **KF 3. Percentage of staff agreeing that their role makes a difference to patients/ service users** | 87% | 89% |
| **KF 24. Percentage of staff / colleagues reporting most recent experience of violence** | 85% | 88% |
| **KF 27. Percentage of staff / colleagues reporting most recent experience of harassment** | 54% | 58% |

Of the NHS staff survey results relating to leadership and culture, one of the five key questions had worse results than other similar trusts.

The question that scored worse was relating to staff recommending the organisation as a place to work or receive treatment. This showed no change since the 2015 survey

The trust scored the same as the national average for the percentage of staff feeling unwell due to work related stress in last 12 months, experiencing harassment, bullying or abuse from staff in last 12 months and believing the organisation provides equal opportunities for career progression / promotion. All three questions showed no change since 2015.

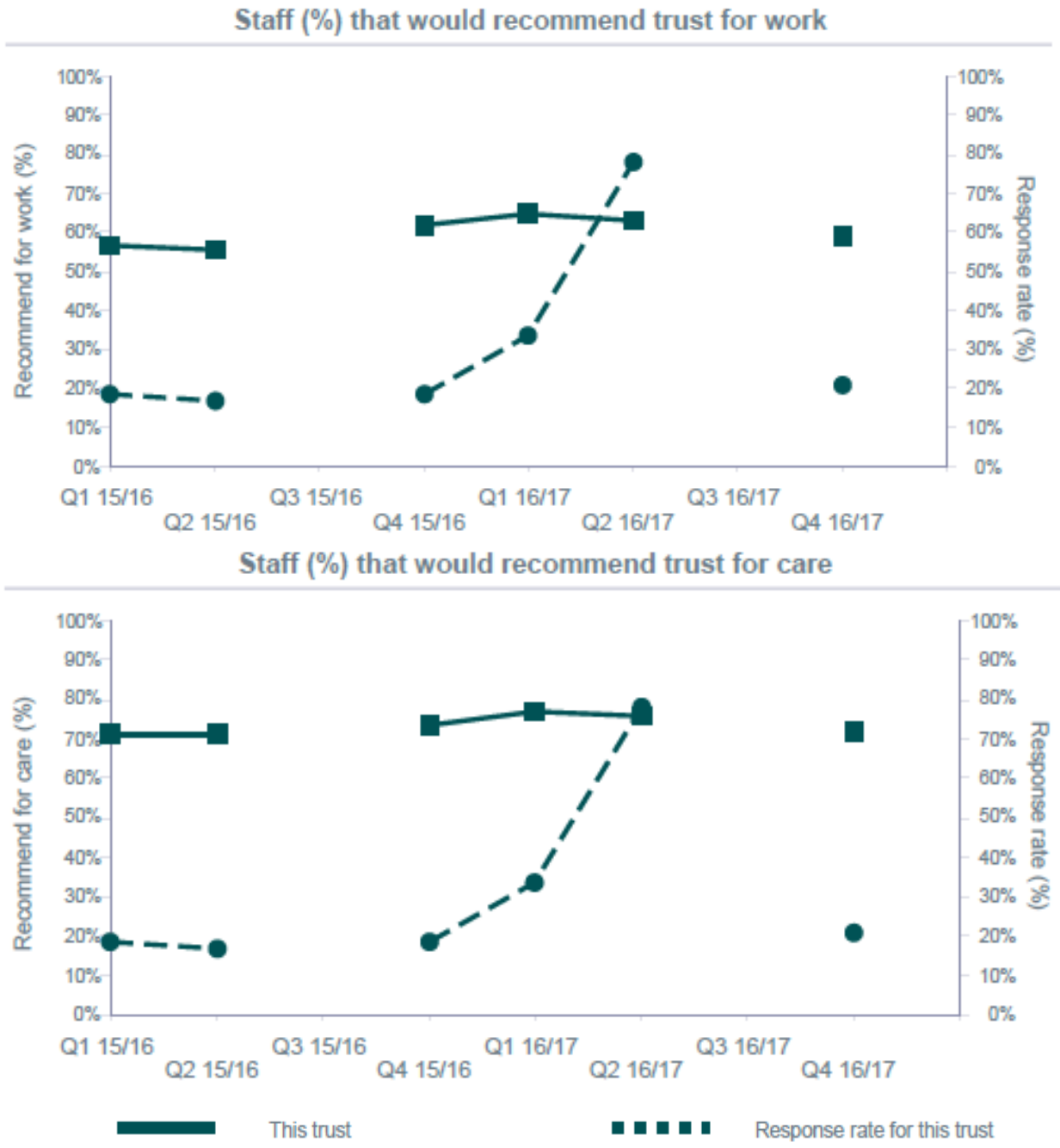
The trust scored better than similar trusts for the percentage of staff reporting good communication between senior management and staff. However, this showed no change since the 2015 survey.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 85% and 96% and was better than the England average for patients recommending it as a place to receive care for two of the six months in the period (February 2017- July 2017). July 2017 saw the highest percentage of patients who would recommend the trust as a place to receive care with 96%. The trust was better than the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in three of the months.

| | Trust wide responses | | | | England averages | |
|---|---|---|---|---|---|---|
| | Total eligible | Total responses | % that would recommend | % that would not recommend | England average recommend | England average not recommend |
| **July 2017** | 10,434 | 186 | 96% | 3% | 89% | 4% |
| **June 2017** | 11,093 | 304 | 88% | 5% | 88% | 4% |
| **May 2017** | 10,812 | 136 | 88% | 6% | 89% | 4% |
| **April 2017** | 10,484 | 214 | 93% | 2% | 89% | 4% |
| **March 2017** | 11,687 | 244 | 89% | 2% | 89% | 4% |
| **February 2017** | 53,827 | 173 | 85% | 7% | 88% | 5% |

The staff friends and family test asks staff members whether they would recommend the trust as a place to receive care and also as a place to work. The trust showed a steady trend over the last six quarters for the number of staff that would recommend the trust as a place to work. Response rates were the highest in Q2 2016/17 and are therefore more likely represent the staff views overall. The percentage of staff that would recommend this trust as a place to work in Q4 16/17 stayed about the same when compared to the same time last year

The trust showed a steady trend over the last six quarters for staff that would recommend the trust to receive care. Response rates were the highest in Q2 2016/17 and are therefore more likely represent the staff views overall. The percentage of staff that would recommend this trust as a place to receive care in Q4 16/17 stayed about the same when compared to the same time last year. There is no reliable data to enable comparison with other individual trusts or all trusts in England.




## Definition

Substantive – how many staff in post currently.
Establishment – substantive plus vacancies, e.g. how many they want or think they need in post.

| **Substantive staff figures** | | | **Trust target** |
|---|---|---|---|
| Total number of substantive staff | At 30 June 2017 | 4656.9 | N/A |
| Total number of substantive staff leavers | 1 July 2016- 30 June 2017 | 600.4 | N/A |
| Average WTE* leavers over 12 months (%) | 1 July 2016- 30 June 2017 | 12.6% | 10% |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) | At 30 June 2017 | 333.5 | N/A |
| Total vacancies overall (%) | At 30 June 2017 | 11% | 7% |

| | | | |
|---|---|---|---|
| Total permanent staff sickness overall (%) | At 30 June 2017 | 4.5% | 4.5 |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | At 30 June 2017 | Not provided | N/A |
| Establishment levels nursing assistants (WTE*) | At 30 June 2017 | Not provided | N/A |
| Number of vacancies, qualified nurses (WTE*) | At 30 June 2017 | Not provided | N/A |
| Number of vacancies nursing assistants (WTE*) | At 30 June 2017 | Not provided | N/A |
| Qualified nurse vacancy rate | At 30 June 2017 | Not provided | 7% |
| Nursing assistant vacancy rate | At 30 June 2017 | Not provided | 7% |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) | 1 July 2016- 30 June 2017 | 63,748 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 July 2016- 30 June 2017 | 27,674 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 July 2016- 30 June 2017 | 8312 | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 July 2016- 30 June 2017 | Not provided | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 July 2016- 30 June 2017 | Not provided | N/A |
| Shifts NOT filled by bank staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 July 2016- 30 June 2017 | Not provided | N/A |

*WholeTime Equivalent

The trust provided vacancy data on the five core services inspected immediately prior to the inspection of core services. There was a high vacancy rate of 12.9% for band 5 and 6 nurses in community based mental health services for adults of working age, 18.9% for band 5 and 6 nurses in crisis service and 17.3% across community health services for adults.

As at 30 June 2017 the 26 training courses listed, nine failed to achieve the trust target and of those two failed to score above 75%. These were management of actual or potential aggression holding skills (medium risk) and display screen equipment with 72%.

The trust's target rate for appraisal compliance is 80%. As at 30 June 2017, the overall appraisal rates for non-medical staff was 90%.

All of the core services achieved the trust's appraisal rate. Wards for people with learning disabilities or autism achieved 87%. The rate of appraisal compliance for non-medical staff reported during this inspection is higher than the 83% reported at the last inspection.

| Core Service | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % of non-medical staff who have had an appraisal |
|---|---|---|---|
| **Wards for people with learning disabilities or autism.** | 172 | 200 | 116% |
| **Community-based mental health & wellbeing services for older people.** | 311 | 308 | 99% |
| **Wards for older people with mental health problems.** | 330 | 323 | 98% |
| **MH - Specialist community mental health services for children and young people** | 310 | 293 | 95% |
| **MH - Mental health crisis services and health-based places of safety.** | 179 | 169 | 94% |
| **Community health services for children, young people and families** | 1594 | 1462 | 92% |
| **MH - Community-based mental health services for adults of working age.** | 523 | 474 | 91% |
| **MH - Long stay/rehabilitation mental health wards for working age adults** | 338 | 307 | 91% |
| **Other** | 329 | 300 | 91% |
| **CHS - Community health services for adults** | 2059 | 1828 | 89% |
| **Provider wide** | 1840 | 1629 | 89% |
| **MH - Community mental health services for people with learning disabilities or autism** | 195 | 172 | 88% |
| **CHS - Community inpatient services** | 920 | 788 | 86% |
| **MH - Child and adolescent mental health wards.** | 71 | 60 | 85% |
| **MH - Acute wards for adults of working age and psychiatric intensive care units.** | 412 | 330 | 80% |
| **Total** | 9583 | 8643 | 90% |

No appraisals data for permanent medical staff was provided by the trust.

The trust's target rate for clinical supervision is 85%. As at 30 June 2017, the overall clinical supervision compliance was 64%.

**Caveat:** there is no national standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

One of the 14 core services (7%) achieved the trust's clinical supervision target. The core services with the lowest clinical supervision rate was Acute wards for adults of working age and psychiatric intensive care units (42%), MH - Mental health crisis services and health-based places of safety (57%) and CHS - Community health services for adults (58%) . The clinical supervision compliance staff reported during this inspection is higher than the 60 reported at the last inspection.

| Core Service | Formal supervision sessions each identified member of staff had in the period | Formal supervision sessions should each identified member of staff have received | Clinical supervision rate (%) |
|---|---|---|---|
| **MH - Child and adolescent mental health wards.** | 405 | 315 | 78% |
| **MH - Community-based mental health services for older people** | 1397 | 1079 | 77% |
| **MH - Specialist community mental health services for children and young people** | 1668 | 1252 | 75% |
| **MH - Community mental health services for people with learning disabilities or autism** | 1220 | 902 | 74% |
| **Community health services for children, young people and families** | 9331 | 6604 | 71% |
| **MH - Long stay/rehabilitation mental health wards for working age adults** | 1840 | 1261 | 69% |
| **MH - Wards for older people with mental health problems.** | 1826 | 1249 | 68% |
| **Other** | 1948 | 1261 | 65% |
| **MH - Community-based mental health services for adults of working age.** | 2281 | 1456 | 64% |
| **CHS - Community inpatient services** | 5055 | 3171 | 63% |
| **MH - Wards for people with learning disabilities or autism.** | 710 | 435 | 61% |
| **CHS - Adults Community** | 10016 | 5833 | 58% |
| **MH - Mental health crisis services and health-based places of safety.** | 1119 | 638 | 57% |
| **Provider wide** | 811 | 402 | 50% |
| **MH - Acute wards for adults of working age and psychiatric intensive care units.** | 2326 | 974 | 42% |
| **TOTAL** | 41953 | 26832 | 64% |

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

| | In Days | Current Performance |
|---|---|---|
| **What is your internal target for responding to* complaints?** | 3 | 99.5% |
| **What is your target for completing a complaint?** | 10 and 25 | 64.3% |
| **If you have a slightly longer target for complex complaints please indicate what that is here** | 40 and 60 | 63.8% |

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

| | Total | Date range |
|---|---|---|
| **Number of complaints resolved without formal process*** in the last 12 months** | 868 | 1 July 2016- 30 June 2017 |
| **Number of complaints referred to the ombudsmen (PHSO) in the last 12 months** | 12 | 1 July 2016-30 June 2017 |

**Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example PALS resolved or via mediation/meetings/other actions

This trust received 172 compliments from 1 June 2016 to 30 June 2017. This is lower than the 1441 reported at the last inspection. Community health services for adults had the highest number of compliments with 50%, followed by community health services inpatients with 11%.

| Core Service | Total compliments received |
|---|---|
| **CHS - Adults Community** | 86 |
| **CHS - Community Inpatients** | 19 |
| **Other** | 14 |
| **MH - Community-based mental health services for adults of working age.** | 12 |
| **MH - Acute wards for adults of working age and psychiatric intensive care units** | 10 |
| **CHS - Children, Young People and Families** | 9 |
| **MH - Other Specialist Services** | 8 |
| **MH - Specialist community mental health services for children and young people.** | 6 |
| **MH - Long stay/rehabilitation mental health wards for working age adults** | 5 |
| **MH - Mental health crisis services and health-based places of safety** | 1 |
| **MH - Child and adolescent mental health wards** | 1 |
| **MH - Community mental health services for people with a learning disability or autism** | 1 |
| **Grand Total** | 172 |

## Governance

The trust provided its board assurance framework. This detailed any risk scoring three or higher and gaps in the risk controls that affect strategic ambitions. The trust outlined five strategic ambitions:

1 – Staff will be proud to work here and we will attract and retain the best people.
2 – Deliver Safe, Effective, Patient-centred care in the top 20% of our peers.
3 – Ensure sustainability
4 – Partner with others to deliver the right care in the right place at the right time.

The trust had a clear governance structure for overseeing performance, quality and risk with board members represented at sub board committee level. Reports on performance were scrutinised and challenged where appropriate at board level. However, we identified that improvements were required in relation to the environment in acute wards for adults of working age, community based services mental health services for working age adults, and in specialist community mental health services for children and young people. Whilst governance processes had identified the issues we found in relation to cleanliness, maintenance, medicines management, and record keeping, they had not all been addressed.
The trust provided examples of their monitoring processes and minutes of meetings to show they were monitoring these issues. The trust provided cleaning audit score for the 12 months prior to

the inspection. The scores were predominately between 90 and 100%. However, we found dirt and dust on Ashby ward which had not been identified and rectified.
The trust had identified the record keeping concerns through its governance processes and taken action to resolve the issue. However, record keeping was still identified as requiring improvement in community health services for adults and in specialist community mental health services for children and young people.
Whilst 75% of the maintenance jobs which had been reported had been resolved the same day, there were occasions when there was a delay in resolving the issue. Information provided showed that a shower room was out of action for 12 days and a water fountain was out of action from 23 March to 19 may 2017.

The role of the medicines safety officer sat with the chief pharmacist. However, the pharmacy risk register identified that the trust may benefit from a dedicated post to enable more detailed investigation and learning from medicine incidents.

Supervision was not being recorded on the electronic system. Waiting times remained high in community based services mental health services for working age adults, and in specialist community mental health services for children and young people.
The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees and team meetings.
Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. Non-executive and executive directors were clear about their areas of responsibility.
Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance and the Mental Capacity Act, including deprivation of liberty safeguards monitoring.
A clear framework set out the structure of ward, team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed.
Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person.
The trust was working with third party providers effectively to promote good patient care. One example of this was the weekly discharge meeting with other organisations to prevent or address delayed discharges.

The trust provided a document detailing their highest profile risks. Each of these have a current risk score of four or higher. The risks listed below are those with a risk score 15 or above.

**Key:**

| High (15-20) | Moderate (8-15) | Low 3-6 | Very Low (0-2) |
|---|---|---|---|

| ID | Description | Risk level (initial) | Risk score (current) | Last review date |
|---|---|---|---|---|
| **1094** | Failure to meet agreed waiting time targets is a risk to patient safety, experience, finance (penalties applied) and Trust reputation (overall risk) | 20 (High) | 16 (High) | 19/08/2017 |
| **1111** | Failure to deliver AMH/LD planned financial target | 20 (High) | 16 (High) | 09/10/2017 |
| **1923** | Risk of failing to complete CQC action/improvements arising from CQC Inspection in November 2016 | 15 (High) | 15 (High) | 01/09/2017 |

Leicestershire Partnership Trust has submitted details of five external reviews commenced or published in the last 12 months 1 July 2016 – 30 June 2017.

Leicestershire Fire Authority communicated advice to the trust which has resulted in subtle modifications of premises, environment or management arrangements for fire safety. No formal prosecution or enforcement notifications have been received.
The outcome of the Internal Audit reviews were: 11 significant assurance; 5 split opinion assurance; 3 limited assurance. The MHPRA review had a major failure reported for transportation of goods, and specific issues raised over documentation, customer and supplier qualification, the Quality system and ambient temperature mapping. The corrective actions were signed off and our wholesale dealers licence was subsequently issued.
November 2016 Ofsted outcome report published in February 2017 had assessment at "Requires Improvement". Information has been exchanged between the Carter review team and trust leads and the outcome of their considerations is awaited. In the meantime the trust has been involved in various work streams of work that are aligned to the Carter Review

**Management of risk, issues and performance**

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. However, there were some data quality issues in some services, although other services had been through data cleansing. There was a programme for all service to go through this.

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed. Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. Staff concerns matched those on the risk register. Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. The trust board had sight of the most significant risks and mitigating actions were clear.

There were plans in place for emergencies. For example, to deal with adverse weather, a flu outbreak or a disruption to business continuity.

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. Where cost improvements were taking place, the focus was on not compromising patient care.

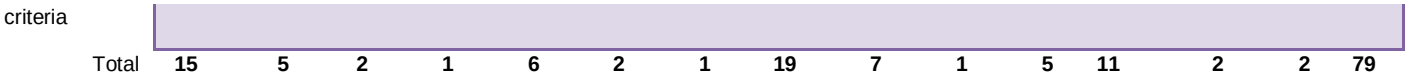
Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of identifying an incident.

Between 1 July 2016 and 30 June 2017 the trust reported 79 STEIS incidents. The most common type of incident was apparent/actual/suspected self-inflicted harm meeting serious incident criteria with 37. 13 of these incidents occurred in community based mental health services for working age adults. Four of the unexpected deaths were instances of apparent/actual/suspected self-inflicted harm. Three of these occurred in acute wards for adults of working age and psychiatric intensive care units.

A ‘never event’ is a wholly preventable serious incident that should not happen if the available preventative measures are in place. Leicestershire Partnership Trust reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months on their incident reporting system. The number of the most severe incidents was not comparable with the number the trust reported to STEIS. There were 31 incidents of Apparent/actual/suspected self-inflicted harm reported within the incident reporting system and in comparison there were 37 incidents of Apparent/actual/suspected self-inflicted harm reported to STEIS.

| Type of incident reported | CHS - Adults **Community** | CHS - Children, Young People and Families | Community Inpatients | End of Life Care | MH- Acute wards for Adults | CAMHS Wards | LD Community | MH- Community Adults | MH- Community Older Peoples | Forensic Inpatient | MH Crisis | Other | MH- Community Children | MH- Older peoples Wards | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Apparent/actual/suspected self-inflicted harm meeting SI criteria | | | | | 3 | 2 | | 13 | 6 | | 3 | 10 | 1 | | **37** |
| Pressure ulcer meeting SI criteria | 12 | | 1 | | | | | | | | | | | | **13** |
| Confidential information leak/information governance breach meeting SI criteria | 1 | 1 | | 1 | | | | 2 | 1 | | | | 1 | | **7** |
| Abuse/alleged abuse of child patient by third party | | 4 | | | | | | | | | | 2 | | | **6** |
| Apparent/actual/suspected homicide meeting SI criteria | | | | | | | 1 | 3 | | | 1 | | | | **5** |
| Abuse/alleged abuse of adult patient by third party | | | | | 1 | | | 1 | | | | | | | **2** |
| Commissioning incident meeting SI criteria | | | | | 1 | | | | | | 1 | | | | **2** |
| Slips/trips/falls meeting SI criteria | | | 1 | | | | | | | | | | | 1 | **2** |
| Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria | | | | | | | | | | | | | | 1 | **1** |
| Medication incident meeting SI criteria | 1 | | | | | | | | | | | | | | **1** |
| Sub-optimal care of the deteriorating patient meeting SI criteria | 1 | | | | | | | | | | | | | | **1** |
| Treatment delay meeting SI criteria | | | | | 1 | | | | | | | | | | **1** |
| Unauthorised absence meeting SI | | | | | | | | | | 1 | | | | | **1** |




Providers are encouraged to report patient safety incidents to the national reporting and learning system (NRLS) at least once a month. They do not report staff incidents, health and safety incidents or security incidents to NRLS.

The highest reporting categories of incidents reported to the NRLS for this trust for the period 1July 2016 to 30 June 2017 were patient accident (2183), Self-harming behaviour (1435) and Implementation of care and ongoing monitoring / review (1397). These three categories accounted for 5,015 of the 11,276 incidents reported. Self-harming behaviour accounted for 24 of the 35 deaths reported.

99% of the total incidents reported were classed as no harm (64%) or low harm (35%).

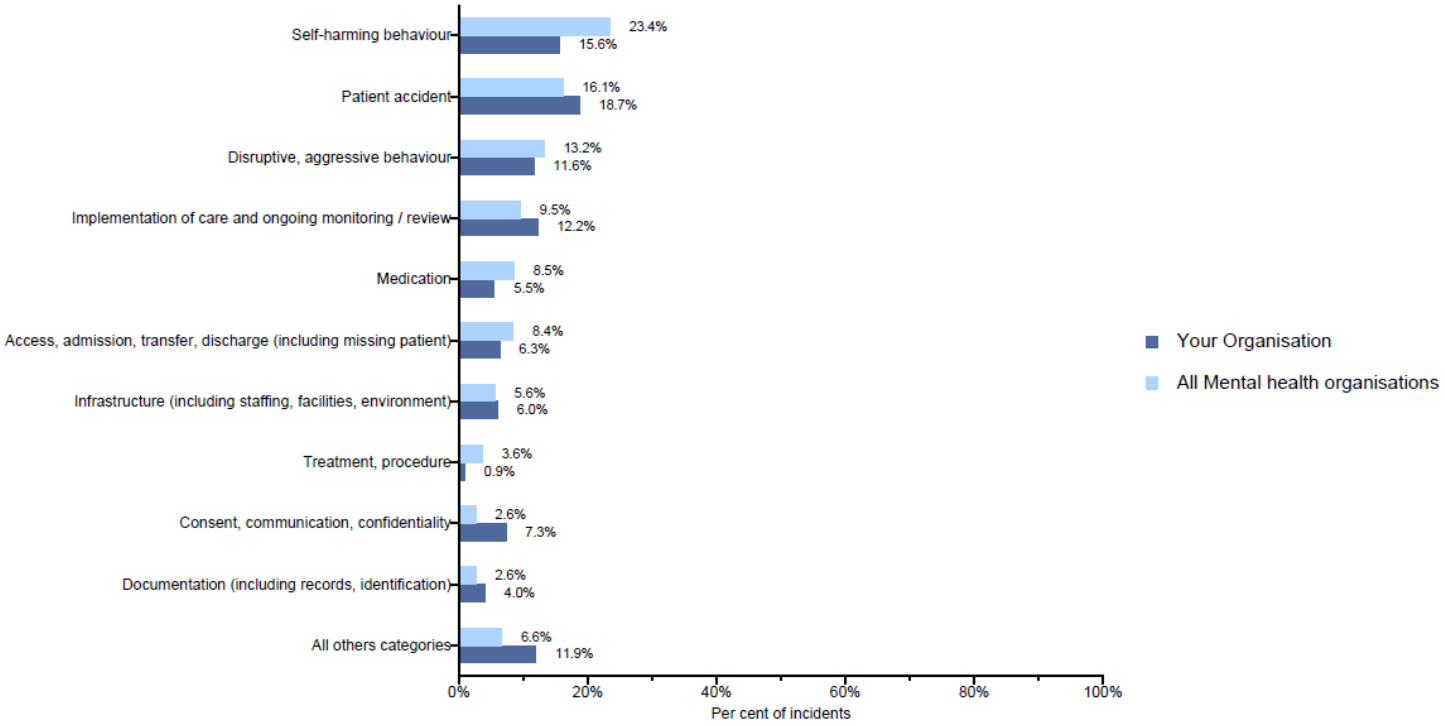
| Incident type | No harm | Low harm | Moderate | Severe | Death | Total |
|---|---|---|---|---|---|---|
| **Access, admission, transfer, discharge (including missing patient)** | 616 | 67 | 1 | | | 684 |
| **Clinical assessment (including diagnosis, scans, tests, assessments)** | 19 | 6 | | | | 25 |
| **Consent, communication, confidentiality** | 685 | 107 | 1 | | | 793 |
| **Disruptive, aggressive behaviour (includes patient-to-patient)** | 1086 | 285 | 1 | | 7 | 1379 |
| **Documentation (including electronic & paper records, identification and drug charts)** | 427 | 49 | | | | 476 |
| **Implementation of care and ongoing monitoring / review** | 92 | 1294 | 10 | | 1 | 1397 |
| **Infection Control Incident** | 19 | 15 | | | | 34 |
| **Infrastructure (including staffing, facilities, environment)** | 813 | 103 | 1 | | | 917 |
| **Medical device / equipment** | 25 | 4 | | | | 29 |
| **Medication** | 476 | 119 | | | | 595 |
| **Other** | 659 | 552 | 1 | | 1 | 1213 |
| **Patient abuse (by staff / third party)** | 18 | 5 | 1 | 1 | | 25 |
| **Patient accident** | 1322 | 838 | 19 | 2 | 2 | 2183 |
| **Self-harming behaviour** | 898 | 503 | 6 | 4 | 24 | 1435 |
| **Treatment, procedure** | 66 | 25 | | | | 91 |
| **Total** | **7221** | **3972** | **41** | **7** | **35** | |

According to the latest six-monthly national patient safety agency organisational report (October 2016 to March 2017) the trust was in the highest 25% of reporters nationally for similar trusts.

“Implementation of care and ongoing monitoring/review” and “All other categories” accounted for a higher proportion of the total number of incidents reported compared to similar trusts.

**What types of incidents are reported in your organisation?**

**Figure 2: Top 10 incident types**




Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

Leicestershire Partnership Trust reported more incidents from October 2016 to March 2017 compared with the previous six months. However moderate and severe incidents have decreased marginally.

| Level of harm | April 2016 - September 2016 | October 2016 - March 2017 |
|---|---|---|
| No harm | 3,104 | 3,613 |
| Low | 1,924 | 1,995 |
| Moderate | 21 | 15 |
| Severe | 4 | 2 |
| Death | 20 | 13 |
| **Total incidents** | **5,073** | **5,638** |

## Information management

The board received holistic information on quality and sustainability. Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Staff said they had access to all necessary information and were encouraged to challenge its reliability.

There were some data quality issues and local managers kept their own records to ensure records were accurate.

The trust was aware of its performance through the use of key performance indicators and other metrics. This data fed into a board assurance framework. Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Systems were in place to collect data from wards and teams, however, this was perceived by staff in some teams as over burdensome.

Staff had access to the information technology equipment and systems needed to do their work. The trust had identified a risk in relation to the rolling programme for refresh of computers in order to meet the standards for software updates in 2020. The programme required significant capital to achieve which was not available. However, the trust had identified some capital for this.

The trust submitted notifications to external bodies as required. The trust had completed the information governance toolkit assessment. An independent team had audited it and the trust took action where needed. The trust was on track to achieve satisfactory at year end.

Information governance systems were in place including confidentiality of patient records. The trust learned from data security breaches and followed a robust process for investigating such incidents.

## Engagement

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. There was a patient experience lead who worked with staff and other organisations to engage with people. The ward, team and division had access to feedback from patients, carers and staff and were using this to make improvements.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs – refer to results of surveys such as friends and family test. The friends and family test asks patients and carers if they would recommend the services to a family or friend.

The trust had a structured and systematic approach to staff engagement. Staff were involved in decision making about changes to the trust services. However, staff in some teams were not aware of development and improvement plans.

Patients, staff and carers were able to meet with members of the trust's leadership team and governors to give feedback. There was a session at every board meeting where the patient voice was heard in terms of feedback on services.

Senior managers, on behalf of front line staff, engaged with external stakeholders such as commissioners and healthwatch. The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans.

## Learning, continuous improvement and innovation

The trust actively sought to participate in national improvement and innovation projects. Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. The trust had a planned approach to take part in national audits and accreditation schemes and shared learning. The trust was actively participating in clinical research studies.

There were organisational systems to support improvement and innovation work.

Effective systems were in place to identify and learn from unexpected deaths.

Staff had time and support to consider opportunities for improvements and innovation and this led to changes. We were given examples of when staff had implemented changes to improve services. External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning.

### Financial summary

| | Historical data | | Projections | |
|---|---|---|---|---|
| **Financial Metrics** | Previous financial year (2 years ago) | Last financial year (2016/17) | This financial year | Next financial year (2018/19) |
| **Income** | £275,422,000 | £277,664,000 | £269,107,000 | £269,680,000 |
| **Surplus** | £1,356,000 | £2,244,000 | £3,115,000 | £3,115,000 |
| **Full costs** | £274,066,000 | £275,420,000 | £265,992,000 | £266,565,000 |
| **Budget** | £274,066,000 | £275,420,000 | £265,992,000 | £266,565,000 |

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed.

The table below shows services across the trust awarded an accreditation (trust-wide only). No dates of accreditation have been provided.

| Accreditation scheme | Service accredited | Comments and Date of accreditation / review |
|---|---|---|
| **AIMS - WA (Working Age Units)** | Langley Ward - Adult Eating Disorder Unit | Not provided |
| **Quality Network for Inpatient CAMHS (QNIC)** | Ward 3 | Not provided |
| **Quality Network for Eating Disorders (QED)** | Langley Ward - Adult Eating Disorder Unit | Not provided |
| **ECT Accreditation Scheme (ECTAS)** | Acute Recovery Team | Not provided |

# Community health services

## Community health services for adults

Information about the sites which offer community health services for adults at this trust is shown below:

### Facts and data about this service

| Location site name | Team/ward/satellite name | Patient group | Number of clinics per month | Geographical area served |
|---|---|---|---|---|
| **HQ Bridge Park Plaza** | Community based nursing services | Not Given | N/A | Leicester, Leicestershire & Rutland |
| **HQ Bridge Park Plaza** | Community based nursing services (ICS) | Not Given | No clinics service operates in patient's homes | Leicester, Leicestershire & Rutland |
| **HQ Bridge Park Plaza** | Community Therapy Services - adults | Not Given | City = 8 clinics a month, Hinckley = 32 sessions a month | Leicester, Leicestershire & Rutland |
| **HQ Bridge Park Plaza** | Continence services -Community service | Not Given | | Leicester, Leicestershire & Rutland |
| **HQ Bridge Park Plaza** | Community Stroke and Neuro Service | Not Given | | Leicester, Leicestershire & Rutland |
| **HQ Bridge Park Plaza** | Falls Services | Not Given | 24 falls programmes a month (6 a week) | Leicester, Leicestershire & Rutland |
| **HQ Bridge Park Plaza** | Musculoskeletal Therapy Services- adults | Not Given | Service comprises of 47.33wte clinicians | Leicester, Leicestershire & Rutland |
| **HQ Bridge Park Plaza** | Podiatry Service - community services | Not Given | 30 bases that operate clinics throughout the week TBC | Leicester, Leicestershire & Rutland |
| **HQ Bridge Park Plaza** | Specialist nurses and LTC teams; Heart Failure Services ;Pulmonary Rehabilitation | Not Given | 75 clinics for respiratory, 72 for Pulmonary rehab, 190 heart failure | Leicester, Leicestershire & Rutland |
| **Rutland Memorial Hospital 5PACW** | Intermediate care team and community nursing services integrated health and social care team | Not Given | N/A | Leicester, Leicestershire & Rutland |
| **Coalville Community Hospital RT5YD** | Speech and Language Therapy Community service | Not Given | N/A | Leicester, Leicestershire & Rutland |
| **Market Harborough Hospital** | Speech and Language Therapy services | Not Given | N/A | Leicester, Leicestershire & Rutland |

# Is the service safe?

## Mandatory training

Key:

| *Below CQC 75%* | Between 75% & Trust Target | **Above Trust Target** |
|---|---|---|

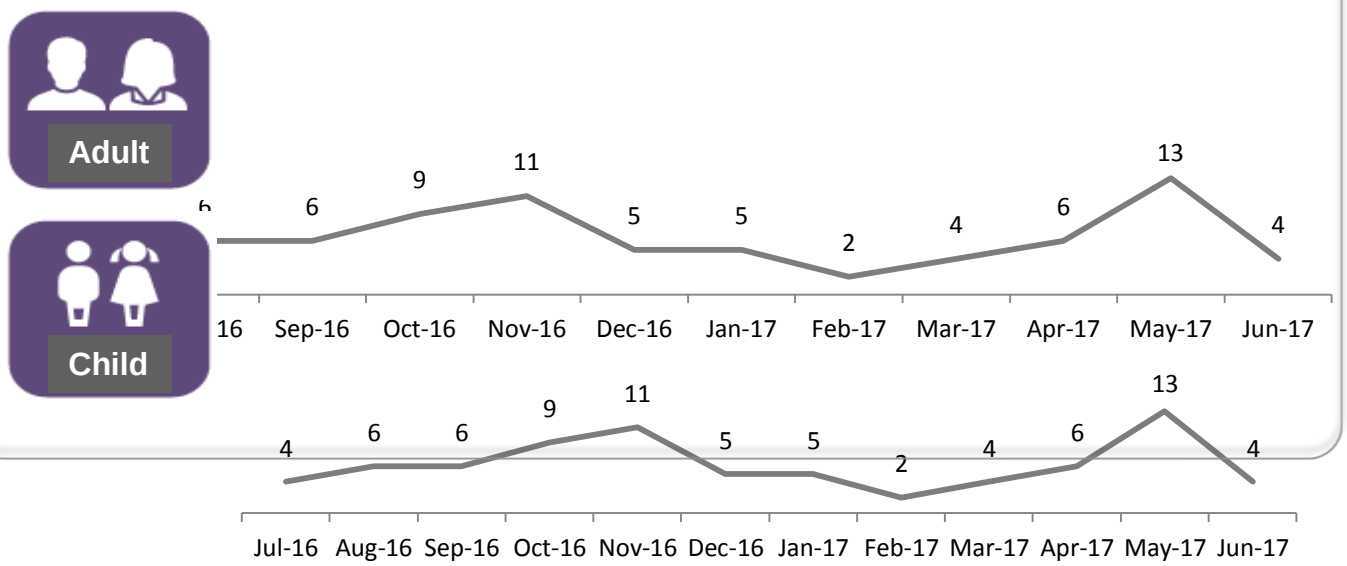
| Training Course | Total Staff who have completed the training | Total Staff Eligible | % Compliance |
|---|---|---|---|
| **(Clinical Mandatory) MAPA Disengagement Skills - 3 Years** | 39 | 39 | 100% |
| **(Core Mandatory) Infection Prevention & Control - Level 1 - 3 Years** | 171 | 173 | 99% |
| **(Core Mandatory) Conflict Resolution - 3 Years** | 1051 | 1089 | 97% |
| **(Core Mandatory) Equality, Diversity & Human Rights - 3 Years** | 1046 | 1089 | 96% |
| **(Core Mandatory) Health, Safety & Welfare - 3 Years** | 1039 | 1089 | 95% |
| **(Core Mandatory) Moving & Handling - Level 1 - 3 Years** | 1031 | 1089 | 95% |
| **(Core Mandatory) Safeguarding Adults - Level 1 - 3 Years** | 1033 | 1089 | 95% |
| **(Core Mandatory) Safeguarding Children - Level 1 - 3 Years** | 1033 | 1089 | 95% |
| **(Clinical Mandatory) Hand Hygiene - 2 Years** | 863 | 918 | 94% |
| **(Core Mandatory) Information Governance - 1 Year** | 984 | 1089 | 90% |
| **(Clinical Mandatory) Medicines Management - 2 Years** | 417 | 461 | 90% |
| **(Clinical Mandatory) Safeguarding Adults - Level 2 - 3 Years** | 812 | 916 | 89% |
| **(Clinical Mandatory) Moving & Handling - Level 2 - 2 Years** | 809 | 912 | 89% |
| **(Clinical Mandatory) Safeguarding Children - Level 2 - 3 Years** | 790 | 916 | 86% |
| **(Clinical Mandatory) Mental Capacity Act - 3 Years** | 787 | 916 | 86% |
| **(Clinical Mandatory) Infection Prevention & Control - Level 2 - 2 Years** | 777 | 916 | 85% |
| **(Core Mandatory) Fire Safety Awareness - 1 Year** | 911 | 1089 | 84% |
| **(Clinical Mandatory) Adult Basic Life Support - 1 Year** | 733 | 875 | 84% |
| **(Clinical Mandatory) Adult and Paediatric Basic Life Support - 1 Year** | 36 | 43 | 84% |
| **(Clinical Mandatory) Record Keeping & Care Planning - 2 Years** | 769 | 918 | 84% |
| **(Core Mandatory) Display Screen Equipment (DSE) - Once** | 785 | 1089 | 72% |
| **Core Service Total** | **15916** | **17804** | **89%** |

Most staff told us they were allocated time on the rota to complete or attend mandatory training. Most of the mandatory training modules were available on the trusts intranet which meant they were easily accessible to staff. Some staff told us they could catch up on mandatory training at home through the trust intranet and that they were happy to do this, whilst other staff told us that it was perceived to be the norm for them to have to this in their own time. On the whole the trust was exceeding their targets for mandatory training except in display screen equipment this was an improvement since the last inspection.

The compliance for mandatory training courses as of 30 June 2017 is 89%. Of the training courses listed six failed to achieve the trust target of 85% (exception of 95% for information governance training) and of those one failed to score above 75%. This module was display screen equipment with 72%.

## Safeguarding

**Total referrals (*1 July 2016 to June 2017*)**




Compliance for attendance at safeguarding children and safeguarding adults training was above the trust target of 85%. Staff described the referral procedure to us and gave examples of when they had made a safeguarding referral and we observed a member of staff following the procedure.

Safeguarding incidents were discussed within teams and at wider team meetings and we saw evidence of this in minutes of the meetings.

The policies and procedures for making safeguarding referrals were easily accessible and we saw contact numbers for local safeguarding services displayed on notice boards. There was a safeguarding team to support staff with complex cases and a named lead for safeguarding at board level.

We saw domestic abuse posters displayed in patient waiting areas.

The trust was also a member of the Leicester City, Leicestershire and Rutland local safeguarding children and adult boards. There were no serious case reviews for community adult services in the period July 2016 to June 2017.

Staff described completing vulnerable adults risk management forms for at risk patients who had capacity but were deemed unsafe.

One-percent (4807) of patients attending community health adults' services within the last 12 months were identified as being a child aged 17 years or under.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted

to determine whether an external referral to Children's Services, Adult Services or the police should take place.
Community hospitals made 75 safeguarding referrals between 1 July 2016 and 30 June 2017, of which 75 concerned adults and no children.
Looking at adult referrals across the 12 month period, overall there was a consistent level of referrals throughout the year in referrals with peaks in November 2016 (11) and June 2017 (13)
There were no Deprivation of Liberty Safeguards applications submitted for this core service during the last 12 months.

## Cleanliness, infection control and hygiene

All the areas we visited appeared visibly clean. An infection prevention and control policy was in place which clearly described staff responsibilities and the monitoring processes in place to ensure staff were complying with infection control policies and procedures.
We saw cleaning schedules which included the frequency of cleaning, the schedules were up to date and complete.
Equipment in the clinics we visited was labelled clean for use and we saw staff cleaning couches and chairs in-between patients.
We inspected store cupboards where sterile equipment was stored and checked 10 items of equipment which were all within their expiry date.
We observed staff changing wound dressings both in clinics and patients' homes, staff were bare below the elbow for these procedures. They followed good hand hygiene practices and all carried cleansing gel. Staff followed the principles of the five moments for hand hygiene. The five moments for hand hygiene focuses on five moments when hand hygiene should take place, these are, before patient contact, before undertaking a clean or aseptic procedure, following an exposure risk, after patient contact and after contact with a patient's surroundings.
We saw evidence of hand hygiene audits and the results of these with identified learning displayed on staff notice boards.
Personal protective equipment was readily available and we observed staff using disposable gloves and aprons.
Staff demonstrated a non-touch technique when changing dressings which is a technique to minimise the possibility of causing wound infection. We observed staff using a sterile dressing pack to prepare a clean area for the preparation of a syringe driver.
IPC mandatory training compliance was 99%, above the trust target of 85%.

## Environment and equipment

Community staff had adequate amounts of the right equipment to carry out their duties. We inspected store rooms which appeared well stocked. Staff told us that equipment for patients' homes was easy to obtain from the nominated supplier. Each hub had a store of equipment and larger items such as beds or pressure relieving mattresses could be ordered from the supplier and arrived the same day if necessary. Maintenance and repair of equipment was also carried out by the supplier, staff told us that an engineer usually arrived within 24 hours following report of faulty equipment. An out of hours on call system was available for essential equipment.
Standard non- urgent equipment was supplied within five days with discussion with the patients.
Manual handling training was mandatory every two years, 89% of staff had completed training against the trust target of 85%.

All waste was disposed of appropriately. Clinical waste bins were secure and locked. Sharps bins were sealed and signed when full and taken back to base for disposal. A waste management policy was in place dated January 2015.

Work had been performed within Hinkley therapy services unit. Windows no longer leaked and the bare brick painted.

The Hinkley therapy unit had an automated external defibrillator within the department. Records demonstrated staff had received training on the device. We saw evidence that the device had been checked every day the department was in use since the instalment in September 2017.

There was suitable arrangements in place for the management of clinical specimens such as blood samples. We observed staff taking samples during our inspection and following the policies and procedures appropriately.

## Assessing and responding to patient risk

All new patient referrals were triaged by the single point of access and then allocated to the appropriate community nursing teams.

We observed single point of access staff triaging patients according to set referral criteria. Triage is the process of prioritising the needs of the patient to make sure that those patients most in need receive care as soon as possible. A band seven nurse was available to the single point of access staff at all times for support and advice with complex cases.

Single point of access staff were able to recognise when callers required an alternative service for example, callers with urgent medical problems were connected directly to the 999 emergency services.

Priority was given to calls from palliative care patients and patients with blocked catheters. If these patients were on the phone for longer than two minutes single point of access staff would offer to call them back to reduce the cost of their telephone call.

We reviewed ten sets of patient records, paper and electronic versions. Recognised risk assessment tools were used to inform care plans and treatment. Nine of the records had risk assessments completed for the patients. We saw a set of paper notes for a patient in a nursing home who did not have a completed risk assessment. Staff told us they had not had time on the initial visit the day before to complete the paper assessments and care plans. These were not completed on the second visit. There were risk assessments and care plans from the nursing home in use.

Integrated care teams identified visits through care plans ensuring all patients had up to date risk assessments for skin assessments, mental health assessments a modified waterlow score and a malnutrition universal screening tool.

All members of the community team were familiar with patients whose condition was deteriorating. Track and trigger systems were used to highlight deteriorating patients on the electronic record system and in some teams twice weekly meetings or board rounds were held to discuss patients with the highest level of need. A board round is a virtual ward round where members of the team reviewed and discussed a patient's condition, treatment and plan of care

All patients were given information on how to contact community staff in between visits; the number was available throughout the 24 hour period.

Community staff could contact the hub co coordinator for advice or support. We observed a coordinator taking a call from a member of staff at a patient's home and advising what action to take.

During one home visit the patient mentioned that their morning blood sugar test was high, the nurse re checked the blood sugar test to reassure the patient and confirm that no further action was required.

During a visit to a patient to remove staples following a surgical operation the nurse noticed the wound was red and swollen so referred the patient to the GP for further assessment and possible prescription for antibiotics.

## Staffing

Planned visits and work was organised up to a week in advance. This was completed on an electronic system. The system colour coded tasks according to urgency to support allocation. Managers told us they were developing a more sophisticated rota planning system, an auto planner which would include work breaks.

Staff told us that visit numbers were between 17 and 22 visits a day, some teams described making 24 visits per day. We reviewed staffs work diaries and confirmed this had been the case. Some staff described that the situation had not improved however others said due to agency and extra staff, things had improved.

Unplanned visits were triaged and managed by a duty co-ordinator. At present the additional visits were shared out between all staff. A new process was being implemented to develop a 'responder role'. The responders would purely attend to the unplanned visits leaving other community staff to complete, uninterrupted, their planned visits.

Monitoring of caseload numbers was challenging due to duplicate entries for patients within the system. Matrons and senior staff told us work had been done on reducing these duplicates on the systems.

Matrons reviewed staffing levels and patient numbers daily and reported these to senior managers through a daily situation report (sitrep). Staff told us the sitrep did not include unplanned patient visits or cancelled visits so did not represent a true picture.

During busy times staff moved from county hubs into the city centre to support colleagues.

Staff told us long term sickness was the greatest challenge in many clinical areas.

The Integrated care service team managed visits daily through a 'board round'. These were allocated according to the patients address and the level of care required.

Senior managers told us they felt there were enough staff but that there were patients who were being visited unnecessarily or too often and that one of the work streams of the transformation programme was to cleanse the caseloads to make sure that all patients were receiving the right care in the right place at the right time.

The trust advised they are unable to provide vacancy data by ward/team due to restrictions with the finance system. The most amount of detail held centrally is at provider level by profession. However, the trust provided vacancy data on the five core services inspected immediately prior to the inspection of core services. There was a high vacancy rate of 17.3% across community health services for adults.

Between 1 July 2016 and 30 June 2017, the trust reported an overall turnover rate of 8% in community health services for adults.

| Ward/Team | Total number of substantive staff | Total number of substantive staff leavers in the last 12 months | Total % of staff leavers in the last 12 months |
|---|---|---|---|
| **313 L6 CHS Community Management** | 10.3 | 2.3 | 20.9% |
| **313 L6 CHS County Wide Podiatry** | 45.4 | 10.5 | 20.8% |
| **313 L6 CHS Community Support Service** | 57.1 | 11.6 | 19.8% |
| **313 L6 CHS MSK Physiotherapy** | 53.7 | 8.8 | 15.9% |
| **313 L6 CHS East North Hub** | 40.1 | 6.4 | 14.6% |
| **313 L6 CHS Palliative Care** | 24.4 | 3.5 | 14.2% |
| **313 L6 CHS Community Specialist** | 45.6 | 7.8 | 12.4% |
| **313 L6 CHS Community Therapy West** | 43.4 | 6.2 | 12.3% |
| **313 L6 CHS Community Therapy East** | 25.4 | 4.0 | 11.9% |

| | | | |
|---|---|---|---|
| **313 L6 CHS Community Planned West** | 87.1 | 11.9 | 11.5% |
| **313 L6 CHS East South Hub** | 37.0 | 5.9 | 11.1% |
| **313 L6 CHS Long Term Conditions** | 37.1 | 4.1 | 10.4% |
| **313 L6 CHS County Wide SALT Service** | 44.0 | 3.5 | 8.2% |
| **313 L6 CHS City West Hub** | 48.8 | 4.2 | 7.3% |
| **313 L6 CHS Neuro/Stroke Rehab Service** | 25.6 | 1.0 | 7.3% |
| **313 L6 CHS City East Hub** | 49.3 | 3.4 | 6.5% |
| **313 L6 CHS Planned Care Admin** | 30.3 | 2.0 | 6.3% |
| **313 L6 CHS East Central Hub** | 41.7 | 2.7 | 6.2% |
| **313 L6 CHS Community Therapy City** | 30.2 | 2.2 | 6.1% |
| **313 L6 CHS ICS** | 145.1 | 3.7 | 3.8% |
| **313 L6 CHS Business Support Nursing** | 22.0 | 0.0 | 0.0% |
| **Core service total** | 943.5 | **105.7** | 10.8% |

Between 1 July 2016 and 30 June 2017, the trust reported an overall sickness rate of 4.3% in community health services for adults.

| Ward/Team | Total available permanent staff days (June 2017) | Total % permanent staff sickness overall (June 2017) |
|---|---|---|
| **313 L6 CHS Hinckley Hub** | 35761.6 | 8.1% |
| **313 L6 CHS Community Management** | 9575.3 | 7.8% |
| **313 L6 CHS Community Specialist** | 42415.8 | 7.3% |
| **313 L6 CHS ICS** | 134491.3 | 7.3% |
| **313 L6 CHS Charnwood Hub** | 46555.8 | 6.6% |
| **313 L6 CHS East South Hub** | 33915.7 | 5.5% |
| **313 L6 CHS City East Hub** | 46115.6 | 5.3% |
| **313 L6 CHS East North Hub** | 37828.7 | 5.0% |
| **313 L6 CHS Community Support Service** | 53475.0 | 4.5% |
| **313 L6 CHS Community Therapy City** | 28345.9 | 4.3% |
| **313 L6 CHS City West Hub** | 46090.8 | 3.6% |
| **313 L6 CHS Planned Care Admin** | 27869.0 | 3.6% |
| **313 L6 CHS North West Hub** | 34410.0 | 3.4% |
| **313 L6 CHS Long Term Conditions** | 35743.0 | 2.7% |
| **313 L6 CHS County Wide SALT Service** | 40161.5 | 2.5% |
| **313 L6 CHS County Wide Podiatry** | 42902.9 | 2.2% |
| **313 L6 CHS MSK** | 56346.2 | 2.1% |

| | | |
|---|---|---|
| **Physiotherapy** | | |
| **313 L6 CHS Neuro/Stroke Rehab Service** | 23976.8 | 1.7% |
| **313 L6 CHS East Central Hub** | 38830.6 | 1.4% |
| **313 L6 CHS Community Therapy West** | 41384.9 | 0.8% |
| **313 L6 CHS Palliative Care** | 22645.5 | 0.5% |
| **313 L6 CHS Community Therapy East** | 24116.8 | 0.0% |
| **Core service total** | 902958.6 | 4.3% |

Between 1 July 2016 and 30 June 2017, bank staff filled 3,490 shifts to cover sickness, absence or vacancy for qualified nurses.
In the same period, agency staff covered 7,112 shifts and 3,152 (30%) of shifts were not filled by either bank or agency staff.
Staff told us that bank and agency staff were usually known to them and worked regularly for the service.

| Team | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| **313 L6 CHS Community Management** | N/A | 0 | 0 | 0 |
| **313 L6 CHS City West Hub** | N/A | 287 | 893 | 343 |
| **313 L6 CHS Community Planned City** | N/A | 546 | 2520 | 689 |
| **313 L6 CHS Community Planned East** | N/A | 1302 | 897 | 830 |
| **313 L6 CHS Community Planned West** | N/A | 486 | 407 | 417 |
| **313 L6 CHS East North Hub** | N/A | 0 | 0 | 0 |
| **313 L6 CHS East South Hub** | N/A | 0 | 0 | 0 |
| **313 L6 CHS Hinckley Hub** | N/A | 0 | 0 | 0 |
| **313 L6 CHS North West Hub** | N/A | 0 | 0 | 0 |
| **313 L6 CHS Planned Care Admin** | N/A | 0 | 0 | 0 |
| **313 L6 CHS Community Specialist** | N/A | 583 | 5 | 140 |
| **313 L6 CHS Long Term Conditions** | N/A | 0 | 0 | 0 |
| **313 L6 CHS Palliative Care** | N/A | 19 | 0 | 3 |
| **313 L6 CHS Community Support Service** | N/A | 0 | 0 | 0 |
| **313 L6 CHS Community** | N/A | 7 | 965 | 113 |

| | | | | |
|---|---|---|---|---|
| **Unscheduled City** | | | | |
| **313 L6 CHS Community Unscheduled East** | N/A | 145 | 661 | 316 |
| **313 L6 CHS Community Unscheduled West** | N/A | 27 | 225 | 113 |
| **313 L6 CHS East Community Adult** | N/A | 0 | 0 | 0 |
| **313 L6 CHS West Community Adult** | N/A | 0 | 0 | 0 |
| **313 L6 ICS** | N/A | 88 | 539 | 188 |
| **Core service total** | N/A | 3490 | 7112 | 3152 |
| **Trust Total** | **N/A** | **63748** | **27674** | **8312** |

Staffing levels for the single point of access were calculated using a recognised call centre planning tool. The calculator looks at previous demand on a service and predicts how many calls in the future and how many staff will be needed on duty to deal with the calls and achieve targets.

Staff told us that there was always a shortfall in staffing levels on the evening and weekend shifts resulting in large numbers of patient visits and large distances to travel between patients for each member of staff. Staff told us that although patients were safe the quality of care was compromised due to capacity of staff.

We spoke with groups of staff who felt that their workload was not realistic and resulted in them completing work from home after their shift had finished, for example ordering equipment for patients, not having time to read notices and not completing documentation. . However, on the whole staff felt that staffing and daily workload had improved but there were still busy days when they had a large number of visits.

Action plans to address staff issues had been in place since our last inspection in October 2016. However managers still described staff and workload issues as the biggest challenge within the service.

During the reporting period there was one case where staff have been suspended, placed under supervision or moved to an alternative team.

**Caveat: Please note** Investigations into suspensions may be ongoing, or staff may be suspended.

## Quality of records

Staff used a combination of paper and electronic records. The amount of paper records had been streamlined to make referrals quicker. Staff completed records on tough books (robust laptops). These could be completed remotely and then the information uploaded to the central system when secure wireless connections were available. The wait to upload the information did cause a potential delay if members of staff didn't visit healthcare premises during the working day. This meant that in an emergency a staff member may not have the most up to date record on the system.

The electronic record system was used by primary care and hospital services which meant that patient information could be accessed across health service providers.

Senior managers told us that the information available from the electronic system was not accurate due to duplicate records and records being left open on the system after the patient had been discharged.

We observed out of the six patient homes we visited records held by the patient varied, for example one patient did not appear to have any notes in the home and the others were not completed in a consistent manner.

Matrons and senior nurses performed care plan audits. This data was highlighted on the patient safety at a glance board in the community hubs. Results across the eight hubs varied but showed an overall improvement over the three months, July, August and September 2017 with four of the eight hubs resulting in 100% compliance against a target of 90%. Unfortunately two hubs had not submitted data and the remaining two hubs were below target. The Matrons had an action plan to improve compliance with the target.

## Medicines

Suitable policies were in place for the management of medicines. Although we found two staff had not followed policy when transporting controlled drugs to patients' homes.

Monitoring charts were maintained for each medication given within the patient's home. We reviewed five records that were all up to date, legible and signed.

Medicines were ordered through patient's GPs or nurse prescribers. We saw staff liaising with care home staff to prevent a delay in medicine orders.

We saw patients planning future dressing orders with the nurse due to a GP refusing to supply the specific dressings.

Where possible patients were involved in planning and administering their medication such as the use of anti-sickness drugs for a patient receiving chemo therapy.

The trust had recently reviewed the nurse prescribing formulary resulting in a standardised formulary. The medicines management policy supported the role of the non-medical prescribers.

Patient group directives (PGD's) were in place for influenza vaccines, catheter maintenance and instillagel. PGD's provide a legal framework that allows some registered health professionals to supply and administer specified medicines to a pre-defined group of patients without them having to see a doctor. In order to be able to use the PGD staff had to successfully complete an e-learning module. Instillagel is an anaesthetic antiseptic lubricant used in urinary catheterisation procedures.

A medication error policy was in place. This described the action staff should take and included the Bennion Error Scoring System to monitor and score medication errors. We reviewed a medication error incident which had followed the reporting procedure in the medication error policy.

GPs were responsible for reviewing patients' medication; we observed community staff liaising with GPs when they had concerns about a patient's medication.

## Safety performance

Staff were aware of reporting safety performance but could not describe how this was monitored and the comparison with other similar services.

A monthly dashboard included the number of avoidable pressure ulcers and missed dose incidents. This information was discussed at governance meetings and team meetings.

## Incident reporting, learning and improvement

| Incident Type | Number of Incidents |
|---|---|
| **Medication incident meeting SI criteria** | 1 |
| **Pressure ulcer meeting SI criteria** | 12 |
| **Confidential information leak/information governance breach meeting SI criteria** | 1 |
| **Sub-optimal care of the deteriorating patient meeting SI criteria** | 1 |
| **Core Service Total** | **15** |

Staff understood their responsibilities to raise concerns, to record safety incidents and to report them internally and externally. We were given examples of reporting grade three and four pressure ulcers and medication errors. Staff received varying feedback according to the incident. Pressure ulcer feedback was detailed and staff were involved in the local assurance group. The local assurance group was specifically created to critically analyse the root cause of serious pressure ulcers and involved the tissue viability nurse.

Sharing from incidents was restricted to teams at monthly meetings or learning boards in the offices. However, external safety alerts were shared via emails and team meetings.

Staff had an understanding of the duty of candour and the need to involve patient's families when something went wrong, however, matrons would be asked to support them to do so. We reviewed a serious incident report and saw the completed duty of candour assurance form.

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in Community health services for adults, which met the reporting criteria, set by NHS England between, 1 July 2016 and 30 June2017. Of these, the most common type of incident reported was pressure ulcer meeting SI criteria (80%).

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS.

The Chief Coroner's office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there has been no prevention of future death reports sent to Leicestershire Partnership Trust related to this core service.

### Major incident awareness and training

The single point of access had robust business continuity plans in place in the event of any disruption to the telephony or information technology systems. The business continuity plan was accessible to staff and action cards described what each member of staff should do, including utilisation of mobile phones. The business continuity plans were regularly tested alongside fire evacuation rehearsals.

In the event of adverse weather conditions the trust had plans in place with suitably equipped volunteer drivers to ensure the most serious patients still received care.

The trust participated in the emergency preparedness, resilience and response annual assurance process, they were rated 'substantially compliant' for 2016 – 17.

The trust was also a member of the local resilience forum working with other agencies on major incident responses and taking part in rehearsals.

# Is the service effective?

## Evidence-based care and treatment

Clinical policies and procedures were in line with the national institute of care excellence (NICE) guidance. We reviewed the catheter care policy which was in line with NICE Quality Standard 90, the pressure ulcer prevention and management policy which was in line with NICE Clinical Guideline179 and the guideline for the management of lower limb wounds.

We observed patients in the lower limb clinic having their wounds assessed by the tissue viability nurse. The assessment was carried out according to the trust lower limb pathway. A treatment plan was formulated and the patient was referred back to the district nursing service.

The tools used to assess patients were nationally recognised and based on best practice guidance. For example the Waterlow pressure area risk assessment, the daily living assessment tool and the sepsis screening tool.

We saw in the patient records we reviewed, tools based on best practice guidance were used in the delivery of care, for example SSKIN. SSKIN is a five step model for pressure ulcer prevention.

A recent audit of the care and treatment of pressure ulcers revealed that risk assessments were not being completed consistently and there was poor record keeping. Staff were encouraged to record this information on the Nursing and Midwifery reflective accounts form which allows staff to identify learning. This contributed to the continuing professional developments requirements of the nursing and midwifery council for qualified staff.

The trust has participated in five clinical audits in relation to this core service as part of their Clinical Audit Programme.

| Audit | Audit Type | Date Completed |
|---|---|---|
| **Chronic Obstructive Pulmonary Disease (COPD) re-audit** | Clinical | 05-Jun-17 |
| **Reasons patients decline referral to Pulmonary Rehabilitation within LPT re-audit** | Clinical | 30-Jan-17 |
| **Clinical Car Boot audit** | Clinical | 08-May-17 |
| **T34 Ambulatory Syringe Pump (Syringe Driver) re-audit - Diana Service** | Clinical | 27-Oct-16 |
| **Compliance with Controlled Drugs regulations - Community - QSI45** | Clinical | 09-Mar-17 |

## Nutrition and hydration

Patients' nutritional status was assessed using the malnutrition universal screening tool (MUST). We saw that these had been completed and revised when necessary in the patient records we reviewed. The tool identifies when patients may be at risk of malnutrition or obesity. We heard staff discussing diet and nutrition with patients treated for diabetes.

Community staff could refer patients to the nutrition and dietetics service for advice on nutrition including bariatrics (obesity), weight management or patients receiving home enteral nutrition.

Enteral nutrition is also known as tube feeding and is a way of delivering nutrition directly to the stomach or small intestine.
We observed staff discussing mouth care, hydration and swallowing with care home staff for a patient receiving care in the last days of life.
Leaflets providing information on healthy eating were available in clinic areas.

## Pain relief

Where appropriate staff monitored pain levels through discussion with patients or other staff. They demonstrated an understanding of methods of monitoring pain through scoring systems, body position or patient distress. We saw pain assessment tools completed in patient records.
We observed staff checking patient's pain and discomfort levels during wound dressing changes.
Patients told us that staff always checked if they were comfortable and advised on pain medication particularly prior to changing dressings on painful wounds.

## Patient outcomes

Patient outcomes were not being routinely measured across the service, with the exception of the physiotherapy and occupational therapy services, who used the modified Westcotes individual outcome measures tool. The Westcotes tool is patient goal focused, goals are set with the patient and the outcome of what needs achieving is written in a measurable way for example "Mr/Mrs X will be able to walk around the ground floor of his/her home using a mobilator within 2 weeks". Use of the tool was audited during the period 2016/2017 which identified a list of key actions and gave a re-audit date. Actions included: raising awareness of the tool, staff training and having MWIOM champions.
The service had two commissioning for quality and innovation (CQUIN) standards in place, improving the assessment of wounds (CQUIN ten) and leg ulcer pathway (CQUIN four). A re-audit report of the leg ulcer pathway from April 2016 identified that the level of staff skill and knowledge had improved over the CQUIN year and the standards of care provided were in line with national standards. Recommendations were made within the audit to maintain the improvements.
Unfortunately the trust did not provide more up to date information on progress against the CQUIN standards, or data against the improving the assessment of wounds standard.
A programme of audit was in place for the district nursing service spread across the period 2017/2018. These included: do not attempt resuscitation re-audit; clinical car boot re-audit; improving the assessment of wounds; the management of sharps bins within the community services; community falls audit; secure handling and storage of prescriptions; controlled drugs; pressure ulcer documentation (agency nurses); aseptic technique and urinary catheter care re-audit. Information for June to September 2017, highlighted improvement by staff from east, west and Hinckley hubs in record keeping audits, although, city hubs did not complete the audit.
Staff monitored the patient outcomes for those receiving pulmonary rehabilitation. This was a six-week programme of exercise and education for patients with chronic breathing difficulties. Quality measures highlighted significant improvements in exercise capacity, health related quality of life, anxiety and depression and level of knowledge.

The trust did not participate in the non-mandatory national intermediate care audit.

## Competent staff

| Team | Clinical Supervision Target | Clinical Supervision Delivered | Clinical supervision rate (%) |
|---|---|---|---|
| **313 L6 CHS Business Support Nursing** | 270 | 208 | 77% |
| **313 L6 CHS Charnwood Hub** | 761 | 223 | 29% |
| **313 L6 CHS City East Hub** | 346 | 85 | 25% |
| **313 L6 CHS City West Hub** | 339 | 93 | 27% |
| **313 L6 CHS Community Management** | 28 | 15 | 54% |
| **313 L6 CHS Community Planned West** | 555 | 156 | 28% |
| **313 L6 CHS Community Specialist** | 678 | 246 | 36% |
| **313 L6 CHS Community Therapy City** | 494 | 387 | 78% |
| **313 L6 CHS Community Therapy East** | 463 | 343 | 74% |
| **313 L6 CHS Community Therapy West** | 653 | 469 | 72% |
| **313 L6 CHS County Wide Podiatry** | 579 | 489 | 84% |
| **313 L6 CHS County Wide SALT Service** | 513 | 435 | 85% |
| **313 L6 CHS East Central Hub** | 298 | 111 | 37% |
| **313 L6 CHS East North Hub** | 325 | 156 | 48% |
| **313 L6 CHS East South Hub** | 244 | 119 | 49% |
| **313 L6 CHS Hinckley Hub** | 509 | 243 | 48% |
| **313 L6 CHS ICS** | 1188 | 696 | 59% |
| **313 L6 CHS Long Term Conditions** | 491 | 398 | 81% |
| **313 L6 CHS MSK Physiotherapy** | 714 | 520 | 73% |
| **313 L6 CHS Neuro/Stroke Rehab Service** | 195 | 128 | 66% |
| **313 L6 CHS Palliative Care** | 373 | 313 | 84% |
| **Core Service Total** | **10016** | **5833** | 58% |

Staff told us they were encouraged to identify areas for development during appraisal meetings and that they found the appraisal process useful and supportive.

Most staff were equipped with the knowledge and skills to work effectively. Some senior staff told us that they felt the increase in pressure ulcers was due to increased use of bank and agency staff who did not have the skills to be able to assess skin.

Between 1 July 2016 and 30 June 2017 the average clinical supervision rate for the core service was 58% against the trust's target of 85%.

Between 1 July 2016 and 30 June 2017, 89% of permanent non-medical staff within the community health services for adults core service had received an appraisal compared to the trust target of 80%.

No appraisals data for permanent medical staff was provided by the trust for this core service.

Some staff told us they did not have time to attend formal clinical supervisions sessions but that clinical supervision occurred informally between members of staff and was not recorded. Other staff told us they attended clinical supervision every three months but was a mix of formal and informal sessions. Clinical supervision is an activity that brings skilled supervisors and practitioners together in order to reflect upon their practice, to think about knowledge and skills and how they may be developed to improve care.

Clinical supervision rates were slightly improved against the reporting period of the last inspection, August 2015 to July 2016, 56.7%, July 2016 to June 2017 58%.

One member of staff described receiving a debrief after a difficult situation and how useful it had been.

Two staff we spoke with had completed the district nursing qualification. Some staff felt the risk of being moved to another area put them off completing the qualification. Some staff described finding it hard to attend modules and training due to a reduced availability and staff shortage.

Staff returning from extended periods of leave told us they were able to access refresher training on clinical procedures easily or shadow other members of staff to update their competencies.

Health care assistants told us that staff were given the opportunity to progress to band four support assistants. Previously one member of staff had progressed to her nurse training from this.

| | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| **Core service Total** | **2059** | **1828** | 89% |

Staff we spoke with undertaking specialist roles had undertaken additional training
Single point of access staff reviewed voice recordings of calls they had taken in order to highlight any areas for improvement.
There were inconsistencies in what staff told us about the level of support to new members of staff. One nurse described a four week supernumerary role followed by a normal patient list with very little extra support. Another member of staff described a four week supernumerary period followed by a gradual introduction of a normal patient list, a competency assessment pack and with support available as required. We did not speak to any new members of staff during our inspection to corroborate this information. One nurse told us that a new team member had her supernumerary period extended by a month to give her extra time to build her competencies and confidence.
Bank staff were managed by the bank office and attended the same training and staff meetings as substantive staff.

## Multidisciplinary working and coordinated care pathways

We saw examples of effective multidisciplinary working. The integrated care teams were located in a joint office and planned care and visits collaboratively.
Community teams attended local integrated care meetings to discuss best practice and plan ongoing care. Clinical commissioning group representatives, GPs, social services, council staff, therapists and nursing staff were all present at these meetings.
The integrated health and social care team were multidisciplinary and described how working together produced quicker and better outcomes for the patients.
Community staff worked closely with the local acute hospital to reduce the amount of insulin dependent diabetics requiring community nurse visits. Patients were being discharged from hospital unable to give their own insulin injections.
Primary care co coordinators worked in the emergency departments of the acute hospitals to actively identify patients who could be cared for in the community.
Staff from the community adult mental health services performed joint visits for young people transitioning into adult care, for example, if blood tests were required.
Community staff took time to discuss patients with care home staff to prevent unnecessary visits.
Each patient had a named nurse who had overall responsibility for their care. Patients we spoke with didn't always know the name of their responsible nurse.
Community staff were informed of patients discharged from hospital through the single point of access. Staff told us that care was planned with discharge in mind, if that was appropriate for the patient.

During our inspection we observed joint home visits with the physiotherapist and occupational therapist who worked together to create a shared plan of care for the patient.
The falls team worked closely with local exercise groups to identify suitable patients who would benefit from for example a weekly walking group.
The matrons participated in the integrated leadership teams taking place in Leicestershire. These were compiled of GPs, local authority staff and care home staff and were meeting to identify better ways of working between the services.

### Health promotion

We saw staff discussing diet and self-care with patients during routine visits.
Where possible staff worked with GPs and hospital staff to empowered patients to take responsibility for own care, such as self-administering insulin. Even when the nurses attended to administer insulin staff gave patients the option of performing the tasks.
We observed a falls prevention programme session attended by eight patients. The session included a nutrition quiz and led to discussion about how a healthy diet could improve bone health.
We saw various healthy living leaflets in patient waiting areas.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood the legal requirements of gaining consent including the Mental Capacity Act 2005. We observed staff asking for patient consent before delivering care.
We saw staff ensuring an appropriate do not attempt cardio pulmonary resuscitation record was in place during a visit for care in the last days of life.
There was evidence in the patient records we reviewed that discussions had taken place with patients about mental capacity.
The mental capacity act was included in staff mandatory training. Results demonstrated 86% of community staff had attended training against the trust target of 85%.

## Is the service caring?

### Compassionate care

Care was delivered in a way which maintained patient privacy and dignity. We observed staff in the lower limb clinic maintaining a patient's privacy assessing a leg wound.
The staff we observed delivering care in the community, clinics and the single point of access spoke to patients with kindness and compassion. Patients told us that nurses were always kind. Staff respected patient's home life during visits. Relationships were built between staff, patients and their families.
We saw staff taking time to ask about other family members and any changes in the patient's social circumstances.
The wishes of family members were considered, particularly during distressing times. For example drawing up medication in a clinical room away from the bedside when a family were upset their parent needed constant pain relief.
The friends and family test score across the trust was 97%. Community service scores for May to July 2017, highlighted 98% of patients would recommend the service to friends and family. The friends and family test is a survey measuring patient's satisfaction with the care they have received and asks if they would recommend the service to their friends and family.

### Emotional support

Staff understood the impact of a person's care on their emotional wellbeing, and that of the families. Patients told us they looked forward to the visit from the staff as they were always cheerful and made them feel important.
Patient's enjoyed the friendly relationship they had with staff despite some of the staff 'keeping me in check with what I eat'.
We observed one member of staff calming an agitated patient in a gentle and persuasive manner.
Patient records we reviewed included completed assessments of the patient's psychological and emotional wellbeing.
Staff were able to refer patients and carers to local support groups. The falls team referred patients to local walking groups.

### Understanding and involvement of patients and those close to them

Patients and carers were involved in decisions about their care we witnessed this in patient interactions and saw evidence of this recorded in patient records.
Visits to frail elderly patients were planned when carers would be present, we heard staff talking to carers and giving advice and reassurance.
We saw young people attending nurse clinics and having time to discuss the impact of their condition on their work and planning appointments that would have the least impact on their work commitments.
Time was taken to involve patients as partners in their care. Patients were listened to when discussing care and their preferences.
Community therapists involved patients in setting their own goals, this meant that patients understood what they were trying to achieve and improved their motivation to achieve it.

## Is the service responsive?

### Planning and delivering services which meet people's needs

The trust worked closely with commissioners, stakeholders and other providers to plan and deliver integrated health and social care. An example of this was the Rutland integrated health and social care service which had improved the provision of care packages for patients leading to care being organised more quickly and better patient outcomes.
Care was planned according to the patients need, for example the intensive community support team could deliver care seven days per week for up to ten days until the patient was well enough to be transferred to the community nurse caseload or discharged.
Community teams were based in hubs which were geographically planned to meet the needs of patients and meant the same staff visited patients in that location.
Therapists and nurses planned and performed visits together to provide joined up care for patients.
Patients had access to specialist nurses and therapists. Specialisms were planned based on patient demographics and disease prevalence, for example tissue viability nurse, diabetes nurse, chronic obstructive pulmonary disease therapist and a musculo-skeletal physiotherapist.
Interpreters and translation services were available for patients whose first language was not English. We saw details of these on staff notice boards with instructions on how to contact the service and we observed a single point of access member of staff arranging an interpreter for a patient.

## Meeting the needs of people in vulnerable circumstances

Care plans and electronic notes identified patient's needs particularly those in vulnerable circumstances.
The trust had systems in place to support people who were visually impaired or hard of hearing. For people with visual impairments information could be provided in large print, audio recording or in Braille. For people with hearing loss a British sign language signer could be arranged.
All premises we visited had wheelchair access and designated toilets with wheelchair access.
Staff told us they completed vulnerable adults risk management forms for at risk patients who had capacity but were deemed unsafe. The risk assessment resulted in an action plan which usually involved referral to other agencies for social care support.
Specialist nurses liaised with other community staff to make sure the needs of patients living with a long term condition were understood and that care was planned accordingly.

## Access to the right care at the right time

- All referrals to community adult services were made through the single point of access a small telephone contact centre manned by specially trained staff. The single point of access operated from 07.30 am to 9.30 pm seven days a week and took calls from all health and social care staff, patients and carers. Between 07.30 am to 9.30 pm calls were managed by a GP out of hours service. All calls to the single point of access and the GP out of hours service were recorded.
- Pre-recorded telephone messages and filters were in place to ensure the most urgent calls were given priority, for example, a person wanting to cancel or change an appointment would be a lower priority than someone in pain with a blocked catheter.
- The single point of access had set of targets for answering the call within 30 seconds and less than five percent abandoned calls. Abandoned calls are when the caller terminates the call before it is answered usually because of a long wait. In August 2017, during 3760 hours of call answering, ten calls were re-queued due to not being answered on the first call. This was within acceptable levels for contact centre performance.
- Calls were transferred to the community nursing teams though an electronic system. The trust had a two hour response time from referral to home visit for palliative care patients and patients with a blocked catheter. There was also a same day and routine visit outcome. Staff told us they did not know if they were achieving this target as they did not see any data or get any feedback in relation to this.
- The trust was unable to supply validated information on response times of unplanned care for community nursing services.
- Staff contacted patients following referral from the single point of access to ascertain the best time to visit and check on any access issues.
- We visited a falls clinic. We were told and saw evidence of how the waiting time from initial referral to assessment had improved significantly. Previously all patients referred to the falls clinic were first seen by a medical consultant this was creating a bottleneck resulting in lengthy waiting times. Falls staff implemented a triage system and found that a large proportion of patients did not need to see the consultant.
- Clinic appointments could be accessed electronically which enabled staff to allocate an appointment to a patient easily.
- Occasionally visits or appointments were cancelled or rearranged in order to manage more urgent unplanned visits as they occurred. Only patients of low acuity had appointments

cancelled, they received a phone call from community staff with a rearranged visit or appointment time.

- Continence staff ran clinics and home visits according to patient needs. At times visits were performed by and in conjunction with nursing staff to suit the patient needs.
- Patients could attend appointments in one of several locations. We heard a patient organising her appointments according to transport arrangements and family circumstances.
- Waiting times for appointments to physiotherapy services and the continence clinic had improved since the last inspection. At the last inspection patients with chronic back pain were waiting between 20 to 26 weeks to be seen by the musculoskeletal physiotherapy service and patients were waiting 46 weeks to be seen by the continence service.
- The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'. No targets have been provided by the trust.

| Service Type | Days from referral to initial assessment | Days from assessment to treatment |
|---|---|---|
| | Actual (median) | Actual (median) |
| **Integrated Therapy and Nursing** | 9 | 9 |
| **Intensive Community Support** | 1 | 1 |
| **Heart Failure Service** | 29 | 28 |
| **Primary Care Coordinators** | 0 | 2 |
| **The Falls Clinic Program** | 46 | 32 |
| **Continence Nursing Service** | 51 | 28 |
| **Older Persons Unit** | 3 | 0 |
| **Respiratory Specialist Service** | 13 | 37 |
| **Reablement** | 9 | 9 |
| **Oxygen Service** | 59 | 46 |
| **Stroke & Neuro** | 77 | 15 |
| **Peaker Park** | 2 | 1 |
| **Residential Reablement** | 2 | 1 |
| **Care Home Project** | 21 | 9 |
| **Physiotherapy** | 35 | 18 |
| **Occupational Therapy** | 4 | 6 |
| **Podiatry** | 27 | 50 |
| **Speech Therapy** | 8 | 15 |

## Learning from complaints and concerns

Staff were aware of the complaints procedure, learning from complaints was shared in team meetings. Patients we spoke with did not have any need to complain, but said they would call the single point of access if they had a concern. They appreciated that in their experience, these calls were always dealt with when concerns were raised.

Patients were encouraged to give feedback on the care they received via surveys. The integrated care team always asked patient to complete a feedback form when they were discharged from the service. Patients regularly said in feedback that they would like more information on the timing of home visits. The integrated care team improved communication with patients so they knew approximately what time to expect the visit.

We saw outcomes from complaints involving better assessment of patient needs prior to therapy appointments, assurance that attempts will be made to achieve continuity of care, and prompts for staff to communicate visit times with patients.

Complaints leaflets were available in easy read/large print and included information about the patient advice and liaison service.

Community adult services received 81 complaints between 1 July 2016 and 30 June 2017. The main complaints themes were: all aspects of clinical treatment (48), attitude of staff (11) and appointments, delay/cancellation (outpatient) (10).

| Team | Total Complaints | Most common Theme |
|---|---|---|
| New Parks Health Centre | 10 | All aspects of clinical treatment (6) |
| Market Harborough District Hospital | 6 | All aspects of clinical treatment (5) |
| Braunstone HSCC | 4 | All aspects of clinical treatment (3) |
| Loughborough Hospital | 4 | All aspects of clinical treatment (2) |
| The Warrens | 4 | All aspects of clinical treatment (2)<br>Attitude of staff (2) |
| Uppingham Road Health Centre | 4 | All aspects of clinical treatment (3) |
| Westcotes Health Centre | 4 | All aspects of clinical treatment (2) |
| Charnwood Mill | 3 | Communication / information to patients (written and oral) (2) |
| Coalville Hospital | 3 | All aspects of clinical treatment (1)<br>Appointments, delay / cancellation (outpatient) (1)<br>Attitude of staff (1) |
| Hinckley & Bosworth Community | 3 | All aspects of clinical treatment (3) |
| Merlyn Vaz HSCC | 3 | All aspects of clinical treatment (2) |
| Pasley Road Health Centre | 3 | Other (2) |
| South Wigston Health Centre | 3 | All aspects of clinical treatment (2) |
| Beaumont Leys Health Centre | 2 | Attitude of staff (1)<br>All aspects of clinical treatment (1) |
| Bennion Centre | 2 | Attitude of staff (2) |
| Hinckley And District Hospital | 2 | All aspects of clinical treatment (1)<br>Attitude of staff (1) |
| Hinckley Health Centre | 2 | Appointments, delay / cancellation (outpatient) (2) |
| Leicester General Hospital | 2 | All aspects of clinical treatment (1)<br>Attitude of staff (1) |
| Lutterworth Health Centre | 2 | All aspects of clinical treatment (1)<br>Appointments, delay / cancellation (outpatient) (1) |
| Melton Mowbray Hospital | 2 | All aspects of clinical treatment (2) |
| OSL House | 2 | All aspects of clinical treatment (2) |
| Agnes Unit | 1 | All aspects of clinical treatment |
| Bradgate Unit | 1 | All aspects of clinical treatment (1) |
| Cameron Statsny House | 1 | All aspects of clinical treatment (1) |
| Evington Centre Community Beds | 1 | All aspects of clinical treatment (1) |
| Neville Centre | 1 | Appointments, delay / cancellation (outpatient) (1) |
| Overton House | 1 | Attitude of staff (1) |
| Rushey Mead Health Centre | 1 | All aspects of clinical treatment (1) |
| Rutland Memorial Hospital | 1 | All aspects of clinical treatment (1) |
| St Matthew's H&CC | 1 | All aspects of clinical treatment (1) |
| Syston Health Centre | 1 | All aspects of clinical treatment (1) |

| | | |
|---|---|---|
| Westcotes House | 1 | Failure to follow agreed procedures (1) |
| **Core service Total** | 81 | **All aspects of clinical treatment (48)** |

Community health services for adults received forty-five compliments between 1 June 2016 and 31 May 2017, which accounted for 17% of all compliments received by the trust as a whole.

# Is the service well-led?

## Leadership

During our inspection we saw that senior managers were visible in the clinics and community nurse bases we visited. Most staff told us that senior managers were well known to them and available for advice and support, however they told us that they were not so familiar with board level managers.

We spoke with a variety of staff who described positively the support they had received from management to allow flexible working to suit family commitments/domestic arrangements, whilst other staff described feeling unsupported.

The new appointment of matrons had meant they were more accessible to staff. Matrons were described as approachable and had an open door policy. We saw a good working relationship between senior staff and all teams.

The matrons and senior nursing staff were currently taking part in a leadership development programme. It was hoped that this would allow them to develop the workforce.

Matrons we spoke with understood that staffing, visits, recruitment and retention were a challenge throughout the service and were working with senior managers through the transformation programme and recruitment plans to address them.

The use of county staff to support the city teams was perceived as a positive approach to staffing issues, and staff did not appear concerned at being asked to work in other regions. They told us it improved their understanding of the demands in other areas.

Team meetings and the attendance at the meetings was inconsistent across the service. We saw the minutes of a team meeting held June 2017. The agenda was based on the five Care Quality Commission key questions of safe, effective, caring, responsive and well led. The agenda reflected current issues for the service and feedback on incidents, staff training, staffing and the risk register.

## Vision and strategy

The trust had a clear simple vision statement and values of respect, integrity, compassion and trust which had been developed collaboratively with staff members.

The trust strategic objectives were realistic and in line with projects and developments described to us by senior managers and the transformation programme. For example partnering with others to deliver the right care in the right place at the right time and working with the local sustainability and transformation partnership.

Some staff were able to describe the trust's vision and values.

## Culture

Staff described an open and honest working culture. They told us they felt able to raise concerns and made reference to the whistle blowing policy. We saw a recent whistle blowing

action plan which detailed additional training for senior members of staff on how to develop strategies to support staff. Staff told us the freedom to speak up guardian had visited the hubs following the whistle blowing incident.

Staff had access to, and were aware of, the staff counselling and psychological support service.

Most staff told us they had regular 121 meetings with managers and annual appraisals. Career development was discussed at the appraisal meeting and staff were encouraged to develop within their roles. We spoke with several staff who had progressed in their job by attending further training.

Staff described a divide between working in the county and the city. Pressures, workload and morale were impacted by vacancies and staff sickness. The use of bank and agency staff improved the numbers, but the pressures these staff brought was also having an impact. In the county hubs, staff described workloads as improving.

The trust held a dedicated staff committee to look at staff support mechanisms and most staff told us they felt supported.

We reviewed the lone worker policy dated January 2015. The service had processes in place to keep staff safe. In remote rural areas staff had a special number they could ring if they felt concerned about their safety; this resulted in police attendance within ten minutes. All staff had a text buddy who would check on their safety. However staff in some teams were unaware of the lone worker policy.

Mandatory training included conflict resolution; the service reported a 97% attendance against a target of 85%.

Through our observations of staff and patients it was clear that staff had a focus on supporting patients in their own homes. Community staff encouraged patients to self-care whenever possible to promote independence.

## Governance

Community adult services had a clear governance structure led by a director. The newly appointed matrons and introduction of the senior district nurse post and complex care manager had not yet fully embedded so some staff were unable to describe the structure.

Each hub held self-governance meetings that covered topics such as incidents, complaints and results of audits. Action points from these meetings were escalated to the trust clinical governance meeting and information from the clinical governance meeting was relayed to staff.

A nursing dashboard had been introduced which showed monthly data on a range of topics such as staffing, sickness, complaints, incidents and pressure ulcers for each community nursing team. This allowed matrons and managers to review and benchmark the data to identify areas for improvement or further development. However, the service did not have robust processes and information to manage current and future performance in particular planning community nurse workloads and measuring response times to unplanned care. The service did not have robust processes in place to measure patient outcomes so could not assure itself of the quality of care being delivered. Information to drive service improvement was not robust.

## Management of risk, issues and performance

Matrons in the hub were responsible for different aspects of the risk register. Due to the new appointments at the time of our visit, this was in its infancy with some risks only recently added. These included hand hygiene assessments and assurance around the audit process, staffing

and compliance with clinical supervision. These were relevant to operational issues in the service at the time of the inspection.

Matrons produced a monthly quality and highlight report based on the Care Quality commissions five key questions of safe, effective, caring, responsive and well led. The report was reviewed at meetings with senior managers. This meant senior managers had an overall picture of community nursing services and could in turn highlight any emerging trends to the trust governance group.

Managers acknowledged that recruiting staff to the service was a challenge. Actions to address this risk area included attending job fairs, continuous advertising, upskilling health care assistants, trying to reduce numbers of low level tasks and introducing assistive technology for the administration of medicines. For example health care assistants were being trained to give insulin injections.

The electronic record system used by community staff to record patient information and by the single point of access to transfer information to nursing teams about new patients was not able to report on the response times for patient visits. Managers told us that changes needed to be made to the system but that they were monitoring incidents and complaints through the governance meetings and were not seeing any increasing trends for poor response times.

It was difficult to ascertain a true picture of the average number of visits each member of staff had per day. Staff gave us different numbers, we were told the daily situation report (sitrep) was not accurate and some of the visits were of a low acuity. For example in one area 40% of the daily visits were to administer insulin injections.

We saw that relevant topics were discussed at board level from the board meeting minutes we reviewed. These included learning from incidents, engaging with staff and patients, complaints and patient feedback and a review of the corporate risk register.

## Information management

Mandatory training for staff included an annual session on information governance, the compliance for information governance training as of 30 June 2017 was 90%.

Most patient information was stored electronically on secure password protected systems. A brief outline of the patient care plan was kept in the patient's home although this was inconsistent.

Staff printed a work list for the day and shredded this at the end of their shift.

Information included on the tough laptops was kept secure and staff could only access records via the secure network.

Information to support staff such as policies and procedures was available on the trust intranet.

The trust used emails as one of the methods of communication with staff.

Staff had access to information about the service, we saw this in the minutes of meetings we reviewed and on notice boards. Staff told us they did not always have time to attend meetings or read the minutes.

We saw examples of where information was being used for service improvement, for example an increase in catheter urinary tract infections had led to the continence team carrying out further investigations and producing an action plan to reduce the number of infections.

Managers told us the information available from the electronic patient record system could not be validated and the system needed upgrading.

## Engagement

- The trust had a variety of mechanisms to engage with staff, newsletters, but some groups of staff did not feel engaged with the changes and developments taking place. Staff satisfaction

was mixed. Staff did not always feel actively engaged or empowered. There were teams working in silos, management and clinicians did not always work cohesively.

- Managers told us that the service was in phase two of a three year transformation programme. The transformation programme was developed following consultation with staff and patients and from trends in complaints and patient feedback. Staff were invited to the transformation programme work stream meetings but they told us they rarely had time to attend.
- Some staff told us that senior managers implemented changes without understanding the full impact this had community staff, for example the type of tasks allocated to the assistant practitioners had changed resulting in the registered nurses picking up extra work. However other groups of staff told us the changes to the staffing structure had been an improvement and had resulted in greater sharing of workloads.
- Managers told us that in response to feedback from staff that they were not able to take their allocated breaks, guidance titled 'fifty ways to take a break' had been produced. From this there was a 'No eating at desks' rule in some hubs which had prompted positive feedback from staff.
- The service performed quarterly staff pulse checks to monitor staff satisfaction. Results for September 2017 highlighted worse than expected results from staff being able to deliver the care they aspired to (59 out of 169 responses could not), and the level of support available from managers (70 out of 169 felt supported). Despite these areas of concerns all scores across the survey had improved from the previous quarter.

## Learning, continuous improvement and innovation

- NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.
- The teams within this core service have not participated in any accreditation schemes.
- Staff recognition schemes were in place in the form of monthly awards and a yearly 'Celebrating excellence award'. We saw an example of staff receiving an award and congratulations for their work on integrated teams.
- The trust was working with local commissioners towards one integrated point of access for health and social care services as part of sustainability and transformation planning.
- The service had two commissioning for quality and innovation (CQUIN) standards in place, improving the assessment of wounds CQUIN ten and leg ulcer pathway CQUIN four. The trust did not provide up to date information on progress against the standards.
- The service was committed to improving leadership skills in order that staff were managed more effectively.
- The trust was attempting to implement the care hours per patient day programme for community adult services in order to benchmark with other community health service trusts. However this was proving challenging due to the varying ways different trusts collected information. It was anticipated that this work would not be complete until 2018.

# Mental health services

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

## Facts and data about this service

| Location site name | Ward name | Number of beds | Patient group (male, female, mixed) |
|---|---|---|---|
| Bradgate Mental Health Unit | Aston Ward | 23 | Female |
| Bradgate Mental Health Unit | Ashby Ward | 21 | Female |
| Bradgate Mental Health Unit | Beaumont Ward | 22 | Mixed |
| Bradgate Mental Health Unit | Bosworth Ward | 20 | Male |
| Bradgate Mental Health Unit | Heather Ward | 18 | Female |
| Bradgate Mental Health Unit | Thornton Ward | 24 | Male |
| Bradgate Mental Health Unit | Watermead Ward | 20 | Mixed |
| Bradgate Mental Health Unit | PICU | 10 | Male |

## Is the service safe?

**Safe and clean environment**

**Safety of the ward layout**

The trust had undertaken recent (from 11 May 2017 onwards) ligature risk assessments at eight locations. All wards had a ligature risk assessment undertaken in the last 12 months.

Five of the wards presented a high level of ligature risk due to ligatures and ligature points that could, potentially, be used by patients to self-harm and three wards presented a lower risk due.

The trust has introduced a door handle replacement programme across the unit, which commenced on 24 July 2017, to mitigate ligature risks. Staff completed individual patient risk assessments, searching property and the use of increased staff observations of patients who presented as high risk. Staff locked some rooms when not in use and maintained a presence in patient areas. Staff had access to ligature cutters in all areas in the event of an emergency occurring. The trust had installed mirrors in some areas to aid staff's observation of patients. However, wards continued to have blind spots where staff could not easily observe patients. Staff managed this by maintaining a presence in the clinical areas.

Over the 12 month period from 1 July 2016 to 30 June 2017 there were 21 mixed sex accommodation breaches within this core service: 14 on Watermead Ward, four on Aston Ward and three on Beaumont Ward. There were three incidents due to urgent admission of female patient allocated a bedroom within opposite sex corridor to enable admission and 11 for

male patients. At the time of the inspection the two mixed sex wards had been designated as single sex. When we inspected wards complied with the Department of Health and Mental Health Act 1983 guidance on mixed sex accommodation.

Staff had access to personal alarms for use in an emergency.

The psychiatric intensive care unit was a ten bedded, purpose built unit, accepting only male patients. The unit consisted of large open areas with good visibility for staff. Staff could see patients in communal corridors from the ward office and staff were visible in patient areas to maintain a safe environment.

**Maintenance, cleanliness and infection control**

Ward areas were visibly clean except on Ashby ward where we found dust and dirt in the clinic room and on the floor near the ward kitchen door. The shower had been out of order for four weeks, staff had reported this to the maintenance department, however, at the time of inspection it had not been repaired. This meant there was only one shower for 20 patients. The cold water fountain on Aston ward had been out of order for four weeks. This had also been reported to the maintenance department and had not been repaired at the time of the inspection.

Staff had access to protective personal equipment, such as gloves and aprons in accordance with infection control practice. Posters advising staff of the principles of effective handwashing techniques were on display on all wards.

The shower on Ashby ward had been out of order for four weeks which left one shower and one bathroom for 20 patients. Staff said they had reported this but it had not been repaired.

The acoustics were loud on Belvoir ward, one patient said the ward was very noisy. The unit was generally clean and tidy, however some walls were scuffed. Staff told us the cleaning services were generally good.

Belvoir ward had two extra care beds within a separated area. Staff nursed patients who required extra support in these rooms. A large de-escalation room was available for staff to support patients in a safe environment.

The trust supplied data relating to the patient led assessments of the care environment (PLACE) scores for cleanliness, condition appearance and maintenance, dementia friendly and disability. PLACE assessments are self-assessments undertaken by NHS and private/ independent health care trusts, and include at least 50% members of the public (known as patient assessors).
Bradgate Unit scored better than the similar trusts for one of the four aspects overall. Bradgate Unit received a scored worse than other similar trusts for three of the four aspects scoring 93.2% compared to 97.8% nationally including cleanliness, condition appearance and maintenance ( 88.6%% compared to 94.5% nationally) and disability (82.4% compared to 82.4% nationally).

| Site name | Core service(s) provided | Cleanliness | Condition appearance and maintenance | Dementia friendly | Disability |
|---|---|---|---|---|---|
| Bradgate Unit | Acute wards for adults of working age and psychiatric intensive care units<br>MH - Mental health crisis services and health-based places of safety<br>MH - Forensic inpatient/secure wards<br>MH - Wards for older people with mental health problem | 93.2% | 88.6% | 92.3% | 82.4% |
| Trust overall | | **94.8%** | **86.2%** | **78.4%** | **79.4%** |
| England average (Mental health and learning disabilities) | | **97.8%** | **94.5%** | **82.9%** | **84.5%** |

### Seclusion room

There were seclusion rooms on Watermead, Ashby, Belvoir and Aston wards which allowed clear observation, two way communications, had access to toilet facilities and a clock. The seclusion room on Bosworth ward did not have en-suite toilet facilities; however there was a toilet in an adjacent room.

Aston, Beaumont and Thornton wards did not have seclusion facilities which meant patients were transferred to alternative wards if seclusion was required.

### Clinic room and equipment

Wards had fully equipped clinic rooms with examination couches and accessible resuscitation equipment, which staff checked regularly. Emergency drugs were available, staff completed regular checks, and recorded these appropriately. Clinic rooms varied across the service. For example, clinic rooms on Ashby, Bosworth and Aston wards were small; however, the clinic rooms on Beaumont and Watermead wards were spacious.

Staff maintained equipment; stickers were in place specifying when it had been cleaned.

## Safe staffing

### Nursing staff

Substantive – how many staff in post currently.
Establishment – substantive plus vacancies, e.g. how many they want or think they need in post.

| Substantive staff figures | | | Trust target |
|---|---|---|---|
| Total number of substantive staff | At June 2017 | 279.5 | N/A |
| Total number of substantive staff leavers | 1 July 2016 -30 June 2017 | 20.7 | N/A |
| Average WTE* leavers over 12 months (%) | 1 July 2016 -30 June 2017 | 7.2% | 10% |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) | Vacancy data could not be provided | N/A | N/A |
| Total vacancies overall (%) | Vacancy data could not be provided | N/A | N/A |
| Total permanent staff sickness overall (%) | At June 2017 | 7.1% | 4.5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Establishment levels nursing assistants (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Number of vacancies, qualified nurses (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Number of vacancies nursing assistants (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Qualified nurse vacancy rate | Vacancy data could not be provided | N/A | N/A |
| Nursing assistant vacancy rate | Vacancy data could not be provided | N/A | N/A |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified and unqualified nurses) | 01 July 2016 to 30 June 2017 | 22,944 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (qualified and unqualified nurses) | 01 July 2016 to 30 June 2017 | 4424 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (qualified and unqualified nurses) | 01 July 2016 to 30 June 2017 | 1578 | N/A |

*Whole Time Equivalent

The trust had advised they were unable to provide establishment or vacancy data by ward/team due to restrictions with the finance system. The most amount of detail held centrally is at provider level by profession.

However, the provider sent through additional data prior to the inspection on the core services which were being inspected. Staff vacancy rates were variable across this service. Ashby ward reported the highest qualified nurse vacancy rate at 50% and Aston ward the lowest with no vacancies. Beaumont ward reported the highest number of unqualified vacancies at 22% and Thornton and Ashby ward had no vacancies. The overall vacancy rate was 23.4%.

Managers calculated the number of staff required to cover shifts, the staffing rotas showed there was the appropriate number of staff on each shift. However, unqualified staff were used to achieve the numbers required when the trust were unable to book qualified staff. Ward matron's reported that they were able to adjust staffing levels to take account of increased clinical need.

Between 1 July 2016 and 30 June 2017, bank staff filled 17,452 shifts to cover sickness, absence or vacancy for qualified nurses and unqualified nurses. The trust was unable to provide a breakdown detailing how this was split between qualified and unqualified nurses.

In the same period, agency staff covered 4000 shifts and 1337 (6%) of shifts were unable to be filled by either bank or agency staff. Staff said that wherever possible they booked staff who were familiar with the ward.

We saw that a qualified nurse was often in the communal areas of the wards, and a healthcare support worker was present in the communal areas at all times

Staffing levels allowed for patients to have regular one to one time with their named nurse, patients we spoke with said that one to one time, activities or escorted leave was rarely cancelled but sometimes was rearranged due to staffing issues.

Staffing levels were sufficient to carry out physical interventions including increased observation levels.

| Ward | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| **313 L6 AMH ICL Bradgate Wards** | N/A | 17452 | 4000 | 1337 |
| **Core service total** | N/A | 17452 | 4000 | 1337 |
| **Trust Total** | **N/A** | **63748** | **27674** | **8312** |

***Percentage of total shifts

**Sickness, turnover and vacancies[1] (Internal use only - Remove before publication)**

The sickness rate for this core service was 7.2% between 1 July 2016 and 30 June 2017 and was at 7.1% in June 2017.

This service had 20.7 staff leavers between 1 July 2016 and 30 June 2017.

The trust had advised they were unable to provide vacancy data by ward/team due to restrictions with the finance system. The most amount of detail held centrally is at provider level by profession. However, data obtained whilst on inspection showed a vacancy rate of 24.3% for the service, 12% for qualified staff and 15.5% for unqualified staff.

| Ward/Team | Substantive staff | Substantive staff Leavers | Average % staff leavers | Total % vacancies | Total % staff sickness (As of June 2017) | Ave % permanent staff sickness (over the past year) |
|---|---|---|---|---|---|---|
| 313 0340 Bosworth Ward - Bradgate Unit | 21.2 | 0.0 | 0.0% | N/A | 4.6% sickness provided as an all Bradgate wards figures | 6.4% sickness provided as an all Bradgate wards figures |
| 313 0820 Medical Staffing - Bradgate Unit | 5.9 | 0.0 | 0.0% | N/A | 4.6% sickness provided as an all Bradgate wards figures | 6.4% sickness provided as an all Bradgate wards figures |

[1] Turnover Analysis

| | | | | | | |
|---|---|---|---|---|---|---|
| Inpatients | | | | | | |
| 313 0940 Thornton Ward - Bradgate Unit | 24.0 | 0.8 | 3.2% | N/A | 4.6% sickness provided as an all Bradgate wards figures | 6.4% sickness provided as an all Bradgate wards figures |
| 313 0945 Bradgate Wards 15/16 CIP | 0.0 | 0.0 | 0.0% | N/A | 4.6% sickness provided as an all Bradgate wards figures | 6.4% sickness provided as an all Bradgate wards figures |
| 313 0950 Watermead Ward (Bradgate Unit) | 20.7 | 0.0 | 0.0% | N/A | 4.6% sickness provided as an all Bradgate wards figures | 6.4% sickness provided as an all Bradgate wards figures |
| 313 0955 Psychotherapy Bradgate | 0.0 | 0.0 | 0.0% | N/A | 4.6% sickness provided as an all Bradgate wards figures | 6.4% sickness provided as an all Bradgate wards figures |
| 313 1850 Beaumont Ward - Bradgate Unit | 18.7 | 3.1 | 14.7% | N/A | 4.6% sickness provided as an all Bradgate wards figures | 6.4% sickness provided as an all Bradgate wards figures |
| 313 2370 Aston Ward (Bradgate Unit) | 20.8 | 0.0 | 0.0% | N/A | 4.6% sickness provided as an all Bradgate wards figures | 6.4% sickness provided as an all Bradgate wards figures |
| 313 2410 Ashby Ward (Bradgate Unit) | 20.8 | 2.0 | 9.9% | N/A | 4.6% sickness provided as an all Bradgate wards figures | 6.4% sickness provided as an all Bradgate wards figures |
| 313 1860 Belvoir Psychiatric Intensive Care Unit | 33.7 | 1 | 3.3% | N/A | 4.6% sickness provided as an all Bradgate wards figures | 6.4% sickness provided as an all Bradgate wards figures |
| Heather Ward | 19.4 | 1.5 | 7.4% | N/A | 4.6% sickness provided as an all Bradgate wards figures | 6.4% sickness provided as an all Bradgate wards figures |
| Core service total | 185.2 | 8.4 | 4.4% | N/A | 4.6% sickness provided as an all Bradgate wards figures | 6.4% sickness provided as an all Bradgate wards figures |
| Trust Total | 4656.9 | 558.9 | 12.6% | N/A | 4.5% | 5.2% |

The table below covers staff fill rates for registered nurses and care staff during May 2017, April 2017 and March 2017.

Nearly all wards had too many care staff for all day and night shifts across the three months.

Beaumont ward was consistently under staffed for all the months for nursing shifts during the day however; the fill rates have been gradually improving across the three months.

Key:

| > 125% | < 90% |
|---|---|

| | Day | | Night | | Day | | Night | | Day | | Night | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff | Nurses | Care staff |
| | May 2017 | | | | April 2017 | | | | March 2017 | | | |
| Ashby | 91.0% | 146.3% | 100.0% | 200.0 % | 85.0% | 170.0% | 103.3% | 246.7 % | 90.9% | 171.8% | 110.0% | 293.5% |
| Aston | 91.4% | 146.8% | 98.4% | 264.5 % | 93.8% | 134.5% | 100% | 236.7 % | 89.2% | 141.1% | 101.6% | 261.3% |
| Beaumont | 89.8% | 178.2% | 100.0% | 283.9 % | 87.8% | 170.8% | 106.8% | 280.0 % | 77.4% | 279.0% | 106.5% | 522.6% |
| Belvoir Unit | 106.6% | 242.3% | 148.4% | 247.6 % | 108.0% | 238.1% | 103.3% | 237.5 % | 98.4% | 319.4% | 103.2% | 325.8% |
| Bosworth | 91.4% | 138.7% | 101.6% | 164.5 % | 96.6% | 138.7% | 103.3% | 200.0 % | 89.2% | 177.4% | 101.6% | 47.0% |
| Heather | 100.0% | 130.1% | 103.2% | 164.5 % | 104.2% | 135.0% | 100% | 193.3 % | 95.2% | 122.6% | 100.0% | 41.5% |
| Thornton | 100.5% | 133.1% | 100.0% | 280.6 % | 95.6% | 130.0% | 108.3% | 260.0 % | 92.5% | 151.6% | 95.2% | 31.0% |
| Watermead | 107.1% | 187.9% | 93.5% | 322.6 % | 95.6% | 204.2% | 105.1% | 296.7 % | 97.3% | 161.3% | 100.0% | 44.4% |

## Medical staff

The service had adequate medical cover day and night. This ensured a doctor could attend the wards quickly in an emergency.

## Mandatory training

The compliance for mandatory training courses as of 30 June 2017 was 87%. Of the training courses listed nine failed to achieve the trust target of 85% (exception of 95% for information governance training) and of those one failed to score above 75%. This module was Display Screen Equipment with 68%.

Compliance for one out of 24 modules was below 75% training (4% of all modules).

Key:

| *Below CQC 75%* | Between 75% & Trust Target | **Above Trust Target** |
|---|---|---|

| | |
|---|---|
| **Service** | AMH ICL Bradgate Wards |
| **Core service** | MH - Acute wards for adults of working age and psychiatric intensive care units. |
| **Total number of staff** | 228 |
| **(Core Mandatory) Conflict Resolution - 3 Years** | 96.50% |
| | (220/228) |
| **(Core Mandatory) Display Screen Equipment (DSE) - Once** | *67.50%* |
| | (154/228) |
| **(Core Mandatory) Equality, Diversity & Human Rights - 3 Years** | 96.50% |
| | (220/228) |

| | |
|---|---|
| (Core Mandatory) Fire Safety Awareness - 1 Year | 78.10% |
| | (178/228) |
| (Core Mandatory) Health, Safety & Welfare - 3 Years | 95.60% |
| | (218/228) |
| (Core Mandatory) Infection Prevention & Control - Level 1 - 3 Years | n/a |
| | n/a |
| (Core Mandatory) Information Governance - 1 Year | 86.00% |
| | (196/228) |
| (Core Mandatory) Moving & Handling - Level 1 - 3 Years | 94.30% |
| | (215/228) |
| (Core Mandatory) Safeguarding Adults - Level 1 - 3 Years | 93.90% |
| | (214/228) |
| (Core Mandatory) Safeguarding Children - Level 1 - 3 Years | 93.90% |
| | (214/228) |
| (Clinical Mandatory) Adult Basic Life Support - 1 Year | 79.70% |
| | (94/118) |
| (Clinical Mandatory) Adult Immediate Life Support - 1 Year | 79.10% |
| | (87/110) |
| (Clinical Mandatory) Safeguarding Adults - Level 2 - 3 Years | 89.50% |
| | (204/228) |
| (Clinical Mandatory) Safeguarding Children - Level 2 - 3 Years | 88.20% |
| | (201/228) |
| (Clinical Mandatory) Mental Capacity Act - 3 Years | 93.40% |
| | (213/228) |
| (Clinical Mandatory) Moving & Handling - Level 2 - 2 Years | 86.20% |
| | (169/196) |
| (Clinical Mandatory) MAPA Disengagement Skills - 3 Years | 100.00% |
| | (31/31) |
| (Clinical Mandatory) MAPA Holding Skills (High Risk) - 1 Year | 85.30% |
| | (162/190) |
| (Clinical Mandatory) MAPA Holding Skills (Medium Risk) - 1 year | 80.00% |
| | (4/5) |
| (Clinical Mandatory) Record Keeping & Care Planning - 2 Years | 79.40% |
| | (181/228) |
| (Clinical Mandatory) Infection Prevention & Control - Level 2 - 2 Years | 76.30% |
| | (174/228) |
| (Clinical Mandatory) Hand Hygiene - 2 Years | 88.60% |
| | (202/228) |
| (Clinical Mandatory) Medicines Management - 2 Years | 91.20% |
| | (103/113) |
| (Clinical Mandatory) Mental Health Act for Nurses - 3 Years | 84.10% |
| | (95/113) |

## Assessing and managing risk to patients and staff

### Assessment of patient risk

We reviewed 34 care records. Staff used a recognised risk assessment tool. Each patient had an individualised risk assessment which was completed on admission and updated on a regular basis.

### Management of patient risk

Staff were aware of and dealt with specific risk issues, for example they provided specialist equipment to meet the needs of a patient who was physically frail.

Staff identified and recorded changing risks on the risk assessment form in the electronic care record.

There were no blanket restrictions in place in this service.

Staff did not adhere to best practice in implementing the smoke free policy on some wards. We saw evidence that patients were smoking in the garden area on some wards. However; we saw that patients were offered the use of electronic cigarettes.

**Use of restrictive interventions**

This core service had 561 incidents of restraint (on 244 different service users) and 367 incidents of seclusion between 1 July 2016 and 30 June 2017.
Over the 12 months, there was an increase in the incidence of seclusion and a decrease in the incidence of restraint.
The table below focuses on the last 12 months' worth of data: 1 July 2016 and 30 June 2017.
Staff reported that they used restraint only after de- escalation had failed.
We reviewed eight rapid tranquilisation records. Staff had completed seven out of eight physical health monitoring records of patients following rapid tranquilisation. The trust's policy for rapid tranquillisation was not in line with national institute for health and care excellence guidelines.

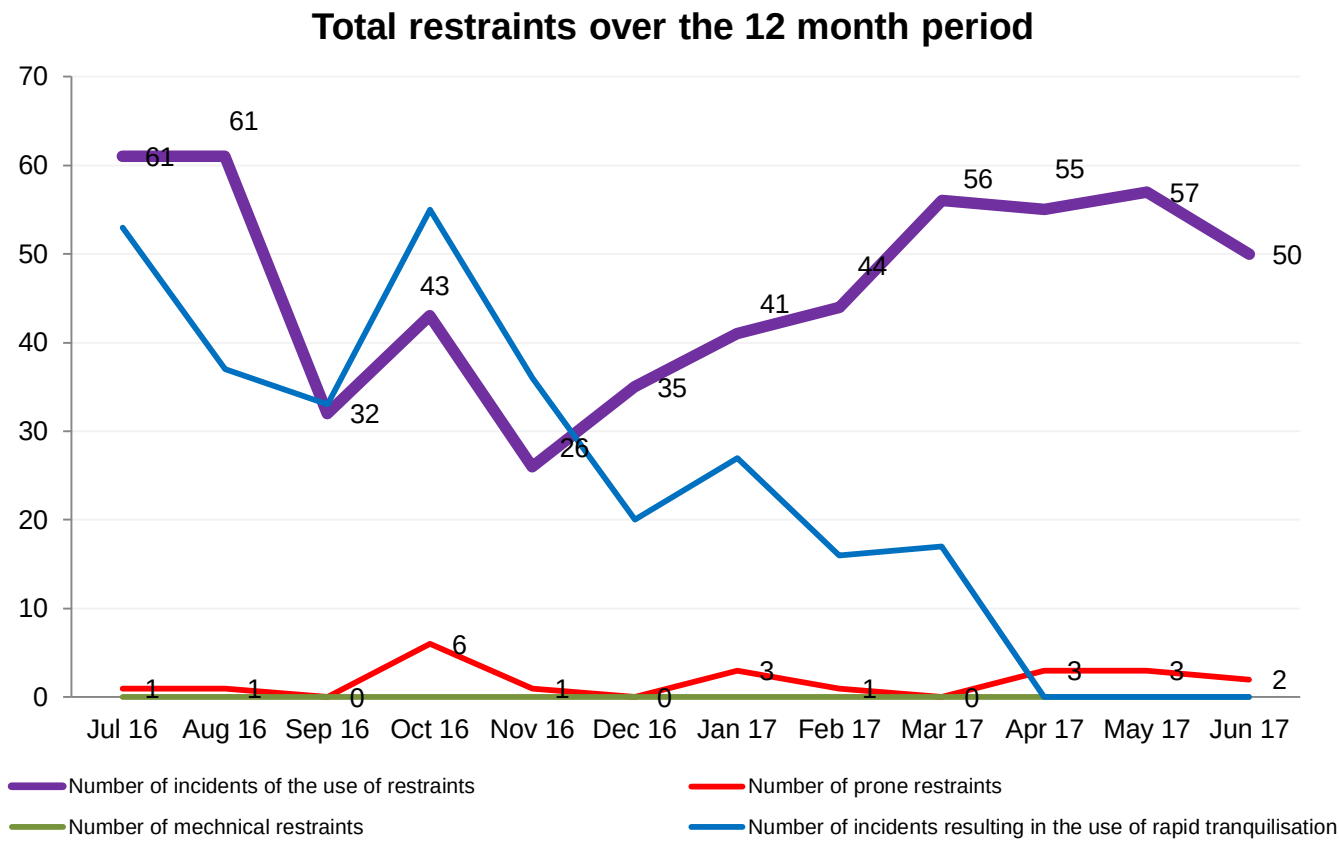
| Ward Unit or Team | Seclusions | Restraints | Patients restrained | Of restraints, incidents of prone restraint | Rapid tranquilisations |
|---|---|---|---|---|---|
| Ashby Ward | 46 | 81 | 23 | 1 (1%) | 66 (81%) |
| Aston Ward | 34 | 56 | 29 | 0 (0%) | 27 (48%) |
| Beaumont Ward | 10 | 45 | 22 | 4 (9%) | 10 (22%) |
| Bed Management Team | 0 | 1 | 1 | 0 (0%) | 0 (0%) |
| Belvoir Ward (PICU) | 101 | 62 | 30 | 8 (13%) | 25 (40%) |
| Bosworth Ward | 48 | 54 | 31 | 1 (2%) | 8 (15%) |
| Heather Ward | 16 | 104 | 37 | 3 (3%) | 43 (41%) |
| Thornton Ward | 34 | 68 | 38 | 2 (3%) | 13 (19%) |
| Watermead Ward | 78 | 90 | 33 | 2 (2%) | 102 (113%) |
| Core service Total: | 367 | 561 | 244 | 21 (3.7%) | 294 (52.4%) |

There were 21 incidents of prone restraint which accounted for 3.7% of the restraint incidents.

Over the 12 months, there was a decrease in the use of restraint. Restraint peaked in July 2016 when there were a total of 61 incidents.

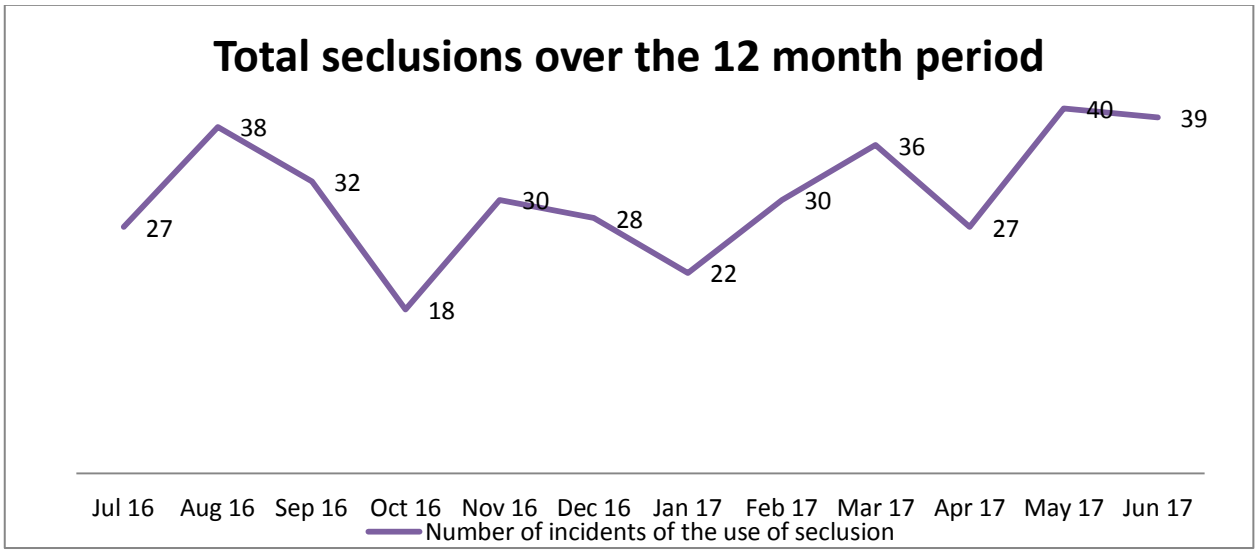
Incidents resulting in rapid tranquilisation for this core services seem to have been decreasing, with the highest numbers in October 2016.

The number of restraint incidents reported during this inspection cannot be compared to the data reported at the time of the last inspection.




Over the 12 months, there was an increase in the use of seclusion. Seclusion peaked in May 2017 where there were a total of 40 instances.
The number of seclusion incidents reported during this inspection cannot be compared to the data reported at the time of the last inspection.

We reviewed six seclusion records, staff completed accurate records of seclusion, in line with the Mental Health Act 1983 code of practice and the trust's policy. Ward managers and the service manager quality checked each record at the conclusion of seclusion.




There have been no instances of long term segregation over the 12 month reporting period.
The number of segregation incidents reported during this inspection cannot be compared to the data reported at the time of the last inspection.

**Safeguarding**

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 109 safeguarding referrals between 1 July 2016 and 30 June 2017, of which 109 concerned adults and 0 children. There were two peaks identified in adult referrals across the period in May 2017 and June 2017 with 13 and 14 respectively.

This data was not collected before the last inspection.

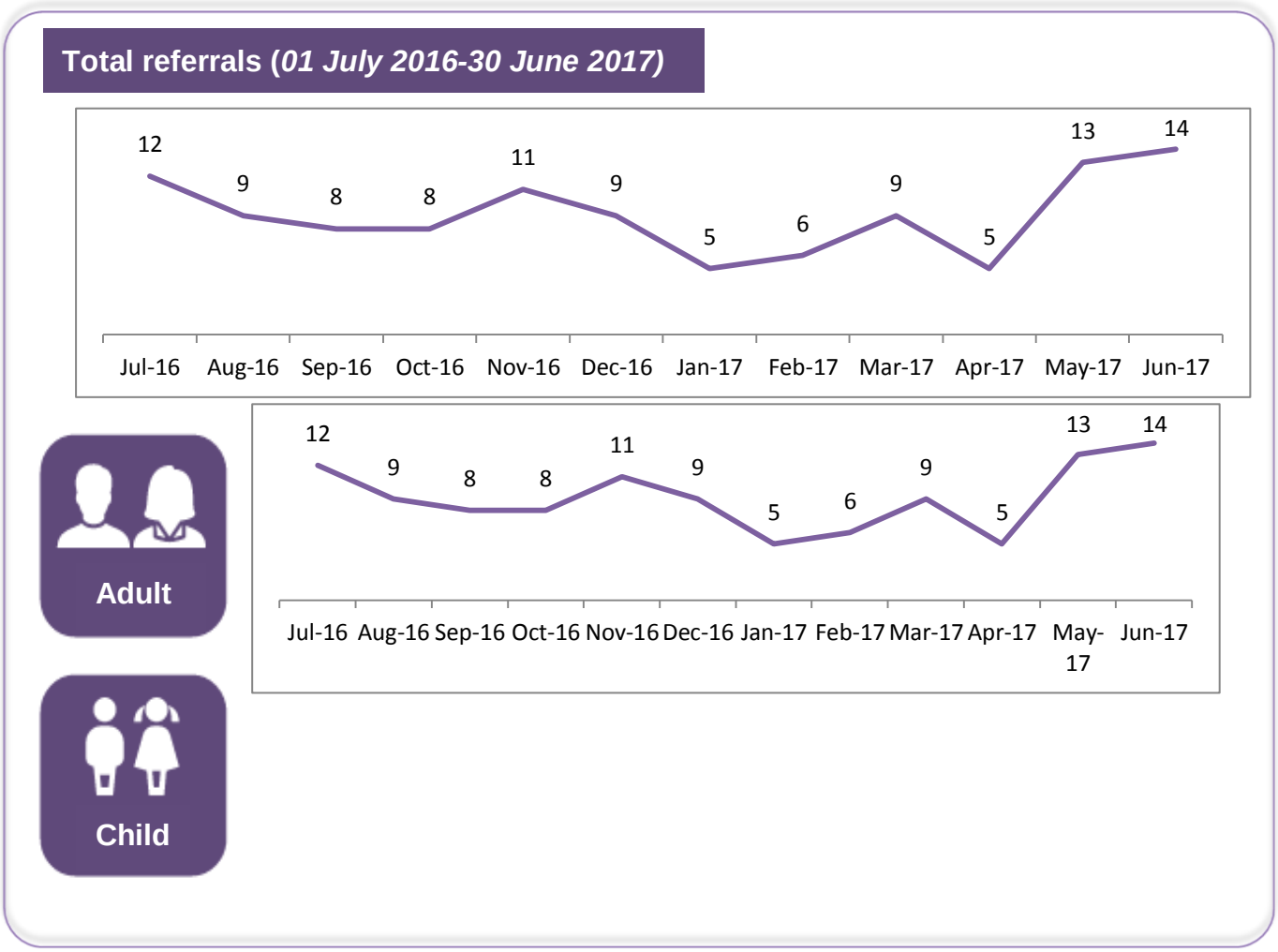
Safeguarding adults and children training compliance rates for this service was 94%.

Staff demonstrated how they identified and made a safeguarding referral. They described how they would protect patients from harassment and discrimination including those with protected characteristics under the Equality Act 2010. Protected characteristics which are, age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity.

The trust had safe procedures for children that visited the wards. A family room was available, within the Bradgate unit and Watermead ward had a visitor's room with access from the external corridor. This meant that children did not enter the ward when visiting.

Patients on the psychiatric intensive care unit received visitors in the quiet room, or dining room. Staff supervised family visits in the dining room and visitors entered via the outside door. This meant visitors did not walk through the patient areas which may disturb other patients.

| Referrals | | |
|---|---|---|
| Adults | **Children** | **Total referrals** |
| 109 | **0** | **109** |




## Staff access to essential information

The service used a combination of electronic and paper records. Staff, including agency and bank staff, had access to the electronic patient record system and were able to input patient information in a timely way.

## Medicines management

Staff did not always follow good practice in the storage of medicines. We found out of date medication on Watermead and Thornton wards and out of date urinalysis testing equipment on Thornton and Belvoir wards. Staff said they had reported one out of date controlled medication to the pharmacy department in September; however, at the time of the inspection the medication had not been removed.

We reviewed the prescription and medicine administration records for 25 patients. The trust had appropriate arrangements in place for recording the administration of medicines. Staff completed accurate records, which showed patients were receiving their medicines when they needed them. Medical staff recorded patient allergies on their electronic prescribing and medication administration record.

Staff had timely access to medicines and medicines for discharge were readily available with electronic discharge records.

Patients detained under the Mental Health Act received medicines that were duly authorised and administered in line with the Mental Health Act code of practice. Staff had access to T2 (consent to treatment) and T3 (record of second opinion) for reference when administering medication for patients.

Staff reviewed and recorded the effects of medication on patient's physical health in line with the national institute for health and care excellence guidance especially when a patient was prescribed high doses of antipsychotic medication. However, this was not the case for one patient who had received rapid tranquilisation.

**Track record on safety**

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 July 2016 and 30 June 2017 there were six STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was Apparent/actual/suspected self-inflicted harm with two incidents.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

The number of serious incidents reported during this inspection is lower than the seven reported at the last inspection.

| Ward | Type of incident reported | Total |
|---|---|---|
| Thornton Ward | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 2 |
| Ashby Ward | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| Ashby Ward | Treatment delay meeting SI criteria | 1 |
| Aston Ward | Abuse/alleged abuse of adult patient by third party | 1 |
| Beaumont Ward | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| | Total | 6 |

**Reporting incidents and learning from when things go wrong**

Staff described the electronic system to report incidents and their role in the reporting process. We saw each ward had access to an online electronic system to report and record incidents and near misses.

Staff were able to describe the various examples of serious incidents that had occurred within the services.

Staff were aware of, and demonstrated the duty of candour placed on them to inform people who use the services of any incident affecting them.

Staff discussed incidents and learning points in team meetings. We saw minutes of these meetings where staff had discussed changes that needed to be made to prevent incidents.

Managers held formal and informal debrief meetings with staff and patients after incidents. Staff were able to access support from the trust occupational health team.

The Chief Coroner's office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been four 'prevention of future death' reports sent to Leicestershire Partnership Trust. One of these related to this core service, details of which can be found below.

There was one prevention of future deaths report in relation to this service in October 2016.

The Coroner stated that there was ample evidence available to suggest that the patient was starting to experience psychotic symptoms from May onwards, but opportunities were missed to fully and adequately explore these and reconsider the necessity for in-patient care.
On 29 July the final missing person search was commenced. The patient was discovered to have taken their own life

The Coroner's concerns were:

- There are currently no local psychiatric intensive care unit beds for female patients and this means all female patients can only be placed out of area, potentially many miles away from home and local support.
- There was no, or no effective, community psychiatric nurse involvement and this was a missed opportunity to monitor and assist the patient when they were in the community.
- The "community support" referred to by the in-patient clinicians does not exist in reality for patients with this challenging presentation, leaving discharged patients and their families without adequate support.
- The care programme approach was not adhered to and NICE guidelines were not followed, specifically in ensuring there was a review after two admissions within six months, and to ensure the roles and responsibilities of all health and social care professionals involved were identified.
- There is no local network for the community support of patients diagnosed with personality disorder, although evidence suggested such networks were effective when adopted elsewhere.
- The trust responded to this report with the actions they were taking to address the concerns raised by the Coroner.

## Is the service effective?

**Assessment of needs and planning of care**

Staff completed comprehensive mental health assessments for patients on admission. We looked at 34 care plans, they were up to date, personalised, holistic, recovery orientated and included physical health checks.

Staff monitored patient's weight, pulse, temperature and ongoing neurological investigations to identify when a patient was becoming unwell.

**Best practice in treatment and care**

The service had one psychologist in post, patients were referred for interventions, however staff said there was a waiting list of about four weeks. On all wards, staff (doctors and nurses) told us there was a limited amount of psychology input. No evidence was recorded as to how care was being provided in line with relevant national institute for health and care excellence guidance, particularly relating to the provision of psychological therapies for patients. However; we were informed at the inspection that four psychologists had been appointed and three were due to commence work in October 2017.

Patients were supported to access specialists when required for physical healthcare needs. Hydration and nutrition were monitored regularly and recorded in care records.

Staff supported patients to live healthier lives; there was access to smoking cessation services, healthy cooking groups and an onsite gym.

Medical staff completed health of the nation outcomes scales and assigned patients to specific mental health clusters. These are specific pathways of care, individualised to patient needs.

This core service participated in eight clinical audits as part of their clinical audit programme01 July 2016– 30 June 2017.

| Audit type | Key Successes | Key Concerns |
|---|---|---|
| Service User Experience in Adult Mental Health – Inpatients | Achieved the 80% threshold in six of the eight items of information patients should be provided with upon admission. The patient's experience exceeded that documented in all but one criteria. | There were two main areas where the patient's experience was significantly below guidance target; explanation and information about their treatment plan and information and pharmacist input about medications. |
| Record keeping AMH - Bradgate Unit (re-audit) | The evidence of patient involvement was higher than expected. Mental capacity is being assessed. The Must/Waterlow on admission. | Patient involvement in care plans varies between wards and requires improvement, as does family involvement. Evaluations of care plans should be weekly and need to be dated. Validation of progress notes requires improvement. Documentation of observation levels requires improvement. Admission paperwork is not complete within first 72 hours following admission. |
| Prescribing for substance misuse: alcohol detoxification (POMH Topic 14b) | The decision to undertake acute alcohol detoxification was informed by a documented assessment of drinking history and current daily alcohol intake in 87% of cases. In 100% cases pharmacotherapy to treat the symptoms of acute alcohol withdrawal was limited to a benzodiazepine, carbamazepine or clomethiazole. | Low compliance with remaining criteria. |
| MDT forms for Patients on Belvoir Ward | Nursing completion of 82% and an MDT plan completion of 86% while below the expected standard was better than we had anticipated. | Physical health pre-MDT was not completed. |
| Polypharmacy & antipsychotics | Presence of evidence that the | Details about above BNF limits made |

| | | |
|---|---|---|
| above BNF recommended dose | decision to prescribe above BNF limits has been discussed with the patient. Recording of the reason for the prescription of antipsychotics above BNF recommended | clear |
| Procyclidine prescribing on the Bradgate Unit | This data suggests that the majority of procyclidine prescriptions are being done without any documentation of the patient having any EPSEs. | We did not look at data of whether patients actually received PRN doses, therefore cannot make judgements on whether patients have been receiving procyclidine inappropriately. |
| Weekly MDT evaluation forms | In the majority of wards the weekly MDT evaluation form has been used to record ward rounds and the number of MDT forms corresponds to or is slightly smaller than the number of weeks since admissions (ratio was 18:16). | The majority of the wards at BMHU had low percentage of completion of the sections of MDT evaluation forms. |
| Benzo & Z drug MDT prescription review - Ax 4882 | Consider the addition of pre-programmed reducing regimes into e-prescribing to aid with weaning patients off benzodiazepines. Work with RiO team to have B&Zs included on the weekly review MDT template that is being developed as a result of the PRN LiA event. Pharmacy to include documenting rationale for benzodiazepines and Z drugs at junior doctors' induction. | |

**Skilled staff to deliver care**

The wards had a range of disciplines to provide care and treatment. The multidisciplinary team consisted of consultants, doctors, qualified nurses, healthcare support workers, a psychologist, occupational therapists and therapeutic liaison workers. The unit did not have an allocated social worker. However, community psychiatric nurses and social workers would attend care reviews from the community mental health teams when required.

The trust provided a formal induction period for new permanent staff. This involved attending a corporate induction, learning about the ward and trust policies and a period of shadowing existing staff before working alone.

The trust provided training for health care support workers in the care certificate. The care certificate aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care.

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

The teams/teams failing to achieve the trust's appraisal target were Thornton ward with an appraisal rate of 79%, Beaumont ward with an appraisal rate of 65% and Ashton ward at 78%.

The rate of appraisal compliance for non-medical staff reported during this inspection is lower than the 83% reported at the last inspection.

| Ward | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| 313 0340 Bosworth Ward - Bradgate Unit | 47 | 38 | 81% |
| 313 0940 Thornton Ward - Bradgate Unit | 58 | 46 | 79% |
| 313 0950 Watermead Ward (Bradgate Unit) | 48 | 40 | 83% |
| 313 1850 Beaumont Ward - Bradgate Unit | 49 | 32 | 65% |
| 313 1860 Belvoir Psychiatric Intensive Care Unit | 66 | 56 | 85% |
| 313 2365 Heather Ward | 50 | 42 | 84% |
| 313 2370 Aston Ward (Bradgate Unit) | 49 | 38 | 78% |
| 313 2410 Ashby Ward (Bradgate Unit) | 45 | 38 | 84% |
| Core service total | 412 | 330 | 80% |
| Trust wide | 4118 | 3693 | 90% |

No appraisals data for permanent medical staff was provided by the trust for this core service.

Between 31 July 2016 to 30 June 2017 the average rate for clinical supervision across all eight teams in this core service was 42% against the trust's target of 85%.

**Caveat:** there is no national standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

The rate of clinical supervision reported during this inspection is lower than the 60% reported at the last inspection.

Staff said they were given opportunities to develop their skills and knowledge by attending both internal and external training, for example personality disorder and leadership training.

The trust had processes for identifying and managing poor staff performance, including involvement from occupational health and the human resources departments. Managers said they had good support to manage poor staff performance.

| | Clinical supervision target | Clinical supervision delivered | Clinical supervision rate (%) |
|---|---|---|---|
| 313 0340 Bosworth Ward - Bradgate Unit | 282 | 83 | 29% |
| 313 0940 Thornton Ward - Bradgate Unit | 326 | 144 | 44% |
| 313 0950 Watermead Ward (Bradgate Unit) | 255 | 116 | 45% |
| 313 1850 Beaumont Ward - Bradgate Unit | 278 | 87 | 31% |
| 313 1860 Belvoir Psychiatric Intensive Care Unit | 369 | 175 | 47% |
| 313 2365 Heather Ward | 275 | 141 | 51% |
| 313 2370 Aston Ward (Bradgate Unit) | 285 | 120 | 42% |
| 313 2410 Ashby Ward (Bradgate Unit) | 256 | 108 | 42% |

| | | | |
|---|---|---|---|
| Core service total | **2326** | **974** | **42%** |
| Trust Total | **41953** | **26832** | **64%** |

### Multidisciplinary and inter-agency team work

Staff attended multidisciplinary team meetings. Patients were encouraged to participate and share their views; one patient said that too many people attended the meeting that they found this quite intimidating. The meetings were effective in enabling staff to share information about patients and review their progress.

Occupational therapists and therapeutic liaison workers worked as part of the team and we saw that they worked closely with patients. The patients we talked with spoke positively about the support they received.

We attended one handover meeting. Staff provided details including each patient's level of observations, risks, and Mental Health Act status. Staff received information on diagnosis, current presentation, and activities for the day and physical health care, as appropriate.

Ward matron's reported they had good relationships with community mental health teams and local housing services.

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

Mental Health Act training for this core service was at 95% compliance at 30 June 2017 against the trust target of 85%.

| Service | Total number of staff | (Clinical Mandatory) Mental Health Act for Nurses - 3 Years | (Clinical Mandatory) Mental Health Act for Doctors - 2 years |
|---|---|---|---|
| **313 L6 AMH Medical Services** | 44 | 94.1% (16/17) | 100.0% (4/4) |

We reviewed the systems in place to ensure compliance with the Mental Health Act and adherence to the guiding principles of the Mental Health Act code of practice. All patients whose care records we reviewed were lawfully detained and treatment was given under an appropriate legal authority. Staff had access to policies via the trust's intranet.

Staff completed Mental Health Act paperwork correctly. There was administrative support to ensure paperwork was up to date and regular audits took place. Staff scanned Mental Health Act paperwork onto the electronic record for staff reference.

Mental Health Act administrators were available to offer support and legal advice to staff on the implementation of the Act and its code of practice. The Mental Health Act administration office provided reminders to consultants for section renewals and consent to treatment.

The trust provided access to independent mental health act advocates for patients and contact details were contained in admission packs and displayed on wards for patient reference. Staff described how they supported patients to access the service.

Staff explained patients their rights under section 132 of the Mental Health Act in a way they could understand, on admission and regularly thereafter. Patients were able to take section 17

leave as approved by the responsible clinician and this was rarely cancelled although it was sometimes re-arranged.

### Good practice in applying the Mental Capacity Act

Staff we spoke with had varying degrees of knowledge about the Mental Capacity Act and Deprivation of Liberty Safeguards process. Some staff explained how capacity was assessed for significant decisions and told us medical staff completed mental capacity assessments for patients.

Staff had access to policies via the trust's intranet and could seek advice when needed. The trust had arrangements to monitor adherence to the Act.

Mental Capacity Act training was at 94% compliance for this core service at 30 June 2017 against the trust target of 85%.

| Service | Total number of staff | (Clinical Mandatory) Mental Capacity Act - 3 Years |
|---|---|---|
| **313 L6 AMH Medical Services** | 44 | 94.1% (43/44) |

Leicestershire Partnership Trust told us that no Deprivation of Liberty Safeguards applications were made to the local authority between 1 July 2016 and 1 July 2017 relating to this core service.

## Is the service caring?

### Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with kindness, compassion and respect. We observed interactions between staff and patients during the inspection and saw that staff were responsive to patient's needs, discreet and respectful. Staff treated patients with dignity and remained interested when engaging patients in meaningful activities. Staff interacted with patients in a timely way and at a level that was appropriate to individual needs.

We spoke with 31 patients who told us that staff were generally kind and caring.

We spoke with nursing staff who described how they took patient's personal, cultural, social and religious needs into account when care planning.

Staff said they could raise concerns about discriminatory, disrespectful or abusive behaviour towards patients without fear of recrimination.

Three patients said that staff helped them to access services to find accommodation in the community.

The 2016 PLACE score for privacy, dignity and wellbeing at Bradgate Unit scored worse compared to similar organisations.

| Site name | Core service(s) provided | Privacy, dignity and wellbeing |
|---|---|---|
| The Bradgate Unit | Acute wards for adults of working age and psychiatric intensive care units<br>MH - Mental health crisis services and health-based places of safety<br>MH - Forensic inpatient/secure wards<br>MH - Wards for older people with mental health problem | 81.5% |
| Trust overall | | 80.4% |
| England average (mental health and learning disabilities) | | 89.7% |

**Involvement in care**

**Involvement of patients**

We reviewed 34 care and treatment records for patients and found seven lacked evidence of patient involvement.

From the notes reviewed, 21 patients had received a copy of their care plan. We spoke with 31 patients, 23 said they knew about their care plan and had been involved in developing it.

Patients had access to advocacy services on the wards and information and contact details were contained in patient admission packs and on posters and leaflets available on the wards.

Wards had information boards detailing the staff on duty and staffing levels. This informed patients of the staff available for care and treatment for that day.

Weekly community meetings took place on the acute adult mental health wards, these allowed patients to raise concerns and provide feedback about the wards. The minutes of the meetings showed that actions had been taken following the meetings.

**Involvement of families and carers**

Staff invited patients to attend the multidisciplinary reviews along with their family where appropriate.

Staff described how they would support carers to access a carer's assessment.

## Is the service responsive?

**Access and discharge**

**Bed management**

The trust provided information regarding average bed occupancies for eight wards in this core service between 1 July 2016 and 30 June 2017. The bed occupancy ranged from 53% to 132% across the wards.

The bed occupancy reported during this inspection is not comparable to data reported at the last inspection.

| Ward name | Average bed occupancy range (01/07/16 - 30/06/17) (current inspection) |
|---|---|
| Ashby | 99.4%-106.9% |
| Aston | 58.1%-69.4% |
| Beaumont | 103.3%-131.7% |
| Belvoir Unit | 59.6%-62.9% |
| Bosworth | 106.2%-122.5% |
| Heather | 98.7%-122.9% |
| Thornton | 107.9%-130.9% |
| Watermead | 53.1%-94.5% |

The trust provided information for average length of stay for the period 1 July 2016 to 30 June 2017. The average length of stay ranged from 1 day to 145 days across the wards.
The length of stay reported during this inspection is not comparable to data reported at the last inspection.

| Ward name | Average length of stay range (01 July 2016 to 30 June 2017) (current inspection) |
|---|---|
| Ashby | 22.8-73.6 |
| Aston | 27.2-90.0 |
| Beaumont | 42.4-120.4 |
| Belvoir Unit | 1-135.0 |
| Bosworth | 33.8-81.7 |
| Heather | 29.0-145.0 |
| Thornton | 39.1-97.0 |
| Watermead | 22.8-122.1 |
| Core service total | 1-145 |
| Trust total | 1-2068 |

This core service reported 112 out area placements between 1 June 2016 and 30 June 2017.
As of 28 July 2017 this core service had one ongoing out of area placement.
At the time of the inspection there were no out of area placements.
All placements that lasted longer than one day, and the placement that lasted the longest amounted to 130 days.

| Number of out of area placements | Number due to specialist needs | Number due to capacity | Range of lengths (completed placements) | Number of ongoing placements |
|---|---|---|---|---|
| 112 | N/A | N/A | 2-130 | 1 |

Staff reported that when patients went on leave their beds were regularly used for patients needing admission to hospital. This meant that patients returning from leave would not have access to their bed and would be nursed on a different ward which led to inconsistency of care.

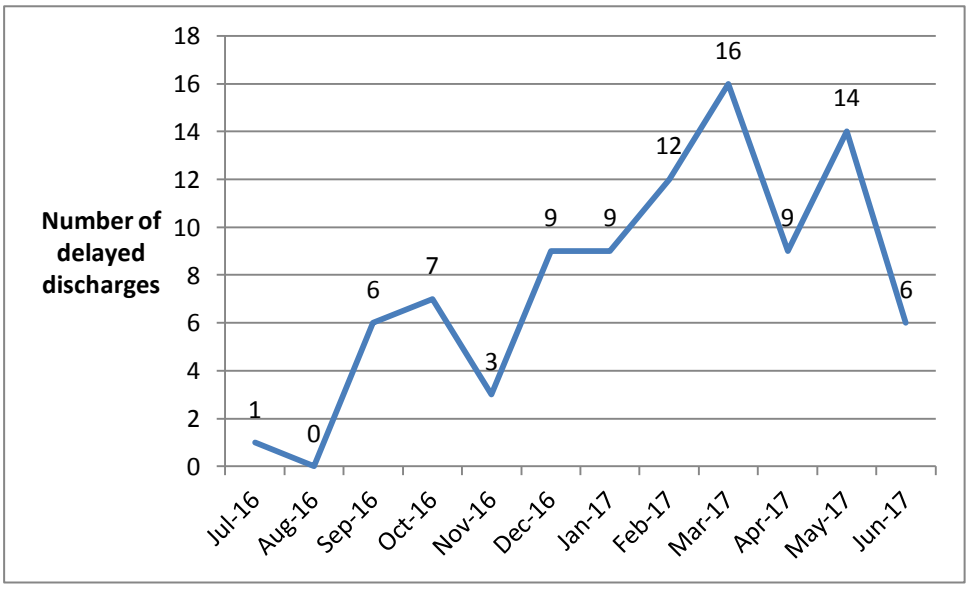
Staff said that a bed was usually available, when needed, in the psychiatric intensive care unit which was located on the same site as the acute wards. This is a male only ward.

This core service reported 58 readmissions within 28 days between 1 July 2016 and 30 June 2016.
Five of readmissions (9%) were readmissions to the same ward as discharge.
The average of days between discharge and readmission was 6 days. There were 21 instances whereby patients were readmitted on the same day as being discharged but there were 11 instances where patients were readmitted the day after being discharged.

| Ward/Team | Number of readmissions (to any ward) within 28 days | Number of readmissions (to the same ward) within 28 days | % readmissions to the same ward | Range of days between discharge and readmission | Average days between discharge and readmission |
|---|---|---|---|---|---|
| Ashby | 11 | 11 | 100 | 0-16 | 5 |
| Aston | 7 | 11 | 100 | 0-19 | 9 |
| Beaumont | 3 | 2 | 66 | 5-23 | 13 |
| Belvoir Unit | 1 | 1 | 100 | 0 | 0 |
| Bosworth | 10 | 9 | 90 | 0-26 | 9 |
| Heather | 11 | 8 | 73 | 0-19 | 4 |
| Thornton | 9 | 8 | 89 | 0-22 | 6 |
| Watermead | 6 | 6 | 100 | 0-18 | 4 |
| Core service Total | 58 | 21 | 9 | 0-26 | 6 |

## Discharge and transfers of care

Between 1 July 2016 and 30 June 2017 there were 824 discharges within this core service. This amounts to 16% of the total discharges from the trust overall (5037).
Over the 12 month period there was a peak in the number of delayed discharges in March 2017. August 2016 was the only month with no delayed discharges within this core service at all.
The proportion of delayed discharges reported during this inspection is worse than the 48 delayed discharges reported at the time of the last inspection.



The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

No target times were provided by the trust. General psychiatry inpatients had the longest median days from referral to initial assessment with 85 days.

| Name of hospital site or location | Name of in-patient ward or unit | Days from referral to initial assessment | | Days from assessment to treatment | |
|---|---|---|---|---|---|
| | | **National target** | **Actual (median)** | **National target** | **Actual (median)** |
| Bradgate Mental Health Unit RT5KF | AMH General Psychiatry Inpatients | Not provided | 85 | Not provided | 1 |
| Bradgate Mental Health Unit RT5KF | AMH Inpatient Occupational Therapy Group | Not provided | 37 | Not provided | Not given |

Staff planned for patients' discharge in partnership with community care co-ordinators and other agencies such as housing and probation services.

**Facilities that promote comfort, dignity and privacy**

Patients had their own bedrooms on Belvoir, Beaumont, Watermead and Heather wards. Bosworth, Ashby, Aston and Thornton ward had a mixture of single rooms and two and four bedded dormitories. Staff told us that three rooms intended as single bedrooms on Thornton ward were used as two bedded rooms, we looked at these rooms which were cramped and patients had very little access to private space.

Patients were able to personalise their bedrooms, for example with artwork and photographs. Patients accommodated in bed bays and dormitories had less space; however, we observed personal items in these areas.

The accommodation and facilities for patients at the Bradgate Mental Health Unit varied between wards. For example, on Ashby, Bosworth and Thornton wards, we found inadequate numbers of rooms for care and treatment of patient's. Wards did not have sufficient rooms for patient's to access 1-1 time with nursing staff, to receive visitors or to participate in ward based activities. Patients had difficulty having confidential and private conversations with staff and visitors.

Patients had use of their mobile phones across all wards. Wards had payphones for patient use in communal areas and staff facilitated private phone calls in ward offices or by use of cordless telephones when needed. The trust provided information on accessing telephone calls and the internet in patient welcome packs.

All wards had good access to outside space. Patients could access the garden areas between 06:00 am and midnight. Staff would facilitate access to the garden during the night, when needed.

Patients had access to ward kitchens to make hot and cold drinks and access fresh fruit. Staff closed access to these rooms after midnight. Staff provided patients with drinks when kitchens were closed, on request.

Patients could store their valuable in lockers. Staff accessed valuables on behalf of patients, subject to risk assessment, when requested.

The 2016 patient led assessments of the care environment (PLACE) score for ward food at Bradgate mental health unit scored much better than the trust overall scored as well as better than similar trusts.

| Site name | Core service(s) provided | Ward food |
|---|---|---|
| Bradgate Mental Health Unit | Acute wards for adults of working age and psychiatric intensive care units<br>MH - Mental health crisis services and health-based places of safety<br>MH - Forensic inpatient/secure wards<br>MH - Wards for older people with mental health problems | 100% |
| Trust overall | | **85%** |
| England average (mental health and learning disabilities) | | 89.7% |

**Patients' engagement with the wider community**

Staff supported patients to maintain contact with their families and cares and invited them to attend multidisciplinary meetings where appropriate.

**Meeting the needs of all people who use the service**

The trust did not have facilities for disabled patients on all wards. However, the trust had disabled facilities for patients on some wards. For example on Heather ward, an assisted bathroom was available. Staff told us they could access mobility aids and equipment when needed.

Staff could access information leaflets in a variety of languages for patients whose first language was not English. The trust had a specific email address and contact telephone number to ensure information was available quickly when needed. We found these details contained in patient admission packs.

Patients had access to a wide range of information leaflets in ward areas. For example, information on advocacy, patients' rights, how to complain and local services.

Staff had access to interpreters to ease communication with patients, as needed. Staff had access to contact telephone numbers in ward offices.

The trust provided a choice of food to meet differing dietary needs and choices. However, patients told us that halal options were limited.

The trust provided a chaplaincy service that provided patients with access to support from a variety of religions and faiths.

### Listening to and learning from concerns and complaints

This core service received 36 complaints between 1 July 2016 and 30 June 2016.
This is a decrease from the 47 complaints received the 12 months before the last inspection.

| Ward | Total Complaints | Most common Theme |
|---|---|---|
| AMH/LD Duty Managers Team | 1 | All aspects of clinical treatment |
| Ashby Ward | 7 | Attitude of staff (3) |
| Aston Ward | 8 | All aspects of clinical treatment (5) |
| Beaumont Ward | 4 | All aspects of clinical treatment (2) |
| Belvoir Ward (PICU) | 1 | Attitude of staff |
| Bosworth Ward | 9 | All aspects of clinical treatment (4) |
| Heather Ward | 3 | All aspects of clinical treatment (2) |
| Thornton Ward | 1 | Communication / information to patients (written and oral) |
| Watermead Ward | 2 | All aspects of clinical treatment (4) |
| Core service Total | **36** | **All aspects of clinical treatment (17)** |

Patients had access to information on how to make a complaint. Wards had information on the complaints process available to patients on ward notice boards and in leaflets. Staff supported patients to raise concerns when needed.
The trust had systems for the recording and management of complaints. We saw minutes of team meetings where the outcomes and learning from complaints was discussed.
This core service received 24 compliments during the last 12 months from 1 June 2016 and 30 June 2016 which accounted for 7% of all compliments received by the trust as a whole.

## Is the service well-led?

### Leadership

Leader's had a good understanding of their service, explained how the teams provided high quality care and had the knowledge and experience to perform their role.

Staff we spoke with said that matrons and the team manager were visible and approachable.

Leader's said that the trust provided them with opportunities to develop their own and their team's skills.

### Vision and strategy

Staff we spoke with were aware of the organisation's values. They identified that these were available on the trust's intranet system and were regularly highlighted in meetings and training.

Staff we spoke with knew who the most senior managers in the organisation were. They told us that senior staff within the trust had visited the wards. These included the chief executive and various executive directors.

Manager's explained how they were working to deliver high quality care within the budget available.

**Culture**

Staff said they felt respected and supported by their manager and they were proud to work at the Bradgate unit and that morale was good.

Staff we spoke with said they felt able to raise concerns without fear of retribution and knew the trust had a whistle blowing policy which they would use if they need to.

Managers were supported by colleagues in the human resource department to manage poor staff performance.

Staff sickness for the service was 7% which was above the trust target of 4.5%. There was a policy to support managers to manage sickness with staff.

Staff said they could access the trust occupational health service for support with both physical and mental health issues.

During the reporting period there were two cases where staff have been either suspended, placed under supervision or moved to an alternative ward.

This is a slight increase from the one member staff under supervised practice reported during the last inspection.

**Caveat:** Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

| Name of Hospital or Site | Name of Ward/Team | Alternative duties | Suspended |
|---|---|---|---|
| Bradgate Mental Health Unit | Beaumont Ward | 1 | 0 |
| Bradgate Mental Health Unit | Phoenix Ward | 1 | 0 |

**Governance**

Manager's used a standard agenda for ward meetings, items covered at the meeting included safeguarding, feedback and actions following incidents and performance data.

The trust had systems for monitoring compliance with annual appraisal of staff. Data provided showed 80% of non-medical staff had received an appraisal over the past 12 months. However, Thornton, Beaumont and Aston ward did not achieve this target. Managers and staff reported that supervision was taking place. However, the data submitted by the trust did not reflect this. Compliance rates for acute wards and PICU was 42% which was below the trust target of 85%. Managers kept local records to evidence this.

The trust had an overall vacancy rate for the service of 24.3%, for qualified nurses of 12.5%. Ashby ward had a vacancy rate of 50%. The overall vacancy rate for unqualified staff was 15.5%, Bosworth ward had a vacancy rate of 20% and Beaumont ward had a vacancy rate of 22%. Managers used temporary staff to maintain a safe environment. However, there were insufficient numbers of registered staff across the service. The trust had ongoing recruitment and retention processes to address this.

Staff participated in several audits, for example record keeping, weekly multidisciplinary evaluation forms and procyclidine prescribing. They described how the outcome of audits had led to changes in the way patients were cared for.

Managers did not ensure all clinical areas were clean and that equipment was maintained in a timely way.

Managers supported staff to work in collaboration with community teams and external agencies such as, housing and the criminal justice service to meet the need of patients.

The trust have provided their board assurance framework, which details any risk scoring three or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. There are no risks relating to this core service identified.

The trust has provided a document detailing their highest profile risks. Three risks relate to this core service.

**Key:**

| High (15-20) | Moderate (8-15) | Low 3-6 | Very Low (0-2) |
|---|---|---|---|

| Opened | ID | Description | Risk level (initial) | Residual Risk score (current) | Risk level (target) | Link to BAF strategic objective no. | Last review date |
|---|---|---|---|---|---|---|---|
| - | 1991 | Some of the seclusion rooms in the Trust do not meet good practice environmental standards for seclusion rooms. (Two main areas of non-compliance are lack of ensuite facilities directly off the seclusion rooms and the location of the room on wards). | 15 High | 12 Moderate | | | 07 October 2017 |
| | 1435 | There is currently only 1 wte Psychologist between the seven AMH acute admission wards and the PICU. This is not enough to deliver care to the inpatients on the 8 wards and offer support and training to staff. This was also raised on our last CQC report as something the trust needs to address. | 12 Moderate | 4 Low | | | 18 October 2017 |
| | 1516 | There is a risk that patient-centred risk assessments, records and care plans are not updated consistently in line with changes to patients' needs or risks. This could lead to patient harm as well as having a detrimental impact on effective care | 12 Moderate | 8 Moderate | | | 30 July 2017 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | planning and reputation | | | | | |

**Management of risk, issues and performance**

Staff were supported to submit issues to the trust risk register. Managers were aware of what local risks were on the risk register.

The trust had business continuity plans in place for any disruption to services.

**Information management**

The trust collected data from wards to produce a performance dashboard which monitored for example: sickness levels, turnover and ward budgets.

Managers used information and technology to assist them in their role; they described how they looked at trends in the types of incidents on the wards. However, this information was not always accurate and needed to be adjusted.

**Engagement**

Wards had information boards detailing the staff on duty and staffing levels. This informed patients of the staff available for care and treatment for that day.

Manager's and staff facilitated weekly community meetings, these allowed patients and carers, where appropriate to raise concerns and provide feedback about the wards. The minutes of the meetings showed that actions had been taken following the meetings.

**Learning, continuous improvement and innovation**

Staff collected data on performance. Ward matrons completed a database that recorded their performance against a range of indicators, for example agency use and staff sickness. Ward matrons reported this monthly to the senior managers.

The ward matrons were able to provide us with an up to date picture of how the wards were performing and had a good understanding of where improvements were required.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to support the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

Neither the acute wards nor the psychiatric intensive care unit participated in AIMS (accreditation for inpatient mental health services). AIMS-WA engages staff and service users in a comprehensive process of review, through which good practice and high quality care are recognised and services are supported to identify and address areas for improvement. Accreditation assures staff, service users and carers, commissioners and regulators of the quality of the service being provided.

# Community-based mental health services for adults of working age

## Facts and data about this service

| Location site name | Team name | Number of clinics | Patient group (male, female, mixed) |
|---|---|---|---|
| Evington Centre RT5KT | Cognitive Behavioural Therapy Services. | N/A | Not given |
| Evington Centre RT5KT | Dynamic Psychotherapy Service | N/A | Not given |
| Evington Centre RT5KT | Therapeutic services for people with personality disorders - TSPPD (Francis Dixon Lodge) | N/A | Not given |
| Evington Centre RT5KT | Clinical Neuro Psychology Service | N/A | Not given |
| HQ Bridge Park Plaza | Assertive Outreach and Homeless Team | AO - Mostly home visits but occasionally individual seen in a clinic session as home visit not appropriate. Homeless - Medical Clinic held once a fortnight at the Dawn Centre | Not given |
| HQ Bridge Park Plaza | Clinical Psychology Services - Rehab, Forensic and Community | N/A | Not given |
| HQ Bridge Park Plaza | Community based Mental Health Teams | City Central and City West CC - 10 x consultant clinics , 2 x VTS (GP trainees) clinics, 2 x ST5 clinics , 1 x depot clinic , 1 x NMP (non-medical prescriber) clinic and 2 x NLC (nurse led clinic) clinics. CW - 10 X consultant clinics, 6 x SHO clinics, 2 x SPR and 2 x NLC. | Not given |

## Is the service safe?

### Safe and clean environment

Managers had completed environmental risk assessments, including ligature risk assessments, at all team locations visited. At city central, staff had assessed the waiting area as a medium risk. However, inspection team members observed a patient sitting for 20 minutes in the waiting area without staff supervision. There was a blind spot and an unlocked room filled with items that could potentially cause harm, for example parasols, a water dispenser, plugs, cables and small tables.

Interview rooms were either fitted with alarms or staff took personal alarms in with them, when seeing patients. Staff were on site to respond to alarms. Teams operated a duty worker system. The duty worker was based on site to respond to any emergencies.

Clinic rooms at city west and city central were equipped with the necessary equipment to carry out physical examinations. City east did not have emergency drugs, a de-fibrillator or a blood pressure machine. Charnwood did not have an examination couch. Staff reported that one had been ordered.

Areas were clean, with good furnishings and well maintained. However, at city central reception, the décor was old and there were torn posters held up with curling, old tape.

Staff were observed to follow infection control principles, including hand washing. Staff had displayed hand-washing posters above washbasins.

Staff had maintained equipment and kept it clean. at city central and city east there were no clean stickers on any of the equipment. Staff could not be assured that the equipment they were using was clean.

**Safe staffing**

The provider had reviewed staffing levels across the service and made reductions in the number of staff required. Overall, the service staffing establishment had been reduced by 19 whole time equivalent staff. Some staff reported that this was too much of a reduction and impacted on them being able to provide a full service to patients.

The teams visited reported a total of 8.8 whole time equivalent qualified vacancies and one whole time equivalent vacancy for a health care support worker. Assertive outreach reported five qualified staff vacancies out of 20.7. City central reported 0.8 qualified vacancies out of seven. City east reported two qualified vacancies out of 9.4. Charnwood reported one qualified vacancy out of nine posts and one health care support worker vacancy. City west had no permanent vacancies but the manager was recruiting to temporary posts to back fill act up roles.

Managers and staff told us caseloads were high. Nursing staff in the community mental health teams reported caseloads of between 40 and 60 patients each. Consultants reported high caseloads; one consultant had a caseload of 600 patients. Managers discussed caseloads with staff in supervision. Managers were in the process of introducing a complex case tracking tool. This tool would enable managers to assess the workload of each individual staff member and make changes accordingly. Staff told us that high caseloads impacted on the quality of service provided. Staff told us that high caseloads made it difficult to keep care plans and risk assessments up to date. We found 45% of patients did not have an up to date care plan and 25% of patients did not have an up to date risk assessment.

Team members would cover each other's short term absences. Bank or agency staff would cover longer term absence. Managers would only use bank and agency staff as a last resort. Managers would try to use bank staff that were familiar with the service and patients.

The teams reported that they could usually access a consultant during the day for emergencies. However, at Charnwood there was one out of 2.5 consultants on long term sick. Staff reported that this made it difficult to get rapid access to a psychiatrist.

Compliance with mandatory training for the service was 86% as of 30 June 2017. Managers provided data from 30 September 2017 for teams visited. This evidenced a compliance rate of 91%. The team with the highest compliance rate was city west at 95%, followed by city east at 94%, Assertive outreach at 93%, city central at 88% and Charnwood at 84%. All teams visited were below 75% for display screen equipment training. However, managers advised that the trust had introduced this training recently.

**Definition**

Substantive – how many staff in post currently.

Establishment – substantive plus vacancies, e.g. how many they want or think they need in post.

| Substantive staff figures | | | Trust target |
|---|---|---|---|
| Total number of substantive staff | At June 2017 | 211.2 | N/A |
| Total number of substantive staff leavers | 1 July 2016 -30 June 2017 | 23.4 | N/A |
| Average WTE* leavers over 12 months (%) | 1 July 2016 -30 June 2017 | 10.9% | 10% |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) | Vacancy data could not be provided | N/A | N/A |
| Total vacancies overall (%) | Vacancy data could not be provided | N/A | N/A |
| Total permanent staff sickness overall (%) | At June 2017 | 3.4% | 4.5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Establishment levels nursing assistants (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Number of vacancies, qualified nurses (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Number of vacancies nursing assistants (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Qualified nurse vacancy rate | Vacancy data could not be provided | N/A | N/A |
| Nursing assistant vacancy rate | Vacancy data could not be provided | N/A | N/A |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified and unqualified nurses) | 1 July 2016 to 30 June 2017 | 94 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (qualified and unqualified nurses) | 1 July 2016 to 30 June 2017 | 1536 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (qualified and unqualified nurses) | 1 July 2016 to 30 June 2017 | 65 | N/A |

*WholeTime Equivalent

The trust has advised they are unable to provide establishment or vacancy data by ward/team due to restrictions with the finance system. The most amount of detail held centrally is at provider level by profession. However, the trust provided us with data for this core service prior to the inspection which showed a vacancy rate of 8.7% for the service and 12.9% for band 5 and 6 nurses.

Between 1 July 2016 and 30 June 2017, bank staff filled 94 shifts to cover sickness, absence or vacancy for qualified nurses and unqualified nurses. The trust was unable to provide a breakdown detailing how this was split between qualified and unqualified nurses.

In the same period, agency staff covered 1360 shifts. 63 (4%) of shifts were unable to be filled by either bank or agency staff.

| Ward | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|

| | | | |
|---|---|---|---|
| **313 L6 AMH Community Clinic Therapy Management** | 0 | 0 | 0 |
| **313 L6 AMH Community Management** | 0 | 0 | 0 |
| **313 L6 AMH Community Team City** | 5 | 295 | 5 |
| **313 L6 AMH Community Team East** | 0 | 454 | 1 |
| **313 L6 AMH Community Team West** | 0 | 611 | 32 |
| **313 L6 AMH Complex Assertive Outreach** | 89 | 0 | 25 |
| **313 L6 AMH ICL Recovery Services** | 0 | 0 | 0 |
| **Core service total** | 94 | 1360 | 63 |
| **Trust Total** | **63748** | **27674** | **8312** |

The sickness rate for this core service was 6.4% between 1 July 2016 to 30 June 2017 and fell to 3.4% in the most recent month's data (June 2017).

This core service had 23.4 WTE (10.9%) staff leavers between 1July 2016 to 30 June 2017.

The trust has advised they are unable to provide vacancy data by ward/team due to restrictions with the finance system. The most amount of detail held centrally is at provider level by profession. However, the trust provided us with data for this core service prior to the inspection which showed a vacancy rate of 8.7% for the service and 12.9% for band 5 and 6 nurses.

| Ward/Team | Substantive staff (As of June 2017) | Substantive staff Leavers | Average % staff leavers | Total % vacancies | Total % staff sickness (As of June 2017) | Ave % permanent staff sickness (over the past year) |
|---|---|---|---|---|---|---|
| **313 L6 AMH Community Clinic Therapy Management** | 41.1 | 5.6 | 13.3% | Unable to provide | 1.0% | 4.2% |
| **313 L6 AMH Community Management** | 17.0 | 2.6 | 14.0% | Unable to provide | 3.5% | 3.2% |
| **313 L6 AMH Community Team City** | 29.3 | 3.2 | 11.0% | Unable to provide | 6.3% | 6.1% |
| **313 L6 AMH Community Team East** | 15.2 | 3.8 | 23.4% | Unable to provide | 1.9% | 16.2% |
| **313 L6 AMH Community Team West** | 26.6 | 2.0 | 7.3% | Unable to provide | 0.0% | 9.2% |
| **313 L6 AMH Complex Assertive Outreach** | 35.0 | 1.0 | 2.9% | Unable to provide | 2.7% | 3.7% |
| **313 L6 AMH CPLD Psychology** | 13.6 | 0.8 | 6.2% | Unable to provide | 0.0% | 1.4% |

| Services | | | | | | |
|---|---|---|---|---|---|---|
| **313 L6 AMH ICL Recovery Services** | 17.4 | 2.0 | 11.1% | Unable to provide | 0.6% | 2.9% |
| **313 L6 AMH ICL Rehab** | 2.0 | 1.0 | 52.2% | Unable to provide | 5.4% | 7.8% |
| **313 L6 AMH Medical & Neuro Psychology** | 13.9 | 1.4 | 10.1% | Unable to provide | 0.8% | 3.2% |
| **Core service total** | 211.2 | 23.4 | 10.9% | Unable to provide | 3.4% | 6.4% |

The compliance for mandatory training courses as of 30 June 2017 is 86%. Of the training courses listed 11 failed to achieve the trust target of 85% (exception of 95% for information governance training) and five failed to score above 75%.

MAPA Holding Skills (High Risk) course scored the lowest out of all the training courses with 0% however there was only one eligible member of staff. This was followed by Moving & Handling - Level 2 at 50%, display screen equipment at 60%, Infection Prevention & Control - Level 2 at 71% and Mental Health Act for Nurses at 71%.

A number of teams were below 75% for some of the mandatory training. Community Clinic Therapy Management was below 75% training compliance for two out of 19 modules (11% of all modules), Complex Assertive Outreach was below 75% training compliance for one out of 19 modules (5% of all modules) and CPLD Psychology Services was below 75% training compliance for 0 out of 16 modules (0% of all modules).

Key:

| *Below CQC 75%* | Between 75% & Trust Target | **Above Trust Target** |
|---|---|---|

| Service | Community Clinic Therapy Management | Community Management | Community Team City | Community Team East | Community Team West | Complex Assertive Outreach | CPLD Psychiatry | CPLD Psychology Services | ICL Recovery Services | Medical & Neuro Psychology |
|---|---|---|---|---|---|---|---|---|---|---|
| Total number of staff | 48 | 17 | 32 | 17 | 32 | 41 | 4 | 16 | 20 | 18 |
| (Core Mandatory) Conflict Resolution - 3 Years | 95.8% | 100.0% | 93.8% | 82.4% | 93.8% | 95.1% | 100.0% | 100.0% | 90.0% | 88.9% |
| | (46/48) | (17/17) | (30/32) | (14/17) | (30/32) | (39/41) | (4/4) | (16/16) | (18/20) | (16/18) |
| (Core Mandatory) Display Screen Equipment (DSE) - Once | *75.0%* | *58.8%* | *56.3%* | *23.5%* | *37.5%* | *73.2%* | *75.0%* | 87.5% | *40.0%* | *66.7%* |
| | (36/48) | (10/17) | (18/32) | (4/17) | (12/32) | (30/41) | (3/4) | (14/16) | (8/20) | (12/18) |
| (Core Mandatory) Equality, Diversity & | 91.7% | 100.0% | 93.8% | 82.4% | 90.6% | 97.6% | 100.0% | 100.0% | 90.0% | 88.9% |
| | (44/48) | (17/17) | (30/32) | (14/17) | (29/32) | (40/41) | (4/4) | (16/16) | (18/20) | (16/18) |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Human Rights - 3 Years | | | | | | | | | | |
| (Core Mandatory) Fire Safety Awareness - 1 Year | 81.3% | 88.2% | 78.1% | 64.7% | 78.1% | 87.8% | 75.0% | 100.0% | 60.0% | 72.2% |
| | (39/48) | (15/17) | (25/32) | (11/17) | (25/32) | (36/41) | (3/4) | (16/16) | (12/20) | (13/18) |
| (Core Mandatory) Health, Safety & Welfare - 3 Years | 93.8% | 100.0% | 93.8% | 82.4% | 93.8% | 97.6% | 100.0% | 100.0% | 85.0% | 88.9% |
| | (45/48) | (17/17) | (30/32) | (14/17) | (30/32) | (40/41) | (4/4) | (16/16) | (17/20) | (16/18) |
| (Core Mandatory) Infection Prevention & Control - Level 1 - 3 Years | 81.8% | 100.0% | n/a | 100.0% | n/a | n/a | 100.0% | 100.0% | 100.0% | 88.9% |
| | (9/11) | (15/15) | n/a | (1/1) | n/a | n/a | (4/4) | (16/16) | (7/7) | (16/18) |
| (Core Mandatory) Information Governance - 1 Year | 89.6% | 88.2% | 87.5% | 82.4% | 90.6% | 90.2% | 75.0% | 93.8% | 90.0% | 77.8% |
| | (43/48) | (15/17) | (28/32) | (14/17) | (29/32) | (37/41) | (3/4) | (15/16) | (18/20) | (14/18) |
| (Core Mandatory) Moving & Handling - Level 1 - 3 Years | 91.7% | 100.0% | 93.8% | 82.4% | 93.8% | 92.7% | 100.0% | 100.0% | 85.0% | 88.9% |
| | (44/48) | (17/17) | (30/32) | (14/17) | (30/32) | (38/41) | (4/4) | (16/16) | (17/20) | (16/18) |
| (Core Mandatory) Safeguarding Adults - Level 1 - 3 Years | 89.6% | 100.0% | 93.8% | 82.4% | 93.8% | 92.7% | 100.0% | 100.0% | 85.0% | 88.9% |
| | (43/48) | (17/17) | (30/32) | (14/17) | (30/32) | (38/41) | (4/4) | (16/16) | (17/20) | (16/18) |
| (Core Mandatory) Safeguarding Children - Level 1 - 3 Years | 89.6% | 100.0% | 93.8% | 82.4% | 93.8% | 92.7% | 100.0% | 100.0% | 85.0% | 88.9% |
| | (43/48) | (17/17) | (30/32) | (14/17) | (30/32) | (38/41) | (4/4) | (16/16) | (17/20) | (16/18) |
| (Clinical Mandatory) Adult Basic Life Support - 1 Year | 86.8% | 100.0% | 81.3% | 81.3% | 81.3% | 85.4% | n/a | 80.0% | 69.2% | 60.0% |
| | (33/38) | (2/2) | (26/32) | (13/16) | (26/32) | (35/41) | n/a | (12/15) | (9/13) | (9/15) |
| (Clinical Mandatory) Adult Immediate Life Support - 1 Year | n/a | n/a | n/a | n/a | n/a | n/a | 75.0% | n/a | n/a | n/a |
| | n/a | n/a | n/a | n/a | n/a | n/a | (3/4) | n/a | n/a | n/a |
| (Clinical Mandatory) Safeguarding Adults - Level 2 - 3 Years | 97.4% | 100.0% | 90.6% | 87.5% | 81.3% | 95.1% | 100.0% | 100.0% | 69.2% | 100.0% |
| | (37/38) | (5/5) | (29/32) | (14/16) | (26/32) | (39/41) | (4/4) | (15/15) | (9/13) | (15/15) |
| (Clinical Mandatory) Safeguarding Children - Level 2 - 3 Years | 97.4% | 80.0% | 93.8% | 100.0% | 78.1% | 92.7% | 75.0% | 100.0% | 46.2% | 100.0% |
| | (37/38) | (4/5) | (30/32) | (16/16) | (25/32) | (38/41) | (3/4) | (15/15) | (6/13) | (15/15) |
| (Clinical Mandatory) Mental Capacity Act - 3 Years | 97.4% | 80.0% | 93.8% | 87.5% | 71.9% | 90.2% | n/a | 86.7% | 69.2% | 100.0% |
| | (37/38) | (4/5) | (30/32) | (14/16) | (23/32) | (37/41) | n/a | (13/15) | (9/13) | (15/15) |
| (Clinical Mandatory) Moving & Handling - Level 2 - 2 Years | n/a | 0.0% | n/a | n/a | n/a | n/a | n/a | n/a | 100.0% | n/a |
| | n/a | (0/1) | n/a | n/a | n/a | n/a | n/a | n/a | (1/1) | n/a |
| (Clinical Mandatory) MAPA Disengagement Skills - 3 Years | 94.7% | 100.0% | 90.6% | 81.3% | 93.8% | 97.6% | 75.0% | 100.0% | 91.7% | 80.0% |
| | (36/38) | (1/1) | (29/32) | (13/16) | (30/32) | (40/41) | (3/4) | (15/15) | (11/12) | (12/15) |
| (Clinical | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 0.0% | n/a |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Mandatory) MAPA Holding Skills (High Risk) - 1 Year | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | (0/1) | n/a |
| (Clinical Mandatory) SCIP-UK - 1 Year | n/a | 100.0% | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| | n/a | (1/1) | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| (Clinical Mandatory) Record Keeping & Care Planning - 2 Years | 76.3% | 100.0% | *71.9%* | *62.5%* | *65.6%* | 75.6% | n/a | 86.7% | *46.2%* | 86.7% |
| | (29/38) | (2/2) | (23/32) | (10/16) | (21/32) | (31/41) | n/a | (13/15) | (6/13) | (13/15) |
| (Clinical Mandatory) Infection Prevention & Control - Level 2 - 2 Years | 78.4% | 100.0% | *65.6%* | *68.8%* | *75.0%* | 75.6% | n/a | n/a | *38.5%* | n/a |
| | (29/37) | (2/2) | (21/32) | (11/16) | (24/32) | (31/41) | n/a | n/a | (5/13) | n/a |
| (Clinical Mandatory) Hand Hygiene - 2 Years | 86.5% | 100.0% | 81.3% | 100.0% | 87.5% | 97.6% | *50.0%* | n/a | *69.2%* | n/a |
| | (32/37) | (2/2) | (26/32) | (16/16) | (28/32) | (40/41) | (2/4) | n/a | (9/13) | n/a |
| (Clinical Mandatory) Medicines Management - 2 Years | n/a | *0.0%* | 88.5% | *72.7%* | *56.0%* | 96.2% | *50.0%* | n/a | *33.3%* | n/a |
| | n/a | (0/1) | (23/26) | (8/11) | (14/25) | (25/26) | (2/4) | n/a | (1/3) | n/a |
| (Clinical Mandatory) Mental Health Act for Nurses - 3 Years | *61.1%* | *0.0%* | *69.2%* | *72.7%* | *68.0%* | 84.6% | n/a | n/a | *66.7%* | n/a |
| | (11/18) | (0/1) | (18/26) | (8/11) | (17/25) | (22/26) | n/a | n/a | (2/3) | n/a |
| (Clinical Mandatory) Mental Health Act for Doctors - 2 years | n/a | n/a | n/a | n/a | n/a | n/a | *75.0%* | n/a | n/a | n/a |
| | n/a | n/a | n/a | n/a | n/a | n/a | (3/4) | n/a | n/a | n/a |

**Assessing and managing risk to patients and staff**

**Assessment of patient risk**

Staff had completed and regularly reviewed risk assessments for 75% of patients. Out of 36 records reviewed, four patients had no risk assessment and staff had not updated five risk assessments.

**Management of patient risk**

During our visit, we observed staff respond quickly to a sudden deterioration in patient's health. The staff member left immediately to support a patient who had taken an overdose.

Staff monitored waiting lists and responded to increases in risk levels. The trust had introduced a patient tracker tool to support managers to monitor waiting lists. Staff met weekly to review the patient tracker list and took appropriate action, such as bringing forward an assessment to respond to changing levels of risk.

The service had developed personal safety protocols to keep staff safe, especially when lone working. The service had introduced new lone worker devices. These devices looked like a staff identity badge. Staff used the devices to log their whereabouts at the start and end of a patient visit. Staff could activate the devices to call the office base and relay a live recording. The staff member answering the call could listen and decide on the course of action required. However, a number of staff told us they were still waiting to complete training that would authorise them to use the devices. These staff were left without any device and had to call in and out of the service with their phones.

**Safeguarding**

Team managers at the sites visited provided data that evidenced 88% of staff had completed safeguarding training as of 30 September 2017. Data provided by the trust for the service

evidenced that 91% of staff had completed safeguarding adults training and 86% children's safeguarding as of 30 June 2017. Staff were able to explain how to raise a safeguarding alert. We saw evidence in patient records and through observation of a joint working meeting with social services that staff worked with the local authority to safeguard vulnerable adults and children.

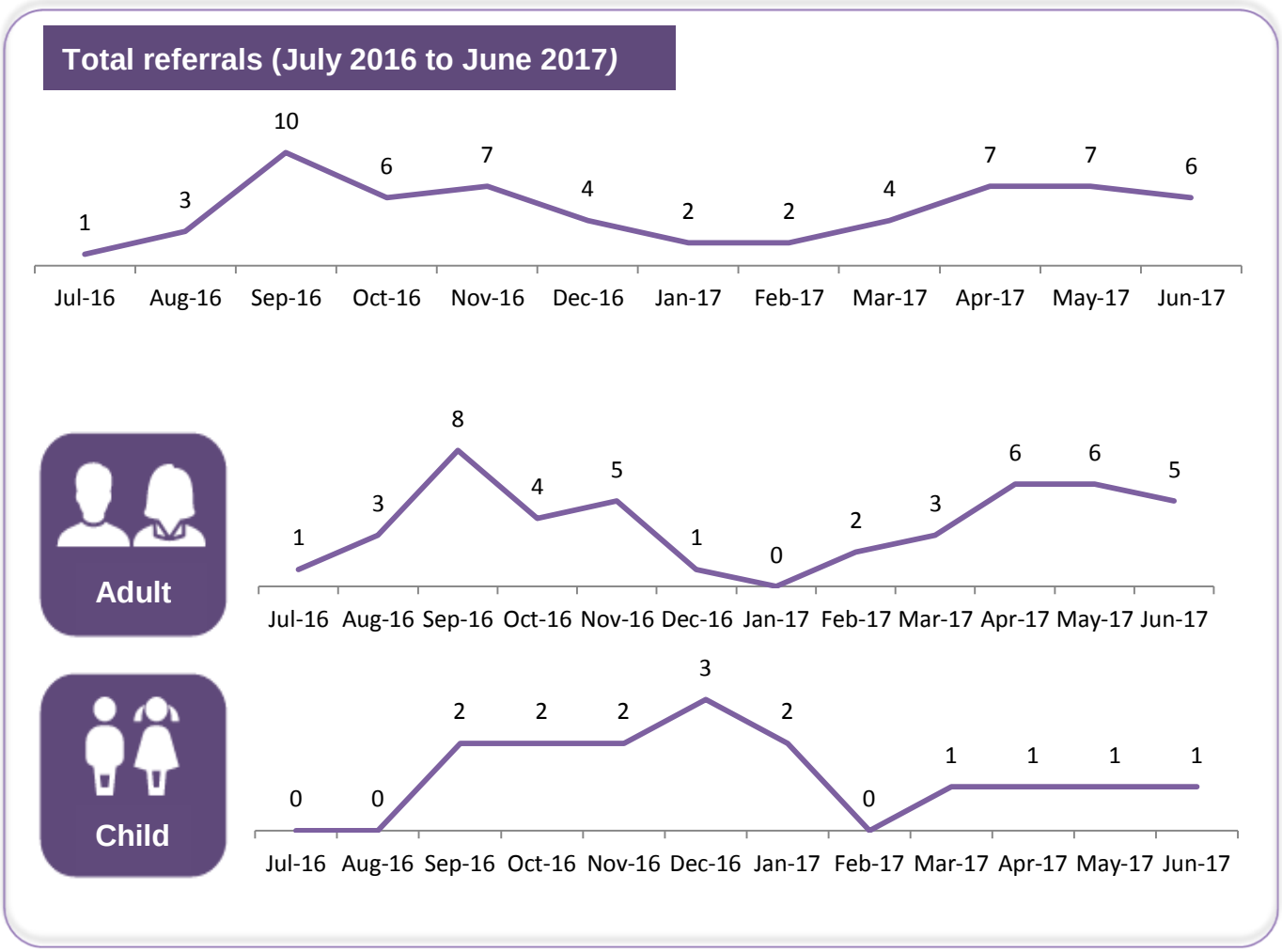
A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 59 safeguarding referrals between 1 July 2016- 30 June 2017, of which 44 concerned adults and 15 children.

| Referrals | | |
|---|---|---|
| Adults | **Children** | **Total referrals** |
| 44 | **15** | **59** |

There was one peak identified in adult referrals across the period in August 2016 with eight referrals.



**Staff access to essential information**

Staff used an electronic records system for the majority of records. Some records were held in paper files. The trust was starting a scanning project to put all records on the electronic system. Staff told us they were concerned about the time needed to scan and upload the documents. Staff told us that the system was sometimes inaccessible. Staff we spoke with reported that a feature of the system, whereby records written off line would automatically upload, did not work. The trust had provided some staff with technological equipment to access the system away from the office. Staff that did not have this equipment could not work as flexibly as their colleagues. Managers told us that there were plans to provide all staff with the necessary equipment.

**Medicines management**

The service had developed a policy for the storage and transportation of medicines following the previous inspection. During our visit we checked clinic rooms at four locations and medicines arrangements at all five locations. At city central and city east staff had not consistently recorded the temperature of medicines fridges. At four of the five locations, staff had not recorded the allergy status of patients on medication cards. Medicines were stored and transported correctly at all sites visited. There was no dedicated pharmacy input to the team. This was raised as a concern during the last inspection. However, staff reported that they could access support from the trust pharmacy team when required.

**Track record on safety**

The service had reported 19 serious incidents between 1 July 2016 and 30 June 2017. Managers had reported 15 of these to the Strategic Information Executive System. The most common type was apparent/actual/suspected self-inflicted harm. Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 July 2016 and June 2017 there were 15 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was apparent/actual/suspected self-inflicted harm.

A ‘never event’ is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

The number of serious incidents reported during this inspection is the same as the 19 reported at the last inspection.

| Ward | Type of incident reported | Total |
|---|---|---|
| Assertive Outreach - County | Abuse/alleged abuse of adult patient by third party | 1 |
| AMH Outpatients / Homeless Team | Apparent/actual/suspected homicide meeting SI criteria | 1 |
| AMH South Leicestershire CMHT | Apparent/actual/suspected homicide meeting SI criteria | 1 |
| AMH Charnwood CMHT | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| AMH City Central CMHT | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| AMH City East CMHT | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| AMH City West CMHT | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| AMH East Leics CMHT | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| AMH South Leicestershire CMHT | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| City West CMHT | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| Dynamic Psychotherapy | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| Melton, Rutland & Harb CMHT | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| North West Leics CMHT | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| City Central CMHT | Confidential information leak/information governance breach meeting SI criteria | 1 |
| North West Leics CMHT | Confidential information leak/information governance breach meeting SI criteria | 1 |
| | Total | 15 |

**Reporting incidents and learning from when things go wrong**

Staff knew what incidents to report and how to report them. Staff told us that they would report incidents on the trust's electronic incident system.

Staff understood the duty of candour. They told us how they explained to patients and families if things went wrong. Team managers told us about visiting relatives to talk to them about incidents.

Managers discussed learning from investigation of incidents with staff in monthly team meetings. Staff told us about this and we saw minutes from team meetings that confirmed this. The trust issued a quarterly serious incident newsletter, which included wider learning. Managers told us about changes made from feedback following incident investigations. These included making staff aware of personality disorder training available through the trust.

The service had introduced a new lone worker safety device for staff. This device was discreet and enabled staff to summon help quickly if needed. However, not all staff had completed the training required to enable them to use the device.

Staff told us that they received de briefs following serious incidents and managers and colleagues provided support. However, non-medical staff reported that managers did not offer them debriefs, even though they were often involved in incidents.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there has been one 'prevention of future death' reports sent to Leicestershire Partnership Trust related to this core service, details of which can be found below.

There was one prevention of future deaths report in relation to this service in October 2016.

The Coroner stated that there was ample evidence available to suggest that the patient was starting to experience psychotic symptoms from May onwards, but opportunities were missed to fully and adequately explore these and reconsider the necessity for in-patient care.
On 29 July the final missing person search was commenced. The patient was discovered to have taken their own life

The Coroner's concerns were:

- There are currently no local psychiatric intensive care unit beds for female patients and this means all female patients can only be placed out of area, potentially many miles away from home and local support.
- There was no, or no effective, community psychiatric nurse involvement and this was a missed opportunity to monitor and assist the patient when they were in the community.
- The "community support" referred to by the in-patient clinicians does not exist in reality for patients with this challenging presentation, leaving discharged patients and their families without adequate support.
- The care programme approach (CPA) was not adhered to and NICE guidelines were not followed, specifically in ensuring there was a review after two admissions within six months, and to ensure the roles and responsibilities of all health and social care professionals involved were identified.
- There is no local network for the community support of patients diagnosed with personality disorder, although evidence suggested such networks were effective when adopted elsewhere.
- The trust responded to this report with the actions they were taking to address the concerns raised by the Coroner.

## Is the service effective?

**Assessment of needs and planning of care**

We reviewed 36 care records during the inspection. Staff had completed and regularly reviewed care plans for 55% of patient records checked. Seven patient records reviewed had no care plan and staff had not updated a further nine patient care plans. Out of these, 50% evidenced patient's views but only 6% were detailed. Staff had completed holistic care plans for 76% patients, although 51% were not thorough.

Staff had completed physical health assessments for 48% of patient records reviewed. Of these, 36% were comprehensive.

**Best practice in treatment and care**

Staff provided a range of care and treatments to patients. These included occupational therapy interventions, for example, model of human occupation and group activities and psychological interventions, such as family therapy and cognitive behavioural therapy. Charnwood community mental health team had recently introduced an educational programme for patients with bi polar disorder. Staff supported patients with their medication and helped them to access support with housing, employment and benefits. Staff told us that they followed national institute for healthcare excellence guidance for the treatment of schizophrenia, bi-polar and depression.

In patient records reviewed, staff had evidenced provision of ongoing physical health support to 67% of patients. We observed a clinic at city central where staff administered injections of anti-psychotic medication to patients. Staff did not ask the patients about their physical health or carry out any physical health observations before administering the injection. Staff told us that they did not carry out any physical observations and encouraged patients to see their GP as part of the shared care agreement. Other teams reported that GP's were not always engaging with the shared care agreement and that the lead pharmacist had escalated this issue.

Staff used health of the nation outcomes scores, brief symptom inventory, social phobia ratings, Glasgow antipsychotic side effect scale, Liverpool University neuroleptic side effect rating scale and clustering to monitor outcomes for patients.

The service had participated in a number of audits, including GP contacts, pregabalin prescribing, outpatients on care programme approach, record keeping and cares planning, infection control and risk of suicide.

This core service participated in three clinical audits as part of their clinical audit programme.

| Audit Scope | Audit type | Audit Name/Title |
|---|---|---|
| AMH.LD | Clinical | Pregabalin Prescribing - Charnwood outpatient clinic |
| AMH.LD | Clinical | Outpatients on CPA. Are we following the Trust guidelines? |
| FYPC | Clinical | EIP Self-Assessment |

**Skilled staff to deliver care**

Teams consisted of nurses, health care support workers, psychologists, occupational therapists, and psychiatrists. The trust had stopped funding social work provision resulting in the local authority withdrawing social worker input from some of the teams. Staff reported that this had been challenging and had increased caseloads and resulted in a lack of joint working. An example of this was social workers completing assessments for patients without discussion with the care coordinator or professional lead. The service did not have any dedicated pharmacy input. We had raised this as an issue in the last inspection. However, staff told us they could access pharmacy support from the trust when required. The pharmacy team had also developed a medication policy for community teams.

Managers provided staff with regular supervisions and appraisals. Data provided by managers of the teams visited evidenced supervision rates to be at 72% and appraisals at 94%. Managers told us that supervisions had taken place for staff but not all had been recorded. This was the result of a recent change whereby staff had to log their own supervision. Previously managers had done this. Managers had been reminding staff to do this. Psychologists provided weekly group supervisions to some teams. Staff reported that this was useful.

Managers facilitated monthly business meetings with their teams. We reviewed minutes of these meetings. These meetings included learning from incidents and complaints, updates from the wider trust, link working and feedback from different roles within the team.

Managers discussed training and development needs with staff in supervisions and appraisals. Staff completed a range of mandatory training relevant to their role. Senior staff completed leadership training. Staff told us that they had completed additional training on topics including public heath, phlebotomy and cognitive behavioural therapy. Staff had identified that they required specialist training relating to community treatment orders and the process when a patient required recalling back to hospital. The team managers had forwarded a proposal to the trust for this training and were waiting for confirmation.

Managers dealt with poor staff performance. We reviewed records relating to two staff that had undergone performance management. We saw that managers had raised issues and put support in place to enable staff to reach required targets.

The trust's target rate for appraisal compliance is 80%. As at 30 June 2017, the overall appraisal rates for non-medical staff within this core service was 91%.

The/teams failing to achieve the trust's appraisal target were AMH ICL Day Services (77%), AMH ICL Recovery Services (79%) and AMH ICL OT (25%).

The rate of appraisal compliance for non-medical staff reported during this inspection is higher than the 77% reported at the last inspection.

| Ward | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| 313 L6 AMH Community Clinic Therapy Management | 99 | 88 | 89% |
| 313 L6 AMH Community Management | 36 | 33 | 92% |
| 313 L6 AMH Community Team City | 67 | 56 | 84% |
| 313 L6 AMH Community Team East | 34 | 30 | 88% |
| 313 L6 AMH Community Team West | 65 | 55 | 85% |
| 313 L6 AMH Complex Assertive Outreach | 80 | 80 | 100% |
| 313 L6 AMH CPLD Psychology Services | 32 | 30 | 94% |
| 313 L6 AMH ICL Acute Recovery | 53 | 57 | 108% |
| 313 L6 AMH ICL Day Services | 13 | 10 | 77% |
| 313 L6 AMH ICL Management | 3 | 4 | 133% |
| 313 L6 AMH ICL OT | 4 | 1 | 25% |
| 313 L6 AMH ICL Recovery Services | 19 | 15 | 79% |
| 313 L6 AMH Medical & Neuro Psychology | 18 | 15 | 83% |
| Core service total | 523 | 487 | 91% |
| Trust wide | 4118 | 3693 | 90% |

No appraisals data for permanent medical staff was provided by the trust for this core service.

Between 31 July 2016 and 30 June 2017 the average clinical supervision rate across all ten teams in this core service was 64%.

**Caveat:** there is no national standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

| | Clinical supervision target | Clinical supervision delivered | Clinical supervision rate (%) |
|---|---|---|---|
| 313 L6 AMH Community Clinic Therapy Management | 463 | 351 | 76% |

| | | | |
|---|---|---|---|
| 313 L6 AMH Community Management | 53 | 26 | 49% |
| 313 L6 AMH Community Team City | 388 | 216 | 56% |
| 313 L6 AMH Community Team East | 188 | 112 | 60% |
| 313 L6 AMH Community Team West | 367 | 198 | 54% |
| 313 L6 AMH Complex Assertive Outreach | 482 | 347 | 72% |
| 313 L6 AMH CPLD Psychology Services | 176 | 135 | 77% |
| 313 L6 AMH ICL Recovery Services | 149 | 62 | 42% |
| 313 L6 AMH Medical & Neuro Psychology | 15 | 9 | 60% |
| Core service total | **2281** | 1456 | 64% |
| Trust Total | **41953** | **26832** | **64%** |

**Multidisciplinary and interagency team work**

The teams held weekly multidisciplinary meetings. All members of the multidisciplinary team attended these. We observed a multidisciplinary meeting. Team members discussed patients in detail and participants were encouraged to share their clinical view. Matters discussed included risk management, care plans, medication, the hopes and aspirations of the patient and social inclusion.

The service had recently introduced protocols for working with other teams within the trust. Staff told us that there had been issues working with some of the other teams, including access to crisis support. The new protocols were helping to resolve these issues.

The service had links with external agencies, including GP's and social services. Staff reported that some GP's were not adhering to the shared care agreements. Since social workers had been withdrawn from the teams staff told us of issues relating to communication with social services. These issues included lack of joint working and not receiving feedback on safeguarding referrals. This resulted in patients not receiving the level of support they required. An example of this was a patient who the community team had assessed as requiring supported accommodation following their planned discharge from inpatient services. The social work team undertook their own assessment without any discussion with the community team and concluded the patient could return to unsupported accommodation.

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

Mental Health Act training for this core service was at 71% compliance at 30 June 2017.

Staff demonstrated a good understanding of the Mental Health Act, especially about community treatment orders. Team managers were sourcing additional training for staff on the processes involved in community treatment orders.

The service did not receive any specific support from the Mental Health Act team.

We did not find any evidence in records checked that staff had explained rights to patients subject to community treatment orders. Charnwood and city east did not display information about advocacy services. Of 11 patients asked, 82% were aware of advocacy services.

Staff had completed community treatment order paperwork correctly in patient records checked.

| Service | Total number of staff | (Clinical Mandatory) Mental Health Act for Nurses - 3 Years | (Clinical Mandatory) Mental Health Act for Doctors - 2 years |
|---|---|---|---|

| | | | |
|---|---|---|---|
| **313 L6 AMH Community Clinic Therapy Management** | 48 | 61.1% (11/18) | n/a |
| **313 L6 AMH Community Management** | 17 | 0% (0/1) | n/a |
| **313 L6 AMH Community Team City** | 32 | 69.2% (18/26) | n/a |
| **313 L6 AMH Community Team East** | 17 | 72.7% (8/11) | n/a |
| **313 L6 AMH Community Team West** | 32 | 68.0% (17/25) | n/a |
| **313 L6 AMH Complex Assertive Outreach** | 41 | 84.6% (22/26) | n/a |
| **313 L6 AMH CPLD Psychology Services** | 16 | n/a | n/a |
| **313 L6 AMH ICL Recovery Services** | 20 | 66.7% (2/3) | n/a |
| **313 L6 AMH Medical & Neuro Psychology** | 18 | n/a | n/a |

### Good practice in applying the Mental Capacity Act

Mental Capacity Act training for this core service was at 87% at 30 June 2017.

Staff were able to describe how they applied the Mental Capacity Act within their roles. Staff told us that they are continually assessing patient's capacity during every interaction. We observed a staff member undertaking an assessment of a patient's capacity to understand their finances. Of 36 patient records checked, 78% included evidence of mental capacity assessments, either formal or informal.

The trust had a Mental Capacity Act policy. There was no evidence that staff carried out audits of the application of the Mental Capacity Act.

| Service | Total number of staff | (Clinical Mandatory) Mental Capacity Act - 3 Years |
|---|---|---|
| **313 L6 AMH Community Clinic Therapy Management** | 48 | 97.4% (37/38) |
| **313 L6 AMH Community Management** | 17 | 80.0% (4/5) |
| **313 L6 AMH Community Team City** | 32 | 93.8% (30/32) |
| **313 L6 AMH Community Team East** | 17 | 87.5% (14/16) |
| **313 L6 AMH Community Team West** | 32 | 71.9% (23/32) |
| **313 L6 AMH Complex Assertive Outreach** | 41 | 90.2% (37/41) |
| **313 L6 AMH CPLD Psychiatry** | 4 | n/a |
| **313 L6 AMH CPLD** | 16 | 86.7% (13/15) |

| | | |
|---|---|---|
| **Psychology Services** | | |
| **313 L6 AMH ICL Recovery Services** | 20 | 69.2% (9/13) |

## Is the service caring?

### Kindness, privacy, dignity, respect, compassion and support

We observed staff treating patients with dignity and respect. Staff were empathetic, kind, non-judgemental and supportive. We observed staff listening attentively and responding positively to meet patients' needs. However, at city central we observed a member of staff talking to a patient with their back towards them, only turning round occasionally to look at them. Another member of staff at city central was dismissive of a patient who had been waiting for 20 minutes in the reception area.

We observed staff talking to patients about their care and supporting them to access the right treatments. An example of this was a staff member making plans with a patient to refer them to psychology.

Patients told us staff were kind, compassionate, empathetic, approachable and respectful. One patient told us that staff go above and beyond. Another told us that staff had saved their life and one patient told us their support was brilliant.

We observed staff addressing patients personal, social and cultural needs. Staff knew the patients well and expressed interest in the patients and their families.

Staff maintained confidential records for patients.

### The involvement of people in the care they receive

### Involvement of patients

The involvement of patients in care planning and risk assessment was variable across the service. We observed staff discussing care plans with some patients during home visits. Of 13 patients asked, 85% said they were involved in their care and 54% said staff had offered them a copy of their care plan. In care records reviewed, 50% included patients' views.

We observed staff using paraphrasing and reflection to ensure patients understood their care and treatment.

Patients and staff told us that there were no opportunities for patients to be involved in decision about the service, for example, recruitment of staff. The service used the friends and family test to gather feedback from patients. The assertive outreach team had conducted a survey of patient experience of the service.

Staff were aware of the local advocacy service and 82% of 11 patients asked were aware of how to access advocacy.

### Involvement of families and carers

Patients told us that staff involved their families and carers with their permission. We observed staff involving carers during home visits.

### Access and waiting times

The service had clear criteria for which patients could be offered a service. We reviewed the service operational policy that detailed this.

The assertive outreach team had a target time from assessment to treatment of six weeks. The community mental health teams had a target time from assessment to treatment of six weeks for routine appointments and 5 days for urgent appointments.

The assertive outreach team reported six patients on the waiting list for treatment. City east reported 13 patients on the waiting list, city west reported five patients and Charnwood seven.

Data provided by the trust reported 2891 breaches of waiting times from October 2016 to September 2017. Psychiatric outpatients was responsible for 2094 of the breaches, with city east reporting the highest of these breaches at 429. There were 39 breaches of the five day urgent referral target for community mental health teams, with Charnwood reporting 14 of these. The community mental health teams and assertive outreach team reported 550 breaches of the routine referral target. Charnwood reported the most at 138. Charnwood reported that a patient referred in April 2017 would not get an appointment until February 2018. City central reported that a patient referred in July 2017 would not get an appointment until February 2018.

We observed staff responding promptly to phone calls from patients. An example of this was a patient calling to advise they had taken an overdose. The nurse left immediately to respond to the situation.

The provider had a 'did not attend' procedure for staff to follow. Due the nature of the patient group, the assertive outreach team had their own 'did not attend' procedure. Staff would attempt to re-engage patients with services by offering a choice of where and when to meet.

Staff rarely cancelled patient appointments and if they did, they would explain and apologise to the patient and re schedule for as soon as possible.

Team managers used a patient tracking tool to monitor patients on the waiting list. The multidisciplinary team reviewed this every two weeks.

Staff continued to support patients if they required treatment in another service, for example, inpatient wards. Staff would attend reviews and support the patient to plan for their transfer back into the community.

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

No target times were provided by the trust. AMH Dynamic Psychotherapy Service Group had the longest median days from referral to initial assessment 222 days. AMH HD Advisory Service had the longest median days from assessment to treatment times. The median waiting time was 162 days.

| Name of hospital site or location | Name of in-patient ward or unit | Days from referral to initial assessment<br>**Actual (median)** | Days from assessment to treatment<br>**Actual (median)** | Comments, clarification |
|---|---|---|---|---|
| Evington Centre RT5AP | AMH Assertive Outreach Assessment | 38 | 10 | |
| Evington Centre RT5AP | AMH Assertive Outreach Inpatients | 37 | 0 | |
| Evington Centre RT5AP | AMH Assertive Outreach Treatment | 59 | 5 | |
| Evington Centre RT5AP | AMH Cognitive Behavioural Therapy Assessment | 77 | 23 | |
| Evington Centre RT5AP | AMH Cognitive Behavioural Therapy Group | 109 | 25 | |
| Evington Centre | AMH Cognitive Behavioural Therapy | 73 | 21 | |

| | | | | |
|---|---|---|---|---|
| RT5AP | Individual | | | |
| Evington Centre RT5AP | AMH Community Mental Health | 40 | 26 | |
| Evington Centre RT5AP | AMH Dynamic Psychotherapy Service - ATC | 36 | 7 | |
| Evington Centre RT5AP | AMH Dynamic Psychotherapy Service Assessment | 80 | 24 | |
| Evington Centre RT5AP | AMH Dynamic Psychotherapy Service Brief | 170 | 9 | |
| Evington Centre RT5AP | AMH Dynamic Psychotherapy Service Group | 222 | 52 | |
| Evington Centre RT5AP | AMH Dynamic Psychotherapy Service Individual | 86 | 12 | |
| Evington Centre RT5AP | AMH Forensic Community | 47 | 27 | |
| Evington Centre RT5AP | AMH Forensic Community Group | 24 | 10 | |
| Evington Centre RT5AP | AMH Forensic Outpatient | 45 | 50 | |
| Evington Centre RT5AP | AMH Homeless Mental Health Service | 6 | 9 | |
| Evington Centre RT5AP | AMH Medical Psychology | 62 | 24 | |
| Evington Centre RT5AP | AMH Medical Psychology Community Group | 17 | 11 | |
| Evington Centre RT5AP | AMH Neuro Psychology | 22 | 14 | |
| Evington Centre RT5AP | AMH Outpatients | 84 | 86 | |
| Evington Centre RT5AP | AMH Personality Disorder Service Assessment Group | 106 | 34 | |
| Evington Centre RT5AP | AMH Personality Disorder Service Group | 96 | 12 | |
| Evington Centre RT5AP | AMH Personality Disorder Service Individual | 84 | 74 | |
| Evington Centre RT5AP | AMH Personality Disorder Service Individual Assessment | 160 | 29 | |
| Evington Centre RT5AP | AMH Psycho Oncology Community | 24 | 28 | |

| | | | | |
|---|---|---|---|---|
| Evington Centre RT5AP | AMH Psycho Oncology Community Group | 37 | 27 | |
| Evington Centre RT5AP | AMH Psycho Oncology Outpatient | 72 | 64 | |
| Evington Centre RT5AP | AMH Psychology Adult | 40 | 24 | |
| Evington Centre RT5AP | AMH Psychology Complex | 54 | 22 | |
| Evington Centre RT5AP | Early Intervention Community Group | 61 | 0 | |
| Evington Centre RT5AP | Early Intervention Service | 27 | 8 | |
| Evington Centre RT5AP | Early Intervention Service - Assessment | 14 | 9 | |

**The facilities promote comfort, dignity and privacy**

The service had a range of rooms and equipment to support treatment and care to patients. The exception to this was Charnwood, which did not have an examination couch and city east which had no emergency drugs, defibrillator or blood pressure machine.

**Patients' engagement with the wider community**

Staff supported patients to access education, employment and other services in their communities.

**Meeting the needs of all people who use the service**

The service was accessible to patients with a disability. There was some information available to patients in the waiting areas on treatments and local services. The service was able to provide leaflets in other languages on request. Managers told us they could request an interpreter when required.

Staff in the assertive outreach team applied to a charity for funds to provide activities for patients based upon their needs.

**Listening to and learning from concerns and complaints**

We asked 14 patients if they knew how to make a complaint, 72% said they did. Two patients told us about raising concerns that they did not get on with their key worker. The team managers listened to these concerns and allocated a different staff member. Team managers told us about specific complaints and how they responded. They advised they would either ring or arrange to meet the complainant in person. If they were unable to resolve the complaint to the patient's satisfaction, they would escalate it within the trust.

Staff told us that they encourage patients to raise concerns and try to resolve them locally if possible. Staff would support patients to make a formal complaint and would talk them through the process. Staff told us that there was a central person in the trust who managed complaints. Staff advised that they try to learn from complaints to improve the service. Team managers and staff told us outcomes from complaints investigations are discussed in weekly business meetings and supervisions. We reviewed minutes of meetings that confirmed this.

This core service received 74 complaints between 1 July 2016 and 30 June 2017.
The number of complaints reported during this period is lower than the 80 reported at the last inspection.

AMH South Leicestershire CMHT received the highest number of complaints of all the locations for this core service and seven of these were relating to all aspects of clinical treatment.

| Ward | Total Complaints | Most common Theme |
|---|---|---|
| AMH South Leicestershire CMHT | 22 | All aspects of clinical treatment (7) |
| AMH City Central CMHT | 11 | All aspects of clinical treatment (4)<br>Attitude of staff (4) |
| AMH City West CMHT | 9 | All aspects of clinical treatment (4) |
| AMH City East CMHT | 8 | All aspects of clinical treatment (3)<br>Attitude of staff (3) |
| AMH West Leics CMHT | 6 | All aspects of clinical treatment (3) |
| AMH Charnwood CMHT | 5 | All aspects of clinical treatment (3) |
| Assertive Outreach | 5 | All aspects of clinical treatment (1)<br>Attitude of staff (1)<br>Communication / information to patients (written and oral) (1)<br>Other (1)<br>Patients privacy and dignity (1) |
| CBT | 3 | All aspects of clinical treatment (2) |
| AMH NW Leicestershire CMHT | 2 | All aspects of clinical treatment (1)<br>Attitude of staff (1) |
| | | |
| Forensic CMHT | 2 | All aspects of clinical treatment (2) |
| AMH Melton Rutland & Harborough | 1 | Appointments, delay / cancellation (outpatient) (1) |
| Core service Total | **74** | **All aspects of clinical treatment (30 )** |

This core service received 40 compliments during the last 12 months from 1 July 2016 and 30 June 2017. The Medical Psychology team received the most compliments with 14.

| Hospital | Ward | Total Compliments |
|---|---|---|
| Hadley House | Medical Psychology | 14 |
| Gwendolen House | CBT | 8 |
| Hawthorn Centre | AMH NW Leicestershire CMHT | 5 |
| Loughborough Hospital | AMH Charnwood CMHT | 4 |
| OSL House | Homeless Team | 3 |
| OSL House | AMH Clinical Psychology Admin | 2 |
| OSL House | Assertive Outreach | 2 |

| | | |
|---|---|---|
| Cedars Centre | AMH South Leicestershire CMHT | 1 |
| Orchard Resource Centre | AMH West Leics CMHT | 1 |
| OSL House | Assertive Outreach County | 0 |
| Core service Total | | **40** |

## Is the service well-led?

**Leadership**

Team managers we met with demonstrated that they had the skills, knowledge and experience to perform in their roles. They had a good understanding of their service and many of them had worked as nurses in their teams before promotion to their current role. Team managers were visible in their services and staff told us that they were approachable. The trust provided senior staff with opportunities to develop their leadership skills. They told us they could access a range of leadership courses within the trust.

**Vision and strategy**

Of staff asked, 60% were aware of the provider's vision and values. The majority of staff (92%) told us that they had opportunity to be involved in service developments.

**Culture**

Staff told us they felt respected and supported by their team managers and were proud to work for their teams. There was some impact on staff morale due to high caseloads.

All staff asked told us they felt able to raise concerns without fear of retribution and knew about the trust whistle blowing process.

Managers dealt with poor staff performance. We reviewed records relating to two staff that had undergone performance management. We saw that managers had raised issues and put support in place to enable staff to reach required targets.

Staff told us that teams worked well together. However, staff from some disciplines reported that they were being used for general work, for example, duty cover that took them away from their role specific duties. This was a result of staff shortages.

Staff told us that managers discussed career development in appraisals. Managers were supporting two healthcare support workers to train to become qualified staff.

The service had low sickness rates; the sickness rate for permanent staff was 3.4% as of 30 June 2017. This was lower than the trust target of 4.5%.

The trust provided support for staff physical and emotional health needs through a free counselling service and occupational health support.

The trust recognised staff success and contribution through awards schemes. We saw one staff award displayed in the reception area. Another staff member told us about a long service award they had received.

During the reporting period, there were five cases where staff have been either suspended or placed under supervision or moved ward. One member of staff has been suspended and 4 had been moved to an alternative ward.

Of the five cases, the member of staff who was suspended the longest was for 39 weeks between 27 November 2015 and 26 August 2016.

**Caveat:** Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

| Name of Hospital or Site | Name of Ward/Team | Alternative duties | Suspended |
|---|---|---|---|
| Gwendolen House | CPLD | 2 | 0 |
| Cedars Centre | CPLD | 0 | 1 |
| The Maidstone Centre | CPLD | 1 | 0 |
| The Gillivers | CPLD | 1 | 0 |

## Governance

Team managers facilitated weekly business meetings with their teams. These meetings included standard agenda items set by the trust to ensure managers shared and discussed essential information, such as learning from incidents and complaints.

Managers told us that they had implemented recommendations following investigations into serious incidents and complaints. An example of this was the introduction of a specific 'did not attend' procedure for the assertive outreach team. This procedure included the requirement for all patients to have a 'did not attend' care plan. We viewed patients records, which confirmed these were in place.

The service had participated in a number of audits, including GP contacts, pregabalin prescribing, outpatients on care programme approach, record keeping and cares planning, infection control and risk of suicide.

Staff told us about procedures in place for working with other teams and external agencies. We reviewed procedures relating to working with other teams within the trust.

The trust have provided their board assurance framework, which details any risk scoring three or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. There are no risks relating to this core service identified.

The trust has provided a document detailing their highest profile risks.
The following relate to this core service.

**Key:**

| High (15-20) | Moderate (8-15) | Low 3-6 | Very Low (0-2) |
|---|---|---|---|

| Opened | ID | Description | Risk level (initial) | Risk score (current) | Risk level (target) | Link to BAF strategic objective no. | Last review date |
|---|---|---|---|---|---|---|---|
| | 1516 | There is a risk that patient-centred risk assessments, records and care plans are not updated consistently in line with changes to patients' needs or risks. This could lead to patient harm as well as having a detrimental impact on effective care planning and reputation | 12 Moderate | 8 Moderate | | | 30/07/2017 |

**Management of risk, issues and performance**

Staff had access to the risk register and were able to escalate any concerns.

Team managers had drawn up contingency plans to ensure business continuity in the event of emergencies, for example, adverse weather.

Staff and team managers told us that a recent cost cutting exercise, which had resulted in a reduction of staffing levels had left the service struggling. The impact was higher caseloads. Staff told us they were struggling to keep patient records up to date, but that they prioritised direct contact with patients.

**Information management**

Team managers told us that the trust used a variety of systems to collect data. Managers told us that having different systems was complicated.

Staff told us that the electronic system used for patient records was sometimes inaccessible and would crash. The trust was working towards providing staff with the technology needed to enable them to work more flexibly. For staff that did not have this technology, the systems were difficult to access remotely.

Team managers showed us monthly performance reports they received from the trust. These included information on supervisions, appraisals, training and care records. Managers told us that the data was often incorrect and they would then have to spend time finding the correct information and feeding this back to the trust.

**Engagement**

The service did not provide patients and carers with any updates about the work of the trust, for example, through a newsletter.

The service sought feedback through the friends and family tests. The assertive outreach team had conducted a survey of patient satisfaction.

The service did not provide patients and carers with opportunities to get involved in decision making about changes to the service.

Managers told us that members of the trust board visit services and talk to patients and staff.

**Learning, continuous improvement and innovation**

Managers told us that there were research opportunities but it was difficult for staff to get involved due to time constraints.

One of the teams was currently piloting a caseload complexity tool. This tool enabled managers to review staff caseloads and the level of patient engagement. The tool would be rolled out to the other teams if found to be effective.

Two of the teams were piloting joint assessments to reduce waiting lists.

Senior managers have been meeting with local GP's to address the issue of them not wanting to take patients who are ready for discharge from the community mental health team. Managers have offered training to GP's to support them to feel confident to take patients with mental health issues.

The service had not participated in any audits or accreditation schemes.

# Mental health crisis services and health-based places of safety

## Facts and data about this service

| Location site name | Team name | Number of clinics | Patient group (male, female, mixed) |
|---|---|---|---|
| Bradgate Mental Health Unit | Crisis Home Treatment Services | N/A | Not provided |
| Bradgate Mental Health Unit | Acute Recovery Team | N/A | Not provided |
| Bradgate Mental Health Unit | Acute Assessment Services | N/A | Not provided |
| Bradgate Mental Health Unit | Liaison Psychiatry Services | N/A | Not provided |
| Bradgate Mental Health Unit | Triage Care | N/A | Not provided |
| Bradgate Mental Health Unit | Health-based Place of Safety | N/A | Mixed |

## Is the service safe?

**Safe and clean environment**

The trust had made improvements to the health based place of safety since our last inspection. The unit had been completely refurbished to meet Royal College of Psychiatry guidelines. The unit was now able to accommodate two patients; nursed in separate facilities. Facilities were now suitable to support a child or young person if required. The unit was located in a discreet and quiet location and was secure. It had been redesigned to assist the assessment process and enabled patients to be safely managed. The trust had installed closed circuit television to monitor patient safety. It had an emergency alarm system, and furniture that should not cause injury.

There was a clinical nurse manager identified as the person in charge of the Health based place of safety. There was dedicated staffing who were supernumerary and attached to the acute wards responsible for the place of safety. Staffing levels were sufficient 24 hours a day to enable handover of a detained person from the police as soon as possible after arrival.

We found that medication was stored and managed appropriately at each location. There was no clinic room at the Bradgate Unit crisis team; however there was a locked cupboard with stock of regularly prescribed medications secured to the wall of the team office. The health based place of safety had a fully equipped resuscitation trolley and small supply of stock medication in a locked cupboard in the nursing office. The trust had rectified concerns from our last inspection by providing nurses with lockable bags for transporting medication to patients in the community.

Staff regularly updated risk assessments of the care environment. We reviewed the environmental risk assessments in all locations and found that most ligature risks had been removed. Where risks remained, the trust had plans to manage the risks identified. A ligature risk is any fixed item which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.

The assessment rooms used by the crisis team posed a risk to patients and staff. The team had access to three assessment rooms in which they saw the most challenging patients. These rooms did not have anti-barricade doors and the rooms only had one exit. There was lightweight furniture and office equipment that could be used as a weapon or as means to barricade the exit. It was not possible for staff to be visible whilst assessing in these rooms as glass panels in the doors were frosted. However, staff carried working alarms to summon assistance if needed.

Staff working in the crisis team staff carried identification badges when in the community, which when activated would identify their location via GPS signal.

The décor, furniture and carpets at the crisis resolution home treatment team were stained and in need of updating.

Staff maintained cleaning records; which were up to date and demonstrated that the premises were cleaned regularly. Staff maintained equipment and kept it clean. The ‘clean’ stickers were visible and in date.

Staff adhered to infection control principles, including handwashing. There were visible reminders for staff and patients to wash their hands in bathrooms.

**Safe staffing**

**Definition**

Substantive – how many staff in post currently.
Establishment – substantive plus vacancies, e.g. how many they want or think they need in post.

| **Substantive staff figures** | | | **Trust target** |
|---|---|---|---|
| Total number of substantive staff | At June 2017 | 114.6 | N/A |
| Total number of substantive staff leavers | 01 July 2016 -30 June 2017 | 7.7 | N/A |
| Average WTE* leavers over 12 months (%) | 01 July 2016 -30 June 2017 | 6.7% | 10% |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) | Vacancy data could not be provided | N/A | N/A |
| Total vacancies overall (%) | Vacancy data could not be provided | N/A | N/A |
| Total permanent staff sickness overall (%) | At June 2017 | 7.2% | 4.5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Establishment levels nursing assistants (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Number of vacancies, qualified nurses (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Number of vacancies nursing assistants (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Qualified nurse vacancy rate | Vacancy data could not be provided | N/A | N/A |
| Nursing assistant vacancy rate | Vacancy data could not be provided | N/A | N/A |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified and unqualified nurses) | 1 July 2016 to 30 June 2017 | 1494 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (qualified and unqualified nurses) | 1 July 2016 to 30 June 2017 | 1834 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (qualified and unqualified nurses) | 1 July 2016 to 30 June 2017 | 321 | N/A |

*WholeTime Equivalent

The trust has advised they are unable to provide establishment or vacancy data by ward/team due to restrictions with the finance system. The most amount of detail held centrally is at provider level by profession. However, the trust provided vacancy data prior to the inspection which showed an overall vacancy rate of 12.9% and 18.9% for band 5 and 6 nurses in the crisis service.

Between 1 July 2016 and 30 June 2017, bank staff filled 1494 shifts to cover sickness, absence or vacancy for qualified nurses and unqualified nurses. The trust was unable to provide a breakdown detailing how this was split between qualified and unqualified nurses.

In the same period, agency staff covered 1834 shifts. 321 shifts were unable to be filled by either bank or agency staff. Therefore, data showed that 15% of shifts were not filled. On these occasions, teams worked below established staffing levels.

| Ward | Available shifts | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|---|
| 313 L6 AMH ICL Acute Assessment | N/A | 0 | 0 | 0 |
| 313 L6 AMH ICL Acute Recovery | N/A | 0 | 0 | 0 |
| 313 L6 AMH ICL Crisis | N/A | 1494 | 1834 | 321 |
| 313 L6 AMH ICL Liaison Services | N/A | 0 | 0 | 0 |
| **Core service total** | N/A | 1494 | 1834 | 321 |
| **Trust Total** | N/A | 63748 | 27674 | 8312 |

The sickness rate for this core service was 6.6% between 1 July 2016 and 30 June 2017. This is similar to the sickness rate of the trust in the 12 months (5.1%) before the last inspection.

This core service had 7.7 staff leavers between 1 July 2016 and 30 June 2017. This is similar to the number of staff leavers reported before the last inspection (9 staff leavers).

The trust has advised they are unable to provide vacancy data by ward/team due to restrictions with the finance system. The most amount of detail held centrally is at provider level by profession.

Staff we spoke with told us that sickness was rarely covered within the team and that staff leaving the team had left the team short staffed making it difficult to achieve the team's target of assessing patients within 4 hours.

| Ward/Team | Substantive staff (As of June 2017) | Substantive staff Leavers | Average % staff leavers | Total % vacancies | Total % staff sickness (As of June 2017) | Ave % permanent staff sickness (over the past year) |
|---|---|---|---|---|---|---|
| **313 0110 Crisis Resolution** | 50.6 | 2.5 | 4.6% | N/A | 12.0% | 8.5% |
| **313 0250 Liaison & Diversion Pilot** | 12.8 | 1.4 | 12.9% | N/A | 0.2% | 2.9% |
| **313 0255 Urgent Care** | 5.0 | 0 | 0.0% | N/A | 18.7% | 2.3% |
| **313 0260 Mental Health Triage Car** | 4.0 | 1 | 24.5% | N/A | 0.0% | 0.0% |
| **313 0265 Deliberate Self Harm** | 6.0 | 0 | 0.0% | N/A | 20.0% | 8.0% |

| | | | | | | |
|---|---|---|---|---|---|---|
| **313 0275 Access Bed Management Team** | 11.2 | 1.8 | 14.8% | N/A | 3.2% | 2.8% |
| **313 0280 PAVE** | 2.0 | 0 | 0.0% | N/A | 0.0% | 0.0% |
| **313 0380 Liaison Psychiatry Service** | 5.4 | 0 | 0.0% | N/A | 0.0% | 2.4% |
| **313 0400 Medical Staffing - Liaison Psychiatry** | 2.9 | 0 | 0.0% | N/A | 0.0% | 10.9 % |

The compliance for mandatory training courses as of 30 June 2017 is 87%. Of the training courses listed nine failed to achieve the trust target of 85% (exception of 95% for information governance training) and four failed to score above 75%.

Moving & Handling - Level 2 course scored the lowest out of all the training courses with 62%. This was followed by display screen equipment at 65%, adult immediate life support with 70% and fire safety awareness with 74%.

A number of teams were below 75% for some of the mandatory training. AMH ICL Crisis was below 75% training compliance for one out of 23 modules (4% of all modules). AMH ICL Liaison Services was below 75% training compliance for five out of 23 modules (22% of all modules). AMH Medical Services below 75% training compliance for six out of 18 modules (33% of all modules).

Key:

| *Below CQC 75%* | Between 76% & 89% | **Above 90%** |
|---|---|---|

| **Service** | 313 L6 AMH ICL Crisis | 313 L6 AMH ICL Liaison Services | 313 L6 AMH Medical Services |
|---|---|---|---|
| **Core service** | MH - Mental health crisis services and health-based places of safety. | MH - Mental health crisis services and health-based places of safety. | MH - Mental health crisis services and health-based places of safety. |
| **Total number of staff** | 106 | 18 | 48 |
| **(Core Mandatory) Conflict Resolution - 3 Years** | 95.30% | 88.90% | 97.90% |
| | (101/106) | (16/18) | (47/48) |
| **(Core Mandatory) Display Screen Equipment (DSE) – Once** | 80.20% | *16.70%* | *50.00%* |
| | (85/106) | (3/18) | (24/48) |
| **(Core Mandatory) Equality, Diversity & Human Rights - 3 Years** | 97.20% | 88.90% | 97.90% |
| | (103/106) | (16/18) | (47/48) |
| **(Core Mandatory) Fire Safety Awareness - 1 Year** | 83.00% | *50.00%* | *64.60%* |
| | (88/106) | (9/18) | (31/48) |

| | | | |
|---|---|---|---|
| **(Core Mandatory) Health, Safety & Welfare - 3 Years** | 96.20% | 88.90% | 97.90% |
| | (102/106) | (16/18) | (47/48) |
| **(Core Mandatory) Infection Prevention & Control - Level 1 - 3 Years** | 90.00% | 75.00% | 97.90% |
| | (9/10) | (3/4) | (47/48) |
| **(Core Mandatory) Information Governance - 1 Year** | 88.70% | 83.30% | *68.80%* |
| | (94/106) | (15/18) | (33/48) |
| **(Core Mandatory) Moving & Handling - Level 1 - 3 Years** | 91.50% | 88.90% | 97.90% |
| | (97/106) | (16/18) | (47/48) |
| **(Core Mandatory) Safeguarding Adults - Level 1 - 3 Years** | 91.50% | 83.30% | 97.90% |
| | (97/106) | (15/18) | (47/48) |
| **(Core Mandatory) Safeguarding Children - Level 1 - 3 Years** | 91.50% | 83.30% | 97.90% |
| | (97/106) | (15/18) | (47/48) |
| **(Clinical Mandatory) Adult Basic Life Support - 1 Year** | 81.10% | 76.90% | n/a |
| | (73/90) | (10/13) | n/a |
| **(Clinical Mandatory) Adult and Paediatric Basic Life Support - 1 Year** | n/a | 100.00% | n/a |
| | n/a | (1/1) | n/a |
| **(Clinical Mandatory) Adult Immediate Life Support - 1 Year** | 100.00% | n/a | *66.70%* |
| | (6/6) | n/a | (32/48) |
| **(Clinical Mandatory) Safeguarding Adults - Level 2 - 3 Years** | 93.90% | 76.90% | 85.40% |
| | (93/99) | (10/13) | (41/48) |
| **(Clinical Mandatory) Safeguarding Children - Level 2 - 3 Years** | 90.90% | 85.70% | 78.70% |
| | (90/99) | (6/7) | (37/47) |
| **(Clinical Mandatory) Safeguarding Children - Level 3 - 3 Years** | n/a | 100.00% | 100.00% |
| | n/a | (7/7) | (1/1) |

| | | | |
|---|---|---|---|
| (Clinical Mandatory) Mental Capacity Act - 3 Years | 93.90% | 85.70% | n/a |
| | (93/99) | (12/14) | n/a |
| (Clinical Mandatory) Moving & Handling - Level 2 - 2 Years | *66.70%* | *57.10%* | n/a |
| | (4/6) | (4/7) | n/a |
| (Clinical Mandatory) MAPA Disengagement Skills - 3 Years | 97.80% | 92.90% | 89.40% |
| | (88/90) | (13/14) | (42/47) |
| (Clinical Mandatory) MAPA Holding Skills (High Risk) - 1 Year | 100.00% | n/a | n/a |
| | (6/6) | n/a | n/a |
| (Clinical Mandatory) Record Keeping & Care Planning - 2 Years | 90.90% | 85.70% | n/a |
| | (90/99) | (12/14) | n/a |
| (Clinical Mandatory) Infection Prevention & Control - Level 2 - 2 Years | 79.20% | *71.40%* | n/a |
| | (76/96) | (10/14) | n/a |
| (Clinical Mandatory) Hand Hygiene - 2 Years | 89.60% | 78.60% | 75.00% |
| | (86/96) | (11/14) | (36/48) |
| (Clinical Mandatory) Medicines Management - 2 Years | 79.50% | 91.70% | *70.20%* |
| | (62/78) | (11/12) | (33/47) |
| (Clinical Mandatory) Mental Health Act for Nurses - 3 Years | 83.30% | 75.00% | n/a |
| | (65/78) | (9/12) | n/a |
| (Clinical Mandatory) Mental Health Act for Doctors - 2 years | n/a | n/a | 87.50% |
| | n/a | n/a | (42/48) |

**Assessing and managing risk to patients and staff**

We looked at 24 patient records for the crisis teams; including six patient records each for the psychiatric liaison team, mental health triage team and the health based place of safety. All records were comprehensive and contained up to date and regularly reviewed risk assessments.

**Assessment of patient risk**

Staff completed a risk assessment of every patient at telephone triage and then conducted a further more detailed risk assessment and updated it regularly, including after any incident.

The trust had devised a risk assessment tool for use across the crisis resolution home treatment team. A similar core assessment was used by the mental health triage teams and health based place of safety.

We saw that staff created and made good use of crisis plans with patients taking the lead in the planning of their care. However advance decisions were rarely used.

**Management of patient risk**

Staff responded promptly to sudden deterioration in a patient's health. Patients we spoke with told us that staff had responded to their crisis promptly and utilised skills in the team to best meet patients' needs.

The crisis and mental health triage teams did not hold a waiting list. However in the psychiatric liaison team there was a maximum of a 39 week wait to see a consultant against a target of 13 weeks. Staff did not maintain oversight of changes to patient risks whilst waiting for assessment.

The service had developed good personal safety protocols, including lone working practices, and there was evidence that staff followed them. There were staff whereabouts boards in team offices, and staff carried identification badges with GPS trackers which could be activated to alert an external team to their whereabouts, should assistance be needed.

**Safeguarding**

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm. That included working in partnership with other agencies.

However, the trust provided data prior to the inspection which showed this core service made no safeguarding referrals between 1 July 2016 and 30 June 2017.Subsequent data provided showed three safeguarding alerts made by staff which had been wrongly allocated to another team. However, we saw evidence in patient records that staff were referring safeguarding concerns to the local authority in accordance with policy. Staff we spoke with during our inspection reported that this was due to safeguarding alerts not being accurately recorded on the trusts electronic incident recording system. Managers were aware of the issue and had raised the anomalies at a service governance meeting. At the time of the inspection, we were concerned that managers did not have accurate oversight of the numbers of safeguarding alerts raised by staff to ensure patients were protected from abuse.

**Staff access to essential information**

The trust used electronic recording systems for all patients within adult mental health meaning that information was accessible to staff when they needed it, including when patients moved between teams. However, staff working within the child and adolescent mental health services used a different recording system, to which not all staff in adult mental health teams had access. This meant when the crisis team and the health based place of safety staff provided out of hours support for children and young people, staff relied on comprehensive handovers from other teams; as opposed to electronic records. There was a risk that staff might not have access to all relevant information at all times for the safe care and treatment of children and young people.

**Medicines management**

Staff followed good practice in medicines management when medicines were administered on site or in patients' own homes. Staff transported medication in locked bags to patients in the community.

Teams did not provide direct physical health monitoring. However, the patient records showed that staff had discussed the need to monitor for side effects of medication both with the patient and with their GP and the frequency of entries in patient records showed that physical health concerns were monitored when needed.

**Track record on safety**

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 July 2016 and June 2017 there were four STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was *Apparent/actual/suspected self-inflicted harm* with three.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was not comparable with STEIS. Three serious incidents were missing from the PIR. Two of these were in relation to apparent/actual/suspected self-inflicted harm and one was in relation to a commissioning incident.

The number of serious incidents reported during this inspection is lower than the six reported at the last inspection.

| Ward | Type of incident reported | Total |
|---|---|---|
| **Bed Management** | Commissioning incident meeting SI criteria | 1 |
| **Crisis Resolution Team** | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 2 |
| **Deliberate Self Harm Team** | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| | **Total** | **4** |

## Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been five 'prevention of future death' reports sent to the trust. One of these related to this core service, details of which can be found below.

There was one prevention of future deaths report in relation to this service in October 2016.

The Coroner stated that there was ample evidence available to suggest that the patient was starting to experience psychotic symptoms from May onwards, but opportunities were missed to fully and adequately explore these and reconsider the necessity for in-patient care.
On 29 July the final missing person search was commenced. The patient was discovered to have taken their own life

The Coroner's concerns were:

- There are currently no local psychiatric intensive care unit beds for female patients and this means all female patients can only be placed out of area, potentially many miles away from home and local support.
- There was no, or no effective, community psychiatric nurse involvement and this was a missed opportunity to monitor and assist the patient when they were in the community.
- The "community support" referred to by the in-patient clinicians does not exist in reality for patients with this challenging presentation, leaving discharged patients and their families without adequate support.
- The care programme approach (CPA) was not adhered to and NICE guidelines were not followed, specifically in ensuring there was a review after two admissions within six months, and to ensure the roles and responsibilities of all health and social care professionals involved were identified.
- There is no local network for the community support of patients diagnosed with personality disorder, although evidence suggested such networks were effective when adopted elsewhere.
- The trust responded to this report with the actions they were taking to address the concerns raised by the Coroner.

## Is the service effective?

**Assessment of needs and planning of care**

We reviewed 36 care records across the teams we visited. Records showed that staff completed a comprehensive mental health assessment of each patient. In the crisis team staff completed an initial telephone triage assessment; followed by a more detailed assessment during a subsequent appointment.

Care plans were written in a way that suggested the patient was engaged in their care and had the opportunity to set goals with their key worker.

Staff ensured that any necessary assessment of the patient's physical health had been completed. Physical health assessments were completed by the patients' GP, staff in the accident and emergency department or during an inpatient admission.

Staff developed personalised, holistic and recovery-oriented care plans for patients that met the needs identified during assessment. Staff updated care plans regularly and as needed.

**Best practice in treatment and care**

This core service participated in one clinical audit as part of their clinical audit programme.

| Directorate | Core service | Audit type | Objective |
|---|---|---|---|
| **AMH.LD** | MH - Mental health crisis services and health-based places of safety | Clinical | Record Keeping AMH - Crisis Resolution & Home Treatment Team 2015/16 |

Staff provided a range of care and treatment interventions in accordance with the national institute for health and care excellence guidance. These included medication and psychological therapies; such as cognitive behaviour therapy for anxiety and depression, mindfulness and relaxation techniques. The teams also referred to outside agencies for support for employment, housing and benefits, and interventions that enable patients to acquire daily living skills.

Staff ensured that patients' physical healthcare needs were being met, including their need for an annual health check. There was a shared care agreement between the trust and local GP surgeries in which the GP was responsible for ongoing monitoring of physical healthcare needs for their patients. However, staff maintained communication with GPs to ensure that monitoring was completed and updated the records accordingly.

Staff supported patients to live healthier lives – for example, through participation in smoking cessation schemes, acting on healthy eating advice, managing cardiovascular risks, screening for cancer, dealing with issues relating to substance misuse. This was done via the patients GP surgery.

Staff used recognised rating scales and other approaches to rate severity and to monitor outcomes for example, Health of the Nation Outcome Scales.

**Skilled staff to deliver care**

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

The team failing to achieve the trust's appraisal target were Liaison Psychiatry Service which had an appraisal rate of 60% and 67% respectively.

The rate of appraisal compliance for non-medical staff reported during this inspection is higher than the 78% reported at the last inspection.

| Ward | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| **313 0110 Crisis Resolution** | 57 | 53 | 93% |
| **313 0250 Liaison & Diversion Pilot** | 26 | 27 | 104% |
| **313 0255 Urgent Care** | 9 | 10 | 111% |
| **313 0260 Mental Health Triage Car** | 7 | 8 | 114% |
| **313 0265 Deliberate Self Harm** | 14 | 12 | 86% |
| **313 0275 Access Bed Management Team** | 25 | 24 | 96% |
| **313 0280 PAVE** | 2 | 2 | 100% |
| **313 0380 Liaison Psychiatry Service** | 12 | 8 | 67% |
| **313 2422 Vanguard** | 5 | 4 | 80% |
| **Core service total** | 157 | 148 | 94% |
| **Trust wide** | 4118 | 3693 | 90% |

No appraisals data for permanent medical staff was provided by the trust for this core service.

Between 1 July 2016 and 30 June 2017 the average rate of clinical supervision across all nine teams in this core service was 60% against a trust target of 85%. Staff we spoke with during inspection told us they received monthly managerial and group supervision as well as daily informal supervision within the teams. We were assured that senior managers were auditing the occurrence of clinical and managerial supervision and that staff were receiving supervision in line with the trust policy.

**Caveat:** there is no national standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

| Ward/Team | Clinical supervision target | Clinical supervision delivered | Clinical supervision rate (%) |
|---|---|---|---|
| **313 0110 Crisis Resolution** | 477 | 277 | 58% |
| **313 0250 Liaison & Diversion Pilot** | 157 | 101 | 64% |
| **313 0255 Urgent Care** | 54 | 44 | 81% |
| **313 0260 Mental Health Triage Car** | 53 | 33 | 62% |
| **313 0265 Deliberate Self Harm** | 73 | 45 | 62% |

| | | | |
|---|---|---|---|
| **313 0275 Access Bed Management Team** | 120 | 47 | 39% |
| **313 0280 PAVE** | 8 | 7 | 88% |
| **313 0380 Liaison Psychiatry Service** | 48 | 30 | 63% |
| **313 2422 Vanguard** | 17 | 16 | 94% |
| **Core service total** | 1007 | 600 | 60% |
| **Trust Total** | 41953 | 26832 | 64% |

The multidisciplinary teams were made up of a variety of professionals including psychiatrists, nurses, social workers, occupational therapists, support time and recovery workers and assistant mental health practitioners. The teams did not have access to a psychologist but other members of the team were skilled in short term psychological therapies such as cognitive behaviour therapy for anxiety and depression.

Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. Staff told us the trust had provided specialist training for their role. There was an incentive for support staff to become assistant mental health practitioners by completing extra training and also for mental health professionals to add to their qualifications.

All staff new to the trust received a trust 2 day induction alongside a specific induction to the team they would be working in.

We saw evidence in staff files that managers dealt with poor staff performance promptly and effectively.

**Multidisciplinary and interagency team work**

Teams held effective multidisciplinary team meetings. We observed two meetings with the crisis and psychiatric liaison teams and found that staff shared information about appointment allocation, risks and case formulation within these meetings.

Staff shared information about patients at effective handover meetings within the team at shift changeover times.

The community teams had good working links, including effective handovers, with primary care, social services, and other teams external to the organisation. Staff spoke about good links with GP practices and a crisis house run by an external organisation. Amongst other services several patients gave positive feedback about a local mindfulness group which had aided their recovery.

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

Mental Health Act training for this core service was at 84% compliance at 30 June 2017 against the trust target of 85%.

| Service | Total number of staff | (Clinical Mandatory) Mental Health Act for Nurses - 3 Years | (Clinical Mandatory) Mental Health Act for Doctors - 2 years |
|---|---|---|---|
| **313 L6 AMH ICL Crisis** | 106 | 83% (65/78) | N/A |
| **313 L6 AMH ICL Liaison Services** | 18 | 75% (9/12) | N/A |
| **313 L6 AMH Medical Services** | 48 | N/A | 88% (42/48) |

Staff were trained in and had a good understanding of the Mental Health Act (1983) particularly relating to Community Treatment Orders, the Code of Practice and the guiding principles.

The trust employed a mental health act administrator to provide support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were.

The provider had relevant policies and procedures that reflected the most recent guidance.

Staff we spoke with told us they had easy access to Mental Health Act policies and procedures and to the Code of Practice on the trust internet

We saw evidence in patient records that if the team worked with patients who were detained under the Mental Health Act or subject to a Community Treatment Order, staff explained to patients their rights in a way they could understand. There was evidence in records that the advice had been repeated, and patients had been given a leaflet explaining their rights.

Care plans referred to identified Section 117 aftercare services to be provided for patients who had been subject to detention under relevant parts of the Mental Health Act.

If the team worked with patients detained under the Mental Health Act or subject to a Community Treatment Order, staff did regular audits to ensure that the Act was being applied correctly and there was evidence of learning from the audits. Managers also conducted audits of three case notes each on a weekly basis. Managers discussed any learning with staff during supervision.

**Good practice in applying the Mental Capacity Act**

Mental Capacity Act training for this core service was at 88% at 30 June 2017.

| Service | Total number of staff | (Clinical Mandatory) Mental Capacity Act - 3 Years |
|---|---|---|
| **313 L6 AMH ICL Crisis** | 106 | 94% (93/99) |
| **313 L6 AMH ICL Liaison Services** | 18 | 86% (12/14) |
| **313 L6 AMH Medical Services** | 48 | N/A |

Staff were trained in and had a good understanding of the Mental Capacity Act 2005; we saw entries in patient records that showed patients' capacity was appropriately assessed.

The trust's Mental Capacity Act policy was available on the intranet for all staff to access.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the capacity. Where capacity was assessed it was completed on a decision-specific basis with regard to significant decisions.

Staff we spoke with gave examples of decisions that had been made in the patient's best interests, recognising the importance of the person's wishes feelings, culture and history.

Managers audited the application of the Mental Capacity Act as part of their weekly patient records audit, and discussed any learning with staff at supervision.

## Is the service caring?

**Kindness, privacy, dignity, respect, compassion and support**

We observed staff interacting with patients both over the telephone and face to face. Staff were respectful and responsive to patients' needs providing patients with help, emotional support and advice when needed.

Staff spoke positively about patients and were passionate about their work.

Staff supported patients to understand and manage their care, treatment or condition. Patients we spoke with were positive about the care they received and told us staff treated them well and they put their needs and wishes at the centre of their care plan.

Staff referred patients to other services when appropriate for example if patients in crisis needed support away from their usual home environment they were referred to a local crisis house provided by another organisation.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs, and were able to access additional support to meet the needs of the diverse patient group. Staff told us they were able to access interpreters at short notice.

Staff we spoke with understood and maintained the boundary of patient confidentiality.

**The involvement of people in the care they receive**

**Involvement of patients**

Patients we spoke with told us they were involved in formulating their care plans and risk assessments. Patients received copies of their care plans. We found evidence of this in the records we reviewed.

Staff communicated with patients to ensure they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Staff involved patients when appropriate in decisions about the service; for example, patients and carers sat on the recruitment panel and interviewed new staff.

The trust had recently devised a patient feedback survey in addition to the friends and family test. This was available electronically as well as in paper form.

Staff ensured that patients could access advocacy, both within the trust and from an independent advocacy service.

**Involvement of families and carers**

Carers we spoke with told us they had been involved in the care of their relative, and staff had provided support to them.

Carers were provided with information on how to access a carer's assessment and some of those we spoke with had accessed this service.

Carers were encouraged to provide feedback on the care their relative received via the friends and family test.

## Is the service responsive?

### Access and waiting times

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'. No target times were provided by the trust.

| Name of hospital site or location | Name of in-patient ward or unit | Days from referral to initial assessment | Days from assessment to treatment |
|---|---|---|---|
| | | Actual (mean) | Actual (mean) |
| **Bradgate Mental Health Unit RT5KF** | Acute Recovery Team - Nurse Led Clinics | 16 | 18 |
| **Bradgate Mental Health Unit RT5KF** | AMH Home Treatment Team | 1 | 1 |
| **Bradgate Mental Health Unit RT5KF** | AMH Place of Safety Unit | 0 | Not completed |
| **Bradgate Mental Health Unit RT5KF** | AMH Triage Car Service | 0 | Not completed |
| **Bradgate Mental Health Unit RT5KF** | AMH Urgent Care Centre Triage | 0 | 2 |

The service had clear criteria for patients accessing the service. Staff in the psychiatric liaison team discussed referrals in their weekly referrals meeting to determine how best to meet the patient needs. Staff placed patients were on a waiting list for assessment by either a psychiatrist or a qualified practitioner.

The psychiatric liaison team were not always meeting the target of 13 weeks for an assessment with a psychiatrist. Data provided during the inspection showed 110 patients on the waiting list, of which 36 (33%) had waited over 14 weeks. Thirteen patients had waited in excess of 20 weeks. The longest wait was 39 weeks. Staff told us this was partly due to the consultant covering consultant assessments in a different team. The trust included failure to meet agreed waiting time targets as a risk to patient safety and experience on the trust risk register.

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

The crisis team were not meeting targets for 4 hour or 24 hour assessments. A subsequent data request revealed that for the period April to August 2017 an average of only 32.5% of all referrals were assessed within 4 hours. The average number of referrals seen within a 24 hour period for April to August 2017 was 75%.There was, however, rapid access to a psychiatrist in the crisis team should a patient need to be assessed in an emergency

The teams responded promptly when patients telephoned the service. In the crisis team there were specific staff available to take calls and triage patients over the telephone.

The trust had improved staffing in the health based place of safety since our last inspection. The trust ensured dedicated staff were available to support patients accessing this service from the point of admission. These staff worked on the acute wards when the unit was not in use.

The teams tried to engage with people who found it difficult or were reluctant to engage with mental health services; staff arranged visits at times and places to suit the patient, and made repeated attempts to communicate with patients.

We saw evidence in patient records that the teams tried to make follow-up contact with people who did not attend appointments.

Staff offered patients flexibility with appointments, where possible. Staff cancelled appointments only when necessary and offered explanations and apologies. Staff assisted patients to access treatment as soon as possible. Appointments usually ran on time and patients were kept informed when delays occurred.

Staff supported patients during referrals and transfers to other teams and services from external organisations. Patients we spoke with told us that staff supported them when they accessed the local crisis house, and told us there was a smooth transition to the community mental health team when they needed ongoing care.

The trust had secured funding to enable crisis teams and mental health triage teams to support patients suffering from functional mental health difficulties out of hours, regardless of their age. This meant that children and young people, and older adults, could access the service out of hours.

**The facilities promote comfort, dignity and privacy**

The crisis team had three interview rooms in which they saw the most challenging patients. The rooms were unsafe; they did not have anti-barricade doors and there were no windows. There was lightweight furniture and office equipment which could have been used as a weapon, or to barricade the door. However, staff carried working alarms. Interview rooms had adequate soundproofing to promote confidentiality.

Staff working in the MH triage team had access to two interview rooms in the acute hospital. One was a temporary room whilst refurbishment was completed. The second room was purpose built. Both rooms were suitable for interviewing patients suffering from a mental health crisis and staff were supported but the security staff working for the acute hospital trust.

There was no clinic room at the mental health triage team, psychiatric liaison team or crisis team. The mental health triage team saw patients in the emergency department of the acute hospital and so a specific clinic room was not necessary. Similarly the psychiatric liaison team saw patients on physical health wards, at the Bradgate Unit, or in the community. The crisis team did not dispense medication or provide physical health screening routinely as this was done by GP services.

**Patients' engagement with the wider community**

When appropriate, staff ensured that patients had access to education and work opportunities. The trust linked with other agencies which supported patients with education and work as part of their recovery. The trust also provided a recovery college and involvement centre at the Bradgate unit.

Patients were encouraged to develop and maintain relationships with people that mattered to them, both within the services and the wider community. We saw evidence in care plans that carers support and community groups were encouraged as part of the recovery plan.

**Meeting the needs of all people who use the service**

The trust had ensured their services were accessible to patients with mobility difficulties and had processes in place to support patients with specific communication needs. Information leaflets were available in easy read format and in a variety of languages.

The trust had access to interpreters for patients whose first language was not English. When needed, the trust also had access to signers for patients with hearing difficulties.

**Listening to and learning from concerns and complaints**

This core service received 20 complaints between 1 July 2016 and 30 June 2017. Seven of these were related to attitude of staff and seven regarding all aspects of clinical treatment.

| Ward | Total Complaints | Most common Theme |
|---|---|---|
| Criminal Justice Service | 1 | Attitude of staff (1) |
| Crisis House | 1 | Communication / information to patients (written and oral) (1) |
| Crisis Resolution Team | 17 | All aspects of clinical treatment (7) |
| Triage Car | 1 | Communication / information to patients (written and oral) (1) |
| **Core service Total** | 20 | Attitude of staff (7)<br>All aspects of clinical treatment (7) |

This core service received seven compliments during the last 12 months from 1 July 2016 and 30 June 2017. All of these compliments were attributed to the Crisis Resolution Team.
Patients we spoke with told us they knew how to complain or raise concerns.

Staff we spoke with knew how to handle complaints appropriately, and told us that they tried to resolve as many issues as possible within the team.

Staff received feedback on the outcome of investigation of complaints and acted on the findings. We saw evidence of learning from complaints in team meeting minutes.

## Is the service well-led?

**Leadership**

Leaders had the skills, knowledge and experience to perform their roles.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

Staff we spoke with told us that leaders were visible in the service and approachable for patients and staff.

Leadership development opportunities were available, including opportunities for staff below team manager level.

**Vision and strategy**

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The trust's vision was to improve the health and wellbeing of the people of Leicester, Leicestershire and Rutland by improving high quality integrated physical and mental healthcare pathways. The trust values were respect, integrity, compassion and trust. The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Staff told us their annual appraisal was centred on the trust vision and values.

Staff were able to explain how they were working to deliver high quality care within the budgets available; by linking in with other agencies in the local community, providing mutual aid and support groups.

**Culture**

Staff we spoke with felt respected, supported and valued, and felt positive and proud about working for the provider and their team.

Staff we spoke with felt able to raise concerns without fear of retribution, and knew how to use the whistle-blowing process.

Teams worked well together. Staff we spoke with talked about a culture of mutual support and respect within the team.

Staff we spoke with told us that appraisals included conversations about career development and how it could be supported.

During the reporting period there were no cases where staff have been either suspended or placed under supervision. However, managers dealt with poor staff performance when needed. Managers told us how they dealt with poor staff performance, and explained the systems and processes that supported them.

**Governance**

The trust have provided their board assurance framework, which details any risk scoring three or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. There are no risks relating to this core service identified.

The trust has provided a document detailing their highest profile risks.
The following relate to this core service.

**Key:**

| High (15-20) | Moderate (8-15) | Low 3-6 | Very Low (0-2) |
|---|---|---|---|

| Opened | ID | Description | Risk level (initial) | Risk score (current) | Risk level (target) | Link to BAF strategic objective no. | Last review date |
|---|---|---|---|---|---|---|---|
| | 1516 | There is a risk that patient-centred risk assessments, records and care plans are not updated consistently in line with changes to patients' needs or risks. This could lead to patient harm as well as having a detrimental impact on effective care planning and reputation | 12 Moderate | 8 Moderate | | | 30 July 2017 |
| | 1866 | A lack of suitable transport for patients who may present behaviours which may cause risk of harm to themselves or others during transportation if the appropriate mode of | 12 Moderate | 9 Moderate | | | 30 July 2017 |

| | |
|---|---|
| | secure transport cannot be used. Delays in transportation can increase the risk of harm at the current location of the patient. |

There was a clear framework for discussion at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. We saw evidence of this in team meeting minutes.

Staff undertook or participated in clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. For example, care plan audits had resulted in staff making improvements to care planning documentation.

Staff we spoke with understood arrangements for working with other teams, both within the trust and external organisations, to meet the needs of the patients.

**Management of risk, issues and performance**
Staff maintained and had access to the risk register either at a team or directorate level and could escalate concerns when required through line managers.

Staff concerns matched those on the risk register. Staff in the psychiatric liaison team were concerned about the amount of time patients waited to see a psychiatrist.

**Information management**
The trust's quality dashboard did not support accurate collection of data to monitor staff performance in line with trust targets and safeguarding referrals. Senior managers told us, and data provided showed, that the information contained within the quality dashboard was unreliable. Senior staff advised that the quality dashboard did not accurately record the team activity; therefore administration staff were required to cleanse all data to show mitigation when target times were not met.

The trust had identified a recording issue in the data provided which was partly due to staff not recording correctly. However, the trust was not able to provide accurate data relating to safeguarding alerts made by staff, despite the anomalies in the information provided prior to the inspection being highlighted. We were concerned that senior managers had no oversight of whether staff were referring patients at risk of abuse appropriately.

Managers and staff reported that supervision was taking place. However, the data submitted by the trust did not reflect this. Data provided showed an overall compliance rate of 60% which was below the trust target of 85%. Managers kept local records to evidence compliance with supervision for their staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure worked well and helped to improve the quality of care by ensuring all staff had timely access to relevant and updated information to support patient care. However there were issues with the transfer of information between child and adolescent mental health services and adult mental health teams, as they used different electronic recording systems, not accessible to all staff.

Information governance systems included confidentiality of patient records.

Staff made notifications to external bodies as needed such as notifications to the CQC and safeguarding authorities.

**Engagement**

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. Patients' feedback to the crisis team requested flexibility of appointment times. Teams had implemented a system of which offered patients a morning or afternoon appointment. Staff notified patients when they left the office, ensuring it was clear when staff would arrive. Patients we spoke with told us this worked well for them.

Directorate leaders engaged with external stakeholders – such as commissioners and Healthwatch.

**Learning, continuous improvement and innovation**

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to support the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

No services within this core service are currently participating in any national accreditation schemes.

# Specialist community mental health services for children and young people

## Facts and data about this service

| Location site name | Team name | Number of clinics | Patient group (male, female, mixed) |
|---|---|---|---|
| **HQ Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester LE4 8PQ RT5Z1** | CAMHS Community Based Services - Eating Disorders Team | N/A | Not given |
| **HQ Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester LE4 8PQ RT5Z1** | CAMHS Community Based Services City Multidisciplinary Outpatients | N/A | Not given |
| **HQ Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester LE4 8PQ RT5Z1** | CAMHS Learning Disabilities Services | N/A | Not given |
| **The Agnes Unit RT5NH** | CAMHS Crisis Team | N/A | Not given |
| **HQ Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester LE4 8PQ RT5Z1** | CAMHS Primary Mental Health Service | N/A | Not given |
| **HQ Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester LE4 8PQ RT5Z1** | CAMHS Young Persons Team | N/A | Not given |

## Is the service safe?

**Safe and clean environment**

Interview rooms at Valentine Centre and Westcotes House were not equipped with alarms. Staff told us that they held personal alarms. At Westcotes House we tested one staff member's personal alarm but found it was not working. Some staff were unsure how to maintain their alarms. At Loughborough county team, there were no alarms fitted or personal alarms, staff would call out if they needed assistance.

We found the blood pressure machines at the three services were calibrated. Therefore, staff could ensure accurate measures of blood pressure were being recorded. However, the service did not have all equipment provided to carry out physical health observations at two sites. At the Valentine Centre we found blood pressure cuff were adults' size, no cuff for paediatric care, small sterile plasters were dated 2015, and no cleaning materials to clean equipment. At Westcotes House the ophthalmoscope (a device to view and capture retinal images) had no batteries.

At Westcotes House city team, we found the environment was not visibly clean and general maintenance of the building was poor. Rooms were smelly, carpets, and woodwork were marked and grubby. We saw a water service machine in the reception area labelled with a test date of June 2016. At Loughborough county team, we found some marked paintwork. At Valentine Centre in the video family therapy room, three items of electrical equipment were out

of date for safety testing. The family interview rooms did not have vision panels to keep people safe. Across the three services, we saw a range of cleaning and maintenance schedules. At the Valentine Centre improvements had been made cleaning materials were secured and stored safely.

Staff adhered to infection and control principles including had washing. We saw notices in the toilets to advising people to clean their hands and at services there were hand sanitising gels available.

Across the services, we found up to date ligature audits in place. Ligature cutters were available at all locations.

**Safe staffing**

The staffing data provided by the trust was not broken down into teams. For the whole service, there was 161 substantive staff with 5% vacancy rates. Westcotes House city team, had 14 whole time equivalent and Valentine Centre and Loughborough county teams had 31 whole time equivalent staff. Across the three services, we found teams had the required number of staff to match the service. Managers told us staff frequently worked across sites to meet the needs of patients.

In some teams locum and bank staff covered vacancies. One locum consultant covered for over one year at Valentine Centre and another locum was due to start late October and work between the county and city team. One locum nurse and one cognitive behaviour therapist were based at the Westcotes House city team. At Loughborough county team, there was one staff vacancy for psychology. The city team were advertising for a psychologist. Where there were other vacancies, staff shared the workload.

The service provided sickness rates across the three teams from April to August 2017 but did not identify team names. The sickness rates had reduced since our last inspection. At both county teams, the average sickness levels were between 5 and 7 %. Sickness levels in one county team were highest in August at 7%. The city team's sickness rates were high in April at 6% and reduced to nil in July and August. The city average sickness rates were 3% per cent. The trust absence target was 4%.

Managers told us there was little use of agency staff. Managers used bank and locum staff to fill vacant posts. Some locum staff worked as part of the recovery and improvement plan and focused on reducing the waiting lists. Staff told us some locum contracts would end in December 2017. Staff told us they were concerned that waiting lists levels would increase without the additional staff to manage waiting lists.

There was a new process for managing new referrals and waiting lists. We found there were separate waiting lists for each specific treatment pathway. Waiting times from referral to initial assessment was less 13 weeks. The trust was meeting its target in this area.

The average caseload was from seven for new and part time staff, and 40 cases for full time staff. Psychiatrists held higher caseloads in relation to the prescribing and monitoring of medication. The service had introduced a duty system with a daily duty clinician in order to manage caseload and keep patients safe. Managers told us there was a new caseload management tool. Caseloads numbers were based on the type and complexity of work required, and the skills and experience of the staff member. Managers managed and reassessed caseloads through monthly supervision. Some staff told us the caseloads were too high.

There was an on call rota for a child adolescent mental health psychiatrist that covered 9am until 9pm seven days a week. A children and adolescent mental health crisis service had been developed and commenced in April 2017. The service was available up to 10pm including weekends. Out of hours, patients could contact the adult crisis team for any immediate support. The adults' crisis team could contact a CAMHS consultant 24/7 when needed.

The staffing data provided by the trust was not broken down into teams. Managers provided evidence of mandatory staff training on site. We saw evidence of staff training for safeguarding children, health and safety, infection control, equality and diversity. The core service achieved 75% compliance or higher in all but one course. Display screen equipment was the only course below 75% compliance benchmark achieving 71% compliance as at 1 July 2017. The trust training rate was above 85%.

## Definition

Substantive – how many staff in post currently.
Establishment – substantive plus vacancies, e.g. how many they want or think they need in post.

| **Substantive staff figures** | | | **Trust target** |
|---|---|---|---|
| Total number of substantive staff | At June 2017 | 158.2 | N/A |
| Total number of substantive staff leavers | 1 July 2016 -30 June 2017 | 12.9 | N/A |
| Average WTE* leavers over 12 months (%) | 1 July 2016 -30 June 2017 | 8% | 10% |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) | Vacancy data could not be provided | N/A | N/A |
| Total vacancies overall (%) | Vacancy data could not be provided | N/A | N/A |
| Total permanent staff sickness overall (%) | At June 2017 | 3.3% | 4.5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Establishment levels nursing assistants (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Number of vacancies, qualified nurses (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Number of vacancies nursing assistants (WTE*) | Vacancy data could not be provided | N/A | N/A |
| Qualified nurse vacancy rate | Vacancy data could not be provided | N/A | N/A |
| Nursing assistant vacancy rate | Vacancy data could not be provided | N/A | N/A |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified and unqualified nurses) | Data provided was not in correct format | 689 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (qualified and unqualified nurses) | Data provided was not in correct format | 673 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (qualified and unqualified nurses) | Data provided was not in correct format | 26 | N/A |

*WholeTime Equivalent

The trust had advised they were unable to provide establishment or vacancy data by ward/team due to restrictions with the finance system. The most amount of detail held centrally is at provider level by profession. We received data from the provider about this service at the time of the inspection and it showed from 30 September 2017 for overall staff, the county team had seven staff over establishment. The city team had no vacancies and no staff rates over establishment.

However, these rates were not broken down in a way which reflected the teams we inspected. Please refer to the table for detail.

Between 1 July 2016 and 30 June 2017, bank staff filled 16 shifts to cover sickness, absence or vacancy for qualified nurses and unqualified nurses. The trust was unable to provide a breakdown detailing how this was split between qualified and unqualified nurses.

In the same period, agency staff covered 647 shifts. Twenty-six shifts (4%) of were unable to be filled by either bank or agency staff.

| Team | Shifts filled by bank staff | Shifts filled by agency staff | Shifts NOT filled by bank or agency staff |
|---|---|---|---|
| **313 L6 FYPC CAMHS County South Team** | 0 | 0 | 0 |
| **313 L6 FYPC CAMHS Childrens LD** | 0 | 0 | 0 |
| **313 L6 FYPC CAMHS County Team** | 689 | 673 | 26 |
| **313 L6 FYPC CAMHS Outpatients City Team** | 0 | 0 | 0 |
| **Core service total** | 689 | 673 | 26 |
| **Trust Total** | **63748** | **27674** | **8312** |

The sickness rate for this core service was 5.1% between 1 July 2016 and 30 June 2017 and increased to 8% in June 2017.

This core service had 12.9 (8%) staff leavers between 1 July 2016 and 30 June 2017 which is better than the trust average.

| Ward/Team | Substantive staff (As of June 2017) | Substantive staff Leavers | Average % staff leavers | Total % vacancies | Total % staff sickness (As of June 2017) | Ave % permanent staff sickness (over the past year) |
|---|---|---|---|---|---|---|
| **CAMHS City Team** | 15.1 | 1.8 | 12% | N/A | 0.6% | 7.3% |
| **Young Peoples Team** | 10.9 | 2.5 | 23% | N/A | 0.9% | 2.0% |
| **Primary Ment Healthcare Worker** | 12.7 | 3 | 24% | N/A | 15.7% | 8.5% |
| **CAMHS Management** | | | | N/A | | |
| **CAMHS Crisis & Home Treatment** | 15.8 | 0.4 | 3% | N/A | 0.0% | 0.6% |
| **CAMHS Group Work** | 1.5 | | 0% | N/A | 0.0% | 7.3% |
| **CAMHS County OPD** | 32.8 | 2.4 | 7% | N/A | 5.4% | 9.5% |
| **CAMHS County South Team** | | | | N/A | | 0% |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Learning Disabilities** | 8.5 | 0.4 | 5% | N/A | 4.9% | 6.4% |
| **CAMHS LD Outreach team** | 9.2 | | 0% | N/A | 7.2% | 7.3% |
| **CAMHS ED Team** | 12.6 | 1.8 | 14% | N/A | 0.0% | 0.9 |
| **Early Intervention Services (EIS/PIER)** | 39.1 | 0.6 | 2% | N/A | 0.5% | 1.8 |
| **Core service total** | **158.2** | **12.9** | **8%** | **N/A** | **3.3%** | **5.1%** |
| **Trust Total** | 4656.9 | 558.9 | 12.6% | N/A | 4.5% | 5.2% |

Please note only 10% of staff in PIER teams work with children.

Key:

| | | |
|---|---|---|
| *Below CQC 75%* | Between 76% & 85% | **Above Trust target 85%** |

The core service achieved 75% compliance or higher in all but one course. Display screen equipment was the only course below CQC's 75% compliance benchmark achieving 71% compliance as at 1 July 2017.

Please note only 10% of staff in PIER teams work with children.

| **Service** | CAMHS Childrens LD | CAMHS County Team | CAMHS Crisis & Home Treatment | CAMHS EDT | CAMHS Outpatients City Team | CAMHS Primary M H Team | CAMHS Young Persons | PIER Team | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Total number of staff** | 21 | 41 | 16 | 15 | 21 | 15 | 12 | 43 | |
| **(Core Mandatory) Conflict Resolution - 3 Years** | 95.20% | 87.80% | 100.00% | 100.00% | 100.00% | 100.00% | 75.00% | 100.00% | 96.70% |
| **(Core Mandatory) Display Screen Equipment (DSE) - Once** | *57.10%* | 75.60% | *62.50%* | 93.30% | *71.40%* | 93.30% | *41.70%* | 88.40% | *71.90%* |
| **(Core Mandatory) Equality, Diversity & Human Rights - 3 Years** | 95.20% | 87.80% | 100.00% | 100.00% | 95.20% | 100.00% | 75.00% | 100.00% | 96.40% |
| **(Core Mandatory) Fire Safety Awareness - 1 Year** | 95.20% | 85.40% | *68.80%* | 93.30% | 81.00% | 100.00% | 83.30% | 93.00% | 85.30% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **(Core Mandatory) Health, Safety & Welfare - 3 Years** | 95.20% | 87.80% | 100.00% | 100.00% | 95.20% | 100.00% | 75.00% | 100.00% | 96.00% |
| **(Core Mandatory) Infection Prevention & Control - Level 1 - 3 Years** | n/a | 100.00% | 100.00% | 100.00% | n/a | n/a | n/a | 100.00% | 96.30% |
| **(Core Mandatory) Information Governance - 1 Year** | 95.20% | 87.80% | 81.30% | 100.00% | 81.00% | 93.30% | 91.70% | 97.70% | 89.90% |
| **(Core Mandatory) Moving & Handling - Level 1 - 3 Years** | 95.20% | 87.80% | 100.00% | 100.00% | 95.20% | 100.00% | 75.00% | 100.00% | 95.50% |
| **(Core Mandatory) Safeguarding Adults - Level 1 - 3 Years** | 95.20% | 87.80% | 100.00% | 100.00% | 95.20% | 100.00% | 75.00% | 100.00% | 95.30% |
| **(Core Mandatory) Safeguarding Children - Level 1 - 3 Years** | 95.20% | 87.80% | 100.00% | 100.00% | 95.20% | 100.00% | 75.00% | 100.00% | 95.30% |
| **(Clinical Mandatory) Adult Basic Life Support - 1 Year** | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 97.10% | 86.10% |
| **(Clinical Mandatory) Adult and Paediatric Basic Life Support - 1 Year** | 90.00% | *72.50%* | *71.40%* | 92.30% | 81.00% | 93.30% | 83.30% | n/a | 87.90% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **(Clinical Mandatory) Adult Immediate Life Support - 1 Year** | 78.90% | n/a | n/a | n/a | n/a | n/a | n/a | 100.00% | 81.20% |
| **(Clinical Mandatory) Safeguarding Adults - Level 2 - 3 Years** | 90.50% | n/a | n/a | n/a | n/a | n/a | n/a | 100.00% | 92.30% |
| **(Clinical Mandatory) Safeguarding Children - Level 2 - 3 Years** | 100.00% | 100.00% | 75.00% | n/a | n/a | n/a | n/a | 100.00% | 90.50% |
| **(Clinical Mandatory) Safeguarding Children - Level 3 - 3 Years** | 100.00% | 84.20% | 90.00% | 100.00% | 95.20% | 93.30% | 91.70% | n/a | 93.60% |
| **(Clinical Mandatory) Mental Capacity Act - 3 Years** | 100.00% | 76.90% | 85.70% | 100.00% | *71.40%* | 93.30% | 100.00% | 100.00% | 88.70% |
| **(Clinical Mandatory) Moving & Handling - Level 2 - 2 Years** | 94.70% | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 89.10% |
| **(Clinical Mandatory) MAPA Disengagement Skills - 3 Years** | 100.00% | 94.90% | 85.70% | 100.00% | 95.20% | 100.00% | 100.00% | 100.00% | 95.70% |
| **(Clinical Mandatory) MAPA Holding Skills (High Risk) - 1 Year** | 78.90% | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 78.90% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **(Clinical Mandatory) Record Keeping & Care Planning - 2 Years** | 95.20% | 85.00% | 78.60% | 92.30% | 85.70% | 93.30% | 91.70% | 91.40% | 84.50% |
| **(Clinical Mandatory) Infection Prevention & Control - Level 2 - 2 Years** | 85.70% | 85.00% | *71.40%* | 92.30% | *66.70%* | 93.30% | 91.70% | 90.60% | 84.00% |
| **(Clinical Mandatory) Hand Hygiene - 2 Years** | 100.00% | 95.00% | 85.70% | 100.00% | 95.20% | 100.00% | 100.00% | 97.30% | 93.60% |
| **(Clinical Mandatory) Medicines Management - 2 Years** | 87.50% | 85.70% | *60.00%* | 83.30% | 87.50% | n/a | 100.00% | 92.30% | 87.90% |
| **(Clinical Mandatory) Mental Health Act for Nurses - 3 Years** | 86.70% | *66.70%* | *60.00%* | 100.00% | 100.00% | n/a | 83.30% | 100.00% | 84.30% |
| **(Clinical Mandatory) Mental Health Act for Doctors - 2 years** | 100.00% | 100.00% | n/a | 100.00% | 100.00% | n/a | 100.00% | 100.00% | 88.90% |

**Assessing and managing risk to patients and staff**

We reviewed 17 care records and found risk assessments were in place. Core risk assessments were undertaken within the 12 weeks and contained information about home and family life relationships, physical health schooling, and previous mental health history. The trust had met 99% performance on 13 week target wait before the initial assessment. The service had introduced new electronic care planning templates on 27 September 2017 but not all staff were using the care plan templates. Staff told us the templates took a long time to complete.

Managers provided up to date information, which showed 1180 patient risk assessments had been completed with 46 patients without risk assessments. Since the last inspection over 1500 risk assessments had been completed. Staff and the recovery and improvement team ensured risk assessments were up to date and reviewed appropriately, and completed jointly with other teams colleagues where appropriate.

The recovery and improvement team and senior staff had operational oversight of internal waiting lists. No one was waiting over 12 months. There had been a reduction over 100 plus

patients who had been waiting up to years. However at the point of our inspection there were 935 children and young people on internal waiting lists.

**Assessment of patient risk**

Staff from the access and assessment teams undertook risk assessments for each referral during the triage and initial assessment stage. The initial assessment determined whether staff considered a referral urgent or routine. Where there was any doubt about the severity of risk staff could access medical and or psychological opinion before allocating to a pathway with any recommendations.

The service had introduced a duty clinician system. A duty clinician for each team was on duty every day. Their role was to respond to any urgent clinical matters review risks, manage the children and young people who are waiting for assessment and treatment. While patients were on the pathway and awaiting allocation to a permanent lead professional (the clinician who has case holding responsibility for a patient), staff from the pathway maintained contact with the patient and their families or carers. Staff offered telephone support, brief interventions to manage any specific needs such as anxiety, carer stress, and coping strategies. During this waiting period, patients were contacted depending on their risk ratings and as a minimum every three months. The multidisciplinary team reviewed all patients waiting for a lead professional at their weekly team meetings.

Children and young people subject to care program approach would have a care coordinator rather than a lead professional. During our inspection, there were no young people subject to a community treatment order or guardianship.

**Management of patient risk**

Staff we spoke with understood how to recognise deterioration in a patient's presentation and know how to respond appropriately. The duty clinician responded to any urgent clinical matters and reviewed risks.

The service provided risk support with the new "My safety plan". This was for patients who struggled around self-harm. The patient developed a plan with coping strategies and would follow the plan when they felt overwhelmed.

The service monitored patients on the waiting list to detect increases in levels of risk. Managers had introduced a specialist traffic light system red, amber green risk-rating tool. Staff would assess the risk of patients on the waiting list. Green was for low risk up to red high risk. Patients if red rated were seen face-to-face by an experienced staff member, if amber or green rated, patients would receive a telephone call or letter.

A short term specialist team had been employed to eliminate back log on the waiting list. Staff reviewed internal waiting lists weekly to ensure patient's risks were being monitored. In addition, these risk assessments were comprehensive and reviewed as per the trust policy, six monthly or after risk incidents. Staff reviewed patients risk at every appointment and recorded this in patients records.

**Safeguarding**

The staffing data provided by the trust was not broken down into the specific teams we inspected. However, the table on page 123 shows the detail of training by trust teams. Managers showed us staff training records on the inspection. Staff told us they had been trained in safeguarding adults and safeguarding children levels two and three. Staff knew what

a safeguarding issue was and explained the procedure for raising a safeguarding alert. Managers told us they took a “whole family approach to safeguarding” The teams had established links with the trust safeguarding nurses and would have regular contact and training events. Staff would share complex cases to aid their learning.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include physical, emotional, financial, sexual, neglect and institutional.

Each authority has guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

The initial safeguarding data provided by the trust was not broken down into teams. The trust provided additional data following on the inspection. In the last 18 months both county teams made 72 child safeguarding referrals for Leicestershire and Rutland, and the city team made 22 referrals. For the period, April and May 2017 showed the highest number of child safeguarding referrals.

Personal safety protocols were in place and staff were aware of lone working policies and procedures. For example at Valentine Centre county team family therapy sessions were available early evening and there was a separate intercom system and procedures to keep patients and staff safe whilst in the building.

Staff advised us they did not handle or transport medications for patients. No medicines were stored in any of the locations or teams we inspected.

A community adolescent mental health crisis service opened 1st April 2017. We visited the crisis service. We found the crisis service waiting area was small and shared with the adult learning disability community team. Staff told us five to six patients were seen each day. Children and young people may wait unescorted for their appointments in the same waiting room as vulnerable adults. There was a potential safeguarding risk.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

This core service made 60 safeguarding referrals between 1 July 2016 and 30 June 2017, all of which were regarding children.

| Referrals | | |
|---|---|---|
| **Adults** | Children | Total referrals |
| 0 | 60 | 60 |

The final two months of the period, April and May 2017, reported the highest number of child safeguarding referrals during the period.

**Staff access to essential information**

Staff told us that twelve months ago they had moved from using paper systems to paperless systems. Staff had received new operating guidance for this service. There were new electronic child and adolescent risk assessment, safety plan and care plan templates. Staff followed the trust record keeping and care planning policy 2017 and completed patient records contemporaneously within 24 hours. Internal waiting lists had been reviewed and due to transfer onto the electronic patient's record system. Staff had access to essential information.

**Medicines management**

No medicines were stored in any of the locations or teams we inspected.

**Track record on safety**

Providers must report all serious incidents to the strategic information executive system (STEIS) within two working days of an incident being identified.

Between 1 July 2016 and June 2017, there were two strategic information executive system incidents reported by this core service. Managers and staff knew about two serious incidents in 2017 and were still under review and awaiting feedback from the investigations. Staff confirmed they received relevant feedback from investigation of incidents both internal and external to the service.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The trust reported one incident which is broadly comparable/ with strategic information executive system.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 July 2016 and June 2017, there were two STEIS incidents reported by this core service. One was an actual/suspected suicide from a patient at Westcotes and the other a confidentiality information leak at the CAMHS county team.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The trust reported one incident which is broadly comparable/ with STEIS.

| Team | Type of incident reported | Total |
|---|---|---|
| **CAMHS City Team, Westcotes House** | Apparent/actual/suspected self-inflicted harm meeting SI criteria | 1 |
| **CAMHS County Team Valentine** | Confidential information leak/information governance breach meeting SI criteria | 1 |
| | **Total** | **2** |

### Reporting incidents and learning from when things go wrong

Staff we spoke with knew what incidents and accidents needed to be reported, and could tell us how they did this. Staff told us they were open and transparent with patients if things went wrong.

Managers discussed significant incidents at monthly team meetings. However, at Loughborough county team learning from incidents was not discussed or recorded in minutes of the team meetings we reviewed.

Staff reported all incidents appropriately, and they were open and transparent and explained to patients when something went wrong. Staff told us they received a de-brief and support after a serious incident. The team manager usually delivered this or the team psychologist, would follow up with support if required.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been four 'prevention of future death' reports sent to Leicestershire Partnership Trust. None of these related to this core service.

## Is the service effective?

### Assessment of needs and planning of care

We reviewed 17 care records. Care plans were generally up to date but not written in a holistic and personalised manner, not focused on outcomes, strengths, or age appropriate. Not all care plans had evidence of family involvement. A new safety plan template was part of the new care plan to keep patients safe. We saw two completed pictorial care plans.

Staff told us the new care plan template had been designed in consultation with a service user group. Some staff said they had received care planning training months ago and the quality of training was variable. The new care plan template had been released 27 September 2017, but not consistently used by staff. Most staff said they found the electronic care plans cumbersome and difficult to navigate, this resulted in delays in writing core assessments and care plans.

We found 924 care plans had been completed after the initial assessment, however, 179 patients still did not have a care plan in place.

We saw care plans were reviewed for example when there was deterioration in mental health, following completion of a specific intervention, prior to discharge and every six months

All information needed to deliver care was stored securely on an electronic system. This meant that when staff transferred patients between teams or discharged to other services, notes were easily accessible.

**Best practice in treatment and care**

Staff followed national institute for health and care excellence guidance for prescribing and provided a range of therapeutic interventions in line with the guidance. Therapies included cognitive behavioural therapy, systemic family psychotherapy, and psychodynamic psychotherapy, integrative therapy including family parent or individual work.

For patients the team provided one to one therapy sessions, and group work for example understanding yourself and protective behaviours group this included managing anxiety. The team provided workshops for patient's parents/carers for example positive behaviour support, autistic spectrum disorder and sleep workshops.

Interventions offered by the teams included sign posting to external agencies, as well as support for employment matters, housing and benefits.

The majority of care records we looked at did not have any regular physical health monitoring. Staff told us that the patient's general practitioner was responsible for completing annual physical health checks. Staff recorded height and weight if there was a concern about a patient being underweight.

Staff followed national institute for health and care excellence guidelines when screening for side effects of anti-psychotic medications prescribed.

Staff used a range of nationally recognised outcome measures. Examples of these included goals based outcome measure (GBO), as a measure of change in a young person. The health of the nation outcome scales for child and adolescents (HONOSCA) as a clinical view of change. SCORE 15 a proven measure of therapy and of therapeutic change in family functioning, and revised children's anxiety and depression scales (RCADS) used for early identification of anxiety among youths.

Managers had participated in one clinical audit for the treatment of obsessive-compulsive disorder a type of anxiety disorder as part of their clinical audit programme. In addition, managers had completed reports relating to unexpected deaths, infection control, caseload management, and quality of risk assessments.

The service had started a pilot scheme initiative for neurodevelopment team developing a new treatment pathway. This scheme commenced in summer 2017.

This core service participated in one clinical audit as part of their clinical audit programme.

| Audit name / title | Audit scope (names of teams, services or units that participated in the audit) | Audit type | Key actions |
|---|---|---|---|
| **The Treatment of OCD in CAMHS (NICE CG31)** | FYPC | Clinical | Ensure that staff are aware of the Choice and Medication link on SystmOne which will print off a leaflet for clinicians to give patients during clinic appointment. Include a slide in the presentation to staff raising this awareness. Explore the logistics of adding in a tick box on SystmOne that indicates whether a patient information leaflet was given. Explore the possibility of presenting information to Commissioners in order to gain more resources and cut down waiting times for patients. |

**Skilled staff to deliver care**

The teams consisted of doctors, clinical psychologists, family therapists, nurse specialists, registered mental health nurses, occupational therapists, and assistant practitioners. Within the trust, staff could refer to physiotherapists and dieticians when required.

Systems were in place for all new staff to undertake a trust and a local induction. The trust induction offered an overview of the trust and appropriate mandatory training. The local inductions gave staff the opportunity to develop role specific training and knowledge within the teams they were to work in. Staff we spoke with told us there were opportunities for further development within the trust.

Some teams had developed local, in house training sessions around themes such as autistic spectrum disorders. Different professionals with knowledge and experience would offer training sessions if thought to be beneficial to the staff group.

All teams held regular team meetings. We saw the minutes of these meetings recording discussion about new referrals, caseloads, and high-risk patients.

Staff told us they received monthly clinical and management supervision where they were able to reflect upon their practice. The data provided by the trust was not broken down into teams. The trust provided some training data following the inspection. The compliance data for clinical supervision; one county team had achieved 95 %, the second county team 88% and the city team 80%. There were exceptions for example staff on long-term sick leave, maternity leave and new starters. The trust target was 85%.

One staff member showed us the trust ULearn electronic systems did not accurately record clinical supervision, so they kept their own records. We found managers collated staff, supervision and appraisals data at team level in various ways and to variable standards. This meant that data reliability was not robust or consistent across the trusts or between teams.

The appraisal rates for the core service were 92%. The year before the appraisals rate had been 87%. The service had made improvements with 97% of permanent medical staff and 86% permanent of non-medical staff had received appraisals. The trust's target rate for appraisal compliance was 80%.

Reflective practice groups were provided bi-monthly across sites, open to all staff, and facilitated by psychotherapists.

Mandatory case reviews were led by operational managers or clinical leads. The case reviews were held every six to eight weeks and focused on the problems of a patient and considers the holistic care of the individual patient for case discussion and review.

Managers addressed poor staff performance promptly and effectively. Team managers told us they would address poor staff performance with support from senior managers and advice from the human resources department, if required.

The trust's target rate for appraisal compliance is 80%. As at 30 June 2017, the overall appraisal rates for non-medical staff within this core service was 95%.

The rate of appraisal compliance for non-medical staff reported during this inspection is higher than the 77% reported at the last inspection.

| Team | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| CAMHS City Team | 33 | 32 | 97% |
| Young Peoples Team | 23 | 20 | 87% |
| Primary Ment Healthcare Worker | 28 | 30 | 107% |
| CAMHS Crisis & Home Treatment | 16 | 15 | 94% |
| CAMHS On Call Service | 9 | 10 | 111% |
| CAMHS Group Work | 2 | 1 | 50% |
| CAMHS County OPD | 62 | 49 | 79% |
| Learning Disabilities | 18 | 14 | 78% |
| CAMHS LD Outreach team | 22 | 18 | 82% |
| CAMHS ED Team | 27 | 28 | 104% |
| **Core service total** | 310 | 293 | 95% |
| **Trust wide** | 4118 | 3693 | 90% |

No appraisals data for permanent medical staff was provided by the trust for this core service.

Between 31 July 2016 and 30 June 2017 the average clinical supervision rate across all ten teams in this core service was 75%.

**Caveat:** there is no national standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide. LPT monitors compliance on a central system, ULearn. The compliance target was 85%.

| | Clinical supervision target | Clinical supervision delivered | Clinical supervision rate (%) |
|---|---|---|---|
| CAMHS City Team | 193 | 130 | 67% |
| Young Peoples Team based at Westcotes House- Focus Looked After & Adoptive Children | 129 | 86 | 67% |
| Primary Ment Healthcare Worker. Staff based at Valentine Centre | 161 | 129 | 80% |
| CAMHS Crisis & Home Treatment | 14 | 5 | 36% |
| CAMHS Group Work | 59 | 27 | 46% |
| CAMHS County OPD | 313 | 227 | 73% |
| Learning Disabilities | 104 | 67 | 64% |
| CAMHS LD Outreach team | 132 | 105 | 80% |
| CAMHS ED Team | 144 | 130 | 90% |
| **Grand Total** | 1668 | 1252 | 75% |

**Multidisciplinary and interagency team work**

Teams in the service met weekly as a multidisciplinary team to discuss cases. Staff had a slot in the multidisciplinary team meeting to present the risks, concerns and to obtain further consultation regarding a patient.

We saw evidence of effective handover between teams within the organisation such as crisis team to outpatient's service.

Managers told us teams had good working links with child and adolescent mental health crisis team, child and adolescent mental health in patient unit, general practitioners, educational psychologists, school nurses, paediatric departments and with adult mental health crisis team.

There was a young person's team based at Westcotes House city team who supported young people and young people who were looked after by the local authority and included a provision for unaccompanied asylum seekers who were young people.

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

The staffing data provided by the trust did not identify team names. As at 30 June 2017, Mental Health Act training for this core service was at 91%. From the 1st October 2017 for Mental Health Act training in the county team, five nurses Mental Health Act training was out of date and five had booked in for training. One doctor's Mental Health Act training was out of date and one doctor was booked for training. There were exceptions for example where staff were on maternity leave or long term sick. Staff had a good understanding of the Mental Health Act. Particularly about community treatment orders, the Code of Practice and guiding principles, and how these principles applied to their roles with young people subject to the Mental Health Act. Staff told us further Mental Health Act training was scheduled for October and November 2017.

During our inspection, there were no young people subject to a community treatment order (CTO) or guardianship. Staff told us that if there had been young people subject to CTOs and that they were able to contact the Mental Health Act administrator when necessary.

Mental Health Act administrators for the trust examined all Mental Health Act paperwork at the point of admission. Mental Health Act administrators carried out regular audits to ensure staff were applying the act correctly.

Mental Health Act administrators were able to offer support to managers and doctors to make sure they were following the Act correctly. They offered support to staff around Mental Health Act renewals, consent to treatment, and appeals against detention. Staff we spoke with knew who their Mental Health Act administrators were, or who they could go to for advice on the Mental Health Act.

Staff adhered to consent to treatment and capacity requirements as required, and were able to explain to patients and their families or carers their rights and responsibilities under the mental health act.

Patients had access to the independent mental health advocacy services and staff knew how to access and support engagement with the independent mental health advocates. We saw notices in the waiting rooms of some team bases explaining how patients could get more information about the Mental Health Act if they required this.

As at 30 June 2017, Mental Health Act training for this core service was at 91%.

CAMHS crisis and home treatment team had the lowest compliance with only six of ten nurses completing the training during the period.

| Team | (Clinical Mandatory) Mental Health Act for Nurses - 3 Years | (Clinical Mandatory) Mental Health Act for Doctors - 2 years |
|---|---|---|
| CAMHS Childrens LD | 86.7% (13/15) | 100.0% (1/1) |
| CAMHS County Team | 66.7% (8/12) | 100.0% (9/9) |
| CAMHS Crisis & Home Treatment | 60.0% (6/10) | n/a |
| CAMHS EDT | 100.0% (5/5) | 100.0% (1/1) |
| CAMHS Outpatients City Team | 100.0% (5/5) | 100.0% (3/3) |
| CAMHS Primary M H Team | n/a | n/a |
| CAMHS Young Persons | 83.3% (5/6) | 100.0% (1/1) |

**Good practice in applying the Mental Capacity Act**

Mental Capacity Act training for this core service was at 89% at 30 June 2017.
The staffing data provided by the trust did not identify team names. The trust supplied some training data following on the inspection. From the 1st October 2017 for Mental Capacity Act training in the county team, six staff were out of date with training and three booked in for training. In the city three staff's Mental Capacity Act training were out of date, with two booked in for training. There were exceptions for example staff where on maternity leave or long term sick. As at 30 June 2017 Mental Capacity Act training compliance was at 89%. Mental Capacity Act applies to those young people over the age of 16 years. The trust had a policy on the Mental Capacity Act, which staff were aware of and could refer to. There was a Mental Capacity Act lead appointed by the trust.

We saw patient's mental capacity assessments templates were completed at Westcotes city team and Valentine Centre county team but not at Loughborough county team.

Staff were aware of their responsibilities in obtaining consent and understood the need to consider 'Gillick competency' for young people under the age of 16 years. Gillick competence is the principle used to judge capacity in children to consent to medical treatment. Staff were also aware of the 'Fraser' competence, which relates to a child under 16 who is deemed competent to receive contraceptive advice without parental knowledge.

We found patients were encouraged to make decisions for themselves with the support of parents and carers. Where appropriate and when patients lacked capacity and parents were not able to act on the patient's behalf, staff made decisions based on the patients best interests, recognising the importance of the person's wishes, feelings, culture, and history.

| Service | (Clinical Mandatory) Mental Capacity Act - 3 Years |
|---|---|
| CAMHS Childrens LD | 100.0% (21/21) |
| CAMHS County Team | 76.9% (30/39) |
| CAMHS Crisis & Home Treatment | 85.7% (12/14) |
| CAMHS EDT | 100.0% (13/13) |
| CAMHS Outpatients City Team | 71.4% (15/21) |
| CAMHS Primary M H Team | 93.3% (14/15) |
| CAMHS Young Persons | 100.0% (12/12) |

## Is the service caring?

**Kindness, privacy, dignity, respect, compassion and support**

We saw that staff interacted with patients in a respectful way. Patients reported that staff were supportive of them, understood their needs and involved their carers and families appropriately and only after seeking their permission.

Patients, carers and family members we spoke with told us it was hard to get an appointment the waiting lists were long, for some patients this made them more anxious. Once seen by staff patients felt whatever they said was taken seriously, and staff were kind and helpful even on the phone. Patients told us there were always seen by the same staff member and this helped them build up trust and a rapport.

We observed a clinician at the Valentine Centre. They were kind and caring and appropriately brought humour and a child centred approach. We observed a clinician at Westcotes House was positive with a younger patient engaging with them, using paper and colouring materials, and steering them in a balanced and focused way.

One patient said they did not need any further treatment as they had their triggers under control. They felt they could not have had a better service.

One patient waited a couple of months to be seen, however when rang up, they said staff called them back the same day. They told us they were always seen by the same person and thought they received a great service.

Staff we spoke with showed passion about their roles and were proud of the work they undertook.

Whilst reviewing records we found that staff completed information sharing requests indicating whether a young person had consented to sharing information with other agencies.

**The involvement of people in the care they receive**

Staff told us joint care planning was part of their routine and ongoing intervention with patients and their families and that this information was recorded in the general notes section of the clinical records. Care records showed that the teams had appropriate contact with the families and carers of patients.

Patients had access to advocacy services. Staff would support patients to contact these services if required.

At the Valentine Centre county team, we saw staff provide an iPad to a patient after their appointment to seek their feedback. We saw some feedback from these surveys in “you said we did” notices in the waiting areas at the Valentine Centre. Feedback from patients said to look at prevention of mental health and not a cure. The trust responded they were working on this with campaigns to break the stigma around mental health issues. Patients asked for a better introduction to services. The trust responded with developing a leaflet for new patients. Patients said waiting times were too long. The trust responded they had developed a child and adolescent mental health access team, and there was patient contact within 14 days by phone or letter. Patients said the buildings were depressing. The trust responded we are making the sites more colourful, with user-friendly displays to make the buildings more welcoming.

Staff told us they routinely gave out surveys to patients and families to gain feedback of services. It was unclear if this was consistent practice across sites. We asked the trust for patient survey feedback but did not receive the data.

**Involvement of patients**

Staff told us a user involvement group had collaborated with the service to design the care plan. The group were made up of young people from Leicester Leicestershire and Rutland who wanted to make services’ more user friendly. We saw on notice boards that young people had help shape the new crisis service and formed a group to help make the service friendlier.

We saw patients waiting in the waiting area at Valentine Centre. A doctor came out to the waiting area and asked to see the patient. The patient and family member were prepared to go into the interview room together. The clinician explained in a friendly and positive manner why it was important for this appointment to see the patient alone. This confirmed the care was patient focused. We saw other patients and families members attend appointments together.

**Involvement of families and carers**

A parent told us they felt relaxed with clinicians, could say anything, and were able to attend appointments as a family.

Parents and carers reported that the staff were professional, kept their boundaries and provided treatment and advice.

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

## Is the service responsive?

**Access and waiting times**

There was no self-referral pathway. Young people could access the service via their general practitioner, school nurse, social worker, educational psychologist, A& E consultants, or other heath professional working with a child.

The staffing data provided by the trust was not broken down into teams for referral to assessment and treatment times. Within 14 days, staff team would make contact with the patient usually by a letter or telephone call, or arranged a face-to-face meeting with the patient and their families or carers. The purpose of the meeting was to carry out more in depth assessment of needs and level of risk.

Staff screened the referrals into the service on a daily basis and assessment slots for urgent cases were available on the same day.

Following contact patients were given a risk rating. A red rating (high-risk) urgent referral would be seen within four weeks for a core assessment. For an amber or green rating (lower risk) routine assessment would be seen within the 13 weeks. Waiting times from referral to initial assessment was less than 13 weeks. The trust was meeting its target rate with 99% compliance.

Some target waiting times were provided by the trust following the inspection. For September 2017, 35 patients met the 4 week urgent waiting time at 92% with three patients outside the waiting time target. For the 13 week, routine waiting time targets 142 patients met the waiting time at 99% with one patient outside waiting time target.

The risk rating would be reviewed after contact with the patient. Following the core assessment, staff confirmed which pathway would suit the patients' needs and an interim care plan and risk assessments were formulated and a lead professional allocated. (This clinician has case holding responsibility). Patients were placed on a waiting list for a specialised treatment pathway.

The service had several internal waiting lists for specialist treatment pathways. These included psychiatric opinion, psychology, and school observations. There was no contractual target for internals waiting lists. We saw on the waiting list one patient was seen by four different clinicians within the service for different diagnostic reasons. Due to patients co morbidity some patients were duplicated on the wait list. (When two disorders or illnesses occur in the same person, simultaneously or sequentially, they are described as comorbid). Following these discussion managers revised the waiting lists and adjusted the waiting lists.

Since the last inspection, the trust had made improvements and developed a recovery and improvement plan. The trust told us they had taken steps to reduce the waiting list. This included a short-term specialist team directed towards long waits, thus reducing patients from harm whilst waiting. The team scrutinised the waiting lists weekly. At the point of this inspection, 945 patients were waiting for treatment. The longest wait was between 181-365 days for 89 patients. Staff contacted patients on the waiting list depending on their risk and as a minimum very every three months.

The trust told us no one was waiting over 12 months to commence treatment and there had been a reduction of over 100 plus patients who had waited up to two years in March 2017. Under the NHS Constitution, no patients should wait more than 18 weeks for any treatment. The current waiting times remained high for 945 patients.

Since the last inspection, the trust had opened a child and adolescent mental health crisis service. This covered out of hour's provision for those patients requiring an immediate assessment. The on call team worked 9am to 5pm Monday to Friday. Outside of those times, a child and adolescent mental health consultant psychiatrist was available for face to face or telephone consultations.

The service had clear eligibility criteria and a policy for how to respond when patients did not attend an appointment. In the event a patient was not engaging staff attempted to contact via a phone call and letters and sent a letter to the referrer also.

We spoke with eight patients and 15 parents and carers. Most patients told us appointments were rarely cancelled. If the clinician were unavailable, they were telephoned and given the choice if they still wanted to attend their appointment with another clinician. One family had their appointment cancelled on four separate occasions. Another family reported they were on their way to their appointment and received a phone call to inform them that the appointment had been cancelled.

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

No target times were provided by the trust. CAMHS Access Team had the longest median days from referral to initial assessment at 66 days. CAMHS Paediatric Psychology had the longest median days from assessment to treatment times.

| Name of hospital site or location | Team name | Days from referral to initial assessment | Days from assessment to treatment | Comments, clarification |
|---|---|---|---|---|
| | | Actual (median) | Actual (median) | |
| **HQ Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester LE4 8PQ RT5** | CAMHS - Eating Disorders | 18 | 12 | |
| **HQ Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester LE4 8PQ RT5** | CAMHS - Learning Disability Service | | 29 | |
| **HQ Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester LE4 8PQ RT5** | CAMHS - On Call Team | 3 | 6 | |
| **HQ Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester LE4 8PQ RT5** | CAMHS - Young Peoples Team | 45 | 32 | |
| **HQ Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester LE4 8PQ RT5** | CAMHS Access Team | 63 | 37 | |
| **HQ Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester LE4 8PQ RT5** | CAMHS Crisis and Home Treatment | 3 | 4 | |
| **HQ Bridge Park Plaza, Bridge Park Road,** | CAMHS- Outpatient & Community | 60 | 25 | |

| | | | | |
|---|---|---|---|---|
| **Thurmaston, Leicester LE4 8PQ RT5** | | | | |
| **HQ Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester LE4 8PQ RT5** | CAMHS Paediatric Psychology | 62 | 66 | |
| **HQ Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester LE4 8PQ RT5** | CAMHS Primary Mental Health Contract | 54 | 34 | |

**The facilities promote comfort, dignity and privacy**

There were multiple rooms for care and treatment including those for activities, therapy sessions, interviews, assessments, and physical health clinics. However, at Westcotes House city team we found multiple problems with suitability of the building. This included poor soundproofing in patient interview rooms, we could clearly hear conversation in the corridor. The building was made up of three floors with accessibility on the ground floor only. A portable wooden ramp was available but needed to be booked for appointments, the lift was decommissioned. The reception area was child friendly but not throughout the building. There were some specific child friendly rooms. General maintenance of the building was poor. Rooms were smelly, carpets, and woodwork was marked and grubby. We saw worn and broken young children's toys in one interview room. At Loughborough county team, we found some marked paintwork and patients pictures.

In waiting areas, we saw there were a variety of information leaflets to include aspects of mental health issues, how to complain, and the rights of patients. There was information on more specific topics such as 'hearing voices and coping with depression. At Valentine Centre we saw bright reception area with age appropriate leaflets and information.

**Patients' engagement with the wider community**

Staff supported patients to access education, employment and other services in their communities.

**Meeting the needs of all people who use the service**

The trust had disabled facilities for patients across services, including toilets. Westcotes House had accessibility on the ground floor only.

Staff had access to an interpreter service and signers when and as required. Staff assured us that they could access these easily and book in advance for reviews and appointments. Information leaflets were available on request including electronic versions.

One patient told us they lived in a remote area and had requested a prescription but had difficulties travelling; the prescription was sent to their local pharmacy. The service had ensured the patient received prompt care according to their individual need.

Patients had access to a wide range of information leaflets in reception areas. For example, information around depression, bereavement, self-harm and mood disorders. In addition, we saw information of advocacy, patients' rights, how to complain and local services.

**Listening to and learning from concerns and complaints**

The core service received 30 complaints between 1 July 2016 and 30 June 2017. Valentine received the highest number of complaints of all the locations for this core service with 20.

Nine complaints were around clinical treatment. City team had six complaints around clinical treatment, appointments delays and cancellations, and attitude of staff. Loughborough received three complaints with one each for clinical treatment, appointments delays and cancellations, and attitude of staff. All aspects of clinical treatment were the most common complaint subject with 14 (47%).

Patients and their families knew how to complain and we saw information about this on the walls in waiting rooms. Managers gave examples of complaints they had dealt with and had given feedback to complainants in the form of a letter. One manager explained how they had made telephone contact with a complainant to give feedback as they had found this more helpful than a letter. Staff knew how to handle complaints appropriately.

The data received by the trust was not accurate around compliments received. This core service received 12 compliments during the last 12 months from 1 July 2016 and 30 June 2017. Valentine Centre received the most compliments with two.

This core service received 30 complaints between 1 July 2016 and 30 June 2017.
CAMHS county team (VC) received the highest number of complaints of all the locations for this core service with 20.
All aspects of clinical treatment was the most common complaint subject with 14 (47%).

| Team | Total Complaints | Most common Theme |
|---|---|---|
| **CAMHS City Team** | 6 | Appointments, delay / cancellation (outpatient) (2)<br>All aspects of clinical treatment (3)<br>Attitude of staff (1) |
| **CAMHS County Team (HC)** | 1 | All aspects of clinical treatment |
| **CAMHS County Team (LH)** | 3 | Appointments, delay / cancellation (outpatient) (1)<br>All aspects of clinical treatment (1)<br>Attitude of staff (1) |
| **CAMHS County Team (VC)** | 20 | Appointments, delay / cancellation (outpatient) (5)<br>All aspects of clinical treatment (9)<br>Attitude of staff (3)<br>Communication / information to patients (written and oral)(2)<br>Admissions, discharge and transfer arrangements (1) |
| **Core service Total** | 30 | All aspects of clinical treatment (14) |

This core service received 12 compliments during the last 12 months from 01 July 2016 and 30 June 2017. Valentine centre received the most compliments with nine.

| Hospital | Team | Total Compliments |
|---|---|---|
| **Valence Road** | CAMHS Eating Disorders (VR) | 9 |
| **Paediatric Psychology (LRI)** | Paediatric Psychology (LRI) | 1 |
| **Valentine Centre** | Primary Mental Health Team | 2 |

## Is the service well-led?

**Leadership**

Leader's had a good understanding of their service, explained how the teams provided high quality care and had the knowledge and experience to perform their role.

Staff we spoke with said that managers were visible and approachable.

Leader's said that the trust provided them with opportunities to develop their own and their team's skills.

**Vision and strategy**

Staff we spoke with aware of the organisation's values. They identified that these were available on the trust's intranet system and were regularly highlighted in supervisions, meetings and training.

Staff we spoke with knew who the most senior managers in the organisation were. They told us that senior staff within the trust had visited the teams. These included the various senior managers within the Families Young People and Children services.

Following on our last inspection managers had set up a recovery and improvement plan to make improvements to the service including the electronic record keeping systems more useable. Senior managers had a clear vison; however, staff at local levels had not embedded the changes. For example, the new patient care plans were released 27 September 2017. Not all staff had begun to use the new templates, and staff that had used the templates, reported the template was cumbersome.

Other improvements since the last inspection the service had opened a child and adolescent mental health crisis service in April 2017. When we visited, staff were proud of the service. In addition, the service now has a Section136 suite for use by young people that meet the standards set out in the Royal College of Psychiatrists.

**Culture**

Staff said they felt supported by their manager. Some staff said morale had improved as the changes had taken place within the service. Other staff said the pace of changes was too fast. Staff we spoke with said they felt able to raise concerns and knew the trust had a whistle blowing policy, which they would use if they needed to.

Managers were supported by colleagues in the human resource department to manage poor staff performance.

Staff sickness for the service was still high but had reduced since last year. The average staff sickness levels were between 5 and 7 % across the three teams. The trust target was 4%.

As part of the recovery and improvement plans there are health and wellbeing events for staff to attend. Monthly bulletins provided staff with service updates.

Staff said they could access the trust occupational health service for support with both physical and mental health issues.

During the reporting period, there were no cases where staff have been either suspended or placed under supervision or moved team within the core service.

**Governance**

Staff told us the trust had plans to reduce staffing across sites in December 2017. Locum staff who worked in the short term recovery and improvement team were due to leave in December 2017, and not replaced. Staff felt this would impact negatively on reducing patient waiting lists. Clinicians frequently worked across sites to meet the needs of the patient. Staff participated in several audits.

Managers did not ensure all sites where services were delivered were well designed, visible clean and met the needs of the patient's. At Westcotes House and Valentine Centre we found issues around cleanliness and general maintenance. At Westcotes House we found maintenance was poor, rooms were smelly, carpets and wood work was marked and grubby. At city and county sites, interview rooms were not equipped with alarms. Staff held personal alarms except at staff at the Loughborough county team. Across sites, the clinic rooms had all the equipment calibrated.

We found a new care plan had been released two week prior to our inspection and was not consistently used by staff. Staff told us the care plans longer to complete and were difficult to navigate. Care plans were not holistic and personalised, focused on outcomes, strengths or age appropriate. Loughborough county teams had not completed patient mental capacity assessments.

Managers leant from incidents, complaints, and some patient feedback. However, we did not find services were consistently seeking patient, and parent, carer feedback.

We found staff were trained in Mental Health Act the training rate was 88 % and this was an improvement from our last inspection.

The service was on the corporate risk register around demand and capacity. The waiting times were outlined in the trust board meeting minutes.

**Management of risk, issues and performance**

This core service was rated as inadequate at the last CQC inspection. The trust had submitted action plans to the Care Quality Commission (CQC) with actions rated amber and red, which meant work was in progress and awaiting assurance. The service had improvement and transformation phase plans in place from March 2017 to April 2018 and were making progress, however, there were still significant risks for this core service.

Managers had systems in place for monitoring patient access to treatment. However, these were not always effective. Care plans were not in place for all patients awaiting treatment. We found 924 patients care plans completed after an initial assessment but 179 patients still did have care plans from caseloads. Despite improvements, care plans we saw were not personalised and reflected patient preferences.

Risk assessments were not in place for all patients awaiting treatment. We found 1180 patients risk assessments had been completed with 46 patients still without risk assessments.

Whilst managers had systems to monitor compliance with waiting times, patient's access to treatment was not quick. We found 935 patients on the waiting list. The longest wait was between 181-365 days for 89 patients. There had been a reduction in waiting times with no patients waiting over 12 months, but there were still long waits for patients.

Waiting times from referral to initial assessment was less than 13 weeks. The service met the national target.

Managers had introduced a duty clinician and specialist traffic light system rating for managing risk. Some staff reported caseloads were still high.

We visited the child and adolescent mental health crisis service. We saw the waiting room was shared with the adult learning disability community team. This was a potential safeguarding risk for children and young people who maybe unescorted.

**Information management**

Staff were received regular training appraisals and supervisions. However, staff told us the electronic systems for recording staff training appraisals and supervisions were not reliable. Staff collated data at a team level in various ways.

Staff reported difficulties using the new risk assessment care plan template.

Managers had set up a recovery and improvement plan tasked to make improvements to the service including, making the electronic record keeping systems more useable. Several service champions were in place to input into change, and assist staff with the changes.

**Engagement**

We saw at Valentine information boards detailing staff roles. This informed patients of the staff available for care and treatment for that day.

Staff had engaged with a service user group when developing the new care plan and setting up the crisis team to make services more user friendly, but it was unclear if this work was still ongoing. Friends and family information feedback was requested but not made available.

Patients, parents and carers told us there was poor communications between agencies, autism outreach, schools, and children and adolescent mental health services. However, patients and parents, carers spoke positively about staff knowledge, and skills of staff and their trustworthiness.

**Learning, continuous improvement and innovation**

As part of the recovery, improvement and transformation phase, staff were working towards a new model of care for this core service. The THRIVE framework had been identified as a way to meet the vision of improvements to children and young people's mental health services. Events and seminars were planned from December 2017.

The core service was learning from other trusts. Managers had established links with other child and adolescent mental health services and shared good practise learning.