Trust-wide leadership

Facts and data about this trust

The trust had 15 locations registered with the CQC (on 11 October 2018).

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

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

Total number of inpatient beds	614
Total number of inpatient wards	40
Total number of day case beds	n/a
Total number of children's beds (MH setting)	10
Total number of children's beds (CHS setting)	n/a
Total number of outpatient clinics a week	n/a
Total number of community clinics a week	n/a

Is this organisation well-led?

Leadership

The trust board and executive team had the necessary skills and experience to perform its role. Services were divided into three divisions. Each division had senior staff allocated as leads, for adult mental health services and learning disability (AMH/LD), community health services (CHS), and for families, young people and children (FYPC). Non-executive directors and directors were aligned to services throughout the trust.

Fit and proper person checks were in place. We reviewed and sampled eight personnel files of directors and non-executive directors and found all necessary documents were in place to meet

this regulation. Non-executive directors had been recruited with board level experience and brought knowledge from industry, leadership and governance to the trust. Most senior staff told us the board of directors worked well together and were supportive of each other, although three senior directors gave conflicted views and reported some tension between directors and executive directors. During our inspection, senior staff reported change within the trust board with new appointments and a desire to openly challenge and bring about change.

The trust delivered a leadership programme to develop staff. Staff across the trust accessed this training which consisted of ten elements including essential HR for managers, appraisal training, supportive management behaviour and team development skills. From December 2017 to October 2018, staff attended a variety of elements and attendance ranged from 50 for one element to 280 for another. The trust recorded a total of 1,640 staff participants across the range of modules, (however, staff could attend more than one module). The organisational development team produced a newsletter called Leadership Matters, with edition five distributed in October 2018 and planned to launch a tool kit in January 2019 for new leaders into post.

Ten leaders of the trust, since September 2018, participated in the Aspire Director programme, and the trust had plans for next year to be part of a pilot to facilitate the NHS High Potential scheme which develops staff at executive level. The trust had links with the East Midlands Leadership Academy and were considering being part of the scheme called 'Stepping up' for aspiring leaders of BAME backgrounds into leadership roles. At the time of inspection, the trust could not give numbers of those staff who were identified for this training.

Succession planning was in place across the trust. The trust had a programme called 'WeNurture' which coached, mentored and developed staff to progress into higher graded roles. In November 2018, twenty-six staff applied and twenty-two successfully obtained a place on the programme. Of those, 7 staff were from BAME backgrounds (32% of the total) from ten who applied. 12 were administrative staff, four from additional clinical services, three from allied health professions, one medical and six nursing. We heard of an example where a member of staff came to present at the trust board, who had started work in the trust as a cleaner and developed into an assistant practitioner role.

The trust experienced challenges to ensure the right leaders were in the right roles. Several senior staff told us the trust were challenged to develop and nurture the right people into leadership roles to manage staff and teams effectively. Several directors had concerns about the demand on leaders in the organisation. We heard leadership teams asked too much of middle managers to be proactive to manage and lead teams through change as well as have robust oversight of compliance alongside their day to day roles.

Directors and non-executive directors had a schedule of board walks that took place across the services in the trust to meet staff. Non-executive directors had completed 60 board walks in the last year. The Chief Executive made unplanned visits to wards every Friday. Each director and non-executive director was aligned to a particular service. Whilst they were informal, feedback from staff was sought, concerns escalated, the board did not collate themes and we heard from the board they would like to do more to measure the success of boardwalks.

During our inspection of core services, staff in two core services (acute wards and psychiatric intensive care units, and mental health community services for older people) told us they did not know who the director aligned to their service was, rarely saw senior leadership staff, felt disconnected from the trust, but did know who the chief executive was. The other three units said

the senior leadership team was visible, had seen a director visit their service and had seen senior leaders on a pod cast or web chat.

Data provided prior to the inspection showed the executive board had 14% black and minority ethnic (BAME) members (as at last inspection). The board comprised of 57% women (compared to 43% last inspection); however, two new female board members who came to post recently and a third will join in 2019. The non-executive board had 14% BAME members and 57% women.

	BAME %	Women %
Executive	14%	57%
Non-executive	14%	57%
Total	14%	57%

Key board members (director of nursing, director of finance, and medical director) left the trust in recent months prior to our inspection and there were gaps until posts had been replaced causing some delays to service development plans starting. There were some concerns amongst senior leaders that a further post was vacant from December 2018, and not filled until March 2019. However, we heard much positivity and excitement about what new post holders could bring to the organisation with energy and enthusiasm for change. Key staff told us that January 2019 would be a time when the board had a new start and could be more cohesive.

The trust held a strong position within the wider local health economy and the CEO led on the overall STP, the mental health work stream and the workforce workstream. However, mental health provision had only recently been allocated as one of the five priorities at the STP at number five. Several directors and senior leaders told us this could have happened sooner.

Vision and strategy

The trust had four clear values which most staff across the trust knew and applied into their everyday practice. Staff showed caring attitudes towards their patients. We saw numerous interactions between staff and patients with very complex needs and staff managed some extremely challenging situations with knowledge and compassion. Staff demonstrated a respectful manner when working with patients, carers, within teams and showed kindness in their interactions.

The trust told us they had an organisational corporate strategy as part of its rolling five-year plan. It outlined four strategic objectives:

1 – Quality - deliver safe, effective, patient-centred care in the top 20% of our peers.
2 – Partnerships - partner with others to deliver the right care in the right place at the right time.
3 – Staff - staff will be proud to work here and we will attract and retain the best people.
4 – Sustainability - ensure sustainability.

The board told us each objective had sub-objectives each with a delivery plan over a five-year period. The trust provided a document written in March 2018, called the Five-year Plan 2018/19 to 2022/23. It stated, “The trust has much to do in 2018/19”. It cited a strategic direction and a delivery plan for project areas, but no clear plan for how and when this would be delivered with agreed targets and timescales.

Prior to inspection, the trust submitted a list of their six key priorities for the next 12 months. We spoke with a large range of board members, executive directors, non-executive directors and

senior leaders of the organisation. Some senior directors felt the trust had not yet aligned and agreed its priorities. During interviews, each board member was clear of their own view of the trust's key priorities. However, when collated, amongst seven directors and non-executive directors, there were eleven key priority themes. Four agreed on quality improvement, three on middle management development and two on the mental health strategy. The other eight priorities were highlighted as single priorities between them. We heard of 158 programmes in place across the trust, and when a review followed in October 2017, reduced to 124. One director told us in reality, there was only five key programmes, which created mixed message for staff across the trust.

The trust had three strategies. One called 'All Age Mental Health Transformation'. This described the plans of the trust across all mental health and learning disability services, with five stages over five years. Stage one reported it delivered formulated principles in February 2018, through to designing pathways until May 2019 and phased implementation due by March 2022. This had been designed with the help of another mental health trust.

The second strategy was to provide an integrated model of service for children's healthcare, including a fundamental re-provision of children and adolescent mental health services (CAMHS) inpatient units.

The third strategy was a transformation programme for Community Health Services to improve productivity and quality of services.

The trust had a clinical strategy, dated 2014 to 2019 (reviewed in 2017), and referred to the latest strategy workstreams. It did not contain dates of when action commenced and no target end date.

A further strategy existed called the Quality Strategy 2017/18. We were provided with a copy of this on inspection. It was aligned to the All Age Mental Health Transformation programme, vision and values. However, it was out of date. The trust had included the CQC 2015 inspection ratings (not current). We were not assured this was current, or had been refreshed by the board.

Given the number of strategies in existence, we were concerned the trust lacked an overarching strategy, vision and approach for how they operated, which everyone within the trust knew. Staff in core services we inspected and senior leaders could not articulate the trust's direction of travel and how this was co-ordinated. There was a lack of understanding in teams how their own plans, visions and objectives connected with the trust's vision. The trust told us that staff and senior service managers contributed to the objectives each year when refreshed. However, we heard limited evidence from staff and managers at ward level how they had been engaged and they could not tell us the direction of travel of the trust over the next five years.

Several directors and non-executive directors we spoke with described some frustration about the slow pace of change in delivering on projects and the board's ability to make timely decisions to progress. Some directors described the trust needed better clinical engagement from clinical leaders and ward staff to ensure the planned strategic pathways were successful. We heard middle managers had little space to make changes amongst their day to day duties along with a burden of assurance and compliance in their roles. Others reported too many projects running at the same time without clear oversight or decision.

Department leads were not able to articulate where their individual strategies fitted into an overarching trust strategy. Most strategic department leads we spoke with, had robust and comprehensive visions about their service, for example a people strategy, an estates strategy, equality objectives, physical healthcare strategy and Information Technology (IT) strategy. Each team produced exciting projects and innovative work in their subject areas, and reported back to board on progress quarterly and through governance meetings. The board had not set clear timescales for their projects, but when they reported back to trust board they were encouraged and praised for their work and supported to continue.

We were not assured that the pace of change throughout the trust was as progressive as it could have been. We consistently heard about plans to develop strategic goals, projects or workstreams, and senior leaders frequently used phrases such as ‘we plan to’, ‘we are considering’, ‘we are developing’ and ‘we are about to’. Some of these plans were ideas at the last inspection in 2017, such as the redevelopment of the Bradgate Unit, and career progression for professions outside of nursing.

The chief executive (CEO) told us they were disappointed in the pace of estates change for the acute mental health inpatient units, due to a lack of funding available. However, the trust had not been as proactive or robust at seeking funding from all possible sources or seeking help to do so. Plans to redevelop the wards are planned to be completed between 2023 to 2027.

The trust continued to have much to achieve in their CAMHS redevelopment programme to ensure the pathway was robust, not just with estate, but service models, provision and oversight. Whilst funding had been received to develop new estate, the sustainability plans included:

- the trust needing to understand the workforce requirements,
- to propose a trajectory for a reduction of current waiting times, develop a methodology for calculating demand and
- capacity and to develop a model to explore scenarios of demand and capacity.

These points were crucial to a successful redesign, but the trust continued to discuss them with limited action.

Some staff across the trust felt they had been involved in strategy development across CAMHS and older people’s community mental health services. The trust used surveys to obtain feedback from staff, patients and carers, but in almost all senior departments, we heard little evidence that patients had been involved in strategy meetings or had been collaborated with about projects.

We heard one example where the lead for the estates strategy did not sit on any working groups for the redevelopment of the inpatient acute mental health redesign and the director of operations did not sit on the board.

The board underwent a well-led review in September 2018. An external body visited the trust and examined governance, culture, systems and improvement of the trust and how the board led the organisation.

Five key areas for focus were identified; the trust needed to build its approach to quality improvement; the trust needed a step change in the board’s approach to staff engagement; clinical leadership required strengthening; the trust leadership programme required strengthening; and the trust needed to ensure frameworks were in place to develop service delivery at pace. However, positive areas identified included a commitment to improvement at every level of the organisation,

staff lived and demonstrated the values of the trust, there were examples of improvement work, and the trust recognised a need to engage in the wider system.

In addition, the trust had also agreed to be part of a national programme, Good and Beyond, which helps trusts to review and improve their systems. This was due to commence in January 2019. In October 2018, in a well-led self-assessment against eight domains from the CQC, the trust rated themselves as amber in five domains and green in three.

Culture

The culture across the trust required improvement. The board considered culture of the organisation to be highly important and all those we spoke with were determined to develop a positive culture, yet trust directors described it with the phrase ‘not yet right’.

Whilst staff across all services clearly described and demonstrated the trust values, senior leaders acknowledged that staff did not talk about the values and culture enough in their everyday work. Leaders were pleased that the Good and Beyond programme was starting in January 2019, to help better define the trust culture. Senior directors described the need to connect staff to the trust vision.

It was disappointing that staff did not inform us during the inspection of the trust staff pledge. The pledge was launched in April 2017, with the vision and values at its heart and this was considered by the board to be the internal brand of the trust. It included pledges for staff, for the organisation and for mangers / leaders of the organisation.

The trust made some positive attempts to recruit staff to work for the them. Recruitment involved values based interviews to support the trust’s vision and values. However, there was limited targeted recruitment specifically for Black Asian and Minority Ethnic (BAME) groups despite the diverse, multicultural makeup of the population in the geographical area. Instead, the trust described an inclusive approach to recruitment.

The trust’s agenda on equality and diversity was slow and we were not assured the equality agenda had pace or direction. The trust’s lead post for equality and diversity was vacant since January 2018 with the vacancy to be filled in March 2019. The trust had an Equality Approach for 2017 to 2021 which contained six objectives, including improving data quality, improving uptake of mental health services, and BAME career development. The trust had a people strategy in which strands of equality work sat. However, lead staff responsible for equality were unable to articulate where the strategies sat within the overarching trust strategy or direction and timescales for travel. Staff told us of several plans to formulate an agenda for equality in the trust; examples given were to use WRES data and EDS2 data more effectively; to consider possible further reverse mentoring; to develop unconscious bias training by the end of March 2019; to consider how to integrate black British workers into the workforce effectively; to start to analyse data about BAME issues; plan to integrate a talent management programme into the appraisal system in phases, starting January 2019, to run as a 12 month programme. Whilst staff described these plans and ideas we did not hear of concrete actions to bring about change.

Equality and diversity within the trust focused mostly on data analysis from various surveys such as the WRES, deep dives on themes, and developing further training for staff in this area. Oversight of equality and diversity sat with the human resources function where focus was more on workforce planning, retention and career development. Members of the trust board told us

‘diversity should be our strength, given the diversity of the geographical area of Leicestershire’. We found no evidence of this throughout the inspection.

The trust’s director of human resources and operational development chaired a monthly group called the BAME Staff Focus Group. This group was not specifically for BAME staff, but was a management group which looked at BAME issues within the trust**.** Staff of BAME origin set up their own support group in the trust led by two members of staff who also sat on the Staff Focus Group and took issues from the support group to discuss. The two groups were chaired separately. During our inspection, we held focus groups for BAME staff which were poorly attended. Staff reported they knew little about the WRES plan for the trust, but felt supported by line managers with supervision felt valued in the team. Senior staff of band eight and above had limited representation from BAME staff and progression to senior roles was halted due to BAME status. BAME staff told us they had seen or had been bullied at work and a lack of action had been taken. Staff felt they had time and support to carryout work within the BAME groups. Staff felt the trust were aware of issues for BAME staff but saw little action. The trust told us that there was a link between whistleblowing incidents (Speak Up incidents) received from BAME staff. The issues were themes around how patients treated BAME staff and not sufficient support from the trust over such issues.

The trust worked in partnership with staff side and continued to promote the anti-bullying and harassment advice service, a counselling service and an external helpline for those experiencing bullying and harassment at work. We saw posters of this around trust headquarters during our inspection, but they did not give details or contain information about the FSUG.

The trust did not submit evidence prior to our inspection to highlight good practice around ensuring people’s needs were met around protected characteristics. We heard of plans to work with the director of the national implementation programme to facilitate a pilot programme on equality and diversity within the trust. The trust hoped this would give them direction on actions around equality, diversity and their WRES. We found little evidence without this support the trust would not be able to meet the peoples needs. However, the trust did provide staff support groups for

staff with protected characteristics were in place, for staff with disability, BAME, young people, LGBT and carers. The trust had a team of staff to provide spiritual, pastoral and religious support across faiths to staff and patients. The trust had engaged with a national initiative around WRES implementation in organisations to visit in January 2019.

In the 2017 NHS Staff Survey the trust had better results than other similar trusts in four key areas:

Key finding	Trust score	Similar trusts average
KF6. Percentage of staff reporting good communication between senior management and staff	38%	34%
KF 11. Percentage of staff appraised in the last 12 months	95%	92%
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	62%	58%
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	25%	26%

In the 2017 NHS Staff Survey: the trust had worse results than other similar trusts in 14 key areas

Key finding	Trust score	Similar trusts average
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.58	3.68
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.61	3.85
KF3. Percentage of staff agreeing that their role makes a difference to patients / service users	87%	89%
KF4. Staff motivation at work	3.86	3.93
KF7. Percentage of staff able to contribute towards improvement at work	69%	73%
KF8. Staff satisfaction with level of responsibility and involvement	3.83	3.90
KF10. Support from immediate managers	3.85	3.89
KF13. Quality of non-mandatory training, learning or development	3.99	4.06
KF14. Staff satisfaction with resourcing and support	3.24	3.33
KF17. Percentage of staff feeling unwell due to work related stress in last 12 months	42%	40%
KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	55%	53%
KF27. Percentage of staff / colleagues reporting most recent experience of most recent experience of harassment, bullying or abuse	51%	57%
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	24%	23%
MF31. Staff confidence and security in reporting unsafe clinical practice	3.66	3.72

Staff reported issues of bullying within the trust. Staff had been subject to bullying from their line manager, peers or both, and senior leaders were aware of these issues. Whilst the trust had processes in place to manage staff accused of bullying it was not robust. The trust considered using an approach called Just Culture to investigate staff performance during incidents as a way to determine where staff could be managed under a performance management route or a disciplinary route. We were not given timescale of plans to implement this, although a checklist was being used in its early stages. Although we heard examples where managers dealt with poor staff performance that did not demonstrate trust values. Rates of dismissal were low, and investigations were used where information and formal conversation options had been exhausted. Data collected by the trust showed staff of BAME backgrounds were more likely to enter disciplinary investigations that white staff.

The NHS staff survey in 2017 reported 51% of staff who responded to the survey, reported a recent experience of bullying, harassment or abuse. Senior directors had awareness bullying took place in the trust between peers and line manager to staff. We made a request for the number of cases where allegations of bullying and harassment had been made in the last 12 months from December 2017. It showed six cases of bullying and harassment since April 2018, three were ongoing. Two cases were upheld, both colleague to colleague, one followed an appeal, one with formal action recommended. One was not upheld, one partially upheld both with informal action recommended, both against a manager. One of the six allegations, partially upheld against a colleague, was a member of staff with protected characteristics. The data supplied by the trust did not indicate allegations of bullying and harassment was more common for BAME staff or those

with protected characteristics, however, staff across the trust told us that it was more likely that allegations about bullying and harassment affected BAME staff in the trust.

The trust had a Freedom to Speak Up Guardian (FSUG) in post and a policy in place. The trust had developed a freedom to speak up strategic approach 2018 to 2020 with five strategic aims and key actions over the next two years. These included culture, visibility, support, a co-ordinated approach and workforce engagement. The strategy had methods to measure and monitor outcomes, but lacked dates for achieving steps along the way. Staff were signposted to the FSUG who gave advice and further signposting for support to staff as needed. The trust had a mediation process on offer for staff to use before escalating to a complaint or formal process. Staff told us the FSUG was approachable. The trust had 64 incidences of whistleblowing from July 2017 to June 2018, and a process was in place to formally investigate incidents where necessary. Senior staff had oversight of themes raised through whistleblowing concerns and we saw copies of reports taken to trust board. A self-review conducted against national standards and reported to board in September 2018 showed 59 questions rated as fully met and ongoing, two not tested and nine as amber, partially met with a plan to address.

Reverse mentoring had started within the trust. Several directors had mentors from staff within the trust. Board members told us they wanted to see this happen more and had discussed plans to make this happen.

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

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 89% and 97%, higher than the England average for patients recommending it as a place to receive care for all six months in the period (February 2018 to July 2018). July 2018 saw the highest percentage of patients who would recommend the trust as a place to receive care with 97%, and each month in the period scored above 89%.

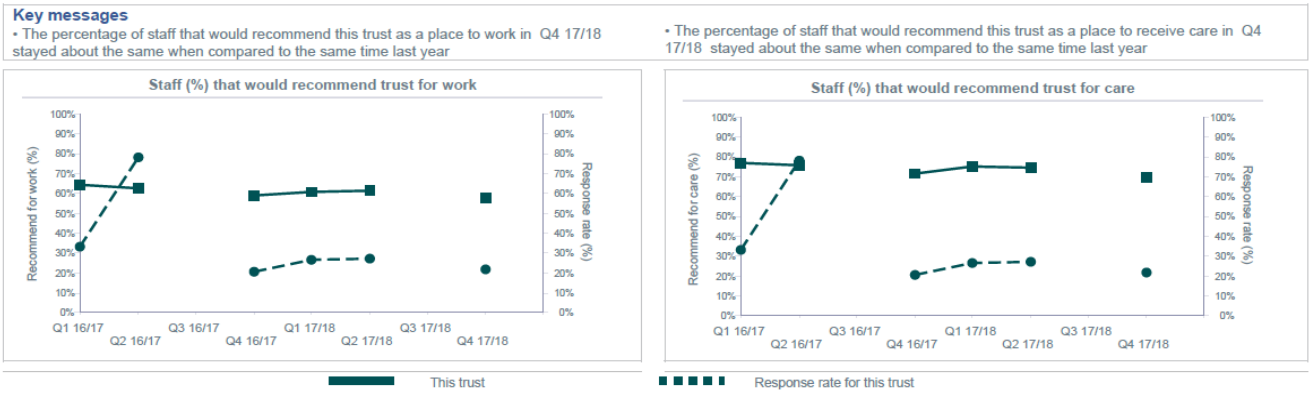
The trust scored lower than the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in all six months.

	Trust wide responses				England averages	
	Total eligible	**Total responses**	**% that would recommend**	**% that would not recommend**	**England average recommend**	**England average not recommend**
Feb 2018	10735	156	90%	1%	89%	4%
Mar 2018	19453	131	89%	2%	89%	4%
Apr 2018	20093	260	91%	2%	89%	4%
May 2018	20620	189	92%	3%	89%	4%
Jun 2018	20392	156	96%	1%	89%	4%
Jul 2018	20256	155	97%	0%	89%	4%

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.

Quarter 1 2016/2017 had the highest scores for staff recommending the trust as a place to receive care and work. Response rates were the highest in Q2 2016/2017.

There is no reliable data to enable comparison with other individual trusts or all trusts in England.



Substantive – All filled allocated and funded posts.

Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 30 June 2018	3150.0	N/A
Total number of substantive staff leavers	1 July 2017 – 30 June 2018	349.0	N/A
Average WTE* leavers over 12 months (%)	1 July 2017 – 30 June 2018	10%	≤ 10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 30 June 2018	376.3	N/A
Total vacancies overall (%)	At 30 June 2018	10%	7%
Total permanent staff sickness overall (%)	Most recent month (At 31 May 2018)	5%	≤ 4.5%
	1 June 2017 – 31 May 2018	5%	≤ 4.5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 30 June 2018	Not given	N/A
Establishment levels nursing assistants (WTE*)	At 30 June 2018	Not given	N/A
Number of vacancies, qualified nurses (WTE*)	At 30 June 2018	Not given	N/A
Number of vacancies nursing assistants (WTE*)	At 30 June 2018	Not given	N/A
Qualified nurse vacancy rate	At 30 June 2018	Not given	N/A
Nursing assistant vacancy rate	At 30 June 2018	Not given	N/A
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (Qualified nurses)	1 July 2017 – 30 June 2018	15,536	N/A

Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 July 2017 – 30 June 2018	16,726	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 July 2017 – 30 June 2018	9344	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	46,364	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	5825	N/A
Shifts NOT filled by bank staff where there is sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	5674	N/A

*WholeTime Equivalent

The trust did not provide data to show staffing establishments prior to the inspection. This data was collected locally in service during our inspection. The trust submitted information that it reviewed staffing information using a tool called Safer Staffing. This information only related to in-patient facilities and the trust did not have a coherent approach to ensure appropriate oversight and assurance of safe staffing for community services. It was unclear how the board was appropriately sighted on any risks within these large areas of provision. It was recognised the trust was undertaking work to address this, however, the full scope of the work and timescales for completion were not confirmed through discussions in the review process.

The trust collaborated with the local university to encourage nursing and medical students to work as bank staff. To date, 30 staff had been recruited. In February / March 2019, a cohort of 100 planned to start work with the trust with plans to increase to 200 staff the following year. The workforce team had a focus to reduce agency spend, increase the pool of bank staff and use substantive staff in different ways, including encouraging those who were due to retire to continue to work on the bank.

As at 30 June 2018, the training compliance for trust wide services was 91% against the trust target of 85%. Of the training courses listed 10 failed to achieve the trust target and of those, two failed to score above 75%. The trust had made improvements to data collection in this area since our last inspection.

CAVEAT: The trust was unable to provide the training data in the required format and therefore the compliance has been calculated on available data.

The trust developed a Grow Your Own programme to promote routes into nursing from apprentice to registered nurse. This was a role for student nurses or HCA staff to progress into, which could lead to training as a qualified nurse. The trust saw three cohorts of staff progress through this programme, it worked in conjunction with a local acute hospital. Staff who had progressed on this route produced short videos to promote recruitment to the trust for other staff.

In July 2018, the trust launched a nursing career pathway. This consisted of an online tool for registered nurses to access a page on the trust intranet which showed various career pathways available to them and which skills and experience was required for each role. This programme still had not been developed for other professions despite hearing of plans by the trust to do this at the last inspection in 2017. The workforce team were not sure why this had not progressed and cited other priorities such as the All Age Mental Health Transformation Strategy.

A human resources study of leavers from the trust had highlighted staff expressed 'career development' as the biggest reason for leaving employment of the trust.

The trust's target rate for appraisal compliance is 80%. As at 30 June 2018, the overall appraisal rates for non-medical staff was 89%.

All core services achieved the trust's appraisal rate. The rate of appraisal compliance for non-medical staff reported during this inspection is lower than the 90% 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
MH - Community-based mental health services for older people.	146	139	95%
CHS - End of life care	73	68	93%
CHS - Community health services for adults	979	887	91%
CHS - Community health services for children, young people and families	824	751	91%
MH - Acute wards for adults of working age and psychiatric intensive care units.	224	204	91%
MH - Mental health crisis services and health-based places of safety.	132	119	90%
MH - Specialist community mental health services for children and young people	175	157	90%
CHS - Community inpatient services	619	549	89%
MH - Community-based mental health services for adults of working age.	344	303	88%
MH - Forensic inpatient/secure wards.	25	22	88%
MH - Wards for older people with mental health problems.	175	151	86%
MH - Wards for people with learning disabilities or autism.	49	42	86%
MH - Community mental health services for people with learning disabilities or autism	163	138	85%
MH - Child and adolescent mental health wards.	38	32	84%
MH Other Specialist Services	54	45	83%
MH - Long stay/rehabilitation mental health wards for working age adults	113	93	82%
Total	**4957**	**4425**	**89%**

The trust did not provide appraisals data for medical staff.

The trust had plans to embed the trust pledge into the appraisal system alongside a talent management scoring tool over a 12-month programme to be started in January 2019. Managers would be expected to use this tool to identify career development potential for staff during the appraisal process.

Prior to inspection, the trust submitted data to show compliance with supervision. The trust's target rate for clinical supervision was 85%. As at 30 June 2018, the overall clinical supervision compliance was 74%. At this time, none of the 16 core services achieved the trust's clinical supervision target. We obtained up to date figures to show the trust had improved compliance with supervision in most clinical services across the trust.

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

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 - Community-based mental health services for older people.	723	865	84%
MH - Wards for older people with mental health problems.	621	746	83%
MH - Community mental health services for people with learning disabilities or autism	525	640	82%
CHS - Community health services for children, young people and families	3,660	4,559	80%
CHS - End of life care	441	575	77%
MH - Specialist community mental health services for children and young people	553	716	77%
MH Other Specialist Services	253	330	77%
CHS - Community inpatient services	2,150	2,827	76%
MH - Community-based mental health services for adults of working age.	1,551	2,030	76%
MH - Mental health crisis services and health-based places of safety.	649	862	75%
MH - Child and adolescent mental health wards.	49	66	74%
MH - Long stay/rehabilitation mental health wards for working age adults	525	721	73%
MH - Wards for people with learning disabilities or autism.	175	249	70%
CHS - Community health services for adults	2,759	4,337	64%
MH - Acute wards for adults of working age and psychiatric intensive care units.	860	1,345	64%
MH - Forensic inpatient/secure wards.	81	134	60%
Total	**15,868**	**21,454**	**74%**

During our inspection, core service managers provided us with updated data on supervision compliance. They used dashboards to effectively record compliance and all managers knew how to access the data and report compliance through governance systems. The trust improved its data collection with supervision since our last inspection. Of the five core services we inspected, two had met over and above the trust target for supervision (wards for learning disability and autism, and older people's community mental health services). However, compliance at the Willows was at 78% and all acute inpatient wards and psychiatric intensive care units and CAMHS were all below 80%.

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	99.2%
What is your target for completing a complaint?	10 and 25	86.4%
If you have a slightly longer target for complex complaints please indicate what that is here	40 and 60	60.5%

* 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**	791	1 July 2017 – 30 June 2018
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	7	1 July 2017 – 30 June 2018

**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

We were assured of trust oversight of complaints. The trust held a very comprehensive data base which collated all information regarding complaints. We sampled complaints during our well-led inspection. Complaints had been responded to within timescales on average on 84% of occasions. The complaints team collated monthly data and provided quarterly reports to the Quality Assurance Committee (QAC) and effectively triangulated data from complaints, incidents, and PALs concerns. Main themes from complaints in the last year included staff attitude towards patients and carers. As a response, the trust developed a customer care training module to improve staff communication and managing patient expectation. The complaints team told us their priorities for the future included work around patient's experience. A survey of patients and carers who had made a complaint were sent a letter to gain feedback on their experience. The complaints team had a schedule to monitor responses received and would determine the priorities of themes to work on. An agreed timescale had not been set by the board.

The trust received 1240 compliments during the last 12 months from 1 July 2017 to 30 June 2018. Community Health Services (CHS) - Adults Community had the highest number of compliments with 50%, followed by CHS - Community Inpatients with 19% and 'MH - Wards for older people

with mental health problems and Mental Health - Other Specialist Services both with 6% respectively.

Governance

The trust's arrangements for governance and meeting structures were robust and comprehensive and fit for purpose. It ensured there were limited gaps in reporting and necessary overlaps of meetings were not over burdensome. Non-executive directors had membership at key meetings and had oversight of the information shared in various forums. They could report any repetition or gaps in information sharing. The audit committee led on annual reviews of all governance systems in the trust.

Each of the three divisions (AMH/LD, FYPC, CHS) had a dashboard which contained key data from which leaders and senior managers monitored performance. Staff in services designed and drove development of the dashboards.

The Chief Executive told us further steps were required to improve fundamentals of holding staff to account for performance. Performance of each division was not specifically reviewed by the board but reviewed by exception.

All senior staff felt confident in and could describe the governance structures in place to provide feedback to the board and that it supported their work. The board had recently been part of an external review around their governance systems. One recommendation made included a review of governance arrangements. The trust encouraged divisions to use a nationally recognised tool (the single oversight framework, SOF) to review divisional performance and report into the finance and performance team on a six-monthly basis. The board hoped this would encourage accountability for performance at divisional level.

The trust had robust systems in place to manage safeguarding. The safeguarding team consisted of a combined adults and children's team, recently amalgamated, and created a duty system to cover all safeguarding, which meant both adult and children's teams worked together. The team were in the process of merging two IT systems into one, taking the best from each. For example, a risk management system in the adult service would be transferred into the children's service in order to report data more effectively and report to board. The team set up an advice line for front line staff to call should they have queries or issues. However, we noted some reporting issues for safeguarding within specialist community services for children and adolescents.

The trust delivered safeguarding training for all staff, but were not assured that agency staff had full awareness of safeguarding issues to the same level of permanent staff. We heard that a training package was being reviewed, and improvements were needed to evaluate how training was taken forward into practice. The safeguarding team extracted data from electronic reporting forms to hold services to account and report on themes of safeguarding incidents which went to trust board.

The trust submitted details of 44 reviews considered to be from external parties between 01 July 2017 and 30 June 2018. They included local commissioning reviews, CQC, Ofsted and SEND Leicester City Inspection, accreditation bodies and local groups such as Healthwatch and local MPs. The board received the outcome of such reviews via the audit and assurance committee.

The trust had assurance processes to adhere to obligations under the Mental Health Act, Mental Capacity At and Deprivation of Liberty Safeguards. The trust had an identified lead for the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), a DoLS policy (dated July

2017) and an MCA policy (dated July 2016). The trust planned to review both policies. The trust provided face-to-face training for MCA and DoLS which took place on a three-yearly basis. This was mandatory training. The lead for MCA and DoLS had completed specific MCA and DoLS training with band 6 and band 7 nurses over the past year and ad-hoc training to staff in relation to specific cases. An independent advocacy service provided mental capacity advocacy to the trust.

The trust had a two networks of MCA champions across the wards and services, one for inpatient staff and one for community staff. The MCA champions networks met on a quarterly basis. The MCA committee met on a quarterly basis. The MCA and DoLS lead produced a quarterly DoLS report for the safeguarding committee, which met every month. All reported into the QAC and the onto the trust board.
The trust had effective systems and processes in place relating to the governance of the MHA. trust had a Mental Health Act Assurance Committee (MHAAC), chaired by a non-executive director which met on a two-monthly basis and reported directly to trust board. The committee had oversight of, and monitored, all aspects of MHA performance across the trust.

The trust had a MHA procedural document, last reviewed in May 2018, which provided a user-friendly guide for staff about the MHA. Staff completed mandatory, face-to-face, training about the MHA every three years.

The MHA administration team disseminated information, such as updates relating to the MHA, to trust staff. The MHA administration team had good working relationships with the wards, community teams and the executive team.

The trust had robust arrangements in place for the receipt and scrutiny of detention paperwork. The trust had developed checklists to assist staff with the receipt and scrutiny process.

The MHA administration team effectively escalated issues within robust structures. The trust had a system in place to address issues raised by the CQC's MHA monitoring visits. The MHAAC had oversight of the process.

The trust had 12 hospital managers (members of a committee authorised to consider the discharge of patients detained under certain sections of the MHA). The composition of the current hospital managers' team was representative of the diverse local community. Hospital managers received an induction and training, which included shadowing panel hearings, and regular supervision. The trust's chairperson chaired the twice-yearly hospital managers' meetings. The chief executive also attended this meeting. A third meeting took place during the year which focussed on training.

The trust had effective collaborative working with partners around MHA. The trust had a service level agreement in place with the neighbouring acute NHS trust. This related to providing a MHA administrative function to the acute NHS trust. Leicestershire County Council operated a daytime approved mental health professional (AMHP) service. Leicester City Council operated a daytime AMHP service and the out-of-hours county-wide emergency duty team. The information the AMHP service received from referrers, requesting a MHA assessment, was variable in quality.

We had concerns about the availability of beds within the trust. Some patients needed to be admitted to out of area beds, due to no appropriate beds being available within the trust. There were some difficulties, usually during the daytime, in arranging section 12 doctors (practitioners having special experience in the diagnosis or treatment of mental disorder) to participate in MHA assessments. The specialist registrars, from the crisis team, often participated in the MHA assessments, in absence of the patients' own medical team.

AMHP leads gave positive feedback about the working relationship they had with the trust's staff. East Midlands Ambulance Service (EMAS) said the service had a good working relationship with the trust. Whilst there were no specific meetings between EMAS and the trust, both providers attended multi-agency meetings where they shared information. EMAS employed a mental health nurse in an advisory capacity. The nurse regularly liaised with the trust.

The trust used an independent mental health advocacy service to provide services to the trust. The IMHAs visited most of the wards within the trust on a weekly basis. The IMHA service met with the trust on a two-monthly basis (in line with their contract). The IMHA service had undertaken training about the role of the IMHAs with staff on their induction. A training schedule had been developed for 2019.

Management of risk, issues and performance

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

Between 1 July 2017 and 30 June 2018, the trust reported 48 STEIS incidents. The most common type of incident was Apparent/actual/suspected self-inflicted harm with 28. Ten of these incidents occurred in MH Community based mental health services for adults of working age.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Leicestershire Partnership NHS Trust reported one never event during this reporting period.

We asked the trust to provide us with the number of serious incidents from the same period on their incident reporting system. The number of the most severe incidents (46) was broadly comparable with the number the trust reported to STEIS (48).

Type of incident reported on STEIS	CHS - Adults Community	CHS – Children, Young People & Families	CHS – Community Inpatients	MH – Acute PICU	MH – Child & Adolescent Health Wards	MH – Community MH Services For Adults Of Working Age	MH – Community MH Services For Older People	MH – Forensic Inpatients	MH – Crisis Services & Health Based Places Of Safety	MH – Other Specialist Services	MH - Specialist Community MH Services For Children & Young People	MH – Wards For Older People With MH Problems	MH – Wards For People With Learning Disabilities Or Autism	N/A	Total
Apparent/actual/suspected self-inflicted harm	0	0	0	6	1	10	3	0	5	1	2	0	0	0	**28**
Sub-optimal care of the deteriorating patient	2	0	0	1	0	0	0	0	0	1	0	0	0	0	**4**
Abuse/alleged abuse of child patient by third party	0	3	0	0	0	0	0	0	0	0	0	0	0	0	**3**
Pending review	0	0	0	1	0	0	0	1	0	0	0	1	0	0	**3**
Abuse/alleged abuse of adult patient by staff	0	0	0	0	0	0	0	0	0	0	0	1	1	0	**2**
Failure to obtain appropriate bed for child who needed it	0	0	0	0	2	0	0	0	0	0	0	0	0	0	**2**
Unauthorised absence	0	0	0	1	0	0	0	1	0	0	0	0	0	0	**2**
Confidential information leak/information governance breach	0	0	0	0	0	0	0	0	0	0	0	0	0	2	**2**
Slips/trips/falls	0	0	1	0	0	0	0	0	0	0	0	0	0	0	**1**
HCAI/Infection control incident	0	0	0	0	0	0	0	0	0	0	0	1	0	0	**1**
Total	**2**	**3**	**1**	**9**	**3**	**10**	**3**	**2**	**5**	**2**	**2**	**3**	**1**	**2**	

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 1 July 2017 to 30 June 2018 were Patient accident, Other and Implementation of care and ongoing monitoring / review. These three categories accounted for 4754 of the 10307 incidents reported. Self-harming behaviour accounted for 18 of the 27 deaths reported.

Ninety-nine percent of the total incidents reported were classed as no harm (65%) or low harm (34%).

Incident type	No harm	Low harm	Moderate	Severe	Death	Internal Comprehensive	Internal Concise	To Be Confirmed	Total
Patient accident	1332	736	11	1	0	0	0	0	**2080**
Other	805	522	4	1	9	0	0	0	**1341**
Implementation of care and ongoing monitoring / review	97	1234	2	0	0	0	0	0	**1333**
Self-harming behaviour	869	414	12	3	18	0	0	0	**1316**
Disruptive, aggressive behaviour (includes patient-to-patient)	984	269	1	0	0	0	0	0	**1254**
Access, admission, transfer, discharge (including missing patient)	598	51	1	0	0	0	0	0	**650**
Infrastructure (including staffing, facilities, environment)	541	72	0	0	0	0	0	0	**613**
Consent, communication, confidentiality	485	63	0	0	0	0	0	0	**548**
Medication	387	95	1	0	0	0	0	0	**483**
Documentation (including electronic & paper records, identification and drug charts)	427	29	0	0	0	0	0	0	**456**
Infection Control Incident	45	22	1	0	0	0	0	0	**68**
Treatment, procedure	37	17	0	0	0	0	0	0	**54**
Patient abuse (by staff / third party)	19	9	2	1	0	0	0	0	**31**
Apparent/actual/suspected self-	0	0	0	0	0	2	25	0	**28**

Incident type	No harm	Low harm	Moderate	Severe	Death	Internal Comprehensive	Internal Concise	To Be Confirmed	Total
inflicted harm meeting SI criteria									
Clinical assessment (including diagnosis, scans, tests, assessments)	16	0	0	0	0	0	0	0	16
Medical device / equipment	15	1	0	0	0	0	0	0	16
Sub-optimal care of the deteriorating patient meeting SI criteria	0	0	0	0	0	2	2	0	4
Abuse/alleged abuse of child patient by third party	0	0	0	0	0	0	3	0	3
Pending review (a category must be selected before incident is closed)	0	0	0	0	0	1	2	0	3
Abuse/alleged abuse of adult patient by staff	0	0	0	0	0	0	2	0	2
Confidential information leak/information governance breach meeting SI criteria	0	0	0	0	0	0	1	1	2
Failure to obtain appropriate bed for child who needed it	0	0	0	0	0	0	2	0	2
Unauthorised absence meeting SI criteria	0	0	0	0	0	0	2	0	2
HCAI/Infection control incident meeting SI criteria	0	0	0	0	0	0	1	0	1
Slips/trips/falls meeting SI criteria	0	0	0	0	0	0	1	0	1
Total	6657	3534	35	6	27	5	41	1	

According to the latest six-monthly National Patient Safety Agency Organisational Report[1] (April 2017 to September 2017), patient accident and disruptive, aggressive behaviour accounted for a higher proportion of the total number of incidents reported compared to similar trusts.

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 NHS Trust reported fewer incidents from 1 July 2017 to 30 June 2018 compared with the previous 12 months.

Level of harm	1 July 2016 – 30 June 2017	1 July 2017 – 30 June 2018
No harm	7220	6657
Low	3972	3534
Internal Concise	59	41
Moderate	42	35
Death	35	27
Severe	7	6
Internal Comprehensive	9	5
To Be Confirmed	0	1
Total incidents	**11348**	**10307**

We were assured that reporting of incidents by staff in the trust was robust. The trust had systems in place which allowed staff to effectively report incidents. Staff knew how to complete incident forms across all services.

We were not assured that sharing of information about incidents or learning from incidents was effective across the trust. Staff in three of the five services we visited, told us they did not hear about shared learning from incidents and at times, the information about the incidents themselves were not shared, despite them taking place within their own services. The trust made learning from incidents available information on the trust. Managers in four core services we inspected did not routinely record incidents that had taken place or learning from them in team meeting minutes.

For example, prior to our inspection, we were made aware of an incident where a fire had been set on a ward in the Bradgate Unit. It had been raised to us by a family member of the patient and not by the trust. Further investigation revealed the trust had not rated it as a serious incident until our concerns changed this. During our inspection, we found little evidence of staff who worked in the area, had awareness of the event, and we were not assured that learning had been shared given the seriousness of the issue. At the time of our inspection this incident was under investigation, but we were aware of 14 fire setting incidents that had taken place across the service, and shared learning between teams may have prevented further incidents.

It was unclear if the trust board was clear and had a co-ordinated approach on its overall safety improvement and key risks. The trust gave us information prior to the inspection and told us their key safety priorities were:

[1] RT5 NRLS Six Monthly Report

- to improve clinical recording and care planning
- to improve discharge planning
- improve engagement in clinical supervision
- reduce ligature risk in acute inpatient settings
- reduce medication errors, falls and harm from medical devices and
- improve understanding and application of the MCA and DoLS.

We were not assured that the trust risk register clearly documented action taken or progress of action, within agreed timescales.

The trust had a corporate risk register. The trust had a risk strategy, formalised in November 2018. Each of the three divisions had a risk register, and all risks were categorised into a three-tier system. The highest rated risks appeared on the corporate risk register which the trust named the Integrated Corporate Risk Register and Board Assurance Framework (BAF) report. The trust's Board Assurance Framework (BAF) was lengthy, was combined with a corporate risk register and had overdue actions. Due to the lack of a trust overarching strategy, the BAF did not provide an effective oversight against strategic objectives and gaps in control and assurance.

The board reviewed escalated risks from the divisions and agreed their inclusion into the corporate risk register / BAF as necessary.

The document was 80 pages and contained 25 risks, 12 graded as high and 13 as moderate. Eight risks showed they had exceeded their review date. One was dated July 2018, five were dated October 2018 and two for November 2018. Eight risks passed their review date on the week of our inspection, three were set for review in late December 2018, and five for January 2019.

The document listed 114 actions against the risks, with assigned responsibility to an individual or committee. Seventeen actions had been closed. At the time of our inspection, 29 actions (25%) were out of date, (had exceeded the target date for when action was required). Two of these were dated May 2017. Most dates for action were set for the end of December 2018 with a few in the first few months of 2019. The risk register had space to record details of the action outcomes. However, of the actions listed, 61 (54%) had no action outcomes recorded. The remaining outcomes listed were recorded as awaiting further action or outcome under review. Many of the actions listed included plans to review process, establish an approach, or to develop areas. We felt this contributed to senior staff views that pace of change in the trust was slow.

The quality assurance committee owned the corporate risk register. Trust directors had differing views on risk priorities of the trust. Some senior directors told us the key risks for the trust were performance in length of stay and CAMHS waiting times and the trusts progress with mitigating these risks. Other directors told us risks were out of area beds, workforce and data quality. Risk and performance was manged in collaboration between committees. The length of stay and waiting list risks were overseen by the finance performance committee and reported into board. The overall plan of action to manage length of stay was identified to be led by the finance and performance committee.

The corporate risk register was due to be reviewed and oversight to be changed from the audit committee. On a quarterly basis, more detailed information was submitted, including control measures and actions required for each risk. The trust regularly reviewed risks at QAC where

scrutiny and challenge of the risk registers took place. The QAC assigned actions to relevant committees as required.

The trust ran drop in sessions and telephone sessions where staff raised issues. Staff across the trust completed E-learning and classroom training on risk.

Non-executive directors felt confident and able to challenge the board of directors over risk, performance and safety issues. They were positive about recent changes and new appointments to the board. Several directors told us the trust had considered a simplified model for managing risk across the trust.

The trust had a safety improvement programme in place. Senior clinicians had been involved in the change programme and were given the required mentoring and coaching from senior directors during their input.

The trust had a mortality surveillance group with established quarterly meetings. It scrutinised investigations of deaths, themes and actions taken in response. Staff highlighted reports to the QAC. We reviewed deaths in the quarter four period for 2017/18. There were 118 deaths in adult mental health and learning disability services, eight of which were subject to a desk top review. We saw evidence of learning which was documented and shared through appropriate channels in the trust.

The trust had an end of life steering group in which all divisions had representation. A total of 103 champions were in place across the trust to promote best practice in end of life care.

The trust had plans to develop its business case and estates strategy with medium and long-term plans, to include re-provision of the acute mental health inpatient unit, CAMHS estate (2018-2020), two new wards for mental health services for older people (from 2028 to 2030) and consolidation of rehabilitation wards (from 2029 to 2030). We heard the board were disappointed in the priority the estates progress had in the mental health wider economy only recently being added to five priorities of the STP at number five. The trust corporate risk register listed estate as a high risk. Two actions were recorded against this risk and the action target date was 31 December 2018; they were to seek sign off of a service level agreement in 2018/19 and finalise and approve the estates strategy. The risk register described the estates strategy being reviewed by trust board in 2017, with formal review in 2018 with 6 monthly progress reports due.

A small team of two staff ran the patient incident team. This limited their ability to develop work in this area, for example forward facing work with patients. We heard they had little contact with non-executive directors, apart from sitting on a panel for serious incidents. They also reported they had no contact with the board and there was no patient safety representative at the QAC, which limited the detail that could be shared by those who knew it well, with some misinterpretation of data by the QAC.

A family liaison role was in place, and worked with families during the investigation of serious incidents. The patient incident team reported to QAC monthly, and quarterly with a more in depth report. They also provided a report to board on duty of candour and deaths. We heard that the staff felt issues were raised and listened to by senior managers, but little action was taken to resolve them. The team had plans to devise a patient safety strategy to sit alongside the clinical strategy. We heard how teams across the trust worked in different ways, limited evidence of cross service working and the opportunity to share lessons learnt was missed.

The patient incident team carried out a review of serious incident reporting and made changes to improve the reporting process, categorise incidents in a better way and improved reporting of safeguarding. The group established a deliberate self harm and suicide group in the last year to

oversee specific incidents of this nature. We heard how this group had plans to review the policy and strategy for this area.

During inspection, we case tracked four serious incident cases. Without exception, all files sought feedback from carers and relatives and a plan of action was in place to support relatives. Terms of reference for investigations were clear and lessons learned were outlined.

The trust had robust processes in place to manage infection prevention and control (IPC), although some concerns were noted in two core services we inspected. Champions for infection control were in place across services who supported audits, had membership within several networks, ward walk rounds, flu group, involvement in training, updates on topics such as sepsis and reported into the IC lead and the safety committee. The trust board received highlight reports quarterly. An electronic app was recently piloted to be in place by January 2019 to share the top five themes and trends from reports and audits. Leads for IPC had links with national and regional groups and networking helped to develop practice within the trust.

The trust had invested in physical healthcare of mental health patients. Patients received improved screening tests on admission, daily monitoring of vital signs and the use of national screening tools such as NEWS and MEWS as a result of a trust wide project. The physical health team collaborated closely with pharmacy staff and monitored those patients on antipsychotic medication. The trust had processes in place for staff to monitor patients at risk of falls, obesity, nutrition screening, pressure ulcer management, medical equipment provision and management of conditions such as cancer. The physical health team reported into the trust board via a clear governance structure.

The trust struggled to make repairs to its estate in a timely way. A repair service was contracted to a local stakeholder. Trust staff who noticed a repair was needed in a patient area, contacted a helpdesk managed by the stakeholder. 85% of urgent repairs were rectified within timescales, 80 to 90% of routine repairs has been carried in with the required timescale. However, we were concerned to hear that the trust did not acknowledge the impact of the delays adversely contributed to patient care and their experience. We saw examples during the inspection where patient environments had not been repaired. A patient at the Bradgate unit had a broken window in their bedroom during very cold weather. Patients told us about blocked toilets and we saw environmental issues within several services that had not been repaired. The estates team had two property office posts vacant. These posts worked at ward level and escalated issues through to the property manager and onto the estates lead.

The trust had processes in place to review restrictive practices, restraint and analyse data collected in these areas to improve patient care. The positive and safe group reported to the patient safety group and upward to the QAC and provided quarterly reports.

Whilst the trust had a smoke free policy we were not assured that the trust took necessary action to manage this effectively in some areas. Senior managers and directors we spoke with, knew it was manged inconsistently across services. Ward staff felt strongly that the trust had not supported them to work with patients to manage smoking in the Bradgate Unit, or that reasonable attempts had been made to respond to incidents of fire setting, and shared learning from such incidents. During our inspection we saw evidence that some patients smoked in their bedrooms, in gardens and outside buildings rather than off site. Staff allowed patients to smoke as this was the option that caused less confirmation or incident. There had been 14 fire setting incidents within this service. Patients secreted lighters onto the wards and we saw staff left patients unchallenged

who walked down a ward corridor with a lighter in their hands. The smoke free issues did not appear on the trust risk register.

The trust's over sight of seclusion data was not robust. During our core service inspection, we found significant gaps in seclusion documentation that had not been picked up by the trust's audits. Senior staff told us the annual audit had been very robust however, the monthly assurance had failed as data was incorrect. Whilst seclusion practice had improved, the process for data collection has not moved forward. We had concerns over the standard of record keeping in seclusion records, in particular, medical reviews, nursing reviews and care plans for those who required the intervention of seclusion. During our inspection we reviewed 58 seclusion records, 34 did not record a medical review within one hour of the start of seclusion; forty did not record a nursing review by two nurses every two hours throughout seclusion. Twenty-four did not record continuing medical reviews every four hours until the first multidisciplinary review. Ten of 15 records did not record an independent MDT review after eight consecutive hours of seclusion. Sixty-one records did not record in a care plan how de-escalation attempts would continue or how risks would be managed.

The safe management of medicines across the services was poor. We found issues with disposal of medication, lack of oversight from the trust pharmacy team, poor management of controlled drugs and a lack of effective labelling of medication. Some of these issues were found at the last inspection in 2017. Although the trust's medicines review group had compiled an action plan following the last inspection and stated that all actions had been completed and closed May 2018, the previous issues were still evident and further issues had been found. We made a request to the trust to provide supporting evidence as to how the trust met this action, but it was not received.

Information Management

The trust had a Senior Information Risk Owner (SIRO) in place and had processes in place to report data breaches and escalate to the correct channels. The role of the SIRO worked alongside the Caldicott Guardian and was involved with the NHS Digital network. The trust had an information governance (IG) tool kit. During our inspection, we reviewed the personal data breach report for an IG breach that had occurred. Whilst the tool kit was in place, it did not outline the procedures to be followed in the event of an IG breach.

Data quality was not assured at all levels of the trust, despite established systems which produced data for directors to review. Locally derived data caused some concern for some executive staff. The trust verbalised to the inspection team they 'had always had data quality issues'. We found examples where data quality was not robust. For example, the trust could not provide medical staff appraisal data; data on mixed sex accommodation breaches was inconsistent (the trust reported none prior to inspection yet breaches were found); sickness, turnover and vacancy rates in wards for people with learning disability and autism were collected at local level, but not provided by the trust prior to inspection. Local commissioners told us they continued to have concerns over data quality in relation to systems and accuracy. A contract performance notice was in place in relation to CAMHS including the children and young people's crisis and home treatment team data. As of August 2018, the commissioners' concerns remained. Data quality was rated as high on the trust risk register with ten actions listed against it, even though staff we spoke with told us it had been removed from the corporate risk register. Although Significant improvements had been made in areas such as collection of supervision data and training data and improvements occurred across the trust; the trust had developed a way to monitor waiting lists in CAMHS and had a system to

monitor those at risk on the waiting list; staff had been aligned to services to manage data collection.

The trust had a clear structure for Information Management and Technology (IMT), a strategy group who monitored this and a working group. They held a service level agreement with Leicestershire Informatics Service who assisted the trust with issues such as cyber security. The IMT strategy group gave assurances to the board through QAC and reported IT breaches on a quarterly basis. We heard about improvements to IT systems for managers who accessed automatic reports generated from dashboards, which now saved time and gave managers the right information at the right time. Plans were in place to aim towards a paperless organisation, and to move to a single patient record system by 2021. Clinical input drove the decision to move seven different clinical systems into one and took six months to debate in phase one planning. The trust consulted with staff, and held engagement events on the project.

The trust delivered training for staff on risks to IT, such as phishing, and ran a simulated phishing attack. Following this, the learning developed a threat profile for the organisation. The IMT team collaborated with police and delivered sessions to staff about protection of data and promoted good practice. The trust mandated controls for IT security to ensure due diligence for patient information held electronically.

Engagement

The trust board and directors had engaged with other NHS organisations to help learning and development and influence the direction of travel for the trust. 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 and key roles with sustainability and transformation plans.

Patient and staff engagement in service re-design took place in some areas but not all. Staff told us that mental health services for older people and CAMHS services had engaged carers and relatives in discussing ideas. Staff from community health services had been involved in new ways of working developments and, the acute inpatient wards had started to seek feedback from friends and families on new developments.

The trust ran groups across services called Listening into Action. This encouraged staff to make changes in practice and be responsive to patient / service need. We saw examples of the last three cohorts, run since September 2017 and March 2018 where the trust supported 15 projects into action and ten further actions proposed by staff in September 2018. These ranged from more relaxing environments for staff, tracking syringe drivers, flu clinics, physical health clinics, team away days and improvements to medical device servicing. However, the trust did not label this as quality improvement and senior staff felt the language of self-regulation needed change.

Board and executive members complimented the chief executive on being visible in services, presenting awards and being approachable to staff across the trust. We heard examples of six roadshows delivered to staff, monthly awards, annual awards, handwritten retirement cards to staff and active social media activity on behalf of the trust.

The trust delivered conferences and workshops to engage with staff over different issues such as nursing and therapy conferences, annual workforce and wellbeing conference, quarterly HR listening events and a quality improvement conference. The trust had an active social media platform to promote staff engagement.

Champions for different topics promoted and shared messages across the trusts, such as workforce champions who promoted health and wellbeing, end of life champions, and physical health champions.

Each director and non-executive director was assigned to services conducted board walks to ensure visibility with ward staff. Whilst they were informal, feedback from staff was sought, concerns escalated, but themes were not collated by board and we heard from the board they would like to do more to measure the success of boardwalks. Non-executive directors expressed concerns over transforming feedback into action from the boardwalks. The trust identified the need to strengthen medical and clinical engagement within the organisation and how the clinical voice was heard and influenced the board.

The trust completed the Staff, Friends and Family Test in three quarters of the last year. An additional ten questions made up the Staff Pulse Survey, distributed to all staff. The average response rate was 20 to 25% and for the first time in 2017/18, the trust included bank staff. Concerns raised included, the use of temporary workforce to fill gaps in substantive staffing; waiting times and services that staff considered to be stretched; support from and responsiveness of line managers; issues around autonomy and ability to make changes; stress and environmental issues such as estate and equipment.

The trust had links with the Child Sexual Exploitation (CSE) hub, local police; The safeguarding team had positive links with the local domestic violence hub, established links to six local authority pathways and local social care pathways. A nurse from the trust was based in the CSE hub and was only one of two funded nationally, after a pilot of the scheme from the police and crime commissioner. The trust had devolved responsibility for section 42 enquiries for the inpatient setting. There was a clear escalation policy and process to deal with local authority issues. Monthly meetings ensured oversight, where themes and trends were reviewed. The lead for safeguarding sat on a regional providers forum and brought shared learning to the trust. For example, a safeguarding competency framework embedded into the FYPC service planned to roll out to adult mental health services.

Engagement with local commissioning groups was evident and effective. We saw minutes of meetings with commissioners and contained appropriate scrutiny and review of governance, finance, risks and papers tabled for exception reporting. Positive stories were also shared.

Commissioners gained assurance from the trust through data submission, open discussion, service quality assurance reviews, clinician to clinician meetings, targeted Clinical Quality Review Group sub groups, agreed audit processes and action plan monitoring. A lead commissioner had been invited to participate in the QAC meeting since March 2018. Partnership working around safeguarding was effective. Commissioners gave notice to the trust of a service redesign for community health services. Work was ongoing in this area for the trust. The commissioners reported they had good assurance from the trust on reporting of incidents and the trust were open and transparent with serious incident management.

Engagement with local stakeholders to manage safeguarding was effective. The trust produced quarterly stakeholder bulletins for most stakeholders including CCG's, Healthwatch, police, universities, county and city councils and voluntary sector organisations.

The trust engaged with the public in some service redesign including face to face sessions, online surveys, and use of social media.

The FSUG delivered a comprehensive programme of engagement. The message to staff about raising concerns was delivered through Listening into Action roadshows, induction, within the HR training for managers, drop in sessions ('Here for you'), six bespoke training sessions 'Concerned about raising concerns?', presentations and a specific annual survey on speaking up. The trust enabled the FSUG to meet the national guardian, and they were actively involved in regional groups and met quarterly.

The board invited staff to attend its meetings. Patient stories were presented, and when invited, staff presented issues, and good news stories.

We saw limited evidence of patient involvement in strategic groups in the trust. Almost all project leaders, who were senior staff, told us they did not have patients attend their working groups. Overwhelmingly, patients feedback was gathered through surveys rather than face to face inclusion of patients in groups or meetings. The trust did not have a patient involvement policy. A patient involvement lead had been in post for 12 weeks at the time of our inspection, extended until March 2019. The trust developed a 'Plan on a Page' which gave the trust target, and methods for involving patients and carers in care. This was a single A4 page and included 5 key objectives, but no dates for implementation, and ways in which the objectives would be achieved.

We heard how senior matrons visited ward community meetings and forums, delivered monthly drop-ins to wards, and delivered targeted events such as care planning. All directorates gathered ward level feedback on patients' experience of care through questionnaires, complaints, PALs, patient stories presented at each board meeting and compliments. The trust used various methods to encourage more feedback at ward level such as 'biscuits and banter', 'mocktail conversations and forums'.

The trust started a change project called Always Event in December 2017 with NHS England to engage staff and patients in discussions to improve care in inpatient settings. One examples we saw on Heather ward where patients were asked how to improve their ward round experience. Posters displayed the feedback and developed a vision statement and aim statement to improve attendance at ward rounds. Adult mental health and learning disability services included patient survey feedback in their redesign plans, CHS services held a series of Listening into Other action events to gain patients and carers feedback included a series of questions on pressure ulcer care, a survey about transformation plans and the Diana Children's Community Service created a survey to ask for feedback about the service.

The trust held two Spotlight on Quality and Patient Involvement events where patients, carers and stakeholders were invited to give feedback on the trust's future plans. In April 2018, 16 staff, 20 patients / carers and 13 stakeholders attended and in October 2018, 14 staff, 17 patients / carers and 11 stakeholders attended.

A volunteer policy existed and the trust had plans to consider payment of volunteers in the trust but there was a lack of clarity on how the trust considered and included patients in all its activity. We had concerns about this omission and patient involvement not being at the centre of engagement across the trust.

Learning, continuous improvement and innovation

	Historical data		Projections	
Financial Metrics	Previous financial year (2016/2017)	Last financial year (2017/2018)	This financial year (2018/2019)	Next financial year (2019/2020)
Income	£277,664,000	£274,503,000	£263,190,000	£267,677,000
Surplus	£2,244,000	£4,675,000	£3,273,000	£2,657,000
Full costs	£275,420,000	£269,828,000	£259,917,000	£265,020,000

Budget	£275,420,000	£269,828,000	£259,917,000	£265,020,000

The trust's delivery against the NHS improvement Single Oversight Operating Framework (SOF) had been maintained at level 2 since it was introduced in October 2016. The Trust had been able to deliver its statutory duties with only minimal input being provided by regulators. The trust was challenged by cash flow over the last 2 years and appeared on the corporate risk register. The 2018/19 cash flow forecast position had much improved, following the prioritisation of capital investment and receipt of 2017/18 bonus STF funding. The trust continued to invest in fixed assets, ensuring that priority clinical and backlog maintenance schemes were undertaken, at the same time as investing in digital schemes to underpin transformation of services. The trust had been awarded £8m of capital funding through the Department of Health for implementing STPs in support of the CAMHS agenda.

Cost improvement plans had been debated at board level and scrutinised. An audit report on cost improvement took place and the chair of the audit and assurance committee requested a 360-degree review of the outcome.

The trust told us about opportunities for innovation and improvement in three main areas; technology in healthcare, investment into middle manager development and information technology for patient records. However, the pace of change and improvement from quality improvement projects was slower than expected. We had concern that the board had varying degrees of oversight on all projects without an overarching framework to manage them. Projects and objectives described by the trust at the last inspection continued to remain in plans or discussions and not converted into action at this inspection.

Several senior directors and senior leaders told us they felt workstreams had been slow and the leadership teams had asked too much of middle managers to manage change and have robust over sight of compliance alongside their day to day roles. Service directors told us quality improvement (self-regulation) was embedded at ward staff level and senior leaders felt time was spent responding to issues rather than being proactive.

The trust had a model known as self-regulation. The trust empowered and enabled staff to deliver on ideas and innovation. Staff and teams also used the model to quality assure projects and performance. Both executive leaders and senior leaders referred to self-regulation as quality improvement in action and wanted the term changed.

Local innovation and service development was proactive and frequent. Senior staff felt self-regulation was a positive framework for identifying local improvements. Staff at some levels of the trust had flexibility to come up with ideas to improve service delivery, present ideas and find ways to develop them into action. However, some staff at ward level felt engagement and the opportunity for ideas to be heard was dependent on which service they worked in.

The trust worked with a self-developed tool kit called Time to Shine, (commenced in 2015) as way to show case innovations and quality care projects at the time of inspection. It had a stepped approached where staff completed forms with reflections on team strengths and areas for improvements, signed off by the team leader, peer reviewed by a manager and finally agreed by a governance lead. Senior staff conducted quality visits to check the self-regulation in place. Time to shine remained in place at this inspection, and whilst it embraced staff ideas and gauged staff feedback about services, we were not assured that the board had full oversight of all projects and innovation and were not robustly sharing good practice between services, or even wards.

The trust provided information on an initiative called WeCreate. This encouraged staff to come up with ideas, no matter how small, to improve service delivery and create a culture celebrating innovation. It had a strap line of 'no idea is a bad idea'. The trust had 20 ideas for innovation since our last inspection in November 2017, 17 of which remained open, two closed and one suspended. Fifteen of the 17 open projects had a timescale of 12 months or more, and one had no timescale.

We had concerns that learning from the many quality improvement projects was not robustly shared. The board clearly celebrated individual team and staff success but did not capitalise on their talents by sharing the ideas and celebrating success at a wider level. Several directors confirmed this. Other senior leaders felt the trust would benefit from a way to co-ordinate such learning. For example, a healthcare assistant developed a healthy snack group for patients to cook their own health food in the evenings to replace buying and eating regular take away meals. Other wards in the same service had not heard of this and therefore had not considered implementing it in their area.

The safeguarding team had instigated a change to strategy calls to the local authority. Instead of the safeguarding team making such calls to discuss cases, more clinicians and staff at ward level, involved with the patients and families make the calls. The safeguarding team provided a supportive role to these calls. The second phase of this change was to include practitioners from therapy teams and the third phase to involve partners and external services known to the patient. The local authority reported they had seen positive change to strategy calls.

Staff told us about examples of improvement projects that came from staff working on wards. These included Auto Planner, a system for booking outpatient appointments to help staff use time more effectively, mortality review groups, duty system changes, end of life champions, pharmacy technicians on wards, nurse prescribers in police triage and discharge co-ordinators in acute inpatient wards. Innovations in IT included a lone worker app on smart phones, body worn camera trial (in collaboration with another trust who had successfully implemented this), and a metal detector for searches.

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) and the relevant dates.

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
AIMS - WA (Working Age Units)	MH Other specialist services	Langley Ward (Adult Eating Disorders)	-
AIMS - OP (Wards for older people)	Wards for older people with mental health problems	n/a	Welford & Kirby wards are awaiting results of accreditation visit in May 2018. Results due September 2018
Quality Network for Inpatient Learning Disability Services (QNLD)	Wards for people with learning disabilities or autism	Agnes Unit	March 2017

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
Quality Network for Inpatient CAMHS (QNIC)	Child and adolescent mental health wards	Ward 3	-
ECT Accreditation Scheme (ECTAS)	-	ART Nursing/ECT	2018
Therapeutic Community Accreditation	-	Royal College of Psychiatry Therapeutic Community Accreditation	November 2017

The trust submitted information about various accreditation schemes in addition to those mentioned in the table above. These included Accreditation for Psychological Therapies Services (APPTS), Psychiatric Liaison Accreditation Network (PLAN), MacMillan Quality Environment Award (MQEM), CHKS Accreditation for radiotherapy and oncology services, Commission for the Accreditation of Rehabilitation Facilities (CARF) and Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care.

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 – Glenfield Hospital	Aston Ward	19	Female
Bradgate Mental Health Unit – Glenfield Hospital	Ashby Ward	21	Male
Bradgate Mental Health Unit – Glenfield Hospital	Beaumont Ward	22	Mixed
Bradgate Mental Health Unit – Glenfield Hospital	Bosworth Ward	20	Male
Bradgate Mental Health Unit – Glenfield Hospital	Heather Ward	18	Female
Bradgate Mental Health Unit – Glenfield Hospital	Thornton Ward	21	Male
Bradgate Mental Health Unit – Glenfield Hospital	Watermead Ward	20	Mixed
Bradgate Mental Health Unit – Glenfield Hospital	Belvoir PICU	10	Male
The Herschel Prins Centre – Glenfield Hospital	Griffin Ward PICU	6	Female

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Over the 12-month period from 1 July 2017 to 30 June 2018 the trust reported no mixed sex accommodation breaches reported within this core service.

The number of same sex accommodation breaches reported in this inspection was lower than the 21 reported at the time of the last inspection.

During the inspection, staff showed a lack of clarity as to what constituted a mixed sex accommodation breach and we observed an inconsistency as to when and how these were reported.

The service provided two mixed sex wards - Watermead and Beaumont – with separate male and female corridors as well as two 'swing rooms' in the middle which can be used either sex. Ward managers reported that males and females were often admitted onto corridors of the opposite sex or into a swing room next to a patient of the opposite sex. Although, these were ensuite rooms and staff told us that they tried to place patients in rooms nearest to communal areas, patients' privacy and dignity was breached by the need for closer observations to keep them safe.

During our inspection a female patient was admitted into one of the swing rooms on Watermead necessitating 1to1 observations while accessing her bedroom. The ward manager reported that this had happened twice in September and October. However, we found there was inconsistency as to whether managers would report this as a breach of mixed sex accommodation, a breach of privacy and dignity, or not report at all. We found several occasions where staff recorded into a patients' record, and within team meeting minutes, that a patient had been admitted into a 'breach bed'. We felt this added to the staff's misunderstanding of a breach of mixed sex accommodation or a breach of privacy and dignity.

There were ligature risks on nine wards within this core service. The trust told us they had undertaken recent (from October 2017 onwards) ligature risk assessments at one location. All wards had a ligature risk assessment in the last 12 months.

The trust submitted data prior to inspection which reported none of the wards presented a high level of ligature risk and nine wards presented a lower risk due to the presence of 'ligatures and ligature points that could, potentially, be used by patients to self-harm'.

The trust stated that actions taken to mitigate ligature risks were detailed on a risk assessment and the risk register (not provided).

However, during the inspection, we reviewed all ligature risk assessments and noted that all ligature risk assessments identified risks and cautions to inform staff but did not identify any actions the trust intended to take to remove or update identified areas of concern. We found ligature risks which had not been identified on the assessments. Senior managers acknowledged our concerns and advised they would take immediate action to address this. The trust provided data which showed that significant environmental improvements had received funding approval; with works to commence in January 2019.

On Watermead we found unidentified blind spots in the garden area, on the male and female corridors, in two of the bedrooms and in the seclusion room. There was also visible pipework underneath the bath and sink in the assisted bathroom. Anti-barricade strips to doors posed a ligature risk and were not on the ward risk assessment. The CCTV camera in the seclusion room malfunctioned after a power cut and there was no easy access to loft space, where the reset was,

to rectify this. At the end of the male corridor, we found 20 panels which covered essential pipework, some of which appeared to have cracks or additional screws from having been previously pulled away from the wall. Three of these panels had corners that could be pulled away from the wall allowing a lanyard to be slid behind, thus creating a ligature risk. This corridor is not on the ligature risk assessment.

On Ashby we found anti-ligature wardrobes not fixed to walls, so they could be used as a barricade or pose a risk if they were pushed over. There were broken ceiling lights in bedrooms with exposed wiring visible. There were two bedrooms with windows that were in a state of disrepair or would not shut properly.

On Aston ward, there was a blind spot outside bedroom six which could not be picked up in the convex mirror and was not on the ward risk assessment. One out of four ceiling lights were not working which affected staff's ability to see clearly all parts of the ward, particularly when viewing areas via CCTV or the convex mirrors. Only seven out of 24 members of staff had signed to confirm they had read the most up to date ligature risk assessment on this ward. In one patient room, there were large screws sticking out of the bathroom wall and loose screws in the broken window frame. Screws protruding from a broken wardrobe were also observed.

On Bosworth ward, a risk assessment dated September 2017 identified a number of risks associated with the windows on the ward, i.e. windows in a state of disrepair causing ligature points, a risk of the fragile perspex being broken and being used for self-harm or harm to others and risks of absconding as some windows led out onto a walkway. The risk assessment advised the windows be replaced as a matter of urgency, however as of the date of the inspection no work had been carried out and there was no update or further actions on the risk assessment. Staff were aware of the risks posed by the windows and mitigated this by risk assessing patients admitted into those rooms.

On Thornton ward, the TV cabinet was broken so the TV, which was too big for the cabinet, was sitting on top of the cabinet which was lightweight and could easily be thrown. Wardrobes were not attached to the walls. Windows were broken in places with sharp, broken pieces of frame visible.

On Belvoir ward, there was a fire door that had broken closures on one side and a missing closure on the other. This had been reported but was still awaiting repair and was escalated during the inspection.

Not all wards had patient assistance alarms.

Maintenance, cleanliness and infection control

For the most recent Patient-Led Assessments of the Care Environment (PLACE) assessment 2017 the two locations scored higher than the similar trusts for one of the three relevant aspects, lower than similar trusts for one of the aspects and the same as similar trusts for one aspect.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
Bradgate Mental Health Unit	MH – Acute wards for adults of working age	98.7%	93.5%	-	92.0%

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
	adults and psychiatric intensive care units MH – Mental health crisis services and health-based places of safety MH – Forensic inpatient / secure wards MH – Wards for older people with mental health problems MH – Other specialist services				
The Herschel Prins Centre	MH – Acute wards for adults of working age adults and psychiatric intensive care units MH – Forensic inpatient / secure wards	97.6%	88.2%	-	94.3%
Trust overall		97.6%	91.2%	72.9%	85.1%
England average (Mental health and learning disabilities)		98.0%	95.2%	84.8%	86.3%

Overall, we found wards to be clean. Staff cleaned ward areas regularly and cleaning records were up to date for bedrooms and communal areas. However, the older wards were tired and dated and in need of refurbishment and redecoration throughout.

We found examples where response times to maintenance requests had taken longer than necessary. For example, the cold water fountain on Aston ward had been reported out of order four weeks before the last inspection in April 2018 and was observed as still needing repair during this inspection. The ward manager of Watermead had reported broken lights in November 2017 which had still not been repaired. Eighteen lights outside Belvoir were reported as not working and posing a security and safety issue on October 24th and again on October 30th and these were still not fixed at the time of the inspection.

Seclusion room

We visited six out of seven of the seclusion rooms across the service. We found environmental issues of concern in three of the six seclusion rooms. On Ashby ward, the seclusion room had loose plastic strips around the floor to the wall which could potentially be a hazard. The observation window was damaged and had sharp edges. There were small areas of the wall where plaster was damaged. On Aston ward, the intercom was not working; staff were unable to operate the intercom at the time of our visit, and there were safety hazards resulting from a wall to floor metal strip. There was no clock visible to the patients from within the room. On Watermead there was a ligature point at the top of the door which staff had not identified on the ligature risk assessment. Also, patients had direct access to a toilet area (with hand-basin) within the seclusion room, a shower was available in a separate, locked room. Staff had to enter the seclusion room to unlock the shower room. We noticed that the patient could shut themselves into the shower room and be entirely unobserved during this time. Furthermore, the patient was reliant on staff to re-open the shower room door.

On Belvoir ward, there were some small areas where the plaster was damaged in the seclusion room.

Clinic room and equipment

We inspected clinic rooms on all wards.

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Blood monitoring and blood pressure monitoring equipment was not checked or calibrated on a regular basis.

On Ashby ward, the staff did not check the blood monitoring machine, which should be checked daily had only been calibrated four times during the month and there was no date on the testing solution. On Aston ward, staff did not record the opening date recorded on the blood monitoring testing solution. On Belvoir ward, staff had only checked the blood monitoring machine twice in 2018. On Bosworth ward, the blood monitoring machine calibration was overdue from May 2018 and staff had not recorded the opening date on the testing solution. On Beaumont ward, staff had not calibrated the blood monitoring machine or the blood pressure machine and there was no calibration book. Staff had not dated the testing solution.

All wards had an examination couch and other appropriate equipment.

Safe staffing

Nursing staff

Staffing was a challenge for this service. Between June 2017 and May 2018, the overall permanent staff sickness rate was 6.5% which was higher than the trust target.

The overall vacancy rate at June 2018 was 25% against the trust target of 7%. During October 2018, Ashby, Belvoir, Watermead and Griffin all had vacancy rates of above 30%.

Patients and staff told us that the high use of bank and agency staff had an impact on their ability to get to know patients well, including their risks, and to develop positive therapeutic relationships.

The trust did not have dedicated staffing for the health-based place of safety. Senior staff told us that there had been a significant increase in patients admitted over the past year. A more senior nurse, rostered on a management day, was on call to staff the place of safety. However, they were frequently needed to cover shortfalls on the wards and therefore not always available. In these

instances, one of the duty managers attended. This had an impact on duty cover for the wards, as well as staff consistency in the place of safety.

Managers ensured the service had enough staff on each shift to carry out any physical interventions safely. Wards located near each other would request support if required.

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 30 June 2018	240	N/A
Total number of substantive staff leavers	1 July 2017 – 30 June 2018	16	N/A
Average WTE* leavers over 12 months (%)	1 July 2017 – 30 June 2018	7%	≤ 10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 30 June 2018	72.0	N/A
Total vacancies overall (%)	At 30 June 2018	25%	7%
Total permanent staff sickness overall (%)	Most recent month (At 31 May 2018)	6.3%	≤ 4.5%
	1 June 2017 – 31 May 2018	6.5%	≤ 4.5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 30 June 2018	Not given	N/A
Establishment levels nursing assistants (WTE*)	At 30 June 2018	Not given	N/A
Number of vacancies, qualified nurses (WTE*)	At 30 June 2018	Not given	N/A
Number of WTE vacancies nursing assistants	At 30 June 2018	Not given	N/A
Qualified nurse vacancy rate	At 30 June 2018	Not given	N/A
Nursing assistant vacancy rate	At 30 June 2018	Not given	N/A
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 July 2017 – 30 June 2018	3,536	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 July 2017 – 30 June 2018	2,316	N/A

Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 July 2017 – 30 June 2018	1,499	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	13,902	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	1,329	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	1,151	N/A

*Whole-time Equivalent

This core service reported a vacancy rate for all staff of 25% as of 30 June 2018.

Across the 12-month reporting period vacancy rates for all staff types ranged between 32% (July 2017) and 22% (April 2018).

Caveat: The trust has been unable to provide a breakdown of vacancy data by staff type.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Trust Medical Trainees	n/a	n/a	n/a	n/a	n/a	n/a	11.0	11.0	100%
Beaumont Ward - Bradgate Unit	n/a	n/a	n/a	n/a	n/a	n/a	10.7	29.3	36%
Ashby Ward (Bradgate Unit)	n/a	n/a	n/a	n/a	n/a	n/a	9.4	29.3	32%
Aston Ward (Bradgate Unit)	n/a	n/a	n/a	n/a	n/a	n/a	7.9	29.3	27%
Bosworth Ward - Bradgate Unit	n/a	n/a	n/a	n/a	n/a	n/a	7.5	29.3	26%
Heather Ward	n/a	n/a	n/a	n/a	n/a	n/a	7.1	29.3	24%
Watermead Ward (Bradgate Unit)	n/a	n/a	n/a	n/a	n/a	n/a	5.8	29.3	20%
Griffin Ward	n/a	n/a	n/a	n/a	n/a	n/a	4.2	22.8	18%
Belvoir Psychiatric Intensive Care Unit	n/a	n/a	n/a	n/a	n/a	n/a	6.1	37.8	16%
Thornton Ward - Bradgate Unit	n/a	n/a	n/a	n/a	n/a	n/a	3.6	29.5	12%
Medical Staffing - Bradgate Unit Inpatients	n/a	n/a	n/a	n/a	n/a	n/a	-1.3	7.5	-17%
Core service total	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**72.0**	**284.7**	**25%**
Trust total	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**376.3**	**3687.3**	**10%**

NB: All figures displayed are whole-time equivalents

Managers used high levels of bank and agency staff. Where possible, managers booked staff familiar with the wards and booked staff in advance. However, managers and patients told us that often staff were moved to other wards to cover gaps. This affected consistency of staffing on the wards.

Between 1 July 2017 and 30 June 2018, bank staff filled 3536 shifts to cover sickness, absence or vacancy for qualified nurses.

Bank usage ranged between 240 shifts (September 2017) and 382 shifts (March 2018) per month.

In the same period, agency staff covered 2,316 shifts for qualified nurses. One thousand four hundred and ninety-nine shifts were unable to be filled by either bank or agency staff.

Caveat: the trust has not provided available shifts data.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Ashby Ward	n/a	592	306	217
Aston Ward	n/a	265	498	242
Beaumont Ward	n/a	619	323	262
Belvoir Psychiatric Intensive Care Unit	n/a	238	117	22
Bosworth Ward	n/a	470	78	222
Griffin Ward	n/a	215	305	140
Heather Ward	n/a	290	500	206
Thornton Ward	n/a	380	49	109
Watermead Ward	n/a	467	140	79
Core service total	**n/a**	**3,536**	**2,316**	**1,499**
Trust Total	**n/a**	**15,536**	**16,726**	**9,344**

Between 1 July 2017 and 30 June 2018, 13,902 shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

Bank usage ranged between 1,047 shifts (September 2017) and 1,319 shifts (May 2018) per month.

In the same time period, agency staff covered 1,329 shifts. One thousand one hundred and fifty-one shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Ashby Ward	n/a	1395	84	120
Aston Ward	n/a	1509	109	188
Beaumont Ward	n/a	2341	153	182
Belvoir Psychiatric Intensive Care Unit	n/a	2279	431	13
Bosworth Ward	n/a	1441	68	173

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Griffin Ward	n/a	1036	113	161
Heather Ward	n/a	1272	120	90
Thornton Ward	n/a	1359	105	58
Watermead Ward	n/a	1270	146	166
Core service total	**n/a**	**13,902**	**1,329**	**1,151**
Trust Total	**n/a**	**46,364**	**5,825**	**5,674**

This core service had 16 (7%) staff leavers between 1 July 2017 and 30 June 2018. This was the same as than the 7% reported at the last inspection (from 1 July 2016 to 30 June 2017).

Monthly turnover ranged between 0% and 1% across the 12-month reporting period.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Psychotherapy Bradgate	3	1	35%
Griffin Ward (HPC)	21	4	30%
Bradgate Admin	4	2	24%
Aston Ward	24	4	17%
Ashby Ward	24	2	9%
Heather Ward	24	1	4%
Thornton Ward	28	1	4%
Belvoir Psychiatric Intensive Care Unit	34	1	3%
Bosworth Ward	23	0	0%
Medical Staffing - Bradgate Unit Inpatients	9	0	0%
Watermead Ward	26	0	0%
Beaumont Ward	20	0	0%
Core service total	**240**	**16**	**7%**
Trust Total	**3150**	**349**	**10%**

The sickness rate for this core service was 6.5% between 1 June 2017 and 31 May 2018. The most recent month's data (May 2018) showed a sickness rate of 6.3%. This was lower than the sickness rate of 7.1% reported at the last inspection at 30 June 2017.

Across the 12-month reporting period, sickness rates ranged between 4.7% (July 2017) and 8.7% (December 2017) for this core service.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Heather Ward	9.0%	11.0%
Griffin Ward	19.7%	10.7%
Medical Staffing - Bradgate Unit Inpatients	2.9%	9.4%
Beaumont Ward	10.3%	8.9%
Belvoir Psychiatric Intensive Care Unit	8.0%	7.4%
Watermead Ward	5.4%	6.5%
Aston Ward (Bradgate Unit)	2.7%	5.2%
Ashby Ward (Bradgate Unit)	3.6%	4.8%
Thornton Ward	1.3%	4.2%
Bradgate Admin	1.5%	3.9%
Bosworth Ward	2.0%	2.4%
Psychotherapy Bradgate	1.6%	0.3%
Core service total	**6.3%**	**6.5%**
Trust Total	**5.3%**	**5.3%**

The below table covers staff fill rates for registered nurses and care staff during May, June and July 2018.

Ashby, Beaumont and Bosworth wards were under 90% full for all day shifts for registered nurses.

All wards were over 125% full with care staff for all day and night shifts for all months reported.

Griffin Ward was over 125% full with both registered nurses and care staff for day and night shifts for all months reported.

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 2018				June 2018				July 2018			
Ashby	81.1%	155.6 %	98.4%	138.7 %	77.2%	172.5 %	98.30 %	160.0 %	74.7%	170.2 %	96.80 %	145.2 %
Aston	90.3%	157.3 %	103.2 0%	341.9 %	92.2%	144.2 %	101.7 0%	340.0 %	83.3%	154.0 %	106.5 %	251.6 %

Beaumont	81.7%	209.7 %	95.2%	412.9 %	82.0%	133.3 %	95.00 %	183.3 %	82.8%	150.0 %	96.8%	196.8 %
Belvoir Unit	109.8 %	343.9 %	171.0 %	342.6 %	102.5 %	326.7 %	150.0 0%	313.3 %		180.5 %	164.5 %	256.1 %
Bosworth	88.2%	170.2 %	90.3%	225.8 %	87.2%	180.8 %	90.00 %	323.3 %	83.9%	229.8 %	95.2%	371.0 %
Heather	93.5%	186.3 %	101.6 %	274.2 %	94.9%	177.5 %	95.00 %	213.3 %		183.1 %	100.0 %	177.4 %
Thornton	94.0%	155.3 %	101.6 %	261.3 %	92.8%	142.5 %	91.70 %	213.3 %	90.3%	156.5 %	98.4%	248.4 %
Watermead	90.3%	157.3 %	101.6 %	193.5 %	95.6%	170.0 %	98.30 %	246.7 %	89.8%	154.8 %	98.4%	141.9 %
Griffin Female PICU	185.5 %	524.2 %	196.8 %	335.5 %	166.2 %	302.6 %	190.0 %	190.0 %	163.9 %	234.1 %	180.6 %	125.8 %

Medical staff

The service had enough daytime and night time medical cover and a doctor available to come to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Between 1 July 2017 and 30 June 2018, 167 shifts were filled by bank staff to cover sickness, absence or vacancy for medical staff.

In the same period, agency staff covered 113 shifts. No shifts were unable to be filled by either bank or agency staff.

Caveat: the trust has not provided available shifts data.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Medical staffing – Bradgate Unit Inpatients	n/a	0	113	0
Bradgate – 1st On call shifts	n/a	167	0	0
Core service total	**n/a**	**167**	**113**	**0**
Trust Total	**n/a**	**459**	**1,926**	**0**

Mandatory training

The compliance for mandatory and statutory training courses at 30 June 2018 was 89%. Of the training courses listed eight failed to achieve the trust target and of those, one failed to score above 75%.

As of October 2018, all wards had compliance for statutory and mandatory training of over 92%.

Managers kept track of staff and their mandatory training by using ward dashboards and the E learning and E rostering systems.

CAVEAT: The trust was unable to provide the training data in the required format and therefore the compliance has been calculated using available data.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	This core service %	Trust target %	Trust wide mandatory/ statutory training total %
Conflict Res	97%	85%	97%
EDHR	97%	85%	96%
Health Safety and Welfare	96%	85%	96%
Move and Hand Level 1	96%	85%	95%
MCA	95%	85%	95%
Infection Prevention and Control Level 1	95%	85%	94%
Safeguarding Adults Level 1	95%	85%	95%
Safeguarding Children Level 1	95%	85%	95%
MAPA Disengagement Update	95%	85%	95%
DSE	94%	85%	94%
Record Keeping and Care Planning	91%	85%	92%
Hand Hygiene	91%	85%	94%
Infection Control	90%	85%	92%
Info Gov	89%	85%	89%
Medicine Management	88%	85%	92%
MAPA Disengagement and Holding Skills - High Risk	86%	85%	83%
Fire Safety	85%	85%	87%
Safeguarding Adults Alert and Refer	85%	85%	88%
Safeguarding Children Level 2	84%	85%	88%
Status Move and Hand Level 2	80%	85%	87%

Training course	This core service %	Trust target %	Trust wide mandatory/ statutory training total %
MHA for Nurses	79%	85%	82%
MHA for Doctors	78%	85%	88%
Adult Immediate Life Support	77%	85%	79%
Anaphylaxis Update	76%	85%	78%
Adult Basic Life Support	75%	85%	80%
Prevent WRAP	69%	85%	79%
Core Service Total %	**89%**		**91%**

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff used the trust risk assessment tool.
Staff completed a risk assessment for each patient when admitted. There was no standard policy for how often staff should update risk assessments. Staff told us they reviewed and updated risk assessments following incidents. Therefore, there was a variation in how up to date they were. On Belvoir ward, staff had not updated one patient risk assessment since June 2018.

Risk assessments were thorough. However, risk assessments did not always appear joined up with care plans. For example, staff would identify a risk, but there were no details in the care plan of how this risk would be managed or mitigated as part of the patient's care.

Management of patient risk

Staff searched patients based on risk assessment and followed trust policies. The trust had a smoke free policy across all sites. However, we found issues with patients having access to lighters.

Poor physical environments and difficulties for staff with implementing the smoke free policy posed a challenge to patient safety and risks were not always recognised. Staff told us that the use of lighters and smoking in and outside the wards was a significant issue. We observed patients smoking in the garden areas on Thornton, Ashby and Beaumont wards and evidence of smoking, such as cigarette ends, ash and odour, was apparent on all the other acute wards.

Staff did not sufficiently recognise, or manage, resultant fire risks, for example from patients secreting lighters onto the wards. There was no evidence of a clear plan or oversight as to how these risks would be mitigated. Senior managers did not share lessons learned from incidents effectively across the wards and staff were not aware of incidents on other wards that could be relevant to their ward, including 14 incidents of patients setting fires with lighters or matches over the past year. This raised a significant concern for patient safety.

Two patients with limited mobility and physical disability did not have personal evacuation plans as part of their care plans. Staff did not complete fire warden checks regularly on Watermead ward. Over 24 months staff completed less than 50% of the required weekly checks.

Use of restrictive interventions

Staff and managers worked to keep the use of restrictive interventions to a minimum.

Staff made every attempt to avoid using restraint by using de-escalation techniques and only restrained patients when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and, where appropriate, worked within it.

This core service had 524 incidents of restraint (on 245 different service users) and 401 incidents of seclusion between 1 July 2017 and 30 June 2018.

The below table focuses on the last 12 months of data: 1 July 2017 to 30 June 2018.

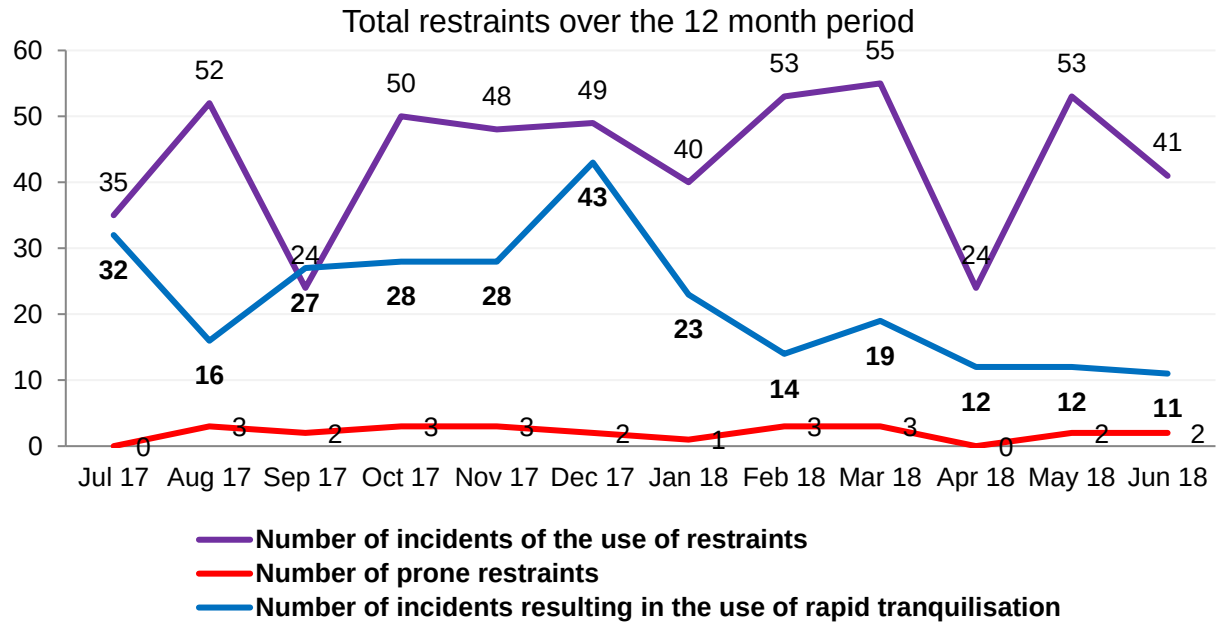
Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Ashby Ward	69	71	36	3 (4%)	52 (73%)
Aston Ward	20	49	23	2 (4%)	35 (71%)
Beaumont Ward	26	37	22	0 (0%)	14 (38%)
Bed Management Team	2	1	1	0 (0%)	0 (0%)
Belvoir Ward (PICU)	139	97	40	13 (13%)	63 (65%)
Bosworth Ward	47	47	24	2 (4%)	2 (4%)
Heather Ward	20	78	27	1 (1%)	28 (36%)
Thornton Ward	25	53	33	1 (2%)	13 (25%)
Watermead Ward	32	41	25	1 (2%)	20 (49%)
Griffin Ward (PICU)	21	50	14	1 (2%)	38 (76%)
Griffin Ward	0	0	0	0 (0%)	0 (0%)
Core service total	**401**	**524**	**245**	**24 (5%)**	**265 (51%)**

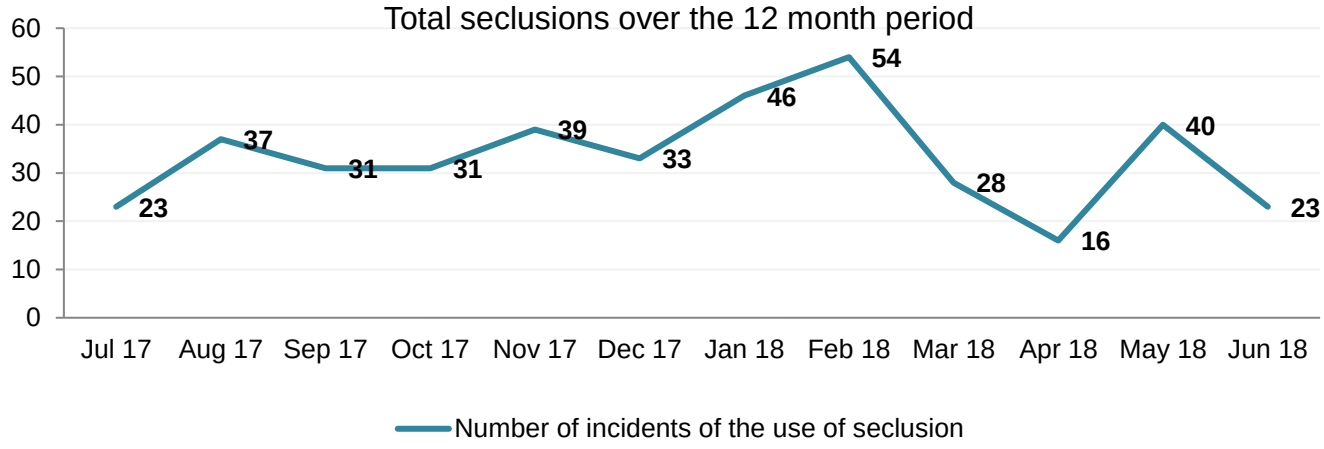
There were 24 incidents of prone restraint which accounted for 5% of the restraint incidents.

Incidents resulting in rapid tranquilisation for this core services decreased, with the highest numbers in December 2017.

There have been no instances of mechanical restraint over the reporting period.

The number of restraint incidents reported during this inspection was similar to the 561 reported at the time of the last inspection.





When staff secluded patients, they did not keep clear records, apply the appropriate safeguards or follow best practice guidelines.

We reviewed records relating to 53 episodes of seclusion. Overall, we found the documentation relating to seclusion was poor.

In 34 records we reviewed, we were unable to find a written entry by a doctor of a medical review taking place within one hour or without delay if the patient is not known or there is a significant change from their usual presentation. In some cases, we saw an annotation in the medical review column on the seclusion observation sheet. However, we could not be assured that this was by a doctor. The annotations were not supported with a written entry by the doctor on the provider's electronic recording system.

In 40 records we reviewed, it was unclear if the nursing reviews had been carried out by two nurses every two hours throughout the patients' period of seclusion. Many entries contained the initials, and not the designation, of the staff involved in the reviews. We also saw examples of gaps in the reviews exceeding two hours, with no explanation as to why this was the case.

In 24 records we reviewed, we were unable to find a written entry, on the provider's electronic recording system, by a doctor in relation to continuing medical reviews every four hours until the first internal multi-disciplinary team review. In these records, it was unclear who undertook scheduled medical reviews, their assessment and a record of the patient's condition and recommendations.

None of the records we reviewed included a specific care plan relating to seclusion to include, for example, treatment objectives, how de-escalation attempts will continue and how risks will be managed, or how the patient's dietary needs are to be provided for. However, overall, staff had documented the patients' clinical needs (including any physical or mental health problems) and risks at the commencement of the episode of seclusion on the seclusion instigation form.

The majority of the records we reviewed, staff had clearly recorded the date and time the patients' seclusion ended and staff had clearly recorded details of who determined that seclusion should come to an end.
Almost all records we reviewed, staff had recorded who authorised the seclusion, and staff had recorded the date and time of the commencement of seclusion.

In 37 records we reviewed, there was evidence that the seclusion area was within constant sight and sound of staff member and staff monitoring the patient in seclusion made a documented report every 15 minutes. However, we were unable to locate this information in the remaining 8 records we reviewed on the provider's electronic recording system. Both Belvoir and Griffin wards had a back-log of paperwork awaiting scanning onto the provider's electronic recording system, however, staff were unable to locate the original paperwork.

On Belvoir ward, in one patient's record, we saw staff had documented a number of entries that the patient was asleep or awake and behaving appropriately. However, staff documented in the two-hourly nursing reviews that the patient remained unpredictable. We noted the patient's episode of seclusion lasted more than 72 hours.

On Bosworth ward, we saw one patient was detained on section 5(4) at the start of their episode of seclusion. The duty doctor detained the patient on section 5(2) when they attended the ward four hours after the start of the patient's episode of seclusion.

On Watermead ward, we saw one patient was detained on section 5(4) at the start of their episode of seclusion. The duty doctor detained the patient on section 5(2) when they attended the ward over four hours after the start of the patient's episode of seclusion.

In all the records we reviewed, staff had recorded the reasons for the patients' episode of seclusion.

On Belvoir ward, the manager had recently introduced a new template for recording nursing reviews of the patients' seclusion. This provided greater clarity and detail of the assessments which had taken place.

There have been no instances of long term segregation over the 12-month reporting period.

Safeguarding

Ninety five percent of eligible staff received training in safeguarding children and safeguarding adults (level one). Ninety five percent of eligible staff received training in safeguarding children (level three).

Staff gave clear examples of how to protect patients from harassment and discrimination. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff followed clear procedures to keep children visiting the ward safe. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

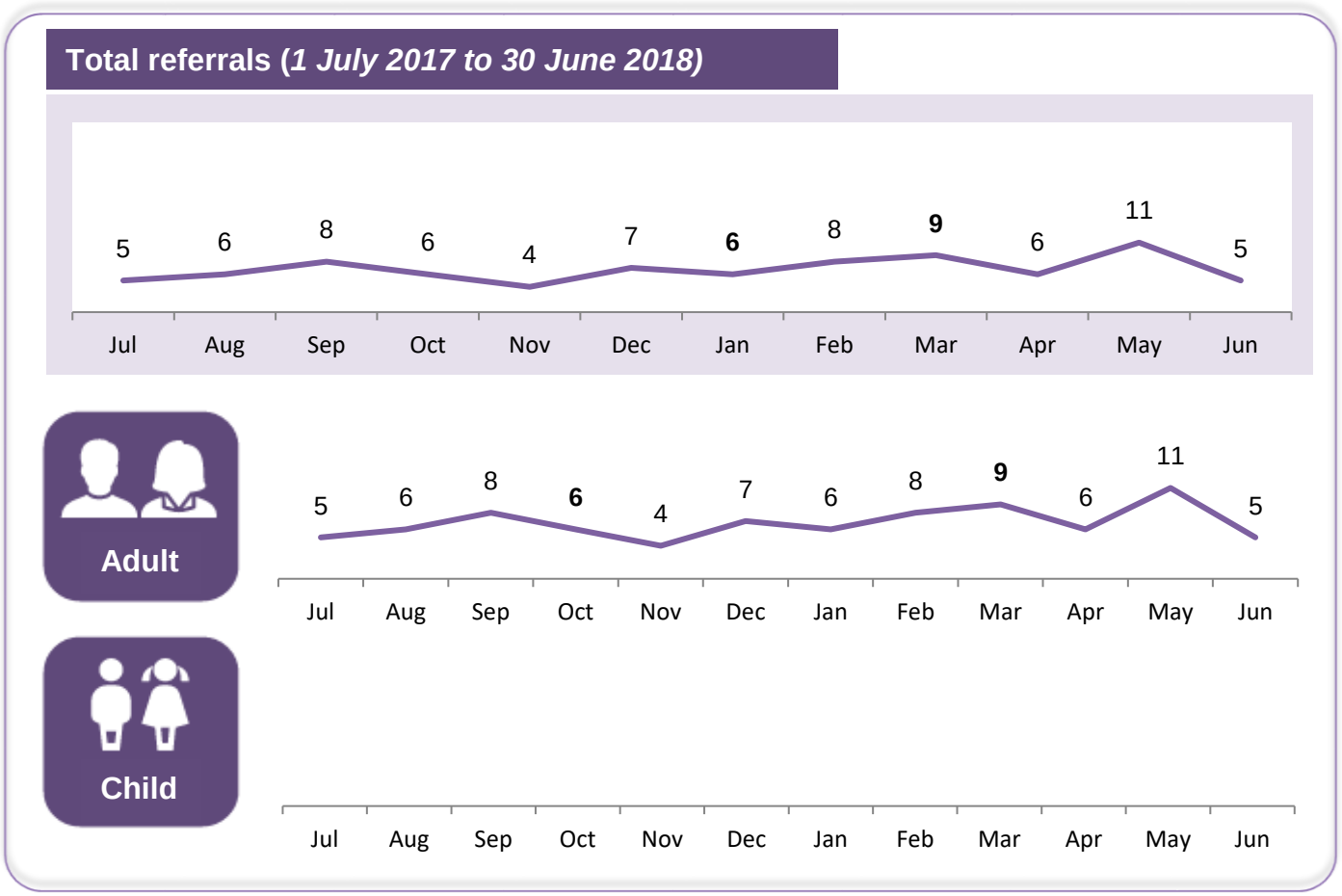
A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own 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 81 safeguarding referrals between 1 July 2017 and 30 June 2018, of which all concerned adults. The trust is not able to provide a breakdown of the 374 child referrals by core service.

The number of safeguarding referrals reported during this inspection was lower than the 109 reported at the last inspection

Referrals		
Adults	**Children**	**Total referrals**
81	**N/A**	**81**



Leicestershire Partnership NHS Trust has submitted details of no serious case reviews commenced or published in the last 12 months (1 July 2017 to 30 June 2018) that relate to this core service.

Staff access to essential information

All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form. When patients transferred to a new team there were no delays in staff accessing their records. Staff kept comprehensive daily patient notes.

Medicines management

Overall, the management of medicines in this core service was poor.

Staff did not always store medicines safely. We found medicines which became short dated when opened were not always dated when opened. This meant that we could not be assured that medicines remained safe and effective in use.

On Ashby, there were three patients on insulin with pens in drawers not labelled with an opening date. On Bosworth, Tiotropium Zonda inhalers and Diprosalic scalp application were not labelled with the date of opening. On Aston, there was one patient on 2 types of insulin which were not labelled with the date of opening.

On Bosworth, we found Oramorph solution with a pharmacy printed label with an expiry date of 19th November 2018. On Thornton, we found Oramorph solution with a pharmacy printed label with an expiry date of 11th November 2018.

We spoke to a deputy ward sister who was not aware that an insulin pen required a date of expiry once removed from the fridge.

We saw that the pharmacy team sometimes included an expiry date on the labels of medicines that would be short dated once opened, this date was based on date of dispensing. However, if those items were not opened for several days or weeks that expiry date would not be relevant.

We found that there was confusion on the wards regarding medicines disposal and return to pharmacy. Medicines were returned to pharmacy in green tote boxes but not all wards had a tote box available to place returned medicines in. These were unsealed boxes and we did not see facilities on any of the wards for actual disposal rather than return (e.g. DOOP bins). The trust policy suggested that wards would have both disposal bins and return containers. We were told that odd tablets e.g. that were dropped, were placed into sharps or clinical waste bins. On one ward we found their green tote box was over filled but the ward staff told us they could not get another as the pharmacy did not have any. On another ward we saw that the medicines stock cupboard contained medicines for a patient who had been discharged, these had not been returned to pharmacy as a returns box was not available.

Controlled drugs (CD) were not always managed and recorded in accordance with regulations. We found examples on three wards where ten different makes of controlled drugs (with serious side effects or effects if taken by mistake) such as opioid based pain killers, tranquilisers and anti-depressant medications were not correctly managed – for example temazepam, morphine and fentanyl.

On Bosworth ward there was a full box of Fentanyl patches and a 100ml bottle of morphine oral solution in the CD cupboard but not in the CD register.

Ashby ward was not using a stock balance check sheet.

We saw an instance where the medicines reconciliation for a patient had not identified two medicines that the patient was taking. The staff on the ward were aware of these medicines and were undertaking checks to determine whether they were to continue but pharmacy staff had not been included in these checks. The doctor we spoke to was unaware of the reconciliation process already undertaken by the pharmacy team.

We found loose tablets in patient's drawers on five wards. Staff had not stored them in labelled boxes and in some cases the tablets were virtually unidentifiable. For example, antipsychotic medication, laxatives, contraceptives, antidepressants, diabetic medication and pain killers.

Staff reported that the pharmacy team did not have a regular presence on the ward and although a controlled drugs audit was completed annually, no member of staff was able to recall how their ward had performed. None of the staff we spoke to were able to describe any other audits relating specifically to medicines on the ward. We were told there was no process for medicines incident information being shared. Staff were not aware of any regular communication (e.g. bulletin or newsletter) from the medicines team.

Medicines were administered in accordance with the prescriber's intentions. We saw that when medicines were omitted reasons were recorded and the electronic prescribing system alerted staff when medicines were due.

We saw emergency medicines and equipment were available, appropriate to each setting and were accessible to staff.

Medicines reconciliation was completed by medical and pharmacy staff, we saw evidence of the pharmacy team input to patients e-prescribing records.

Medicines were stored at suitable temperatures which were monitored electronically remotely by matrons.

Track record on safety

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

Between 1 July 2017 and 30 June 2018 there were nine 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 six. The three unexpected deaths were instances of 'apparent / actual / suspected self-inflicted harm', 'sub-optimal care of the deteriorating patient' and 'category pending'.

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 one never event during this reporting period taking place on Heather Ward.

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 was higher than the six reported at the last inspection.

	Number of incidents reported				
Type of incident reported on STEIS	**Aston Ward**	**Beaumont Ward**	**Heather Ward**	**Watermead Ward**	**Total**
Apparent/actual/suspected self-inflicted harm	2	1	2	1	6
Pending review	1	0	0	0	1
Sub-optimal care of the deteriorating patient	1	0	0	0	1
Unauthorised absence	0	1	0	0	1
Total	**4**	**2**	**2**	**1**	**9**

Reporting incidents and learning from when things go wrong

Staff lacked awareness of incidents that took place on other wards, that may be relevant to their patients and ward environment. Staff were not aware of 14 fire incidents that took place on other wards, including a recent serious fire on Beaumont ward. Some staff commented they had heard about the fire in general chat or by hearsay.

Information and learning was discussed at team meetings but not all wards held regular team meetings and it was difficult to see how information discussed and minutes were disseminated to those not attending.

Staff knew what incidents to report and how to report them. We saw examples of incident forms completed by staff that were detailed in all cases.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff were debriefed and received support after a serious incident.

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 2018, and since the last inspection, there had been three 'prevention of future death' reports sent to Leicestershire Partnership NHS Trust, however none of these related to this core service. The trust received one further report in January 2019, relating to this core service.

Is the service effective?

Assessment of needs and planning of care

Staff completed comprehensive mental health assessments of each patient either on admission or soon after.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

We looked at 43 care plans. None of the 43 care plans recorded patient involvement or whether the patient had been offered a copy of their care plan. Staff did not complete individualised, person centred care plans with patients. Wards used templates for care plans which contained generic wording and statements and consistently showed no evidence of patient involvement, no patient voice or views or wishes. Care plans appeared holistic, in that they covered many areas, but they did not identify patient strengths and did not demonstrate a recovery focus. Care plans did not reflect management or mitigation of risks identified in the patient's risk assessment. There was little evidence of ongoing assessment of mental capacity and consent.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for the patients in the service. Staff provided informal activities on the wards and occupational therapists and therapeutic liaison workers provided therapeutic activities. Patients able to leave the ward could access activities and resources at the Involvement Centre on the Unit. However, patients subject to detention under the Mental Health Act could not access this facility without the provision of Section 17 approved leave.

There was insufficient opportunity for some patients to access psychological therapy and therefore not in line with best practice guidance and National Institute for Health and Care Excellence guidance. There was a vacancy in the psychology team which impacted on patient's ability to access psychology input. All wards employed therapeutic liaison workers to develop activities for patients. However, at the time of inspection, there was a vacant post on Thornton ward and staff were not aware when this post would be filled. The trust told us, following inspection, this post had been filled on 26 November 2018.

Staff identified the physical health needs of patients and made sure patients had access to physical health care, including specialists as required. A dedicated physical health nurse supported ward teams and patients. We saw evidence of staff consistently recording physical health care checks in records.

Some patients told us they were having blood pressure and blood monitoring checks daily, despite this not being indicated in their care plans.

Staff met patient's dietary needs and assessed those needing specialist care for nutrition and hydration. Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. Staff offered all patients appropriate smoking cessation advice, including access to nicotine withdrawal therapy and vaping.

On Griffin ward, staff supported patients' physical activity whilst on the ward. Patients had pedometers and a map to show how far they had walked by comparing with a map of the UK.

This core service participated in 17 clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Compliance with NICE Guidance on ECT & Usage of Stimulus Dosing Protocol re-audit (573)	ECT Service	Clinical	27/10/2017	Consider the creation of a post ECT follow-up pack that would include a copy of the HADS (Hamilton) and MoCA, (subject to copyright issues) which could be sent to referrers for completion and returning to the ECT department. Include, in next batch of consent forms, a yes/no box to indicate if there are any special requirements, a way of drawing attention to the number of treatments consented to on the second sheet of the consent form, and a tick box to indicate that a copy of the consent form has been offered to the patient.
Frequency of errors of inadvertent, excessive dosing during ECT re-audit (1143)	ECT Service	Clinical	29/06/2018	To remind ECT leads and other ECT practitioners of the importance of recording the reason for deviating from the protocol

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
CPA & Non-CPA Case-note re-audit (1299)	Bradgate MHU Forensics (Community & IP) Rehab wards CAMHS LD Liaison Psychiatry AMH Outpatients LD Inpatient & Community Psychological Therapies	Clinical	09/04/2018	Create a poster for individual wards with ward results and key actions for the ward. - Bradgate MHU Improve the process for recording CPA reviews onto Rio - Speak with Ian Maslin about the potential for functionality training within the teams - Bradgate MHU Add a section in the Rio out-patient letter care plan template where this can be documented - AMH Outpatients Develop a new hard copy of the care plan template for the team which can be scanned into Rio. Liaison Psychiatry During clinical supervision a review of patient notes will be included - LD Further actions incorporated into the Trust action plan concerning CPA
Management of Specimens (1421)	District Nursing, Phlebotomy and Ward teams	Clinical	07/11/2017	All clinical teams to identify nearest fridge for storage of specimens Where designated fridges not available, review to be carried out to locate nearest available fridge. Policy for the management and transportation of specimens to be shared with clinical teams access to a DGSA approved/ designated transport container for specimens is not used. Provision of DGSA approved/ designated transport container for specimens for staff who transport samples as part of their day to day clinical role
Inpatients Annual Physical Health Checks re-audit (1432)	Rehab Wards Bradgate MHU MHSOP Wards Agnes Unit (LD) Langley Ward (ED) Forensic Ward	Clinical	18/04/2018	Eye-catching best practice reminder email to be sent to all relevant clinicians, emphasising need to ensure abdomen and MECC assessments are completed as part of annual physical health checks. Additional training for pharmacists to be arranged. To increase awareness of monitoring tools within the RiO template. This will enable them to better direct doctors to complete all required elements. Pharmacists to be reminded to continue follow up with doctors re annual physical health checks until all elements are complete. Develop automated reminder system to prompt clinicians to complete annual physical health checks.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
MHA Section 58 - treatment requiring a second opinion (Forms T2/ T3) (1441)	MHSOP Wards AMH Wards (Acute, Rehab & Forensic) Langley Ward (ED)	Clinical	08/08/2017	Organise training events to ensure that assessment of mental capacity to consent for medication form is completed as per the code of practice. Pharmacy services are working with software providers to find a software solution which will stop prescribers from prescribing medication not authorised on statutory forms.
Venous thromboembolism (VTE) - assessment and appropriate prophylaxis (1463)	Bradgate Unit, MHSOP wards, community hospitals and Langley ward (ED)	Clinical	12/07/2017	Electronic monitoring system to be established in community hospitals to flag to the ANPs that action is required for patients at risk of VTE.
MCA Training - Impact upon (In-patient) Practice re-audit (1489)	All wards in AMH.LD, CHS (including MHSOP), and FYPC	Clinical	18/10/2017	To complete focus groups with medics, and other relevant professionals, in order to identify and address any barriers To engage with Training Programme Directors to review training programmes for medical trainees regarding their inclusion of Mental Capacity Assessment and Deprivation of Liberty processes An aide memoir of the good example of a capacity assessment to be included within the medical staff induction pack / programme A strategy to be devised in order to engage with medical Consultants to ensure capacity assessments are recorded, reviewed and appropriate discussion relating to patient's capacity assessments are included within (for in-patient audit) ward rounds, (and for Community audit, within MDT discussions) A filter question to be included within the core health assessment on RiO and holistic assessment on SystmOne In-patients Champions Group to continue to be Trust wide For FYPC to establish their inpatient / community champions and engage in the trust wide champion schedule.
Preventing ill health by risky behaviours - alcohol and tobacco (Nat. CQUIN 9) (1498)	AMH.LD Wards MHSOP Wards Community Hospitals	Clinical	18/06/2018	Reinforce key criteria with relevant staff Raise awareness of new NCSCT e-learning module Feedback results at weekly AMH matron meetings - advising that failure to complete relevant assessments will be treated as a performance issue
Positive and Proactive Care re-audit (1512)	All Mental Health & LD Wards	Clinical	11/04/2018	Training to be rolled out in areas where the audit identified that this was required i.e. AMH. Care Plan training and Risk assessment training to include theory of PBS. Debrief Training to be implemented across all areas. All 10 safe wards interventions to be fully implemented

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Improving the management and care of patients with Diabetes re-audit (1520)	Bradgate MHU Stewart House The Willows	Clinical	18/05/2018	Rehab - Senior Matron to undertake monthly spot check in line with the audit criteria in June, July and Aug. Rehab - To establish need for additional Diabetes training for rehab Bradgate MHU - undertake random fortnightly spot checks of diabetes care plans and feedback/escalate to ward matron/deputies and named nurse regarding any concerns or missing data. Bradgate MHU - For all members of the MDT to use a standardised method of documenting any intervention required in the care plan under the headings of 'Health promotion' or 'lifestyles' to ensure this is recoded clearly and easily captured by the data collectors.
Inpatient treatment for people with depression (1546)	Bradgate MHU	Clinical	22/09/2017	Disseminate results by email to relevant staff groups Discuss findings and recommendations at the Postgraduate Open Meeting
Quality of Mental Health Act Recommendations (1547)	MHSOP Wards AMH Wards	Clinical	10/04/2018	To improve the legibility of recommendations, and recording of rationales for why detention is needed in the interests of self and others' safety on MHA Training Day
MHA Section 5(2) (1548)	AMH Acute Inpatients AMH Rehab Inpatients MHSOP Inpatients	Clinical	10/04/2018	No actions required
Suicide Prevention on AMH inpatient wards (modified Ward Manager's checklist) (1566)	Bradgate MHU	Clinical	17/11/2017	Continue with good practice systems where this has been embedded. To share the results of the audit and report with the team. Matron to remind staff and the ward administrators of the importance of arranging a contingency plan of discharge within 48 hours.
Trust wide laundry and linen management (1586)	All Inpatient Wards	Clinical	08/05/2018	Ensure all wards/areas are aware that any ripped or stained laundry is returned to Beresden laundry with an advice slip - reminder to staff in in patient areas Future building works will design in a hand wash basin in a laundry. Personal protective equipment should be made available in all laundry areas - reminder to staff in in patient areas Place sanitisers in all laundry areas

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
ECT - Compliance with NICE (1594)	ECT Service	Clinical	26/01/2018	The clinicians need to ensure that evidence of VTE examination is documented on patient electronic record (RiO) and that the NHS number for all patients is written on the consent form. A memo will be sent to all doctors regarding this.

Skilled staff to deliver care

The service had access to a range of specialists to meet the needs of the patients on the wards. Although staff described a lack of access to psychology on Watermead, Aston, Belvoir and Beaumont. Multi-disciplinary teams included: doctors, nurses, occupational therapists and discharge nurses.

Staff had the right skills, qualifications and experience to meet the needs of the patients in their care.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work.

The trust's target rate for appraisal compliance was 80%. As at 30 June 2018, the overall appraisal rates for non-medical staff within this core service was 91%.

All teams within this core service achieved the trust's target as at 30 June 2018.

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 80% reported at the last inspection.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Psychotherapy Bradgate	3	3	100%
Belvoir Psychiatric Intensive Care Unit	33	33	100%
Bradgate Admin	4	4	100%
Ashby Ward	23	23	100%
Heather Ward	24	23	96%
Beaumont Ward	19	18	95%
Watermead Ward	26	24	92%
Bosworth Ward	22	19	86%
Aston Ward	23	19	83%
Thornton Ward	27	22	81%
Griffin Ward	20	16	80%
Core service total	**224**	**204**	**91%**
Trust wide	**4957**	**4425**	**89%**

The trust's measure of clinical supervision data was the number of staff who had undertaken at least one clinical supervision in the last three months divided by the number of staff who required clinical supervision.

Between 1 July 2017 and 30 June 2018, the average rate across all nine teams in this core service was 64% of the trust's target.

Caveat: there is no 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 was higher than the 42% reported at the last inspection.

Caveat: the clinical supervision data is reporting for nursing staff only. The trust state that while clinical supervisions do take place for medical staff they are not recorded centrally.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Ashby Ward	137	121	88%
Heather Ward	148	115	78%
Belvoir Psychiatric Intensive Care Unit	157	115	73%
Beaumont Ward	148	98	66%
Bosworth Ward	157	94	60%
Thornton Ward	187	110	59%
Watermead Ward	170	92	54%
Griffin Ward	82	41	50%
Aston Ward	159	74	47%
Core service total	**1,345**	**860**	**64%**
Trust Total	**21,454**	**15868**	**74%**

During our inspection, we obtained updated figures for supervision compliance. During October 2018 five wards had supervision rates of over 90% with two wards achieving 100% supervision attendance.

Multi-disciplinary and inter-agency team work

Staff and managers did not demonstrate evidence of collaborative working between wards, learning from incidents and sharing of best practise. Some wards had good initiatives underway such as healthy eating and seclusion recording. These positive outcomes were not shared.

We observed a ward round which had limited multi-disciplinary team input, involving medical and nursing staff only with no input from pharmacy or other disciplines such as occupational therapy or psychology.

We observed an effective discharge planning meeting which demonstrated good inter-agency working with other services including, social care, housing and local council services. Discharge dates were identified and discussed and amended if not realistic.

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

As of 30 June 2018, 79% of the nursing workforce in this core service had received training in the Mental Health Act and 78% of the doctor workforce. The trust stated that this training is mandatory for all core services for inpatient and all community staff.

We reviewed the Mental Health Act 1983 (MHA) detention paperwork of 43 patients.

The detention paperwork of 42 patients was complete and appeared to be in order, in relation to the patients' detention under the MHA.

We found outline reports by the approved mental health professional (AMHP) in 42 of the 43 patient records we reviewed in relation to the MHA. In the remaining patient's record, we were unable to locate an outline report. We drew the absence of the outline report to the attention of a MHA administrator.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up to date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and staff supported patients who lacked capacity by referring to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary in accordance with the Mental Health Act Code of Practice and recorded it clearly in the patient's notes each time.

Good practice in applying the Mental Capacity Act

As of 30 June 2018, 95% of the workforce in this core service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff.

Care plans did not routinely contain formal capacity assessments and ongoing assessments of capacity and consent to treatment were not recorded. We did see two separate capacity assessments in relation to occupational therapy, and one in relation to consent to a specific treatment.

The trust told us that eight Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 July 2017 and 30 June 2018.

The greatest number of DoLS applications were made in October 2017 with three.

CQC received 38 direct notifications from Leicestershire Partnership NHS Trust between 1 July 2017 and 30 June 2018 (not relating to this core service)[2]. This is lower than the 351 applications made by the trust.

[2] DoLS CQC notifications

The number of DoLS applications made during this inspection was lower than the 27 reported at the last inspection.

Number of DoLS applications made by month

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Total
Applications made	0	0	2	3	0	1	0	0	1	1	0	0	**8**
Applications approved	0	0	0	0	0	0	0	0	0	0	0	0	**0**

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at one core service location scored lower than similar organisations and one location scored like similar trusts.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Bradgate Mental Health Unit	MH – Acute wards for adults of working age adults and psychiatric intensive care units MH – Mental health crisis services and health-based places of safety MH – Forensic inpatient / secure wards MH – Wards for older people with mental health problems MH – Other specialist services	83.1%
The Herschel Prins Centre	MH – Acute wards for adults of working age adults and psychiatric intensive care units MH – Forensic inpatient / secure wards	90.3%
Trust overall		**81.8%**
England average (mental health and learning disabilities)		**90.6%**

We observed staff carry out physical observations of patients on Ashby, Aston and Thornton wards. This included weight and blood pressure monitoring carried out in public areas (patient lounges, with staff sitting at a desk) which impacted the privacy and dignity of these patients.

Staff told us that female patients were regularly admitted into bedrooms on male corridors and vice versa. This had an impact on patient privacy and dignity as they were nursed on one to one observations, escorted through bedroom corridors and had to walk past bedrooms and bathrooms used by the opposite sex.

Staff were discreet, respectful, and responsive when caring for patients. We observed staff interacting with patients in a way that was responsive to their needs. Staff described the needs of their patients and how they worked with patients to support them.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said most staff treated them well and behaved kindly. Two patients on Heather ward told us that they did not always feel supported by staff who worked at night.

Staff clearly told us they felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

We found a lack of involvement of patients in their care across all wards. Staff wrote risk assessments and care plans in formal language that did not represent the patient voice. None of the 43 care plans we looked at reflected the patient voice.

Eleven patients either were not aware they had a care plan or did not feel involved with care planning. There was no evidence of patients being offered copies of their care plans.
Two patients could describe having a ‘My Care Plan’ document, however these were not uploaded onto their patient files.

Patients did not understand their care plan as they stated they had not been involved and had not chosen their goals.

Staff gave patients the opportunity to get involved in the service by taking part in community meetings and ward forums. Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff ensured that patients could access advocacy.

Involvement of families and carers

Care plans contained details of families and carers, where patients had people involved. Staff recorded contact they had with carers in electronic notes.

All carers that we spoke to said they had been involved in the care of their relative and were satisfied with the level of information they had been given.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for nine wards in this core service between 1 July 2017 and 30 June 2018.

All wards within this core service reported average bed occupancies ranging above the provider benchmark of 85% over this period with four of nine wards reporting average bed occupancies above 100% for all months reported.

At the time of the inspection, all wards had bed occupancy above 91%.

We were unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	Average bed occupancy range (1 July 2017 to 30 June 2018) (current inspection)
Ashby Ward	**95% - 108%**
Aston Ward	**83% - 109%**
Beaumont Ward	**102% - 126%**
Belvoir Unit	**98% - 105%**
Bosworth Ward	**105% - 130%**
Heather Ward	**97% - 115%**
Thornton Ward	**104% - 132%**
Watermead Ward	**103% - 113%**
Griffin Ward	**0% - 100%**

The trust provided information for average length of stay for the period 1 July 2017 to 30 June 2018.

We were unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	Average length of stay range (1 July 2017 to 30 June 2018) (current inspection)
Ashby Ward	22 - 70
Aston Ward	19 - 153
Beaumont Ward	27 - 106
Belvoir Unit	2 - 208
Bosworth Ward	36 - 97
Heather Ward	28 - 93
Thornton Ward	54 - 115
Watermead Ward	13 - 106
Griffin Ward	16 - 71

High bed occupancy meant that bed management was challenging. At the time of the inspection, 18 patients had been admitted out of area because of lack of suitable beds. A member of staff told us that very occasionally seclusion rooms were used when patients needed to be admitted in an emergency. However, data provided by the trust did not support this.

This core service reported 171 out area placements between 1 July 2017 and 30 June 2018.
As of 3 October 2018, this core service had five ongoing out of area placements.

There were no placements that lasted less than one day, and the placement that lasted the longest amounted to 192 days.

All of the 171 out of area placements were due to 'a placement with another provider due to capacity issues'.
The number of out of area placements reported during this inspection was higher than the 112 reported at the time of the last inspection.

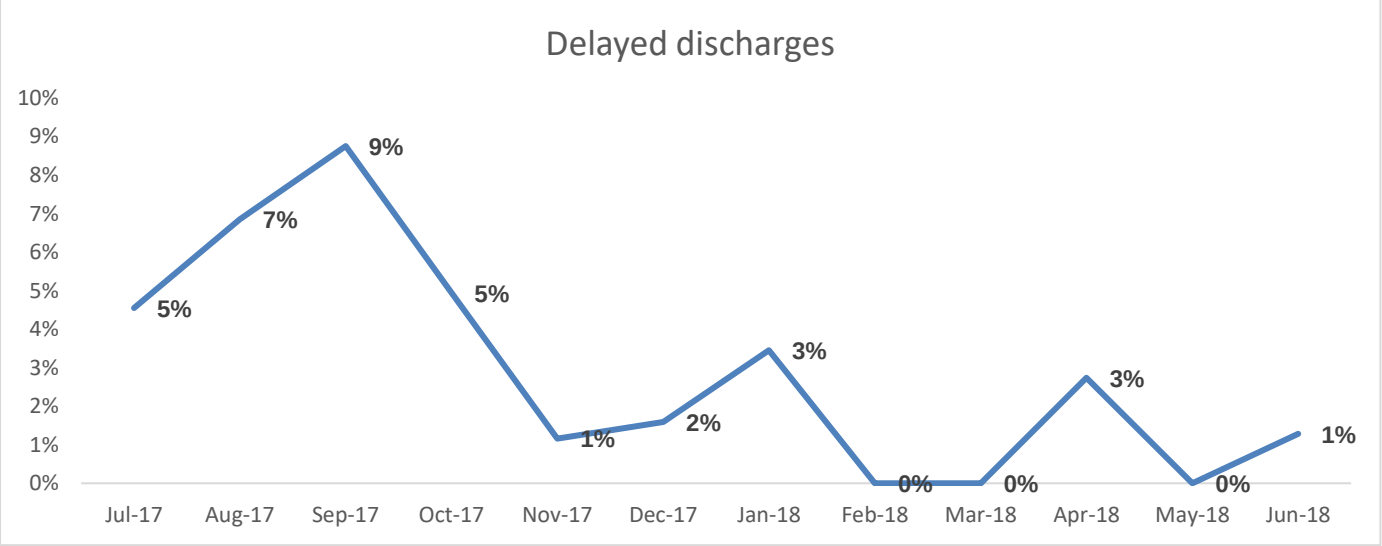
Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed placements)	Number of ongoing placements
171	0	171	2-192 days	5

Discharge and transfers of care

Staff planned effectively for patient's discharge and wards had discharge facilitators who liaised proactively with social care, voluntary sector and housing services to prevent barriers to discharge. A weekly meeting was held and those patients identified for discharge were discussed thoroughly. This meeting had helped to discharge patients effectively and engage local agencies and stakeholders in being involved early in the discharge process to prevent delays when discharge happened.

Between 1 July 2017 and 30 June 2018 there were 906 discharges within this core service. This amounts to 17% of the total discharges from the trust overall (5289).

The graph below shows the trend of delayed discharges across the 12-month period.



The proportion of delayed discharges reported during this inspection was similar to the 824 reported at the time of the last inspection.

The trust has not provided referrals data for inpatient services.

Facilities that promote comfort, dignity and privacy

Aston, Ashby, Bosworth and Thornton wards still had dormitory accommodation and some double rooms. We observed one room intended as a single bedroom on Thornton ward used as a two-bedded room. This room was very cramped, and patients had very little access to private space, separated by a curtain.

Patients in dormitory accommodation had limited space to store belongings and had to use lockers located in another part of the ward to store valuable items.

On Aston, Ashby, Bosworth and Thornton wards there were not enough rooms to support treatment and care. These wards had insufficient quiet areas and rooms where patients could meet with visitors or make phone calls in private.

Patients on Aston, Ashby and Thornton wards had physical observations carried out in public areas, despite a clinic room being available to use. This practice did not promote privacy or dignity for these patients.

On Ashby, Heather, Watermead, Thornton and Beaumont wards there were insufficient chairs in the dining area for all patients to sit together at mealtimes. We observed patients waiting for others to finish their meal before they could sit at a table.

Wards had outside space that patients could access easily. Staff restricted the use of outside areas at night and explained that this was to encourage positive sleep patterns.

Staff provided food that met patients' cultural and dietary needs. Four patients told us that the food was over-processed with poor consistency, quality and flavour.

Patients could make their own hot drinks and snacks and cold drinks were available throughout the day and night.

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the one location scored higher than similar trusts and lower than similar trusts for one location.

Site name	Core service(s) provided	Ward food
Bradgate Mental Health Unit	MH – Acute wards for adults of working age adults and psychiatric intensive care units MH – Mental health crisis services and health-based places of safety MH – Forensic inpatient / secure wards MH – Wards for older people with mental health problems	96.4%

	MH – Other specialist services	
The Herschel Prins Centre	MH – Acute wards for adults of working age adults and psychiatric intensive care units MH – Forensic inpatient / secure wards	81.1%
Trust overall		**94.9%**
England average (mental health and learning disabilities)		**91.5%**

Patients' engagement with the wider community

Patients that had people involved in their care told us staff encouraged them to keep in contact with families and carers.

Meeting the needs of all people who use the service

The service could support and make adjustments for people with disabilities, communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The service had information leaflets which staff could make available in languages spoken by the patients and local community.

Managers made sure staff and patients could arrange interpreters or signers when needed.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

Patients knew how to complain or raise concerns. They told us staff supported them to do this so they did not feel any fear about doing so.

Staff understood the policy on complaints and knew how to handle them.

Patients received feedback from managers after the investigation into their complaint.

This core service received 48 complaints between 1 July 2017 and 30 June 2018. Thirteen of these were upheld, eleven were partially upheld and twenty were not upheld. None were referred to the Ombudsman.

The number of complaints reported during inspection this was higher than the 36 reported at the last inspection.

Complaint subject	Fully upheld	Partially upheld	Not upheld	Withdrawn	Total Complaints
Patient Care	3	2	8	0	13
Patient Safety	2	4	3	1	10
Values and Behaviours (Staff)	4	2	3	0	9
Clinical	0	0	2	2	4

Privacy, Dignity and Wellbeing	1	1	1	0	3
Communications	1	2	0	0	3
Admissions, Discharges and Transfers Exc Delays	0	0	2	1	3
Prescribing Error	2	0	0	0	2
Consent	0	0	1	0	1
Core Service total	**13**	**11**	**20**	**4**	**48**

This core service received 20 compliments during the last 12 months from 1 July 2017 to 30 June 2018 which accounted for 2% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

There had been a high turnover of ward managers on some wards. On Ashby, Bosworth, Belvoir and Thornton the ward managers had all been in post for less than a year. On Aston ward there had been five managers in the space of three years.

Ward managers we spoke with knew their service and their staff and patients. Leaders had the skills required for their role. They displayed passion for their jobs and put patient care and staff support first.

Patients and staff knew who their ward managers were, and we saw them on the wards engaging with staff and patients.

All staff we spoke with described learning opportunities, particularly those created for them at ward level, and how they could access specialist training for their roles.

Vision and strategy

Not all staff could describe the vision and values of the trust. Some staff knew they could find information about the values on the trust intranet.

Culture

Staff described local morale as highly positive and gave examples of how ward teams supported each other, despite challenges with staffing levels and a lack of connection to other wards in the unit.

We saw an excellent example of an activity used to develop and strengthen staff morale and team dynamics. One ward had a day away from the ward, where the morning was dedication to learning and staff development and the afternoon focused on a team building exercise where staff were required to complete various tasks. Photographs of the event had been displayed in the ward office.

Staff felt very proud of the work they did, and described their focus as giving the best patient care possible. Staff were proud of, and passionate about, their wards but did not feel a strong connection to the wider unit and senior leaders.

Staff described being confident in raising concerns.

Staff understood the whistle-blowing policy and knew where to access the policy. No staff

referred to the speak up guardian or told us they knew about how to contact them.

Local ward managers knew the needs of their staff well and always supported them to develop in their roles.

Local managers supported staff during their appraisals and positively discussed career progression and development. Managers made referrals to occupational health, if required.

Managers addressed sickness and absence appropriately, and supported ward staff to return to work.

During the reporting period there were two cases where staff have been either suspended, placed under supervision or were moved to a different ward. The trust states 'alternative' action was taken against these staff members.

The number of staff placed under supervision, suspended or moved ward during this inspection was the same than those reported at the last inspection (two).

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

Ward name	Total
Beaumont Ward	2
Core service total	**2**

Governance

Managers had a clear framework of items they must discuss at each ward, team and directorate meeting. They knew who to report to, in which forum and what to discuss. Leaders felt the systems in places supported their roles and they had oversight of key performance indicators in the form of dashboards. Each manager demonstrated how they could manipulate the dashboard to review their local data and ward performance.

Staff knew how and when to report incidents. However, we were concerned that lessons learned from incidents and complaints was not always shared with staff across the unit. This was demonstrated when staff had limited knowledge of a recent fire on one ward and the learning points from the incident which would have impacted their ward practice.

Ward managers told us that regular clinical audits were completed on their wards. However, staff had not identified where medical equipment had not been appropriately calibrated and there were issues with clinical equipment identified in clinic rooms.

Staff understood the trust's arrangements for working with other teams both inside and outside the trust.

Mental Health Act Paperwork was appropriately completed and demonstrated patients subject to detention were detained under the appropriate legal authority.

Managers ensured staff were in receipt of regular supervision and appraisals to support them in their roles.

Management of risk, issues and performance

The trust did not have sufficient oversight of key risk issues for this service. Staff on wards

reported significant concerns about the implementation of the trust smoke free issues with restricting patients having access to ignition sources. There were consistent themes that re-occurred, including the impact of the smoking ban and staff's ability to manage smoking on the wards and to search patients on return from leave. A recent fire was not initially reported as a serious incident and there was a lack of sharing of immediate learning or actions.

Ward risk assessments contained cautions rather than actions and, on all wards, there were identified risks that were not identified on risk assessments.

There were significant concerns regarding the safe management of medicines which was a regulatory breach at the last inspection.

Documentation relating to seclusion was poor and secluded patients were not having appropriate medical and nursing reviews or care planning whilst in seclusion.

There was a lack of understanding amongst staff at all levels as to what constitutes a breach of mixed sex accommodation and when and how to report these as incidents. The trust reported no mixed sex breaches between July 2017 and June 2018. However, two ward managers on both stated that breaches happened regularly.

The service had clear plans for dealing with emergencies and staff understood these. However, we did not find evidence of personal emergency evacuation plans in the records of patients with mobility difficulties.

Information management

The systems to collect ward and directorate data did not create extra work for frontline staff.

Staff had access to equipment and technology to support them to do their work.

Information governance systems clearly stated policy on confidentiality of patient records.

Team managers had access to information that supported them.

Staff notified and shared information with external organisations when necessary, seeking patient consent when required to do so.

Engagement

Staff did not feel always feel connected to the wider trust. They described visible local leadership to service manager level but felt above that role there was a lack of visibility and understanding of their service's needs. We heard examples where local leaders felt there was a lack of response from the trust regarding issues significant to their wards.

Some staff members knew who the executive team were, in particular the chief executive, but were not able to name who the director was linked to the service or had seen them on a board walk.

Staff we spoke with were either not aware of the trust improvement programme due to start in January 2019 or were sceptical about it starting on time.

Learning, continuous improvement and innovation

Not all ward teams were having regular team meetings and minutes were not always up to date nor comprehensive. There was little evidence of how information from minutes was shared with non-attendees. Whilst staff told us this was a forum for staff learning, limited attendance, a lack of minutes meant that not all staff would hear about learning and areas for improvement.

Staff across the unit did not demonstrate collaborative working. Senior managers did not encourage the sharing of best practise, innovative working and learning from incidents. For example, a healthcare assistance had established a healthy eating group whereby patients cooked fresh meals instead of take-away options. This was extremely popular with patients on one ward and patients spoke highly of how well received this initiative was. Other wards had not heard of this idea and this practice had not been implemented in other areas.

We found serious incidents and risks relating to the environment, fire and management of the smoke free policy. The trust had not identified links between incidents to identify wider trust learning. Staff were not always aware of incidents that had occurred within the service.

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.

No accreditations held by the trust were relevant to this core service.

Long stay/rehabilitation mental health wards for working age adults

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
The Rise (Stewart House) RT5KE	Adult treatment and recovery service for complex enduring mental illness	30	Mixed
The Willows RT5FK	Acacia	10	Mixed
The Willows RT5FK	Cedars	10	Mixed
The Willows RT5FK	Sycamore	10	Male
The Willows RT5FK	Maple	8	Male

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Staff could observe patients in all parts of the wards.

Managers had not ensured safe care environments. Managers had not ensured that the

occupational therapy kitchen at Stewart House was safe. One cooker had worn numbers on the dials that were difficult to read. There was no evidence that the gas cooker had been serviced. Managers had tried to resolve this and showed us communications with the estates team.

Managers had not ensured environments were well maintained. At Stewart House the door from the female lounge to the garden was in a state of disrepair and could not be closed. We observed a tile falling off the wall whilst a patient was cooking in the occupational therapy kitchen.

On Maple ward patients and staff told us that the toilets were continually blocked. Two toilets at Stewart House could not be locked.

However, managers had fitted new window restrictors and refurbished the patient kitchens at Stewart House and the occupational therapy kitchen at the Willows.

Stewart House, Cedar and Acacia were all mixed sex wards. Two of these wards were not compliant with mixed sex guidance.

Cedar and Acacia were not compliant with guidance on eliminating mixed sex accommodation. There were no locked doors between male and female areas and no single sex lounges.

Stewart House was compliant with guidance on eliminating mixed sex accommodation. The ward was split into two wings, a male wing and a female wing. Each wing housed single sex lounges and bedrooms.

Over the 12-month period from 1 July 2017 to 30 June 2018 there were no mixed sex accommodation breaches within this core service.

Managers had not ensured ligature risks were safely managed. We found unidentified ligature risks on Maple ward and ligature risks that were not safely managed at Stewart House.

On Maple ward staff had not identified the table football in the quiet room as a ligature risk. The table football also posed a risk due to the small size of room it was located in. The table football would need to be pulled away from the wall to be used and would then block access to and from the room. A staff member on Maple did not know what a ligature risk was.

Managers at Stewart House had identified all ligature risks and had plans in place to manage these risks. Staff reviewed ligature risks and management plans as part of the handover process between shifts. However, we were informed by managers that they had recently agreed to leave the dining area open for patients to access freely throughout the day. The mitigation for the ligature risks present in the dining room was that the area was locked when not in use.

The trust had completed work to remove ligature risks from the reception area at the Willows.

There were ligature risks on five wards within this core service. The trust had undertaken recent

(from October 2017 onwards) ligature risk assessments at two locations.

None of the wards presented a high level of ligature risk and five wards presented a lower risk due to the presence of ‘ligatures and ligature points that could, potentially, be used by patients to self-harm’.

Staff had easy access to alarms. The Willows did not have call bells for patients. Managers advised that this was not required as they were a low risk patient group. Stewart House had call bells fitted in patient bedrooms. However, the manager had identified as a risk in October 2017 that not all the call bells were working. The risk assessment for this had been reviewed in July 2018 and the situation remained the same. The mitigation in place was for high risk patients to be

placed in rooms with working call bells. There was no evidence of any incidents occurring due to there being no call bells.

Maintenance, cleanliness and infection control

For the most recent Patient-Led Assessments of the Care Environment (PLACE) assessment (2017) the two locations both scored higher than the similar trusts for one of the three aspects overall. The Willows scored lower than similar trusts for the condition, appearance and maintenance and disability aspects of the care environment.

Stewart House scored higher than similar trusts for the cleanliness, condition, appearance and maintenance and disability aspects of the care environment.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
The Willows	MH - Long stay/rehabilitation mental health wards for working age adults.	99.3%	92.0%	-	83.2%
Stewart House	MH - Long stay/rehabilitation mental health wards for working age adults.	98.9%	96.7%	-	92.4%
Trust overall		**97.6%**	**91.2%**	**72.9%**	**85.1%**
England average (Mental health and learning disabilities)		**98.0%**	**95.2%**	**84.8%**	**86.3%**

Managers had not ensured safe and well maintained care environments. Managers had not ensured that the occupational therapy kitchen at Stewart House was safe. The gas cooker had not been serviced and cooker dials were worn. We observed a tile falling off the wall whilst a patient was cooking. At Stewart House the door from the female lounge to the garden was in a state of disrepair and could not be closed. On Maple ward patients and staff told us that the toilets were continually blocked. We found that two patient toilets at Stewart House were not able to be locked. This impacted on patients' privacy and dignity.

Staff followed infection control policy, including hand washing.

Seclusion rooms

Managers had not ensured seclusion facilities were safe. On Acacia ward the sink tap in the en suite area of the seclusion room was a potential ligature anchor point. A patient could potentially head-butt the metal enclosure of this tap, causing serious injury to themselves. On Maple ward we noted that the sealant where the floor and wall met was sharp. There was a blind spot in the en suite area of the seclusion room. Managers were aware of this (from a recent Mental Health Act monitoring visit) and were awaiting the delivery of a mirror to negate this blind spot. The key of the seclusion door was jammed and could not be removed from the lock. However, the lock still operated satisfactory.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs.

Staff checked, maintained, and cleaned equipment.

The trust had installed air conditioning in clinic rooms.

Safe staffing

Nursing staff

The trust did not provide data on staffing establishment figures prior to inspection. On inspection we gathered this from local managers. The service had enough staff with the right skills, qualifications and experience for each shift.

Definition

Substantive – All filled allocated and funded posts.

Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 30 June 2018	113.0	N/A
Total number of substantive staff leavers	1 July 2017 – 30 June 2018	8.0	N/A
Average WTE* leavers over 12 months (%)	1 July 2017 – 30 June 2018	7%	≤ 10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 30 June 2018	21.1	N/A
Total vacancies overall (%)	At 30 June 2018	17%	7%
Total permanent staff sickness overall (%)	Most recent month (At 31 May 2018)	4%	≤ 4.5%
	1 June 2017 – 31 May 2018	6%	≤ 4.5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 30 June 2018	Not given	N/A
Establishment levels nursing assistants (WTE*)	At 30 June 2018	Not given	N/A
Number of vacancies, qualified nurses (WTE*)	At 30 June 2018	Not given	N/A
Number of vacancies nursing assistants (WTE*)	At 30 June 2018	Not given	N/A
Qualified nurse vacancy rate	At 30 June 2018	Not given	N/A
Nursing assistant vacancy rate	At 30 June 2018	Not given	N/A
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 July 2017 – 30 June 2018	1088	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 July 2017 – 30 June 2018	12	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 July 2017 – 30 June 2018	91	N/A

Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	5053	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	58	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	265	N/A

*WholeTime Equivalent

This core service reported a vacancy rate for all staff of 17% as of 30 June 2018.

Across the 12 month reporting period vacancy rates for all staff types ranged between 12% (September 2017) and 17% (November 2017).

Caveat: The trust did not provide a breakdown of vacancy data by staff type.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Stewart House	n/a	n/a	n/a	n/a	n/a	n/a	10.9	39.4	28%
Willows Unit	n/a	n/a	n/a	n/a	n/a	n/a	2.2	7.7	28%
Maple Ward	n/a	n/a	n/a	n/a	n/a	n/a	5.4	21.0	26%
Sycamore (Willows)	n/a	n/a	n/a	n/a	n/a	n/a	3.0	19.0	16%
Acacia (Willows)	n/a	n/a	n/a	n/a	n/a	n/a	0.4	19.0	2%
Cedar (Willows)	n/a	n/a	n/a	n/a	n/a	n/a	-0.8	19.0	-4%
Core service total	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**21.1**	**125.2**	**17%**
Trust total	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**376.3**	**3687.3**	**10%**

NB: All figures displayed are whole-time equivalents

Managers told us that they limited their use of bank and agency staff and requested staff familiar with the service. However, some staff and patients told us that the service used a lot of bank staff at night.

Between 1 July 2017 and 30 June 2018, bank staff filled 1088 shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 12 shifts for qualified nurses. Ninety-one shifts were unable to be filled by either bank or agency staff.

Caveat: the trust did not provide available shifts data.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Acacia (Willows)	n/a	164	2	4
Cedar (Willows)	n/a	150	1	2
Sycamore (Willows)	n/a	215	3	0
Maple Ward (Willows)	n/a	164	2	6
Stewart House	n/a	395	4	79
Core service total	**n/a**	**1088**	**12**	**91**
Trust Total	**n/a**	**15536**	**16726**	**9344**

*****Percentage of total shifts

Between 1 July 2017 and 30 June 2018, bank staff filled 5053 shifts to cover sickness, absence or vacancy for nursing assistants.

In the same period, agency staff covered 58 shifts for nursing assistants. Two hundred and sixty-five shifts were unable to be filled by either bank or agency staff.

Caveat: the trust did not provide available shifts data.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Acacia (Willows)	n/a	757	7	7
Cedar (Willows)	n/a	803	15	7
Sycamore (Willows)	n/a	1079	21	11
Maple Ward (Willows)	n/a	934	11	12
Stewart House	n/a	1480	4	228
Core service total	**n/a**	**5053**	**58**	**265**
Trust Total	**n/a**	**46364**	**5825**	**5674**

***** Percentage of total shifts

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had low turnover rates.

This core service had 8 (7%) staff leavers between 1 July 2017 and 30 June 2018.

Monthly turnover ranged between 0 and 2% across the 12 month reporting period.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Stewart House Inpatient Admin	2.0	1.0	52%
Willows Unit	7.0	1.0	16%
Stewart House	28.0	5.0	16%
Maple Ward (Willows)	16.0	1.0	5%
Acacia (Willows)	20.0	0.0	0%
Cedar (Willows)	22.0	0.0	0%
Sycamore (Willows)	18.0	0.0	0%
Core service total	**113.0**	**8.0**	**7%**
Trust Total	**3150**	**349**	**10%**

Managers supported staff who needed time off for ill health and helped to keeps rates low.

The sickness rate for this core service was 6% between 1 June 2017 and 31 May 2018. The most recent month's data (May 2018) showed a sickness rate of 4%. This was lower than the sickness rate of 8% reported at the last inspection at 30 June 2017.

Across the 12 month reporting period, sickness rates ranged between 3% (April 2018) and 11% (December 2017) for this core service.

Ward/Team	Total % staff sickness (at May 2018)	Ave % permanent staff sickness (1 June 2017 – 31 May 2018)
Stewart House	6%	8%
Maple Ward (Willows)	1%	7%
Cedar (Willows)	10%	6%
Sycamore (Willows)	4%	6%
Willows Unit	0%	5%
Acacia (Willows)	2%	3%
Stewart Hse Inpatient Admin	0%	1%
Core service total	**4%**	**6%**
Trust Total	**5%**	**5%**

Managers calculated the number and grade of nurses and healthcare assistants they needed for each shift based on the needs of the patients. This matched the actual number on each shift. Managers deployed additional staffing to meet changing needs of patients. At Stewart House additional nursing staff were employed for three days a week to cover meetings and ward rounds.

The below table covers staff fill rates for registered nurses and care staff during May 2018, June 2018 and July 2018.

Skye Wing / Stewart House was over 125% full for night shifts for all months reported for registered nurses.

Willows Unit was over 125% full for care staff day and night shifts for all months reported and over 125% full for all day shifts for registered nurses.

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 2018				June 2018				July 2018			
Skye Wing / Stewart House	123%	115%	200%	103%	120%	105%	186%	103%	109%	119%	190%	105%
Willows Unit	150%	285%	122%	260%	134%	259%	123%	234%	156%	248%	127%	239%

Patients had regular one to one sessions with their named nurse.

Patients rarely had their escorted leave cancelled, even when short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to come to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

The trust provided no medical locum data for this core service.

Mandatory training

Staff had completed and were up to date with their mandatory training, however figures for some courses fell below the trust's target Managers told us that data provided did not take into account staff who were on long term sickness absence or maternity meaning that the compliance figure was close to 100%.

The compliance for mandatory and statutory training courses at 30 June 2018 was 90%. Of the training courses listed seven failed to achieve the trust target and of those, none failed to score above 75%.

CAVEAT: The trust was unable to provide the training data in the required format and therefore the compliance has been calculated based on internal trust dashboards.

The mandatory training programme met the needs of staff and patients in the service.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	This core service %	Trust target %	Trust wide mandatory/ statutory training total %
MAPA Disengagement Update	100%	85%	95%
Infection Prevention and Control Level 1	100%	85%	94%
Mental Capacity Act	98%	85%	95%
Conflict Resolution	98%	85%	97%
Hand Hygiene	96%	85%	94%
Display Screen Equipment (DSE)	96%	85%	94%
Equality, Diversity & Human Rights	96%	85%	96%
Health Safety and Welfare	96%	85%	96%
Infection Control	94%	85%	92%
Safeguarding Adults Level 1	94%	85%	95%
Safeguarding Children Level 1	94%	85%	95%
Record Keeping and Care Planning	92%	85%	92%
Move and Hand Level 1	91%	85%	95%
Safeguarding Adults Alert and Refer	89%	85%	88%
Mental Health Act for Nurses	89%	85%	82%
Information Governance	89%	85%	89%
Safeguarding Children Level 2	87%	85%	88%
Medicine Management	85%	85%	92%
Anaphylaxis Update	83%	85%	78%
Move and Hand Level 2	82%	85%	87%
Prevent WRAP	81%	85%	79%
MAPA Disengagement and Holding Skills - High Risk	81%	85%	83%
Fire Safety	81%	85%	87%
Adult Basic Life Support	78%	85%	80%
Adult Immediate Life Support	78%	85%	79%
Core Service Total %	**90%**	**85%**	**91%**

Managers kept track of staff and their mandatory training and staff received electronic alerts so they knew when to update or complete training modules.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed a risk assessment for each patient when they were admitted on most wards. Staff reviewed these regularly, including after any incident on five of the six wards.Staff on Maple ward were not completing or updating patient risk assessments. We reviewed eight patient records and the following six had risk assessments that staff had not updated.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff could observe patients in all areas (of the wards) and followed procedures to minimise risks where they could not easily observe patients.

Staff followed trust policies and procedures when they needed to search patients or patients' bedrooms to keep them safe from harm. However, on Maple ward we reviewed incidents relating to a patient hiding illicit substances in his bedroom. Staff had searched his bedroom, found the substance and removed it but later that day the patient was found in a comatose state and further substances were found.

Staff applied blanket restrictions on patients' freedom only when justified, for example, managers at Stewart House had locked the kitchen due to risks presented by a patient. Staff would unlock the kitchen for other patients on request.

Staff adhered to best practice in implementing a smoke-free policy. Staff supported patients to access stop smoking aids.

Use of restrictive interventions

Staff and managers worked to keep the use of restrictive interventions to a minimum.

This core service had 46 incidents of restraint (on 18 different service users) and 10 incidents of seclusion between 1 July 2017 to 30 June 2018.
The below table focuses on the last 12 months' worth of data: 1 July 2017 to 30 June 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Skye Wing	0	12	5	0 (0%)	12 (100%)
Acacia	4	17	4	0 (0%)	0 (0%)
Cedar	0	6	2	0 (0%)	0 (0%)
Maple	6	10	6	0 (0%)	0 (0%)
Sycamore	0	1	1	0 (0%)	0 (0%)
Core service total	**10**	**46**	**18**	**0 (0%)**	**12 (26%)**

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

There were no incidents of prone restraint and no instances of mechanical restraint over the reporting period.

The number of restraint incidents reported during this inspection was lower than the 49 reported at the time of the last inspection.

Staff made every attempt to avoid using restraint by using de-escalation techniques and only restrained patients when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and, where appropriate, worked within it.

Staff had not administered rapid tranquillisation over the 12 month reporting period.

There had been 10 instances of seclusion over the 12 month reporting period.

The number of seclusion incidents reported during this inspection was the same as the 10 reported at the time of the last inspection.

Staff had secluded one patient on Maple ward between 01 April 2018 and 30 September 2018. We reviewed this seclusion record. We were unable to find a written entry by a doctor of a medical review taking place within one hour in line with the Code of Practice. It was unclear if the nursing reviews had been carried out by two nurses every two hours throughout the patient's period of seclusion. A few entries contained the names, and not the designation, of the staff involved in the reviews. We also saw examples of gaps in the reviews exceeding two hours, with no explanation as to why this was the case. We were unable to find a written entry, on the provider's electronic recording system, by a doctor in relation to continuing medical reviews every four hours until the first internal multidisciplinary team review. The record we reviewed did not include a specific care plan relating to seclusion to include for example; patients' clinical needs, treatment objectives, how de-escalation attempts will continue and how risks will be managed, or how the patient's dietary needs are to be provided for. The seclusion paperwork staff used related to a historic seclusion policy, rather than the trust's current seclusion policy.

There had been no instances of long term segregation over the 12 month reporting period.

Safeguarding

All staff received training in safeguarding that was appropriate for their role.

Staff could give clear examples of how to protect patients from harassment and discrimination.

Staff knew how to recognise adults and children at risk of, or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

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 their own 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 13 safeguarding referrals between 1 July 2017 and 30 June 2018, of which all concerned adults. The trust was not able to provide a breakdown of the 374 child referrals by core service.

Number of referrals		
Adults	Children	Total referrals
13	n/a	13

Staff access to essential information

Patient notes were comprehensive and all staff could access them easily.

When patients transferred to a new team there were no delays in staff accessing their records.

Medicines management

Staff did not follow good practice in medicines management.

At Stewart House we found medicines in each clinic room that were no longer needed and should have been returned to the pharmacy for disposal. However, there were no medicines disposal /returns boxes on site. Staff told us that expiry date checking and checks for medicines not in use were conducted at the weekend and a green box to dispose medicines in would be requested when necessary. Staff were not able to tell us where any medicines identified for removal would be stored until the green box was delivered.

We found staff used sharps bins in the medicines trolleys to dispose of unwanted medicines (e.g. patient refusals after having been dispensed). The staff we spoke to were unaware of how to dispose of these sharps boxes.

Staff had not labelled one in use medicine, which should be dated when opened, and with date of expiry.

Staff had stored two medicated creams in an unlocked cupboard in the clinic room.

We found loose tablets (unboxed in their foils) in the medicines trolley.

At Stewart House we checked the e-prescribing system to view the medicines administration charts for six people on the unit. For one patient receiving a cream we saw that administration records variably stated ‘administered’ or ‘patient self-medicates’. A member of staff told us that the patient self-administered this cream but that, on occasion, incorrect codes had been used to suggest staff had administered it. This meant that the information on a patient medicines administration record could not be relied upon as an accurate description of the medicines they had received.

We found one patient who had been due her depot antipsychotic the previous day but her record had been annotated with ‘pt on leave’. The nurse on the ward on the day of the inspection was not aware that the depot remained due to be given until we identified this.

On Maple ward, staff had not reconciled two out of eight patient’s medicines on admission. Staff were not reviewing PRN (as required) medicines in line with national guidance.

Track record on safety

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

Between 1 July 2017 and 30 June 2018 there were no STEIS incidents reported by this core service.

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.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them.

Staff reported all the incidents they should.

Staff understood duty of candour. They were open, transparent and gave patients a full explanation when things went wrong.

Managers did not feedback learning from incidents to staff. We reviewed 14 team meeting minutes and found brief references made to incidents that had occurred on that ward but no evidence of wider learning across the service or from other incidents in the trust.

Managers and staff made changes to practice as a result of incidents and feedback. Examples included increased room searches following substance misuse incidents, splitting the staff team into two for each wing at Stewart House after an incident where a patient went missing and providing a patient with a nurse call alarm following three falls.

Managers debriefed and supported staff after any serious incident.

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 2018, and since the last inspection, there had been three 'prevention of future death' reports sent to Leicestershire Partnership NHS Trust. None of these related to this core service.

Is the service effective?

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed 30 records and all had a comprehensive mental health assessment.

Not all patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff had not completed a physical health examination in 14 out of 30 records. Six of these records were at Stewart House, three on Maple ward, four on Sycamore ward and one on Cedar ward.

Staff had not developed care plans to meet patient specific physical health needs for two patients who required this support. One patient at Stewart House had been admitted and staff had not completed a physical health assessment or specific physical health care plans but the patients progress notes indicated that they had a range of physical health issues. Staff had completed a physical health examination on admission for another patient at Stewart House over a year ago and indicated that the patient required an electro cardiogram. We were unable to find a record that this had been done. Staff on Maple ward had identified a number of physical health issues, including asthma, arthritis, eczema and a high BMI in one patient's risk assessment. Staff had not completed care plans to meet this patinet's physical health needs. Staff on Sycamore ward had made reference to a patient's diabetes in their risk assessment but had not completed a diabetes care plan.

Staff regularly reviewed and updated care plans when patient's needs changed in 22 out of 30

records.

Staff had not completed care plans that were personalised, holistic and recovery orientated in 19 out of 30 records. Ten of these records were at Stewart House, four on Maple ward, three on Sycamore ward and two on Cedar ward.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. These included the following occupational therapy interventions; model of human occupation and model of human occupation screening tool, life skills groups, walking groups, shop and cook sessions, discharge assessments, sports activities, community leave group, Assessment of Motor Processing Skills, activity of daily living assessments and the following psychological interventions; cognitive assessments, cognitive behaviour therapy, hearing voices work, recovery, coping skills, managing social anxiety, trauma work, relapse prevention, mood management, substance misuse awareness and a staged self medication programme. Staff encouraged patients to access educational opportunities at the local recovery college and through open university.

Staff told us how they had used National Institute for Health and Care Excellence guidance to improve their support to a patient with obsessive compulsive disorder.

Staff did not always identify the physical health needs of patients in care plans. However, staff supported patients to access physical healthcare support through primary care services. Local GP's visited the service on a twice weekly basis.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. Staff completed malnutrition universal screening tools for all patients.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. This included advice on healthy eating. We saw an informative display at Stewart House about the amount of sugar in different food and drinks. Staff were promoting healthy eating by supporting patients to cook healthy versions of their favourite takeaway meals. Staff encouraged patients to give up smoking through the use of stop smoking aids. The service employed a substance misuse worker to support patients with issues relating to substance misuse.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. These included health of the nation outcomes scales, the Camberwell assessment of need short appraisal schedule, hospital anxiety depression scale and the recovery star. Staff took part in clinical audits, benchmarking and quality improvement initiatives.

This core service participated in 11 clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Do not attempt resuscitation (DNA-CPR) re-audit (1241)	MHSOP Wards End of Life Care CHS	MH - Long stay/rehabilitation mental health	Clinical	02/02/2018	Provide clearer guidance to staff completing the DNA CPR form by designing a prompt/ guide for staff

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
	Community Nurses Community Hospitals Mill Lodge & Stewart House	wards for working age adults			to refer to when completing the form To be added to the MCM agenda for discussion to increase the awareness of the need for timely consideration of DNA CPR in MHSOP patients.
CPA & Non-CPA Case-note re-audit (1299)	Bradgate MHU Forensics (Community & IP) Rehab wards CAMHS LD Liaison Psychiatry AMH Outpatients LD Inpatient & Community Psychological Therapies	MH - Long stay/rehabilitation mental health wards for working age adults	Clinical	09/04/2018	Create a poster for individual wards with ward results and key actions for the ward. - Bradgate MHU Improve the process for recording CPA reviews onto Rio - Speak with Ian Maslin about the potential for functionality training within the teams - Bradgate MHU Add a section in the Rio out-patient letter care plan template where this can be documented - AMH Outpatients Develop a new hard copy of the care plan template for the team which can be scanned into Rio. Liaison Psychiatry During clinical supervision a review of patient notes will be included - LD Further actions incorporated into the Trust action plan concerning CPA
Inpatients Annual Physical Health Checks re-audit (1432)	Rehab Wards Bradgate MHU MHSOP Wards Agnes Unit	MH - Long stay/rehabilitation mental health wards for working age adults	Clinical	18/04/2018	Eye-catching best practice reminder email to be sent to all relevant clinicians, emphasising need to ensure abdomen and MECC

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
	(LD) Langley Ward (ED) Forensic Ward				assessments are completed as part of annual physical health checks. Additional training for pharmacists to be arranged. To increase awareness of monitoring tools within the RiO template. This will enable them to better direct doctors to complete all required elements. Pharmacists to be reminded to continue follow up with doctors re annual physical health checks until all elements are complete. Develop automated reminder system to prompt clinicians to complete annual physical health checks.
MHA Section 58 - treatment requiring a second opinion (Forms T2/ T3) (1441)	MHSOP Wards AMH Wards (Acute, Rehab & Forensic) Langley Ward (ED)	MH - Long stay/rehabilitation mental health wards for working age adults	Clinical	08/08/2017	Organise training events to ensure that assessment of mental capacity to consent for medication form is completed as per the code of practice. Pharmacy services are working with software providers to find a software solution which will stop prescribers from prescribing medication not authorised on statutory forms.
MCA Training - Impact upon (In-patient) Practice re-audit (1489)	All wards in AMH.LD, CHS (including MHSOP), and FYPC	MH - Long stay/rehabilitation mental health wards for working age adults	Clinical	18/10/2017	

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Capacity to consent for treatment in Rehab Wards (1497)	The Willows Stewart House	MH - Long stay/rehabilitation mental health wards for working age adults	Clinical	17/11/2017	To arrange teaching on mental capacity assessment and practical completion of these forms within rehab services To present this audit in formal meetings
Positive and Proactive Care re-audit (1512)	All Mental Health & LD Wards	MH - Long stay/rehabilitation mental health wards for working age adults	Clinical	11/04/2018	Training to be rolled out in areas where the audit identified that this was required i.e. AMH. Care Plan training and Risk assessment training to include theory of PBS. Debrief Training to be implemented across all areas. All 10 safe wards interventions to be fully implemented
Improving the management and care of patients with Diabetes re-audit (1520)	Bradgate MHU Stewart House The Willows	MH - Long stay/rehabilitation mental health wards for working age adults	Clinical	18/05/2018	Rehab - Senior Matron to undertake monthly spot check in line with the audit criteria in June, July and Aug. Rehab - To establish need for additional Diabetes training for rehab Bradgate MHU - undertake random fortnightly spot checks of diabetes care plans and feedback/escalate to ward matron/deputies and named nurse regarding any concerns or missing data. Bradgate MHU - For all members of the MDT to use a standardised method of documenting any intervention required in the care plan under the headings of 'Health promotion' or 'lifestyles' to ensure this is recoded clearly and

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
					easily captured by the data collectors.
Quality of Mental Health Act Recommendations (1547)	MHSOP Wards AMH Wards	MH - Long stay/rehabilitation mental health wards for working age adults	Clinical	10/04/2018	To improve the legibility of recommendations, and recording of rationales for why detention is needed in the interests of self and others' safety on MHA Training Day
MHA Section 5(2) (1548)	AMH Acute Inpatients AMH Rehab Inpatients MHSOP Inpatients	MH - Long stay/rehabilitation mental health wards for working age adults	Clinical	10/04/2018	No actions required
Trust wide laundry and linen management (1586)	All Inpatient Wards	MH - Long stay/rehabilitation mental health wards for working age adults	Clinical	08/05/2018	Ensure all wards/areas are aware that any ripped or stained laundry is returned to Beresden laundry with an advice slip - reminder to staff in in patient areas Future building works will design in a hand wash basin in a laundry. Personal protective equipment should be made available in all laundry areas - reminder to staff in in patient areas Place sanitisers in all laundry areas

Skilled staff to deliver care

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

Staff had the right skills, qualifications and experience to meet the needs of the patients in their care.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work.

The trust's target rate for appraisal compliance was 80%. As at 30 June 2018, the overall appraisal rates for non-medical staff within this core service was 82%.

Stewart House failed to achieve the trust's appraisal target with an appraisal rate of 61%.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Stewart Hse Inpatient Admin	2	2	100%
Acacia (Willows)	20	19	95%
Maple Ward (Willows)	16	15	94%
Sycamore (Willows)	18	16	89%
Willows Unit	7	6	86%
Cedar (Willows)	22	18	82%
Stewart House	28	17	61%
Core service total	**113**	**93**	**82%**
Trust wide	**4957**	**4425**	**89%**

The trust did not provide appraisals data for medical staff.

Managers supported nursing staff through regular, constructive clinical supervision of their work.

Managers supported medical staff through regular, constructive clinical supervision of their work.

The trust's measure of clinical supervision data was the number of staff who had undertaken at least one clinical supervision in the last three months divided by the number of staff who required clinical supervision.

Between 1 July 2017 and 30 June 2018, the average rate across all six teams in this core service was 73% of the trust's target. Managers told us that the data provided by the trust did not take into account staff off on long term sickness absence or maternity leave. Managers provided data for October 2018 that evidenced a compliance rate of 100% for Stewart House and 78% for the Willows.

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

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Sycamore (Willows)	121	104	86%
Stewart House	209	159	76%
Acacia (Willows)	115	82	71%
Cedar (Willows)	129	90	70%
Willows Unit	30	19	63%
Maple Ward (Willows)	117	71	61%

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Core service total	**721**	**525**	**73%**
Trust Total	**21,454**	**15,868**	**74%**

Managers made sure staff attended regular team meetings or gave staff information from those they could not attend. We reviewed minutes of team minutes for the 12 months preceding the inspection and meetings had taken place regularly.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. This included support workers undertaking training to become registered mental health nurses.

Managers made sure staff received any specialist training for their role. This included training on the use of the recovery model in the service and discharge planning.

Managers recognise poor performance, can identify the causes and respond appropriately.

Multi-disciplinary and interagency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed two care programme approach meetings and a discharge meeting which evidenced this.

Staff made sure they shared clear information about patients and any changes in their care during handover meetings.

Ward teams had effective working relationships with other teams in the organisation. This included with the community mental health team, acute inpatient services and physical health teams.

Ward teams had effective working relationships with external teams and organisations. This included with the local authority, housing providers and third sector providers.

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

Nursing staff received training on the Mental Health Act and the Mental Health Act Code of Practice and were able to describe the Code of Practice guiding principles.

As of 30 June 2018, 89% of nurses had received training in the Mental Health Act. The trust stated that this training was mandatory and renewed every three years.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up to date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy. Advocates visited the wards on a weekly basis.

Staff explained to most patients their rights under the Mental Health Act in a way that they could understand, repeated as necessary in accordance with the Mental Health Act Code of Practice

and recorded it clearly in the patient's notes each time. However, one patient, who had been admitted two weeks ago, did not know if he was detained or an informal patient.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patient's detention papers and associated records correctly and staff could access them when they needed to.

Care plans included information about after care services available for those patients who qualified for section 117 aftercare under the Mental Health Act.

Managers told us that staff completed audits of the application of the Mental Health Act which would then be checked by a senior nurse. We reviewed staff meeting minutes which evidenced findings were discussed.

Good practice in applying the Mental Capacity Act

Staff received training in the Mental Capacity Act and most had a good understanding of the five principles.

As of 30 June 2018, 98% of the workforce in this core service had received training in the Mental Capacity Act. The trust stated that this training was mandatory and renewed every three years.

Managers at Stewart House had made one Deprivation of Liberty Safeguards application to the local authority for a patient on 18 October 2018. The local authority had not completed their assessment. Managers told us there was a process to chase up applications.

The trust told us that 11 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 July 2017 and 30 June 2018.

The greatest number of DoLS applications were made in July 2017, August 2017, October 2017 and February 2018 with two in each month respectively.

CQC received 38 direct notifications from Leicestershire Partnership NHS Trust between 1 July 2017 and 30 June 2018 (none for this core service)[3]. This is lower than the 351 applications made by the trust.

Number of DoLS applications made by month

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Total
Applications made	2	2	0	2	1	1	0	2	0	0	0	1	**11**
Applications approved	1	1	0	0	0	0	0	0	0	0	0	0	**2**

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty

[3] DoLS CQC notifications

Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff only made applications for a Deprivation of Liberty Safeguards order when necessary and monitored the progress of these applications.

Staff had completed audits of patients informed consent to treatment.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff were discreet, respectful, and responsive when caring for most patients. However, we were informed by a patient on one to one observations that staff were observing him when he used the toilet and had a shower. The patient was not happy about this. We reviewed this patient's care records and found evidence in staff observation records that they were observing the patient in these situations. The trust observation policy stated that any decision regarding observations during personal care would be recorded by the doctor in the patients care records. We did not find evidence that this had been done.

We found that two patient toilets at Stewart House were not able to be locked. This impacted on patient's privacy and dignity.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. Patients told us that staff were brilliant, really caring and supportive.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at both core service locations scored lower than similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
The Willows	MH - Long stay/rehabilitation mental health wards for working age adults.	77.3%

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Stewart House	MH - Long stay/rehabilitation mental health wards for working age adults.	86.0%
Trust overall		**81.8%**
England average (mental health and learning disabilities)		**90.6%**

Involvement in care

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients were provided with a welcome pack on admission.

Staff did not always involve patients and give them access to their care planning and risk assessments. In 20 out of 30 records checked there was no evidence that staff had involved patients in their care planning and there was no evidence in any records that patients had been offered a copy of their care plan. However, out of five patients asked, three said they had a copy of their plan and another patient showed us their recovery star that they had completed themselves. Managers told us that they were working with staff to ensure they improved how they evidenced patient involvement in care planning and that patients were offered a copy of their care plan at every care programme approach meeting.

Staff involved patients in decisions about the service, when appropriate. We reviewed minutes of community minutes which evidenced this. However, community meetings on Sycamore had not taken place regularly. In the past 12 months there had only been four meetings.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to produce a newsletter at the Willows that was shared with patients and staff across the service. We observed an occupational therapy session where patients were in the process of producing the latest newsletter.

One patient had produced a video of his recovery journey.

Staff did not always support patients to make advanced decisions on their care. In 20 out of 30 records staff had not supported patients to do this.

Involvement of families and carers

Staff supported, informed and involved families or carers. Carers were provided with a welcome pack. We spoke with four carers. Carers told us that staff were brilliant, helpful and polite and looked after their relative well. Carers were invited to meetings about their relative's care and were kept updated. One carer told us that there didn't seem to be many activities on Acacia Ward and another said there are no activities on Maple Ward at weekends.

Staff helped families to give feedback on the service. The service had recently implemented carers meetings and was planning a carers event.

Staff gave carers information on how to find the carer's assessment. One carer told us that they were in the process of accessing a carer's assessment.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for five wards in this core service between 1 July 2017 and 30 June 2018.

All the wards within this core service reported average bed occupancies ranging above the provider benchmark of 85% over this period.

We were unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	Average bed occupancy range (1 July 2017 to 30 June 2018) (current inspection)
Skye Wing - Stewart House	88% - 99%
Acacia - Willows	93% - 100%
Cedar - Willows	85% - 108%
Maple - Willows	85% - 100%
Sycamore - Willows	97% - 109%

Managers told us that patients length of stay at the service should be no more than 15 months. The average length of stay for patients at the service ranged from eight months to 29 months. Managers advised that patients were able to stay longer than the 15 months if this was clinically justified.

The trust provided information for average length of stay for the period 1 July 2017 to 30 June 2018.

We were unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	Average length of stay range (1 July 2017 – 30 June 2018) (current inspection)
Skye Wing - Stewart House	122 – 1201
Acacia - Willows	361 – 745
Cedar - Willows	216 – 951
Maple - Willows	235 – 783
Sycamore - Willows	330 - 774

This core service reported no out area placements between 1 July 2017 and 30 June 2018.

Managers and staff worked to make sure they did not discharge patients before they were ready.

This core service reported two readmissions within 28 days between 1 July 2017 and 30 June 2018.

None of the readmissions were readmissions to the same ward as discharge.

The average of days between discharge and readmission was 0.5 days. There was one instance whereby patients were readmitted on the same day as being discharged and there was one instance where patients were readmitted the day after being discharged.

At the time of the last inspection, for the period 1 July 2016 to 30 June 2017, there were a total of two readmissions within 28 days. Of these, one readmission was to the same ward (50%) and the average days between discharge and readmission was 1.5 days.

Therefore, the number of readmissions within 28 days is the same as between the two periods and the average time between discharge and readmission has decreased.

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
2	0	0%	0-1	0.5

When patients went on leave there was always a bed available when they returned.

Patients only moved between wards during admission when there were clear clinical reasons or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

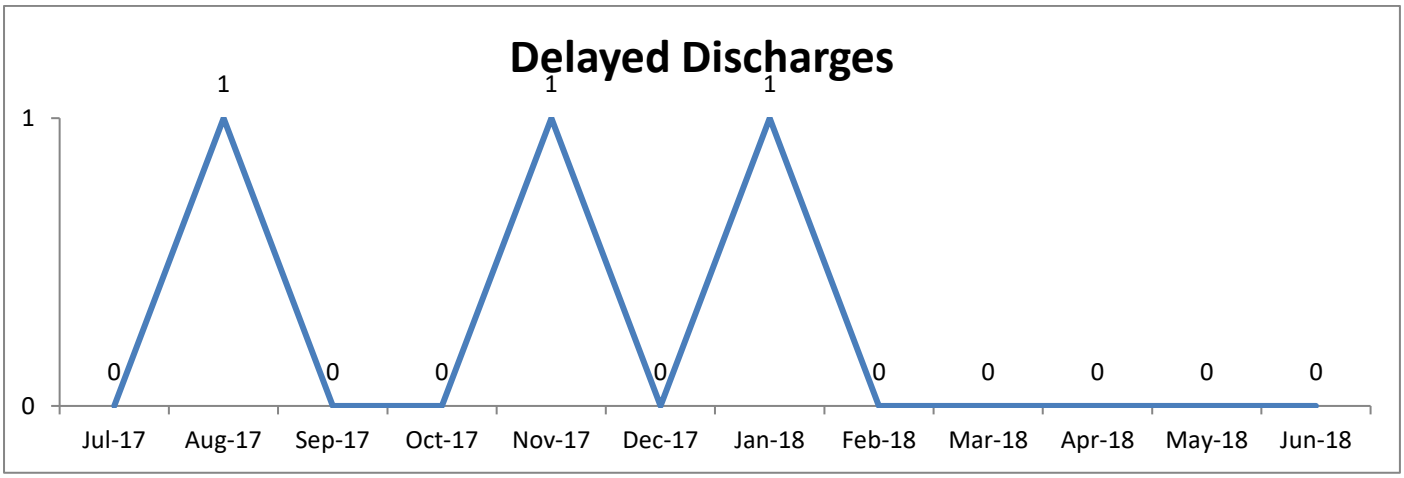
The Psychiatric Intensive Care Unit always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends.

Discharge and transfers of care

The service had three delayed discharges in the past year and managers monitored the number of delayed discharges and knew which wards had the highest number.

Between 1 July 2017 and 30 June 2018 there were 52 discharges within this core service. This amounts to 1% of the total discharges from the trust overall (5289).

The graph below shows the trend of delayed discharges across the 12 month period.



Reasons for delayed discharges included lack of suitable accommodation and delays in getting authorisation from the Ministry of Justice for patients' subject to their restrictions. Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. The service employed discharge nurses to enable a smooth transition for patients being discharged. Staff had completed detailed discharge plans that were regularly reviewed in 26 of the 30 records reviewed.

Staff supported patients when they were referred or transferred between services.

The trust had not provided referrals data for this core service.

Managers told us that they held weekly referral meetings to review any referrals and plan assessments. Managers told us they were developing clearer criteria for the service as currently they were receiving referrals for patients who were acutely unwell. Managers had escalated this issue within the trust as a potential service gap.

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom, which they could personalise. Staff risk assessed patients before giving them their own room key.

Patients had a secure place to store personal possessions.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. The occupational therapy kitchen at The Willows and the patient kitchens at Stewart House had been refurbished. However, we found that two patient toilets at Stewart House were not able to be locked. This impacted on patient's privacy and dignity. We raised this with the service managers.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private. There were no payphones available within any of the wards at The Willows but patients had access to a pay phone in the communal area shared by all of the wards. Patients were allowed mobile phones or could request to use the cordless office phone.

The service had an outside space that patients could access easily.

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the locations scored higher than similar trusts.

Site name	Core service(s) provided	Ward food
The Willows	MH - Long stay/rehabilitation mental health wards for working age adults.	97.5%
Stewart House	MH - Long stay/rehabilitation mental health wards for working age adults.	97.5%
Trust overall		**94.9%**
England average (mental health and learning disabilities)		**91.5%**

Patients could make their own hot drinks and had access to snacks. Each ward had a hot drink making 'station' that patients could access freely. We observed staff responding promptly to patients requests for snacks.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities for education and work, and supported patients. This included access to the local recovery college and open university.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

Stewart House could support and make adjustments for patients with physical disabilities. The Willows wards were not able to support patients with physical disabilities and patients with these needs would be placed at Stewart House.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get hold of interpreters or signers when needed. We observed a member of staff communicating with a patient using Makaton.

Patients were not happy with the quality and variety of food available. Patients had made repeated requests for more salads, vegetarian dishes and a greater choice of food. We saw evidence of these requests being made in community meeting minutes. There was no evidence that staff had met these requests. However, managers at Stewart House told us that they had recently held a food tasting session and feedback from this would be used to produce new menus next year.

Listening to and learning from concerns and complaints

Patients told us that they knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them. Staff would try and resolve complaints if possible or would escalate to the nurse in charge.

The service received a low number of complaints.

This core service received four complaints between 1 July 2017 and 30 June 2018. None of these were upheld, one was partially upheld and one was not upheld. None were referred to the Ombudsman.

Complaint subject	Fully upheld	Partially upheld	Under Investigation	Not upheld	Total Complaints
Values And Behaviours (Staff)	0	0	0	1	1
Patient Safety	0	0	1	0	1
Clinical	0	0	1	0	1
Patient Care	0	1	0	0	1
Core Service total	**0**	**1**	**2**	**1**	**4**

This core service received 10 compliments during the last 12 months from 1 July 2017 and 30 June 2018 which accounted for 1% of all compliments received by the trust as a whole.

Is the service well-led?

Leadership

Leaders had not ensured a clear model of service. Most leaders at the service were new in post. Leaders were working on a transformation programme for the service but this was not yet embedded.

Leaders had made changes to the service, including splitting the staff team at Stewart House in

to two - one for each wing. Leaders had received positive feedback about this, including that staff knowledge of the patients had improved. Leaders were increasing the occupational therapy input to the service to make it more therapeutic.

Most staff knew who the leaders were, could approach them and often saw them in the service. Seven out of nine staff we spoke with said that members of the executive team and senior leaders had visited the service.

The trust gave opportunity for leaders to develop their skills and for other staff to develop leadership skills. Leaders told us they had accessed leadership courses through the trust, including a 'building leaders' course. One staff member told us they were completing a course in line management as part of a leadership pathway. The trust had an agreement in pace with the local university enabling staff to access some of their courses.

Vision and strategy

Staff knew and understood the trust's visions and values and could describe how they applied to their work. Out of 16 staff asked, all of them were able to describe the trust's vision and values. Staff told us vision and values were discussed in induction, supervision and appraisal.

The senior leadership team had successfully communicated the trust's visions and values to staff at all levels of the service.

Staff could contribute to discussions about the service's strategy and changes to the service. Staff told us they could feedback in supervision and through surveys and consultations. Managers told us they were planning away days for staff to discuss the vision for the service.

Culture

Most staff felt respected, support and valued by their team and wider management. However, three staff told us about concerns related to bullying and feeling overloaded and pressurised.

Staff felt proud to work for their team and the trust.

Staff could raise concerns without fear.

Most staff (14 out of 16) understood the whistle-blowing policy and were aware of who the speak up guardian was. One staff member, who had started recently, had been given a card with details of the speak up guardian.

Teams worked well together and their manager dealt with any difficulties when they happened.

Managers supported staff during their appraisals and discussed career progression and development.

The service had low staff sickness and absence. Managers were supporting staff on sickness absence in line with the trust policy.

The trust supported their staff with access to occupational health services and counselling.

The trust recognised staff success and innovation. Staff had won awards for outstanding achievements.

During the reporting (1 July 2017 to 30 June 2018) there were no cases where staff have been either suspended, placed under supervision or were moved to a different ward.

Governance

Governance systems and processes had not ensured safety and environmental issues were addressed, that staff adhered to the Mental Health Act Code of Conduct, that patient involvement was evidenced in records and that patients' requests were responded to in a timely manner.

Managers had a clear framework of items they must discuss at each ward, team and directorate meeting. We reviewed governance and ward meeting minutes which confirmed this.

Managers were implementing changes to the service in line with the trust's transformation process. Changes made included the service now having one team manager across the two sites and this manager was working closely with the community rehabilitation manager and one governance meeting over all the rehabilitation wards.

Staff undertook or participated in local clinical audits and acted on the results.

Staff understood the trust's arrangements for working with other teams both inside and outside the trust.

Management of risk, issues and performance

Staff knew how to escalate any concerns.

We reviewed minutes of governance meetings where risk issues had been escalated.

Information management

The systems to collect ward and directorate data did not create extra work for frontline staff.

Staff had access to equipment and technology that worked well and supported them to do their work.

Information governance systems clearly stated policy on confidentiality of patient records.

Team managers had access to information that supported them.

All information was accessible and identified areas for improvement. However, managers raised that staff compliance data, for example, supervision and training data included staff on long term sickness absence and maternity leave.

Staff notified and shared information with external organisations when necessary, seeking patient consent when required to do so.

Engagement

Staff could access up to date information about the services and the trust as a whole through social media, webchats and videos by the chief executive officer. The Willows produced a quarterly newsletter for staff and patients. However, two staff told us that they thought communication could be better between the trust and the service.

Patients and carers could give feedback about their care and in ways that reflected their individual needs. This included though friends and family tests, patient satisfaction surveys, community meetings, carers meetings and in patient review meetings.

Managers used the feedback from patients and carers to make improvements to the service. Managers had made changes to the facilities at Stewart House following feedback from carers. These included keeping one of the lounges open at the weekend, changing the layout of the room and putting in a television and music system.

Managers and staff involved patients in staff interviews for the service. Managers told us they

wanted to improve involvement of patients and carers.

Learning, continuous improvement and innovation

Managers supported staff to take part in research. This included one staff involved in diabetes research and another involved in looking at patients post discharge to prevent readmission to the service.

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 trust has reported that this core service had not been awarded an accreditation.

Wards for people with a learning disability or autism

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Short breaks homes – Linkfield Road	Rubicon Close – Residential short breaks	5	Not stated
Short break homes – The Grange, Farm Drive	The Gillivers – Residential short breaks	5	Not stated
Short break homes – Farm Drive	1 The Grange – Residential short breaks	4	Not stated
Gorse Hill Hospital	The Agnes Unit Pods – Learning disability inpatient unit	12	Not stated

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Over the 12-month period from 1 July 2017 to 30 June 2018 the trust informed us there were no mixed sex accommodation breaches within this core service.

The Agnes unit complied with guidance on the elimination of mixed sex accommodation. There were separate bathrooms and bedroom areas and a female only lounge in one of the pods.

The short breaks services did not meet this guidance. The three services could not segregate bathroom and sleeping areas and did not contain any single sex lounges or day rooms. When men and women were admitted at the same time, this therefore constituted a breach of the guidelines. Since the last inspection, the short breaks services had responded by planning male and female

only stays at all the services to avoid breaching the guidelines. The trust was in breach of this guidance but these breaches were unavoidable to meet the needs of the people and families that used this service. Managers told us that they admitted male and female patients at the same time when families and carers were in great need, in emergencies. Carers felt passionate about the accommodation being mixed sex to promote social interaction and quality of life for their relatives.

We were not assured the trust reported mixed sex breaches accurately. Prior to inspection, the trust reported no mixed sex accommodation breaches. Following inspection, data provided by the trust stated that in the last 12 months men and women were admitted at the same time on 16 occasions at The Grange, 12 occasions at Gillivers and on nine occasions at Rubicon Close.

Staff completed regular environmental risk assessments of the Agnes unit and of the short breaks services.

There were ligature risks on four wards within this core service. The trust had undertaken recent (from December 2017 onwards) ligature risk assessments at four locations. All wards had a ligature risk assessment in the last 12 months.

None of the wards presented a high level of ligature risk and four wards presented a lower risk due to the presence of ligatures and ligature points that could, potentially, be used by patients to self-harm.

The trust stated that actions taken in order to mitigate ligature risks were detailed on a risk assessment and the risk register (not provided prior to inspection).

Staff could not observe all areas of the wards. The Agnes unit consisted of four ‘pods’, each with three bedrooms. There were blind spots in the bedroom areas. The short breaks services also contained some blind spots in bedroom and communal areas. Staff managed these risks effectively by appropriate levels of observations based on risk assessments. The short breaks services did not admit people with high levels of risk of tying ligatures.

Staff completed ligature risk assessments which addressed all the ligature risks on the wards. The Agnes unit had been fitted with anti-ligature fittings. Staff used individual risk assessments to ensure patients were safe and used enhanced levels of observations when needed. Short breaks services contained potential ligature points. Risk assessments showed that the risk of patients admitted to this service was low and any risks of self-harming behaviour was managed by staff observations.

Staff on the Agnes unit were equipped with alarms to request additional help when needed. Staff were identified on the rota to act as a responder for each shift to respond when staff summoned assistance. Staff at the short breaks unit did not carry alarms. The units were small and staff could be summoned easily if required. The wards were not fitted with nurse call systems.

Maintenance, cleanliness and infection control

The wards were clean and well maintained although decoration in the communal areas of Rubicon Close was tired and needed updating. Cleaning schedules showed that the wards were cleaned daily. Furnishings were generally of good quality. However, at Rubicon Close, the garden path was uneven and the bench and two garden chairs were broken and presented a risk to patients if used. This was raised with the provider at the time of inspection.

We observed that at Rubicon Close, the door to the cleaning cupboard, containing Control of Substances Hazardous to Health (COSHH) materials, had been left in the door and the door had been left open.

Staff followed good practice guidelines to reduce the risk of spreading infections. This included handwashing and the use of hand gels. However, at the short breaks services, rooms were not en-suite and all patients were supported to use the communal bathroom. At Rubicon Close, we found a jug on the edge of the bath, containing several used hair brushes. Staff had labelled these brushes with the name of the service and not individual patients. Patients present at the time of the inspection had brought their own toiletries with them. However, staff told us some patients did not bring sufficient toiletries with them and the service would on occasions supplement this. This issue was raised with the service at the time of the inspection.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) assessment (2017) the location scored higher than the similar trusts for two of the four aspects overall and similar to other trusts for one aspect. The location received a lower score than other similar trusts for 'dementia friendly' scoring 79.6% compared to 84.8% nationally.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
Agnes Centre	MH – Wards for people with learning disabilities or autism	98.4%	96.7%	79.6%	92.7%
Trust overall		**97.6%**	**91.2%**	**72.9%**	**85.1%**
England average (Mental health and learning disabilities)		**98.0%**	**95.2%**	**84.8%**	**86.3%**

Seclusion room

The seclusion facilities on the Agnes unit complied with national guidelines. The room was temperature controlled and there was a two-way communication system in operation. Toilet facilities were available but were not placed within the seclusion room but just outside, in the low-stimulation area. Staff escorted and supervised patients who needed to use these facilities and returned them to the seclusion room when they had finished. A clock was kept in the nursing office next to the seclusion room and placed on a chair outside the room so patients could see it. The provider had put up a sign to remind staff to ensure the clock was displayed when a patient was in seclusion.

There were no seclusion rooms at the short breaks services.

Clinic room and equipment

The clinic room at the Agnes unit was clean, well-organised and fully equipped. Emergency equipment was well maintained and regularly checked. The short breaks services did not contain clinic rooms. Patients brought their prescribed medication with them and staff kept this securely in the staff offices along with emergency equipment.

Safe staffing

Nursing staff

The trust did not provide data on staffing establishment figures prior to inspection. On inspection we gathered this from local managers. Managers had calculated the numbers and grades of nursing staff. The trust did not supply accurate data in relation to the numbers of substantive staff employed to cover the Agnes unit prior to inspection. However, local managers had access to staffing information through the inpatient dashboard. Managers and staff told us that staffing rates varied based on the levels of individual observations which fluctuated according to patient need. Staff told us they rarely cancelled activities due to staffing shortages.

Ward managers ensured there were sufficient staff to maintain the safety of patients. At the Agnes unit, the trust employed 20 whole time equivalent registered nurses and 38 whole time equivalent healthcare assistants. The trust did not provide vacancy data for this service; however, managers told us that they were recruiting to 4.4 registered nursing posts. Managers deployed internal 'bank' staff and agency staff when required. Managers told us these staff completed the same mandatory training as permanent staff and that they tried to ensure that they used people familiar with the ward. However, one staff told us that while there were enough staff, many did not know the patients and were unfamiliar with the ward. One carer told us this happened regularly. There were sufficient staff to ensure patients had time with their named nurse and staff told us that activities were rarely cancelled because there were not enough staff. There were sufficient staff to ensure physical interventions could be carried out when needed.

The trust employed 15 whole time equivalent registered nurses at the short breaks services and 26 whole equivalent healthcare assistants. There was a 9% vacancy rate. The service ensured that there was a registered nurse on shift at all times on Gillivers and Rubicon Close. There was not always a registered nurse on shift at The Grange; however, the service manager and deputy manager, based at The Grange, where registered nurses and were available when needed.

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 30 June 2018	49	N/A
Total number of substantive staff leavers	1 July 2017 – 30 June 2018	3	N/A
Average WTE* leavers over 12 months (%)	1 July 2017 – 30 June 2018	6%	≤ 10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 30 June 2018	4.3	N/A
Total vacancies overall (%)	At 30 June 2018	9%	7%
Total permanent staff sickness overall (%)	Most recent month (At 31 May 2018)	11.9%	≤ 4.5%
	1 June 2017 – 31 May 2018	9.8%	≤ 4.5%

Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 30 June 2018	n/a	N/A
Establishment levels nursing assistants (WTE*)	At 30 June 2018	n/a	N/A
Number of vacancies, qualified nurses (WTE*)	At 30 June 2018	n/a	N/A
Number of vacancies nursing assistants (WTE*)	At 30 June 2018	n/a	N/A
Qualified nurse vacancy rate	At 30 June 2018	n/a	N/A
Nursing assistant vacancy rate	At 30 June 2018	n/a	N/A
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 July 2017 – 30 June 2018	498	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 July 2017 – 30 June 2018	25	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 July 2017 – 30 June 2018	48	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	3419	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	20	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	202	N/A

*Whole-time Equivalent

This core service reported a vacancy rate for all staff of 9% as of 30 June 2018. It is not possible to compare this data to the previous inspection.

Across the 12 months, vacancy rates for all staff ranged between 3% (January and February 2018) and 14% (September 2017).

Caveat: The trust has been unable to provide a breakdown of vacancy data by staff type.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Gillivers	n/a	n/a	n/a	n/a	n/a	n/a	4.4	16.1	27%
The Grange	n/a	n/a	n/a	n/a	n/a	n/a	0.2	16.3	1%

3 Rubicon Close	n/a	n/a	n/a	n/a	n/a	n/a	-0.4	13.4	-3%
Core service total	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**4.3**	**45.7**	**9%**
Trust total	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**376.3**	**3687.3**	**10%**

NB: All figures displayed are whole-time equivalents

Between 1 July 2017 and 30 June 2018, bank staff filled 498 shifts to cover sickness, absence or vacancy for qualified nurses.

Across the 12 months, bank usage for qualified nurses ranged between six shifts (November 2017) and 72 shifts (March 2018) per month.

In the same period, agency staff covered 25 shifts for qualified nurses. Forty-eight shifts were unable to be filled by either bank or agency staff.

Caveat: the trust has not provided available shifts data.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Agnes Unit Pod 1	n/a	244	25	33
Agnes Unit Pod 2	n/a	97	0	7
The Grange	n/a	76	0	6
3 Rubicon Close	n/a	35	0	0
Gillivers	n/a	46	0	2
Core service total	**n/a**	**498**	**25**	**48**
Trust Total	**n/a**	**15,536**	**16,726**	**9,344**

Between 1 July 2017 and 30 June 2018, 3,419 shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

Across the 12 months, bank usage for nursing assistants ranged between 94 shifts (December 2017) and 470 shifts (August 2017) per month.

In the same time period, agency staff covered 20 shifts. Two-hundred and two shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Agnes Unit Pod 1	n/a	1498	15	94
Agnes Unit Pod 2	n/a	432	4	31
The Grange	n/a	534	0	39
3 Rubicon Close	n/a	522	1	18
Gillivers	n/a	433	0	20
Core service total	**n/a**	**3,419**	**20**	**202**
Trust Total	**n/a**	**46,364**	**5,825**	**5,674**

This core service had three (6%) staff leavers between 1 July 2017 and 30 June 2018. It is not possible to compare this data to the previous inspection.

Across the 12 months, turnover ranged between 0% and 2% per month.

The trust did not provide data for staff turnover in relation to the Agnes unit. Data from the trust stated that the staff turnover rate at the short breaks units was six percent, lower than the trust average of 10%.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Gillivers	14	2	13%
The Grange	18	1	6%
Agnes Unit Pod 4	0	0	0%
3 Rubicon Close	17	0	0%
Core service total	**49**	**3**	**6%**
Trust Total	**3150**	**349**	**10%**

The sickness rate for this core service was 9.8% between 1 June 2017 and 31 May 2018. The most recent month's data (May 2018) showed a sickness rate of 11.9%. It is not possible to compare this data to the previous inspection.

Sickness rates across the 12 months ranged between 7.3% (September 2017) and 11.9% (May 2018).

The trust did not provide data for sickness in relation to the Agnes unit. However, local managers had access to this information through the inpatient dashboard.

Ward/Team	Total % staff sickness (May 2018)	Ave % permanent staff sickness (1 June 2017 – 31 May 2018)
Gillivers	14.7%	13.1%
The Grange	19.4%	11.1%
3 Rubicon Close	0.9%	4.7%
Agnes Unit Pod 1	n/a	0.0%
Agnes Unit Pod 4	n/a	0.0%
Core service total	**11.9%**	**9.8%**
Trust Total	**5.3%**	**5.3%**

The below table covers staff fill rates for registered nurses and care staff during May, June and July 2018.

Rubicon Close and The Gillivers were under 90% full for registered nurses for all night shifts.

The Agnes Unit and The Grange were over 125% full for all care staff shifts for all day and night shifts.

Key:

> 125%	< 90%

	May 2018				June 2018				July 2018			
	Day		Night		Day		Night		Day		Night	
	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff
Agnes Unit	195%	467%	153%	475%	211%	493%	142%	515%	138%	400%	103%	402%
3 Rubicon Close	102%	180%	77%	136%	75%	123%	53%	83%	107%	205%	77%	229%
The Gillivers	92%	194%	42%	171%	65%	123%	30%	120%	102%	189%	55%	168%
The Grange	-	186%	-	168%	-	190%	-	175%	-	197%	-	158%

Medical staff

Between 1 July 2017 and 30 June 2018, no shifts were filled by bank staff to cover sickness, absence or vacancy for medical staff.

In the same time period, agency staff covered no shifts and no shifts were reported as unfilled.

Mandatory training

The compliance for mandatory and statutory training courses at 30 June 2018 was 89%. Of the training courses listed six failed to achieve the trust target and of those, two failed to score above 75%.

Data from the Agnes unit provided on inspection showed that mandatory Mental Health Act training for nurses stood at 85% and 78% for Workshops to Raise Awareness of Prevent.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	This core service %	Trust target %	Trust wide mandatory/ statutory training total %
Infection Prevention and Control Level 1	100%	85%	94%
EDHR	98%	85%	96%
Move and Hand Level 1	98%	85%	95%
MCA	98%	85%	95%
Conflict Res	96%	85%	97%
Health Safety and Welfare	96%	85%	96%
Safeguarding Adults Alert and Refer	96%	85%	88%
Safeguarding Children Level 2	96%	85%	88%
Status Move and Hand Level 2	96%	85%	87%
Adult Basic Life Support	96%	85%	80%
Safeguarding Adults Level 1	92%	85%	95%
Safeguarding Children Level 1	92%	85%	95%
Medicine Management	91%	85%	92%
DSE	90%	85%	94%
Record Keeping and Care Planning	89%	85%	92%
Hand Hygiene	87%	85%	94%
Infection Control	83%	85%	92%

Anaphylaxis Update	82%	85%	78%
Fire Safety	82%	85%	87%
Info Gov	78%	85%	89%
MHA for Nurses	71%	85%	82%
Prevent WRAP	57%	85%	79%
Core Service Total %	**89%**		**91%**

Staff were up to date with mandatory training. Mental Health Act training for nurses was 85% at the Agnes unit at the time of inspection, higher than in the core service as a whole. The short breaks services did not admit patients under the Mental Health Act.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments prior to admission and updated them regularly. We looked at 13 patient records. In each record, there was a full account of patient risks and strategies for minimising and managing the risks to patients and staff. Staff used the trust's risk assessment tool and recorded this electronically. Staff ensured they reviewed risk regularly and made changes to observation levels to keep patients safe.

Management of patient risk

Staff linked risk assessments to care plans and positive behaviour support plans to ensure risks were managed proactively where possible. Staff used handovers to ensure staff were aware of changing risks for individual patients. At the Agnes unit, in addition to electronic notes and risk assessments, staff also used alert cards to access information quickly.

Staff completed risk assessments in relation to self-harming behaviour where appropriate. Staff monitored these risks, including risks from ligatures, through observations and engaging with patients. Trained staff searched patients when they returned from unescorted leave.

Staff tried to avoid the use of blanket restrictions on the Agnes unit. For example, staff assessed patients individually in relation to accessing the internet or mobile phone and created individual care plans and risk assessments. There were some blanket restrictions, for example patients could not access outside space without supervision, but staff told us they tried to ensure patients could go outside whenever they wanted.

Staff spoken with told us informal patients could leave when they wanted. However, managers told us they would perform risk assessments to ensure patient safety and discuss with patients what support they needed.

Use of restrictive interventions

This core service had 202 incidents of restraint (on 28 different service users) and 14 incidents of seclusion between 1 July 2017 to 30 June 2018.

The below table focuses on the last 12 months data: 1 July 2017 to 30 June 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Activity Centre	0	4	4	0 (0%)	0 (0%)
Pod 1	4	33	4	0 (0%)	3 (9%)
Pod 2	10	136	10	0 (0%)	5 (4%)
Pod 3	0	20	5	0 (0%)	1 (5%)
Pod 4	0	0	0	0	0
1 The Grange	0	6	4	0 (0%)	0 (0%)
The Gillivers	0	0	0	0	0
3 Rubicon Close	0	3	1	0 (0%)	0 (0%)
Core service total	**14**	**202**	**28**	**0 (0%)**	**9 (4%)**

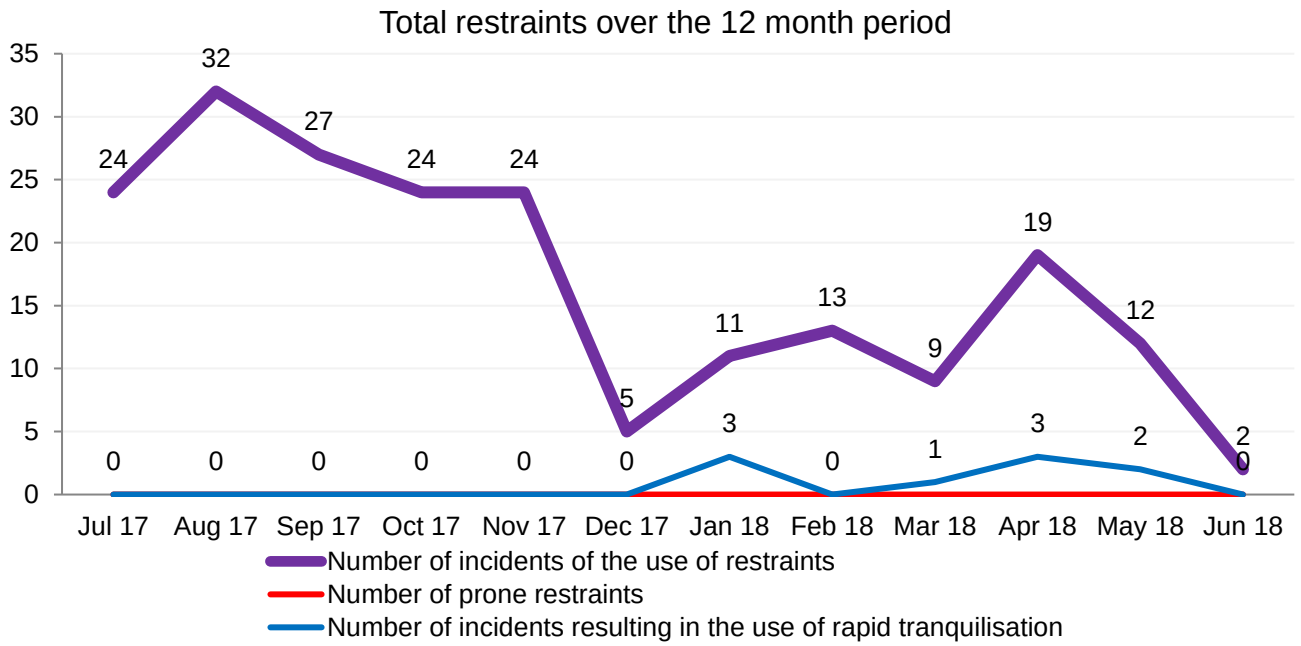
There were no incidents of prone restraint.

Incidents resulting in rapid tranquilisation for this core service ranged between zero and three (January 2018 and April 2018).

There have been no instances of mechanical restraint over the reporting period.

The number of restraint incidents reported during this inspection was lower than the 361 reported during the previous year (1 July 2016 to 30 June 2017).

There were 202 reported episodes of restraint of which 193 were on the Agnes unit. None of these were prone (face-down) restraints. Staff used rapid tranquilisation in nine instances of restraint and followed national institute of health and care excellence guidance. The number of restraints was significantly lower than the previous 12-month period. Staff worked towards reducing numbers of restraints by using strategies identified in positive behavioural support plans, including distraction and de-escalation techniques. Staff consistently reported that restraint was always used as a last resort. Staff received training in restrictive interventions.

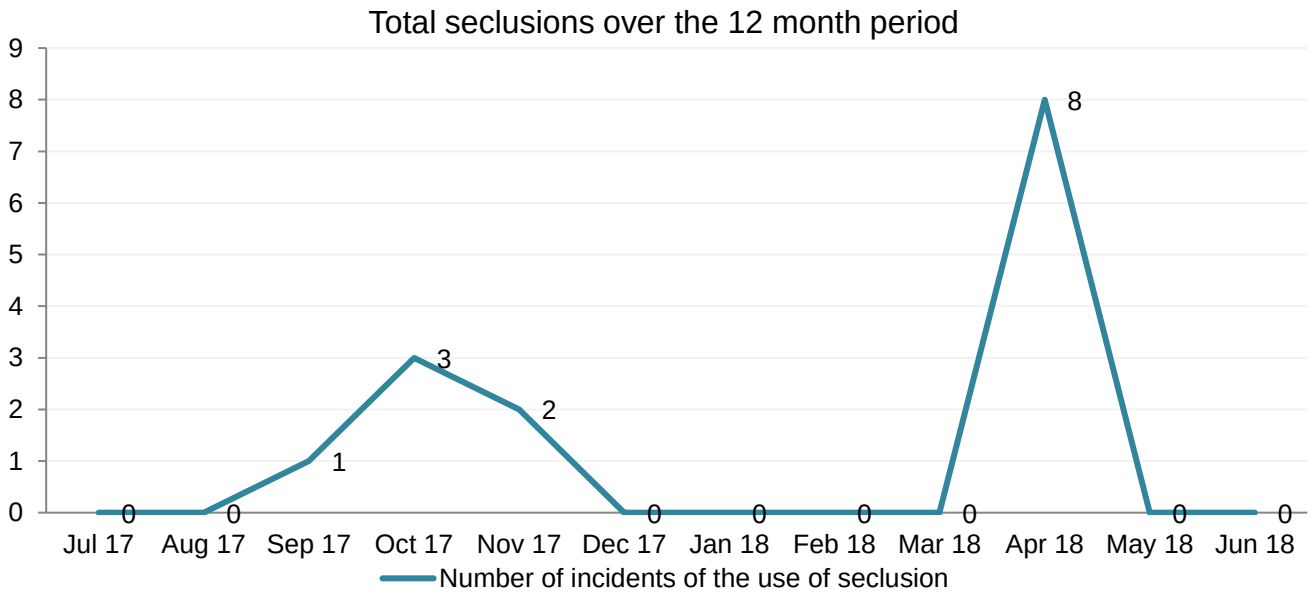


Over the 12 months, the instances of seclusion ranged between zero and eight (April 2018) per month.

The number of seclusion incidents reported during this inspection was lower than the 100 reported during the previous year (1 July 2016 to 30 June 2017).

Staff did not always comply with the Mental Health Act code of practice and did not complete seclusion paperwork appropriately. We looked at four seclusion records. In three cases, there was no medical review within one hour and in two cases no regular nursing reviews throughout the seclusion. In one of the four notes we looked at there was also no evidence of four-hourly medical reviews taking place. In all four notes, there was no seclusion care plan.

Data from the trust stated that staff secluded patients 14 times in the previous 12 months. All episodes of seclusion took place on the Agnes unit as the short breaks service did not use seclusion. At the time of the inspection, staff had not secluded patients during the previous six months.



There have been no instances of long term segregation over the 12-month reporting period at the Agnes unit. The short breaks service did not use long term segregation.

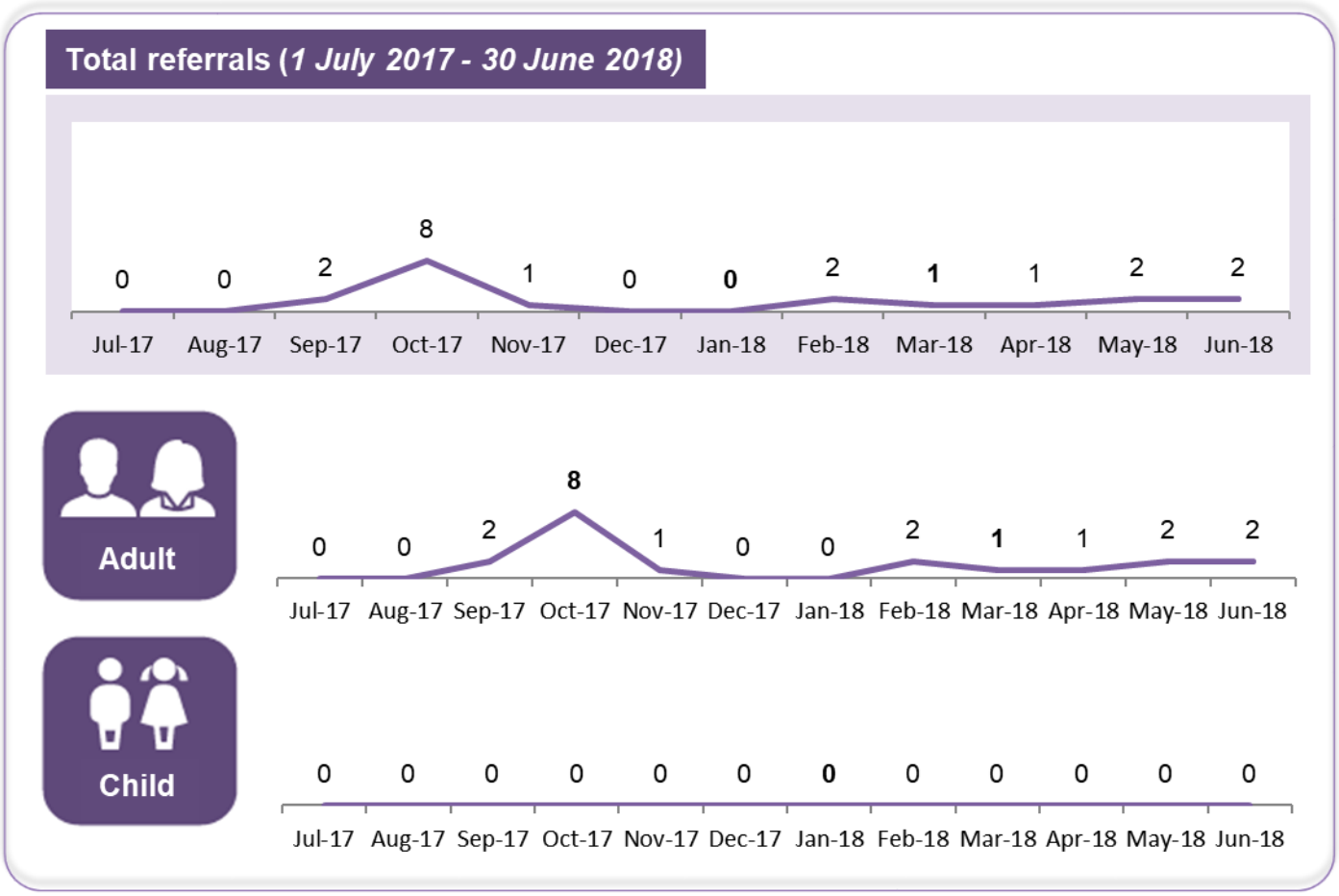
Safeguarding

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 their own 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 19 safeguarding referrals between 1 July 2017 and 30 June 2018, of which all concerned adults. The trust is not able to provide a breakdown of the 374 child referrals by core service.

Number of referrals		
Adults	**Children**	**Total referrals**
19	**0**	**19**



Staff spoken with were trained in safeguarding were aware of how to recognise abuse and how to report it. Staff gave examples of how they had acted to protect patients, including seeking advice

from colleagues, the trust's safeguarding lead and referring to the local authority safeguarding teams. The Agnes unit worked well with other agencies, including commissioners and local social work teams.

Leicestershire Partnership NHS Trust has submitted details of no serious case reviews commenced or published in the last 12 months (1 July 2017 and 30 June 2018) that relate to this core service.

Staff access to essential information

Staff accessed essential information easily through the trust's electronic recording system. Access was subject to the trust's security processes to keep patient information confidential. However, agency staff could not access the electronic system directly and relied on permanent staff to give them access to the information they needed. Staff also used some paper records, such as alert cards, for quick access to information. However, it was not clear how these were updated so staff could be sure they had access to the most recent assessments and information.

Recording of assessments, care plans and incidents was done on the electronic system.

Medicines management

Staff managed medicines safely at the Agnes unit. Medicines were managed safely and stored securely. The provider ensured medication was stored at appropriate temperatures which were monitored electronically. Emergency medications, appropriate for the service, were stocked and managed in accordance with trust policy and resuscitation council guidance. The provider used an electronic prescribing system which reduced the possibility of medication errors and allowed easy access to historical prescribing. Two members of staff administered medication to ensure medicines were administered safely and in line with prescriber's instructions. Medicines were prescribed in line with national institute of health and care excellence guidance. We looked at seven prescription charts and found everything was correct. The electronic prescribing system reduced the possibility of medication errors and allowed easy access to historical prescribing.

The Agnes unit did not have the facilities to dispose of medicines on the ward. Staff told us that unwanted and out-of-date medications would be returned to the pharmacy. Staff followed a process for reporting medication errors. This included a process of internal investigation to ensure that staff involved in errors remained safe to administer medicines.

The Agnes unit held monthly meetings with the trust pharmacy team who also provided telephone support for advice about medicines. The pharmacist attended some ward rounds and supported patients and their families when needed.

Staff did not always manage medicines safely in the short breaks services. Staff used electronic prescribing at The Grange and the trust pharmacy team supported staff to ensure medicines were administered safely. At Gillivers and 3 Rubicon Close, staff used a paper system to record the administration of medication. We looked at seven prescription charts. Where staff used the paper based system there were errors in signing for medicines. At 3 Rubicon Close, it was not clear on one of the charts whether the patient had received their medication or not. We raised this with the service during the inspection.

Track record on safety

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

Between 1 July 2017 and 30 June 2018 there was one STEIS incidents reported by this core service categorised as abuse / alleged abuse of adult patient by staff taking place in the Agnes Unit. This

incident related to the death of a patient due to physical health issues and who died in another hospital. The investigation into this incident has not concluded. There were no unexpected deaths.

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.

Reporting incidents and learning from when things go wrong

Staff spoken with knew what incidents to report and how to report them. These included injuries to patients or staff, violence and aggression, staff shortages and medication errors. All staff accessed the trust's electronic incident reporting system and completed incident forms. Staff told us that they were open and transparent with patients and their families after incidents. Four carers told us staff kept in regular touch with them and in let them know about incidents involving their relative.

Managers held debrief sessions for staff after incidents. This was done on both an individual basis and in reflective practice meetings, run by the psychologist. However, one member of staff told us they found it difficult to get a debrief after an incident. Manager's, multi-disciplinary and registered staff shared learning from incidents, complaints and concerns at weekly meetings. However, there was no system in place to ensure that this learning was shared with healthcare assistants.

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 2018, and since the last inspection, there had been three 'prevention of future death' reports sent to Leicestershire Partnership NHS Trust, however none of these related to this core service.

Is the service effective?

Assessment of needs and planning of care

Staff completed comprehensive mental health assessments at the Agnes unit on or shortly after admission. Short breaks units mostly admitted patients well known to the team; assessments were updated on new admission dates or before if needed. We reviewed 13 patient care records across both the Agnes unit and short breaks services and found staff had completed assessments in a timely fashion.

Staff at the Agnes unit completed physical health checks for patients on admission and ensured this was monitored during their stay. The short breaks services updated physical health check on each new admission or prior to this if they received information from families or GPs.

Care plans reflected the information contained in assessments and were holistic, recovery focused and personalised. Staff updated plans regularly and daily notes linked to the goals and strategies within the care plan. Staff completed positive behavioural support plans for patients and transferred the format and methodology into the main care plan.

Best practice in treatment and care

Staff provided a range of psychological therapies at the Agnes unit, including cognitive behaviour therapy and dialectic behaviour therapy. Staff also ensured patients had access to a sensory room and therapeutic activities such as pottery, music and exercising in the gym. Staff also taught

independence skills to patients such as laundry and cooking to assist patients when they moved back into the community. In the short breaks services, staff worked with patients

Patients had access to physical healthcare services. We saw examples of patients managed with chest infections and pressure sores. Staff referred to specialist services when necessary and procured specialist equipment to address patient need, for example, an air bed. Staff at the short breaks services liaised with patients' families and GPs. A number of the patients they supported had profound physical needs and required specialist care. Staff supported patients to get annual health checks through their GP.

Doctors followed national institute for health and care excellence guidance when prescribing medication for patients. We looked at seven prescription charts on the Agnes unit. Doctors met with the pharmacist prior to ward round to discuss the best medication to use for individual patients. In the short breaks services, staff administered medication to patients prescribed by their GP for the duration of their stay.

Staff used Care Programme Approach documentation to monitor patients progress on the Agnes unit. Staff told us that these meetings took place regularly and frequently according to patient need. Outcome scales were not routinely used in the short breaks services. However, staff used the national early warning score (NEWS) to monitor a patient with deteriorating physical health.

Staff at the Agnes unit participated in clinical audits such as medication and casefile audits. They also undertook audits in relation to service development, for example, a recent audit looked at how best to support someone with autism on an in-patient ward.

Staff assessed patients in relation to their nutritional and hydration needs and ensured these were met. At the short breaks services, some patients required percutaneous endoscopic gastronomy (PEG) feeding and specialist food preparations. Staff received specialist training where necessary for these procedures.

The Agnes unit and The Grange short breaks service use electronic prescribing which worked well to support patients' medication needs. Staff told us that electronic prescribing could not be used at Gillivers and 3 Rubicon Close for technological reasons.

This core service participated in seven clinical audits as part of their clinical audit programme 2017 - 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
CPA & Non-CPA Case-note re-audit (1299)	Bradgate MHU Forensics (Community & IP) Rehab wards CAMHS LD Liaison Psychiatry AMH Outpatients LD Inpatient & Community Psychological Therapies	MH - Wards for people with learning disabilities or autism	Clinical	09/04/2018	Create a poster for individual wards with ward results and key actions for the ward. - Bradgate MHU Improve the process for recording CPA reviews onto Rio - Speak with Ian Maslin about the potential for functionality training within the teams - Bradgate MHU Add a section in the Rio out-patient letter care plan template where this can be documented - AMH

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
					Outpatients Develop a new hard copy of the care plan template for the team which can be scanned into Rio. Liaison Psychiatry During clinical supervision a review of patient notes will be included - LD Further actions incorporated into the Trust action plan concerning CPA
Management of Specimens (1421)	District Nursing, Phlebotomy and Ward teams	MH - Wards for people with learning disabilities or autism	Clinical	07/11/2017	All clinical teams to identify nearest fridge for storage of specimens Where designated fridges not available, review to be carried out to locate nearest available fridge. Policy for the management and transportation of specimens to be shared with clinical teams access to a DGSA approved/ designated transport container for specimens is not used. Provision of DGSA approved/ designated transport container for specimens for staff who transport samples as part of their day to day clinical role
Inpatients Annual Physical Health Checks re-audit (1432)	Rehab Wards Bradgate MHU MHSOP Wards Agnes Unit (LD) Langley Ward (ED) Forensic Ward	MH - Wards for people with learning disabilities or autism	Clinical	18/04/2018	Eye-catching best practice reminder email to be sent to all relevant clinicians, emphasising need to ensure abdomen and MECC assessments are completed as part of annual physical health checks. Additional training for pharmacists to be arranged. To increase awareness of monitoring tools within the RiO template. This will enable them to better direct doctors to complete all required elements. Pharmacists to be reminded to continue follow up with doctors re

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
					annual physical health checks until all elements are complete. Develop automated reminder system to prompt clinicians to complete annual physical health checks.
MCA Training - Impact upon (In-patient) Practice re-audit (1489)	All wards in AMH.LD, CHS (including MHSOP), and FYPC	MH - Wards for people with learning disabilities or autism	Clinical	18/10/2017	To complete focus groups with medics, and other relevant professionals, in order to identify and address any barriers To engage with Training Programme Directors to review training programmes for medical trainees regarding their inclusion of Mental Capacity Assessment and Deprivation of Liberty processes An aide memoir of the good example of a capacity assessment to be included within the medical staff induction pack / programme.
Preventing ill health by risky behaviours - alcohol and tobacco (Nat. CQUIN 9) (1498)	AMH.LD Wards MHSOP Wards Community Hospitals	MH - Wards for people with learning disabilities or autism	Clinical	18/06/2018	Reinforce key criteria with relevant staff Raise awareness of new NCSCT e-learning module Feedback results at weekly AMH matron meetings - advising that failure to complete relevant assessments will be treated as a performance issue
.Positive and Proactive Care re-audit (1512)	All Mental Health & LD Wards	MH - Wards for people with learning disabilities or autism	Clinical	11/04/2018	Training to be rolled out in areas where the audit identified that this was required i.e. AMH. Care Plan training and Risk assessment training to include theory of PBS. Debrief Training to be implemented across all areas. All 10 safe wards interventions to be fully implemented
Trust wide laundry and linen management (1586)	All Inpatient Wards	MH - Wards for people with learning disabilities or autism	Clinical	08/05/2018	Ensure all wards/areas are aware that any ripped or stained laundry is returned to Beresden laundry with an advice slip - reminder to staff in in

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
					patient areas Future building works will design in a hand wash basin in a laundry. Personal protective equipment should be made available in all laundry areas - reminder to staff in in patient areas Place sanitisers in all laundry areas

Skilled staff to deliver care

There was a full range of multi-disciplinary staff at the Agnes unit. The team consisted of nurses, healthcare assistants, occupational therapists and assistants, psychologists and assistants, doctors and speech and language therapists and a discharge co-ordinator. The team also received regular support from the trust pharmacy team. The short breaks services employed nurses and healthcare assistants and accessed other professionals over the phone for support. Both teams liaised with social work team when necessary.

Staff were experienced and qualified where this was required for their role. Staff undertook mandatory and specialist training to ensure they had the relevant skills to undertake their role. This included training in sensory stimulation, positive behavioural support, physical interventions, medication, learning disability, autism and specialist healthcare interventions, particularly at the short breaks services. New staff received an induction which was based on care certificate standards.

The trust's target rate for appraisal compliance was 80%. As at 30 June 2018, the overall appraisal rates for non-medical staff within this core service was 86%.

The wards/teams failing to achieve the trust's appraisal target were 'Gillivers' with an appraisal rate of 79% and 'The Grange' at 78%.

It is not possible to compare this data to the previous inspection.

Managers provided staff with regular appraisals of their work. Refreshed data from the trust stated that 94% of staff at the Agnes unit had completed an appraisal in the previous 12-month period. This had improved since June 2018, when this figure stood at 74%.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
3 Rubicon Close	17	17	100%
Gillivers	14	11	79%
The Grange	18	14	78%

Ward name	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	**49**	**42**	**86%**
Trust wide	**4957**	**4425**	**89%**

The trust has not provided appraisal data for medical staff. The consultant psychiatrist stated that medical staff received regular appraisals.

The trust's measure of clinical supervision data was the number of staff who have undertaken at least one clinical supervision in the last three months divided by the number of staff who require clinical supervision.

Between 1 July 2017 and 30 June 2018, the average rate across all three teams in this core service (does not include Agnes Unit Pods) was 70% of the trust's target.

Managers supervised staff in line with trust policy at the Agnes unit. Data from the managers dashboard at the Agnes unit, showed that in the six-month period from May to October 2018, 92% of staff received monthly clinical supervision. This is slightly higher than the average for the trust as a whole. The lowest month was May when 82% of staff received supervision, and the highest was September with 96%. Staff confirmed that they received regular management and clinical supervision.

Trust data showed that in the short breaks service, the compliance rate with clinical supervision was 70%, slightly below the average for the trust.

Managers dealt with performance issues through supervision.

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

It is not possible to compare this data to the previous inspection.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
3 Rubicon Close	92	71	77%
The Grange	79	55	70%
Gillivers	78	49	63%
Core service total	**249**	**175**	**70%**
Trust Total	**21,454**	**15,868**	**74%**

Multi-disciplinary and interagency team work

Staff attended monthly multi-disciplinary meetings at the Agnes unit. The team discussed a range of issues such as the risk register, training, complaints and compliments and performance reports. The therapy staff and registered nurses also met weekly to discuss current issues on the ward,

any complaints or concerns about the service. Staff in the short breaks service attended regular staff meetings. We reviewed the minutes of meetings at the Grange which were held monthly. Staff discussed patient issues, new referrals and communication from the trust including action plans and lessons learnt from serious incidents. Staff at Rubicon Close told us team meetings were less frequent as staff had to rearrange them on occasions.

Staff shared information about patients and events from the previous shift. We attended two handovers at the Agnes unit where relevant information about patients was discussed and arrangements made for the induction of an agency member of staff.

The Agnes unit maintained good working relationships with community teams, commissioners and safeguarding teams. The unit arranged regular meetings and community treatment reviews which were attended by care co-ordinators and a range of other professions. Multi-disciplinary staff maintained good links with their community counterparts. Both the Agnes unit and the short breaks services maintained good links with GPs and local authority social work teams.

Three staff spoken with told us there was occasional tension between specialists and nursing staff in relation to work capacity and ability to meet the timescales of other professionals.

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

As of 30 June 2018, 71% of the nursing workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff. Trust data from the manager's dashboard unit on inspection stated that 85% of staff at the Agnes unit had received training in the Mental Health Act. Staff had a good understanding of the Act and how it affected their work. The short breaks services did not admit people under the Mental Health Act.

Staff had easy access to the Mental Health Act team who provided administrative support and advice on the implementation of the Act and the code of practice. Staff knew who the team were and how to contact them. The Mental Health Act team ensured paperwork was correct and complete.

Staff had easy access to information about independent mental health advocates. Information was displayed on notice boards in the unit with details of how to refer patients.

Staff explained to patients their rights under the Mental Health Act. We reviewed six patient care records. Four patients were detained under the Mental Health Act. Staff had explained their rights to them in all cases. One patient did not understand and this was clearly recorded. Rights were read to patients weekly.

We looked at seven prescription charts. Doctors adhered to consent to treatment and capacity requirements in all cases with forms T2 or T3 in place as appropriate. Form T2 is a certificate of consent to treatment completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a certificate issued by a second opinion appointed doctor and is a form completed to record that a patient is not capable of understanding the treatment prescribed or has not consented to treatment but that the treatment is necessary and can therefore be provided without the patient's consent.

The ward displayed information about informal patients saying they could leave the ward freely. However, managers and staff told us that they would undertake a risk assessment before allowing informal patients to leave the ward.

Good practice in applying the Mental Capacity Act

Staff had received training in the Mental Capacity Act. As of 30 June 2017, 98% of the workforce in this core service had received training in the Mental Capacity Act. The trust stated that this training was mandatory for all core services for inpatient and all community staff. Staff at the Agnes unit and in short breaks services had a good understanding of the Act and its application to their service.

The trust told us that 74 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 July 2017 and 30 June 2018.

The greatest number of DoLS applications were made in January 2018 with 15.

CQC received 38 direct notifications from Leicestershire Partnership NHS Trust between 1 July 2017 and 30 June 2018 of which 32 related to this core service[4]. This is lower than the 351 applications made the trust.

	Number of DoLS applications made by month												
	M	**M**	**M**	**M**	**M**	**M**	**M**	**M**	**M**	**M**	**M**	**M**	**Total**
Applications made	7	2	1	8	7	10	15	9	7	4	2	2	**74**
Applications approved	3	4	1	6	1	4	1	2	2	2	2	0	**28**

The trust had a policy on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff spoken with were aware of the policy and how to access it. Staff received advice in relation to the Act and DoLS from the Mental Health Act team and from their managers. The Agnes unit had appointed DoLS champions to oversee applications and assist other staff.

Staff applied the Mental Capacity Act appropriately. In the short breaks units, staff had assessed capacity appropriately. Mental capacity assessments and DoLS applications were of good quality, decision specific and correctly submitted. Staff assumed capacity and enabled patients to make decisions for themselves where possible. Some assessments concluded that patients had capacity. Where staff assessed patients as lacking capacity, staff made decisions in their best interests. Staff completed paperwork correctly; they liaised with local day centres when patients were away at day care and liaised with the local authority Best Interests Assessors to monitor the progress of applications and ensure they were complying with the Act.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with kindness and respect. We observed staff interacting with patients. They showed an understanding of patients' conditions and their needs, were compassionate and caring and maintained patient confidentiality.

We spoke with eight patients who told us staff listened to them, were kind and helped them do things when they wanted and gave emotional support when they needed it. They told us staff respected their privacy and helped them understand what was happening to them and what would happen next. Six patients told us they felt safe and were happy with their care.

[4] DoLs notifications

Staff said they could raise issues about the way patients were treated and would do so if needed.

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

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at one core service location scored higher than similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Agnes Centre	MH – Wards for people with learning disabilities or autism	92.8%
Trust overall		81.8%
England average (mental health and learning disabilities)		90.6%

Involvement in the care

Involvement of patients

Staff helped patients to settle into the ward on admission by showing them round and explaining ward activities and routines. Staff provided patients with an easy read booklet with information about staff, activities and what to expect on the ward.

Staff involved patients and their carers in care planning and in formulating risk assessments. There was evidence for this in care plans and in multi-disciplinary reviews, including care and treatment reviews. Staff used ‘my care plan’ for patients and carers to contribute to their plan. However, staff did not always record whether they had offered copies of care plans to patients. In five of the six records we looked at, one stated that staff had given and five records did not record this. Four patients at the Agnes unit told us they had been involved in writing their care plan, although one patient said they did not have a care plan and staff had not talked to them about it. None of the seven records we looked at the short breaks services recorded that patients had received copies of care plans. Patients on these units were severely learning disabled; however, family carers felt they were involved in care planning.

Staff helped patients understand their care and treatment. Therapy staff worked with everyone on the ward to help patients understand what they needed to do to get better and understand their treatment and be involved in it. Speech and language therapists helped develop patients’ understanding and communication.

Patients had access to advocacy on the Agnes unit. Information was displayed on the ward and in a booklet provided on admission.

Managers did not involve patients in recruiting staff.

Involvement of families and carers

Staff involved families and carer’s in their relatives’ care were appropriate. The Agnes unit provided an illustrated information booklet for carers when their relative was admitted. The booklet invited comments and feedback. However, there were no formal support groups for carers run by

the service. One carer we spoke with said they did not feel encouraged to raise issues; another stated they were given the opportunity to provide feedback about the service. All three carers spoken with at the Agnes unit said they felt involved in their relative's care and two said they felt well supported.

Carers said staff at the short breaks service were friendly, helpful, supportive, communicated with them well and kept them informed of any incidents. The service sent out an annual questionnaire which requested feedback. Feedback received was mostly in relation to the move to single-sex accommodation, which was viewed by the majority of carers as negative. Four of the five carers we spoke with told us that it had had a negative impact on their relative or on the availability of the service. Two carers told us that they had raised this with the trust but had not received any feedback about why it had been introduced.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for six wards in this core service between 1 July 2017 and 30 June 2018.

Three of the wards within this core service reported average bed occupancies ranging above the provider benchmark of 85% over this period, however no ward reported average bed occupancies ranging above 100%.

We were unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Beds were available when needed for people living in the catchment area. Data from the trust stated that bed occupancy was high at the Agnes unit, often approaching 100%. However, data from the manager's dashboard stated that the average bed occupancy over the previous six months was 67%. The lowest was 53% in August and the highest was 83% in May 2018.

Patients on home leave did not return to a different bed and patients were not moved from one pod to another during an admission unless there were clinical grounds to do so.

In the short breaks services, staff told us that occupancy was lower during some weeks because of the policy to offer male and female only weeks. Carers also stated that there was less flexibility to get the weeks they wanted because of this policy.

Ward name	Average bed occupancy range (1 July 2017 – 30 June 2018) (current inspection)
1 The Grange	37% - 76%
3 Rubicon Close	44% - 82%
Agnes Unit Pod 1	74% - 100%
Agnes Unit Pod 2	51% - 98%
Agnes Unit Pod 3	51% - 99%
Gillivers	33% - 58%

The trust provided information for average length of stay for the period 1 July 2017 to 30 June 2018.

We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Managers at the Agnes unit told us that the average length of stay varied from two weeks to about two years and the longest staying patient had been on the ward for about two years. Data from the manager's dashboard stated that the average length of stay over the previous six months varied from 4.5 days in August 2018 to 157 days in October 2018. This data varied from the data provided by the trust below, prior to inspection.

Ward name	Average length of stay range (1 July 2017 – 30 June 2018) (current inspection)
1 The Grange	4 - 8
3 Rubicon Close	6 - 9
Agnes Unit Pod 1	672 - 672
Agnes Unit Pod 2	23 - 471
Agnes Unit Pod 3	166 - 1882
Gillivers	5 - 7

Staff arranged patient discharges to ensure they took place at an appropriate time of day.

Managers told us they could refer to a psychiatric intensive care unit (PICU) within the trust when necessary. Now the trust had opened a female PICU, managers did not have to seek an out-of-area placement when a female patient needed this facility.

This core service reported no out area placements between 1 July 2017 and 30 June 2018.

This core service reported no readmissions within 28 days between 1 July 2017 and 30 June 2018.

Discharge and transfers of care

Between 1 July 2017 and 30 June 2018 there were 12 discharges within this core service (Agnes Unit only). This amounts to <1% of the total discharges from the trust overall (5,289).

Across the 12 month period there was one (8%) delayed discharge from this core service in August 2017.

It is not possible to compare this data to the previous inspection.

The Agnes unit employed a discharge co-ordinator who liaised with professionals and families to ensure discharges were planned and patients were discharged in the most appropriate way. We attended one community treatment review which was person centred, compassionate and discharge focused. The meeting identified progress and future plans, working in partnership with the patient, leading to positive feedback from the panel.

There was currently one delayed discharge, due to difficulties in commissioning an appropriate placement. Managers and staff told us that worked hard to keep the number of delayed discharges to a minimum. The service had regular care and treatment reviews, updated timelines for each patient weekly and provided a four-weekly update to the transforming care team. However, two staff told us that patient discharges raised questions about the safety and appropriateness of placements and about the impact this had had on staff.

Staff supported moves to placements and liaised with community teams to ensure a smooth transition. Staff supported patients when they needed treatment for physical health issues at another hospital.

Staff arranged discharges for patients in short breaks services as part of the planning process. On occasions patients stayed longer than planned due to family circumstances.

The trust had not provided referrals data for inpatient services.

Facilities that promote comfort, dignity and privacy

At the Agnes unit, patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Patients personalised their own rooms when they wanted to and had secure places to store their possessions.

At 3 Rubicon Close, there was one bedroom which contained two beds. Staff told us this was due for collection and that patients did share bedrooms at any time. There was also an additional bed and bedside cabinet in the lounge area. Staff told us this was so patients who had severe physical disabilities could move and stretch without having to return to their bedroom. Staff stated that patients did not sleep in this room overnight. The communal lounge contained a bank of staff lockers. Staff told us there was nowhere else to put them.

The Agnes unit had access to a full range of rooms to support treatment and care. There was a separate activity area where patients went to participate in pottery and ceramics, cooking, a variety of groups and other therapeutic activities. The unit had a well organised clinic room where staff examined patients and smaller rooms where staff could speak to patients privately. However, some of the nursing offices, for example on pod two, were very small and were adapted from a cupboard. This room was used to store medication and care files and could support a handover meeting which was held in the staff kitchen. The staff kitchen contained information on the walls about patients' needs, including some personal information. This was not visible outside the room.

The short stay services did not have a full range of room to promote treatment and care. The services did not contain rooms for staff to speak to patients or examine them. Any therapeutic work took place in communal areas or patients' bedrooms.

The Agnes unit had places both on and off the wards where patients could meet with visitors. There were no areas at the short breaks services where families could speak with patients privately apart from their bedrooms.

Patients could use mobile phones on the Agnes unit to contact their relatives or friends, subject to risk assessment. There was no phone available for patients to use. At the short stay services, if a patient needed to make a private call, they would be able to use the office phone.

Patients at the Agnes unit had access to outside space at the Agnes unit with staff supervision. Staff told us they had enough staff to ensure patients could access outside areas when they wanted.

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the locations scored higher than similar trusts. We spoke to four patients about the food. One was positive, one negative and two were neutral.

Patients had access to drinks and snacks. There were set times for snacks but patients could request drinks at any time.

Site name	Core service(s) provided	Ward food
Agnes Centre	MH – Wards for people with learning disabilities or autism	100%
Trust overall		**94.9%**
England average (mental health and learning disabilities)		**91.5%**

Patients' engagement with the wider community

At the Agnes unit, patients accessed the wider community, usually with staff support, within the service's leave arrangements. Staff encouraged patients to maintain contact with people that mattered to them. Staff supported patients and carers to maintain contact. Carers were involved in their relatives care and invited to multi-disciplinary meetings.

Meeting the needs of all people who use the service

Information was provided in an accessible format and was displayed across the services. There were posters on the ward and in information booklets. These were written in several different languages offering information on request. This included information on how to complain, an information booklet about the Agnes unit, information on treatments, access to advocacy and so on. Information was in simple language and in an easy-read form.

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

The Agnes unit was on the ground floor and was accessible to patient and visitors with mobility issues. The trust has installed ramps where needed and the ward environment allowed easy access for wheelchairs, including doors and wide corridors.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups.

At the Agnes unit, staff ensured that patients had access to appropriate spiritual support. The unit had a multi-faith room with ritual washing facilities and resource materials for different faiths.

Listening to and learning from concerns and complaints

Patients knew how to make a complaint on the Agnes unit. We interviewed seven patients on the Agnes unit and four stated they knew how to make a complaint. Managers and staff told us they rarely received complaints but would support patients where needed.

Staff told us they would protect patients from discrimination and abuse and raise this as a safeguarding. Staff were aware of the complaints procedure and felt confident to handle them appropriately.

There were systems to ensure staff received feedback from complaints but there were no examples of this taking place.

This core service received one complaint between 1 July 2017 and 30 June 2018 which was subsequently withdrawn.
This core service received three compliments during the last 12 months from 1 July 2017 and 30 June 2018 which accounted for <1% of all compliments received by the trust as a whole.

Is the service well-led?

Leadership

Managers at the Agnes unit had a good understanding of the services they managed. The ward manager was frequently on the unit and available to staff. Staff knew who were the senior managers in the service and they visited the ward on occasions. The manager of the short breaks services had only recently come into post and was getting to know the services they managed.

Staff felt that leadership opportunities were not always available.

Vision and strategy

The trust's values were respect, integrity, compassion and trust. Some staff were aware of these and felt they were reflected in the work they did.

Team objectives were not formally based on these values at the Agnes unit. The team worked towards providing high quality care for patients but did not have a shared and understood vision about the trust as a whole.

Culture

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

However, three staff told us there was some tension between different parts of the service in relation to work capacity and timescales. Three staff told us that on occasions issues had been escalated to senior managed without being discussed with practitioners. Staff raised this with their manager and discussed this as a bullying issue.

Managers and staff at the short breaks services said they felt isolated from the trust and from each other with little sense of a shared identity.

Managers discussed performance issues with staff in supervision.

Staff sickness at the Agnes unit ranged from 2% in July 2018 to 9% in April 2018. Between 01 April and 30 September 2018, the average sickness was 7%, slightly above the trust average. At the short breaks services had a sickness rate of 10% between 1 June 2018 and 31 May 2018.

Staff had access to the trust's occupational health service where needed.

During the reporting period there was one case where staff have been either suspended, placed under supervision or were moved to a different ward.

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

Ward name	Suspended	Under supervision	Ward move	Total
Agnes Unit Pod 2	1	0	0	1
Core service total	1	**0**	**0**	1

Governance

There was a clear framework of what must be discussed 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 with multi-disciplinary and registered staff. However, we found managers did not have a robust system to ensure that learning was shared and discussed with all staff, including healthcare assistants.

The trust had not ensured that wards for people with a learning disability or autism were compliant with mixed sex accommodation guidelines or that they had reported breaches of this guidance. The trust was in breach of this guidance but these breaches were unavoidable to meet the needs of the people and families that used this service. Carers felt passionate about the accommodation being mixed sex.

Managers had not ensured that seclusion took place in accordance with the Mental Health Act code of practice and that seclusion paperwork was completed correctly.

Managers did not have oversight of some issues affecting the short breaks services, for example medication errors and infection control issues. Staff took part in clinical audits, for example on medication and patient notes.

There were good inter-agency working arrangements in place to support the needs of patients. Multidisciplinary team members worked with their community colleagues to ensure smooth transitions and discharges.

Management of risk, issues and performance

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required. Staff could add things the risk register through the ward manager.

Information management

Both the Agnes unit and the short breaks services had access to information governance systems to measure the performance of the team. Managers received dashboard information for a range of measures, including mandatory training, safeguarding referrals and concerns, supervision, appraisals, sickness, vacancies, bed occupancy and average length of stay. The information was easy to understand and showed trends over the past 6 months. Managers used this information to ensure they were aware of any issues in relation to the running of the team and take steps to address these. Managers used of this information regularly and had knowledge of how the team was performing. The trust could not provide information relating to their staffing data on sickness, vacancies and turnover. However, managers at the Agnes unit had access to this information through the inpatient dashboard.

Information governance systems maintained the confidentiality of patient records.

Staff had access to equipment and information technology to do their work. The patient electronic information system was easy to use and staff found it easy to input information.

Staff made applications to external bodies when required, such as safeguarding and Deprivation of Liberty Safeguards.

Engagement

Managers kept staff and patients up to date about the service by bulletins on notice boards and meetings. Staff kept carers up to date with service developments.

We did not find clear systems in place to gather feedback from patients and carers and use it to make improvements to the service.

Patients and carers did not participate in decision making about the service.

Learning, continuous improvement and innovation

The Agnes unit was accredited to the Quality Network for Learning Disability Services.

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 table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
Quality Network for Inpatient Learning Disability Services (QNLD)	Agnes Unit	March 2017

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	CAMHS Community Based Services - County multidisciplinary out patients	n/a	Not given
HQ Bridge Park Plaza	CAMHS Community Based Services - City multidisciplinary out patients	n/a	Not given
HQ Bridge Park Plaza	CAMHS Community Based Services -	n/a	Not given

	Eating Disorders Team		
HQ Bridge Park Plaza	CAMHS Crisis Resolution and Home Treatment Service for Young People	n/a	Not given
HQ Bridge Park Plaza	CAMHS Learning Disabilities Services	n/a	Not given
HQ Bridge Park Plaza	CAMHS Primary Mental Health Service	n/a	Not given
HQ Bridge Park Plaza	CAMHS Young Persons Team	n/a	Not given
HQ Bridge Park Plaza	PIER Services-Children	n/a	Not given

Is the service safe?

Safe and clean environment

The trust had not fully ensured since our 2017 inspection that clinical premises where patients received care were clean, well equipped, well furnished, well maintained and fit for purpose. For example, the Westcotes House building was old and not built for purpose. Four staff expressed concerns with us about this. There was approximately a one metre length crack both sides of an archway wall near a ceiling. Staff had reported the matter to maintenance staff but they had to wait five weeks for a civil engineer to further assess. During our inspection, we raised our concerns to the trust. The trust informed us that the engineer had since assessed it as subsidence but assured the service that the building was safe and the trust was investigating how best to resolve this. In addition, several window handles at Westcotes House had decayed making them difficult to open.

Staff were not always reducing the risk of infection spreading as they had not ensured that toy and clinic cleaning rotas were available or routinely completed across all sites. Fabric beanbags in Westcotes House's group room had stains and it was unclear who had the responsibility for cleaning them. Loughborough House clinic room had carpet flooring which was not as easy to keep clean and there were no handwashing facilities or gloves for staff in the room. Cleaning records were not available as the as the staff member who kept them was not at work the day we visited. There was not a waste bin to dispose of soiled nappies at Loughborough house reception toilet.

The trust had not fitted interview rooms with alarms. However, the trust had ensured that staff had access to personal alarms and there were staff on site to respond to alarms. The trust's health and safety inspection 3 July 2018 had identified that the alarms provided at the Valentine Centre were not loud enough and not tested and they were exploring other options. The trust had still not ensured there were vision panels in the family therapy room door. However, staff said patients would not be unsupervised and there were camera facilities in the room for other staff to observe sessions.

Staff did not have access to emergency medicines and equipment bags across sites. However, risks were reduced for this patient group as they were not usually prescribed antipsychotic medication. Physical healthcare staff were located nearby.

Trust staff said they were exploring other office alternatives as Westcotes building although there was no timeframe for a move.

Staff completed regular risk assessments of the care environment and maintain other equipment, this included portable appliance testing. The trust had systems in place to keep other areas clean and tidy.

Safe staffing

Substantive – All filled allocated and funded posts.

Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 30 June 2018	188.0	N/A
Total number of substantive staff leavers	1 July 2017 – 30 June 2018	15.0	N/A
Average WTE* leavers over 12 months (%)	1 July 2017 – 30 June 2018	8%	≤ 10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 30 June 2018	-0.2	N/A
Total vacancies overall (%)	At 30 June 2018	0%	7%
Total permanent staff sickness overall (%)	Most recent month (At 31 May 2018)	7%	≤ 5%
	1 June 2017 – 31 May 2018	6%	≤ 5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 30 June 2018	Not given	N/A
Establishment levels nursing assistants (WTE*)	At 30 June 2018	Not given	N/A
Number of vacancies, qualified nurses (WTE*)	At 30 June 2018	Not given	N/A
Number of vacancies nursing assistants (WTE*)	At 30 June 2018	Not given	N/A
Qualified nurse vacancy rate	At 30 June 2018	Not given	N/A
Nursing assistant vacancy rate	At 30 June 2018	Not given	N/A
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (Qualified Nurses)	1 July 2017 – 30 June 2018	11	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 July 2017 – 30 June 2018	610	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 July 2017 – 30 June 2018	184	N/A

Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	10	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	0	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	0	N/A

*WholeTime Equivalent

This core service reported a vacancy rate for all staff of less than -1% as of 30 June 2018.

Across the 12 month reporting period vacancy rates for all staff types ranged between 6% (July 2017) and -4% (March 2018).

Caveat: The trust has been unable to provide a breakdown of vacancy data by staff type.

	Registered nurses			Health care assistants			Overall staff figures		
Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Targeted Cluster 2 CAMHS City admin	n/a	n/a	n/a	n/a	n/a	n/a	3.7	19.9	19%
CAMHS County OPD	n/a	n/a	n/a	n/a	n/a	n/a	5.7	37.2	15%
CAMHS LD Outreach team	n/a	n/a	n/a	n/a	n/a	n/a	0.6	8.2	7%
Learning Disabilities	n/a	n/a	n/a	n/a	n/a	n/a	0.3	8.9	3%
CAMHS on-call service	n/a	n/a	n/a	n/a	n/a	n/a	0.0	21.2	0%
CAMHS ED Team	n/a	n/a	n/a	n/a	n/a	n/a	-0.4	13.5	-3%
Young Peoples Team	n/a	n/a	n/a	n/a	n/a	n/a	-0.5	10.8	-5%
Primary Ment Healthcare Worker	n/a	n/a	n/a	n/a	n/a	n/a	-1.3	11.5	-11%

	Registered nurses			Health care assistants			Overall staff figures		
Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Targeted Cluster 4 CAMHS County Admin	n/a	n/a	n/a	n/a	n/a	n/a	-2.3	15.7	-15%
Assistant Practitioner	n/a	n/a	n/a	n/a	n/a	n/a	-1.0	3.4	-29%
CAMHS CITY TEAM	n/a	n/a	n/a	n/a	n/a	n/a	-5.0	13.8	-37%
Core service total	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**-0.2**	**164.0**	**0%**
Trust total	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**376.3**	**3687.3**	**10%**

NB: All figures displayed are whole-time equivalents

Between 1 July 2017 and 30 June 2018, bank staff filled eleven shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 610 shifts for qualified nurses and 184 shifts were unable to be filled by either bank or agency staff.

Caveat: The trust has been unable to provide a breakdown of vacancy data by staff type.

Team	**Available shifts**	**Shifts filled by bank staff**	**Shifts filled by agency staff**	**Shifts NOT filled by bank or agency staff**
CAMHS On Call Service	n/a	11	0	2
CAMHS County OPD	n/a	0	610	182
Core service total	**n/a**	**11**	**610**	**184**
Trust Total	**n/a**	**15536**	**16726**	**9344**

***Percentage of total shifts

Between 1 July 2017 and 30 June 2018, 10 shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered no shifts and there were no shifts that were unable to be filled by either bank or agency staff.

This core service had 15 (8%) staff leavers between 1 July 2017 and 30 June 2018.

Monthly turnover ranged between 0% (August 2017, September 2017 and January 2018) and 2% (April 2018) across the 12 month reporting period.

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
CAMHS LD Outreach team	9.0	2.0	20%
CAMHS ED Team	17.0	2.0	12%
CAMHS City Team	21.0	2.0	10%
CAMHS County OPD	37.0	4.0	10%
Young Peoples Team	12.0	1.0	9%
Targeted Cluster 2 CAMHS City Admin	11.0	1.0	9%
Primary Mental Healthcare Worker	15.0	1.0	7%
Targeted Cluster 4 CAMHS County Admin	15.0	1.0	7%
CAMHS Crisis & Home Treatment	18.0	1.0	5%
Targeted Cluster 2 CAMHS LD	4.0	0.0	0%
Targeted Cluster 2 CAMHS Manager	1.0	0.0	0%
Targeted Cluster 2 CAMHS PPsych	1.0	0.0	0%
Targeted Cluster 2 CAMHS YPT	1.0	0.0	0%
Targeted Cluster 2 CAMHS City Admin	3.0	0.0	0%
Targeted Cluster 4 CAMHS PMHT	3.0	0.0	0%
CAMHS Group Work	0.0	0.0	0%
CAMHS Neurodevelopmental	5.0	0.0	0%
Learning Disabilities	10.0	0.0	0%
Assistant Practitioner	5.0	0.0	0%
Core service total	**188.0**	**15.0**	**8%**
Trust Total	**3150**	**349**	**10%**

The sickness rate for this core service was 6% between 1 June 2017 and 31 May 2018. The most recent month's data (May 2018) showed a sickness rate of 7%. This was higher than the sickness rate of 5% reported at the last inspection at 30 June 2017.

Across the 12 month reporting period, sickness rates ranged between 4% (July 2017) and 8% (November 2017) for this core service.

Team	Total % staff sickness (May 2018)	Ave % permanent staff sickness (1 June 2017 to 31 My 2018)
Assistant Practitioner	22%	13%
Targeted Cluster 2 CAMHS LD	5%	12%
Primary Mental Healthcare Worker	10%	11%
CAMHS LD Outreach team	1%	10%
Learning Disabilities	2%	7%
Targeted Cluster 2 CAMHS City Admin	9%	7%
CAMHS County OPD	7%	6%
Targeted Cluster 2 CAMHS City Admin	3%	5%
CAMHS Crisis & Home Treatment	14%	5%
CAMHS City Team	8%	5%
Targeted Cluster 4 CAMHS County Admin	2%	4%
Targeted Cluster 4 CAMHS PMHT	15%	5%
Young Peoples Team	1%	1%
CAMHS Neurodevelopmental	7%	2%
CAMHS ED Team	1%	2%
Targeted Cluster 2 CAMHS PPsych	0%	1%
Targeted Cluster 2 CAMHS Manager	0%	0%
Targeted Cluster 2 CAMHS YPT	0%	0%
CAMHS Group Work	0%	0%
Core service total	**7%**	**6%**
Trust Total	**5%**	**5%**

Medical staff

Between 1 July 2017 and 30 June 2018, no shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same time period, agency staff covered 502 shifts and there were no shifts that were unable to be filled by either bank or agency staff.

Caveat: the trust did not provided available shifts data.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
CAMHS County OPD	n/a	0	502	0
Core service total	**n/a**	**0**	**502**	**0**
Trust Total	**n/a**	**459**	**1,926**	**0**

***** Percentage of total shifts

Managers said that there were the following vacancies when we visited:

- County team: 1.4 band six mental health practitioner posts.; one consultant psychiatrist post and one band eight (a) psychologist post
- City team: two consultant psychiatrist vacancies
- Crisis team: none.

The trust had not ensured there were enough staff to meet the needs of the service. Many patients still faced long waits for assessment and treatment. Seventeen out of 35 staff (excluding managers) we spoke with raised concerns about this. Staff said this was due to having some staffing vacancies, short term and long-term sickness and parental leave. Sickness rates for county and crisis teams were above the national average of (5.7%). Examples of the impact of this included crisis team staff held on to patients longer than they had intended to help manage risks. Staff had challenges arranging urgent appointments for patients with doctors due to their availability. From June 2018-November 2018 staff had reported four incidents relating to insufficient staffing, two related to medics' availability. Between 1 July 2017 and 30 June 2018 patients or carers had made seven complaints relating to staffing, resources and appointments cancelled or missed.

Staff reported difficulties recruiting to staffing vacancies notably medical posts (which the trust had placed on their risk register). Locum staff were covering staffing vacancies across city and county teams to try and meet the shortfall and assist with covering the backlog of work. Managers had difficulties getting suitably qualified, competent, skilled and experienced staff.

However, the trust had acted to reduce the caseloads of individual staff and ensure they were more manageable. For example, they had developed a caseload complexity tool which managers and staff said they used this in staff supervision meetings. The average caseload was 25-30 for substantive staff and 40 for locum staff (as had less meetings/training to attend) and 80-120 for medical staff.

The trust had introduced an appointment booking system and job plans for staff to help maximise their staff resources available and reduce backlogs of work. They had introduced staff wellbeing days with the intent of reducing staff sickness.

Managers said they were planning to request resources to cover the shortfall by 2019/20. We saw managers had highlighted staffing risks with senior manager for example at the 'Families, young people and children's (FYPC) services division sustainability group meeting' 16 August 2018 and the child and adolescent mental health (CAMHS) improvement programme board and risk log.

Managers had made some arrangements to cover staff sickness and absence with locum staff. Managers said when we visited, there were five to six non- medical locum staff covering sickness and a backlog of work across city and county teams. Managers limited their use of bank and agency staff and requested staff who knew the service.

Managers did not have easy access to data or percentages for staff turnover rates. Trust data for June to October 2018 showed that the highest staff turnover for the county team was 21% October and the lowest was 13% in June. The highest staff turnover for the city team was 19% in August and the lowest was 9.7% in July. The latest data for October showed 18% turnover. Staff turnover was below 6% in the crisis team during this period. Data for the neurodevelopmental team showed 0% turnover for this period.

Trust data from June to October 2018 showed that the neurodevelopmental team sickness rate was over 20% during that time. In the county team, the highest rate of sickness was 19% and the lowest was 8% July. The latest data available showed 18% sickness for October. In the city team, the highest rate of sickness was 6.5% in June and the lowest was 1.9% in July 2018. The latest data available showed 2.4% for October. In the crisis team the highest rate of sickness was 6.2% in June and the lowest was 0.5% in September 2018. The latest data available showed 5.4% for October.

Managers did not have easy access to data or percentages for staff sickness rates. However, managers had access to information to track the length of time staff were off work with sickness. For example, there were 18 staff taking over 28 days off sick leave as of October 2018. Managers could explain the reasons for this.

Mandatory training

The compliance for mandatory and statutory training courses at 30 June 2018 was 90%. Of the training courses listed four failed to achieve the trust target and of those, two failed to score above 75%.

CAVEAT: The trust was unable to provide the training data in the required format and therefore the compliance has been calculated on available data.

During inspection, staff's compliance with mandatory training was above 80%. Managers had systems in place to monitor when staff attended training and had systems to prompt and remind them when they did not.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	**This core service %**	**Trust target %**	**Trust wide mandatory/ statutory training total %**
Safeguarding Adults Alert and Refer	100%	85%	88%

Training course	This core service %	Trust target %	Trust wide mandatory/ statutory training total %
Mental Health Act for Doctors	100%	85%	88%
MAPA Disengagement Update	96%	85%	95%
Conflict Resolution	96%	85%	97%
Equality, Diversity & Human Rights	96%	85%	96%
Mental Capacity Act	95%	85%	95%
Health Safety and Welfare	95%	85%	96%
Hand Hygiene	94%	85%	94%
Display Screen Equipment (DSE)	94%	85%	94%
Move and Hand Level 1	94%	85%	95%
Safeguarding Children Level 3	93%	85%	94%
Infection Prevention and Control Level 1	93%	85%	94%
Safeguarding Adults Level 1	93%	85%	95%
Safeguarding Children Level 1	93%	85%	95%
Infection Control	92%	85%	92%
Prevent WRAP	91%	85%	79%
Safeguarding Children Level 2	90%	85%	88%
Adult Immediate Life Support	89%	85%	79%
Medicine Management	89%	85%	92%
Move and Hand Level 2	88%	85%	87%
Record Keeping and Care Planning	88%	85%	92%
Mental Health Act for Nurses	88%	85%	82%
Info Governance	87%	85%	89%
Fire Safety	83%	85%	87%
MAPA Disengagement and Holding Skills - High Risk	76%	85%	83%
Adult & Paediatric Basic Life Support	63%	85%	84%
Anaphylaxis Update	46%	85%	78%
Core Service Total %	**90%**	**85%**	**91%**

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed the trust's own risk assessment and crisis plans (my safety plan) for 26 patients records we checked. Staff had updated these regularly, including after any incident, except one, which we raised for staff's attention.

Management of patient risk

The trust had developed systems for staff to follow to give a consistent approach for how they monitored and assessed risk to patients on waiting lists.

Staff used a traffic light system to grade risks with red for high, amber for medium and green for low risk for patients. There was criteria for how staff identified the level of risk. They allocated high risk patients a lead professional straight away to give support.

The trust had an ‘access team’ where a mental health practitioner and doctor reviewed referrals each day. They had developed a duty system where staff monitored patients on treatment waiting lists. Trust information showed the team were supporting 409 patients (311 were rated amber and 98 rated green).

Staff used electronic systems to notify them when a patient was due for review. Managers had a designated administrator to help monitor this.

The trust had systems for managing risks and crisis for patients out of usual working hours. Staff gave patients and carers information including, ‘*Getting help where you’re in mental health crisis’* leaflets. The trust had a specific CAMHS crisis team operating from 0800hrs - 2200hrs seven days per week for crisis assessments and 0800hrs - 2000hr for home treatment. They received referrals from CAMHS teams and other referrers. They held early morning handover meetings to review the risks for patients. Out of hours, patients and carers could contact the triage and liaison team at A&E or the all age mental health crisis and home treatment team to request support. We noted the trust had added to their risk register a potential risk of patients not receive psychiatric assessment within three hours of presenting to A&E. Out of hour’s staff could contact a CAMHS consultant psychiatrist. Additionally, staff could contact the on-call senior nurse or a CAMHS on call manager for support in an emergency.

The trust had processes for staff to follow when patients did not attend appointments. The trust had systems in place to keep staff safe when lone working with patients in the community.

However, staff had reported eight incidents from June to November 2018 relating to the management of waiting lists or staff not following trust processes for monitoring and management of risk to patients.

One carer said staff could improve their response to risk.

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 their own 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 no safeguarding referrals between 1 July 2017 and 30 June 2018. For the same time period, the trust provided safeguarding referrals for children at trust level only (374), not at core service level.

Leicestershire Partnership NHS Trust submitted details of three external case reviews commenced or published in the last 12 months (1 July 2017 to 30 June 2018) that relate to this core service.

For two serious case reviews, the trust awaited sign off from the Leicester Safeguarding Children Board regarding the recommendations for learning. For one serious case review, Leicestershire Partnership Trust services were named and involved in the case, however there was no learning or action plan identified.

Onsite findings showed that staff had completed training on how to recognise and report abuse and/or exploitation. The trust and this core service had identified leads for safeguarding children. Seventy nine percent of staff had received safeguarding supervision.

Teams did not keep details of safeguarding alerts they had made. They said this information was held centrally by the trust safeguarding team. We saw examples where staff had raised concerns with the local authority and had liaised with other agencies, including when parents did not bring their child for urgent appointments.

The trust had a policy for safeguarding children and inter agency referral guidelines. However, this did not clearly specify that CAMHS staff should report safeguarding concerns as an incident on the trust electronic incident reporting system. The trust electronic reporting system had a filter on it for staff and managers to easily identify safeguarding incidents reported. However, during our inspection no safeguarding incidents were identified for this core service. A manager said they would raise this with the trust as an error. We considered this may account for the lack of trust data received. We saw that the central trust safeguarding team staff had reported safeguarding incidents after receiving the alerts from staff, for example 22 September 2017.

Feedback to staff on safeguarding incidents was a standard team meeting agenda. However, two out of three city team minutes held minimal information about feedback and were we not assured that staff received feedback.

We had identified at our 2017 inspection a potential risk where patient's visiting the crisis team were using the same entrance and reception as adults with learning disabilities. The trust had developed a protocol for staff to manage this and reduce the risks to young people. Managers said there had not been any recent incidents and were continuing to monitor the situation and problem solve the issue.

Staff access to essential information

Staff kept detailed records of patients' care and treatment on an electronic record system. The trust had developed templates for staff use to ensure consistency of information and process. Records were clear, up-to-date and easily available to all staff providing care. The trust completed audits to check on this.

All information needed to deliver patient care was available to all relevant staff (including locum agency staff) when they needed it and in an accessible form.

CAMHS teams used a different record system to adult's teams. However, the trust had processes to exchange information between teams.

Teams had identified records champions for staff to approach with any queries and who could deliver staff training.

Medicines management

Staff did not keep or administer medication on site or in patients' own homes.

The trust had employed nurse medical prescribers in teams and they received regular supervision from medics.

However, staff had reported three incidents between June and November 2018 relating to prescriptions.

Staff reported difficulty with medics being able to have time to support the number of patients with attention deficit hyperactivity disorder (ADHD) who were prescribed medication and who needed regular monitoring of this to ensure it was effective and there were no side effects.

Track record on safety

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

Between 1 July 2017 and 30 June 2018 there were two STEIS incidents reported by this core service. Both incidents reported were for 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.

	Number of incidents reported	
Type of incident reported on STEIS	CAMHS County Team	Total
Apparent/actual/suspected self-inflicted harm	2	**2**
Total	**2**	**2**

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 2018, and since the last inspection, there had been three 'prevention of future death' reports sent to Leicestershire Partnership NHS Trust. None of these related to this core service.

On site findings showed that staff knew how to report incidents. We saw examples of where they had done this. The trust had systems to investigate incidents. Staff had access to the trust intranet to get feedback also about learning.

Managers and staff made changes to practice following incidents and feedback. For example, the crisis team had reduced the amount of medication they prescribed for patients. The city and county teams were updating the risk assessment tool they used to make it more relevant for child risks.

The trust had systems to debrief and support staff after any serious incident, for example staff had reflective practice meetings to discuss complex cases and incidents.

Staff said they also received feedback from the investigations of incidents via team meetings and bulletins. However, two out of three city team minutes held minimal information about feedback and did not always capture how managers shared feedback with staff. Bulletins on display for the

city team for staff did not always have dates when the trust had developed them, to show how current the learning was.

Is the service effective?

Assessment of needs and planning of care

We reviewed 26 patient care and treatment records on site. The trust had acted to ensure that 24 patients care plans were personalised and holistic and recovery-oriented and staff had developed a template to achieve this. Two patients were still waiting for care plans (one was waiting assessment).

Staff had completed a comprehensive mental health assessment of each patient who were receiving or awaiting treatment. They had developed care plans that met the needs identified during assessment. Staff updated care plans when necessary. The trust audited records to check they were up to date. CAMHS performance and patient tracking meeting minutes 19 November 2018 had identified that staff had ensured that 1,284 care plans were completed. However, 20 care plans were not present and 352 care plans for city, county and crisis teams were out of date.

We found that staff had considered patients physical health needs for example relating to diabetes or an eating disorder and we fond examples where staff were monitoring their height and weight. However, staff did not routinely or annually assess patients' physical health needs and instead relied on the patients' GP to do so. A trust care records audit showed 77% of patients in October 2018 had their physical health assessed. A staff member in the crisis team said they carried out baseline checks and had requested blood tests for patients if they were on anti-psychotic medication. The trust had information available for patients and carers about their 'Healthy together 'public health programme. A manager said staff were considering how they could gain a baseline physical health check for patients in their notes and if staff should complete them at the patient's initial assessment.

Best practice in treatment and care

This core service participated in five clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
CPA & Non-CPA Case-note re-audit (1299)	Bradgate MHU Forensics (Community & IP) Rehab wards CAMHS LD Liaison Psychiatry AMH Outpatients LD Inpatient & Community Psychological Therapies	MH - Specialist community mental health services for children and young people.	Clinical	9 April 2018	Create a poster for individual wards with ward results and key actions for the ward. - Bradgate MHU Improve the process for recording CPA reviews onto Rio - Speak with Ian Maslin about the potential for functionality training within the teams - Bradgate MHU Add a section in the Rio out-patient letter care plan template where this can be documented - AMH

					Outpatients Develop a new hard copy of the care plan template for the team which can be scanned into Rio. Liaison Psychiatry During clinical supervision a review of patient notes will be included - LD Further actions incorporated into the Trust action plan concerning CPA
Patients on CPA: Communication with General Practitioners (1480)	All community mental health services	MH - Specialist community mental health services for children and young people.	Clinical	11 April 2018	None
Adherence to shared care agreements with primary care re-audit (1517)	CAMHS Outpatients MHSOP Outpatients PIER General Adult LD	MH - Specialist community mental health services for children and young people.	Clinical	25 April 2018	Trust to identify a resource to ensure that completed SCAs are uploaded to Rio with confirmation that they have been sent to GP
Quality Standards for Community CAMHS (1552)	Community CAMHS	MH - Specialist community mental health services for children and young people.	Clinical	21 December 2017	An updated induction plan to be implemented by the lead Consultant and new Matron for CAMHS Circulate the relevant elements of the updated induction plan to current substantive staff members along with an email explanation about the record keeping standards Audit results and action plan to be discussed with staff at team meetings and via supervision Weekly monitoring to continue in the City, County West and County

					east teams with results collated and reported on monthly
CAMHS Time-Limited Psychoanalytic Psychotherapy (1603)	CAMHS Psychotherapy Team	MH - Specialist community mental health services for children and young people.	Clinical	12 April 2018	Identify which ROMS should be used and at which measurement points Work with colleagues within CAMHS to ensure appropriate referrals are received within CAMHS Distribute this report to LPT all age transformation group to assist in improving integration of transitions from CAMHS to AMH

Our onsite findings showed that staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with National Institute for Health and Care Excellence guidance. These included, for example cognitive behavioural therapy and family therapy.

Staff used recognised rating scales and other approaches to rate severity and to monitor outcomes of care and treatment. For example, staff used a recognised risk assessment tool such as the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA).

Staff used technology to support patients effectively for example, giving online access to therapies and other resources.

Staff routinely undertook outcome measures such as the 'revised children's anxiety and depression scale' with patients to use to inform progress. Staff participated in clinical audit, such as for care programme approach (CPA) and non-CPA case-notes.

Skilled staff to deliver care

The trust's target rate for appraisal compliance was 80%. As at 30 June 2018, the overall appraisal rates for non-medical staff within this core service was 90%.

The teams failing to achieve the trust's appraisal target were CAMHS LD Outreach team with an appraisal rate of 78%, CAMHS City Team at 74% and Young Peoples Team at 64%.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 92% reported at the last inspection.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Primary Ment Healthcare Worker	14	14	100%

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Targeted Cluster 2 CAMHS LD	4	4	100%
Targeted Cluster 2 CAMHS Manager	1	1	100%
Targeted Cluster 2 CAMHS PPsych	1	1	100%
Targeted Cluster 2 CAMHS YPT	1	1	100%
Targeted Cluster 2 CAMHS City Admin	3	3	100%
Targeted Cluster 4 CAMHS County Admin	15	15	100%
Targeted Cluster 4 CAMHS PMHT	3	3	100%
CAMHS Neurodevelopmental	4	4	100%
Learning Disabilities	9	9	100%
CAMHS ED Team	16	16	100%
Assistant Practitioner	5	5	100%
CAMHS Crisis & Home Treatment	18	17	94%
Targeted Cluster 2 CAMHS City Admin	11	10	91%
CAMHS County OPD	31	26	84%
CAMHS LD Outreach team	9	7	78%
CAMHS City Team	19	14	74%
Young Peoples Team	11	7	64%
Core service total	**175**	**157**	**90%**
Trust wide	**4957**	**4425**	**89%**

The trust did not provide appraisals data for medical staff.

The trust's measure of clinical supervision data was the number of staff who had undertaken at least one clinical supervision in the last three months divided by the number of staff who required clinical supervision.

Between 1 July 2017 and 30 June 2018, the average rate across all eight teams in this core service was 77% of the trust's target.

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

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
CAMHS Neurodevelopmental	29	28	97%
Learning Disabilities	84	74	88%
CAMHS ED Team	68	57	84%
CAMHS County OPD	154	128	83%

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Young Peoples Team	69	55	80%
CAMHS LD Outreach team	86	68	79%
CAMHS City Team	101	64	63%
CAMHS Crisis & Home Treatment	125	79	63%
Core service total	**716**	**553**	**77%**
Trust Total	**21,454**	**15868**	**74%**

On site information showed the team included, or had access to, a range of specialists. These included doctors, nurses, occupational therapists, clinical psychologists, pharmacists, speech and language therapists. Staff said they had tried to recruit social workers to mental health practitioner posts without much success. They had employed some locum staff.

Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. However, the crisis team had given feedback that A&E liaison triage staff mainly had experience of working with adults and not CAMHS patients. Their team offered staff opportunities to work with them to improve their knowledge and skills.

Managers provided new staff with appropriate induction, this included giving staff greater shadowing opportunities.

Managers ensured that staff had access to regular team meetings Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers ensured that staff received the necessary specialist training for their roles. For example, autism diagnostic observation schedule and domestic and sexual violence training. Managers said sometimes staff might not receive funding for external training, but the trust may agree that staff member could be given time to complete it.

Managers dealt with poor staff performance promptly and effectively. They gave staff an appraisal of their work performance. As of October 2018, the percentage of staff that had had an appraisal was 91%. Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development). Staff additionally said they had access to reflective practice and case discussions and they recorded notes for this in patients notes. The percentage of staff that received regular supervision was 79% at October 2018.

Multidisciplinary and interagency team work

Staff had close links with primary care, social services, education, paediatrics, police, and other community teams including adult services.

Staff engaged in activities and initiatives to improve joint-working and liaison. CAMHS staff had effective working relationships, including good handovers, with other teams within the organisation (for example, community to crisis team).

Staff held regular and effective multidisciplinary team meetings. Although at Westcotes House some staff said it was difficult to get to meetings due to other work pressures.

Staff shared information about patients at effective handover meetings within the team (for example, when staff went on holiday or between shifts for teams that worked out of normal hours).

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

As of 30 June 2018, 88% of nurses and 100% of doctors had received training in the Mental Health Act. The trust stated that this training was mandatory and renewed every three years.

The Mental Health Act training compliance reported at the last inspection was 89% for nurses and 100% for doctors.

On site findings showed as of October 2018, 84% of staff had received training in the Mental Health Act 1983/2007.

Staff advised there were not currently any patients on a community treatment order or requiring a social supervision under Section 41 of the Mental Health Act in this core service.

Staff knew who to contact for information about the Mental Health Act.

Good practice in applying the Mental Capacity Act

As of 30 June 2018, 95% of the workforce had received training in the Mental Capacity Act. The trust stated that this training was mandatory and renewed every three years.

The training compliance reported during this inspection was lower than the 97% reported at the last inspection.

On site findings showed as of October 2018, 91% of staff had received training in the Mental Capacity Act 2005.

The trust had taken action after our last inspection, to ensure that staff recorded patients' mental capacity assessments of patients as relevant, as we saw that staff had considered patients capacity in the 26 records we checked.

The trust audited care records to check on this. The audit showed that staff documented patients' capacity between 54% and 76% of the time. It showed staff had documented 67% of patients' capacity assessment where capacity was in doubt for September 2018 and had documented 100% for October and November 2018. However, the audit had identified staff were not always documenting patients or carer's consent to treatment. Staff had documented their consent in 50% of records in September; 81% in October and 54% in November 2018.

The provider had a policy on the Mental Capacity Act. Staff were aware of the policy and had access to it. Staff knew where to get advice from within the provider regarding the Mental Capacity Act.

Staff had considered Gillick competence (a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge). They had also considered the application of the Mental Capacity Act to young people (16 and over).

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Two patients and 18 of 24 carers we spoke with, gave positive feedback about staff, stating they treated them with kindness dignity and respect. Six carers gave negative feedback stating staff could be more responsive.

Staff involved patients and carers in the setting of relevant goals and in the regular reviewing of goals, progress and outcomes.

Staff ensured that personal information about patients was kept confidential unless this is detrimental to their care and taking into consideration relevant guidelines such as Gillick competency.

Involvement in care

Staff supported patients to understand and manage their care, treatment or condition.

Staff directed patients to other services when appropriate and, if required, supported them to access those services.

Patients said staff treated them well and behaved appropriately towards them.

Staff understood the individual needs of patients.

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

Staff maintained the confidentiality of information about patients.

Involvement of patients

The trust had acted to involve patients in their care plans and staff offered patients a copy of their care plan. The trust audited care records to check that staff had involved patients and that care plans had a recovery focus. It showed positive results with 91% compliance in September and for October and 92% for November 2018.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties.

Staff enabled patients to give feedback on the service they received (for example, via surveys). Family and friends test results for October 2018 showed 100% would recommend service to others. Westcotes staff were involving patients in designing a Christmas card for the service.

Staff ensured that patients could access advocacy.

However, in one instance staff had not sent out a patient's care plan for four weeks. Staff acted to address this when we raised it with them.

Involvement of families and carers

Staff involved carers in assessment, treatment and care planning. Where appropriate, staff informed and involved families and carers and provided them with support when needed.

Staff enabled carers to give feedback on the service they received (for example, via surveys).

Staff gave carers information about how to access a carer's assessment.

Is the service responsive?

Access and waiting times

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

Name of hospital	Service Type	Days from referral to initial assessment		Days from assessment to treatment	
		Target	Actual (median)	Target	Actual (median)
HQ Bridge Park Plaza	CAMHS - Bed Management Team	No Target	0	no target	0
HQ Bridge Park Plaza	CAMHS Crisis and Home Treatment	24 Hours	2	no target	3
HQ Bridge Park Plaza	CAMHS Crisis and Home Treatment	No Target	2	no target	3
HQ Bridge Park Plaza	CAMHS Crisis and Home Treatment	7 Days	6	no target	2
HQ Bridge Park Plaza	CAMHS - Eating Disorders	No Target	15	no target	15
HQ Bridge Park Plaza	CAMHS - Young Peoples Team	No Target	38	no target	29
HQ Bridge Park Plaza	CAMHS - Learning Disability Service	No Target	40	no target	20
HQ Bridge Park Plaza	CAMHS Paediatric Psychology	No Target	47	no target	62
HQ Bridge Park Plaza	CAMHS Access Team	No Target	58	no target	22
HQ Bridge Park Plaza	CAMHS- Outpatient & Community	No Target	78	no target	32
HQ Bridge Park Plaza	CAMHS Primary Mental Health Contract	No Target	92	no target	26

On site findings showed that since our 2017 and previous inspections, the trust had not taken sufficient action to ensure that all patients received the service they needed in a timely way. We found a number of patients were waiting longer than expected for assessment and treatment. Staff could not always respond as quickly as they wanted to patient referrals due to a lack of resources due to staff sickness and vacancies.

As of 19 November 2018, 'patient tracking list' trust data showed, 498 patients were waiting for a routine assessment at city or county teams, 136 patients were waiting over 30 weeks across services for assessment. There were 969 patients waiting for treatment 654 for county and 315 for the city team, this was an increase from our last inspection in 2017 (945); of these approximately 230 patients were waiting 1-2 years for treatment. Fourteen of 24 carers we spoke with, said there were difficulties accessing the service and they had to wait a long time.

Managers said the crisis team was not always able to meet their commissioned target to telephone patients within two hours and assess them within 24 hours. This was confirmed in 'Families, Young People and Children's (FYPC) Services Division Sustainability Group Meeting' minutes 18th October 2018. The crisis team operated a seven-day service from 08:00 to 22:00

hours and worked with patients for up to six weeks. They said sometimes this was because patients or carers were not available when they telephoned or the patient or carer might choose an appointment outside of the timeframe. Staff did not immediately record when they had seen the patient so the time was not 'stop clocked'. The manager had identified weekly time to review this and make improvements. Following our 2017 inspection and with reference to a prevention of future death report, staff were collecting data to assess how many patients required home treatment and how many patients needed longer term work.

Staff including managers told us there was a 34 week wait for patients with 'medium' and 'low' risks requiring a 'routine' assessment. They said the trust was meeting their target of assessing 'urgent' patients within four weeks, but would breach their commissioned target for staff assessing 'routine' patients within 13 weeks. We requested further information from the trust about any breaches of commissioned waiting times and they did not provide this information. However, Families, Young People and Children's (FYPC) Services Division Sustainability Group Meeting' minutes 18th October 2018 indicated the trust had not met both targets at that time. September 2018 minutes showed the trust had not met their commissioned targets for June to August 2018. This indicated that the trust's ability to meet these targets fluctuated. The trust had added this risk to their service risk register.

The trust did not have commissioned targets when patients should receive treatment. There are no specific national standards for waiting times for CAMHS patients. However, under the NHS constitution no patient should wait more than 18 weeks for any treatment. The service was not meeting this target with a waiting time of 34 weeks.

Managers said there were challenges accessing inpatient beds for patients particularly psychiatric intensive care or secure units, which were out of area. We found an example were one patient waited 11 days before trust staff found an appropriate hospital bed. This was out of area over 50 miles away, which posed challenges for the patient to keep in contact with family or friends. Managers said that the trust was planning to open a new CAMHS inpatient unit by 2020 to reduce these challenges.

However, the trust had made some limited steps to try and make changes to their service and decrease waiting times. These included, undertaking a 'demand capacity' review to assess their current resources and staff workload to improve pathways and processes for patients. The trust had set up fortnightly 'patient tracking list' meetings. Minutes from these meetings showed staff monitored the number of patients waiting for services and the length of time. Managers said patients were on different lists waiting for treatment. It may be that some patients were receiving treatment for one matter and awaiting treatment for another. They had moved some staff to help reduce treatment times following our last inspection. We saw patient waiting times had decreased, for example in August 2018 there had been 843 patients on the county waiting list for treatment.

Staff worked with all potential referrers to ensure referrals were appropriate, timely and co-ordinated. Staff gave a rough estimate of 70% of referrals being appropriate for their service. The service had criteria to describe which patients they would offer services to. The trust had set up an 'access team' for staff to triage referrals and assess patients, as appropriate. Staff were triaging patient referrals usually the same day. The day we visited the team had received 17 new referrals. Staff prioritised patients at high risk to be assessed first. The trust paid staff to work extra hours in the evenings and Saturdays, if they wanted, to help reduce the backlog of work.

Staff offered a range of interventions according to individual and family needs.

The trust had developed a pathway and process for staff to follow to meet the national children and young people transitions commissioning for quality and innovation.

The facilities promote comfort, dignity and privacy

Westcotes House reception was not fully private and confidential as visitors could overhear receptionist conversations and trust information. The trust had reviewed noise levels at Westcotes House to determine if soundproofing was required in clinical rooms and had completed a risk assessment. During our visit we could not specifically hear confidential conversations outside rooms where staff met patients or carers.

The service had a range of rooms and equipment to help support treatment and care (for example, a clinic room to examine patients, sufficient chairs in the waiting area, therapy rooms). Staff across sites said there could be difficulties booking rooms for appointments. However, the trust had considered this are part of the service demand capacity review as part of their review of resources.

Westcotes staff had gained money from the trust's charity and had worked with another local charity to 'brighten lives as well as walls'. They had decorated the building with a range of stimulating, fun and friendly artworks in differing shapes, sizes and colours. They worked with patients to create a range of pieces loosely themed around 'diversity' and difference. They held a formal celebration event for this work and invited senior trust staff, stakeholders and the CQC inspection team. This had helped create a welcoming and non- threatening environment for patients and carers.

Westcotes and Valentine centre staff had also displayed other patient's artwork and meaningful and inspirational quotes to promote patient's recovery. These included, 'quote of the week' and '# I feel better when…' posters. Loughborough House waiting room had 'mindful 'colouring books to complete whilst waiting.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities for education and work, and supported patients as relevant. Staff said they had good links with schools, colleges or universities. We observed staff liaising with schools to support patients.

The trust also supported patients as relevant to access their 'recovery college' which provided a range of courses and workshops to develop patient's skills, understand mental health, identify goals and support their access to opportunities.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff helped patients to stay in contact with families and carers as relevant.

Staff supported patients to access an early intervention service. This is made up of various organisations working to deliver support to patients with low to moderate mental health needs who do not meet CAMHS team's referral criteria.

Meeting the needs of all people who use the service

The trust was not meeting the needs of patients with neurodevelopment issues in a timely way as patients often faced the longest waits for a service. As of 19 November 2018, 454 patients with attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) were waiting for either further specialist assessment or treatment, 161 patients had been waiting one to two

years. The crisis team said that approximately 50% of patients on their caseload had ASD, which indicated they needed a crisis service.

However, managers stated they were attempting to reduce the waits for patients with neurodevelopment needs. This included reviewing the pathway (for patients under and over 12 years of age) and service with commissioners. They said challenges included not all GPs being involved in 'shared care' therefore it had affected prescribing and managing medicines. The trust had identified staff for this service and had recruited a paediatrician to start this work on the pathway. Westcotes held a clinic on Fridays for patients with ADHD needs.

Despite small attempts to reduce waiting lists, these issues had been identified at previous inspections, and the trust had not taken adequate and timely action to reduce waiting lists over a number of years.

Trust staff gave limited examples of how they were meeting the diverse needs of patients. This was despite Leicester black and minority ethnic population being significantly greater (49.5%) when compared against the England average. (Joint Strategic Needs Assessment). Twenty out of 26 patients' records checked held limited information about patients protected characteristics for example race, religion or belief or sexual orientation.

The trust had carried out some analysis to identify that black British African children and were underrepresented in service and the reasons why that might be. Staff made information leaflets available in languages spoken by patients. Managers ensured that staff and patients had easy access to interpreters and/or signers and had additional time for appointments.

Staff ensured that patients could obtain information on treatments, local services and patients' rights. The information provided was in a form accessible to the particular patient group, for example, in easy-read form such as picture cards for people where they had difficulties reading or writing or for patients who were selectively mute. They gave information on how patients could access information on the internet such as programmes for example, to support mindfulness and sleep.

The service made adjustments for patients with mobility difficulties for example, by ensuring wheelchair access to premises. Staff could offer flexibility for appointment times and venues.

A Leicester City joint Ofsted and Care Quality Commission (CQC) local area SEND inspection took place in May 2018. The trust had identified leads for SEND who liaised with other agencies about the needs of this group.

The trust has a young people's team which worked with vulnerable young people in care and those who are involved with the youth offending service. The trust had a specialist perinatal outreach mental health service. They had other teams to support patients with an eating disorder or with psychosis.

Listening to and learning from concerns and complaints

This core service received 56 complaints between 1 July 2017 and 30 June 2018. Seven of these were fully upheld, 21 were partially upheld and 24 were not upheld. None were referred to the Ombudsman.

Complaint subject	Fully upheld	Partially upheld	Under Investigation	Not upheld	Withdrawn	Total Complaints
Patient Care	4	8	2	11	0	25
Appointments	1	3	0	6	0	10
Communications	1	4	0	3	0	8
Clinical	0	4	0	1	0	5
Values And Behaviours (Staff)	1	1	0	2	0	4
Privacy, Dignity And Wellbeing	0	1	0	1	0	2
Trust Administration/Policies/Procedures	0	0	0	0	1	1
Patient Safety	0	0	0	0	1	1
Core Service total	**7**	**21**	**2**	**24**	**2**	**56**

This core service received 32 compliments during the last 12 months from 1 July 2017 and 30 June 2018 which accounted for 3% of all compliments received by the trust as a whole (1240).

On site findings showed there were 16 complaints from July to November 2018, five were upheld and four were partially upheld. Eight related to patient care; three related to appointments, two each were for communication and values and behaviours and one was for a clinical issue. It was unclear from the trust information provided how many related to complaints about waiting times. Between 1 July 2017 and 30 June 2018 patients or carers had made three complaints relating to waiting times. Four of 24 carers we spoke with said they had made complaints about the service. We saw examples of where the trust had appropriately dealt with their concerns.

Staff across sites had told us that there were numerous complaints from patients and carers about waiting times although this had reduced. Loughborough staff had displayed information to give to patients or carers if they telephoned to complain about waiting times.

Patients and carers knew how to complain or raise concerns. Staff knew how to handle complaints. They received feedback on the outcome of investigation of complaints and acted on the findings. For example, staff discussed complaints feedback at Westcotes multi-disciplinary meeting regarding the importance of involving and communicating patients and carers when handing over care and treatment to another team.

Staff displayed their responses to ‘you said’ patient and carer feedback in waiting areas. Examples included, Loughborough staff explained actions to make buildings less depressing and young people friendly. Again, these responses did not always have dates to show how current the feedback was.

The trust had systems to record compliments. Managers said they could improve their recording of this. We saw cards displayed at sites where patients and carers gave their thanks for the service. Some did not have dates on to show how recent they were.

Is the service well led?

Leadership

The trust had not ensured adequate higher management leadership to address all actions from our previous inspections. In particular, issues relating to governance and the management of staff resources and waiting lists still posed a risk for the service. The CQC had identified this as a risk for the service since 2015.

Managers were carrying out work to identify the needs of this service and identify what resources they had and needed. However, not all staff were aware of the timescale for the completion of this work. Not all managers could give clear timeframes or assurance for when patient's waiting times for assessment and treatment would be reduced. Staff told us they hoped waiting lists would continue to reduce in future months. Whilst we noted the trust was making changes to the service, we had concerns about the slow pace of change as patients still faced long waits for assessment and treatment.

However, most staff were complimentary about their immediate managers. There had been changes in management of teams since our last visit and the management structure was still being reviewed. Staff including managers said that since our 2017 inspection there was greater trust executive team involvement and oversight of their service. They had more confidence that changes were taking place that would improve the service.

Staff new who the leaders were, could approach them and saw them often in the service. Staff referred to being able to access executive team 'podcasts' or 'web chats' to get to know who they were and what they do.

The trust gave opportunity for leaders to develop their skills and for other staff to develop leadership skills. We saw there were opportunities for staff development including secondment opportunities.

Vision and strategy

Staff knew and understood the trust's visions and values and could describe how they applied to their work. The trust had ensured staff were working to common goals and practices.

The senior leadership team had successfully communicated the trust's visions and values to staff at all levels of the service.

Staff contributed to discussions about the service's strategy and changes to the service. For example, the CAMHS and crisis teams were updating their standard operating policy. Staff were aware and involved as relevant in the trust's, 'All age transformation for mental health and learning disabilities services'. Teams had away days to review their service and plan for the future.

Culture

During the reporting period there was one case where a member of staff has been either suspended, placed under supervision or were moved to a different team but this was not specified.

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

Team name	Suspended	Under supervision	Alternative / not specified	Total
CAMHS YPT	0	0	1	1

Team name	Suspended	Under supervision	Alternative / not specified	Total
Core service total	**0**	**0**	**1**	**1**

Most staff felt respected, supported and valued by their team and wider management. Staff including managers said there was greater trust executive team involvement and oversight of their service. They had more confidence that changes taking place would make a difference to their work and the service. However, administrative staff morale was mixed as some reported not feeling part of the clinical teams and having equal opportunities for development

Staff felt proud to work for their team and the trust. Staff could raise concerns without fear. They understood the whistle-blowing policy and who their speak up guardian was.

Teams worked well together and their manager dealt with any difficulties when they happened. Managers could identify and support staff who needed it to perform their jobs well. Managers supported staff during their appraisals and discussed career progression and development. Managers gave examples of their compassion and understanding when explaining how they supported their staff when they had been unwell. This included gaining access to occupational health and wellbeing services. Managers spoke of how they and the trust were more actively promoting staff wellbeing though events for example where staff could access mindfulness, massage or yoga. Staff had set up a choir and had time to attend. Administrative staff said they could be with therapists to confidentially discuss workplace pressures or issues

Managers said they promoted equality and diversity. The service group manager attended the trust workforce race equality group to promote equality for black and minority ethnic staff within the core service.

The trust supported their staff with access to occupational health services.

The trust recognised staff success and innovation. Staff gave us examples where either they had nominated or had been nominated for service awards.

However, the service had staff sickness rates which were above the national average for NHS Mental Health and Learning Disability NHS services (5.7%). This had further impacted on the staff's ability to give a consistent service.

Governance

The trust's governance systems had not ensured sufficient additional resources to reduce patient waiting lists for assessment and treatment and completion of their action plan following the 2017 CQC inspection. The trust had not ensured that all their governance systems were effective to ensure that premises were safe and clean as audit actions were not always completed or did not identify all risks, for example relating to infection control procedures.

Not all meeting minutes captured discussion and staff actions taken. For example, two out of three city team meeting minutes held limited information relating to how learning from incidents was shared with staff.

However, the trust had ensured that patients care plans were personalised and holistic and patients were involved in care planning

Staff attended a variety of meetings within their teams and externally. These included CAMHS improvement programme board and the specialist CAMHS improvement team meeting.

Staff gave examples of implementing recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

Managers received information about staff training, appraisal and supervision compliance and gave feedback to staff where improvements were needed.

Staff understood arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

The trust did not have sufficient oversight of the risks for this core service. We considered the trust had not taken sufficient actions to reduce the risks for example relating to patients waiting for assessment and treatment. The CQC had highlighted this risk since an inspection in 2015.

However, staff maintained and had access to the risk register either at a team or directorate level and could escalate concerns when required from a team level.

Managers said they had good support from their human resources department to manage staff sickness and recruitment. There was a specific recruitment and retention group for CAMHS.

The service had plans for emergencies, for example for adverse weather.

Information management

The trust had not ensured that all managers had access to data systems to assess and monitor risks in their services, for example waiting list times and staff sickness, despite these areas being risks for service delivery. This posed a risk for the organisation.

For example, access team staff could not easily give us data about the number of ‘high’ risk patients waiting for assessment. Data was not available for how many referrals teams received each month and the number of patients that were discharged to show throughput.

Prior to our inspection the trust had not sent us data about waiting times, despite our request. We requested further data from the trust after our site visit. However, some data provided conflicted with what we found at our site visit and therefore were not assured that the trust had systems to effectively assess, monitor and mitigate risk to patients waiting for a service. Some data was not provided such as if the trust had any commissioned targets for triage, assessment and treatment and if there were any breaches.

However, managers said their access to data had improved and they were more confident they knew who was waiting for assessment and treatment and why. A manager said there was a dedicated staff member in their service they could approach for data and fortnightly operational data meetings.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Staff notified and shared information with external organisations when necessary, seeking patient consent when required to do so.

Engagement

Staff told us there were opportunities to give feedback to make improvements to the service. For example, regarding the changes to the service. The CAMHS business manager told they had also individually met staff to gain feedback on their work as part of the demand capacity review.

Staff had access to up-to-date information about the work of the provider and the services they used for example, through the intranet, bulletins, newsletters and social media.

Directorate leaders engaged with external stakeholders, such as commissioners and the local authority

Patients and carers had opportunities to give feedback on the service by using electronic devices in reception areas.

The trust had held some patient and carer events to gain feedback on the service. For example, the trust held events in March 2018 to gain feedback on their all age transformations work. The trust had invited patients and carers in October 2018 to give feedback on care, plans discharge, estates and the CAMHS journey.

However, managers and staff acknowledged they could do more to routinely gain feedback from patients and carers to influence the service.

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 trust has reported that this core service had not been part of an accreditation scheme.

The trust gave staff some time and support to consider opportunities for improvements and innovation such as via fortnightly improvement team meetings. For example, teams were incorporating ‘iTHRIVE’ into their work. This is an integrated, person centred and needs led approach to delivering mental health services for children, young people and families which conceptualises need in four categories: ‘getting advice and signposting’; ‘getting help’; ‘getting more help’ and ‘getting risk support’.

The crisis team was a member of the East midlands CAMHS crisis network sharing practice and learning with other teams.

The trust had requested monies for a project regarding ‘adverse childhood experiences or ACE's’ that can be stressful or traumatic events.

Community-based mental health services for older people

Facts and data about this service

Location site name	Team name	Number of clinics per month	Patient group (male, female, mixed)
Evington Centre RT5KT	MHSOP In-reach Team	No clinics home visits only	Not specified
Evington Centre RT5KT	Frail Older Persons Assessment and	No clinics ward visits only	Not specified

	Liaison Service FOPALS		
Evington Centre RT5KT	Memory Services	Approximately 95 full day clinics a month	Not specified
Evington Centre RT5KT	MHSOP Unscheduled Care Team	No clinics home visits only	Not specified
HQ Bridge Park Plaza RT5Z1	Integrated Care Team	No clinics home visits only	Not specified
HQ Bridge Park Plaza RT5Z1	Planned Services (Community Mental Health Teams - MHSOP)	Approximately 217 Outpatient clinics as well as home visits	Not specified
HQ Bridge Park Plaza RT5Z1	Psychology services	N/A	Not specified

Is the service safe?

Safe and clean environment

All areas were clean and well maintained and we observed staff adhering to infection control principles including handwashing. An external agency cleaned all premises daily.

However, we found out of date needles in the clinic area. In West Leicester community mental health team, rooms where patients were seen did not have alarms and staff were not provided with alarms. Staff mitigated risk by ensuring that all patients had up to date risk assessments and staff were in visible range of the reception for help to be summoned if needed.

In City East community mental health team managers had not conducted a ligature risk assessment for areas where patients were seen. Staff mitigated against ligature risk by being present with patients in interview rooms.

Safe staffing

The trust did not provide data on staffing establishment figures. On inspection we gathered this from local managers. In the six community mental health teams inspected in this core service there were 34 full time qualified nurses and 13 full time nursing assistants. There were three full time vacancies across three teams for qualified nurses. There were no vacancies for nursing assistants.

Managers reported there had been long term sickness within certain teams, for reasons unrelated to work stress, The Melton, Rutland and Harborough team had a high staff leaver rate as multiple staff members had left due to retirement.

One medical locum consultant psychiatrist was being used in the South Leicester community mental health team due to long term sickness. Prior to this, South Leicester community mental health team had an increased waiting list and increased breaches. Managers, as a result of this, put this team on the trust risk register. Consultant psychiatrists from other teams assisted in seeing patients and managers effectively and during the inspection there was a minimal waiting list for the service.

Since the last inspection, managers had acted to reduce the caseloads of individual staff members to ensure they were more manageable. For example, they had developed a caseload complexity

tool which managers and staff said they used to allocate cases. The average caseload was 19-30 for full time staff.

Managers helped staff improve their workflow to close cases quicker through case discussions within supervisions. Managers also managed the waiting list effectively so that ineligible referrals were sent immediately to the correct team and only eligible referrals were on the waiting list.

Managers had flexibility in terms of staffing and could use agency staff if required. One long term member of agency staff was being used in City West. Managers used a proactive approach to anticipate future problems including staffing levels and staff absence. Managers encouraged staff to prepare patients prior to a planned absence or retirement for a length of time.

Definition

Substantive – All filled allocated and funded posts.

Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 30 June 2018	150.0	N/A
Total number of substantive staff leavers	1 July 2017 – 30 June 2018	13.0	N/A
Average WTE* leavers over 12 months (%)	1 July 2017 – 30 June 2018	8%	≤ 10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 30 June 2018	12.3	N/A
Total vacancies overall (%)	At 30 June 2018	9%	7%
Total permanent staff sickness overall (%)	Most recent month (At 31 May 2018)	4%	≤ 5%
	1 June 2017 – 31 May 2018	5%	≤ 5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 30 June 2018	Not given	N/A
Establishment levels nursing assistants (WTE*)	At 30 June 2018	Not given	N/A
Number of vacancies, qualified nurses (WTE*)	At 30 June 2018	Not given	N/A
Number of vacancies nursing assistants (WTE*)	At 30 June 2018	Not given	N/A
Qualified nurse vacancy rate	At 30 June 2018	Not given	N/A
Nursing assistant vacancy rate	At 30 June 2018	Not given	N/A
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (Qualified Nurses)	1 July 2017 – 30 June 2018	117	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 July 2017 – 30 June 2018	762	N/A

Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 July 2017 – 30 June 2018	75	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	0	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	0	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 July 2017 – 30 June 2018	0	N/A

*WholeTime Equivalent

This core service reported a vacancy rate for all staff of 9% as of 30 June 2018.

Across the 12 month reporting period vacancy rates for all staff types ranged between 9% (September 2017 and June 2018) and 4% (November 2017 and April 2018).

Caveat: The trust was unable to provide a breakdown of vacancy data by staff type.

	Registered nurses			Health care assistants			Overall staff figures		
Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
MHSOP Unscheduled Care Service	n/a	n/a	n/a	n/a	n/a	n/a	1.9	8.0	23%
MHSOP Community Therapy	n/a	n/a	n/a	n/a	n/a	n/a	2.6	13.6	19%
Charnwood CMHT (OP)	n/a	n/a	n/a	n/a	n/a	n/a	2.0	11.2	18%
City East CMHT Admin/Nursing	n/a	n/a	n/a	n/a	n/a	n/a	2.4	13.2	18%
MHSOP Integrated Care Team	n/a	n/a	n/a	n/a	n/a	n/a	1.0	6.0	17%
MRH CMHT	n/a	n/a	n/a	n/a	n/a	n/a	1.3	8.8	15%
S LEICS CMHT	n/a	n/a	n/a	n/a	n/a	n/a	2.0	17.2	11%
City West CMHT	n/a	n/a	n/a	n/a	n/a	n/a	0.5	11.0	4%
Psychology - Elderly	n/a	n/a	n/a	n/a	n/a	n/a	0.1	7.7	1%
Countywide Memory Service	n/a	n/a	n/a	n/a	n/a	n/a	0.1	23.8	0%

	Registered nurses			Health care assistants			Overall staff figures		
Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
HINCKLEY CMHT	n/a	n/a	n/a	n/a	n/a	n/a	-0.4	15.1	-3%
FOPALS	n/a	n/a	n/a	n/a	n/a	n/a	-1.2	4.2	-29%
Core service total	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**12.3**	**139.8**	**9%**
Trust total	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**376.3**	**3687.3**	**10%**

NB: All figures displayed are whole-time equivalents

Between 1 July 2017 and 30 June 2018, bank staff filled 117 shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 762 shifts for qualified nurses. Seventy-five shifts were unable to be filled by either bank or agency staff.

Managers informed us that vacancy rates were also higher in South Leicestershire due to several team managers retiring.

Caveat: the trust did not provide available shifts data.

Team	**Available shifts**	**Shifts filled by bank staff**	**Shifts filled by agency staff**	**Shifts NOT filled by bank or agency staff**
FOPALS	n/a	23	0	0
City East CMHT MHSOP	n/a	0	371	34
MHSOP Integrated Care Team	n/a	0	39	0
City West CMHT	n/a	52	143	12
Charnwood CMHT MHSOP	n/a	42	54	0
Melton & Rutland CMHT MHSOP	n/a	0	155	29
Core service total	n/a	**117**	**762**	**75**
Trust Total	**n/a**	**15536**	**16726**	**9344**

***Percentage of total shifts

Between 1 July 2017 and 30 June 2018, no bank or agency staff were used to cover sickness, absence or vacancy for nursing assistants.

Caveat: the trust did not provide available shifts data.

This core service had 13 (8%) staff leavers between 1 July 2017 and 30 June 2018. Managers explained that in the community mental health teams, the leaver rate was higher due to multiple staff members retiring.

Monthly turnover ranged between 0% (November 2017, December 2017 and February 2018) and 2% (January 2018) across the 12 month reporting period.

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Psychology - MHSOP	8.0	2.0	26%
Melton & Rutland CMHT MHSOP	9.0	2.0	21%
FOPALS	7.0	1.0	13%
Countywide Memory Service	28.0	3.0	12%
City West CMHT	11.0	1.0	9%
Charnwood CMHT MHSOP	11.0	1.0	8%
City East CMHT MHSOP	13.0	1.0	7%
South Leicestershire CMHT MHSOP	16.0	1.0	6%
West Leicestershire CMHT MHSOP	17.0	1.0	6%
MHSOP Community Therapy	14.0	0.0	0%
MHSOP Integrated Care Team	5.0	0.0	0%
MHSOP Site Services	4.0	0.0	0%
MHSOP Unscheduled Care Service	7.0	0.0	0%
Core service total	**150**	**13**	**8%**
Trust Total	**3150**	**349**	**10%**

The sickness rate for this core service was 5% between 1 June 2017 and 31 May 2018. The most recent month's data (May 2018) showed a sickness rate of 4%. This was lower than the sickness rate of 6% reported at the last inspection at 30 June 2017.

Across the 12 month reporting period, sickness rates ranged between 4% (May 2018) and 7% (July 2017) for this core service.

Team	Total % staff sickness (at May 2018)	Ave % permanent staff sickness (1 June 2017 to 31 May 2018)
FOPALS	13%	14%
MHSOP Integrated Care Team	23%	13%
City West CMHT	2%	8%
West Leicestershire CMHT MHSOP	8%	7%
MHSOP Site Services	11%	6%
MHSOP Unscheduled Care Service	1%	6%
Countywide Memory Service	0%	5%
MHSOP Community Therapy	0%	4%
South Leicestershire CMHT MHSOP	9%	4%
Charnwood CMHT MHSOP	0%	4%
Psychology - MHSOP	0%	3%
Melton & Rutland CMHT MHSOP	0%	3%
City East CMHT MHSOP	3%	2%
Core service total	**4%**	**5%**
Trust Total	**5%**	**5%**

Community managers explained that sickness within the six community mental health teams was either due to long term medical conditions or stress unrelated to work as the trust was collecting data on reasons for sickness caused by stress. The trust had now prioritised staff well-being and held well-being events to reduce sickness. Community managers provided staff with time within working hours for activities such as yoga and massages to improve staff well-being.

Full time qualified staff held caseloads that ranged between 19 and 30 patients per worker. Managers regularly assessed caseload sizes and used a case complexity tool to ensure caseloads were manageable.

Managers provided us with data on the week prior to inspection. There were 122 service users across the six teams that were awaiting allocation of a care co-ordinator.

Medical staff

The trust provided no medical locum data for this core service.

During the inspection, managers informed us that one medical locum consultant psychiatrist was being used in the South Leicester community mental health team due to long term sickness. Prior to this, South Leicester community mental health team had an increased waiting list and increased

breaches. Managers, as a result of this, put this team on the trust risk register. Consultant psychiatrists from other teams assisted in seeing patients and managers effectively signposted patients on the waiting list to other teams or third sector organisations. Managers thereby reduced breaches.

Mandatory training

The compliance for mandatory and statutory training courses at 30 June 2018 was 95%. Of the training courses listed one failed to achieve the trust target and of those, none failed to score above 75%.

During the inspection managers provided data which showed that mandatory training compliance had improved and 100% of staff had completed mandatory training. There had been technical issues with some of the electronic training programmes which prevented staff from completing certain courses but this had been resolved in time for inspection.

CAVEAT: The trust was unable to provide the training data in the required format and therefore the compliance has been calculated using the trusts internal training data dashboards.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	**This core service %**	**Trust target %**	**Trust wide mandatory/ statutory training total %**
Infection Prevention and Control Level 1	100%	85%	94%
MAPA Disengagement Update	99%	85%	95%
Conflict Resolution	99%	85%	97%
Equality, Diversity & Human Rights	99%	85%	96%
Health Safety and Welfare	99%	85%	96%
Display Screen Equipment (DSE)	98%	85%	94%
Moving & Handling - Level 1	97%	85%	95%
Safeguarding Adults - Level 1	97%	85%	95%
Safeguarding Children - Level 1	97%	85%	95%
Mental Capacity Act	96%	85%	95%
Mental Health Act (Nurses)	96%	85%	82%
Hand Hygiene	95%	85%	94%
Fire Safety	95%	85%	87%
Information Governance	95%	85%	89%
Medicine Management	94%	85%	92%
Record Keeping and Care Planning	93%	85%	92%
Safeguarding Children Level 2	92%	85%	88%
Infection Control	92%	85%	92%
Safeguarding Adults Alert and Refer	89%	85%	88%
Prevent WRAP	88%	85%	79%
Move and Hand Level 2	86%	85%	87%
Adult Basic Life Support	85%	85%	80%

Training course	This core service %	Trust target %	Trust wide mandatory/ statutory training total %
Anaphylaxis Update	77%	85%	78%
Core Service Total %	**95%**	**85%**	**91%**

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 27 patient records. All records reviewed contained an initial patient risk assessment that was robust and reviewed regularly either on a yearly basis or after an incident. Staff recognised and responded to warning signs in patients' health. Staff worked collaboratively with carers and family members to develop risk managements plans, for instance if patients were suicidal, staff would work with family members to ensure medication was stored safely and not self-administered

In each record, there was a full account of patient risks and strategies for minimising and managing the risks to patients and staff. Staff used the trust's risk assessment tool and recorded this electronically. Staff ensured they reviewed risk regularly and made changes to observation levels to keep patients safe.

Management of patient risk

Staff were aware of specific patient risks and updated risk assessments regularly. Team managers audited risk assessments weekly to ensure all risks had been captured and detailed. Staff developed crisis plans when necessary to respond to sudden deterioration in patient's health. Crisis plans were written in simplified language and included advance decisions about how they wished to be cared for. Staff provided patients with a copy of their crisis plans which detailed coping mechanisms and contact numbers of their care coordinator, should their mental health deteriorate. One carer said staff could improve on the out of hours service as they were unsure who to call out of hours.

Managers called patients weekly to assess risk or deterioration and signposted patients to other teams such as: the crisis team if patients were in crisis, the unscheduled care service who conducted emergency assessments or to third sector organisations. Teams had a duty worker to respond to calls from patients and had capacity to conduct visits if required.

The trust had processes for staff to follow when patients did not attend appointments. Staff informed us they would use a variety of methods to help engage patients such as changing the venue or the times of appointments and offering support from advocates. The trust had systems in place to keep staff safe when lone working with patients in the community such as a trust wide policy. However community managers also developed local lone working policies.

Safeguarding

Staff were trained in safeguarding both children and adults. Staff demonstrated good understanding of safeguarding children and adults and stated the training delivery had improved from online to face-to-face which had improved their understanding.

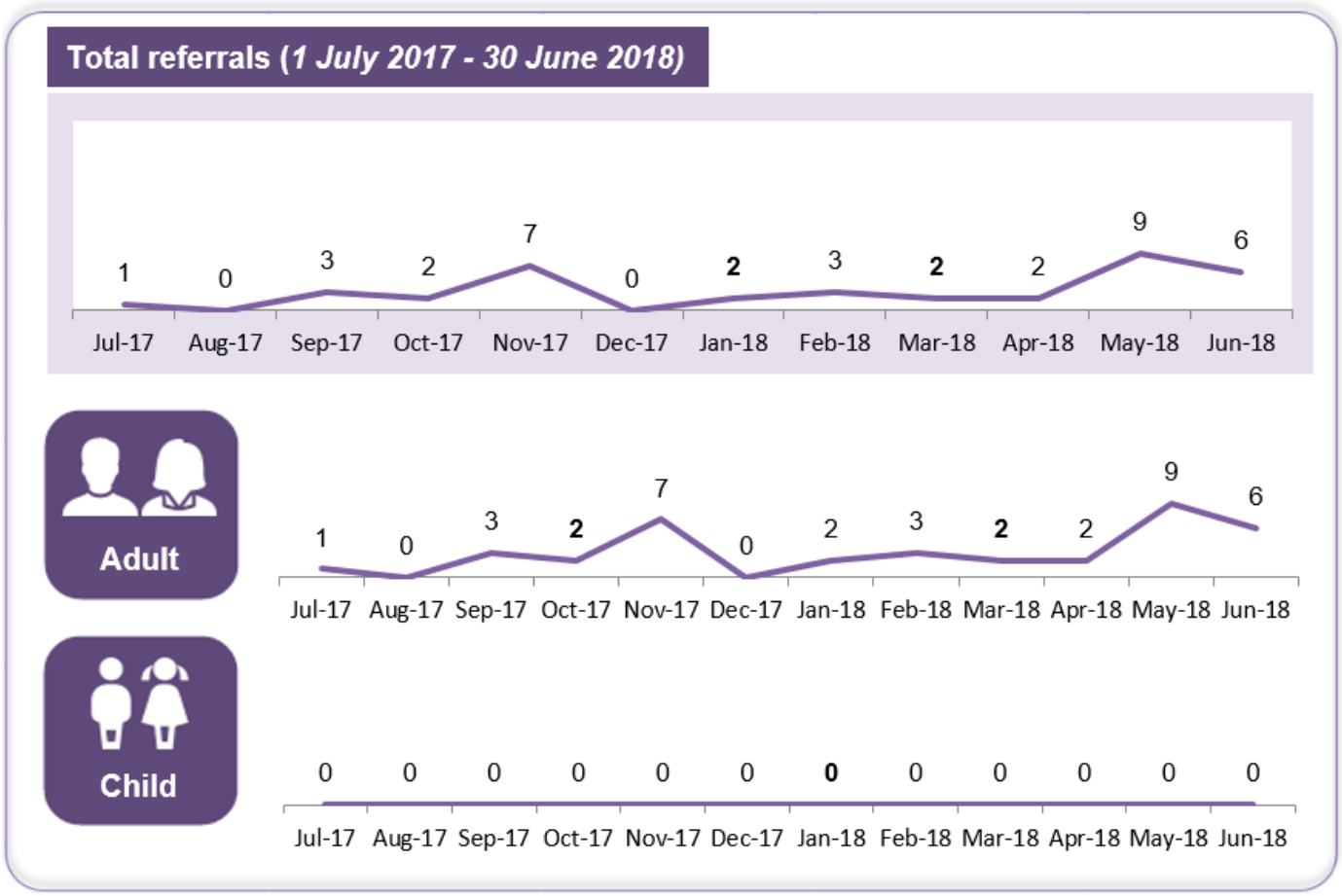
A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own 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 37 adult safeguarding referrals between 1 July 2017 and 30 June 2018, of which all concerned adults. The trust is not able to provide a breakdown of the 374 child referrals by core service.

Staff had a good understanding and working knowledge of safeguarding both adults and children procedures and statutory guidance. Staff were aware of how and when to refer incidents to the safeguarding team and knew their role in reporting incidents. Staff had good working relationships with the trust safeguarding team and the local authority.

Referrals		
Adults	**Children**	**Total referrals**
37	n/a	37



Staff access to essential information

Staff kept detailed records of patients' care and treatment on an electronic record system. Records were clear, up-to-date and easily available to all staff providing care. Team managers completed

audits to check on this and staff were required to self-audit their records using a document template which would be discussed in supervision.

All information needed to deliver patient care was available to all relevant staff (including locum agency staff) when they needed it and in an accessible form.

Team managers created files which were accessible to all staff and kept in all bases, to update staff on new or updated guidelines on patient care.

Medicines management

The service had made improvements in safe medicine management. Clinical staff followed best practice guidelines in the safe storage of adrenaline. Clinical staff completed regular audits which included medication opening and expiry dates.

The audit findings were shared with ward managers. We reviewed 20 depot injection cards which all contained allergy information. Staff documented medication risk information and mitigation in care plans and on risk assessments.

Track record on safety

Staff described the trust's electronic incident reporting system and they knew how to use this.

The trust had a duty of candour policy in place and staff were able to describe how they would use this.

The trust had systems to investigate incidents. Staff had access to the trust intranet to get feedback also about learning.

Managers and staff made changes to practice following incidents and feedback. For example, the teams now had a buddy system, so prior to staff going on leave they would ensure the staff member taking over the case was aware of any risk issues or immediate action plans.

The trust had systems to debrief and support staff after any serious incident, for example staff had reflective practice meetings to discuss complex cases and incidents.

Staff said they also received feedback from the investigations of incidents via team meetings and bulletins.

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

Between 1 July 2017 and 30 June 2018 there were three STEIS incidents reported by this core service. All three incidents reported were for 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.

	Number of incidents reported

Type of incident reported on STEIS	City East CMHT MHSOP	MHSOP CMHT Melton and Rutland	MHSOP CMHT S Leics	Total
Apparent/actual/suspected self-inflicted harm	1	1	1	**3**
Total	**1**	**1**	**1**	**3**

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 2018, and since the last inspection, there had been three 'prevention of future death' reports sent to Leicestershire Partnership NHS Trust. One of these related to this core service.

Is the service effective?

Assessment of needs and planning of care

Staff completed comprehensive assessments on admission. Care plans were recovery focused, up to date and person centred. Staff involved both patients and carers/family members. However copies of care plans were not always given to patients. We reviewed 27 records and 11 patients had not been provided with a copy of their care plan.

Staff recorded information on patients' physical healthcare in care notes which was then routinely monitored by GPs. Staff always received updates about physical health issues from GPs.

Best practice in treatment and care

Staff followed National Institute for Health and Care Excellence (NICE) guidelines in relation to best practice. Patients were supported to access specialist services such as speech and language therapists, occupational therapy and physiotherapy when required for their physical healthcare needs. The service offered psychological therapies which were delivered in line with national institute for health and care excellence such as cognitive behavioural therapy and dialectical behaviour therapy.

Patients were supported to live healthier lives. We saw that staff provided patients with information on healthy eating and smoking cessation.

Staff used recognised rating scales and other approaches to rate severity and to monitor outcomes of care and treatment. For example, staff used a recognised risk assessment tool such as the Health of the Nation Outcome Scales

This core service participated in eight clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Use of Nuclear Medicine Investigations in	MHSOP Wards & Community	MH - Community-based	Clinical	04/09/2017	Circulating the findings by emailing the report to the clinicians, by discussing

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Dementia re-audit (1070)		mental health services for older people			about it in the trust run post-graduate teaching for trainees and other medical staff members.
Dementia investigations in primary and secondary care (1477)	MHSOP memory service	MH - Community-based mental health services for older people	Clinical	05/09/2017	Develop and print out hard copies of an Investigation prompt list to place in the clinic room Create standard letter to be sent to referrers by the Central Referral Hub if referral is rejected as more information is needed, including a copy of recent blood tests.
Patients on CPA: Communication with General Practitioners (1480)	All community mental health services	MH - Community-based mental health services for older people	Clinical	11/04/2018	None
Positive and Proactive Care re-audit (1512)	All Mental Health & LD Wards	MH - Community-based mental health services for older people	Clinical	11/04/2018	Training to be rolled out in areas where the audit identified that this was required i.e. AMH. Care Plan training and Risk assessment training to include theory of PBS. Debrief Training to be implemented across all areas. All 10 safe wards interventions to be fully implemented
Adherence to shared care agreements with primary care re-audit (1517)	CAMHS Outpatients MHSOP Outpatients PIER General Adult LD	MH - Community-based mental health services for older people	Clinical	25/04/2018	Trust to identify a resource to ensure that completed SCAs are uploaded to Rio with confirmation that they have been sent to GP
Mental Capacity (Community) (1550)	AMH CMHTs CLDTs CHS Community Nurses MHSOP CMHTs PIER	MH - Community-based mental health services for older people	Clinical	17/11/2017	Refer to PIR.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
	Children's Physiotherapy				
Quality of Information on CT brain request forms in Memory Service East (1588)	Memory Service East	MH - Community-based mental health services for older people	Clinical	19/03/2018	Introduction of a new optimised Request Form To authorise a single person to populate the CT Brain requests Audit Results Presentation revealing the results will be prepared and delivered to all people involved in writing the CT requests in the Memory Service
Quality of screening assessment and management of psychiatric co-morbidities (memory clinic) (1592)	Memory Service	MH - Community-based mental health services for older people	Clinical	25/06/2018	Presenting the audit in memory service MDT meetings to further explore the reason for noncompliance and how we can improve the compliance.

Skilled staff to deliver care

The service had a range of suitably qualified staff that met the needs of patients. The multidisciplinary team (MDT) consisted of psychiatrists, psychologists, occupational therapists, nurses and health care assistants.

The trust had an induction programme and policy in place that was mandatory for all new starters. Newly recruited staff were required to complete an induction programme for two weeks, which included elements of e-learning and face-to-face training. Managers would then conduct a four-week local induction which included and shadowing experienced staff on the wards before they were able to work independently with patients and visiting services.

Team managers monitored staff performance and conducted weekly audits on patient records. If concerns were identified managers would meet with the staff member in a timely manner to address the concerns. Team managers also had support from the trust's human resources team as required.

Managers ensured that staff had access to regular team meetings Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers ensured that staff received the necessary specialist training for their roles such as dementia awareness.

The trust's target rate for appraisal compliance is 80%. As at 30 June 2018, the overall appraisal rates for non-medical staff within this core service was 95%.

All teams achieved the trust's appraisal target of 80%.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 97% reported at the last inspection.

During inspection community mental health team managers showed us a matrix indicating appraisal and supervision rates had improved and were at 100%.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
FOPALS	7	7	100%
313 3630 City East CMHT MHSOP	13	13	100%
313 3650 City West CMHT	11	11	100%
313 3770 Charnwood CMHT MHSOP	11	11	100%
313 4100 Psychology - MHSOP	8	8	100%
313 J927 MHSOP Unscheduled Care Service	7	7	100%
Countywide Memory Service	28	27	96%
313 3940 West Leicestershire CMHT MHSOP	17	16	94%
MHSOP Community Therapy	14	13	93%
313 3780 Melton & Rutland CMHT MHSOP	9	8	89%
313 3760 South Leicestershire CMHT MHSOP	16	14	88%
313 3640 MHSOP Integrated Care Team	5	4	80%
Core service total	**146**	**139**	**95%**
Trust wide	**4957**	**4425**	**89%**

The trust did not provide appraisals data for medical staff.

The trust's measure of clinical supervision data is the number of staff who have undertaken at least one clinical supervision in the last three months divided by the number of staff who require clinical supervision.

Between 1 July 2017 and 30 June 2018, the average rate across all 10 teams in this core service was 84% of the trust's target.

During inspection managers provided us with data showing community mental health team staff had 100% clinical supervision rates.

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

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
City East CMHT MHSOP	100	95	95%
Charnwood CMHT MHSOP	74	70	95%
West Leicestershire CMHT MHSOP	111	106	95%
City West CMHT	80	70	88%
Melton & Rutland CMHT MHSOP	66	56	85%

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
South Leicestershire CMHT MHSOP	92	71	77%
FOPALS	71	54	76%
Countywide Memory Service	160	120	75%
MHSOP Integrated Care Team	49	36	73%
MHSOP Unscheduled Care Service	62	45	73%
Core service total	**865**	**723**	**84%**
Trust Total	**21,454**	**15,868**	**74%**

Multidisciplinary and interagency team work

The multidisciplinary team worked together as a team to benefit patients. They supported each other to make sure that patients had no gaps in their care. Staff had good working relationships with third sector organisations specialising in help for: housing, veteran support, advocacy and benefits. The service also specialised in helping patients with an early onset of dementia with employment support.

Staff used recognised rating scales to assess and record severity and outcomes.

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

As at 30 June 2018, 96% of nurses had received training in the Mental Health Act. The trust stated that this training is mandatory and renewed every three years.

The training compliance reported during this inspection was the same as the 96% reported at the last inspection.

During inspection, managers showed us data for training compliance for the Mental Health Act which was at 100%.

The trust reported three patients on a community treatment order (CTO) in the core service of community based mental health service for older people, however, we found records indicating four patients, in this core service, were currently on a CTO.
We checked each of the four records (including the patient's detention paperwork prior to their CTO commencing), noting the paperwork for three patients was complete in relation to the patient's CTO under the MHA.

However, when we checked the remaining patient's record (including the patient's detention paperwork prior to their CTO commencing) we found an anomaly. A responsible clinician (RC) had completed a CTO3, Section 17E – community treatment order: notice of recall to hospital", form on 21 August 2018. Staff had completed a CTO4, Section 17E – community treatment order: record of patient's detention in hospital after recall, form on 24 August 2018 at 13.30 hours, which expired on 27 August at 13:29 hours. The RC did not revoke the CTO, which meant the patient could return to their home in the community. We did not find any information to show the staff on the ward explained to the patient their right to do so. Staff had assessed the patient's mental capacity on 24 August 2018 in relation to "medical management" and recorded the patient did not have capacity in relation to this. Whilst the

patient continued to be an inpatient, the RC completed a further CTO3 form on 29 August 2018 at 16.04 hours. Staff also completed a further CTO4 form on 29 August 2018 at 16.04 hours. Thereafter, neither the medical or nursing staff had documented the outcome of the recall (for example, whether the CTO was revoked or whether the patient was discharged).

This issue was raised with the trust.

Good practice in applying the Mental Capacity Act

As of 30 June 2018, 96% of the workforce had received training in the Mental Capacity Act. The trust stated that this training is mandatory and renewed every three years.

The training compliance reported during this inspection was higher than the 95% reported at the last inspection.

During inspection, managers showed us data for training compliance for the Mental Capacity Act which was at 100%. The service had improved staff the delivery of the Mental Capacity Act 2005. The trust changed the delivery of training to be face-to-face and prioritised mental capacity within learning lunches. Staff evidenced mental capacity in care records. Staff obtained consent to treatment and conducted mental capacity assessments and best interest decisions where appropriate.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff showed compassion, respect and were responsive to the needs of patients and carers. Staff demonstrated that they were aware of patients' needs and understood how best to support them.

Feedback from patients and carers was positive. Carers and family members informed us that they felt supported by staff in understanding how to care for the patient. Carers and family members felt their concerns were always taken on board and resolved and support was always provided to them as well as the patient. The service held recovery cafes with carers, patients and staff to ensure the service delivered was person centred.

Involvement in care

Involvement of patients

We found evidence of patients being involved in decisions about their care and treatment. The service held recovery cafes which involved patients and carers who could provide feedback on their care.

We reviewed 27 care plans and all of them were up to date, person centred and involved patients. However, staff did not provide all patients and carers with a copy of their care plan. We reviewed 27 records and 11 records showed that patients had not been given a copy of their care plan. Patients and carers confirmed this.

Staff developed interim support plans which were kept at patient homes to help patients with coping techniques personalised for them, to use in crisis situations.

Patients could also provide feedback through PALS, advocates and the trust feedback form. Managers discussed all feedback with the team at team meetings so improvements could be made to the service.

Involvement of families and carers

We spoke with 11 carers who all stated they had been involved in the patients' care with the patient's consent. Carers reported that staff always kept them updated about patient progress if they could not attend meetings. Carers also informed us that they had the opportunity to feedback at recovery cafes on how the service could be improved. Staff also signposted carers for help and support for things such as carer's assessments

Managers gave us examples of when family had been dissatisfied about certain processes and how staff had implemented improvements to help accommodate suggestions that family members made.

Is the service responsive?

Access and waiting times

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

Name of hospital	Service Type	Days from referral to initial assessment		Days from assessment to treatment	
		Target	Actual (median)	Target	Actual (median)
Evington Centre	MHSOP FOPALS	No Target	1	No Target	2
Evington Centre	MHSOP FOPALS	4 Weeks	2	No Target	3
Evington Centre	MHSOP FOPALS	6 Weeks	2	No Target	3
HQ Bridge Park Plaza	MHSOP Central Referral Hub	No Target	3	No Target	n/a
Evington Centre	MHSOP Unscheduled Care Service	No Target	3	No Target	9
HQ Bridge Park Plaza	MHSOP Community Teams	3 Working Days	7	No Target	8
Evington Centre	MHSOP Outpatient Teams	4 Weeks	18	No Target	82
HQ Bridge Park Plaza	MHSOP Community Teams	4 Weeks	25	No Target	20
HQ Bridge Park Plaza	Integrated Care - Mental Health	No Target	29	No Target	9
Evington Centre	MHSOP Memory Service	No Target	31	No Target	63
HQ Bridge Park Plaza	MHSOP Community Teams	6 Weeks	32	No Target	17
HQ Bridge Park Plaza	Integrated Care - Mental Health	10 working Days	40	No Target	12
HQ Bridge Park Plaza	MHSOP Community Teams	No Target	43	No Target	19

Name of hospital	Service Type	Days from referral to initial assessment		Days from assessment to treatment	
		Target	Actual (median)	Target	Actual (median)
Evington Centre	MHSOP Outpatient Teams	6 Weeks	45	No Target	82
Evington Centre	MHSOP Memory Service	18 Weeks	45	No Target	79
Evington Centre	MHSOP Memory Maintenance Service	No Target	46	No Target	111
Evington Centre	MHSOP Occupational Therapy	No Target	48	No Target	13
Evington Centre	MHSOP Outpatient Teams	No Target	48	No Target	129

Managers provided us with data on inspection, for the previous week allocations and waiting lists. There were 122 service users across the six teams that were awaiting allocation of a care co-ordinator. The service had allocation targets for priority and non-priority referrals. Managers were required to allocate priority referrals within two weeks and non-priority within six weeks. Service users who were not allocated within that time, constituted a breach of the target. In the data provided for the previous week there were 27 breaches.

Breaches of these times generally occurred if: the patient could not be contacted, the patient had moved, the patient was detained, the patient had cancelled the appointment or the patient was difficult to engage or had not yet been seen.

Community managers had robust oversight of waiting list time breaches and reasons for them in monitoring reports. Team managers monitored waiting lists weekly as did community managers to identify potential breaches of waiting times quickly. Managers called patients weekly to assess risk or deterioration and signposted patients to other teams such as: the crisis team if patients were in crisis, the unscheduled care service who conducted emergency assessments or to third sector organisations. Teams had a duty worker to respond to calls from patients and had capacity to conduct visits if required.

The service was easy to refer into. Staff assessed and treated people who needed urgent care promptly and those who did not need urgent care did not wait too long to start treatment. The service did not exclude people who would have benefitted from care. Managers used a case complexity tool to manage staff allocations and caseloads.

Staff only cancelled appointments when necessary. Patients informed us that appointments were only cancelled to be brought forward if staff had capacity, so patients could be seen quicker.

The facilities promote comfort, dignity and privacy

All bases were clean and comfortable however in West Leicestershire and Charnwood community mental health team, there was no soundproofing in areas where patients were seen.

West Leicestershire CMHT did not have privacy glass in rooms where patients were seen. These issues compromised patient privacy and confidentiality. The service mitigated this by ensuring the areas where patients were seen, were away from waiting rooms.

Patients' engagement with the wider community

Staff supported patients to maintain contact with family and carers, for example, inviting family and carers to care reviews. Staff educated family members about mental health issues and ways to support the patient and kept carers and family members involved the care pathway.

Meeting the needs of all people who use the service

All community mental health team bases were fully accessible. Patients had access to information leaflets and were provided with a pack on initial assessment which contained information on: how to complain, patients' rights, local services, information on the service and treatments provided and a named worker. This information was available in a variety of formats such as easy read. The service had access to an interpreter service if required.

Listening to and learning from concerns and complaints

This core service received 11 complaints between 1 July 2017 and 30 June 2018. Four of these were upheld, three were partially upheld and one was not upheld. None were referred to the Ombudsman.

Lessons learned from complaints were shared with the service at team meetings. Managers investigated complaints for different teams to ensure objectivity.

Complaint subject	Fully upheld	Partially upheld	Under Investigation	Not upheld	Total Complaints
Patient Care	1	2	2	0	5
Appointments	2	0	0	0	2
Communications	1	0	0	0	1
Consent To	0	1	0	0	1
Admissions, Discharges And Transfers Exc Delays	0	0	0	1	1
Clinical	0	0	1	0	1
Core Service total	**4**	**3**	**3**	**1**	**11**

This core service received 23 compliments during the last 12 months from 1 July 2017 and 30 June 2018 which accounted for 2% of all compliments received by the trust as a whole (1240).

Is the service well led?

Leadership

Team and community managers had a good understanding of their service and were able to demonstrate how they supported staff to deliver good quality care. For example, managers encouraged staff to develop their careers and understood their well-being was a priority. Managers were able to identify the needs of the service and identify what resources they needed such as the use of agency staff. Managers were also able to identify risks in services and proactively deal with them such as high sickness rates or retiring staff.

Staff told us they felt supported by team and community managers and felt that managers prioritised their well-being. Staff informed us that stress was rarely unmanageable and that the teams had worked hard following the last inspection, to improve the workflow and keep the waiting list low. Staff informed us that managers made effective arrangements to cover vacancies and allocate caseloads using the case complexity tool.

However, staff commented that they felt disconnected from the executive team and felt they were not listened to.

The trust gave opportunity for leaders to develop their skills and for other staff to develop leadership skills. We saw there were opportunities for staff development including secondment opportunities.

Vision and strategy

Staff were aware of the trust's vision which was working to improve lives and the trusts values which included having respect, integrity, compassion and trust. During inspection we saw that staff demonstrated the trust's values in their everyday work. Managers had a service strategy for the next year and staff were aware that waiting list target times would be reduced and they were actively working towards achieving this with management guidance

Culture

All staff felt respected, supported and valued by their team and local managers. Staff and managers said they had more confidence that changes taking place would make a difference to their work and the service.

Staff felt proud to work for their team and the trust. Staff could raise concerns without fear. They understood the whistle-blowing policy and who their speak up guardian was.

Teams worked well together and their manager dealt with any difficulties when they happened. Managers could identify and support staff who needed it to perform their jobs well. Managers supported staff during their appraisals and discussed career progression and development. Managers gave examples of their compassion and understanding when explaining how they supported their staff when they had been unwell. This included gaining access to wellbeing services.

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

During the reporting (1 July 2017 to 30 June 2018) there was one case where a member of staff had been suspended.

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

Team name	Suspended	Under supervision	Team move	Total
MHSOP CMHT	1	0	0	1

Core service total	1	**0**	**0**	1

Governance

The service held monthly governance meetings which had a standard agenda that was followed. Examples of items on the agenda were: safeguarding, risk register, training, patient experience surveys, complaints and staffing.

Team managers completed local audits that were fed back to community managers. Examples of these included care plans, risk assessments, and staffing audits. The results were monitored monthly and improvement plans implemented if required.

Staff attended a variety of meetings within their teams and externally. Staff gave examples of implementing recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

Managers received information about staff training, appraisal and supervision compliance and gave feedback to staff where improvements were needed.

Staff understood arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

The trust collected data to produce a performance monitoring reports which was used to gauge the performance of each service and track where improvements needed to be made. Examples of the information monitored were staff sickness, complaints and patient experience.

Managers told us they had a risk register which they were able to input issues onto such as staffing.

Managers addressed staff performance concerns in a timely manner with the support of the trust's human resource department.

Information management

The trust had an information management policy and process. Patient information was stored securely and password protected.

Staff were aware of the need to protect the confidentiality of patients. For example, when talking to relatives and carers.

The trust had a Caldicott guardian in place and had displayed posters on ward areas informing all staff of who this was.

Managers said their access to data had improved and they were more confident they knew who was waiting for assessment and treatment and why. Managers all had access to weekly reports on their team's performance and had the opportunity to feedback if there were missed target deadlines for assessments.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Information technology systems also allowed staff to work flexibly in the community if required to.

Staff notified and shared information with external organisations when necessary, seeking patient consent when required to do so.

However, staff and managers highlighted issues with data being lost on the electronic systems, such as care plans entered by staff which increased workloads for staff as they had to re-enter the information

Engagement

Staff told us there were opportunities to give feedback to make improvements to the service. For example, staff highlighted the issues and complexities involved in using the case complexity tool. This tool was used by managers to determine allocations of patients. Community managers acknowledged the feedback and have been trying to improve the tool to make it user friendly for staff.

Staff had access to up-to-date information through the intranet, bulletins, newsletters and social media.

Directorate leaders engaged with external stakeholders, such as commissioners and the local authority.

The service ran recovery cafes for patients and carers who were able to input into improving the service and the recovery process.

Staff were encouraged to make suggestions about how the service could improve for patients.

Learning, continuous improvement and innovation

Monthly staff meetings were held to share learning across the trust.

Staff were encouraged to attend suitable training opportunities based on supervision and appraisal feedback.

Managers also analysed any themes where learning could be improved, for instance staff knowledge of Community Treatment Orders, and organised learning lunches for teams with expert guest speakers.

NHS Trusts 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 trust reported that no accreditations had been awarded to this core service.