Leicestershire Partnership NHS Trust

Quality Report

Leicestershire Partnership NHS Trust
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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Bradgate Mental Health Unit (Ashby ward, Aston Ward, Thornton Ward, Beaumont Ward, Heather Ward, Watermead Ward, Bosworth ward) PICU wards (Griffin Ward, Belvoir Ward)	RT5KF
Wards for people with a learning disability or autism	Short Breaks (Rubicon Close, Farm Drive)	RT5FM, RT5FP
Long stay or rehabilitation mental health wards for working age adults	Stewart House The Willows	RT5FK
Specialist community mental health services for children and young people	Bridge Park Plaza (Westcotes House)	RT5Z1

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

Summary of findings

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Overall summary

We did not rate this inspection. The ratings from the inspection which took place in November 2018 remain the same.

This was a focused, unannounced inspection, to follow up on enforcement action we issued to the trust after our last inspection in November 2018. We have not inspected against other requirement notices that were issued at the same time; therefore, all requirement notices from the last inspection remain in place.

At the last inspection, we issued enforcement action because the trust did not have systems and processes across services to ensure that the risk to patients were assessed, monitored, mitigated and the quality of healthcare improved in relation to:

- Access to treatment for specialist community mental health services for children and young people
- Maintaining the privacy and dignity of patients and concordance with mixed sex accommodation
- Environmental issues
- Fire safety issues
- Medicine management
- Seclusion environments and seclusion paper work
- Risk assessment of patients
- Physical health care
- Governance and learning from incidents.

The trust was required to make significant improvements in the following core services where we found concerns in the areas listed above:

- Acute wards for adults of working age and psychiatric intensive care units
- Wards for people with a learning disability or autism
- Long stay or rehabilitation mental health wards for working age adults
- Specialist community mental health services for children and young people.

At this inspection, we found the following areas the trust needed to improve:

Significant improvements had been made to the environments at most wards. It was clear to see the difference the investment and improvements had made since our last visit. The majority of repairs and maintenance issues highlighted within the warning notice at the Bradgate Mental Health Unit had been fixed or resolved. A programme of work was due to start in forthcoming months, for wards yet to be refurbished. New systems were in place for staff to report any repairs or maintenance issues.

There were improvements in ligature risk assessments. All ward ligature risk assessments had been reviewed and were located on each ward together with mitigation summaries. Staff completed risk assessments that were thorough and had been reviewed following incidents.

The trust had improved how staff recorded patients physical healthcare, and monitored patients who had ongoing physical healthcare problems. The trust had recruited two registered general nurses with dedicated time to focus on individual healthcare plans at Stewart House and The Willows. There were effective systems in place to audit and monitor physical health care records.

The trust had improved medicines management. This included labelling, disposal, reconciliation and ward level audit. All wards had developed their own systems to improve medicines management in their areas. Medicine management training sessions had been undertaken with inpatient ward sisters and charge nurses.

Some improvements to address the no smoking policy at the Bradgate Mental Health Unit wards were seen. Smoking cessation had been successful across most wards in the Bradgate Mental Health Unit.The trust had re-drafted the smoke free policy following on patient and staff consultation. Patients were offered smoking cessation treatments, nicotine replacement therapy (NRT), or free vapes.

Fire safety was much improved, with fire drills carried out regularly. An escape plan was developed with patients (PEEP) who may not be able to reach an ultimate place of safety unaided, or within a satisfactory period of time in the event of any emergency. We saw patients that needed a PEEP had a plan in place.

Some improvements were seen in seclusion documentation and seclusion environments. The trust

Summary of findings

had new seclusion paperwork implemented in May 2019. A full audit was scheduled for the end of June 2019. Improvements had been made to seclusion areas at The Willows Acacia and Maple wards.

The trust had maintained patients privacy and dignity at Short Breaks Services. The trust ceased mixed sex breaches by maintaining male and female only weeks. Patients privacy and dignity had been addressed at The Willows, Cedar and Acacia wards with changes made to male and female wards.

The trust had ensured patients privacy and dignity were maintained when receiving physical health observations at the Bradgate Mental Health Unit. Staff had set clear guidelines on where and how physical health observations were completed on wards.

The trust had significantly reduced waiting times and the total numbers of children and young people waiting for assessments. The trust had reviewed existing systems and processes identified improvements and implemented changes. Funding had been secured for increased staff with specialist skills. There had been a change in leadership and a review of key performance indicators (KPIs) with commissioners. The trust had developed new processes and redesigned and improved data validation.

We saw the trust had developed oversight and a vision on how to improve the nine key areas identified by the warning notice. The trust had launched its "Step up to Great" approach, which identified the vision and priorities for the year. Two external governance reviews had been commissioned and undertaken. One review was in response for the delivery of actions for the 2018 CQC inspection. A further review was an examination of processes and procedures within the trust for reporting investigations and learning from serious incidents requiring investigation. The trust provided newsletters, quarterly serious incidence bulletins, regular emails from matrons about incidences and lesson learnt.

However:

Some areas at Bradgate Mental Health Unit required further improvements to the environments. Response times to maintenance request were variable. Whilst there had been some improvements, the process for reporting repairs and issues varied across the wards and a time lag existed for repairs being completed.

New positions such as medicines administration assistants and link nurses to support wards were in place in certain areas, but ward staff still described irregular pharmacy visits and a lack of pharmacy oversight in medicines management.

We found evidence that patients, at the Bradgate Mental Health Unit, and in some instances, staff, smoking in ward areas. Staff told us patients were concealing lighters and cigarettes and bringing them onto wards. There were inconsistent practice around conducting searches on patients. Team meetings were not regular, or didn't take place.The sharing of lessons learnt remained inconsistent across some wards.

We looked at 20 sets of seclusion records and from 17 records, staff were not recording seclusion, in line with the Mental Health Act Code of Practice. Some seclusion rooms had environmental concerns at Belvoir and Griffin units, and Watermead wards.

The waiting list had increased for those children and young people waiting for the start of treatment, following assessment. Demand for neurodevelopment assessments remained high. The trust had long term plans to address this.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement 

Environment

We found during inspection that:

Significant improvements had been made to the environments at most wards. The majority of repairs and maintenance issues highlighted within the warning notice at the Bradgate Mental Health Unit had been fixed or resolved. A further programme of works for older wards were due to commence. Bosworth will complete in July 2019 with works to Aston and Thornton due to commence in August 2019 (for completion in March 2020). Two property managers were appointed with responsibilities for acute, forensic, and rehabilitation wards. New systems were in place for staff to report any repairs or maintenance issues.

There were improvements in ligature risk assessments. The trust used the Manchester ligature audit tool to assess the environment for ligatures in inpatient areas. All ward ligature risk assessments had been reviewed by health and safety staff, ward sisters and matrons. Ligature risk assessments were located on each ward, identified all risks together with mitigation summaries. Colour coded displays identified "heat spots" and photographs of rooms ensured staff were are aware of potential ligature anchor points. Ligature risk assessments and ward mitigation plans were held locally and on a central electronic data base. Ligature audit spot checks were ongoing on wards.

Three newer staff did not know about the ward ligature audits, but explained what ligature points were.

Risk assessments of patients

Risk assessments of patients had improved. Staff completed risk assessments that were thorough and had been reviewed following patient incidents. Some staff groups had received training around patient risk assessments.

Medicines Management

The trust had improved medicines management. All wards had developed their own systems to improve medicines management in their areas. Medicine management training sessions had been undertaken with inpatient ward sisters and charge nurses. A regular programme of spot checks of ward clinic rooms were ongoing and required further time to embed learning. Most medical equipment including blood monitoring and blood pressure equipment had been calibrated to ensure it worked correctly.

Summary of findings

Fire safety

Improvements to address patients smoking on the ward were seen. The trust had re-drafted the smoke free policy following on patient and staff consultation. Patients were offered smoking cessation treatments, nicotine replacement therapy (NRT), or free vapes for seven days. Patients could then purchase vapes on the ward. Smoking cessation had been successful across most wards in the Bradgate Mental Health Unit. No-smoking posters were designed and displayed at the Bradgate Mental Health Unit. The trust had organised the removal of discarded cigarettes and regular and ongoing upkeep in Bradgate ward gardens.

Fire safety was much improved. We looked at six fire drills reports and found fire drills were carried out regularly. The trust fire safety management policy was revised to include information about general emergency evacuation plans and personal emergency evacuation plans (PEEPS). An escape plan was developed with patients who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency. The need for a PEEP was added to patients admission check list and handover agenda. We saw patients that needed a PEEP had a plan in place.

Seclusion environments and documentation

Some improvements were seen in seclusion documentation and seclusion environments. The trust had new seclusion paperwork implemented in May 2019. A full audit was scheduled for the end of June 2019. Improvements had been made to seclusion areas at The Willows Acacia and Maple wards.

Maintaining privacy and dignity of patients and concordance with mixed sex accommodation

The trust had maintained patients privacy and dignity at Short Breaks Services. The trust revised the statement of purpose for emergency requests for Short Breaks Services. Managers liaised with families and rebooked breaks to ensure no breaches. Letters were sent to families to explain the rationale. The trust ceased mixed sex breaches by maintaining male and female only weeks. There have been no breaches since 11 February 2019.

Patients privacy and dignity had been addressed at The Willows, Cedar and Acacia wards. The trust had made changes to the wards in consultation with patients, families, carers and staff. Acacia was now an all-female ward and Cedar was an all-male ward. Changes were completed by 29 April 2019.

Summary of findings

The trust had ensured patients privacy and dignity was maintained when receiving physical health observations. Ward staff at the Bradgate Mental Health Unit had met together and set clear guidelines on where and how physical health observations are completed on wards. Guidance posters were displayed on wards.

However:

There was variability in how staff reported maintenance requests and response times for repairs at Bradgate Mental Health Unit. For example, on Watermead ward staff reported 32 light bulbs in need of repair before Christmas. Most light bulbs were repaired in batches in March, however some lights were still not working. Despite the new maintenance systems some staff still followed the old maintenance process.

On Watermead ward the ligature audit did not include anti-barricade features. Ashby ward had anti-barricade fixtures and fittings but there was a small gap on some doors which could be a potential ligature point and was not on the ligature risk assessment. The ward manager said they would take immediate action.

The trust had been creative in their recruitment strategy; with new positions such as medicines administration assistants and link nurses to support wards in certain areas, but ward staff still described irregular pharmacy visits and a lack of pharmacy oversight in medicines management.

Some patients were still smoking in ward areas. We visited six wards at the Bradgate Mental Health Unit and saw cigarette ends in ward gardens, except on Aston ward. Patients were concealing lighters and cigarettes and bringing them onto wards. There was inconsistent practice around conducting searches on patients, not all staff had security wands to search patients. Some staff on Watermead ward were smoking outside the female ward door area, and patients saw this.

We looked at 20 sets of seclusion records and from 17 records, staff were not recording seclusion, in line with the Mental Health Act Code of Practice. Some seclusion rooms had environmental concerns at Belvoir and Griffin units and Watermead wards.

Are services effective?
Physical Healthcare

Requires improvement

We found during inspection that:

The trust had improved how staff recorded patients physical healthcare, and monitored patients who had ongoing physical healthcare problems. Patients records showed physical health care

Summary of findings

plans and 72 hour checks in place. The trust had recruited two registered general nurses with dedicated time to focus on individual healthcare plans at Stewart House and The Willows. There were effective systems in place to audit and monitor healthcare records.

Are services caring?
We did not inspect this domain during this inspection.

Good

Are services responsive to people's needs?
Access to treatment for specialist community mental health services for children and young people
We found during inspection that:

The trust had significantly reduced waiting times and the total numbers of children and young people waiting for assessments. The trust had reviewed existing systems and processes identified improvements and implemented changes. Funding had been secured for increased staff with specialist skills including locums, a service manager, clinical leads, nurses, psychologist, and allied health professionals.There had been a change in leadership and a review of key performance indicators (KPIs) with commissioners. The trust had developed new processes and redesign and improved data validation.

However:

The waiting list had increased for those children and young people waiting for the start of treatment, following assessment. Demand for neurodevelopment assessments remained high. The trust had long term plans to address this.

Requires improvement

Are services well-led?
Oversight and governance
We found during inspection that:

We saw the trust had developed oversight and a vision on how to improve the nine key areas identified by the warning notice. The trust had launched its "Step up to Great" approach, which identified the vision and priorities for the year. Two external governance reviews had been commissioned and undertaken. One review was in response for the delivery of actions for the 2018 CQC inspection. A further review was an examination of processes and procedures within the trust for reporting investigations and learning from serious incidents requiring investigation. Heads of Service had reviewed governance processes within the remit. A full review of trust committees terms and reference were underway.

The trust provided newsletters, quarterly serious incidence bulletins, regular emails from matrons about incidences and lesson learnt.

Inadequate

Summary of findings

However:

There was variability in sharing of lessons learnt across the acute wards and PICU units. Some teams had regular team meetings, other teams cancelled team meetings due to work pressures.

Summary of findings

Our inspection team

The team that inspected the service comprised two inspection managers, six CQC inspectors, one mental health act reviewer, and two pharmacy inspectors.

Why we carried out this inspection

We inspected Leicestershire Partnership NHS Trust in November 2018, and published our findings in February 2019. We took enforcement action against the Trust and issued a warning notice under Section 29A of the Health and Social Care Act 2008. This inspection looked specifically at nine areas of concern that were detailed in the warning notice. This inspection was unannounced, focused and was part of a programme to monitor performance. We do not revise ratings following an inspection of this type. However, the trust had made significant improvement in the nine areas detailed in the warning notice as required.

How we carried out this inspection

We have reported on the nine areas of concerns listed in the warning notice, within the following domains:

- Safe
- Effective
- Responsive
- Well-led

We did not follow up all the requirement notices issued at the last inspection. They will be looked at in detail during the next comprehensive inspection. This inspection focused on nine key areas of concerns raise at the last inspection on November 2018. Therefore, our report does not include all the headings and information usually found in a comprehensive inspection report.

We have not re-rated this inspection. The ratings from the last inspection remain the same.

During the inspection visit, the team:

- visited four core services, which included 18 wards or locations
- visited nine seclusion rooms and reviewed 20 sets of seclusion records
- spoke with 32 patients and two carers.
- spoke with 58 staff members; including 21 senior managers
- looked at 55 care records
- looked at 29 medication records
- looked at seven ligature risk assessments
- looked at six personal emergency evacuation plans (PEEPS)
- reviewed 20 meeting minutes, 11 patient green forms (pre- multi disciplinary meeting forms), two health and safety folders, one incident system review, six fire drill reports
- looked at a range of policies and procedures.

Information about the provider

The trust was created in 2002 to provide mental health, learning disability and substance misuse services. In April 2011 the trust merged with Leicester City and Leicestershire County and Rutland Community Health Services as a result of the national transforming community services agenda. This has enabled joined up mental health and physical health care pathways to advance health and wellbeing for the people and communities of Leicester, Leicestershire and Rutland. The trust no longer provides substance misuse services. The trust has 15 active locations registered with CQC.

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

Summary of findings

population of approximately one million people across Leicester, Leicestershire and Rutland, has a budget of £270,000,000 and employs over 5,500 staff in a wide variety of roles. The trust obtained a £4.65m surplus year ending March 2018, compared to £2.24m year ending March 2017. The trust predicts a surplus of £3.27m year ending March 2019. Services are commissioned through three local clinical commissioning groups and specialised commissioning within NHS England. The trust's key stakeholders include Leicestershire County and City Council, Rutland County Council, police and ambulance services, Healthwatch, primary care and mental health partners and local universities.

What people who use the provider's services say

We spoke with 32 patients and two carers. Patients gave positive comments about staff, and were generally happy with their care and the ward environments. Many patients commented on the smoking cessation treatments and range of options available. Patients liked the physical health checks, and regular check ups. Patients felt involved in the ward rounds and completed the pre-multidisciplinary form (green sheet) to record their needs on their collaborative care plan. One patient said staff always checked if they experienced any side affects with medicines. One patient said they were provided with diabetic meal choices. Another patient told us there were vegan meal choices but these were limited.

One carer at The Willows told us they had seen their relatives care plans and staff kept them involved and were very friendly. They felt staff had more time to work with their relative.

Areas for improvement

Action the provider MUST take to improve

All the areas for improvement identified during the inspection in November 2018 remain in place. We noted significant improvement in all areas identified in the warning notice. However, we expect the trust to continue to monitor and report to us on the following areas of improvement:

- The trust must continue to address the waiting lists for children and young people and regularly report on progress to the Commission.
- The trust must continue with its programme of refurbishment works to the Bradgate Mental Health Unit and provide regular progress updates to the Commission.
- The trust must review its response times to requests for maintenance repairs at the Bradgate Mental Health Unit.
- The trust must review its arrangements for oversight of medication management by the trusts' central pharmacy department to the wards.
- The trust must continue to focus on staff and patients adherence to no smoking environments at the Bradgate Mental Health Unit.
- The trust must review its process for conducting searches on patients who return from leave, to prevent lighters and prohibited items being secreted onto the wards which pose a risk to themselves and others.
- The trust must continue to review how lessons learned are shared amongst staff within and between the acute wards and PICU units.
- The trust must continue to address its compliance with the Mental Health Act Code of Practice when recording seclusion.

Leicestershire Partnership NHS Trust

Detailed findings

Requires improvement

Are services safe?

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

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

Summary of findings

Environment

Significant improvements had been made to the environments on most wards. The majority of repairs and maintenance issues highlighted within the warning notice at the Bradgate Mental Health Unit had been fixed or resolved. A further programme of works for older wards were due to commence. Bosworth will complete in July 2019 with works to Aston and Thornton due to commence in August 2019 (for completion in March 2020). Two property managers were appointed with responsibilities for acute, forensic, and rehabilitation wards. New systems were in place for staff to report any repairs or maintenance issues.

There were improvements in ligature risk assessments. The trust used the Manchester ligature audit tool to assess the environment for ligatures in inpatient areas. All ward ligature risk assessments had been reviewed by health and safety staff, ward sisters and matrons. Ligature risk assessments were located on each ward, identified all risks together with mitigation summaries. Colour coded displays identified "heat spots" and photographs of rooms ensured staff were are aware of potential ligature anchor points. Ligature risk assessments and ward mitigation plans were held locally and on a central electronic data base. Ligature audit spot checks were ongoing on wards.

Some newer staff (student, associated nurse and bank nurse) did not know about the ward ligature audits, but explained what ligature points were

Risk assessments of patients

Risk assessments of patients had improved. Staff completed risk assessments that were thorough and had been reviewed following patient incidents. Some staff groups had received training around patient risk assessments.

Medicines Management

The trust had improved medicines management. All wards had developed their own systems to improve medicines management in their areas. Medicine management training sessions had been undertaken with inpatient ward sisters and charge nurses. A regular programme of spot checks of ward clinic rooms were ongoing and required further time to embed learning. Most medical equipment including blood monitoring and blood pressure equipment had been calibrated to ensure it worked correctly.

Fire safety

We saw improvements to address patients smoking. The smoke free policy was undergoing further consultation with patients and staff before final adoption in June 2019. Patients were offered smoking cessation treatments, nicotine replacement therapy(NRT), or free vapes for seven days. Patients could then purchase vapes on the ward. Smoking cessation had been successful across most wards in the Bradgate Mental Health Unit. No-smoking posters were designed and displayed at the Bradgate. The trust had organised the removal of discarded cigarettes and regular and ongoing upkeep in Bradgate ward gardens.

Fire safety was much improved. We looked at six fire drills reports and found fire drills were carried out regularly. The trust fire safety management policy was revised to include information about general emergency evacuation plans and personal emergency evacuation plans (PEEPS). An escape plan was developed with patients who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency. We saw patients that needed a PEEP had a plan in place. The need for a PEEP was added to patients admission check list and handover agenda.

Seclusion environments and documentation

Some improvements were seen in seclusion documentation and seclusion environments. The trust

had implemented new seclusion paperwork in May 2019. A full audit was scheduled for the end of June 2019. Improvements had been made to seclusion areas at The Willows Acacia and Maple wards.

Maintaining privacy and dignity of patients and concordance with mixed sex accommodation

The trust had maintained patients privacy and dignity at Short Breaks services. The trust revised the statement of purpose for emergency requests for Short Breaks Services. Managers liaised with families and rebooked breaks to ensure no mixed sex breaches and letters were sent to families to explain the rationale.The trust ceased mixed sex breaches by maintaining male and female only weeks..There have been no mixed sex breaches since 11 February 2019.

Patients privacy and dignity had been addressed at The Willows, Cedar and Acacia wards. Staff had been escorting male patients past female bedrooms and bathrooms to access the laundry area. The trust had made changes to the wards in consultation with patients, families, carers and staff. Acacia was now an all-female ward and Cedar was an all-male ward. Changes were completed by 29 April 2019.

The trust had ensured patients privacy and dignity was maintained when receiving physical health observations. Ward staff at the Bradgate Mental Health Unit had met together and set clear guidelines on where and how physical health observations are completed on the wards. Guidance posters were displayed on wards.

Our findings

Environment

At our last inspection, the trust had not ensured that they maintained the safety of patients due to poor ward environments. Similar environmental issues had been raised with the trust in previous inspections. Fixtures and fittings were often worn, stained and/or in a state of disrepair and not all environmental risks had been identified or mitigated against. The trust were required to ensure all environmental risks were identified and mitigated against and that risk assessments contain appropriate actions detailing plans to update, replace or remove identified ligature risks. We found environmental issues in the acute wards for adults of working age and psychiatric intensive care units, and long stay or rehabilitation mental health wards for working age adults.

At this inspection we noticed the trust had made significant progress in this area. The majority of repairs and maintenance issues highlighted within the warning notice at the Bradgate Mental Health Unit had been fixed or resolved. The trust had invested in redecoration, new lighting and flooring throughout Aston, Ashby and Bosworth wards. We saw bright colours had been used to redecorate the wards, new furniture was in place and new windows allowed more light and fresh air into the wards. The changes had made considerable differences to the wards since our last inspection, and patients told us the environments were much better. Staff told us they felt the investment the trust had made into the wards and improved their place of work, and had had a positive impact on team morale. Staff told us they had felt invested in.

However, on Heather and Watermead wards the general fixtures and fittings looked worn. Scraps and peeling paint were observed in communal areas. Patient wardrobes for all rooms were on order and to be affixed to walls. On Aston ward one ceiling corridor light was not working so it would be harder to see patients in the corridor. New radiator covers were due to be changed in next phase programme of works.

On Thornton ward some wardrobes were fixed to the walls, however bed side tables and old chest of drawers were not fixed o the walls. Replacement for wardrobes in some cases had been a unit with four shelves. Some patients reported this was not enough storage space. Television cabinets were new but not fixed to walls and awaiting refurbishment. On Griffin unit in room 4 bedroom blinds were still awaiting repairs from 18 May 2019.

A further programme of works for four older wards Ashby, Bosworth, Aston and Thornton was due to commence in phases in July and August 2019. Further main refurbishment work will continue on Aston and Thornton wards in August and September 2019 for full completion by March 2020.

At Stewart House all doors had been replaced and the tile in the occupational therapy kitchen replaced. Stained and worn fittings had been addressed including a cooker

replaced. The door from the female lounge had been replaced and two toilets fixed. Staff told us the dedicated maintenance lead at Stewart house had speeded up the process to ensure items were addressed for repair.

Two property managers were appointed with responsibilities for acute, forensic, and rehabilitation wards. New systems were in place for staff to report any repairs or maintenance issues.

Staff at Belvoir psychiatric intensive support unit (PICU) told us it was difficult to get repair work done quickly. Repairs in seclusion were still outstanding 24 hours after being reported.

There was variability in how staff reported maintenance requests and response times for repairs at Bradgate Mental Health Unit. Ward clerks were not aware of maintenance spreadsheets held at reception. Some staff reported making maintenance requests to reception by phone or email. Staff reported they no longer received reference numbers and this made it harder to track progress of jobs. On Watermead ward staff reported 32 light internal and external bulbs before Christmas needed repair. Most were repaired in batches in March, however some lights were still not working. Staff were using torches in unlit areas. Despite the new maintenance systems some staff followed the old maintenance process.

At our last inspection, the trust had not ensured all environmental risks were identified and mitigated against and that risk assessments contain appropriate actions detailing plans to update, replace or remove identified ligature risks. We found issues in the acute wards for adults of working age and psychiatric intensive care units, and long stay or rehabilitation mental health wards for working age adults' services.

There were significant improvements in ligature risk assessments. We looked at seven ligature risk assessments across wards. The trust used the Manchester ligature audit tool to assess the environment for ligatures inpatient areas. All ward ligature risk assessments were reviewed by Health and Safety staff, ward sisters and matrons. Ligature risk assessments were located on each ward, identified all risks and comprehensive. Colour coded displays identified "heat spots" and photographs of rooms ensured staff were are aware of potential ligature anchor points. Ligature risk assessments and ward mitigation plans were held locally and on a central electronic data base. Changes could be tracked where updates had been provided. On Bosworth ward all windows had been replaced with anti ligature windows. Senior staff had delivered training sessions on ligature audits and health and safety on wards. Ligature audit spot checks were ongoing on wards.

Three newer staff did not know about the ward ligature audits, but explained what ligature points were.

On Watermead ward the ligature audit did not include anti-barricade features. Ashby ward had anti-barricade fixtures and fittings but there was a small gap on some doors which could be a potential ligature point and was not on the ligature risk assessment. The ward manager said they would take immediate action.

Risk assessments of patients

At our last inspection, the trust had not ensured that staff were assessing the health and safety of patients receiving care or treatment and the trust did not do all that is reasonably practicable to mitigate any such risks. Staff on Maple ward were not completing or updating patient risk assessments in line with the trust policy or after incidents had taken place.

We looked at 20 patient risk assessments across wards, including eight at the Willows Maple ward. Risk assessments of patients had improved. The trust had reviewed the patients risk assessment. Staff completed risk assessments that were thorough and had been reviewed following patient incidents. Risk assessments were easy to track, with monthly updates with and clear follow up after incidents. Some staff groups had received training around patient risk assessments.

Medicines Management

At our last inspection, the trust had not made sufficient improvements in medicines management since the last inspection in 2017. The trust must ensure the safe management of medicines, to include storage, labelling and disposal of medications. We found the trust medicines management practice was unsafe in relation to the storage, disposal and medicines reconciliation for the following reasons:

We were not assured that staff were administering medication that had not expired as they had failed to record when medication was opened which meant that the expiry dates of the medication could not be determined.

Requires improvement

Are services safe?

The trust had not ensured that staff on the ward had the required amount of green tote bags in order to comply with their own policy for disposal of medications.

Controlled drugs were not always managed and recorded in accordance with regulations. Legislation clearly stipulates that registers should include the form of the medication for every medication entered in to the controlled drugs register.

Within the Bradgate Unit and Stewart we found loose tablets in patients named drawers locked within the clinic. Whilst the medication was still within the plastic packaging it was difficult to ascertain the type and dose of these medications. Therefore, we could not be certain that staff had assured themselves that they were administering the correct medication and dosage to patients.

In addition to the above evidence we also found four other unsafe practices in regard to the trusts management of medication at Stewart House, Maple ward.

Within the acute wards for adults of working age and psychiatric intensive care units staff failed to ensure that medical equipment had been calibrated to ensure that it worked correctly. We found blood monitoring and blood pressure equipment that had not been regularly checked or calibrated.

At this inspection the trust had improved medicines management. We visited 10 clinic rooms, looked at 29 medicine charts and three electronic controlled drugs (CD) registers. The trust had introduced labels for medicines to record the date of opening. Staff complied on most occasions with the new process; however on Aston and Stewart House, there were two liquid medicines with no dates recorded of when opened. On Stewart House we found some eye drops and insulin pens which had expired although were not in use by a patient. These medicines were discarded by the nurse when notified. Medicated creams in all areas were stored securely. There were no loose strips of medicines except one in Aston. All wards had green pharmacy return bins and were used appropriately. On the Bradgate unit, electronic controlled drug (CD) registers were in place and balances were correct on the wards we inspected. On Stewart House we found one instance where the form of one CD had not been recorded in the register. This was rectified by the staff nurse when brought to their attention. Ashby had a new CD cabinet which arrived 2 weeks prior to inspection and had not yet been fixed to the wall in line with CD regulations.

All blood monitoring machines had been calibrated daily and test solutions had open dates on them. Blood pressure machines had been serviced and were within their service interval, except on Beaumont and Bosworth wards. However, we found gaps in blood pressure monitoring checks on Heather, Beaumont and Bosworth wards.

All depot injections for patient charts sampled had been administered on time. All medicines were reconciled on Maple ward and we were informed on Aston ward that pharmacy technicians would visit the ward to check patient own medicines and gain consent from patients to check the medication history from GP surgeries. We were informed by staff on Maple ward that pharmacy sent out a weekly 'snapshot' report of administration of when required (PRN) medicines to aid review. Six charts and care records were inspected. We saw a chart for one patient prescribed PRN medicines since July 2018, but had had no doses. We could not find evidence of review on the care record. Another patient had an almost daily use of PRN benzodiazepine since September 2018, again there was no evidence that this had been reviewed.

All ward areas inspected had a rapid tranquilisation (RT) policy and instances of when RT had been administered. The policy indicated that in an emergency the reversal agent flumazenil must be administered by doctors or suitably trained person. However, not all staff nurses were aware if flumazenil was available on the ward and did not feel confident to administer. We raised this with a senior member of the pharmacy team who told us that flumazenil had been removed from resus trolleys and stored in the out of hours cupboard. However, we found this medicine in the emergency box, within the resus trollies. These emergency boxes were supplied from the pharmacy department.

On Thornton, we found that patients leaving the ward for a few hours at a time were given their PRN benzodiazepines to take away with them by nursing staff which was recorded on a paper system. We examined the record for one patient who had left the ward frequently over a 3 week period and had 11 instances where diazepam had been given. We were told by pharmacy that a nurse supply should only occur when the pharmacy department is closed or authorised by pharmacy in special circumstances. Authorisation forms

were available but we saw no completed forms. Procedure for nurse supply was not being followed as suitable packaging was not available and nurses were handwriting the instructions on envelopes containing the medicine to give to the service user instead of pre-prepared pharmacy labels. The supply was not documented on the administration record of the service user and therefore there was risk that the service user could receive more than the prescribed dose. Immediate action was taken to address this.

All wards had developed their own systems to audit the medicines management in their areas, however there was no consistency across the trust on the frequency and how this was carried out. Pharmacy presence had increased in certain areas, Ashby and Stewart House where a pharmacist would assess patients for self-administration of medicines. Medication administration assistants were part of pilot scheme, with two in post at the Bradgate Mental Health Unit to look after clinic rooms. However, ward staff still described irregular pharmacy visits and a general lack of pharmacy oversight in medicines management.

Fire safety

At our last inspection, staff did not manage the risk of patients smoking in the ward in line with the trust smoke free policy. We found the following evidence of when patients, staff and visitors could have been placed in potential high-risk situations. The trust reported 14 fires caused by lighters or matches brought onto the ward by patients since November 2017, this included a large fire in the garden of Bosworth ward.

We saw at this inspection improvements to address patients smoking. The smoke free policy was undergoing further consultation with patients and staff before final adoption in June 2019. Patients were offered smoking cessation treatments, nicotine replacement therapy(NRT), or free vapes for seven days. Patients were provided with a talk and information from the vape provider. Patients could then purchase vapes from the ward. Smoking cessation had been successful across most wards in the Bradgate Mental Health Unit. No-smoking and banned items posters were displayed at the Bradgate Mental Health Unit. The trust had organised the removal of discarded cigarettes and regular and ongoing upkeep in Bradgate ward gardens.

We visited six wards at the Bradgate Mental Health Unit and saw cigarette ends in ward gardens, except on Aston ward. Some patients were smoking on wards. On Thornton ward we saw a patient walk onto the ward with a lit cigarette. On Beaumont ward we smelt cigarette smoke. Some patients were concealing lighters and cigarettes and bringing them onto wards. There was inconsistent practice around searching patients, not all staff were using security wands to search patients. Staff told us lighters, gas canister and prohibited items were being brought on the wards, which posed a risk to patients and staff. Some patients told us informal patients were being asked smuggle in items as they wouldn't be searched. A drug dog was used where and when it was believed a patients were in possession of an illegal substance. Staff and patients told us there was inconsistent practice on wards about patients vaping and using e-cigarettes in communal areas and on wards. Some staff on Watermead ward smoked outside the female ward door area, and patients saw this.

Staff at Belvoir and Griffin units told us they carried out regular searches of patients upon entering the unit to reduce contraband and keep patients safe; but felt searches were not effectively carried out on acute wards. Not all staff were familiar with the trust's search policy.

We looked at six fire drills reports and found fire drills were carried out regularly, often four to five times a year. Aston ward had not conducted a fire drill since October 2018. Staff told us there had been two fires on acute wards, one in Aston in March 2019 and Beaumont in May 2019. Staff said one fire was linked to a patient concealing a cigarette lighter, and a patients radio caught on fire. Staff discussed learning from these incidences at team meetings with actions for staff to reinforce the smoking policy and searching patients.

At our last inspection two visibly disabled patients on Thornton and Beaumont wards did not have personal emergency escape plans as part of their care plan. Staff had not considered or assessed how they would maintain the safety of these patients if they needed to evacuate the patients in an event of a fire.

At this inspection the trust's fire safety management policy was revised to include information about general emergency evacuation plans and personal emergency evacuation plans (PEEPS). A PEEP is a escape plan developed with patients who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency. We saw patients that needed a PEEP had a plan in place. The need

for a PEEP was added to patients admission check list and handover agenda. Paper copies were held in the handover file, the exception was Bosworth ward paper copies were not available for easy access. On "patient glance boards" showed a red flag and on patient electronic records an alert flag, which demonstrated that patient required a PEEP. Fire drills were completed and rated to test the use of PEEPS.

At our last inspection on Belvoir unit we saw a fire door with broken closure on one side and a missing closure on the other. This had been repaired.

Seclusion environments and documentation

We carried out a review of seclusion practices prior to our inspection in November 2018. We reviewed 58 sets of records relating to periods of seclusion that took place between April 2018 and September 2018. We found that records did not always meet the recommendations set out in the Mental Health Act Code of Practice.

At this inspection we saw the trust had implemented new seclusion paperwork in May 2019. A full audit was scheduled for the end of June 2019. We looked at 20 sets of seclusion records and visited seclusion facilities at Bradgate Mental Health Unit, Belvoir, Griffin psychiatric intensive care units, and The Willows. We found shortfalls in 18 sets of seclusion records sampled. We saw at Bosworth and Ashby wards two patients did not have medical reviews within one hour of seclusion. Fifteen patients were in seclusion for longer than 2 hours and records showed none of the nursing reviews were conducted by two nurses every two hours on Bosworth, Belvoir, Griffin, Ashby and Watermead wards. Fifteen patient records showed nursing reviews were carried out by one nurse. The new seclusion paperwork was not very clear in stating two nurses must conduct reviews. At Maple ward one patient's record showed a medical review took place after one and a half hours, instead of within one hour or without delay.

Staff had not completed six medical reviews for patients in seclusion on Griffin, Belvoir, Bosworth and Watermead wards. From 18 records only one record showed staff were recording every 15 minutes from monitoring the patient in seclusion.

We saw a detailed seclusion care plan for one patient at Griffin psychiatric intensive support unit.

There were environmental concerns identified at Belvoir and Watermead seclusion facilities. On Belvoir seclusion a sink was damaged and was a potential ligature point. The trust were looking at quotes for repairs. Lights on the left area of the seclusion room were not working. At Watermead seclusion the blinds were not working, in the assisted bathroom a nail was coming away from the door and presented a ligature point and could injure a patient. This was raised directly with staff. Staff had arranged for Watermead seclusion to be used as a bedroom for one patient due to bed pressures.

Patients on Ashby, Heather and Beaumont wards could access Watermead seclusion if needed. There was no seclusion facilities at Beaumont, Heather, and Thornton wards. Patients at Thornton ward could use the Bosworth seclusion if needed. Bosworth seclusion could not be assessed as a patient was in this area. Ashby ward seclusion was out of use from September 2018.

We saw improvements had been made to seclusion areas at The Willows Acacia ward new anti-ligature sink was fitted in April 2019 and Maple ward floor had been resealed. Managers told us the last seclusion was used last in March 2019 and the team were looking to remove the seclusion area, as it was not essential. The new seclusion paperwork issued in May 2019 had not been used.

On Bradgate Mental Health Unit some patients reported not wanting to go on leave as they may have to return to another ward. Some patients were admitted onto beds of patients on leave. One patient was sleeping in a lounge and another patient admitted into another patients room. A patient under 18 years were using the Bosworth seclusion room temporary due to bed shortages. Senior managers told us they had experienced exceptional high demand for beds the week of our inspection.

Maintaining privacy and dignity of patients and concordance with mixed sex accommodation

At our last inspection the trust had not ensured that wards for people with a learning disability or autism were compliant with mixed sex accommodation guidelines. We were not assured that the trust had taken action to ensure that they had complied with the Mental Health Act Code of Practice. This issue had been raised following inspections carried out in 2014 and 2016. In addition to this the trust failed to appropriately and accurately report breaches in mixed sex accommodation to commissioners.

At this inspection the "Delivering single sex accommodation" policy had been reviewed and approved.

Requires improvement

Are services safe?

Reporting arrangements had been revised and formalised. The trust had agreed with commissioners to report on any breach of mixed sex guidelines. The trust had maintained patients privacy and dignity at Short Breaks Services. The trust had revised the statement of purpose for emergency requests for Short Breaks Services. Managers liaised with families and rebooked breaks to ensure no breaches and letters were sent to families to explain the rational. The trust ceased mixed sex breaches by maintaining male and female only weeks. There have been no breaches since 11 February 2019.

Patients privacy and dignity had been addressed at The Willows, Cedar and Acacia wards. Staff had been escorting male patients past female bedrooms and bathrooms to access the laundry area. The trust had made changes to the wards in consultation with patients, families, carers and staff. Patients were asked in their ward round by their consultant about their feelings regarding the change. Acacia was now an all-female ward and Cedar was an all-male ward. Changes were completed by 29 April 2019. Staff told us a review of the changes would take place soon.

At our last inspection at Stewart House the door from the female lounge to the garden was in a state of disrepair. This had been repaired.

The trust ensured patients privacy and dignity were maintained when receiving physical health observations. At our last inspection we observed at Bradgate on Ashby, Aston and Thornton wards, staff taking patients physical observations (weight and blood pressure monitoring) in public areas of the ward. Managers at Bradgate Mental Health Unit had set clear guidelines on where and how physical health observations were completed on the wards. Staff offered patients a choice of where they received their physical health observations. Most patients were seen in the clinic room. However some patients requested health checks in the communal area on the wards.

Requires improvement

Are services effective?

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

Summary of findings

Physical Healthcare

The trust had improved how staff recorded patients physical health care; and monitored patients who had ongoing physical healthcare problems. Patients records showed physical health care plans and 72 hour checks in place in place. The trust had recruited two registered general nurses with dedicated time to focus on individual health care plans at Stewart House and The Willows. There were effective systems in place to audit and monitor records.

Our findings

Physical Healthcare

At our last inspection the trust had failed to ensure that all patients' physical health was appropriately assessed on admission and that regular assessments of the physical health needs of patients had been undertaken. Staff had not completed a physical health examination in 14 out of 30 records. We reviewed all records and found that no physical health monitoring had been recorded since the patient had been admitted to the wards.

At this inspection the trust had improved how staff recorded patients physical healthcare; and monitored patients who had ongoing physical healthcare problems. We looked at 55 patients records. Records showed staff ensured physical health care plans and 72 hour checks were in place. The admission checklist for physical health care had been reviewed to include:- nursing staff to carry out base line observations, full physical examination and cardio metabolic review. Staff used National Early Warning Score (NEWS) to assess patients. NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. Staff used the Lester tool for patients annual health checks. The Lester tool guides staff with assessments of cardiac and metabolic health, helping to cut mortality for patients with mental illnesses.

The trust had recruited two registered general nurses with dedicated time to focus on individual healthcare plans at Stewart House and The Willows. The trust carried out an spot check at The Willows on 07 May 2019 which showed 100% compliance for physical health examinations. We saw robust healthcare plans for patients with diabetic needs. There were effective systems in place to audit and monitor records.

Good

Are services caring?

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

Summary of findings

We did not inspect this domain.

Our findings

We did not inspect this domain.

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

Access to treatment for specialist community mental health services for children and young people

The trust had significantly reduced waiting times and the total numbers of children and young people waiting for assessments.The trust had reviewed existing systems and processes identified improvements and implemented changes. Funding had been secured for increased staff with specialist skills including locums, a service manager, clinical leads, nurses, psychologist, and allied health professionals. There had been a change in leadership and a review of key performance indicators (KPIs)with commissioners. The trust had developed new processes and redesigned and improved data validation.

Our findings

Access to treatment for specialist community mental health services for children and young people

Since our inspections from 2015 onwards the trust had not taken sufficient action to ensure that all patients within the specialist community mental health services for children and young people received the service they needed in a timely way.

Since our last inspection the trust had reviewed existing systems and processes identified improvements and implemented changes. Funding had been secured for increased staff with specialist skills including locums, a service manager, clinical leads, nurses, psychologist, and allied health professionals. The service had a dedicated analyst support ,to review demand and capacity.There had been a change in leadership and a review of key performance indicators (KPIs) with commissioners. The trust had developed new processes and redesigned and improved data validation. The trust had increased staffing, changed leadership arrangements, re-structured the scheduling of appointments and refined the process for accepting referrals. Waiting time compliance for assessment had improved substantially and commissioner support has been secured to address concerns regarding GP referral practices to reduce the percentage of patients that cannot be contacted or choose appointment times outside the commissioned targets.

We visited City outpatients team at Westcotes House for Children and Adolescent Community Mental Health Services (CAMHS). Staff told since our last inspection they were happy to see money and resources had been invested into the service. There were new staff in post and staff morale had improved. Staff were able to access reporting data quickly and talked about regular reviews of patients waiting for assessment and treatment.

We saw data that showed the trust had significantly reduced waiting times and the total numbers of children and young people waiting for assessments. In early June 2019 we saw 173 patients were waiting for routine assessments. At last inspection in 2018, 498 patients were waiting. This was a reduction of 325 patients. The median average was under 10 weeks from end of May 2019. Two patients waited more than 20 weeks. The trust planned target for September 2019 was to reduce to 100 patients.

The number of patients who waited for treatment, had increased from last year (969 patients) to 1045. This was 76 patients who waited over 12 months. There was an increase in children and young people waiting to start treatment, following assessment. The trust did not meet the 18 week target for treatment. The trust worked to adjust their electronic record keeping system to capture more accurately when waiting lists came down. March 2019 data showed waiting lists had come down from 31 weeks to 15 weeks.

Demand for neurodevelopment assessments continued to be high. The trust had underestimated the amount of neurodevelopment patients in the pathway. From early June, data showed 1029 patients were waiting with neurodevelopment issues for either a specialist assessment or treatment. Of the 1029 patients, 162 (16%) patients had been waiting for one to two years. 636 patients were waiting less than 180 days (62%) and 391

Requires improvement

Are services responsive to people's needs?

patients were waiting over 180 days (38%). We saw evidence of the service reducing the waiting list by 11 patients the week of our inspection from the previous week. The trust had plans to screen each of these patients on the waiting list to find out patients current needs.

A weekly neurodevelopmental specific patient tracking list meeting takes place to optimise capacity and productivity. Outsourcing arrangements were in place to begin on the 1st July and the support of the NHS Improvement (NHSI) IST. NHS Improvement (NHSI) is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. NHSI IST (Intensive Support Team) had been secured to ensure that capacity and demand analysis is independently re-assessed.

Work was on-going to support the achievement of the CAMHS target to telephone patients within two hours and assess them within 24 hours. We saw data from April and May 2019 124 patients (84%) were telephoned within 2 hours. However 8% fell below the three hours and 6 % fell over the three hours. Some 2% of patients were recorded as "unsuccessful contact/poor data quality."

In April and May 2019 88 patients (72%) were assessed within 24 hours, 11% failed contact, 9% choose to be seen at a later date, 7% unsuccessful contact made and 1% Did Not Attend (DNA). The trust demonstrated significant improvements in this area and had embedded new processes regarding telephone and face to face referral management processes. They had implemented clinic scheduling, and new administration staff.

The trusts KPI target for urgent assessment (assessed within four weeks) and routine assessments (assessed with 13 weeks) was reviewed. We looked at data for May 2019 waiting times for assessment and treatment the trust had a local KPI target rate of 92% and delivery rate of 92%. For routine appointments the local KPI was 92% the delivery rate was 69%. Managers told us their routine performance looked poor because they were clearing the waiting list to complete the pathway for children waiting over 13 weeks. Currently there was one child waiting over 20 weeks (with a booked appointment) the median waiting time was nine weeks. The trust predict their performance for routine appointments will significantly improve rapidly over the coming months.

We saw senior managers and trust leaders had comprehensive trajectory plans to reduce waiting times were ongoing, with daily and weekly monitoring of demand and capacity.

Inadequate

Are services well-led?

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

Summary of findings

Oversight and governance

We saw the trust had developed oversight and a vision on how to improve the nine key areas identified by the warning notice. The trust had launched its "Step up to Great" approach, which identified the vision and priorities for the year. Two external governance reviews had been commissioned and undertaken. One review was in response for the delivery of actions for the 2018 CQC inspection. A further review was an examination of processes and procedures within the trust for reporting investigations and learning from serious incidents requiring investigation. Heads of Service had reviewed governance processes within the remit. A full review of trust committees terms and reference were underway.

There was variability in sharing of lessons learnt across the acute wards and PICU units. Staff on some acute and PICU wards did not have regular team meetings. The trust provided newsletters, quarterly serious incidence bulletins, regular emails from matrons about incidences and lesson learnt.

Our findings

Oversight and governance (including learning from incidents)

At the last inspection the trust did not have robust governance procedures to ensure that they could identify and address issues across the trust in a timely way. These issues with governance procedures had been reported at the last inspection in 2017. The trust governance processes had not identified issues around environmental repairs, medicines management, seclusion documentation and sharing lesson learnt from incidents. The trust needed to make significant improvements in acute wards for adults of working age and psychiatric intensive care units, wards for people with a learning disability or autism, long stay or rehabilitation mental health wards for working age adults, specialist community mental health services for children and young people in order to be compliant with Regulations set out in the Health and Social Care Act.

At this inspection we found the trust had developed oversight and a vision on how to improve the nine key areas identified by the warning notice. We found compliance around:-maintaining the privacy and dignity of patients and concordance with mixed sex accommodation, risk assessment of patients, and meeting patients physical health care needs. The remaining areas we saw significant improvements had been made and we expect the trust to continue to monitor and report to us.

The trust had adopted a three phased approach to responding to the warning notice actions. Phase 1 responded to immediate actions such as repairing fixtures and fittings. Phase 2 addressed quality improvement work to secure changes to systems and processes, and phase 3 was to embed and sustain change. The trust told us the second phase would form part of the trusts "Quality Improvement Plan."

The trust had launched its "Step up to Great" approach, which identified the vision and priorities for the year. Two external governance reviews had been commissioned and undertaken. One review was in response for the delivery of actions for the 2018 CQC inspection. A further review was an examination of processes and procedures within the trust for reporting investigations and learning from serious incidents requiring investigation. Heads of Service had reviewed governance processes within the remit. A full review of trust committees terms and reference were underway. Since our last inspection there had been new leadership at the trust, which had an impact.

We looked at 20 sets of meeting minutes 11 patient green forms (pre-multi disciplinary meeting forms), two health and safety folders, one incident system review. We saw at team meetings staff discussed a range of issues for example incidents, seclusion, smoke free policy, ligatures, PEEPS, audits, observations levels, patient involvement,

patients green sheets, "Step up to Great" approach, staff supervision, lessons learnt, CQC checklists. On Watermead ward meeting minutes did not provide learning or actions as a result of incidents.

Staff told us there had been two fires in 2019 on Aston and Beaumont ward. One fire was linked to a patient concealing a cigarette lighter, and another the patients radio caught fire. Staff discussed learning from these incidences at team meetings with actions for staff to reinforce the smoking policy and search patients. However some staff heard about these incidences through "word of mouth."

There was variability in sharing of lessons learnt across the acute wards and PICU units. Staff on the acute and PICU wards did not have regular team meetings, some teams including matrons had stopped holding team meetings due to work pressures. Staff on Aston ward told us they attended other ward team meetings to gain knowledge. Some wards had safety huddles specifically to discuss safety and any incidences. Most staff told us they read the trust newsletter for the sharing of lessons learnt. The trust provided newsletters, quarterly serious incidence bulletins, regular emails from matrons about incidences and lesson learnt.

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This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust must continue to address the waiting lists for children and young people and regularly report on progress to the Commission. The trust must continue with its programme of refurbishment works to the Bradgate Mental Health Unit and provide regular progress updates to the Commission. The trust must review its response times to requests for maintenance repairs at the Bradgate Mental Health Unit. The trust must review its arrangements for oversight of medication management by the trusts' central pharmacy department to the wards. The trust must continue to focus on staff and patients adherence to no smoking environments at the Bradgate Mental Health Unit. The trust must review its process for conducting searches on patients who return from leave, to prevent lighters and prohibited items being secreted onto the wards which pose a risk to themselves and others. The trust must continue to review how lessons learned are shared amongst staff within and between the acute wards and PICU units. The trust must continue to address its compliance with the Mental Health Act Code of Practice when recording seclusion.