Requires improvement

Lincolnshire Partnership NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RP7EV	Mental Health Unit, Peter Hodgkinson Centre, Lincoln County Hospital	Conolly Ward and Charlesworth Ward	LN2 5QY
RP7LA	Mental Health Unit, Pilgrim Hospital	Ward 12	PE21 9QS

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

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

Summary of findings

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Inadequate** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated acute wards for adults of working age as requires improvement because:

- Bed occupancy rates were over 100%. Staff were using leave beds frequently to accommodate new admissions. There were a number of identified delayed discharges across the service. There were high numbers of patients in out of area beds at the time of inspection. There were 32 re-admissions to hospital within 28 days of being discharged, with half of all patients returning to the same ward they were discharged from. Fifty-five per cent of patients did not have discharge care plans in place.
- Sleeping areas consisted mostly of bays sleeping four or five patients. These areas offered limited space and privacy.
- Staff did not always assess or monitor the physical health of the patients. They did not always have a care plan in place for patients who had identified physical health problems. Staff did not always follow National Institute for Health and Care Excellence guidelines or trust protocol around the administration of rapid tranquillisation.
- Detained patients accessed leave without qualified staff having completed a risk assessment immediately prior to leaving the building.
- Staffing levels at weekends were lower than in the week. This affected staff capacity to escort patients who had leave.
- There had been an increase in the use of restraint and prone restraint across this service, since the last inspection.
- Compliance with mandatory training was below the trust's own target, and some compliance fell below 75%.
- There was absence of care plans for patients being nursed, or had been nursed in seclusion across the service. We reviewed 18 records of seclusion. No patients had a care plan in place to reflect they were being nursed by staff in seclusion
- Clinical staff did not receive regular supervision.
- Not all staff had received an annual appraisal.

However:

- Ligature assessments were robust and management plans were in place to manage risk.
- Clinic rooms were well equipped. Nursing staff checked emergency medications and equipment regularly.
- There were no blanket restrictions across the service. Any restrictions were individually risk assessed.
- Staff had a good knowledge of what constituted a safeguarding concern and the reporting process.
- Staff were trained to use restraint as a last resort. Staff used verbal de-escalation before resorting to physical contact.
- Doctors completed an initial physical health assessment for all new admissions where possible. If the patient declined, staff recorded this and attempted again at the earliest opportunity.
- The trust provided additional training for staff development to enhance their roles.
- There was good access to advocacy services, which was utilised by patients.
- There was appropriate involvement of families and carers.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Detained patients could access leave without having been risk assessed immediately prior to leaving the building by a qualified staff member.
- Staff and patients reported that lower staffing levels at the weekends had an adverse impact upon care and treatment.
- Compliance with mandatory training was below the trust's own target, and some training compliance fell below 75%. This included conflict resolution training (restraint) which was 61% and breakaway which was only 50% across the service.
- Patients nursed in seclusion did not have a care plan in place to reflect this.
- Across the service, there had been an increase in the number of restraints and prone restraints (face down) used since the previous inspection.

However:

- Ligature risk assessments were robust. There were clear management plans in place for staff across the service.
- Clinic rooms were well equipped with emergency equipment that was checked regularly.
- There were no blanket restrictions across the service. Any restrictions used were justified through individual risk assessments and used for the shortest time possible.
- Staff had a good knowledge of what constituted a safeguarding concern and were able to explain the reporting process.
- Staff knew what constituted an incident and knew how to report.
- Staff received feedback from investigations of incidents across the service.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff did not always follow National Institute for Health and Care Excellence guidelines or trust protocol around the administration of rapid tranquillisation.
- Staff were not receiving regular clinical supervision.
- Patients who had identified physical health problems did not always have a care plan in place.
- Not all staff had received an annual appraisal. The trust was not meeting its own target of 95%.

Summary of findings

However:

- There was a range of mental health disciplines and staff that provided input into care and treatment of patients.
- Staff had a good understanding on the Mental Health Act and its application into practice.
- Patients received a physical health assessment upon admission to the service.
- Patients had access to advocacy services. Staff supported patients with referrals.

Are services caring?

Good

We rated caring as good because:

- We observed kind and respectful interactions between staff and patients.
- Staff were motivated to do the best for patients.
- There were good links with advocacy services and staff would initiate referrals on behalf of patients.
- There was appropriate involvement of families and carers.
- Patients were able to give feedback about the services through regular community meetings.

However:

- It was not always evident in care records that patients had been involved in their care planning.

Are services responsive to people's needs?

Inadequate

We rated responsive as inadequate because:

- Sleeping areas consisted mostly of bays sleeping four or five patients. These areas offered limited space and privacy.
- Bed occupancy was consistently above 100%. Leave beds were being used frequently to accommodate new admissions.
- There were a high number of patients placed in hospitals out of area due to no local bed availability.
- Discharges were delayed for non-clinical reasons.
- There were 32 re-admissions to hospital within 28 days of being discharged, with half of all patients returning to the same ward they were discharged from.
- Fifty-five per cent of patients did not have discharge care plans in place. ?

However:

- Patients accessed hot and cold drinks when they wanted.
- There was a good range of space, including outside space and private areas, which patients used for visitors.

Summary of findings

- There was a good range of activities on offer across the service.
- Patients knew how to make a complaint. Staff investigated complaints appropriately.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff were not up to date with some mandatory training. The trust were not meeting their own targets. Staff reported attending training could be difficult if the wards were busy.
- Staff were not receiving regular clinical supervision across the service. Records were inconsistent between the wards.
- Not all staff had received an annual appraisal. The service was not meeting the Trust target.

However:

- Staff felt as part of a team who supported one another.
- Ward managers were highly visible on the wards, and staff felt they were supportive and approachable.
- Staff reported Incidents appropriately. Lessons learned were cascaded to staff.

Summary of findings

Information about the service

The acute wards for adults of working age provided by Lincolnshire Partnership NHS Foundation Trust are part of the trust's acute division. The wards are situated over two sites.

Lincoln Hospital, The Peter Hodgkinson Centre, has two wards for adults of working age: Charlesworth and Conolly. Charlesworth has 20 beds and is a female ward. Conolly has 22 beds and is a male ward.

Pilgrim Hospital in Boston has one ward, Ward 12. This is a mixed gender unit, with 10 beds designated for males, and 10 beds designated for females.

There are also three beds in a separate area, which are specifically allocated for patients referred by the Ministry of Defence.

All wards accept patients detained under the Mental Health Act. The trust do not currently have a psychiatric intensive care facility, however at the time of inspection building works were being carried out which will later offer ten male beds.

The Care Quality Commission last inspected Lincolnshire Partnership NHS Foundation Trust in December 2015. The overall rating for this service was requires improvement. The safe domain was rated as inadequate; effective and caring domains were good; responsive and well led domains were requires improvement. The following areas were identified as actions the provider must take to improve:

- The trust must ensure that all ligature risks are identified on the ligature risk audit.
- The trust must ensure that they do all that is reasonably practicable to mitigate any such risks.
- The trust must ensure that clinical staff receive regular supervision.
- The trust must ensure that staff receive mandatory training in line with trust targets.
- The trust must ensure that patients' dietary preferences are considered at mealtimes.
- The trust must ensure that changes made because of lessons learnt are implemented in all areas.

The trust completed an action plan to address the recommendations made. At the time of inspection, the trust said they had addressed all action plans, with the exception of one. This related to maintenance work to outside courtyards. At the time of inspection, this work was underway and close to completion.

However, during inspection we found that staff were not receiving clinical supervision, and the trust was still not meeting their mandatory training targets.

Our inspection team

Our inspection team was led by:

Chair: Mick Tutt, Deputy Chair, Solent NHS Trust.

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

Inspection Manager: Karen Holland, Inspection Manager, mental health hospitals, CQC.

The team that inspected the acute wards for adults of working age consisted of five people; two CQC Inspectors, two specialist advisors (one nurse and one consultant psychiatrist) and one expert by experience that had personal experience of using, or caring for someone who uses, the type of service we inspected.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all three wards at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 20 patients who were using the service
- spoke with two carers of people who were using the service
- spoke with the managers of each of the wards
- spoke with 33 other staff members; including the acute services manager, doctors, nurses, support workers, housekeepers; occupational therapists, psychologist and activity co-ordinators
- reviewed 22 care and treatment records of patient
- attended and observed one hand-over meeting and three multi-disciplinary meetings
- reviewed specific seclusion documentation for 18 patients across the service
- collected feedback from five patients using comment cards
- looked at 46 medication charts across the service
- looked at medication management on each ward
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- We spoke with 20 patients during inspection. Generally, we were told that the staff were helpful and caring.
- Eleven of the patients we spoke with told us that they thought that there was a good selection of activities offered.
- Patients expressed mixed opinions about the food on offer, although there was some choice, and the wards catered for different dietary requirements.
- Ten of the twenty patients we spoke with reported that they did not feel that there was enough staff on duty to offer the care and treatment needed.
- Two patients told us that privacy was an issue due to the shared dormitories. A further twotold us they had personal belongings go missing.
- Carers we spoke with were complimentary about the staff, and told us staff kept them updated on progress.
- One carer thought that the wards were not very private, in respect of the dormitory accommodation.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that detained patients are appropriately risk assessed by a qualified staff member prior to any prescribed leave commencing.
- The trust must ensure that clinical staff receive regular supervision.
- The trust must ensure that staff receive mandatory training in line with trust targets.
- The trust must ensure that patients who are being nursed in seclusion have care plans in place.
- The trust must ensure that physical health care needs are reflected in care planning.
- The trust must ensure that patients have appropriate discharge plans in place.

Action the provider SHOULD take to improve

- The trust should ensure that staff are following best practice guidelines when prescribing and administering rapid tranquillisation.

Summary of findings

- The trust should ensure that documentation reflects the patient's involvement with care planning.
- The trust should ensure that assessments of patients in seclusion are recorded.
- The trust should ensure that there is sufficient staff on duty over the seven-day period, which meets the needs of the patients.
- The trust should ensure that staff receive annual appraisals in line with trust targets.

Lincolnshire Partnership NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Conolly Ward and Charlesworth Ward	Mental Health Unit, Peter Hodgkinson Centre, Lincoln County Hospital
Ward 12	Mental Health Unit, Pilgrim Hospital

Mental Health Act responsibilities

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

- Detention paperwork was in order and stored appropriately.
- Training in the Mental Health Act was mandatory for staff, 93% of staff had completed this training across the service.
- Staff had a good understanding of the Mental Health Act and its application in practice.
- Staff adhered to consent to treatment and capacity requirements.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training in the Mental Capacity Act and Deprivation of Liberty safeguards was mandatory, 70% of staff had received this training across the service.
- Staff supported patients to make decisions where appropriate. Staff recorded capacity assessments that were decision specific.
- The trust had a policy in place, which staff could refer to.

Detailed findings

- Staff interviewed had a general understanding of the principles of the Act, and knew who to contact for advice if required.

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

Our findings

Safe and clean environment

- The ward layout enabled staff to observe patients on the ward. The trust had installed mirrors to aid observation where blind spots had been previously identified.
- All wards and patient areas had robust ligature risk assessments in place. These provided management plans so that staff knew how to manage risks identified. Measures used were supervision from staff, enhanced observations and closed circuit television.
- Conolly and Charlesworth wards were both same sex accommodation wards. Ward 12 was mixed sex accommodation, offering ten male beds and ten female beds. The wards complied with Department of Health guidance on eliminating mixed-sex accommodation. Conolly ward had reported some single sex breaches over the past 12 months. These were in relation to one female patient nursed in seclusion on a male ward, as the seclusion room on the female ward was in use. Staff reported this to all relevant persons at the time it occurred and reported it in line with the trust incident policy.
- Each ward had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs. Nursing staff checked these regularly.
- Each ward had a seclusion room. The rooms met the guidance in the Mental Health Act Code of Practice. Staff had clear visibility into the room, which enabled staff to closely monitor patients. Toilet facilities were available which patients could access as required. Patients could see a clock and so would be orientated to the time. There was working two-way communication systems in place. On Charlesworth ward there was a small safety cover missing from the metal doorframe. Staff had reported to maintenance and this was being addressed. (There was no patient in this room at the time of the inspection). The seclusion rooms on both Charlesworth and Conolly wards were located in a main corridor. Other patients had to pass this room to reach their bedroom. This compromised the privacy of patients in seclusion. Staff told us that they were mindful of this and always tried to ensure that the area was clear of patients when staff were escorting a person into seclusion. The seclusion room on ward 12 was located in the male corridor. Female patients taken into the room had to walk through the male area. Staff told us they would preserve as much privacy and dignity as possible, and were aware that this was not ideal.
- Ward 12 had a crisis suite located in a private area. The ward also had three beds for patients referred from the Ministry of Defence. This service was commissioned and staffed separately.
- PLACE assessments are self-assessments, undertaken by teams of NHS and independent health care providers, and include at least 50% of members of the public. Assessments are completed annually. In the 2016 PLACE score for cleanliness, both sites scored above the England average (98%) and the trust average (99%). The Pilgrim hospital scored 100%, and the Lincoln site scored 99%.
- For condition, maintenance and appearance, both sites were below the England average (95%). The Lincoln site scored 93%, and the Pilgrim hospital site scored 87%, which was also below the trust average (91%).
- Staff adhered to infection control principles. Each ward had adequate hand washing facilities and visible posters around infection control and hand washing.
- Equipment on the ward was well maintained and staff worked with maintenance staff if they had any concerns.
- Housekeepers were in post and worked throughout the seven day week. Cleaning records were up to date and showed that staff cleaned all areas regularly.
- All staff and visitors had alarms so that they could call for assistance if required. There were also call bells situated around the ward for patients to summon staff.

Safe staffing

- The trust provided data on staffing as of 31 March 2017. The total establishment of registered nurses across the service was 42 with five vacancies. The total establishment of nursing assistants was 46, with five vacancies.
- The trust used bank staff regularly and only used agency staff as a last resort. The wards used bank staff familiar with the wards to cover shifts wherever possible.

Requires improvement

Are services safe?

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Between 1 January and 31 March 2017, 354 shifts had been covered by bank staff, and 67 shifts with agency staff. Of these, 182 were on Ward 12, 134 on Conolly ward and 105 on Charlesworth ward. The total number of shifts, which staff could not cover across the service during this time, was 184. The ward with the most shifts not covered was Ward 12 with 91. Additional staff were requested if patients required enhanced observations. This accounted for many of the shifts requested. The ward managers assisted on the wards if needed.

- Sickness rates varied across the service from 4% on Charlesworth and Ward 12, to 7% on Conolly ward. Most sickness was short-term. Staff received return to work interviews following any periods of sickness.
- The trust had estimated the number and grades of nurses required per shift, and the nursing rotas matched this.
- The ward managers were able to adjust staffing levels daily if there was an identified need, in order to meet patient need.
- Each ward operated a system whereby an allocated support worker "visibility nurse" were present within a short distance from the entrance to the ward, at all times throughout the day. The visibility nurse changed every two hours, with support workers rotating into this role. In addition to this, staff tried to base themselves in communal areas so that patients were visible. However when on the wards, we noted that at times there were patients in communal areas of the ward with no staff member present as they were busy elsewhere.
- Staff told us that they tried to have regular one to one time with patients. Staff were allocated patients to care for on each shift. This included offering one to one time. However, staff told us one to one time with patients was difficult when wards were busy. Staff did not always record one to one time in the patients' notes. We were unclear, therefore how often patients received one to one time with their named nurse.
- Patients and staff told us that ward activities were available. These were rarely cancelled. However, staff and patients said that escorted leave during weekends had been postponed on many occasions, as the staffing levels decreased. This impacted upon the care and treatment offered.
- There was enough staff on shifts to provide any physical interventions (restraint). Staff across Conolly and Charlesworth wards assisted one another if required. Ward 12 was more isolated due to its location. However, we identified no concerns in relation to restraint and staffing numbers on Ward 12 during this inspection.
- The service had 24-hour medical cover. However, staff told us that as the doctors often covered more than one service, they could not always get to the ward quickly. This would depend on the location and the doctor's workload.
- There were 28 mandatory training courses across the trust. Compliance with these courses varied. The compliance rate set by the trust was 95%. Overall, the total compliance rate across this service was 86%. Out of the 28 mandatory courses, 20 fell below trust target. Compliance was 100% for three courses, which were falls; food hygiene and infection control. Mandatory courses that were under 75% compliance included Mental Capacity Act (70%); Adult basic life support (63%); conflict resolution (61%); Safeguarding children (58%) and breakaway training (50%).

Assessing and managing risk to patients and staff

- The service had 92 incidents of seclusion between 1 January and 31 December 2016. Charlesworth ward had the most with 48, Conolly ward had 30, and Ward 12 had 14. Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour, which is likely to cause harm to others. Most patients had been secluded for short periods (hours). Some instances of seclusion over the past 12 months had lasted for 72 hours or more, if the patient had been waiting for a psychiatric intensive care unit placement out of area. There were no reported incidents of long-term segregation across the service.
- Between 1 January 2016 and 31 December 2016, there were 209 incidents of restraint across this service. The trust reported that numbers of restraint had increased since the last inspection. The highest number of restraints occurred on Charlesworth ward (121). These restraints involved 39 different patients; 24 of these were in prone position (face down). Conolly ward recorded 60 restraints over the same time involving 28 different patients, 16 in the prone position. Ward 12 recorded 28 restraints involving 19 different patients. Two of these were in the prone position. Of all of the restraints across the service, 20% were in the prone position. This was an

Requires improvement

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increase since the last inspection. The Positive and Proactive Care guidance from the Department of Health (2014) states that prone restraint should be avoided unless there are specific reasons for doing so. Staff avoided the use of prone restraint where possible due to the known associated risks. Staff turned the patient over or into a different position at the earliest opportunity if prone restraint was used. Incidents of restraint were reviewed monthly by an allocated staff member. Each ward had a specific de-escalation room.

- Staff completed risk assessments for patients. Of the 22 records examined, 21 had these in place. Staff updated these following multidisciplinary meetings.
- The trust used a risk assessment that was specific to the trust and covered many areas including previous and current risks, protecting factors, drug and alcohol abuse and mental health.
- Staff only used restrictions following a team discussion and completion of a risk assessment. The service did not use blanket restrictions.
- The exit doors to the wards were locked. Access in and out of the wards was via a swipe card. Informal patients were able to leave, if they asked the visibility nurse for a swipe card that granted them access. This same process applied to detained patients if the psychiatrist had granted leave.
- There was a policy in place for the observation of patients, as well as the searching of patients, belongings and bedroom areas. Searches took place on a risk basis and staff explained this to patients.
- On Ward 12, when rapid tranquillisation had been utilised for two patients, a combination of medicines had been used together. This was outside of the National Institute for Health and Care Excellence (NICE) guidance, as well as outside of the trust policy.
- We reviewed18 records of seclusion. No patients had a care plan in place to reflect they were being nursed by staff in seclusion. In seven out of the 18 records doctors had signed the appropriate forms regarding the seclusion. However, there was no record of the doctor's assessment.
- Staff had received training in safeguarding of adults. Ninety six per cent of staff had completed this training. Staff were able to make safeguarding alerts when required and had a good understanding of processes. However only 58% of staff had completed training around the safeguarding of children. The trust could not be sure that staff had received sufficient training for their role.
- All wards had good medicines management and staff followed trust policy with regards to the storage and dispensing of medicines. A pharmacist visited the wards on a daily basis between Monday and Friday. The trust completed regular audits around medication to include missed doses of medications; adherence to the policy around controlled drugs and the safe and secure handling of medications.
- Staff were aware that risk assessments for nutrition, falls or skin integrity could be completed to assess a patients risk if indicated by their presentation.
- All wards had private areas whereby children could visit if agreed and risk assessed by the multidisciplinary team.

Track record on safety

- The trust reported 18 serious incidents between 1 October 2015 and 30 September 2016. Two incidents involved the death of a patient. The most common type of serious incident related to deliberate self-harm (44%).
- One incident involved a newly admitted patient. The ward had changed their practice following this incident and no new admissions were left unaccompanied when they first arrived on the ward, prior to being officially admitted. In addition, the staff tried to co-ordinate any admissions outside of meal times.

Reporting incidents and learning from when things go wrong

- Staff were aware of what incidents needed reporting and could explain how they would do this.
- Staff told us that they would be open and transparent if things went wrong. For example, if staff had to postpone a patient's leave, due to high activity on the ward, staff explained this to them. Staff tried to resolve or re-arrange at the earliest opportunity.
- Staff were informed of investigations following incidents and learning was shared across the service. Ward managers attended divisional meetings and discussed incidents. The trust also sent out monthly bulletins of lessons learnt. Each ward had a staff member lead on incidents, who would take responsibility to ensure that

Requires improvement

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all incidents reported on their ward had been actioned appropriately. Staff discussed incidents that involved medication errors during medicines link nurse meetings, and during team meetings.

- Nurses told us that they had an improved understanding of requirements for the monitoring of high dose antipsychotic medications. This was through learning as the result of an investigation following an incident.
- Staff felt supported after serious incidents and de-briefs were offered. One staff member told us their manager, for additional support, referred them to occupational health. This service was available for all staff.

Are services effective?

Requires improvement

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.

Our findings

Assessment of needs and planning of care

- Most patients had comprehensive and timely assessments following admission to the wards. Some entries were more detailed than others.
- Care plans were recovery orientated and holistic. Of the 22 records examined, 14 patients had up to date and relevant care plans. Staff had not updated five care plans to reflect current needs. Staff were working on a further three care plans, as these patients had recently been admitted to the service.
- Care records examined across the service demonstrated that all new admissions received a physical health assessment upon admission or shortly afterwards where possible if the patient had consented. Care records on Conolly and Charlesworth wards demonstrated ongoing monitoring of physical health where appropriate. However, on Ward 12 we found that there was not always robust ongoing monitoring of physical health by the nursing staff. Specific physical health concerns were not recorded in care plans. For example, we saw that one patient had epilepsy, and had recently experienced a seizure. There was an old care plan around physical health, which staff had discontinued in January. A further, relevant care plan was not in place to highlight the patient had epilepsy. In another patient's record, there was no care plan specific to the patient being diabetic. This patient had lost considerable weight within a short space of time, yet there was no recorded referral to a dietician to discuss healthy eating or weight loss. There was no evidence of involvement from a specialist diabetic nurse. A further care record examined described a patient as having angina. A doctor had advised daily monitoring of blood pressure; however documentation showed that staff had not been monitoring this on a daily basis.
- Patient records were electronic. Staff could access these if, for example a patient moved between teams.

Best practice in treatment and care

- Staff followed the National Institute for Health and Care Excellence (NICE) guidelines in relation to prescribing of anti-psychotic medications. Doctors prescribed appropriate doses, alongside assessment of potential side effects. There was appropriate physical health examinations and monitoring of patients.
- The wards had a psychologist in post, on a 12-month contract. This enabled patients to access short-term sessions. The psychologist offered sessions such as mindfulness, psychosis work, preparation for dialectical behavioural therapy, and how to cope with symptoms.
- We saw that staff monitored patients whose dietary and / or fluid intake was a concern. This was reflected in fluid balance charts, where staff recorded the oral intake of foods and drinks.
- Staff used outcome measures, for example, the health of the nation outcome scales. The teams used this to determine the level of need and treatment pathways for patients.
- Staff participated in clinical audits, for example Mental Health Act audits, physical healthcare audits and care audits.

Skilled staff to deliver care

- The service had a good range of mental health disciplines and staff to meet the needs of patients. This included psychiatrists, a psychologist; occupational therapists and assistants; pharmacists; nurses; support workers and physical healthcare co-ordinators.
- Staff had varying degrees of experience and a range of qualifications.
- New staff received an appropriate induction period, which included undertaking mandatory training as well as time on their allocated ward to familiarise them with the ward and patient group.
- Managers told us that staff received appraisals on an annual basis, which enabled staff to discuss learning and development. The trust target rate for appraisals was 95%. All three wards fell below this target; Conolly ward at 90%, Charlesworth ward at 86%, and Ward 12 at 74%.
- Wards held regular team meetings. However, staff did not receive regular clinical supervision. The trust provided data for clinical supervision during October, November and December 2016 for the three wards. Conolly ward reported a rate of 9% for December. All other percentages were 0%. We reviewed a sample of twelve staff files that included a mix of qualified and unqualified staff across the service. There was no regular pattern for staff receiving supervision, and the numbers of supervision sessions differed considerably between staff. We found that four staff had not had supervision between January 2016 and the date of

Are services effective?

Requires improvement

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.

inspection; three staff had received one, two staff had two sessions recorded, one staff member had received five, and two had received six sessions. Within training records seen, some management supervision was evident, which related to training needs and relevant issues on the wards.

- The trust provided staff with specific training for their roles and encouraged personal development. Leadership training was offered to ward managers and deputy ward managers. Registered nurses had opportunities for mentorship training. Nursing assistants undertook the care certificate training. Staff felt that they had opportunity to develop skills and knowledge.
- Senior staff managed poor staff performance in a timely manner and effectively. The human resources department were available to offer support and guidance if required.

Multi-disciplinary and inter-agency team work

- Each ward held regular multidisciplinary meetings. We observed part of these meetings on each ward. The meetings on Conolly and Charlesworth wards were well organised. Staff in attendance clearly knew the patients well. In contrast, nursing staff who attended on Ward 12 did not appear to have a good knowledge of the patients. One staff member told us that this was because they had been on leave recently.
- Hand-overs took place between each shift. These were focused and informative.
- Staff reported different experiences in effective working relationships with other teams in the organisation (for example the crisis team). Some staff reported that relationships were good, with open communication. Whereas other staff felt that communication could be improved between the services. Ward staff communicated regularly with care co-ordinators following patient reviews.
- Staff reported that they had effective working relationships with external agencies, such as social services or general practitioners (GPs).

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

- Mental Health Act administrators examined documentation at the earliest opportunity. Out of hours and at weekends, a senior nurse examined these to ensure the papers were correct before accepting the patient.
- Staff knew who the Mental Health Act administrators were, and felt that they ask for advice if needed.
- Each ward documented what leave patients had been authorised to have. Detained patients had an appropriate section 17 forms in place, which authorised periods of leave. These stipulated whether the leave was escorted or unescorted.
- Mental Health Act training was mandatory for staff, 93% of staff across the service had received this, against a trust target of 95%. Staff we spoke with had a good understanding of the Mental Health Act and its application in practice.
- Where patients required certificates of consent to treatment or second opinion authorisation (T2/T3) documentation we saw that this held with the medicines chart. This ensured staff prescribed and administered medication under the appropriate legal authority.
- Patients had their rights explained to them upon admission and routinely following admission.
- Staff completed detention paperwork correctly. It was up to date and stored appropriately. There was administrative support from Metal Health Act administrators, who regularly audited files.
- Patients had access to advocacy services. We saw visible information across the service with contact details. In addition to this, staff gave us examples of when they had referred patients if they felt that they needed some additional support. For example, in relation to their detention in hospital and not comprehending their rights when explained.

Good practice in applying the Mental Capacity Act

- Across the service, 70% of staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This training was mandatory. The trust had not achieved its target of 95% compliance. Staff we spoke with had a basic understanding of the Act, knew what the purpose of the Act was, and were aware of who to go to if advice was needed.

Are services effective?

Requires improvement

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.

- Between 1 January and 31 December 2016, the service had made six DoLS applications. Of these, two were approved and four were not approved. At the time of inspection, there was one patient under a DoLS. All paperwork was in place.
- The trust had a policy in place for the MCA and DoLS. Staff were aware of this and knew where to locate it.
- We saw that capacity assessments had been completed which were decision specific and recorded in patient files. Staff supported patients to make decisions where appropriate. Staff discussed capacity issues during multidisciplinary meetings.
- Staff contacted the Mental Health Act administrators for advice around the MCA and / or DoLS for advice as required.
- Staff were aware of the process of how to make a DoLS referral.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff interacted with patients in an appropriate, caring and respectful manner. We saw good interactions between staff and patients.
- Patients reported that generally staff treated them kindly and with respect.
- Most staff interviewed had a good understanding of individual patient needs and were able to tell us about current care and treatment.
- Both sites scored below the England average (90%) for privacy, dignity and wellbeing. The Perter Hodgkinson Centre scored below both the trust and England average for privacy, dignity and wellbeing with a score of 74%. However, Pilgrim hospital scored 89%, which is above the trust average of 82%.

The involvement of people in the care that they receive

- Staff admitting the patients orientated them to the ward and introduced them to staff and other patients where possible.
- Staff encouraged patient independence, which was reflected in care plans. Patients attended the multidisciplinary meetings and were able to discuss and question their care and treatment. Staff told us that they offered copies of care plans to patients, although it was difficult to see this recorded in care plans.
- Patients were aware of advocacy services and knew how and when to contact.
- Families and carers were involved in care and treatment where appropriate. The trust had an email account set up for families and carers. This enabled them to email and express their opinions, if for example they could not attend a multidisciplinary meeting.
- Patients were able to express their opinions and any concerns during the weekly community (ward) meetings held across the service. We saw a variety of issues discussed and addressed in these meetings, such as maintenance issues and suggestions for activities.
- We did not come across any patients who had advance decisions in place at the time of inspection.

Are services responsive to people's needs?

Inadequate

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

Our findings

Access and discharge

- The trust risk register highlighted one risk across this service related to insufficient acute inpatient beds. Between 1 January 2015 and 31 December 2016, the average bed occupancy for this service was 106%. All three wards had bed occupancy of 100% or more. Staff frequently admitted patients into beds of others who had gone on a period of leave. Ward 12 had the highest bed occupancy rates at 110%. Conolly ward at 105% and Charlesworth ward 104%.
- Data provided by the trust showed that between March 2016 and March 2017, the trust had placed 306 patients out of area in acute units. Between February 2016 and February 2017, the trust had placed 63 patients in psychiatric intensive care beds (PICU) out of area. At the time of inspection, there were 46 patients who had remained out of area; five patients placed in PICU, and the remaining in acute beds. Some patients were placed over 100 miles from the trust. This could cause difficulty with friends and family visiting. The Care Quality Commission had rated one of the receiving independent hospitals as inadequate. This hospital had taken a high number of patients. Due to the distance from Lincolnshire, we were concerned that the trust had not implemented adequate monitoring to assure that these patients were receiving high quality care.
- The service had two bed managers who located available beds for patients and organised transfers at the earliest opportunity. The bed managers worked between nine and five Monday to Friday. Outside of these hours the crisis home treatment team sourced acute and PICU beds. It was not guaranteed that this would be during the day, as it was dependent upon presentation of the patients. Between January 2015 and 31 December 2016, staff transferred four patients after 22:00hrs.
- At the time of inspection, the trust had no PICU. Any patient who required a PICU would have to be transferred out of the locality to another unit that could meet their needs. The trust was in the process of building a ten bed male PICU at the time of inspection. The trust was also exploring the possibility of providing a similar unit for females in the future.
- There were 32 re-admissions to hospital within 28 days of being discharged, with half of all patients returning to the same ward they were discharged from.
- The teams had a discharge co-ordinator and a social worker who worked with the staff to discharge patients .However, on one ward during a multidisciplinary review, we found that seven patients had been assessed as being recovered and did not need an acute inpatient bed.
- The trust reported that between 1 January and 31 December 2016 there had been 84 delayed discharges across the service. Conolly ward had the highest number at 43; Ward 12 had 25 and Charlesworth ward 16.
- Of the 22 patient records that we examined, ten had a discharge care plan in place. The remaining records had no discharge care plan in place. However, there were three relatively new admissions, who we would not have expected to have discharge care plans.

The facilities promote recovery, comfort, dignity and confidentiality

- All wards were located on the first floor and consisted mostly of bays sleeping either four or five patients. These areas offered limited space and privacy and is not conducive to well-being or recovery. There were some single rooms across the service on each ward. Each ward offered showering and bathing facilities. However, ward 12 only had a bath on the designated male side of the ward and so women did not have the option of a bath. The patients had bought this up during a community meeting in February. Senior staff told us that they were considering altering some of the layout on the female side in order to provide bath facilities.
- The wards had sufficient rooms and equipment to support the care and treatment of patients. This included areas that could be used privately to receive visitors.
- Patients were able to make telephone calls in private, as most had personal mobile phones. Each ward had a telephone and a private area to make and receive calls for patients who did not have a mobile.
- Considerable work had been completed to provide safe outside space for patients on Conolly and Charlesworth wards. Both wards were located on the first floor and so patients had to go to the ground floor to access fresh air.

Are services responsive to people's needs?

Inadequate

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

There was a secure, large outside area for patients, which provided seating. This area could also be used for patients who were using nicotine replacement vapours. The area had live stream CCTV and had an intercom so that two-way communication was available between patients and the wards. Work on this area was being completed during the inspection. Ward 12 was also situated on the first floor so patients had to go to the ground floor to access fresh air. There was a spacious courtyard with seating for patients. Work had been completed in terms of previous concerns around ligature risks. A robust assessment was in place.

- Pilgrim hospital scored above both the England national average (92%) and the trust average (91%) for ward food. The Peter Hodgkinson centre scored below the average for both at 87%.
- Patients could make themselves hot and cold drinks throughout the day and into early evening. Staff facilitated patients to have hot drinks late at night if needed.
- We saw some personalisation of bedroom areas, although there was not much space due to most beds being in dormitories. We saw that some patients had personal belongings and drawings in their bed space.
- Patients had lockable space to store personal belongings, either a lockable drawer in their bed area or a locker on the ward.
- There was access to activities over a seven day period. Each ward had timetables visible so that patients knew what was on offer. Examples of activities included cooking; art; badminton, film night and a trip out to a local garden centre.

Meeting the needs of all people who use the service

- Each service had an internal lift and provided facilities for patients who may have limited mobility or required disabled access. We saw that on one ward, staff used manual handling aids to assist a patient who had mobility difficulties. Staff were appropriately trained to use the equipment.
- Information leaflets were written in English. However, information was sourced in other languages as and when required.
- Each ward had accessible information on treatments, advocacy, how to complain as well as information around local services.
- During one multidisciplinary meeting, staff arranged for an interpreter to accompany a patient to the meeting.
- The service had a choice of food to meet dietary requirements of different religions and ethnic groups.
- Each ward had a spirituality room for the use of patients. These rooms had various different religious literature, prayer mats, a compass, and provided a quiet private space.

Listening to and learning from concerns and complaints

- The trust had received 19 complaints between 1 January and 31 December 2016. Ward 12 received the most complaints with nine. Five of these were either fully or partially upheld and four were not upheld. Conolly ward had six complaints; one was partially upheld; five were not upheld. Charlesworth ward had four complaints; one was partially upheld; three were not (one is still under investigation and has been referred to the Ombudsman). Themes of complaints across the service included communication and information, and issues around the Mental Health Act.
- Patients knew how to make a complaint and told us they would talk to staff on an individual basis; or would bring their complaint to the community (ward) meetings. Staff minuted these meetings.
- Staff were aware of the complaints procedure and how to escalate concerns so they were investigated at the right level.
- Ward managers cascaded information around complaints and outcomes during team meetings.

Are services well-led?

Requires improvement

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.

Our findings

Vision and values

- The trust's vision was to make a difference to the lives of people with mental health needs and learning disabilities and to promote recovery and quality of life. We saw that staff did want to make a positive difference to patients. This was evident within interactions seen, behaviours displayed and through documentation examined. Staff were recovery focused and encouraged patients to be as independent as possible.
- Staff were aware of the senior managers within the trust. The acute services managers had visited the wards. Ward managers felt supported.

Good governance

- The staff mandatory training target was 95%. The service had not met this. Mandatory courses that were under 75% compliance included information governance (74%), Mental Capacity Act (70%), adult basic life support (63%), conflict resolution (61%), safeguarding children (58%) and breakaway training (50%).
- Appraisals across the service fell below the trust target of 95%. The highest rate of completed appraisals was on Conolly ward with 90%; Charlesworth ward 86% and Ward 12 the lowest at 74%. Ward managers told us that they had scheduled outstanding appraisals.
- Staff records seen, and interviews with staff, confirmed that staff were not receiving regular clinical supervision.
- Staff and patients we spoke with on Conolly ward and Charlesworth wards felt that staffing was sufficient during the week. Staffing at weekends, due to decreased numbers of staff, was hindered further by having no receptionist to welcome patients to the wards. Staff could not always make themselves available to patients as and when they needed.
- The service had administration support. This enabled staff to focus upon direct care activities. Examples of administrative support included the bed management staff; discharge co-ordinator as well as support on the wards. Administrative staff on the wards assisted with meeting minutes, scanning documents onto care files and other general tasks that were required.
- Nursing staff participated in clinical audits. For example, the medication management lead nurse regularly undertook audits around missed doses and signatures. The infection control lead would undertake audits related to infection control. The designated lead nurse on incidents reviewed all incidents on a monthly basis.
- Ward managers had access to trust data and systems, such as training, incidents and appraisals. This enabled managers to monitor the performance of their teams.
- Ward managers felt that they had sufficient authority to make decisions on a day-to-day basis, and felt supported by senior managers. Ward managers discussed risks with senior managers regularly. Staff added risks to the hospital risk register if appropriate.

Leadership, morale and staff engagement

- Of the trust staff, 59% completed the last staff survey. This was an increased rate from the previous survey. Themes of the survey included more staff reporting the trust took an interest in their health and wellbeing, staff were more confident at reporting errors, incidents and near misses. The number of staff who had experienced discrimination at work had decreased.
- There was no active bullying or harassment cases ongoing at the time of this inspection.
- Staff were aware of the whistle blowing process and felt that they could raise concerns without fear of victimisation.
- Staff wanted to do the best to meet the needs of the patients. Staff enjoyed their roles, and provided what they could to make the patients as comfortable as possible. This was evident during care observed.
- Ward managers and deputy managers were encouraged to undertake leadership development courses. Some ward managers had undertaken, and deputy ward managers scheduled to undertake. Other grades of staff were also encouraged to develop. Staff had opportunity to discuss personal and professional development with their managers during appraisals. Nurses had opportunity to undertake mentorship training. Nursing assistants were undertaking care certificate training.
- There was a good sense of team working between staff on each of the wards. Staff felt supported by each other.
- Staff felt that they were involved in giving feedback about the service via the staff survey and through meetings / conversations with managers.

Commitment to quality improvement and innovation

Are services well-led?

Requires improvement

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.

- Charlesworth and Conolly ward were awaiting review for the accreditation for inpatient mental health services (AIMS).
- Ward 12 had submitted relevant paperwork for AIMS review and were awaiting confirmation of progress. An administrative error had delayed this.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Detained patients were not always being risk assessed by a qualified nurse prior to going on S17 leave. • Patients being nursed in seclusion did not have care plans in place to reflect this. • Patients with known physical health problems did not have care plans in place to reflect this.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Not all staff were in receipt of regular supervision. • Staff were not up to date with some mandatory training, to include adult basic life support; and safeguarding of children and conflict resolution.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • Patients did not have discharge plans in place.