Requires improvement

Lincolnshire Partnership NHS Foundation Trust

Community-based mental health services for adults of working age

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)
RP7HQ	Trust Headquarters	Boston ICMHT	PE21 0AX
RP7HQ	Trust Headquarters	Gainsborough & Lincoln North ICMHT	DN21 1JD LN2 4WJ
RP7HQ	Trust Headquarters	Grantham & Sleaford ICMHT	NG31 9DF
RP7HQ	Trust Headquarters	Lincoln South ICMHT	LN2 4WJ
RP7HQ	Trust Headquarters	Louth ICMHT	LN11 0LF
RP7HQ	Trust Headquarters	Skegness ICMHT	PE25 2AP
RP7HQ	Trust Headquarters	Stamford & Spalding ICMHT	PE9 1UN PE11 3PB

Summary of findings

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.

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?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated this core service overall as **'requires improvement'** because:

- Staff vacancies and sickness impacted on their ability to deliver a service.
- Some risk assessments and care plans were basic and review dates were not always recorded.
- Some health and safety checks were not always completed.
- The ICMHTs had not been routinely involved in the development serious investigation action plans and staff had difficulty relating the learning from incidents to their work.
- Records did not show that patients received regular physical healthcare examinations.
- Teams were not always meeting trust targets for staff training, supervision and appraisals.
- Records did not show that patients had their rights regularly explained to them when subject to a community treatment order.
- There were delays with staff providing timely patient assessments and treatment.
- Staff told us they had not received adequate communication from the trust regarding restructuring and changes to the service.
- Staff were not aware of any action plans to address areas of poor performance identified following a national Care Quality Commission CMHT survey.

However:

- Staff were aware of their individual responsibility in identifying any safeguarding concerns.
- We observed effective patient assessments and reviews, with staff gaining the patients' history, current needs and risks.
- Staff treated patients with respect.
- Patients and carers told us that staff supported them with their individual needs.
- Staff were proud of their work with patients, despite the challenges they had with staffing resources.
- Teams prioritised urgent referrals and worked closely with crisis teams.
- A 'heat map' and identified service risks.
- Teams had staff champions leading on specific areas to improve the quality of service.
- Staff told us their line managers were approachable and supportive.

Summary of findings

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

Are services safe?

Requires improvement

We rated this core service as '**requires improvement'** for safe because:

- Staff vacancies and sickness impacted on their ability to deliver a service.
- September 2015 trust data showed that no teams had achieved the trust target of 95% staff mandatory training.
- Risk assessments were basic and review dates were not always recorded.
- Staff had not always recorded that they had made checks on equipment used to undertake the physical examination of patients.
- Medication stock records across teams were not clearly recorded.
  Housekeeping staff at Lincoln ICMHT were not completing daily infection control checklists.
- Health and safety checks were not always completed at Gainsborough ICMHT.
- Serious investigation action plans did not routinely involve ICMHTs in their development and staff had difficult relating learning from incidents to their work.

However:

- Staff were aware of their individual responsibility in identifying any safeguarding concerns.
- Staff adhered to personal safety protocols, such as lone working.
- Staff knew how to report incidents and were encouraged to use the reporting system.

Are services effective?

Requires improvement

We rated this core service as '**requires improvement'** for effective because:

- Patient care plans were often limited in detail and review dates were not completed.
- Records did not show that patients received regular physical healthcare examinations.
- Staff used mostly electronic patient records; however, these were not compatible with other systems used by teams within the trust.
- Teams were not meeting trust targets for staff supervision some teams were not meeting trust targets for staff annual appraisals.

Summary of findings

- Records did not show that patients had their rights regularly explained to them when subject to a community treatment order (CTO).

However:

- We observed effective patient assessments and reviews, with staff gaining the patients' history, current needs and risks.
- Some teams were involved in a training pilot to improve patient involvement in care planning.
- Staff used nationally recognised assessment tools, such as the wellness recovery action plan.
- Staff champions had been trained as best interest assessors to help inform their work

Are services caring?

Good 

We rated this core service as '**good**' for caring because:

- Staff treated patients with respect.
- Patients and carers told us that staff supported patients with their individual needs.
- Staff were proud of their work with patients, despite the challenges they had with staffing resources.
- Patients told us that staff involved them in deciding care and treatment options.
- Patients gave feedback on the care they received via friend and family test surveys.

However:

- Records did not consistently show patient involvement in care and treatment options.
- The results of the 2015 community mental health survey showed that nine scores were worse than other trusts.
- Most teams identified that the provision of carers support could be improved.

Are services responsive to people's needs?

Requires improvement 

We rated this core service as '**requires improvement'** for responsive because:

- The ICMHTs were not receiving effectively screened referrals from the single point of access team.
- There were delays with staff providing timely patient assessments and treatment.
- Some patients were waiting 45 weeks for a psychology team assessment.

Summary of findings

- Some teams reported difficulties covering a daily duty system, to respond promptly when patients contacted them, because of insufficient numbers of staff.
- There was no protocol for teams to follow for engaging with patients who did not attend appointments.

However:

- Once accepted for treatment, all patients were allocated a care programme approach (CPA) coordinator.
- Teams prioritised urgent referrals and worked closely with crisis teams.
- Teams offered patients 'fast track' discharges, which meant they could request ICMHT support again if their mental health deteriorated.
- Staff offered flexible patient appointments, including evenings and weekends if required.
- Staff could refer patients to specialist services to meet their needs if required, for example, some patients were referred to the recovery college.
- Systems were in place for processing, monitoring and responding to complaints.

Are services well-led?

Requires improvement

We rated this core service as '**requires improvement'** for well-led because:

- Staff told us they had not received adequate communication from the trust regarding restructuring and changes to the service.
- Staff said morale was low and sickness had increased.
- Most teams were not meeting trust targets for training, supervision, audits and waiting times, which managers had identified as a risk to the service.
- Managers told us trust data could sometimes be incorrect and they had to check it.
- Staff were not aware of any action plans to address areas of poor performance identified following a national Care Quality Commission CMHT survey.

However:

- A 'heat map' and identified service risks.
- Teams had staff champions leading on specific areas to improve the quality of the service.
- A senior manager had plans for further consultation about the service with staff, patients and stakeholders.

Summary of findings

- Staff told us their line managers were approachable and supportive.
- Managers had received leadership training to develop their skills.

Summary of findings

Information about the service

The trust's seven integrated community mental health teams (ICMHT) provide recovery-based interventions and support people to live with a mental health condition. They offer support to patients in their home.

Teams are staffed with: administrative support staff, community psychiatric nurses , occupational therapists, psychiatrists, psychologists, social workers and support workers.

Team coordinators manage the teams. The ICMHT lead and head of division line manage the coordinators.

Teams work closely with other local mental health services, such as the crisis resolution and home treatment teams, as well as inpatient wards. Support is generally provided Monday to Friday from 9am to 5pm.

The Care Quality Commission has not previously inspected the ICMHTs

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell, Chief Executive of Oxford Health NHS foundation trust.

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

Inspection Manager: Lyn Critchley, Inspection Manager, mental health hospitals, CQC

The team that inspected this core service included two CQC inspectors and five specialist professional advisors with medical, nursing, occupational therapy, psychology and social work backgrounds.

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

Why we carried out this inspection

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

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 the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited all integrated community mental health team (ICMHT) offices and looked at the quality of the office environments.
- Spoke with 27 patients and collected feedback from 17 patients via comment cards.
- Spoke with nine carers.
- Observed seven staff appointments with patients, including home visits.
- Observed a multi-agency professionals meeting to review risks for a patient.Spoke with 46 staff members.
- Spoke with eight managers, including team coordinators and the ICMHT lead for the service.
- Attended a senior management review meeting.
- Looked at 56 patient care and treatment records.
- Checked 147 patient medication charts.
- Looked at seven staff records.
- 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

Patients were very positive about a number of staff across all of the teams. The positive comments included staff being kind, listening to them and supporting them with their individual needs.

All but one patient told us that staff involved them in decisions about their care and treatment options.

Patients told us they knew how to access the advocacy services. One patient said they were concerned that they could not always access the staff in the community team because they were often out.

One patient who had moved to the United Kingdom told us that they had been supported with a translator and leaflets were made available to them in their own language.

One patient told us that they had been involved in a focus group and felt their views had been listened to. Another patient told us that they had been signposted to groups in the community, which had supported them to become more socially active and engaged.

Carers told us their relative or friend was supported by the team and support was available to them as appropriate.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure safe staffing levels at all times.
- The trust must ensure that patients are assessed and receive treatment in a timely manner.
- The trust must review its procedures to ensure that the learning from investigations and actions taken are embedded in ICMHTs.
- The trust must ensure that staff are consistently supported through regular supervision and training.
- The trust must ensure that governance systems are in place for informing detained patients under a community treatment order of their legal rights, with regard also to the Mental Health Act and code of practice.

Action the provider SHOULD take to improve

- The trust should ensure that regular environment health and safety checks take place for Gainsborough team.
- The trust should ensure that patients' risk assessments and care plans are regularly reviewed by staff and updated to reflect current needs.
- The trust should ensure adequate engagement with staff regarding proposed changes to their service.

Lincolnshire Partnership NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

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.

Staff knew how to contact the Mental Health Act office for advice when needed.

Staff reported difficulties accessing training because courses were booked up in advance. The trust did not provide specific Mental Health Act training for this core service. Managers stated that not all mandatory training targets were being met. Therefore, we were not assured that staff had adequate information regarding the new Mental Health Act code of practice.

Approved mental health practitioners were from multi-disciplinary backgrounds and most teams reported good access to coordinate Mental Health Act assessments.

Records did not show that patients subject to a community treatment order had their legal rights regularly explained to them under section 132 Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

September 2015 data showed that no teams had met the trust target of 90% for Mental Capacity Act 2005 training.

Staff champions told us they were having best interest assessors training to help inform their work. Records confirmed this.

Staff knew where to get advice within the trust regarding the Mental Capacity Act 2005 and they could refer to trust policy.

Detailed findings

Most patients' records we saw did not identify that any patients lacked the mental capacity to make decisions. Staff told us assessments were decision-specific and people were given every possible assistance to make a decision.

One patient was deemed not to have capacity with regards to finances. There had been a patient's best interests assessment and staff said a relative held power of attorney for health and welfare. However, documentation for this was not in the patient's records.

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

- In most of the ICMHT teams staff had access to alarms to use when using office interview rooms for patient appointments. However, Skegness and Boston did not have alarms and where they were available most staff told us they did not routinely use them. Staff told us that they relied on individual patient risk assessment. Teams had systems for checking alarm equipment. However, Gainsborough staff were not recording these checks.
- Spalding team were located in a modern purpose built facility with spacious rooms. There were alarms in meeting rooms and communal areas.
- Closed circuit television monitored communal areas, with signs displayed to inform people of this.
- Some equipment for the physical examination of patients was not routinely checked, for example, blood pressure monitors at Grantham, Sleaford and Stamford. Staff did not know if equipment had been checked and there was a risk that it would not be working properly.
- Information was displayed for staff and patients on infection control principles, such as handwashing. Most areas were clean and well maintained. However, the radiator in the Skegness team clinic room was heavily compacted with dust and dirt. Because of a recent change of contractor, housekeeping staff at the Lincoln team site were not completing daily infection control checklists to ensure a clean environment. This posed a risk that staff would not have information to enable them to identify and address infection control risks.

Safe staffing

- Data from the trust for the last three months showed that the Skegness team had the highest amount of staff vacancies, at 45%. The team also had the highest number of staff leaving over a year, with 6.4 staff leaving. The Boston team had the lowest staff vacancies, at 5%. Most teams reported staffing challenges affecting workload cover and their ability to deliver the service. For example, staff had left due to the uncertainty of their job because of restructuring. Several teams referred to having significant staff sickness. Managers had identified this on their service risk register.
- Twenty staff raised concerns with us about staffing levels. Two patient records in the Louth team showed that patients had required admission to hospital following missed appointments and difficulties with staff contacting them.
- September 2015 trust data showed six out of seven teams were above the trust staff sickness target of 4.5%, with five teams over 10% above the national average. The lowest was Lincoln South team with 3%; and the highest were Boston and Skegness teams, both with 17%. However, during our inspection 43% of clinical staff were on sick leave.
- A senior manager told us that staff average caseloads for working with patients should be 35, as identified in the commissioning guidance. However, for example, staff in the Gainsborough team reported their caseloads were higher. At Lincoln South, where there were no staff vacancies, staff said caseloads averaged 25. Data received from the trust showed significantly lower staff caseloads and did not correlate with staff and managers' feedback.
- Staff told us of examples of staff being off because of work related stress. Managers told us they regularly assessed the complexity of staff caseloads in supervision. They explained systems to support staff with ill health, such as conducting return to work interviews, consultations with occupational health and a staff wellbeing service.
- Some arrangements were made to cover the shortfall in staffing, such as the use of regular bank staff (employed by the trust as and when required) to ensure consistency of approach.
- Data from the trust for the last three months showed 170 hours filled by bank or agency staff and no unfilled shifts.

Requires improvement

Are services safe?

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

- A senior manager told us that following the restructuring they now had authorisation to advertise and recruit for band five staffing vacancies.
- Staff reported easy access to a psychiatrist as required.
- September 2015 trust data showed no teams had achieved the trust target of 95% staff mandatory training. Managers acknowledged this shortfall and explained it was because of several factors, such as staff going on maternity leave, sickness leave and some trust courses being fully booked until June 2016.
- Some staff had not received supervision. Some supervision that had been completed contained very limited information and did not show support, reflection or in-depth discussion. This was identified as a risk in the trust's 'integrated performance board report October 2014 – October 2015'.

Assessing and managing risk to patients and staff

- Patients had individualised risk assessments. Staff used various risk assessment tools, including the Manchester care assessment schedule (MANCAS) screening tool for mental health needs. Most risk assessments took into account historic risks and identified where additional support was required. We saw examples of crisis and relapse plans that identified triggers when a patient's mental health may be deteriorating. Advance directives electronic forms were available, but none we saw had been completed.
- We found examples where assessments were basic and review dates were not completed. For example, out of a sample of 21 care records in the Skegness and Boston teams, nine risk assessments were not up to date and four reviews had not been recorded. A records audit completed for Skegness and Boston teams, in October 2015, showed incomplete and missing information in six out of 10 care records. This included no risk assessment, incomplete reviews, missing carer's details, no MANCAS assessment and no wellbeing recovery plan. The manager told us that these results were emailed to staff and discussed at supervision. Two staff told us there was insufficient space on the electronic record to give details. Staff had not updated one Gainsborough patient's safeguarding adult tool since April 2015, which was outside the trusts standard of six months.
- September 2015 trust data showed teams were not meeting trust targets for a care programme approach (CPA) audit. Three teams had no data for a records audit. The highest compliance was 80% in the Boston and Skegness teams, and lowest was Spalding team at 66%. This posed a risk that staff would not have updated information that may need to have been referred to in the care and treatment of patients.
- Managers had systems for tracking and monitoring safeguarding referrals. Staff were aware of their individual responsibility in identifying any individual safeguarding concerns, reporting these promptly and ensuring protection plans were in place for patients.
- September 2015 trust data showed that only one team had met the trust target for safeguarding adults training and four teams met the target for safeguarding children training. The lowest for safeguarding adults was Louth team at 73%. The lowest for safeguarding children was 78% for Boston and Skegness teams.
- Staff referred to personal safety protocols, such as lone working. Two staff were not fully aware of the process to follow. Staff carried out risk assessments before visits to ensure patients and others were safe. Louth team were trialling a staff electronic alarm system. Gainsborough team's lone working risk assessment was out of date.
- Staff compliance with breakaway training was low at 62%, which posed a risk that staff may not have up to date knowledge and skills to manage their safety if lone working.
- Teams had systems for health and safety checks. However, at Gainsborough there was no first aider on site, although staff had undertaken basic life support training. A fire safety assessment was due for review. A weekly fire testing record was not documented in November 2015, nor was a gas safety check. A staff member at Gainsborough told us they had insufficient information about their role in leading on this and they had contacted the trust health and safety team to support them with this. The first aid kits in the Skegness team contained out of date plasters. There were no checklists to monitor the first aid kit contents.
- Teams had systems for medicines management, such as transport, storage and dispensing. At Gainsborough, medication was kept in a room where the temperature was above safe levels of 25 degrees Celsius for storing

Requires improvement

Are services safe?

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

medicines. The clinical room temperatures in the Skegness team were also close to the safe level and had been higher in the past. Staff actions to reduce the risk of medication being affected by high temperatures were not recorded. Temperature checks were being carried out on the fridges used to store medication. Some locations had medication stored in cupboards. This medication would not be protected from the high temperatures in the clinic rooms. There were medication stock lists on the cupboards, but these were out of date and did not reflect what was in the cupboards.

- We found errors on medication charts that could have led to incorrect administration of medicines. We looked at 44 medication charts in the Spalding team. Five charts had duplicates where the old chart had not been stopped or discontinued. This meant that there was a risk of medication errors occurring and patients receiving medication multiple times. Ten charts had not recorded patients' allergies, three charts were missing staff signatures and five charts had no GP information on them. The manager told us that pharmacy normally audited the medicine charts but this was usually just a small sample each time. We saw pharmacy feedback and comments on some of the medication charts. We looked at 25 medication charts in the Boston team. Six did not indicate how many medication charts were actively in use and six charts did not record patient allergies.

Track record on safety

- Data from the trust showed from September 2014 to September 2015 there were 21 serious incidents requiring investigation for adult community teams, which included ICMHTS. This was 23% of the trust total and the service with the highest amount.
- From April 2014 to July 2015, 12 (11%) of reported incidents related to adult community services, but not ICMHT specifically.
- A severe risk was identified for this core service on the trust risk register, relating to a 'failure to provide/ maintain quality services to patients', following the Community mental health survey 2015 results. An ICMHT service level risk register was in development, along with a report to the trust quality committee with actions identified.

Reporting incidents and learning from when things go wrong

- There was an effective way to capture incidents, near misses and never events. Incidents were reported via an electronic incident reporting form. Staff knew how to report incidents and were encouraged to use the reporting system. Incidents were discussed at senior staff meetings or in regular team meetings.
- Staff received a group wide staff email and a bimonthly 'lessons learnt' bulletin to keep them updated on trust wide incident learning points. However, most staff were unable to give examples of improvements made in their team as a result of learning from investigations.
- Team coordinators met regularly to review serious incident action plans and a senior staff member attended the trust serious incident review group. However, information we saw did not detail whether actions were completed. A senior manager confirmed that monitoring of individual serious incident investigation action plans took place outside of the ICMHTs, at trust level. The ICMHTs were not routinely involved in the development of action plans for their service. The manager said they needed to address this to ensure more specific learning and actions for their service. There was a risk that learning from incidents was not embedded in teams and practice.
- Incidents we reviewed during our visit showed that investigations and analysis took place, with actions for staff. Staff and patients had access to debriefs and support following incidents.
- We were given an example of staff taking action to reduce the risk of reoccurrence of staff medication administration errors in the Gainsborough team. Following the errors the manager had ensured a trust pharmacist review. A team action plan was being developed, with some immediate actions completed. Information provided by the trust confirmed that the pharmacy team had increased their support to community teams.

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

- Staff had completed care plans such as the 'wellbeing' plan.However, most were limited in detail. We observed effective patient assessments and reviews with staff gaining the patients' history, current needs and risks.
- Records did not show that patients received regular physical healthcare examinations. However, there was some evidence of patients receiving ongoing monitoring of physical health needs, for example, Lincoln South team regarding smoking cessation and monitoring of weight. Louth staff gave examples of supporting patients with these physical health concerns. Staff at Lincoln North said a trust physical healthcare lead monitored when patients' annual checks were due and made GP appointments for them. This was not clear from records.
- We found four examples when care plans review dates were not completed, for example, at Gainsborough.
- Staff used mostly electronic patient records.However, this system was not compatible with other trust teams, such as the drug and alcohol team; and verbal and written communication was required. This posed a risk that teams would be delayed in receiving information. Teams were scheduled to have electronic tablets for easier access to records by September 2015, but this was delayed until 2016.

Best practice in treatment and care

- Staff referred to using nationally recognised assessment tools, such as the wellness recovery action plan . However, we saw no evidence of this in care records.
- Grantham and Sleaford, and Stamford teams referred to involvement in the outcomes oriented approach to mental health services project, originally developed with child and adolescent services to improve outcomes, appointment attendances and dropout rates.
- Staff said they provided a range of therapeutic interventions in line with national institute for health and care excellence guidelines, such as dialectical behavioural skills, mindfulness, emotional first aid and cognitive behavioural therapy. This was not always evident in the care records.
- The adult clinical psychology and psychotherapies service works alongside the community mental health teams. Staff reported a waiting list of more than two years for these services. This was identified as a trust risk and actions were required.

Skilled staff to deliver care

- Teams included psychiatrists, nurses, occupational therapists, psychologists, social workers and support workers. Some teams had psychologists, for example, in early intervention posts. However, staff in most teams reported that the psychology service was separate.
- Staff received a trust induction before starting their work.
- Teams reported not meeting trust targets for staff supervision in the last six months However, trust data as of November showed 94% overall compliance. In teams where targets were being missed, managers gave a number of reasons why supervision and appraisal targets were not being met. These included staffing pressures, staff sickness, staff turnover and managers having to sometimes undertake clinical work.
- Some staff referred to having clinical supervision in addition to managerial supervision. One professional said their clinical supervisor was not replaced in the service restructure. Stamford staff referred to using information technology to provide easier supervision to staff working off site.
- Some teams were meeting trust targets for staff annual appraisals. As of November 2015 Stamford, Grantham and Skegness teams were highest, with 100% overall compliance. The lowest was Gainsborough team with 54% compliance.
- Team meeting minutes showed that meetings were occurring regularly and that a range of staff attended.
- Louth and Stamford staff were involved in the EQUIP training pilot with the University of Nottingham to improve patient involvement in care planning. Louth had received positive feedback from the trainers regarding their engagement in this.

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.

Multi-disciplinary and inter-agency team work

- Teams reported regular and effective multi-disciplinary meetings. However, doctors in the Gainsborough team said they did not regularly attend team meetings.
- Staff attended regular 'interface' meetings with other trust community services to monitor and review referrals. However, minutes from this meeting were not available at sites or for our review.
- Staff worked with external agencies, such as the police and local authority. This included liaison with multi-agency public protection arrangements (MAPPA) where patients had committed a criminal offence.
- Louth team were developing 'neighbourhood team' links with external agencies, such as the ambulance, fire and police services to improve communication. Correspondence and emails showed that this was in process.
- Additionally, staff liaised with SHINE, a local mental health support network.

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

- Staff knew how to contact the Mental Health Act office for advice when needed.
- As of August 2015, staff compliance with the Mental Health Act training across the trust was 72%. Staff reported difficulties accessing training due to courses being booked up in advance. The trust did not provide specific Mental Health Act training for this core service. Managers stated that not all mandatory training targets were being met. Therefore, we were not assured that staff had adequate information regarding the new Mental Health Act code of practice.
- Approved mental health practitioners (AMHP) were from multi-disciplinary backgrounds and most teams reported good access to coordinate Mental Health Act assessments. However, In the Boston team some staff reported limited consultant access for Mental Health Act assessments.
- Records did not show that patients subject to a community treatment order (CTO) had their legal rights regularly explained to them under section 132 Mental Health Act, although we saw some evidence of patients appealing against the order to tribunals. One patient who was subject to a CTO had moved out of the area. Records did not detail that the area the patient had moved to had accepted responsibility for the CTO. Records showed that there had been efforts made to ensure the patient had mental health support. The CTO papers were sent to the mental health trust. Another patient had not had an assessment of their capacity to consent completed in the first month of their CTO, despite being informed by letter that this would be the case.

Good practice in applying the Mental Capacity Act

- September 2015 data showed that no team had met the trust target of 90% for training. The highest was Louth team with 76%, and the lowest was Boston and Skegness teams at 58%. This posed a risk that staff would not have adequate, up to date knowledge and information for their role.
- Staff champions told us they were having best interest assessors training to help inform their work. Records confirmed this.
- Staff knew where to get advice regarding Mental Capacity Act 2005 within the trust and could refer to trust policy.
- Most patients' records we saw did not identify that any patients lacked the mental capacity to make decisions. Staff told us assessments were decision-specific and people were given every possible assistance to make a decision.
- A patient in the Spalding team was deemed not to have capacity with regards to finances. There had been a patient's best interest's assessment and staff said a relative held power of attorney for health and welfare. However, documentation for this was not in the patient's records.

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

- We observed and heard staff talk about patients with respect.
- Patients gave some very positive comments about a number of staff across all of the teams. They told us that staff were kind, listened to them and supported them with their individual needs.
- Staff told us they were proud of their work with patients and it was their priority to give good care, despite the challenges they had with staff resources.

The involvement of people in the care that they receive

- All but one patient told us that staff involved them in deciding care and treatment options. However, their involvement was not captured in most records we saw.
- Carers told us their relatives or friends were supported by the team and support was available to them as appropriate.
- Patients were involved in influencing their service, such as involvement in staff recruitment and peer work in groups.
- Advocacy services and information was displayed across teams for patients. Patients knew how to access advocacy services.
- Patients could give feedback on the care they received via friend and family test surveys.
- The trust was registering with the 'Triangle of care programme,' to support better engagement with carers.
- Most teams identified that the provision of support to carers could be improved. The voluntary organisation Rethink supported Grantham and Sleaford carers' forums. Additionally, ICMHT staff could make referrals to Rethink to complete carers' needs assessments.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- Referrals were made via a trust single point of access team. However, staff said the process had deteriorated in the two weeks prior to the inspection because systems had changed. For example, the teams had received emails which appeared not have been screened appropriately for the ICHMT. Staff had to gain further information to assess if patients were suitable for assessment or not, and to determine the urgency. Feedback had been given to managers to address this. December 2014 to November 2015 data showed the number of ICMHTs referrals ranged from the highest of 841 to the Grantham team to the lowest of 239 to the Stamford team.
- Staff across most teams told us there were delays with providing patient assessments and treatment. This was confirmed by some managers. There was a risk that trust community services were not meeting patients' needs in a timely manner. Trust data for December 2014 to November 2015 showed the average waiting time for referral to assessment ranged from 12 weeks at the Gainsborough team to six weeks at the Grantham team. The waiting time for the early intervention service was the highest in the Louth team with a six week wait and lowest in the Gainsborough team with a one week wait. The standard for providing a service was 50% of referrals seen in two weeks, which the trust had not met for October 2015. The average waiting time for referral to treatment ranged from the highest at Boston with a 17 week wait to Spalding and Grantham with an eight week wait. The team with the most patients waiting was Louth at 186 (125 were for psychology) and lowest was Stamford at 66. Teams had sent letters to inform patients and referrers of the delay.
- Psychology waiting lists were significantly longer than the trust target of 18 weeks. They ranged from the highest waits for referral to assessment of 45 weeks at the Skegness team and 41 weeks at the Boston team. The lowest referral to assessment waits was Grantham team at 25 weeks and the Gainsborough team at 29 weeks. A service improvement plan was being implemented.
- September 2015 trust data showed teams as meeting targets for following up patients within seven days of discharge, but not for October 2015. A staff target of four 'face to face contacts' was set for staff. Staff reported that this was difficult to achieve. They gave us examples of why, which included the time taken up with staff travelling, telephone contacts; the time needed for assessing a patient and writing up notes. Managers stated that once accepted for treatment, all patients had an identified CPA coordinator.
- We received some feedback from crisis and acute inpatient staff; for example, in Lincoln ICMHTs there were difficulties with getting staff to attend CPA meetings and accept referrals and transfer of care. Staff told us child and adolescent services made a referral to adult services within six months of the young person reaching 18 years of age. We noted one referral was made in July 2015 and after five months had not been allocated.
- The ICMHT staff said there were difficulties maintaining contact when patients were placed out of area in inpatient beds. Staff tried to attend meetings via telephone or video links. November 2015 data showed that 51 trust patients had been admitted to out of area inpatient placements. Two patients said staff had maintained contact with them and helped support them back into the community.
- Integrated teams were supposed to provide an early intervention in psychosis, assertive outreach and recovery service. However, most staff reported that this was not consistently being provided due to staffing levels and waiting lists. Four staff reported frustration at a lack of clarity and blurring of roles. Some managers told us that there were plans to move towards staff having dedicated caseloads so that staff with specific roles, such as assertive outreach, could direct the required attention and focus to addressing patients' needs. Managers and staff told us that staff currently had mixed caseloads and the service was not as responsive as it should be.
- Teams had systems to prioritise urgent referrals and non-urgent referrals, for example, at weekly team meetings. However, some teams such as Gainsborough and Louth reported difficulties with having staff to cover a daily duty system to respond promptly when patients contacted them. We saw examples of staff contacting

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other agencies such as the crisis team regarding urgent concerns for patients. In Skegness and Boston, the manager told us that qualified staff were not always available to answer the duty phone. On these occasions the phone was answered by administrative staff who could take a message or direct a call if urgent.

- There was no overall monitoring or written protocol for teams to follow for engaging with patients who did not attend appointments. Staff said they would try to contact the patient if allocated to the team or request a police welfare check. If not allocated then they would be offered two or three appointments before the referrer would be contacted to close the referral. Patients could have a different experience depending on the team they were referred to.
- Teams held paper lists of patients subject to 'fast track' discharges. This meant if the patient deteriorated after discharge, within identified times, they did not need to go through all the referral processes for ICMHT support.

The facilities promote recovery, comfort, dignity and confidentiality

- Teams had interview rooms to meet patients for appointments, with vison panels that could be closed to offer privacy and dignity for patients. The Lincoln staff told us it was difficult to book rooms due to pressure of other staff using them.
- Team offices had ground level access for patients with mobility difficulties. One patient told us there was a lack of car parking space at the Lincoln team offices, which we observed.
- Reception areas had information on treatments, local services, patients' rights and how to complain. There were televisions with music or programmes for patients to watch or listen to whilst waiting. One patient told us they had not been given information by the ICMHT and had to find it themselves. Patients' artwork was displayed in communal areas.
- Lincoln and Gainsborough teams were awaiting information regarding an office location move, which had been delayed. Skegness staff were also due to move to renovated offices. Staff reported deadlines were missed and there had been a lack of clear communication about this. Some offices had 'hot desk' areas where any staff could base themselves. This was reported as a problem at Louth because staff used large open plan offices, which could be hot and noisy. At Grantham, staff had a local flexible working agreement because they had laptops they could use out of the office.

Meeting the needs of all people who use the service

- Staff said they offered flexible patient appointments, to include evenings and weekends if required. Patients reported staff using information technology to keep in contact with them such as having direct access to staff via their mobile telephone. Some teams, for example at Louth, were looking to hold appointments in GP surgeries to reduce patient and staff traveling time.
- Information leaflets were available in different languages spoken by patients who used the service. Staff said they could access interpreters and signers as required. One patient confirmed they had been supported with translated leaflets and an interpreter.
- The trust had developed a recovery college based in Lincoln for patients to attend to develop new skills. However, due to the travelling distance this was not easily accessible for patients at Grantham and Sleaford. The trust had an employment service where patients could be referred for support with finding unpaid or paid employment. Stamford team had developed a patient allotment project.
- The trust had specialist services that patients could be referred to as required. These included a veteran's service for people from the armed forces, a perinatal service for pregnant patients and a forensic team for patients who had committed a criminal offence.
- A senior manager said the teams care pathways were not clearly identified and a staff, patient, carer and stakeholder consultation was in planning and development. Managers and staff confirmed there were no care pathways in place for the ICMHTs. This meant there was a risk that services across the trust could vary significantly in consistency and continuity.
- An identified trust risk was that there was no commissioned pathway for patients with a personality disorder. This was confirmed by staff and was being reviewed as part of pathway consultation process.

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Listening to and learning from concerns and complaints

- Systems were in place for processing, monitoring and responding to complaints. This included a patient advice and liaison service. This service had been used and complaints had been resolved.
- Teams displayed 'You said we did' information, with actions taken in response to family and friends test feedback.For example, following feedback, the Gainsborough staff were sending patients maps to help them find the team. The response rate for all adult community services was low for October 2015, at 7%; but 93% of respondents recommended the service.
- Trust data from September 2014 to July 2015 showed that community services, including the ICHMTs, had the highest number of complaints in the trust at 69. Of these, 18 were formal and upheld, and 42 were informal. The ICMHTs received five complaints in October 2015, which was the highest number in the trust. Issues related to difficulty accessing community psychiatric nurses, lack of contact or limited communication. For example, three complaints at Stamford related to problems accessing the service. Community teams also had highest number of compliments at 165.
- Top trust themes were 'access to services; care and treatment and communication'. For example, three complaints at Stamford related to problems accessing the service.
- The trust stated they had developed 'top tips for complaints handling' information for staff, but staff did not refer to this. Staff told us that any learning from complaints was shared with the staff team. Three staff were not clear on the process of learning from complaints; some team meetings at Lincoln South did not capture this learning.
- One patient told us they were making a complaint regarding the Gainsborough and Lincoln discharge process and not being consulted. One patient told us they had not received any information on how to make a complaint.

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

- Managers we spoke with were aware of the trust's vision. This information was displayed in the teams. An ICMHT away day had taken place to consider the trust's vision and values.
- Some staff referred to chief executive 'roadshows' where they took time to meet staff from the organisation. Staff received regular emails and a newsletter including 'the weekly word' to inform them of trust updates.
- Some staff said their senior managers were approachable and that other directors visited their areas. Grantham staff spoke positively about the contact they had with the chief executive. Some staff within the Skegness and Boston teams did not know who some of the senior staff were and did not think that they were very visible.

Good governance

- The trust had some governance processes in place to manage quality. For example, some managers had access to dashboards, data and key performance indicators for their teams and could compare performance with others. However, at 'heat map' was developed to identify service risks and was reviewed at team coordinator meetings.
- Managers told us performance data could sometimes be incorrect. They said they frequently had to check the performance data with their own records. This included information relating to appraisal data.
- An ICMHT assurance framework had been developed for teams to help identify any risks for their service such as staff being able to provide depots or having allocated care coordinators.
- Teams had staff champions leading on specific areas, such as safeguarding to help embed processes and improve quality. Staff knew who the champions were and how to contact them.
- Staff could submit items to a local risk register. Staff knew how to do this and items from each team had been placed on the risk register.
- Staff were not aware of any action plans to address areas of poor performance in response to a national CQC CMHT survey. A senior manager showed us plans and arrangements for a consultation process.
- Governance systems were not sufficiently embedded or consistent in this core service. For example, most teams were not meeting trust targets for training, supervision, audits and waiting times. Managers had identified this as a risk to the service but it had not been addressed. There were gaps in staff learning from incidents relevant to their service.
- Another example was at the Skegness and Boston teams. We saw 'audit and clinical effectiveness – audit action plans'. These included actions for the issues identified, such as discussing and recording confidentiality with patients, record keeping and scanning documents to the electronic records in a timely manner. Some areas correlated with the issues found during inspection. Actions completed were not always detailed. For example, not all staff were receiving supervision and some staff were off sick so the concerns were not being revisited and discussed.

Leadership, morale and staff engagement

- All staff we spoke with told us about the significant restructuring and changes affecting the service being provided to patients.
- Several transformation projects, such as those within ICMHTs, had taken place to look at workload and use of resources.
- Fourteen staff reported low morale and gave examples where they or colleagues had experienced work related stress or were leaving because of uncertainty about their role. Examples included staff unhappiness about the integrated teams (early intervention in psychosis, assertive outreach team and recovery staff in one team) and losing specialist roles. One manager told us that themes for staff leaving would not always be captured by the trust because exit interviews were not completed when staff moved to other jobs in the trust.
- Some ICMHT and service managers in post were either in acting posts or newly appointed and there had been an inconsistent management approach across teams.

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Some managers were not aware of the systems in place. For example, they did not know if recruitment and agency use was available to them. A new ICMHT lead and service director was in post.

- Staff told us their line managers were approachable and supportive and there was good team working.
- Staff were aware of external confidential support helplines and whistleblowing processes. Managers identified support that had been given to staff, such as access to an occupational health service and employee assistance programme. Some staff referred to attending a 'wellbeing service'.
- Managers had leadership training and meetings to develop their skills and support teams.
- Staff referred to working with a national organisation for lesbian, gay, bi sexual and transsexual people to ensure and improve staff equality in the workplace.

Commitment to quality improvement and innovation

- Quality initiatives included staff nomination and recognition awards for the trust.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staffing** Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements. Staff employed by the trust in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. • The trust must ensure that staff are consistently supported through regular supervision and training. • The trust must ensure safe staffing levels at all times. Regulation 18 (1) (2)(a).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe care and treatment:** The trust are not effectively ensuring that care and treatment is provided in a safe way for patients, by assessing the risks to the health and safety of patients of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. • The service had not ensured that patients were assessed and received treatment in a timely manner. Regulation 12(1)(2)(a)(b)(i).

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Good Governance:** The systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients who may be at risk which arise from the carrying on of the regulated activity, and systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services), are not operating effectively. • The trust must review its procedures to ensure that the learning from investigations and actions taken are embedded in ICMHTs. • The trust must ensure that governance systems are in place for informing detained patients under a community treatment order of their legal rights, with regard also to the Mental Health Act and code of practice. **Regulation 17 (1) (2)(b)(f)**