Good

Lincolnshire Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

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)
RP7MB	Beaconfield site	Grantham crisis and home treatment, single point of access and county triage teams	NG31 9DF
RP7LA	Pilgrim Hospital Site	Boston crisis and home treatment team	PE21 9QS
RP7EV	Lincoln County Hospital Site	Lincoln crisis and home treatment team	LN2 5UA
RP774	Windsor House	Louth crisis and home treatment team	LN11 0YG
RP7EV	Lincoln County Hospital Site	S136 suite/ health-based place of safety	LN2 5UA

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	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

Contents

Summary of findings

Overall summary

We rated mental health crisis services and health-based places of safety as 'good 'because:

- The trust had taken actions to improve the environment of the health based place of safety and to increase the range of multi-disciplinary staff in crisis teams following our last inspection.
- Staff completed risk assessments for all patients and updated them as the level of risk changed.
- Many patients felt their mental health had improved as a result of the service they received from the crisis and home treatment teams.
- The trust took action to address the changes to the Policing and Crime Act 2017 and had identified inpatient beds to ensure patients were not kept longer in the health based place of safety than needed.
- Managers reviewed discharge processes for inpatients to ensure they did not remain in hospital longer than was needed. For example, they reviewed the use of the crisis house, improved communication with discharge coordinators and bed managers.
- The trust arranged crisis team support based out of hours with the police to signpost patients to mental health services.
- The trust met commissioned targets for contacting patients within four hours.
- The trust had plans to develop a clinical decisions unit in 2018 to further support patients in crisis needing hospital admission.
- Grantham crisis and home treatment team had achieved the Royal College of Psychiatrists home treatment accreditation scheme.

However

- The trust had not ensured that staff regularly received clinical and managerial supervision.
- Patients and carers did not have copies of their care plans explaining the support teams would give them.
- Staff did not consistently document that they had assessed patients' physical health care needs.
- Crisis team staff said that patients could wait for hours to be transferred to out of area placements due to delays with the contacted transport service being able to respond and escort them.
- Crisis teams did not include psychologists which meant assessments of patients at the point of crisis were not fully multi-disciplinary.
- Staff morale in Louth was lower than other teams because of increased work due to the community mental health teams and difficulty accessing medical cover.
- The trust had not ensured that all staff completed mandatory training for their role.
- Trust information from April 2016 to March 2017 showed staff had not completed the patient's discharge time on records on 127 occasions.

Summary of findings

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

Are services safe?

Good

We rated safe as 'good' because:

• The trust had taken actions to improve the environment of the health based place of safety after our last inspection had identified issues.

• Patients said appointments took place at clean and well maintained team locations.

• The trust had recruited staff and were using regular bank (as and when) staff to ensure sufficient staffing for the team.

• Staff completed risk assessments for all patients and updated them as the level of risk changed.

• Staff had protocols to check on patients if they failed to keep appointments with them.

• Staff reported safe lone working processes.

• Staff gave examples of reporting and learning from incidents to improve their practice.

However

• The trust had identified they need to take further actions to ensure the health based place of safety fully met the Royal College of Psychiatrist standards.

• Louth staff reported difficulties getting medical cover and appointments for patients, which was raised at our last inspection.

• Staff did not routinely use, or were unfamiliar with, their personal alarm systems.

• The trust had not ensured that their targets for staff compliance with mandatory training were being met.

Are services effective?

Requires improvement

We rated effective as 'requires improvement' because:

• Staff had not received regular clinical and managerial supervision.

• Staff did not complete consistently care or treatment objectives for patients or assessments of patients physical health care needs. This posed a risk that staff would not know patients needed support with any concerns.

• Staff identified they needed to improve how they documented patients' mental capacity to make decisions about their care and treatment.

Summary of findings

However

• The trust had made improvements to increase the range of multi-disciplinary staff in crisis teams such as social workers and occupational therapy staff.

• Managers had made a request to the trust to have a psychologist in the crisis team.

• Staff gave examples for opportunities for specialist training such as suicide prevention.

• The trust had recently employed physical health nurses who could be contacted for advice.

• The trust had made improvements to the documentation of patients admitted to the health based place of safety.

Are services caring?

Good

We rated caring as 'good' because:

• Patients and carers said staff considered their views on their care, gave them support and they knew how to access help out of hours. They were supported to access services on discharge. Many felt their mental health had improved as a result of the service they received.

• We observed and heard staff talking to patients with dignity and respect and giving them help.

• Patients said that staff at the health based place of safety kept them informed as to what was happening to them and the assessment status.

However

• Patients and carers did not have copies of their care plans explaining the support teams would give them.

• One patient and a carer said it was difficult to get an answer at times from the crisis team telephone number. One patient said that help was given although there could be a delay in receiving support from the team.

Are services responsive to people's needs?

Good

We rated responsive as 'good' because:

• The trust met commissioned targets for contacting patients within four hours.

• The trust arranged crisis team support based out of hours with the police to signpost patients to mental health services.

Summary of findings

• Managers gave examples of responding to complaints and sharing feedback with staff to improve practice.

• The trust took action to address the changes to the Policing and Crime Act 2017 and had identified inpatient beds to ensure patients were not kept longer in the health based place of safety than needed.

• Managers reviewed discharge processes for inpatients to ensure they did not remain in hospital longer than was needed. For example, they reviewed the use of the crisis house, improved communication with discharge coordinators and bed managers.

However

• Data from the trust from October 2016 to March 2017 showed 40% of patients (70) had not been followed up by crisis services within 48 hours of discharge from hospital.

• A lack of inpatient hospital beds in the trust meant 46 patients needed out of area placements at the time of our inspection. This issue is further addressed in our acute wards for adults of working age and psychiatric intensive care units report. Crisis team staff said that patients could wait for hours to be transferred due to delays with the contracted transport service being able to respond and escort them.

• Staff did not always explain information in packs given to patients as patients did not know how to make a complaint.

• Information from April 2016 to March 2017 showed 242 patients were discharged from the health based place of safety within 72 hours. On 127 occasions, staff had not completed the patient's discharge time on records.

Are services well-led?

Good

We rated well-led as 'good' because:

• The trust had made significant improvements to address actions identified by the CQC at our last inspection.

• Staff reported good team working and felt able to raise issues with their line managers.

• Senior managers and team managers had oversight of their team's daily work schedule. They attended meetings and shared relevant information with their staff.

• Governance systems were in place to monitor and assess the quality of the service provided.

Summary of findings

• Grantham crisis and home treatment team had achieved the Royal College of Psychiatrists home treatment accreditation scheme. Managers had plans to apply for other teams in 2017.

• Trust staff from community teams and wards attended quarterly operational monitoring group meetings involving the approved mental health professional service, emergency duty team and police to identify risks and areas for improvement.

However

• Staff morale in Louth was lower than other teams because of increased work due to the community mental health teams and difficulty accessing medical cover.

Summary of findings

Information about the service

Crisis and home treatment teams provide emergency and urgent assessment and home treatment for adults who present with a mental health need that require a specialist mental health service. Their primary function is to undertake an assessment of needs, whilst providing a range of short-term treatment as an alternative to hospital admission. The team are also gatekeepers so have the ability to admit patients to an inpatient unit if this is required. This service is available 24 hours a day, 365 days a year and covers Lincolnshire.

Lincolnshire Partnership NHS Foundation Trust has four crisis and home treatment teams in Grantham, Boston, Lincoln and Louth.

The health based place of safety, often referred to as 'the section 136 suite', is based at the Lincoln County Hospital site, the Peter Hodgkinson Centre in Lincoln. This is staffed by Lincoln crisis and home treatment team staff. A health based place of safety is a place where someone who may be suffering from a mental health problem can be taken by police officers, using section 136 of the Mental Health Act 1983, in order to be assessed by a team of mental health professionals.

A health-based place of safety is also used when police have executed a warrant under section 135(1) of the Mental Health Act. It provides a safe place to carry out an assessment when required. A section 135(1) warrant is issued to police officers by the courts. It allows them to enter private premises to remove a person to a place of safety if there are concerns for their own, or others safety resulting from their mental state. An assessment under the Mental Health Act 1983/2007 can then be arranged to assess whether they should be in hospital or be better supported at home.

The trust has a single point of access known as 'SPA' for all adult referrals to their services. This is based at the Grantham crisis and home treatment team location. The county triage system is also based at this location and processes referrals made to all the crisis and home treatment teams in Lincolnshire.

Mental health liaison services are based at Grantham, Boston and Lincoln acute hospitals. These services are funded and line managed by the older adults' service and were not visited as part of this inspection. This service is from 08.00 to 22.00 hours and the crisis and home treatment teams provide cover out of hours.

Each crisis and home treatment team has a team leader. A service manager oversees these teams. An interim divisional manager has oversight of acute wards for adults of working age; long stay/rehabilitation mental health wards for working age adults and forensic inpatient/secure wards.

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 CQC.

Lead Inspector: Karen Holland, inspection manager, mental health CQC.

The team that inspected this core service consisted of two CQC inspectors. We were also supported by an expert by experience that had personal experience of using the type of service we were inspecting and three specialist advisors consisting of two nurses and a social worker.

Why we carried out this inspection

We undertook this inspection to find out whether Lincolnshire Partnership NHS Foundation Trust had

Summary of findings

made improvements to their mental health crisis services and health-based places of safety since our last comprehensive inspection of the trust in December 2015. This was an announced inspection.

When we last inspected the trust, we rated mental health crisis services and health-based places of safety as 'requires improvement' overall.

We rated the core service as 'requires improvement' for safe and effective domains and rated caring, responsive and well-led domains as 'good'.

Following the December 2015 inspection, we told the trust it must make the following actions to improve mental health crisis services and health-based places of safety:

- The trust must ensure that the identified safety concerns in the current HBPoS are addressed in the new HBPoS being built.
- The trust must ensure that rapid access to a psychiatrist is always available when required in a mental health crisis.
- The trust must ensure that crisis resolution teams include or have access to the full range of mental health professional backgrounds.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 safe care and treatment
- Regulation 18 staffing

The trust sent us action plans and we checked these at this inspection. The trust has made improvements relating to the safe domain. However, we identified areas of further improvement for the effective domain.

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, we reviewed information that we held about this core service and requested information from the trust.

During the inspection visit, the inspection team:

- visited four crisis teams and the health based place of safety in Lincoln
- spoke with the team leaders for each of the teams and the service manager
- we met the interim divisional manager with oversight for the teams during the tour of the health based place of safety
- spoke with 34 other staff members; including doctors, nurses , support workers, social workers, occupational therapists, administrative workers and two student nurses
- gained feedback from the local approved mental health professional service and police
- spoke with 12 patients and one carer
- received one comment card
- reviewed 28 patients records including single point of access records and six patients records for the health based place of safety
- observed one initial appointment with a patient
- observed a staff team handover meeting, a caseload review meeting and a multi-disciplinary meeting
- reviewed six 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 said staff were caring. They said staff treated them with dignity and respect and considered their

Summary of findings

views on their care when they were in crisis. Where relevant, patients said staff assisted them to a get admission to hospital and supported them on discharge. Many felt their mental health had improved as a result of the service they received.

- Most patients said they saw different members of the team on appointments. Only one patient said they had to repeat their situation to staff as most said staff had a good understanding of their situation. Two patients said they saw a regular member of staff.
- Patients and carers said they were given telephone numbers to call in case of emergency. One patient and a carer said it was difficult to get an answer at times. One patient said there could be a delay in receiving support but that it was given.
- Patients said they were not given information on how to make a complaint.
- Most patients said they were not asked for feedback on the service but felt able to give feedback. Three patients said they were asked to give feedback on the service.
- We received one comment card from a patient who stated that staff listened to them at all times; staff were courteous and friendly and there were good facilities.

Good practice

- The trust were arranging for trust staff to be based out of hours 12:00 to 20:00hrs with the police to signpost patients in Lincolnshire to mental health services quickly.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that staff receive regular supervision.

Action the provider SHOULD take to improve

- The trust should ensure that patients are given a copy of their care plans.
- The trust should ensure that patients' physical health needs are consistently documented in assessments.
- The trust should review the transport systems used to take patients to hospital to ensure they are not unduly delayed.
- The trust should review their medical cover across crisis and home treatment teams to ensure staff and patients have easy access to a doctor.
- The trust should ensure that actions identified by the trust for improvement of the health based place of safety are completed.
- The trust should review their systems for documenting patients' mental capacity to make decisions about their care and treatment.
- The trust should ensure that all staff are up to date with mandatory training.

Lincolnshire Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Grantham crisis and home treatment, single point of access and county triage teams	Beaconfield site
Boston crisis and home treatment team	Pilgrim Hospital Site
Lincoln crisis and home treatment team	Lincoln County Hospital Site
Louth crisis and home treatment team	Windsor House
S136 suite/ health-based places of safety	Lincoln County Hospital Site

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.

- As of March 2017, 97% of staff had completed Mental Health Act 1983/2007 training.
- Since our last inspection the trust had taken action to ensure that policies and procedures on the use of the health based place of safety adhered to the Mental Health Act 1983/2007 and the Mental Health Act Code of Practice.
- Staff knew how to contact the approved mental health professional service or out of hours emergency duty team if required to request an assessment under the Mental Health Act 1983/2007 for patients.
- Patients and carers were given information about the Mental Health Act 1983/2007 by staff which included information about independent mental health advocacy services.

Detailed findings

- Records for patients in the health based place of safety showed that staff had informed patients of their legal right under section 132 of the Mental Health Act 1983/ 2007. However, two patients' records did not hold the approved mental health professional's report.
- Feedback from staff and the approved mental health professional was there could be delays in conveying patients for admission to hospital due to the availability of ambulances.
- Staff and patients said that the police usually transported patients to the health based place of safety by police vehicle instead of arranging the patient's transport with an ambulance service.

Mental Capacity Act and Deprivation of Liberty Safeguards

- As of March 2017, 79% of staff had completed training, whilst this is below the trust target it is an improvement since our last inspection.
- Managers had identified they needed to make improvements to how crisis team staff documented patients mental capacity to make decisions about their care and treatment. They had given feedback to staff in February and March 2017 team meetings that all patients should have a capacity assessment.
- Patients and carers were given information about the Mental Capacity Act 2005 by staff. Staff asked patients for their consent to share information with carers and other agencies.
- The team was not currently working with patients subject to Deprivation of Liberty Safeguards applications.

Good

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

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- The crisis and home treatment, single point of access and county triage teams share office locations and clinics with other community teams. We have reported on this further in other core service reports.
- Patients told us most appointments took place at their homes. Staff could book interview rooms at their office locations to meet patients for appointments if required. Louth staff said this could be a challenge as the rooms were shared by staff not working in the teams. Alternatively staff could book a room at a GP surgery or other location.
- Office location interview rooms had door vision panels for staff to see through to ensure staff safety. Staff could access ligature cutters if required.
- Staff at Grantham had identified a room for patients assessed as presenting a higher risk to be seen in. However, the ligature assessment had not been completed. Staff took action address this.
- Staff could access personal alarms to call assistance when they interviewed patients on site. However, staff did not always use these; instead they said they referred to individual risk assessments before seeing patients.
- Patients said appointments took place at clean and well maintained locations and this was confirmed at our visit. Infection prevention control audits took place for example seen at Lincoln.
- Two Boston staff said the office was too warm and the manager was investigating air conditioning.

Health-based places of safety

- The trust had taken actions to improve the environment at the health based place of safety since our last inspection. A purpose built suite had been developed in a discreet location. It was quiet and secure.
- Rooms only had one door which created a risk that staff would not be able to exit the area quickly if needed. Managers told us they would take action to address this.
- The trust had improved lines of sight for observation of patients by staff. However, staff had identified an area in the ensuite toilet where they were planning to add a vision panel as there was a small blind spot.
- There had been some damage to a room when patients were unsettled and the trust were looking to replace door frames to increase safety and durability.
- Furniture in the suite was now weighted. However sofas were still movable. Staff were exploring options to stop this.
- The trust had an alarm system for staff to summon assistance from other parts of the hospital in an emergency situation.
- Emergency resuscitation equipment was available and regularly checked. Since our last visit, the trust had taken action to ensure more staff had completed adult basic life support training with 92% of crisis staff (including health based place of safety) completing it.

Safe staffing

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- Staff told us that staffing had improved since our last visit.
- Trust information for March 2017 showed 124 whole time equivalent staff across all of the crisis service, including crisis teams with 10% vacancies, 3% staff turnover and 4% staff sickness rates.
- Crisis teams still had vacancies but recruitment had taken place with staff just starting or due to start. Grantham was near full establishment with two nurses recruited to start in May/June 2017. Louth had a nurse on induction and a support worker starting in May 2017. Boston had a nurse vacancy and Lincoln had two nurses and as support worker starting in May 2017.
- Managers said that recruiting to band five mental health practitioner posts had been particularly difficult.
- The highest staffing vacancies had been at Grantham single point of access team and Lincoln crisis team. Since our last inspection there had been changes to the staffing in the single point of access team and the crisis

Good

Are services safe?

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

team leader had taken over management. Several staff had left because of restructuring changes and staff being regraded from band four to three. There were no vacancies during our visit.

- Managers did not use agency staff instead they were using regular bank staff (not permanently employed instead on an as and when basis) to ensure sufficient staffing for the team and consistency for patients. Boston's manager said they had experienced difficulty getting bank staff cover and two staff were about to go on maternity leave, so further cover was required. Managers told us they could increase staffing levels if required.
- All teams maintained good oversight and management of their caseloads. Staff told us caseloads were now more manageable than previously when staffing had impacted on their ability to manage them. Teams reviewed caseloads weekly. From January to December 2016 the highest average caseloads was 33.9 for Boston in March 2016 and the lowest 13.7 for Louth in August 2016.
- Crisis teams shared doctors with other community teams with dedicated sessional time. Improvements had been made to psychiatrist cover since our last inspection. For example a speciality doctor was employed in Lincoln.
- However, Louth staff reported difficulties getting medical cover since July 2016 and appointments for patients and raised concerns about contingency plans when doctors were on leave. This concern had been escalated to their service manager and the medical director. We asked senior managers and the trust further about this. In March 2017 weekly appointments offered by speciality doctors had doubled from three to six as a doctor from Boston gave additional sessions. The locum consultant psychiatrist gave approximately three hours a week support to the team attending morning team meetings. However, during our visit, both the locum consultant and speciality doctor were on leave. Managers said staff knew how to access a doctor in an emergency and there were no incidents of not being able to do so.
- At Boston there was a consultant psychiatrist vacancy with a locum covering and staff said there were challenges when they were on leave.
- Grantham had a 0.5 whole time equivalent consultant psychiatrist and a speciality doctor two days a week. The consultant was due to leave and another doctor was taking over in June 2017.
- The single point of access team was contacted by trust staff if the on call doctor was required. On 3 April 2017 the on call speciality doctor for Grantham was not contactable but staff contacted the on call consultant for assistance. It was not clear why the doctor was not contactable. We noted from interagency meetings minutes that there were challenges with rotas being updated and not always being sent to the team.
- Staff told us that not all staff training data was correct as there could be delays in trust centrally held data updating. The trust's target for mandatory training compliance was 95%. We saw conflicting information for crisis teams as governance dashboards showed 100% training achieved for March 2017. Four subjects, safeguarding adults and children level three training, medicine management and rapid tranquilisation training were below 75% which posed a risk that staff did not have adequate training for their role.

Health-based places of safety

- The team leader at Lincoln and the service manager were identified as in charge of the health based place of safety.
- There were two dedicated staff on duty from the Lincoln crisis team, a nurse and support worker. Additional staff could be called upon if needed.
- Staff could access staff rotas to contact a doctor to attend.
- Four staff said contacting a children and adolescent mental health services (CAMHS) consultant could be a challenge. March 2017 operational monitoring group minutes referred to an approved mental health professional referring to problems also.
- There was an occasion where a young person was in the place of safety for assessment longer than 24 hours.
- Managers told us CAMHS consultants do not assess patients at the place of safety and the CAMHS service was not commissioned for this. The trust protocol and policy confirmed this.

Assessing and managing risk to patients and staff

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

Good

Are services safe?

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

- We reviewed 28 patients' records. Staff completed a clinical risk framework assessment of patients using the five 'p's model of formulation including considering precipitating, perpetuating, protective and predisposing factors. These were completed at initial assessment and staff updated these regularly as the patient's level of risk changed.
- Staff had developed weekly planners detailing planned contacts and activities required by staff. Staff reviewed patients' risks daily at handover meetings and used a visual traffic light system (red, amber and green) to easily identify patients with higher risks.
- The trust had a protocol in place for staff to follow and monitor patients that did not attend appointments and check on them, to ensure they were safe.
- Eighty seven percent of staff (below trust target) completed clinical risk assessment and management training.
- Information from the trust for March 2017 showed that 90% of staff had completed safeguarding adults level one training. Teams had 87% compliance of safeguarding children level one. These were below the trust target for compliance.
- Teams had safeguarding training and champions. Staff completed safeguarding assessments for each patient. One patient at Louth did not have one. However, staff had considered any safeguarding needs and appropriately liaised with other agencies. Managers did not keep records at team level about the safeguarding alerts made and instead said this was held by the trust. Information from the trust showed in 2016 that 42 of 114 safeguarding referrals were made by these teams. Staff gave us examples of when they made referrals and Boston staff referred also to using 'The domestic abuse, stalking and honour based violence' (DASH 2009) assessment tool.
- Personal safety protocols, including lone working practice, were in place. The trust had made improvements since our last visit as staff said they carried out initial assessments at patients homes in pairs and staff told us they felt safe. Ninety four percent of crisis staff had completed breakaway training. The single point of access staff on duty at night were based at the Lincoln team to ensure they had support in case any concerning calls came in.
- The trust had an alert system to record risks for patients and advice for staff to follow when visiting. However, for one Louth patient's record this was not updated. Louth teams 'working alone resource pack' was dated 2013 although the manager said it had been reviewed. The manager said they would take action to address this.
- However, staff told us they did not routinely used the electronic alarms provided by the trust when on home visits. At Lincoln, guidance had been developed for staff to improve this. The trust's lone working policy gave inconsistent information to staff about the use of these. Managers told us there had not been any incidents where staff's physical safety was at risk in the last year.
- Most teams said they did not keep or give medication; instead patients got their medication via their GPs. The trust had made improvements to mediation management and storage. For example at Boson the temperature where medication was stored was monitored and was not above safe levels.
- The trust had business contingency plans staff to follow in case of an emergency such as extreme weather conditions or power outage, to ensure a service was provided to patients.

Health-based places of safety

- Information from the trust from January to December 2016 showed there was one episode of a patient being placed in seclusion. Seclusion is the supervised confinement of a patient in a room, which may be locked. The aim is to contain severely disturbed behaviour which is likely to cause harm to others.
- All staff had received training in restrictive interventions to ensure they were able to manage patients' disturbed behaviour without the need for police support. There were six incidents of staff restraining a patient, two were in prone position. Prone position restraint is when a patient is held in a face down position on a surface and is physically prevented from moving out of this position.
- The team leader said the police searched patients to ensure they did not have access to items which could harm themselves or others. However, the trust had requested where possible for their staff be present during the search.
- Since our last visit, the trust had ensured that the health based place of safety had a clinic area where medicine could be stored. However, managers said the clinic was still being developed and if required staff could access medication from elsewhere in the hospital in an emergency. They were meeting with pharmacy technicians to write the standard operating procedure.

Good

Are services safe?

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

- The service manager said they were reviewing electronic database systems to be able to gain more easily information about patient allergies when they presented.
- Staff received training in safeguarding children and adults and liaised with other agencies as appropriate if concerns were identified.

Track record on safety

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- There were nine serious incidents between October 2015 and September 2016. Seven of these related to deaths of patients.

Health-based places of safety

- Trust information showed from October 2015 to September 2016, there were no serious incidents relating to the health based place of safety.

Reporting incidents and learning from when things go wrong

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- Staff were clear about their roles and responsibilities for reporting incidents and were encouraged to do so.
- Managers gave examples of actions they had taken to improve their service following incidents, such as updating their paperwork and improving communication with teams. For example, following learning from an incident, each team contacted the community mental health teams by 10:30 hours to give and receive a handover on patients and any risks.
- Managers gave feedback from incidents and investigations at team meetings and the trust sent staff emails with learning from incidents in other departments.
- Staff gave examples of being supported after incidents and having the opportunity for debrief.

Health-based places of safety

- Staff gave examples of learning from an incident to improve their practice. For example, they had supported a young person with complex needs who had been admitted twice to the place of safety. Staff ensured they had access to the patient's positive behavioural support plan on the second occasion to ensure they understood their needs and how to support them. Staff said after an incident where a patient's first language was not English, managers were considering the use of an information technology application to ensure staff had easier access to language translation services.

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

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- We reviewed 28 patients' records. The clinical risk framework assessment was the main document that staff worked from to deliver patients' care and treatment. This was completed where possible at the first initial assessment to determine if patients required hospital admission or home treatment.
- Staff gave examples where staffing, for example at Louth had impacted on the detail of assessments and care plans but said they were developing a 72 hour care plan for patients receiving home treatment with three scheduled contacts by staff. The service manager acknowledged improvements were needed for care planning and action was being taken to address this.
- Whilst staff assessments of patients were individualised, they mostly identified tasks for staff and did not document objectives for patient's care and treatment. They were not consistently recovery focused, for example there was little recording of advance decisions or patient's strengths.

Health-based places of safety

- The trust had made improvements to staff's documentation of patients admitted to the health based place of safety. Documentation was in line with the Mental Health Act code of practice 2015 and included the patient's arrival at the place of safety and times of assessment. However, we reviewed six patients' records and one patient did not have a record.
- Staff followed processes to contact a doctor to assess the patient to determine if the patient should remain for an assessment under the Mental Health Act 1983/2007.
- Trust staff attended the Mental Health Act assessment with the approved mental health professional.
- Staff had documented physical health checks for patients. In the event of a medical emergency, staff would call emergency services via 999 or make arrangements for the patient to attend the local A&E department at the acute hospital on the same site.

Best practice in treatment and care

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- Staff did not consistently document that they had assessed patients' physical health care needs.
- At Boston, we saw examples of staff using 'track and trigger' systems to check patients' physical observations and ensure they monitored patients on high dose anti-psychotic medication. This is identified as best practice by the National Institute for Health and Care Excellence (NICE). However, this was not apparent in other team's records.
- Staff gave examples of where they liaised with patients' GPs regarding physical healthcare, for example ongoing monitoring of patients on lithium carbonate medication.
- The trust had recently employed physical health nurses who could be contacted for advice, except at Louth where there was not one.
- Patients told us that staff asked about their physical health such as if they were eating, drinking and sleeping. They said they were encouraged to go their GP for physical health concerns.
- Since our last inspection, crisis teams still did not have a psychologist which meant that staff did not have easy access to a psychological perspective on patient's assessments and identify psychological therapies for patients. Staff said they could ask for advice or make referrals for a psychologist at monthly 'interface' meetings with the psychology team (capped at two to four a month) or could telephone other teams for advice. Information from the trust November 2016 and March 2017 stated that the crisis teams had made 10 referrals to the psychology service (5% of all psychology team referrals). Managers had submitted a business proposal to the trust requesting a psychologist to work across all the crisis teams, to assist in reducing out of area beds.
- Staff said they could make patient referrals for talking therapies via the 'Steps2change' service, which currently had an eight week waiting list. They gave other examples of supporting patients with therapy such as staff at Grantham and Lincoln gave patients an 'emotional first aid course' and other examples included staff using cognitive behavioural therapy and coping skills training with patients.

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.

- Staff gave examples of where they used the Manchester care assessment schedule (MANCAS) screening tool for mental health needs, when screening older patients out of hours.
- Staff gave examples of audits completed within teams such as for lithium monitoring of patients, risk assessment and carers.
- Staff had access to electronic patient records systems. Single point of access staff also had systems to check and record the initial referral for a patient to the trust and could access to other agencies' systems.

Health-based places of safety

- The trust audited information about patients brought to and diverted from the health based place of safety.

Skilled staff to deliver care

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- The trust had increased the range of multi-disciplinary staff in crisis teams. For example, Lincoln team had social workers and occupational therapy staff. Grantham and Louth teams had occupational therapists and Boston had a social worker but no occupational therapists. Managers said they could contact other teams for specialist occupational therapy or social work advice. However, Louth staff said this did not usually happen.• Permanent and bank staff said they received a trust induction and team orientation which equipped them for their work.
- Staff gave examples of specialist training they had received such as autism basic awareness, 'STORM' suicide prevention and self-injury mitigation training, 'knowledge and understanding framework' training to work with patients with a personality disorder at Lincoln and Grantham. Lincoln team had also requested dialectical behavioural therapy training to work with patients with a personality disorder. Single point of access team staff had been offered specialist training on suicide prevention and also the opportunity to shadow crisis staff to develop their skills and knowledge. Doctors said they had also protected time each week for training and development.
- Trust information for March 2017 showed 100% of crisis staff had appraisals.
- The trust had not ensured that staff received clinical and managerial supervision regularly as per the trust standard of taking place every six to eight weeks, which was confirmed by managers, staff and trust data. Staff said their priority had been to deliver patient care and treatment, which had been affected by staffing in the past. Managers explained actions they were taking to address this such as arranging group clinical supervision sessions for staff in April 2017.

Health-based places of safety

- Managers reviewed staff training needs at interagency meetings, for example search training. Staff had received physical intervention training.
- We have reported above on training, supervision, appraisal and inductions for crisis team staff.

Multi-disciplinary and inter-agency team work

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- Teams had regular meetings and staff shift handovers to discuss patients' needs and risks and communicate key information about the service. Managers arranged regular team meetings to discuss business issues.
- Crisis team representatives attended monthly interface meetings to communicate information and discuss patients' needs with community mental health, child and adolescent mental health, learning disability and older people's teams and other agencies including social care.
- Staff gave examples of working with other professionals and agencies such hospital staff in the trust and out of area, drug and alcohol services, voluntary agencies.
- Managers said they had an identified person in the police to contact and discussed issues at monthly meetings. They reported effective working relationships. The police liaison officer confirmed this.
- Doctors said they could attend medical forums and acute care forums to give feedback on the services.

Health-based places of safety

- The trust had signed up to a multi-agency memorandum of understanding between the ambulance service, local authority, clinical commissioning group and police, dated November 2015. This outlined the roles and responsibilities of agencies in supporting patients' access to and from the health based place of safety and referenced the local crisis care concordat.

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.

- Staff liaised with a range of professionals including crisis and community teams and wards, the approved mental health professional service, emergency duty team and police.
- Trust staff and the police reported good working relationships.
- Staff and patients said that the police usually transported patients to the health based place of safety by police vehicle instead of arranging the patient's transport with an ambulance service. This was confirmed in the six records we reviewed and by two patients. Staff were not able to explain the rationale for this.
- Patients gave examples of where staff had contacted other trust teams and services to support them after leaving the health based place of safety.

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

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- Staff received Mental Health Act 1983/2007 training. As of March 2017, 97% of staff had completed this.
- Staff knew how to contact the approved mental health professional service or out of hours emergency duty team if required, to request an assessment under the Mental Health Act 1983/2007 for patients. During our inspection we observed examples of staff requesting these for patients in crisis. A staff member said there were sometimes difficulties getting access to approved mental health professionals and doctors in the daytime.
- Patients and carers were given information about the Mental Health Act 1983/2007 by staff which included information about independent mental health advocacy services.
- Staff said they were not currently supporting patients subject to a community treatment order or Ministry of Justice restrictions.

Health-based places of safety

- Since our last inspection the trust had taken action to ensure that policies and procedures on the use of the health based place of safety adhered to the Mental Health Act 1983/2007 and the Mental Health Act Code of Practice.
- Staff knew how to contact approved mental health professionals to attend the place of safety for an assessment under the Mental Health Act 1983/2007.
- We reviewed six patients' records and legal documentation relating to detention under section 136 of the Mental Health Act 1983/2007 was in place. Records showed that staff had informed patients of their legal right under section 132 of the Mental Health Act 1983/2007. However, two patients' records did not hold the approved mental health professional report.
- There could be delays in conveying patients to hospital due to availability of ambulances.
- The trust had set up a working group to consider changes to section 136 the Mental Health Act 1983/2007 in line with the Policing and Crime Act 2017.

Good practice in applying the Mental Capacity Act

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- Most staff received Mental Capacity Act 2005 training. As of March 2017, 79% of staff had completed training, an improvement since our last inspection, yet still below the trust target.
- Staff were not consistently documenting that they had considered patients' capacity to make decisions about their care and treatment.
- Managers had identified the need to improve how they documented patients mental capacity to make decisions about their care and treatment. They had given feedback to staff in February and March 2017 team meetings that all patients should have a capacity assessment. Managers said they should now be conducting mental capacity assessment for patients who were informally admitted to hospital. This had been identified after a serious incident. A manager showed that there was standard text that staff should put in the clinical risk framework assessment document.
- Patients and carers were given information about the Mental Capacity Act 2005 by staff. Staff asked patients for their consent to share information with carers and other agencies.
- The team was not currently working with patients subject to Deprivation of Liberty Safeguards applications.

Health-based places of safety

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.

- The trust had ensured that staff considered patients mental capacity to make decisions about their care and treatment and this was documented.
- Staff had access to breathalysers to check if a patient was intoxicated by alcohol, if they had concerns that this would affect their ability to be assessed.

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

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- Patients said staff were caring. They said staff treated them with dignity and respect and considered their individual needs when they were in crisis. This was confirmed from our observation of an appointment and also hearing staff talking to patients on the telephone.
- Where relevant, patients said staff assisted them to get admission to hospital and supported them on discharge. Many felt their mental health had improved as a result of the service they received.
- We received one comment card from a patient who stated that staff listened to them at all times and that staff were courteous and friendly.
- Most patients said they saw different members of the team on appointments. Only one patient said they had to repeat their situation to staff as most said staff had a good understanding of their situation. Two patients said they saw a regular member of staff.
- Patients and carers said they were given telephone numbers to call in case of emergency. One patient and a carer said it was difficult to get an answer at times. One patient said there could be a delay in receiving support from the team but that it was given.

Health-based places of safety

- At the time of inspection the health based place of safety was not in use, therefore we were unable to see any staff and patient interactions.
- Two patients that had used the service said staff were helpful and supportive them during their assessment.

The involvement of people in the care that they receive

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- Staff said they did not give patients and carers documents detailing their care and treatment plans for their reference.
- The trust's clinical risk framework assessments had sections for staff to document patients' and carers' views.
- Patients and carers said staff considered their views on their care.
- Staff supported or signposted patients to access services such as to the recovery college and drug and alcohol services, on discharge from their team.

Health-based places of safety

- Patients said that staff at the place of safety kept them informed as to what was happening to them and the assessment status.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- The single point of access team based at Grantham received referrals to trust community mental health services from patients or other agencies such as GPs. Staff reviewed these referrals and then directed to the most appropriate team such as crisis and home treatment, community mental health, older people and 'Steps2change' talking therapies teams. Staff used an urgent screening tool to help identify the level of risk and could contact crisis team for advice. On 3 April 2017 the team received 96 referrals. The 'Steps2change' referral system had changed and patients could also self-refer directly.
- The county triage team based at Grantham operates from 11:00 to 19:00 hours Monday to Friday and reviewed any referrals and directed as relevant to the relevant crisis and home treatment team.
- Crisis teams provided a service for working age adults and the trust had alternative arrangements for children, older patients and patients with a learning disability. Information from the trust showed that longest wait from initial assessment to onset of treatment was two days. People were offered flexibility with appointment times and we saw crisis teams prioritise urgent home visits to manage immediate risk issues.
- The single point of access team was contactable 24 hours a day. Out of hours at evenings and weekends the crisis team at Lincoln and Boston had staff available for contact for Lincolnshire. Staff from other teams were on call and available by telephone if needed. Crisis teams provided cover also to mental health liaisons service at Lincoln, Boston and Grantham acute hospitals from 17:00 to 21:00 hours as commissioned and provided assessments also for older adults.
- Crisis teams met commissioned targets for contacting patients within four hours As of February 2017, 99% of patients were contacted within this time. Patients said staff kept appointments made with them.
- Data from the trust from October 2016 to March 2017 showed 103 patients had been followed up by crisis services within 48 hours and 70 were above this time.
- Staff had met targets for follow up of patients on discharge from hospital within seven days for 169 patients. There were four occasions when this target had not been met.
- Crisis teams supported patients in the community, where possible, or accessed local crisis houses (managed by a voluntary agency) or hospital admission.
- Louth staff had identified they had additional work because the community mental health team had limited capacity to support patients.
- Staff had identified that they had experienced significant delays with patients transfer to out of area placements due to delays with the contracted transport service. We found examples of patients waiting over 24 hours for transport and escorts in September 2016 and 15 hours March 2017. This impacted on crisis teams who had to arrange staff to wait with the patient until transfer could be arranged. It also meant patients had on occasion waited longer than needed, for example 12 occasions in September 2016 when patients waited over 12 hours.

Health-based places of safety

- The trust had systems in place for the police to contact trust staff 24 hours a day, seven days a week, to notify them that a patient was being brought to the health based place of safety under section 136 of the Mental Health Act 1983/2007.
- December 2016 operational group meeting minutes showed a 50% reduction of people coming to the place of safety since opening.
- Information from the trust April 2016 to March 2017 identified that more men (218) than women (151) were brought to the place of safety. Most patients (102) were aged between 18 to 25 years. Eighteen patients were over 65 years of age. Sixteen patients were under 18 years of age. The busiest usage of the place of safety was June 2016 with 40 patients attending.
- Managers stated that patients usually did not have to wait more than 24 hours at the place of safety for assessments to be initiated and concluded. They stated the average patient's stay was 13 to 15 hours. However, three patients had waited over 24 hours in 2017 because of trust staff having difficulty finding a hospital bed to admit the patient to (not counting people in cells or requiring physical healthcare treatment at hospital).

Are services responsive to people's needs?

Good

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

- Information from April 2016 to March 2017 showed 242 patients were discharged from the place of safety within 72 hours. On 127 occasions, staff had not completed the patient's discharge time on records. On one occasion a patient was detained more than 72 hours.
- The trust were taking action to address the changes to the Policing and Crime Act 2017 from May 2017, and had identified three inpatient beds (two for men) to admit patients to if required and ensure they were not kept longer in the place of safety than 24 hours.

The facilities promote recovery, comfort, dignity and confidentiality

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- Patients were often seen in their homes. Teams mostly had adequately soundproofed rooms in their premises to see patients. However, it was possible to hear a conversation in the Grantham reception area room.
- Interview rooms often had vision panels which meant others could see into rooms. Therefore patient's privacy may not always be protected.
- We received one comment card from a patient who stated that the team they visited had good office location facilities.
- One patient told us that they felt uncomfortable as staff wore their trust identification visibly around their neck. Therefore their privacy was not fully protected as their neighbours could see that someone official was visiting them.
- Each team had developed information packs to give to patients and carers. However, whilst patients could remember being given information, most could not recall what it included. Two patients said they were not given information on advocacy services. Information varied in the packs and carers' packs held different information.
- Louth staff said due to the geographical location there were challenges with patients being able to access trust's services such as the recovery college as they were based in Lincoln, approximately an hour's journey away.

Health-based places of safety

- Patients told us that staff made them as comfortable as possible in the place of safety.
- The suite had two rooms for patients to wait in. There was space for professionals to talk privately. During our visit the trust arranged for clocks and close circuit television signs to be displayed for patients to see.
- Patients could lie down in the rest rooms; they had access to ensuite toilets and fresh air. A portable telephone was available for patients.
- Staff had access to a kitchen to make snacks for patients. Hot meals could be requested from wards if required.
- Staff supported patients to gain clean clothes and bedding where required and washing machines were available in the place of safety area.
- Staff had access to leaflets giving information about the patient's legal rights.
- Managers had arranged to visit another trust's health based place of safety to check if they could improve their facilities.

Meeting the needs of all people who use the service

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- All locations we visited were accessible for patients with mobility difficulties.
- Staff were able to access hearing loops and sign language interpreters if required. Staff gave examples of using translation services for patients whose first language was not English for example Polish and Lithuanian.
- Staff said they did not support many patients from black or ethnic minority backgrounds due to local population make up. They could request literature in different languages if there was a need to do so and the trust had an accessibility service staff could contact for easy read information.
- Staff had not identified in 17 clinical risk framework assessments, information about patients diverse needs, for example relating to race, ethnicity, spirituality and sexuality. However, information was available on the trusts' electronic patient record. Eighty seven percent of staff had attended equality and diversity training, just below the trust target.
- At this inspection staff did not identify any challenges with the pathway for patients with a personality disorder.

Are services responsive to people's needs?

Good

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

- The trust had a street triage service with trust and paramedic staff operating 16:00 to 24:00 hours for Lincolnshire. A rapid response service with trust staff for Lincoln was piloted 10:00 to 18:00 hours for six months since November 2016 and managers were applying for extension to increase cover in other areas. These services responded quickly to urgent situations with patients and signposted them to relevant services quickly. There was positive feedback from GPs. Staff said this had reduced the need for patients to attend A&E or be detained by the police under section 136 of the Mental Health Act 1983. However, there was no data analysis available as yet.
- Additionally the trust had plans to develop a clinical decisions unit in Lincoln 2018 to support patients in crisis needing hospital admission. This would mean that patients had somewhere specific to be assessed and wait for admission.
- The trust were also arranging for trust staff to be based out of hours 12:00 to 20:00 hours with the police control room to signpost patients in Lincolnshire to mental health services quickly.
- We stated in our last inspection report that the trust should review the need for a crisis line. The trust had reviewed this with commissioners. Patients could contact the single point of access or crisis team. Most patients said that they were able to access support out of hours in a crisis. One patient and a carer we spoke to expressed concern about telephone access during crisis. We saw in team meeting minutes February 2017 that the trust continued to review this with commissioners.
- Staff had contact details of local groups to signpost carers to for support and assessments. Some teams had carers' champions. One carer said the team did not give them information on how to get a carer's assessment. A senior manager gave feedback on how they had improved their service following feedback from a carers group. Carers had identified that they wanted to be able to contact staff and pass on risk information about patients. The trust had developed posters to promote this to staff.

Health-based places of safety

- Staff recorded details of the patients' race and ethnicity on the electronic patient record. From April 2016 to March 2017 the majority of patients brought to the place of safety identified themselves as 'white British', 12 identified themselves as 'white any other background' and on 28 occasions staff had not asked for details.
- The place of safety was suitable for patients with mobility difficulties.
- The trust had gained funding to build a specific health based place of safety for young people by 2018.

Listening to and learning from concerns and complaints

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- From December 2015 to January 2017 there were 29 complaints with 16 upheld or partially upheld. The teams received 84 compliments.
- Managers gave examples of responding to complaints and sharing feedback with staff to improve practice.
- You said we did' boards were displayed in team reception areas; giving details on actions the trust had taken in response to patient and others feedback.
- Team information packs for patients and carers, except at Lincoln held details about how to make a complaint. However, patients said they were not given information on how to make a complaint.
- Most patients said they were not asked for feedback on the service but felt able to give feedback. Three patients said staff did ask them about this.

Health-based places of safety

- A staff member had developed a patient feedback questionnaire. Information from 12 responses, January to March 2017 positively showed 100% of patients recommended the service; stated that staff treated them with respect and dignity; stated they had access to food and drinks and the place of safety was clean.

Are services well-led?

Good

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

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- Staff we spoke with had knowledge of the trust's vision and values and felt their work reflected these. They said the trust's vision and values were linked to their appraisal and this was annually reviewed by them and their manager. Information was displayed in the teams.
- Staff said senior managers were visible and accessible.

Health-based places of safety

- Staff said the trust's vision and values were linked to their appraisal and this was annually reviewed by them and their manager. Information was displayed in the teams.
- Staff said senior managers were visible and accessible.

Good governance

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- The trust had made significant improvements in this core service to address actions identified by the CQC at our last inspection.
- Governance systems were in place to monitor and assess the quality of the service provided. For example the trust had systems to share feedback from management meetings via staff team meetings and gain feedback from staff. These included quality and band seven staff meetings which had standard agendas to review learning from complaints, incidents and other key areas of performance.
- Managers had access to an 'early warning tool' to measure the performance of teams in areas such as staff vacancies, sickness, training and appraisals. We noted that supervision data was not included and we identified that teams were not meeting the trust target. Also there was a variation in staff training data.
- Team managers across all mental health crisis services said they had adequate administrative support and sufficient authority to carry out their roles.
- Managers told us that they could submit items to the risk register where appropriate.
- 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.

Health-based places of safety

- Trust staff from community teams and wards attended quarterly operational monitoring group meetings involving the approved mental health professional service, emergency duty team and police. This meeting reviewed the quality of the service provided and any risks and identified actions to be taken to make improvements.

Leadership, morale and staff engagement

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- Two team leaders were in interim positions as was the divisional manager. One team leader managed Boston and Louth teams. Staff reported good team working and said they were able to raise issues with their line managers.
- However, Louth staff morale was lower than other teams. Staff gave examples, including increased work due to the community mental health teams and also difficulty accessing medical cover. The manager said they spent approximately 1.5 days at the location and the rest at Boston. They could be contacted by telephone with any concerns in the interim.
- Managers and other staff said they had access to leadership training.
- Staff were aware of external confidential support helplines and whistleblowing processes.
- Managers identified support that had been given to staff when returning to work after sickness, such as access to an occupational health service and employee assistance programme. Some staff referred to attending a 'wellbeing service'.
- Managers managed staff performance.
- Four staff had left in the previous year with no apparent themes.
- The trust referred to working with a national organisation for lesbian, gay, bisexual and transsexual people to ensure and improve staff equality in the workplace.

Health-based places of safety

Are services well-led?

Good

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.

- The trust had identified a service manager and team leader for oversight of the service.
- Managers told us that they could submit items to the risk register where appropriate.

Commitment to quality improvement and innovation

Grantham, Boston, Lincoln and Louth crisis and home treatment, single point of access and county triage teams

- Grantham had achieved the Royal College of Psychiatrists home treatment accreditation scheme.
- Quality initiatives included staff nomination and recognition awards for the trust. The Boston team leader had received a trust 'heroes' award in 2016 for inclusive leadership.

Health-based places of safety

- Quality initiatives included staff nomination and recognition awards for the trust. The Lincoln crisis and health based place of safety staff had received a trust 'heroes' award in 2016.

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 18 HSCA (RA) Regulations 2014 Staffing **Staff are not consistently supported through regular supervision.** Regulation 18(1)(2)(a)