Lincolnshire Partnership NHS Foundation Trust

Quality Report

Trust Headquarters
St. George's
Long Leys Road
Lincoln
Lincolnshire
LN1 1FS
Tel: 0303 123 4000
Website: www.lpft.nhs.uk

Date of inspection visit: 3 – 7 April 2017 and 20 April 2017
Date of publication: 09/06/2017

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Mental Health Unit, Lincoln County Hospital Site Mental Health Unit, Pilgrim Hospital	RP7EV RP7LA
Child and adolescent mental health wards	Ash Villa	RP7MA
Forensic inpatient/ secure wards	Francis Willis Unit, Mental Health Unit, Lincoln County Hospital Site	RP7EV
Wards for older people with mental health problems	Witham Court Manthorpe Centre Pilgrim Hospital	RP7CG RP7LP RP7LA
Long stay/rehabilitation mental health wards for working age adults.	Ashley House, Beaconfield Discovery House, Long Leys Court Maple Lodge	RP7CG RP7LP RP7LA
Community-based mental health services for adults of working age	Trust Headquarters	RP7HQ
Specialist community mental health services for children and young people	Trust Headquarters	RP7HQ
Community-based mental health services for older people	Trust Headquarters	RP7HQ

Summary of findings

Community mental health services for people with learning disabilities and autism.	Trust Headquarters	RP7HQ
Mental health crisis services and health-based places of safety	Trust Headquarters	RP7HQ

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

Summary of findings

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 services at this Provider	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

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We rated the trust overall as good because:

- The trust had responded in a positive way to the improvements we asked them to make following their last inspection. Improvements in most core services were noted across the trust.
- Patient care environments were clean, in good decorative order and appropriately furnished. Services had sufficient rooms for the safe care and treatment of patients, including private areas for patients to receive 1-1 support from staff or see visitors. All inpatient services had activities programmes for patients. There was access to activities over a seven day period. Each ward had timetables visible so that patients knew what was on offer. Patients could personalise their bedrooms and had lockable storage for their possessions. The trust was meeting Department of Health guidance for eliminating mixed sex accommodation.
- The trust had made significant improvements to the external courtyards on the adult acute wards since our last inspection. For example, installation of closed circuit television and two way intercom systems and removal of ligature risks. Works were still on-going. In the inpatient ward for children and young people, innovative observation panels were fitted on bedroom doors, which had privacy frosting on them that was removed electronically when staff pressed a button.
- The trust was opening a psychiatric intensive care unit for males in the summer of 2017 and had plans to provide a psychiatric high dependency unit provision for females.
- The trust had reviewed its management of ligature risks within services. Staff were aware of the risks in their environments and ligature assessments were re-assessed regularly. On inpatient wards, staff had quick access to 'heat maps', specific to their area, to assist in the safe management of patients presenting with high risk of self harm or suicide.
- Throughout the trust, staff treated patients with kindness, dignity and respect. Consistently, staff attitudes were helpful and understanding. Staff used kind and supportive language that patients would understand. Staff encouraged patients to give feedback about their care in a variety of ways. Information leaflets were available in easy read formats and we saw evidence of a variety of information available to patients, for example on how to access interpreters, make complaints, access to advocacy and Mental Health Act information.
- The trust employed suitably qualified and experienced staff to deliver safe care and treatment to patients and provided them with training and development opportunities. The trust had supported healthcare support workers to undertake training to become registered nurses, provided a robust induction programme and supported clinical apprenticeship to encourage young people to seek employment with the organisation. The trust utilised a values based recruitment checklist during their interview process and revisited this during staff induction. The trust also operated a rewards and recognition system, including individual and team recognition, thank you cards, hero's awards and annual awards ceremonies.
- Managers ensured staffing levels across all core services were planned and regularly reviewed. The majority of services across the trust increased staffing based on clinical need and made arrangements to cover leave, sickness and absence. Local managers had authority to make these decisions. The trust employed bank or agency staff to fill vacancies. Where possible, managers ensured temporary staff were familiar with the patients and teams in which they worked. This ensured continuity of care for patients. Bank staff received appropriate training for their roles.

Summary of findings

- Staff received mandatory and role specific training. As at 31 March 2017, the overall compliance across all core services was 92%. Staff had access to additional specialist training, relevant to their role and medical staff had protected time for training and development.
- Staff received an annual appraisal. As at 31 March 2017, 92% staff were compliant.
- The trust reported a reduction in staff sickness rates. In December 2015, staff sickness was reported as 5.1%. In February 2017, this had reduced to 4.5% as a 12-month average.
- The trust regularly reviewed caseloads for staff working in community teams. Where caseloads were high, staff were able to explain the rationale for this.
- Crisis teams were meeting commissioned targets for contacting patients within four hours. As of February 2017, 99% of patients were contacted within this time. Crisis teams had good working relationships with the local Police
- The trust had a robust governance structure in place to manage, review and give feedback from complaints. Staff consistently knew how to handle complaints, and managers investigated complaints promptly Patients and carers received timely responses and outcomes.
- The trust had safeguarding policies and robust safeguarding reporting systems in place and described how they worked with partner agencies to protect vulnerable adults and children.
- The trust used an electronic system for reporting incidents. Trust staff knew what incidents needed to be reported and how to report them. Managers monitored the reporting and recording of incidents. The trust had robust systems for sharing lessons learned from incidents. We saw evidence of compliance with duty of candour guidance related to investigations from serious incidents and complaints. Patients, families and carers were fully involved and informed throughout all processes. The trust board encouraged candour, openness and honesty from staff. Staff knew how to whistle-blow and staff felt able to raise concerns without fear of victimisation.
- The trust had robust process to monitor the fitness of senior staff to work within the service, under the principles of fit and proper persons requirements.
- Senior managers told us there had been much organisational change and transformation of care within the trust. Staff told us they accepted change and positively embraced the opportunity it provided. They felt supported by the board to work with change and felt able to provide feedback about their experiences. Overall, we found significant improvement to staff morale across most teams.
- The trust had robust systems in place to manage the prescribing, storage and administration of medication. We found good working practices between the pharmacy team and staff across all services.
- Overall, we saw good multidisciplinary working and generally patients' needs, including physical health needs, were assessed and care and treatment was planned to meet them.
- Staff had a process in place to submit concerns and issues to the local risk registers which fed in to the trust wide risk register where appropriate.

However:

- Whilst there had been significant progress since the last inspection in 2015, the trust had not fully addressed all our previous concerns.
- The trust could not always provide a bed locally for patients who required admission to adult acute mental health beds. This meant that patients often received care and treatment outside of the trust. Between March 2016 and March 2017, there were 306 out of area placements from the trust to other providers of acute adult inpatient care. The trust did not have psychiatric intensive care unit (PICU) beds. Therefore, if a PICU bed was required, patients were placed out of area. Between February 2016 and February 2017, 63 patients were transferred to other providers when intensive care was required.
- Bed occupancy rates were above 100% on the adult acute wards. We saw that patient numbers exceeded the number of beds available on wards. Therefore, there were no beds available if patients returned from leave.

Summary of findings

- The majority of beds within the adult acute admission wards were located in bays sleeping either four or five patients. These areas offered limited space and privacy.
- Within the forensic inpatient secure ward we found patients did not have free access to the garden. This was a blanket restriction. We were also concerned about the safety of the security fencing in the garden area. We raised this with the trust who made immediate plans to have this replaced.
- In the inpatient ward for children and young people, most doors on the ward were locked, this included bedrooms, toilets and bathrooms, dining room, the female only lounge and doors to the garden. There was no clinical justification for this practice and it was not individually care planned. This was a blanket restriction. We raised these concerns with senior managers and when we returned on 20 April, the trust had taken action to ensure patients were provided with wrist bands, programmed to allow access to specified areas.
- 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.
- Not all patients had timely access to psychological therapies as recommended by the National Institute for Health and Care Excellence.
- 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.
- The trust provided data for staff compliance with clinical supervision; however, this showed significant variance in compliance across teams. The trust told us they had introduced a new method of recording supervision, which was not yet fully embedded. Clinical and managerial supervision data was not collected separately. However, data provided showed overall compliance with clinical supervision across all core services ranged from 7% in October 2016 to 88% in March 2017, with an overall average compliance across all core services of 48%, against the trust target of 95%. From data provided and on site findings, we were unable to determine how supervision was delivered, for example how often staff received one to one support, or whether managerial supervision was provided in accordance with the trust policy. It was equally unclear how outcomes from staff supervision were reviewed or acted upon. We were not, therefore, assured the trust had clear oversight of compliance with management supervision. The trust could not be sure that all performance issues, training requirements or professional development had been identified for staff working in the service.
- Not all staff had completed mandatory training in line with the trust target. For example, on the acute wards for adults only 58% of staff had completed safeguarding children level 3 training. We were concerned that only 63% of staff were compliant with basic life support training, meaning they might not have the required or up to date skills to support patients in an emergency. Equally, only 61% had completed conflict resolution (restraint) training, meaning they might not have the required or up to date skills to safely manage patients requiring physical interventions.
- The trust policy on the management of violence and aggression did not contain guidance from the Mental Capacity Act relating to the use of prone restraint and did not reference up to date National Institute for Health and Care Excellence guidelines. We found an increase since our last inspection in both incidents of restraint and the use of prone (face down) restraint.
- We found some errors on community treatment order paperwork. Seclusion paperwork did not always meet the guidance in the Mental Health Act Code of Practice and medical assessments were not always fully completed or recorded. Staff did not complete seclusion care plans for patients nursed in seclusion on the adult acute wards.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Good

We rated Lincolnshire Partnership NHS Foundation Trust as good for safe because:

- Environments were clean, with appropriate furnishings and adequate rooms for safe care and treatment of patients.
- The trust had reviewed its management of ligature risks within all inpatient services. Staff were aware of the risks in their environments and ligature assessments were re-assessed regularly. Staff had quick access to 'heat maps', specific to their ward, to assist in the safe management of patients presenting with high risks.
- Overall, staff completed risk assessments for patients and updated these regularly.
- The trust was meeting Department of Health guidance for eliminating same sex accommodation.
- The trust had safeguarding policies and robust safeguarding reporting systems in place and described how they worked with partner agencies to protect vulnerable adults and children.
- The trust had completed work to the external courtyards on the acute wards to ensure the environment was pleasant and safe for patients and staff. Improvements had been made to the ward for children and adolescents to promote privacy and dignity. For example ensuring that male and female patients had their own toilet and shower facilities and providing patients with wrist bands, programmed to allow access to specified areas.
- There were robust policies and procedures for the safe prescribing, storage and dispensing of medications.
- The trust had clear systems for the recording and investigation of incidents. Staff new how, when and what to report and outcomes of investigations were shared with staff for future learning. We saw the trust was open and honest with patients when things had gone wrong, in line with the principles of duty of candour.

However:

- Staff did not complete a risk assessment, prior to leave, for patients admitted to the adult acute admission wards.
- Compliance with some mandatory training within teams was low. The trust could not be assured that all staff were sufficiently trained for their role.

Summary of findings

- We found examples of restrictive practice on the Francis Willis Unit (forensic/secure ward). We also raised concerns about potential risk to patients in the external courtyard area of the Francis Willis Unit. We raised this during the inspection and received assurance the trust would take immediate action. When we returned to the unit on 20 April, we found the trust had agreed to works to be completed in June 2017.

Are services effective?

Requires improvement

We rated Lincolnshire Partnership NHS Foundation Trust as requires improvement for effective because:

- The trust had a new system for recording supervision. The trust provided data which showed the average overall compliance with clinical supervision across all core services between October 2016 and March 2017 was 48%. However, data did not specify whether staff were in receipt of one to one supervision to support professional development. At ward level, we found a lack of clarity from staff regarding the different objectives and outcomes from clinical and management supervision; despite the trust's policy giving clear guidance.
- We found some errors on community treatment order paperwork, which sat outside of the requirements of the Mental Health Act.
- Staff did not complete specific care plans for patients nursed in seclusion. Medical assessments were not always fully completed or recorded in line with the Mental Health Act Code of Practice.
- Not all patients had care plans to meet their physical health care needs.
- Not all patients had timely access to psychological therapies as recommended by the National Institute for Health and Care Excellence (NICE)
- In two services, staff were not consistently assessing or recording mental capacity assessments for patients on a decision specific basis.
- Staff working in the acute wards for adults did not always complete discharge care plans for patients. This meant that staff would not have the information to plan effective discharges.
- Not all staff were compliant with training in the Mental Capacity Act. Overall compliance across all services was 83%, against the trust target of 95%. Two teams fell below 75% compliance; acute wards for adults (70%) and the Louth community teams for older adults with 62%.

Summary of findings

However:

- Overall, staff completed holistic, recovery orientated and patient centred care plans for patients and updated these regularly.
- Mental Health Act paperwork was completed correctly, appropriately stored and regularly audited.
- The trust had good working relationships with the local Police. The trust had a street triage service with trust and paramedic staff. The service responded quickly to crisis situations with patients and signposted them to relevant services quickly. Staff and Police told us 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.

Are services caring?

Good

We rated Lincolnshire Partnership NHS Foundation Trust as good for caring because:

- Throughout the trust, staff treated patients with kindness, dignity and respect. Consistently staff attitudes were helpful, compassionate and understanding. Staff used appropriate language patients would understand. The style and nature of communication was kind, respectful and compassionate. Staff showed strong therapeutic relationships with their patients and clearly understood their needs. Staff offered guidance and caring reassurance in situations where patients felt unwell or distressed, confused or agitated.
- Patients told us staff were kind and caring and were consistently positive about staff and the support they had received from services.
- Staff encouraged patients to give feedback about their care. Staff offered patients the chance to give feedback in a variety of ways.
- Senior managers told us that patients were involved in projects across the organisation. This included recruiting and interviewing staff. The trust had a patient involvement group that was well attended by patients from the mental health pathway.
- The trust employed peer support workers, which allowed people with lived experience of mental illness to mentor and support current patients.
- There were numerous examples of patient involvement in care plans, in risk assessments and patient participation in meetings. Staff encouraged patients, wherever possible, to maximise their independence during their treatment.

Summary of findings

Are services responsive to people's needs?

Good

We rated Lincolnshire Partnership NHS Foundation Trust as good for responsive because:

- The trust had robust systems for recording, investigating and learning from complaints. Patients and families were provided with outcomes and received timely apologies when required.
- The trust used information about the local population when planning service developments and delivering services. The trust had effective working relationships with commissioners and other stakeholders.
- The majority of services had a range of rooms and equipment to support care and treatment. Patients had good access to quiet areas on wards and access to improved outside space.
- Patients had access to information on treatments, local services, patients' rights and how to complain across all services. We saw evidence of information available to patients on how to access interpreters should they need one.
- Crisis teams were meeting commissioned targets for contacting patients within four hours. As of February 2017, 99% of patients were contacted within this time.
- All inpatient services had activities programmes for patients. There was access to activities over a seven day period. Each ward had timetables visible so that patients knew what was on offer.
- Patients could personalise their bedrooms and lockable storage for their possessions.

However:

- The majority of beds within the adult acute admission wards were located in bays sleeping either four or five patients. These areas offered limited space and privacy.
- The trust could not always provide a bed locally for patients who required admissions to acute mental health wards, resulting in significant numbers of patients transferred outside of the trust locality to access treatment. Bed occupancy rates were above 100% for acute wards for adults of working age. We saw that patient numbers exceeded the number of beds available on wards. Therefore, there were no beds available if patients returned from leave.
- The trust did not have psychiatric intensive care beds. Therefore, if a psychiatric intensive care unit bed was required, patients were placed out of area. However, the trust is opening a psychiatric intensive care unit for males in the summer of 2017 and has plans to provide further provision for females.

Summary of findings

- 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.
- Within acute inpatient services, 55% of patients did not have a discharge care plan.

Are services well-led?

Good

We rated Lincolnshire Partnership NHS Foundation Trust as good for well led because:

- Trust board members interviewed were clear about the trust's vision and strategy. Senior clinicians were clear about their role and the trust's direction. The vision and values were on display in the trust and were available on the intranet.
- Staff demonstrated the trust's stated values in their behaviour and attitude. Staff we spoke with were passionate about helping patients with mental illness.
- Staff knew who senior managers in the trust were and said they were visible. Staff reported positive morale and job satisfaction. They reported good relationships with managers and felt empowered in their roles.
- Frontline staff took part in some of the clinical audits. This gave staff the opportunity to be involved in the development of the service.
- Staff knew the trust's whistle blowing policy and said they could raise concerns without fear of victimisation.
- Staff participated in team meetings, reflective practice, sharing skills and supporting each other to help improve the health of the patients in their service.
- The trust utilised a values based recruitment checklist during their interview process and revisited this during staff induction. The trust also operated a rewards and recognition systems, including individual and team recognition, thank you cards, heros' awards and annual awards ceremonies.
- The trust had good processes for report and recording complaints. Complaints files we viewed were detailed and showed evidence of investigations, outcomes and action plans, where needed.
- The trust used an electronic system for reporting incidents. Staff knew what incidents needed to be reported and how to report them. Managers monitored the reporting and recording of incidents and gave feedback to staff on lessons learned.
- Staff had a process in place to submit concerns and issues to the individual ward risk registers which fed in to the trust risk register where appropriate.

Summary of findings

- We found the board of directors worked well together, both internally and externally.
- The trust reported a drop in staff sickness rates. In December 2015, staff sickness was reported as 5.1%. In February 2017, this had reduced to 4.5% as a 12-month average.

However:

- The trust data on compliance with both clinical and managerial supervision variable. Not all staff had received supervision in line with trust policy.
- Mandatory training compliance was low in some areas.
- The trust had made changes to improve their governance processes; however, these were not yet fully embedded. For example, the trust had established a recovery college, based on trust premises, which had led to people accessing services now acting as peer support workers. However, this development was not linked to the national research project (a set of mental health system performance indicators for facilitating mental health recovery).

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Mick Tutt, Deputy Chair, Solent NHS Trust

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

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

The team included six inspection managers, 15 inspectors, two Mental Health Act reviewers, one pharmacy inspector, support staff and a variety of specialists. The specialists included consultant psychiatrists, specialist nurses in mental health, learning disabilities and children's nursing, psychologists, occupational therapists, mental health social workers and six experts by experience who have either used a service or have been a carer of someone using the type of services we were inspecting.

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 trust as part of our on-going comprehensive mental health inspection programme. This was an announced inspection.

How we carried out this inspection

We inspected all wards across the trust including adult acute services, rehabilitation and forensic wards, wards for children and adolescents and older people's wards. We looked at the trust's place of safety under section 136 of the Mental Health Act. We inspected learning disability, children and adolescent mental health services, adult mental health and older people's community services and the trust's crisis services.

To get to the heart of people who use services' experience of care, 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 a range of information we hold about Lincolnshire Partnership NHS Foundation Trust and asked other organisations to share what they knew.

We spoke with commissioners, local Healthwatch, Lincolnshire police and local service user groups. We reviewed information received from service users and carers and members of the public who had contacted the Commission about the trust.

Before the inspection, the team:

- reviewed information that we hold on the trust.
- requested information from the trust and reviewed that information.
- asked a range of other organisations that the trust worked in partnership with for feedback. These included NHS England, local clinical commissioning groups, NHS Improvement, Health watch, local authority overview and scrutiny committees, Health Education England, and other professional bodies.
- met with a number of user and carer groups, both internal and external, to hear their views on the trust.

Summary of findings

- reviewed information from patients, carers and other groups received through our website.

Prior to and during the visit the team:

- held focus groups with 16 different staff groups
- spoke with 116 patients and 48 carers and family members
- collected feedback from 49 comment cards
- attended 31 meetings which included multidisciplinary meetings, handover meetings and ward community meetings
- observed eight episodes of community care which included initial assessments and home visits
- reviewed the personal care or treatment records of 265 patients
- examined in detail 147 medication cards
- reviewed in detail patients' Mental Health Act documentation including the records of people subject to a community treatment order
- observed how staff were caring for people
- interviewed 281 staff members
- interviewed executive directors, senior managers and service directors for all services
- examined eight staff personnel records
- reviewed trust policy and procedures
- reviewed the additional information that we asked the trust to provide.

Following the announced inspection:

- We undertook unannounced inspection visits to Ash Villa (the child and adolescent mental health ward and Francis Willis Unit (the forensic inpatient secure ward) on 20 April 2017.
- Made a number of further data requests of the trust.

Information about the provider

Lincolnshire Partnership NHS Foundation Trust was established on 1 June 2002 when social care and health services, formerly provided by Lincolnshire County Council and Lincolnshire Healthcare NHS Trust, were brought together to create new mental health and learning disabilities services.

Lincolnshire Partnership NHS Foundation Trust operates from 56 sites providing services in Lincolnshire to a population of 718,800 across an area of 2,646 square miles and North East Lincolnshire to a population of 159,000 across an area of 74 square miles. The trust operates from nine locations registered with Care Quality Commission, serving mental health and learning disability needs. The trust has 240 inpatient beds the majority of which are on the main sites in Lincoln, Grantham and Boston and nine community teams operating across the county. In addition, the trust also works closely with Lincolnshire County Council and South West Lincolnshire CCG as the trusts main commissioners of services.

Lincolnshire Partnership Trust received foundation trust status 1 October 2007.

The trust provides integrated health and care services for adults of working age with mental health needs under a section 75 agreement with Lincolnshire County Council. It provides the following core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- Forensic inpatient/ secure wards
- Wards for older people with mental health problems
- Long stay/rehabilitation mental health wards for working age adults.
- Community-based mental health services for adults of working age
- Specialist community mental health services for children and young people
- Community-based mental health services for older people
- Community mental health services for people with learning disabilities and autism.
- Mental health crisis services and health-based places of safety

Lincolnshire Partnership NHS Foundation Trust was last inspected between 30 November and 4 December 2015.

Summary of findings

At this inspection, we rated the trust overall as 'requires improvement'. We rated the safe key question as inadequate, the effective and well-led key questions as requires improvement and the caring and responsive key questions as good.

We rated specialist community mental health services for children and young people as outstanding.

The care quality commission issued 23 requirement notices against nine core services (acute wards for adults of working age and psychiatric intensive care, child and adolescent mental health wards, forensic inpatient/secure wards, long stay/rehabilitation mental health wards for working age adults, wards for older people with mental health problems, mental health crisis services and health based paces of safety, community mental health services for people with learning disability or autism, community based mental health services for adults of working age, and substance misuse services).

We issued five requirement notices against the trust because of breaches of the following regulations:

Regulation 12 – safe care and treatment

- The trust must ensure that all ligature risks are identified on the ligature risk audit and that they do all that is reasonably practicable to mitigate any such risks.
- The trust must ensure that all mixed sex accommodation meets guidance and promotes safety and dignity.
- The trust must ensure that seclusion facilities are safe and appropriate and that seclusion is managed within the safeguards of the Mental Health Act Code of Practice
- The trust must ensure that all risk assessments and care plans are updated consistently in line with changes to patients' needs or risks.
- The trust must ensure effective systems for management of medication.
- The trust must ensure that there are not significant delays in treatment and that access is facilitated to psychological therapy in a timely way.

Regulation 13 – safeguarding service users from abuse and improper treatment

- The trust must ensure that food meets the standard required by patients.

Regulation 14 – meeting nutritional and hydration needs

- The trust must ensure that patients' dietary preferences are met, where reasonable

Regulation 17 – good governance

- The trust must ensure that there are systems in place to monitor quality and performance and that governance processes lead to required and sustained improvement.
- The trust must ensure that learning and improvements to practice are made following incidents.

Regulation 18 – staffing

- The trust must ensure there are sufficient and appropriately qualified staff at all times to provide care to meet patients' needs.

The trust had completed an action plan to address the identified requirements and recommendations detailed in the inspection report. The action plan is divided into six separate action plans - one for trust-wide, five core services including adult inpatient, community adult, older adult, community LD and autism, community CAMHS as well as a well led action plan with actions for the board.

Of the 12 trust-wide and five board level well led actions, only one was not completed (and was due to be completed April 2017). This was as follows: Trust to develop integrated performance reports for each operational division.

In the 12 months leading up to the inspection, the Care Quality Commission carried out 14 MHA monitoring visits across the trust. In total, there were 58 issues identified. The trust had action plans to address these issues.

Summary of findings

What people who use the provider's services say

- We reviewed 49 comments cards. Of these, 31 contained positive comments, eight were negative and 10 contained mixed views.
- We interviewed 116 patients and 48 carers or family members.
- Patients told us they had good relationships with staff and felt genuinely cared for. Patients described staff as kind and respectful and felt that staff listened to them and involved them in making decisions about their care.
- Patients and carers told us that they felt involved and informed about treatment decisions. Staff invited them to attend multi-disciplinary meetings regarding their medication and care. Overall, patients reported being involved with, and having received a copy of, their care plan.
- Overall, carers and families reported being well informed and involved in all aspects of patient care and having opportunities to feedback into the service, when needed. We attended carers and patients forums, prior to the inspection, where the majority of comments made were positive about care and treatment.

However:

- Within the adult acute wards, half of all patients we spoke to reported that they did not feel that there was enough staff on duty to offer the care and treatment needed and some patients told us that their privacy was an issue due to the shared dormitories.
- Within the community services for adults, patients told us they had to wait a long time to access psychological therapies.

Good practice

- On the inpatient wards for older people, volunteers visited the wards regularly with pets as therapy dogs. This gave comfort to patients, particularly those who had previously owned a dog and offered a source of conversation. On the inpatient ward for children and young people, the team had a therapy dog as a member of the team on the unit. We heard about examples from patients and staff of how the dog defused and de-escalated situations. Within the community teams for children and young people, the service had introduced an animal assisted therapy service to group work for young people.
- On the long stay rehabilitation wards, there was a patient run café at Discovery House, which had recently employed a previous patient in a contracted paid role. The service offered a range of temporary paid job opportunities for patients. These included gardening and car valet roles.
- Within the crisis and home treatment teams, the trust had developed good working relationships with the local Police for the benefit of patients. 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.
- Within the community services for children and young people, Staff had established an “outcomes oriented child and adolescent mental health service (CAMHS)” model of care. This evidence based model focussed in the outcomes for young people at every session and at discharge. It was recognised in NHS innovation awards and other child and adolescent mental health services nationally had adopted this model. The service had developed a large crisis and home treatment team, which offered out of hour’s provision for assessment and support 24 hours a day. This service had been praised highly by senior staff at the local hospitals in relation to the responsiveness of the team.
- The psychiatrist working for the forensic secure inpatient ward had developed an IT application for use by staff to access information on National Institute for Health and Care Excellence (NICE) guidelines on the wards.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all patients nursed in seclusion have a seclusion care plan.
- The trust must ensure that all inpatients have discharge care plan for staff to follow.
- The trust must ensure that all inpatients have care plans to address their physical healthcare needs.
- The trust must ensure that mental capacity assessments and best interest decisions are completed and documented in the care records.
- The trust must ensure all staff are in receipt of regular clinical and management supervision, in accordance with its policy, and that accurate records are kept.

Action the provider SHOULD take to improve

- The trust should review its bed capacity and management within the adult acute admission wards.
- The trust should review the continued use of bed bays in the adult acute wards.
- The trust should ensure that documentation for patients detained under community treatment orders reflect the requirements of the Mental Health Act Code of Practice.
- The trust should ensure that its policy on the management of violence and aggression reflects guidance from the Mental Capacity Act and includes the latest National Institute for Health and Care Excellence guidance.
- The trust should ensure that adequate medical cover is available for the safe care and treatment of patients.
- The trust should ensure that patients have timely access to psychological therapies.
- The trust should ensure that actions identified for improvement to the health-based place of safety are completed.
- The trust should ensure that improvements to the garden area on the inpatient forensic secure unit are completed.
- The trust should ensure sufficient staff are employed, over the weekend, to support patients on the adult acute admission wards.
- The trust should review staffing levels within the community team for patients with learning disabilities or autism; specifically at Spalding.

Lincolnshire Partnership NHS Foundation Trust

Detailed findings

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.

- We visited all of the wards at the trust where detained patients were being treated. We reviewed the records of people subject to community treatment and people who had been assessed under section 136 of the MHA. We also looked at procedures for the assessment of people under the MHA.
- At the time of the inspection, the trust had 94 patients detained under the Mental Health Act and 44 patients subject to community treatment orders. Of these, the majority (49) were detained under Section 3 of the Act.
- As at 31 March 2017, 92% of clinical staff had received training in the Mental Health Act, against the trust target of 95%. The trust stated that this training is mandatory for all core services for inpatient staff and all qualified community staff. Staff told us that online MHA training took place on an annual basis, with three yearly face-to-face refresher training.
- The trust target of 95% was not achieved in six core services. However, the lowest compliance was for wards for older people reported at 82%.
- Staff had access to the "Mental Health Act 1983: Code of Practice" (Department of Health, 2015). There was a MHA policy with useful flowcharts for staff to follow along with an online MHA resource centre available to all staff, providing easy access to the relevant MHA policies, procedures, forms and other information.
- The trust wrote to patients detained under the MHA providing them with important information, including the right to appeal. We reviewed the detention paperwork of 45 patients, covering 76
- periods of detention under the MHA. The detention paperwork was in order. We expected to see 35 reports by AMHPs, however only 18 reports were available for inspection.
- Staff had discharged with their responsibilities under section 132 (duty of managers of hospitals to give information to detained patients) at the point of their detention under the MHA. Overall, patients received their rights on admission and at regular intervals thereafter.
- Where patients required certificates of consent to treatment or second opinion authorisation (T2/T3) documentation we saw that staff held these with medicines charts. This ensured staff prescribed and administered medication under the appropriate legal authority. The pharmacy team tracked the dates for this documentation to check that staff completed reviews in a timely manner.
- We reviewed the community treatment order (CTO) paperwork of 24 patients and the guardianship paperwork for one patient. We found nine concerning issues. Following our inspection, the trust informed us they had strengthened their procedures for checking MHA paperwork

- Seclusion was used at a number of services we visited. The seclusion facilities met the requirements of the current code of practice.
- We reviewed 22 seclusion records. Staff had recorded the interventions they used with the patient before seclusion began. However, some seclusion records did not meet the requirements of the Code of Practice. We were concerned that the records did not always provide full information about the patients' period of seclusion.
- Across all inpatient wards, detained patients had an appropriate section 17 forms in place, authorising periods of leave for the hospital. Medical staff completed these correctly and stipulated the conditions of leave.
- 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 and the Mental Health Act Code of Practice. Overall, staff completed legal documentation for patients detained under Section 136 correctly. Staff informed patients of their rights under section 132. The trust had set up a working group to consider changes to section 136 the Mental Health Act in line with the Policing and Crime Act 2017.
- Staff referred detained patients to the independent mental health advocate (IMHA) service on an individual/ needs basis.
- The trust had arrangements in place for the receipt and scrutiny of detention paperwork. The MHA and legal services officer visited the wards on a weekly basis to ensure a visible presence, and to offer drop-in sessions to staff, answering any queries about specific MHA issues. The trust had developed an online MHA resource centre. This provided staff with easy access to information about the MHA, including relevant policies and procedures, forms, flowcharts, and other information.
- The trust had a MHA heat map. This included information about the use of the MHA, and important information such as section expiry, and consent to treatment, dates. The MHA administration staff distributed the heat map to relevant managers and administrators on a weekly basis to ensure they were aware of when action relating to the patients' detention under the MHA was required.
- The trust's legislative committee monitored all aspects of MHA performance. The committee received, and considered, information such as the results of audits and legislative changes. The trust's board of directors received relevant information from the legislative committee, through the quality committee. Recent audits had taken place, which included MHA treatment forms with associated mental capacity assessments, section 132 patients' rights and section 17 leave of absence.

Mental Capacity Act and Deprivation of Liberty Safeguards

CQC have made a public commitment to reviewing provider adherence to MCA and DoLS.

- As at 31 March 2017, the overall compliance rate for training in the Mental Capacity Act across the trust was 83%. This was a nine percentage point increase in compliance from December 2016 but still not as high as the trust target of 95%. It should be noted that this course is level 3 training. All core services failed to achieve the trust target of 95% compliance. The lowest compliance was within the community mental health services for children and young people at 25%.
- However, two core services also had mandatory training in level 2C MCA training, which is reviewed every three years. Wards for children and young people achieved over the target compliance (95%) with 97%. However, community specialist community services for children and young people achieved slightly under at 87%
- Staff we spoke with demonstrated a good understanding of the application of the Act and the five guiding principles.
- Within two core services where we would expect to find exemplary practice, wards for older people and community services for people with learning disabilities or autism, we found staff were not always completing decision specific mental capacity assessments for patients.
- The trust provided information around the Deprivation of Liberty Safeguards applications they have made

between 1 January 2016 and 31 December 2016. The trust stated they made 141 Deprivation of Liberty Safeguards applications during this time. Forty-two of these were approved at the time of inspection.

- Wards for older people had the most applications made with 134 (95%). Forty of these were approved (30%). The highest number of applications made within a month was 18, in March 2016. There was one application made in July 2016 by the long stay/rehabilitation mental health wards for working age adults. This was not approved.

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

Summary of findings

We rated Lincolnshire Partnership NHS Foundation Trust as good for safe because:

- Environments were clean, with appropriate furnishings and adequate rooms for safe care and treatment of patients.
- The trust had reviewed its management of ligature risks within all inpatient services. Staff were aware of the risks in their environments and ligature assessments were re-assessed regularly. Staff had quick access to 'heat maps', specific to their ward, to assist in the safe management of patients presenting with high risks.
- Overall, staff completed risk assessments for patients and updated these regularly.
- The trust was meeting Department of Health guidance for eliminating same sex accommodation.
- The trust had safeguarding policies and robust safeguarding reporting systems in place and described how they worked with partner agencies to protect vulnerable adults and children.
- The trust had completed work to the external courtyards on the acute wards to ensure the environment was pleasant and safe for patients and staff. Improvements had been made to the ward for children and adolescents to promote privacy and dignity. For example ensuring that male and female patients had their own toilet and shower facilities and providing patients with wrist bands, programmed to allow access to specified areas.
- There were robust policies and procedures for the safe prescribing, storage and dispensing of medications.
- The trust had clear systems for the recording and investigation of incidents. Staff new how, when and what to report and outcomes of investigations were shared with staff for future learning. We saw the trust was open and honest with patients when things had gone wrong, in line with the principles of duty of candour.

However:

- Staff did not complete a risk assessment, prior to leave, for patients admitted to the adult acute admission wards.
- Compliance with some mandatory training within teams was low. The trust could not be assured that all staff were sufficiently trained for their role.
- We found examples of restrictive practice on the Francis Willis Unit (forensic/secure ward). We also raised concerns about potential risk to patients in the external courtyard area of the Francis Willis Unit. We raised this during the inspection and received assurance the trust would take immediate action. When we returned to the unit on 20 April, we found the trust had agreed to works to be completed in June 2017.

Our findings

Safe and clean environments

- During our last inspection (December 2015) we found the trust had did not have a robust system for identifying and managing all ligature risks. This was of particular concern on the acute wards for adults of working age, child and adolescent mental health wards, forensic inpatient/secure wards, long stay/rehabilitation mental health wards, and wards for older people. We issued requirement notices requiring the trust to take action to review its identification and management of these ligature risks.
- During this inspection, we found the trust had completed a comprehensive review of the identified risks, had updated ligature risk assessments and had completed works to improve patient safety. Records showed the trust had completed new audits of the clinical environments and for each audit, there was a schedule of estates work undertaken to address the required actions. The trust monitored progress via the continuous quality improvement plan. We reviewed the

work the trust had completed since our last inspection. We found staff had access to ward maps in their teams; identifying high-risk areas and ligature assessment were regularly updated according to changes in patient needs and risks. Staff spoken to in focus groups were well informed of the risks in their areas and responded appropriately to protect patients.

- All areas seen were clean and well maintained with décor and furniture in good order.
- Across all sites, cleaning records were up to date and demonstrated that staff cleaned all locations regularly. Equipment was well maintained and clean stickers were visible and in date.
- The trust had an effective and responsive estates department, who operated a triage system to prioritise work and identify whether outside consultants were needed. The estates lead identified some difficulties, due to the age of some of the buildings, however the trust had a clear process for costing improvement works via the business manager and capital budget meetings.
- The trust ensured that repairs to premises were addressed in a timely manner. All outside contractors received a safety induction.
- Staff had completed environmental risk assessments and where concerns had been identified, staff mitigated these by carrying out additional checks, installed mirrors or had taken other actions to resolve the issues.
- Staff followed the trust's infection control policies. There were handwashing signs visible and hand sanitiser available in the clinic rooms and the reception areas.
- Over the 12 months from 1 January 2016 to 31 December 2016 there were 22 mixed sex accommodation breaches at the trust. Twenty-one of these breaches occurred in the acute wards for adults of working age on Conolly Ward, specifically in the week of 27 August 2016 and involved the same patient. The trust recorded one incident on Ashley House, long stay rehabilitation ward.
- Concerns were noted related to the management of mixed sex accommodation at Ash Villa, the children's inpatient service. We brought these to the attention of senior managers during the inspection. When we re-visited Ash Villa on 20 April 2017, we found changes had been made to protect patients. The trust had further plans for improvements to the environment and facilities on the ward.
- On the Francis Willis Unit (forensic/secure ward), we were concerned that the roofline and the top of fences had rotating spikes. This posed a significant risk to patients should they attempt to climb on to the roof and gave an institutional and custodial appearance to the service. We raised our concern to senior staff during the inspection and received assurance that the rotating spikes would be removed. We returned to the unit on 20 April at which time staff told us the trust had agreed to installation of a new fence. The work was planned for the end of June 2017.
- Following concerns raised during our last inspection, the trust had made considerable improvements to the external courtyards across the adult acute admission wards. Works completed included installation of a live stream closed circuit television system, two-way intercom facilities for staff or patients to seek assistance and removal of ligature risks. A robust environmental risk assessment was in place.
- 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 and was quiet and secure. However, these 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.
- Clinic rooms were visibly clean and had enough space to prepare medications and undertake physical health observations. Staff checked physical health monitoring equipment weekly and ensured it was calibrated to ensure it was in good working order. Emergency resuscitation equipment was checked daily.
- Within inpatient services, all staff had access to personal alarms. However, not all community teams had alarms fitted in interview rooms for staff use in an emergency. Community teams had access to personal alarms, but did not always use these.
- We visited six seclusion rooms across the trust. Overall, the seclusion rooms met the standards required in the Mental Health Act code of practice. However, there was

a blind spot in one seclusion room. We saw issues with the flooring, being in need of repair, in three seclusion rooms on the Francis Willis Unit, The Vales and Charlesworth Ward. We had concerns about the privacy of patients when being nursed in the seclusion rooms on the three acute wards. This was due to the location of the seclusion room on the wards.

- We reviewed data collected from recent PLACE assessments. PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services.
- The 2016 PLACE score for cleanliness for the trust was 98.8%.The trust scored higher than the England average for cleanliness for mental health and/or learning disabilities trusts (97.8%) for eight sites, with four of the eight scoring 100%. The trust scored lower than the England average for Ashley House at 97.5% and the Francis Willis unit, which scored considerably lower, at 93.2%.
- The trust's 2016 PLACE score for condition, appearance and maintenance was 90.9%. The trust scored lower than the England average for mental health and/or learning disabilities wards at 94.5% for all ten sites. The Francis Willis Unit was the lowest with a score of 82.2%.
- The trust's 2016 PLACE score for dementia friendly was 66.1%. The trust scored higher than the England average for mental health and/or learning disabilities wards at 82.9% for two of the nine sites that it applied to, and scored lower than the England average for the others. The Francis Willis unit scored the lowest with 45.7%.
- The trust's 2016 PLACE score for disability was 78.5%. The trust scored higher than the England average for mental health and/or learning disabilities wards at 84.5% for three sites, and scored lower than the England average for seven sites (Maple Lodge, Peter Hodgkinson Centre, Francis Willis Unit, Ash Villa, Discovery House, Department of Psychiatry at Pilgrim Hospital and Ashley House).
- The trust provided details from their board assurance framework, which showed three risks related to the trust environment; failure to effectively plan and maintain the estate, failure to adequately assess outside space, relating to ligature risks and failure to ensure same sex accommodation.

Safe staffing

- The trust identified a staff turnover rate of 15% in September 2016. Fifty-three per cent of turnover was a result of fixed term contracts and retirements. However, staff were still leaving for voluntary reasons. The trust employed a recruitment and retention lead to address staffing issues and implemented a series of projects, for example organising a student careers fair for final year students, attendance at the British medical journal conference for psychiatric consultants and development of key performance indicators in the recruitment process to speed up time to hire and collecting references.
- The trust reported successful recruitment of over 40 newly qualified registered nurses over the year to December 2016.
- The trust completed further work to promote retention of employees by development of exit questionnaires undertaken on a personal level and monthly review of all leavers to investigate the reasons for leaving.
- The trust submitted their establishment, vacancy, levels of bank and agency usage for 1 January 2016 to 31 December 2016.
  - total number of substantive staff was1630
  - total number of substantive staff leavers in the last 12 months was 241
  - total WTE leavers over 12 months was15%
  - total vacancies overall (excluding seconded staff) was 122
  - total vacancies overall 7%
  - total permanent staff sickness overall 5%
  - establishment levels registered nurses (WTE) was 460
  - establishment levels nursing assistants (WTE) was 282
  - number of WTE vacancies registered nurses was 25
  - number of WTE vacancies nursing assistants was 34
  - registered nurse vacancy rate was 5%

Good

Are services safe?

- nursing assistant vacancy rate was 12%
- shifts filled by bank staff to cover sickness, absence or vacancies (registered nurses) was 3598 (4% of all shifts)
- shifts filled by agency staff to cover sickness, absence or vacancies (registered nurses) was 481 (1% of all shifts)
- shifts NOT filled by bank staff where there is sickness, absence or vacancies (registered nurses) was 308 (0.3% of all shifts)
- shifts NOT filled by agency staff where there is sickness, absence or vacancies (registered nurses) was 117 (0.1% of all shifts)
- shifts filled by bank staff to cover sickness, absence or vacancies (nursing assistants) was 7079 (11% of all shifts)
- shifts filled by agency staff to cover sickness, absence or vacancies (nursing assistants) was 2294 (3% of all shifts)
- shifts NOT filled by bank staff where there is sickness, absence or vacancies (nursing Assistants) was 309 (0.5% of all shifts)
- shifts NOT filled by agency staff where there is sickness, absence or vacancies (Nursing assistants) was 1144 (2% of all shifts)

- The trust reported an improving picture by March 2017.
- The trust reported an improved average vacancy rate for registered nurses from 5% in December 2016 to 3% at March 2017. Average vacancy rates for nursing assistants had also improved slightly over the same period from 12% to 11%.
- Data received from the Trust, as at December 2016, showed mental health crisis services and health-based places of safety had the highest registered nurse vacancy rate, at 18%. This had reduced to 14% by 31 March 2017, but remained higher than the trust average of 3%.
- At 31 March 2017, four out of ten core services had nursing assistant vacancy rates higher than the trust average of 11%. Community based mental health services for adults of working age at 22%, wards for older people with mental health problems at 18% and forensic inpatient/secure wards at 13%.
- Wards for older people with mental health problems had the highest number of registered nurse shifts filled by bank staff with 1138, representing 6% of all their shifts over 2016. Between 1 January and 31 March 2017, 288 shifts for qualified nurses were filled by bank staff, representing 10% of all shifts.
- The child and adolescent mental health wards had the highest percentage of registered nursing shifts filled by bank staff over the 12-month period, with 17% of all their shifts filled. Asides from 'other specialist services', community-based mental health services for adults of working age had the highest percentage of their shifts filled by agency staff, at 2%. Five core services had no shifts filled by agency staff during the 12-month period.
- Between 1 January and 31 December 2016, wards for older people with mental health problems had the highest number of nursing assistant shifts filled by bank staff at 2741 (20%) and the highest percentage of shifts filled by agency staff at 12%. Between 1 January 2016 and 31 March 2017, 850 shifts were filled by bank staff (15%) and 6% of shifts filled by agency staff. This demonstrated a decreased reliance on bank and agency staff over the first three months of 2017.
- Child and adolescent mental health wards had highest percentage of their nursing assistant shifts filled by bank staff over the 12-month period, with 31%. However, between 01 January 2017 and 31 March 2017, this had reduced to 18%.
- The trust reported low levels of agency staff use across all core services. Five core services had no shifts filled by agency staff during the 12-month period. The trust reported overall 3% use of agency staff in the year to December 2016 and 2% for the first three months of 2017.
- The trust reported low levels of shifts that remained unfilled. Between January 2016 and December 2016, the total number of shifts for qualified nurses unfilled was 117 (0.01% of all available shifts). Between January 2017 and March 2017, the numbers reported were 33 (0.2%). For the same periods, the reported numbers of unfilled shifts for nursing assistants was 1144 (2%) and 428 (2%).

Good

Are services safe?

- The trust submitted staff fill rates for registered nurses and care staff during October, November and December 2016. Staff fill rates compared the proportion of planned hours worked by staff (nursing) to actual hours worked by staff (day and night).
- Ash Villa, child and adolescent mental health ward, was below the lower fill level for all day shifts filled by registered nurses reported. All wards within the long stay rehabilitation mental health wards were below the lower fill level for day shifts filled by care staff during October 2016. Charlesworth ward was above the upper fill level for day shifts filled by registered nurses for all months reported. Ward 12 was above the upper fill level for night shifts filled by care staff and below the lower fill level for night shifts filled by registered nurses for all months reported.
- The trust submitted their sickness, turnover and vacancy data for the period 1 January 2016 to 31 December 2016. There was 1630 substantive staff in post as at December 2016, 241 leavers throughout the twelve months, 15% turnover, 7% vacancies and 5% staff sickness.
- Community-based mental health services for adults of working age had the highest percentage turnover of substantive staff leavers overall during the period, at 17%.
- Wards for older people with mental health problems had the highest percentage vacancy rate, at 11%. This was an increase of 7% over the 12-month reporting period.
- However, an improving picture was seen for the three months, January 2016 to 31 March 2017, where there was a 5% turnover rate, 4% vacancies and staff sickness per core service ranged from 3% for specialist community mental health services for children and young people and 6% for wards for older people with mental health problems. The most recent national data for mental health and learning disability trusts shows an average sickness rate of 5%. The total number of substantive staff in post as at March 2017 and slightly increased to 1650.
- Between January 2017 and March 2017, community mental health services for people with learning disabilities or autism had the highest percentage turnover of substantive staff leavers overall at 12%.
- From the board assurance framework there was one amber RAG rated risk related to safe staffing which was 'the failure to provide and maintain an effective workforce'. There were also five further risks identified from the organisational risk register. These were concerns about:
  - difficulties recruiting substantive consultant and SAS medical staff.
  - patient safety being compromised due to staff shortages, unfilled shift and over reliance on agency staff.
  - provision of out of hour's psychiatric medical assessment, which is currently provided on a waiver basis to a private provider.
  - number of approved mental health professionals available to ensure adequate cover of daytime rota in Lincolnshire.
  - poor physical health of inpatients on Ward 12, Discovery House and Ash Villa due to no established physical health care nurse posts on these higher risk inpatient areas.
- Senior managers across services effectively monitored their staffing levels and skill mix within teams. Managers had the necessary authority to arrange additional staffing, for example when patients required more intensive support or to cover vacant shifts with regular bank or agency staff where required. On The Vales ward (long stay rehabilitation ward), there was a 15% vacancy rate for qualified staff. The manager advised she had raised this as a risk issue and had put forward a proposal to block book regular agency staff to keep staffing levels safe.
- Overall, we found staffing levels across the trust were sufficient for safe care and treatment of patients and to meet patient need. However, within the acute wards for adults, staff and patients reported lower staffing levels over the weekends. We were told that this affected staff ability to escort patients on leave from the wards. No receptionist was employed over the weekends; meaning staff completed these duties.
- In the community team for patients with learning disabilities or autism, the vacancy rate in the south hub

in Spalding was 69% and in the east hub at Boston, it was 32%. Senior staff told us that vacancies in Spalding were due to service reconfiguration. Some staff had left due to extended distances for travel to work.

- We reviewed average caseloads across community teams. Within the community teams for older people, caseloads were high, ranging from 36 to 98 per qualified nurse. Caseloads were on the risk register, had been reviewed by all team coordinators at the end of 2016, and remained part of the older adult community mental health service transformation plan. However, we found where caseloads were high; teams had considered the likelihood of re-referral of patients and the stress this would cause. We did not find impact on the safe delivery of care to patients.
- Caseloads were reported monthly by the informatics team and available on the trust intranet site. Caseload sizes were also reported and collated by each team coordinator on a monthly spreadsheet. Managers discussed caseloads at the monthly performance meetings and during supervision.
- Overall, within community teams we found patients had appropriate allocation of care co-ordinators. However, within the community team for adults, there were 23 patients waiting allocation to a care co-ordinator at the time of inspection.
- We found some concerns relating to medical cover across a number of services. In the community team for children and young people, there were three posts vacant for psychiatrists. The trust had an active recruitment process in place, but due to the geographical locations, had found difficulty in recruiting. The trust identified this staffing shortage on the trust risk register and had put temporary cover arrangements in place. Within the crisis service and health-based place of safety teams, four staff and one approved mental health professional identified accessing a child and adolescent consultant psychiatrist as a challenge.
- Within the acute wards for adults, doctors covered more than one service. Therefore, there was a risk that a doctor might not be able to attend wards quickly in an emergency. However, we did not find any incidents related to this.
- Within the long stay rehabilitation wards, a locum doctor was covering two other wards in the county and also the consultant post at Maple Lodge. As the wards were located in different parts of the county, staff raised concerns that this could result in insufficient medical cover.
- Staff within the Louth crisis team reported difficulties getting medical cover and appointments for patients. This was raised during our last inspection. However, managers told us staff knew how to access a doctor in an emergency and we found no incidents of not being able to do so.
- The trust identified difficulties in recruiting substantive consultants on the organisational risk register, acknowledging that on-going employment of locum staff did not support continuity of care for patients.
- All staff completed mandatory training as part of the trust's induction process and bank staff had their own list of essential training for completion prior to working with patients. Managers received a monthly report to identify when staff were required to complete or refresh training and staff could review their compliance via the electronic staff record.
- As at 31 March 2017, training compliance for trust-wide services was 92%. There were 29 mandatory training courses, all with a trust compliance target of 95%. Twenty-two out of 29 courses had not met their compliance targets. However, only two training courses failed to achieve over 75% compliance: safeguarding children level 3 (69%) and conflict resolution (restraint and breakaway training) at 73%.
- The trust had recently reviewed their mandatory training programme for all staff. Numbers of training courses had been reduced to focus on statutory and role specific training. Staff received training by taught face-to-face sessions, or via the e-learning system.
- The trust has introduced physical healthcare implementation in practice training, delivered over three consecutive days. This training was not considered mandatory and had not yet been audited for effectiveness, despite positive reports from staff.

Assessing and managing risk to patients and staff

- Staff received training in the management of violence and aggression. The trust employed a clinical lead for

restrictive interventions who held responsibility for the development of trust policies in relation to prevention and management of violence and aggression and observations and for providing detailed reports on behalf of the trust to the patient safety and experience committee and trust board. Over the 12-month period to December 2016, the trust had completed audits, in accordance with National Institute for Health and Care Excellence, in challenging behaviour in learning disabilities and supervised confinement (seclusion).

- The trust had 17 internal trainers amongst the staff group who delivered training to the staff.
- The trust had a policy for the management of violence and aggression, contained in their clinical care policy. However, the trust policy did not detail guidance from the Mental Health Act Code of Practice relating to prone restraint. We found the trust policy cited the National Institute for Health and Care Excellence guidance CG25 (2005), however, NICE updated guidance in 2015. The trust was not, therefore, referring to the most up to date guidance (NICE NG10) within their policy.
- The policy contained detail of training staff should receive, however we found discrepancy between the titles of training recorded in the policy, and that contained in the trust mandatory training matrix.
- As at 31 March 2017, 73% of inpatient staff had completed mandatory conflict resolution (restraint) training, against the trust target of 95%. We were concerned that not all staff working within inpatient services had received training to support them in their role, or to manage physical interventions (restraint) of patients safely.
- Inpatient, community and ancillary staff completed restrictive intervention/breakaway training and the trust recorded 91% compliance.
- The trust reported 748 incidents of restraint on 213 service users across all services between 1 January 2016 and 31 December 2016. Of these there were 114 incidents of prone (face down) restraint, accounting for 15% of restraint incidents.
- Since the last CQC report, the trust reported an increase in both the occurrences of restraint, previously 275 over six months, and the use of prone restraint, previously accounting for 11% of all restraints.
- The Mental Health Act Code of Practice states that prone restraint should be avoided unless there are specific reasons for its use. This guidance is also supported by the Department of Health document Positive and Proactive Care, 2014. The acute wards for adults of working age reported an overall increase in the incidents of restraint since the last report, from 81 over a six-month period, to 209 from January to December 2016. Recorded incidents of prone restraint had also increased from 12% in 2015 to 20% in December 2016.
- Wards for older people with mental health problems had the most incidents of restraint over the 12-month period with 255. This core service also had the most incidents resulting in rapid tranquilisation, with 71 (27%). Staff utilised prone restraint on 21 occasions, (8% of all recorded restraints).However, managers told us the majority of restraint used was low level restrictive standing and seated holds. There had been no reported prone restraints or use of rapid tranquilisation since January 2017. The number of restraints had significantly reduced between January and March 2017 since the introduction of extra care suites and a new de-escalation pathway; which was part of the trust's restrictive intervention reduction programme.
- Forensic inpatient/secure wards reported the fewest number of restraints over this period at 67, of which 11 (16%) were in the prone position and resulted in the administration of rapid tranquilisation.
- The health-based places of safety had the least incidents of restraint at six, of which two were prone.There were no incidents of rapid tranquilisation.
- Across all services, the trust considered the use of restraint and seclusion as reportable incidents. Incidents were regularly monitored and reviewed. Staff told us they avoided the use of prone restraint where possible due to the known associated risks. Staff turned the patient over or into a different position at the earliest opportunity if prone restraint was used.
- Across all services, the trust recorded 156 incidents where staff administered rapid tranquilisation, from 748 recorded restraints, equating to 20%.
- The trust did not use mechanical restraint.
- The trust had an up to date policy for the use of seclusion, giving detail of the requirements under the

Mental Health Act Code of Practice and National Institute for Health and Care Excellence guidance NG10. Seclusion refers to "the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others" (Mental Health Act Code of Practice 26.103). The trust referred to seclusion rooms as 'supervised confinement rooms'.

- The trust reported 120 seclusions across five core services between 01 January 2016 and 31 December 2016.
- Acute wards for adults of working age had the highest numbers of seclusions with 92.
- We reviewed 22 seclusion records. Staff had recorded the interventions they used with the patient before seclusion began. Staff had completed physical health needs assessment forms in 20 of the 22 records. However, some seclusion records did not meet the requirements of the Code of Practice. A number of entries on review sheets and observation forms, made by different staff but at the same time, gave contradictory accounts of what the patient was doing.
- Staff had not developed seclusion care plans for patients. We were concerned that staff did not have guidance on how to support the patients during these episodes. A number of doctors' assessments showed the doctor merely signing the review form instead of recording their assessment of the patient. We were concerned that the records did not always provide full information about the patients' period of seclusion.
- Some staff referred to the special clothing used, on occasion, by patients being nursed in seclusion, as "anti-ligature". However, other staff removed such clothing from patients when they tried to make a ligature. Staff were unclear as to what alternatives were available.
- There were no incidents of use of long-term segregation in the 12-month period in any core service.
- The trust employed a safeguarding lead, who also took the lead on 'Prevent' (part of the Government's anti-terrorism strategy, providing practical help to prevent people from being drawn into terrorism). The safeguarding lead responsibilities included the monitoring of safeguarding concerns, liaison with the local authority safeguarding teams and writing and updating policies.
- The trust had appropriate policies in place relating to safeguarding procedures and within teams there were 83 safeguarding champions; able to offer advice to staff. Additional guidance was available to staff via the trust's intranet. We were told that the trust's internal and the local authorities' safeguarding teams were accessible and available to staff for additional advice. A governance process was in place that looked at safeguarding issues at both a trust and at directorate levels on a regular basis. However, compliance with mandatory safeguarding training fell below the trust target of 95%.
- Safeguarding adults level 1 training was 94%,
- safeguarding adults level 3 was 83%;
- safeguarding children level 1 was 92%,
- Safeguarding children level 3B (training specific to staff working within the children's' services) was 75%.
- We were concerned that staff compliance with safeguarding children level 3 training was 69%. This training is mandatory and delivered to all clinical staff. The trust could not be assured that all staff were in receipt of sufficient training for their role.
- The trust submitted their safeguarding referrals data for the period between 1 January 2016 and 31 December 2016. During this time, the trust submitted 114 adult safeguarding referrals and 76 child safeguarding referrals to the local authority. Adult community services had the highest number of adult referrals with 27. Specialist community mental health services for children and young people received the highest number of child safeguarding referrals with 39
- We reviewed 265 care and treatment records for patients. Overall, we found staff completed comprehensive risk assessments and updated these regularly and after incidents. However, 21% of the records reviewed within the community teams for patients with learning disabilities or autism did not contain a completed risk assessment and a further 18% were not updated.

Good

Are services safe?

- Overall, we found very few blanket restrictions across the trust. However, at the Francis Willis unit (forensic secure inpatient service) access to the garden area was restricted due to risks within the environment. The manager told us that there was a working group looking at all restrictive practice. As part of this work, the trust was considering ways to better manage access to mobile phones and vaping.
- The trust had policies and procedures for the safe administration and monitoring of medicines for patients. These included an updated rapid tranquilisation policy, developed in line with National Institute for Health and Care Excellence guidance, developing high dose antipsychotic use guidance, establishing a rota to ensure regular pharmacy team support for inpatient wards and advice to staff on identifying critical medicines.
- Medicines were stored securely in locked rooms and access was controlled appropriately. Mostly temperatures for medicines refrigerators were recorded to ensure medicines remained safe and effective in use. Medicines stocks were managed by the pharmacy team. We saw suitable quantities of stock were held and were organised in such a way to reduce the risk of incorrect administration.
- The ordering, storage and administration of controlled drugs was in line with regulations. Wards had suitable cupboards and staff kept full records. Staff checked stock daily and pharmacy staff also completed regular checks.The acute hospital's on call service provided medicine supply and advice 24 hours, seven days a week.
- The Trust provided a clinical pharmacy service to all in-patient departments five days a week. Pharmacists were able to attend multidisciplinary meetings and ward rounds; however, time constraints reduced the frequency this could occur. We saw that pharmacists found other ways to communicate with medical staff including email, notes on the electronic patient record and notes on patients' charts. Pharmacists attended community teams weekly and attended as needed to assess administration charts.
- The pharmacy team completed medicines reconciliation generally within 24 hours of admission to wards for inpatients and Staff on wards assessed the medicines that patients brought into hospital to make sure it was safe to use. These processes contributed to ensuring that patients received the right medicines whilst in hospital.
- Where patients required certificates of consent to treatment or second opinion authorisation (T2/T3) documentation we saw that this was held with the medicines chart. This ensured staff prescribed and administered medication under the appropriate legal authority.
- Staff told us that discharge from hospital was not delayed due to waiting for medicines to take home. Staff planed leave for patients and ordered medicines appropriately. We found this occurred in a timely fashion when patients left the wards, including for short-term leave.
- The Trust had an organisational structure that promoted safe medicines use. We saw that each in-patient ward had a medicines link nurse who had responsibility for disseminating medicines information or new medicines policy information to the ward.
- Medicines link nurses met monthly in local teams and then quarterly across the trust. This ensured effective learning and communication of changes to processes.
- The trust had a robust lone working policy. Within the older adult community team, staff used a signing in and out board in reception, work mobiles and had a code word to indicate significant concerns whilst seeing patients. The duty worker checked where all staff were at the end of the day and anyone not accounted for would be contacted with escalation if contact was not achieved.

Track record on safety

- We analysed data about safety incidents from three sources:
  - the National Reporting and Learning system (NRLS)
  - the Strategic Executive Information System (STEIS)
  - serious incidents reported by staff to the trust's own incident reporting system.
- These three sources are not directly comparable because they use different definitions of severity and

type, and not all incidents need to be reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.

- For NRLS, when benchmarked against similar trusts, the trust was in the middle 50% of reporters of incidents. Of all incidents reported, the category of 'self-harming behaviour' had the highest number of incidents at 715 (30%) and was above the national average of mental health organisations at 22%.
- The trust reported 2,229 incidents to the NRLS between 1 October 2015 and 30 September 2016. Twenty-five deaths were reported in this period. Twelve of these, equating to 48%, were related to self-harming or suicides. The adult mental health speciality had the highest number of incidents reported with 1033 (46%) of which 681 resulted in no harm (66%) and 310 resulted in low harm (30%).Fourteen of these incidents resulted in death (1%). Ten incidents relate to an unknown specialty.
- Trusts are required to report serious incidents to the Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable). The trust reported 133 serious incidents to STEIS between 1 October 2015 and 30 September 2016. Trust staff reported 134 serious incidents between the same period. Of these 134 incidents, 52 involved the death of a patient. The numbers of the most severe incidents recorded by the trust incident reporting system was broadly comparable with that reported to STEIS, meaning the trust were reporting correctly.
- The trust submitted details of ten external case reviews commenced or published in the last 12 months. Eight of these are yet to be completed. As such, there are no recommendations or learning points available for the majority of the cases due to their on-going nature.
- The trust has also provided details for one review that was yet to be commenced. However, the internal trust investigation identified 30 recommendations. Since the recommendations were shared, a 'ward improvement plan' has been designed which incorporated all the identified actions. During this improvement process there has been a complete restructure of the trust's operational services. Some of the improvements completed included the assigning of a team manager to oversee the improvement plan, the development of an acute care pathway model with associated treatment pathways based on National Institute for Health and Care Excellence (NICE) guidance, the completion of a skills gap analysis of the clinical team, the employment of a delayed transfer of care social work post, and the implementation of initiatives from triangle of care toolkit to better engage carers with decision making.
- CQC received 13 direct notifications from the trust between 1 January and 31 December 2016. Five were concerning deprivation of liberty safeguards, two notifications were concerning deaths in detention, both of which were within the wards for older people. One notification concerned the unexpected death of a service user with the community-based mental health services for adults. Three notifications were concerning allegations of abuse.
- One instance within acute wards for adults of working age related to staff behaviours and one instance within the mental health crisis services and health-based places of safety concerned a physical altercation between two service users.
- One notification concerned the admittance of a child to an adult acute ward bed due to an unavailability of suitable beds.
- Between December 2015 and November 2016, the trust's percentage prevalence rate for harm free care was generally in the high 90%'s but did fall as low as 93.06% in April 2016. In March 2016, the trust rate reached 100%.

Reporting incidents and learning from when things go wrong

- The trust had ensured that staff were clear about their roles and responsibilities for reporting incidents and were encouraged to do so. We saw evidence of robust incident reporting processes across all services. All staff spoken to knew the process for reporting incidents and had access to an electronic incident reporting system. However, the trust had identified incomplete data across incident and clinical systems on their organisational risk register. This was escalated to the board in September 2016, highlighting difficulties for staff in navigating clinical records system

Good

Are services safe?

- Staff received feedback from the investigation of incidents at staff meetings, through the trust bi monthly learning lessons electronic bulletin and the trust intranet. Staff met to discuss feedback at the staff meetings, multi-disciplinary team meetings and during supervision. There was a robust and clear trust wide reporting structure and governance arrangements for reviewing incidents was embedded amongst the board, senior managers and staff.
- Within the inpatient acute wards for adults, each ward had a staff member who took the lead on incidents, taking responsibility to ensure that all incidents reported on their ward had been actioned appropriately. Staff discussed incidents that involved medication errors during medicines link nurse meetings, and during team meetings.
- Debriefs were held immediately after incidents or as soon as possible thereafter. Staff were referred to the wellbeing service for physical and mental health issues if they required additional support following an incident.
- The Chief Coroner's Office publishes the local coroners' Reports to Prevent Future Deaths, which contain a summary of Schedule 5 recommendations, made by the local coroners with the intention of learning lessons from the cause of death and preventing future deaths. There have been no prevention of future death reports related to Lincolnshire Partnership NHS Foundation Trust since the last inspection(30 November 2015).

Duty of Candour

- In November 2014, the CQC introduced a requirement for NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong. Duty of candour is a statutory requirement to ensure that providers are open and transparent with people who use services in relation to their care and treatment. It sets out specific requirements that providers must follow when things go wrong with that care and treatment. This includes informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- The Trust had a Duty of Candour Policy (including principles of 'being open'), which was most recently updated and ratified at a quality committee held in December 2016. The quality and safety team monitored compliance, reporting outcomes monthly to the board via the quality committee**.**
- The trust ensured all new employees were made aware of the 'being open' process and duty of candour as part of the trust induction programme and recently a more refined presentation had been developed to support better understanding of all staff. In November 2015, the head of quality and safety facilitated a session for the medical staffing committee to support clinicians understanding and implementation of the duty of candour.
- All investigating officers received root cause analysis training before undertaking an investigation. The duty of candour processes formed part of this training. Awareness of the 'being open' principles was promoted to all staff through existing quality governance structures.
- During 2015 to 2016, the trust engaged an external training provider to train 92 senior employees in the use of root cause analysis investigation methodology for serious incidents. This training included the principals and application of duty of candour. The trust collated feedback from this training that showed 47% of staff rated this training as excellent and 53% as good.
- We reviewed two serious investigation incidents and a selection of complaints that met the threshold for duty of candour requirement. We found the trust had followed its duty of candour policy. There was clear evidence of open engagement with patients, families and carers throughout the process, including detailed letters and action plans. The trust ensured that the relevant person(s) had the opportunity to comment upon the final version of the report prior to onward publication and we saw evidence of this within the files we reviewed. The trust were compliant with their obligations under duty of candour, ensured staff had received the relevant training and had systems in place to monitor compliance.

Anticipation and planning of risk

- The trust had a resilience policy, containing the trust's major incident plan and business continuity policy, approved by the emergency planning committee. These two documents combined describe the trust's approach

to planning and responding to any major incidents or breakdown in service provision. Potential risks taken into account ranged from severe flooding, loss of critical infrastructure, environmental pollution and industrial accidents and influenza type disease. Roles and responsibilities of senior staff were clear and communication systems were highlighted

- Core services had operational protocols, which included details of team responses in emergencies. For example, the crisis assessment and home treatment service operational protocol detailed how, in emergencies, the crisis team would support Ashley House and Maple Lodge outside of core hours.
- In June 2016, the trust implemented a smoke-free policy. The trust recognised the potential for increased risk of absconding, violence, aggression and potential fire setting as patients smoked in inappropriate areas. This risk was highlighted on the organisation risk register with a number of actions implemented or under consideration.

Requires improvement

Are services effective?

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

Summary of findings

We rated Lincolnshire Partnership NHS Foundation Trust as requires improvement for effective because:

- The trust had a new system for recording supervision. The trust provided data which showed the average overall compliance with clinical supervision across all core services between October 2016 and March 2017 was 48%. However, data did not specify whether staff were in receipt of one to one supervision to support professional development. At ward level, we found a lack of clarity from staff regarding the different objectives and outcomes from clinical and management supervision; despite the trust's policy giving clear guidance.
- We found some errors on community treatment order paperwork, which sat outside of the requirements of the Mental Health Act.
- Staff did not complete specific care plans for patients nursed in seclusion. Medical assessments were not always fully completed or recorded in line with the Mental Health Act Code of Practice.
- Not all patients had care plans to meet their physical health care needs.
- Not all patients had timely access to psychological therapies as recommended by the National Institute for Health and Care Excellence (NICE)
- In two services, staff were not consistently assessing or recording mental capacity assessments for patients on a decision specific basis.
- Staff working in the acute wards for adults did not always complete discharge care plans for patients. This meant that staff would not have the information to plan effective discharges.
- Not all staff were compliant with training in the Mental Capacity Act. Overall compliance across all services was 83%, against the trust target of 95%. Two teams fell below 75% compliance; acute wards for adults (70%) and the Louth community teams for older adults with 62%.

However:

- Overall, staff completed holistic, recovery orientated and patient centred care plans for patients and updated these regularly.
- Mental Health Act paperwork was completed correctly, appropriately stored and regularly audited.
- The trust had good working relationships with the local Police. The trust had a street triage service with trust and paramedic staff. The service responded quickly to crisis situations with patients and signposted them to relevant services quickly. Staff and Police told us 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.

Our findings

Assessment of needs and planning of care

- Staff completed timely assessments of patients and recorded these in the patient notes.
- Overall, staff completed holistic, recovery orientated and person centered care plans for patients. However, within the community team for adults, 50 care records were reviewed and nine care plans had not been updated regularly. We found inconsistencies across teams for how often they were reviewed and updated.
- Staff working in the crisis teams did not routinely provide patients or carers with care plans. The service manager acknowledged improvements were needed for care planning and action was being taken to address this.
- In the community team for patients with learning disability or autism, staff did not produce overarching

care plans for patients. Most care plans on patients' records were copies of plans sent by third party care providers, acute hospitals and local authority learning disability teams. We were concerned that staff, patients and carers did not have clear oversight of the care to be provided, or the goals to be achieved for patients.

- The trust identified difficulties with their current electronic patient records system, stating it was difficult to navigate and find clinical information in an effective way. This was recognised as a risk to patient care on the organisational risk register. Staff might not have easy access to information required to safely care for patients. The trust had plans to change their electronic patient records system and the deputy director of informatics explained how an internal review of the clinical systems had taken place, including an analysis of other systems available. The trust expected that it would take some time to secure a new system. In the interim, the informatics team were available to support staff to use the current system effectively.

Best practice in treatment and care

- The trust employed physical healthcare nurses across services. However, no physical healthcare nurse was in post on Ward 12, within the adult acute inpatient ward. The trust had identified this on their organisational risk register.
- Not all patients had their physical healthcare needs reflected in care plans. For example, on the acute wards for adults we found patients with epilepsy and diabetes did not have specific care plans to inform staff how to manage these conditions, and within the community team for older adults, patients physical healthcare needs were not regularly reviewed or monitored.
- The trust had a clinical audit policy and clinical audit plan in place, signed off by the quality committee. The clinical audit facilities team worked with staff to support completion of audits within their teams, for example searching the electronic patient records system.
- The trust completed 40 clinical or local audit projects between 24 January 2016 and 23 January 2017. Of the 40 audits, 28 were clinical, five financial, five were workforce or corporate with the remaining two relating information management or governance.
- The trust completed nine National Institute for Health and Care Excellence audits over the twelve months to December 2016. For example, schizophrenia, challenging behaviour in learning disabilities, and antipsychotic prescribing in dementia.
- The trust completed all national statutory and mandatory audits. The results were published in the quality account.
- Clinical staff routinely participated in clinical audit including use of anti-psychotic medication in patients with dementia, health and safety audit, safeguarding audits and ligature audit for premises where patients were seen. Staff working in the crisis resolution and home treatment teams gave examples of audits completed within teams such as for lithium carbonate monitoring of patients, risk assessment and carers.
- Overall, patients across all services received care based on a comprehensive assessment of individual need and outcome measures were completed. For example, the health of the nation outcome scales (HoNOS); to determine the level of need and treatment pathways for patients, the recovery star, depression ratings, clustering and national early warning scores.
- Staff working within the forensic secure inpatient ward used used HoNOS secure and HCR-20 (the historical clinical risk management tool) to identify potential risks and staff within the crisis resolution and home treatment teams used the Manchester care assessment schedule (MANCAS) screening tool for mental health needs, when screening older patients out of hours.
- Staff working with older people within community teams used the geriatric depression scales and Addenbrooke's Cognitive Examination-III (ACE-III) which is a screening test used to assess cognitive performance. However, staff working in the adult community teams were not using outcome measures to assess patient progress.
- Across most services, staff completed physical healthcare assessments using recognised tools such as the malnutrition universal screening tool and the modified early warning system. However, within the community teams for adults we found staff were not consistently completing medication reviews and physical healthcare monitoring for patients.

Requires improvement

Are services effective?

- Within the community teams for older people, we saw evidence that staff completed regular monitoring for people prescribed lithium carbonate, anti-psychotic and anti-dementia medication and a clinical audit had taken place in 2016 for prescribing anti-psychotic medication for older people with dementia.
- Across all services, we saw staff were using evidenced based practice, in accordance with guidance from The National Institute for Health and Care Excellence. For example, within community teams for older adults, staff offered patients with dementia cognitive stimulation therapy to assist with improving and maintaining memory. Inpatient wards followed National Institute for Health and Care Excellence guidelines

Skilled staff to deliver care

- The teams across all services included a full range of mental health disciplines including ward managers, deputy ward managers, nurses, nursing assistants, consultant psychiatrists, speciality doctors, psychologists, speech and language therapists, occupational therapists, social worker and activities co-ordinators. Teams also had support from pharmacists and pharmacy technicians.
- The trust supported specialist training for staff. In all services, staff reported they had access to specialist training. Staff felt supported to maintain their continuing professional development.
- Ward and team managers and deputies were encouraged to undertake leadership development courses. With the community team for children and young people, 17 clinicians had completed child and patients improving access to psychological therapies training and within the forensic inpatient secure service, the forensic services, substance misuse and reinforce the appropriate and implode the disruptive (RAID) training had been provided for front line staff.
- The trust supported healthcare assistants, including bank staff, to complete the care certificate. The care certificate aims to equip health support workers with the knowledge and skills which they need to provide safe, compassionate care. At the time of the inspection, 72 healthcare assistants had completed this training.
- The trust supported the employment of apprentices to their clinical workforce. To date, six apprentices had completed their training and five remained in post at band 2 and 3. Ten staff members were studying under the current framework and a further 26 had expressed an interest in commencing an apprenticeship standard programme when they became available.
- The trust had plans to second five healthcare assistants per annum for the next three years to undertake training to become registered mental health nurses, had five trainee nursing associates (a new role developed as a bridge between health care assistants and graduate registered nurses) and had plans to increase this allocation in the future.
- The trust submitted appraisal data for ten core services for each month between January and December 2016. The trust's target rate for appraisals is 95%. As at 31 December 2016, 1525 permanent non-medical staff had had an appraisal, equating to 88% of those eligible. As at 31 March 2017, the overall trust compliance was 92%. Four core services had achieved the trust target and six had failed to achieve, the lowest being community based mental health services for older people at 82%.
- The trust provided data for the number of medical staff that had an appraisal between 1 January 2015 and 31 December 2016. Overall, the trust reported the appraisal rate as of 31 December 2016 was 88%. As at 31 March 2017, 1008 permanent non-medical staff had had an appraisal, representing 92% of those eligible. Overall, the trust did not achieve their 95% appraisal target. However, child and adolescent mental health wards and forensic inpatient secure wards both achieved a 100% appraisal rate as at March 2017. The other two core services that exceeded the 95% compliance target were mental health crisis services and health based place of safety and specialist community mental health services for children and young people.
- The NHS staff survey 2016, provided circumstantial evidence about the effective of team working and the appraisal process. The trust was equal to the average for mental health and learning disability trusts regarding effective team working and scored equal to the average for mental health and learning disability trusts for the percentage of staff appraised in the last 12 months and the quality of appraisals undertaken.
- The trust has also provided their revalidation information covering the period 1 January 2016 to 31

December 2016. The trust indicated that in total nine doctors had revalidated overall which equates to 100% of those due for revalidation. No medics were overdue for revalidation but two had been deferred, both of which have now been revalidated.

- The trust had a policy for staff supervision. The trust policy referred to management and clinical supervision and gave detail of the purpose, agenda and timescales for each. The policy specified that management supervision should occur at least every six weeks, during which performance, training requirements, review of previous action plans and employee contribution to the CQC key lines of enquiry should be discussed and documented.
- Staff were required to participate in clinical supervision for a minimum of ten hours over a 12-month period. Clinical supervision could be completed on a one to one basis or via group and peer supervision.
- The trust advised they had introduced a new recording system for both clinical and managerial supervision from the 1st October 2016. Data provided by the trust related specifically to clinical supervision. No information was requested by the CQC or provided by the Trust with the respect to the frequency or compliance with management supervision.
- Data provided to March 2017 showed staff were not routinely in receipt of regular supervision. For example, long stay rehabilitation wards and acute wards for adults had clinical supervision rates below 50% for all months reported. Child and adolescent wards had clinical supervision rates below 50% for both January and March 2017. The highest average compliance across all core services was 88% in March 2017. The average overall compliance across all core services between October 2016 and March 2017 was 48%.
- We were not assured that all staff were in receipt of management supervision in accordance with policy or that the trust had oversight of staff compliance. The trust could not be assured that performance issues, training requirements or developmental needs were addressed in a timely manner, or that actions to meet staff needs were identified.
- Across all services, staff had access to regular team meetings where ward issues, complaints and incidents were discussed. We observed eight team handover meetings and saw staff received information to allow them to care for patients safely, including observation levels, current risks, admissions and discharges.
- Not all teams had a psychologist. During our last inspection, we found significant waiting lists for access to psychological therapies, in line with National Institute for Health and Care Excellence guidelines. The trust were recruiting psychologist and had plans to further address waiting lists offering access to contracted independent providers from mid-April 2017.
- In November 2016, the trust introduced a priority allocation model to determine eligibility for treatment and to triage patients according to need.
- The trust provided data as at March 2017 that showed 369 open psychology referrals on the waiting list. Of these, 207 (56%) had been discharged from the community mental health teams or consultant outpatient clinic but had residual therapy needs to address. These patients were not subject to regular risk assessments or reviews; meaning the trust would only respond if further concerns were generated by GPs or by self-presentation.
- Forty-six per cent of those on the waiting list were open to the community mental health team or consultant outpatient clinics and 2% had another open care option (not specified).
- Between November 2016 and March 2017, the specialist psychology service received 193 referrals. Almost half of these were referred from the community mental health teams or consultant psychiatrists, one quarter from Step2Change (IAPT) and the remaining quarter from external sources, comprising GP, neurology and self-referrals. One third were offered treatment and two-thirds were declined.
- Despite the trust having a clear prioritisation model, the trust did not keep easily accessible data showing the reason for declining access to therapy for all patients in all teams. However, data was available for 65 (50%) of these patients which showed 23 (35%) of patients were referred on to more suitable services and 20 (31%) were declined due to history of previous psychological

treatment already offered. The remaining patients (33%) were declined due to either significant substance misuse, history of disengagement or not deemed a priority of need.

- The trust identified gaps in service provision, which needed addressing within the current community mental health service redesign, in liaison with service commissioners. The trust had identified on their operational risk register that delays in treatment and a gap between demand and capacity created clinical risks around unmet need for adult psychological therapy services. We considered that currently not all patients requiring psychological therapies were able to access services in a timely manner. The trust would need to address this shortfall.
- Staff received specialist training for their role, for example autism basic awareness, 'STORM' suicide prevention and self-injury mitigation training. Staff working in the crisis service, single point of access team were offered specialist training on suicide prevention and staff working within the forensic inpatient secure ward completed training specific to forensic services. Substance misuse and reinforce the appropriate and implode the disruptive (RAID) training had been provided for front line staff.
- Medical staff had protected time each week for training and development.
- Managers addressed poor performance when required and support was available from the human resources department. The trust's employment policies supported managers to address poor performance. Staff were supported by colleagues or union representatives when needed.

Multi-disciplinary and inter-agency team work

- All services described effective and collaborative team working. Staff described supportive working relationships across the multidisciplinary team. Staff working within inpatient services described good working relationships with the community mental health service teams, particularly when discharge arrangements were being considered. 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 working in the community teams for adults worked closely with other mental health services within the trust, and held joint appointments with young people moving from children and adolescent mental health service (CAMHS) to aid their transition between services. Staff from wards for older people spoke very positively of the input from the occupational therapy and physiotherapy teams. Staff told us of strong working relationships between nursing and medical staff.
- Staff gave examples of working with other professionals and agencies. For example, the local acute hospital, other providers of acute mental health care, drug and alcohol services, the local Police service and voluntary agencies.
- 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 agreement.
- We received very positive feedback from the local Police liaison officer who reported excellent working relationships with the trust for the benefit of patients. For example, the trust had a street triage service with trust and paramedic staff operating 16:00 to 24:00 hours for Lincolnshire. From November 2016, the trust took part in a six-month pilot scheme to provide trust staff for a rapid response service in Lincoln between 10:00 and 18:00. Managers were applying for an extension to increase cover in other areas. These services responded quickly to urgent situations with patients and signposted quickly to relevant services. There was positive feedback from GPs and staff told us this had reduced the need for patients to attend A&E or detention by the police under section 136 of the Mental Health Act.

- The trust were 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

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

- As at 31 March 2017, 92% of clinical staff had received training in the Mental Health Act, against the trust target of 95%. The trust target of 95% was not achieved in six core services, however, the lowest compliance rate was 82% for wards for older people with mental health problems. The trust stated that this training was mandatory for all core services for inpatient and all qualified community staff. Staff told us that online MHA training took place on an annual basis, with three yearly face-to-face refresher training.
- Staff had access to the "Mental Health Act 1983: Code of Practice" (Department of Health, 2015).
- In the 12 months leading up to the inspection, the Care Quality Commission carried out 14 MHA monitoring visits across the trust. In total, there were 58 issues identified. The majority of concerns related to protecting patients' rights and autonomy with 27, and care, support and treatment in hospital with 19. The trust had action plans in place to address these issues.
- The trust's legislative committee monitored all aspects of MHA performance. The committee received, and considered, information such as the results of audits and legislative changes. The trust's board of directors received relevant information from the legislative committee, through the quality committee.
- The trust had arrangements in place for the receipt and scrutiny of detention paperwork. The MHA and legal services officer visited the wards on a weekly basis to ensure a visible presence, and to offer drop-in sessions to staff, answering any queries about specific MHA issues. The trust had developed an online MHA resource centre. This provided staff with easy access to information about the MHA, including relevant policies and procedures, forms, flowcharts, and other information.
- The trust had a MHA heat map. This included information about the use of the MHA, and important information such as section expiry, and consent to treatment dates. The trust had an audit programme in place. Recent audits had taken place, which included MHA treatment forms with associated mental capacity assessments, section 132 patients' rights and section 17 leave of absence.
- The trust had established a working group to consider, and plan for, the implications of the forthcoming changes to the MHA, particularly in relation to section 136 (in relation the care and management of patients detained under the MHA in local general hospitals.
- We met the lead approved mental health professional (AMHP) for the trust. They explained that the trust was accountable for daytime AMHP cover. At night, accountability rested with the local authority's emergency duty team. They informed us there were no difficulties in obtaining section 12 (medical practitioners having special experience in the diagnosis or treatment of mental disorder) doctors to undertake assessments. The lead AMHP confirmed they attended both the local authority's monthly mental health governance board and the trust's bi-monthly legislative committee. An AMHP forum occurred every two months.
- Overall, staff completed legal documentation for patients detained under Section 136 correctly. Staff informed patients of their rights under section 132. The trust had set up a working group to consider changes to section 136 the Mental Health Act in line with the Policing and Crime Act 2017.
- The trust wrote to patients detained under the MHA providing them with important information, including the right to appeal. We reviewed the detention paperwork of 45 patients, covering 76 periods of detention under the MHA. The detention paperwork was in order. We expected to see 35 reports by AMHPs, however only 18 reports were available for inspection.
- We reviewed the community treatment order (CTO) paperwork of 24 patients and the guardianship paperwork for one patient. We found nine concerning issues. One patient's CTO had lapsed, although the trust was unaware of this. Another patient's CTO was invalid, as it had been incorrectly signed. Three further forms contained minor errors, which we drew to the trust's attention. In the case of four further patients, it was

unclear what legal authority staff were using to treat the patient. Following our inspection, the trust informed us they had strengthened their procedures for checking MHA paperwork.

- We saw that staff had provided patients with their section 132 ((duty of managers of hospitals to give information to detained patients) rights at the point of their detention under the MHA. Overall, patients received their rights on admission and at regular intervals thereafter.
- Staff referred detained patients to the independent mental health advocate (IMHA) service on an individual/needs basis. We saw, in the 12 months leading up to the inspection, 216 patients had been referred.
- Where patients required certificates of consent to treatment or second opinion authorisation (T2/T3) documentation we saw that this was held with the medicines chart. This ensured staff prescribed and administered medication under the appropriate legal authority.
- We reviewed 22 seclusion records. Staff had recorded the interventions they used with the patient before seclusion began. Staff had completed physical health needs assessment forms in 20 of the 22 records. However, some seclusion records did not meet the requirements of the Code of Practice. A number of entries on review sheets and observation forms, made by different staff but at the same time, gave contradictory accounts of what the patient was doing.
- Staff had not developed seclusion care plans for patients. A number of doctors' assessments showed the doctor merely signing the review form instead of recording their assessment of the patient. We were concerned that the records did not always provide full information about the patients' period of seclusion.
- Across all inpatient wards, detained patients had an appropriate section 17 forms in place, authorising periods of leave for the hospital. Medical staff completed these correctly and stipulated the conditions of leave.

Good practice in applying the Mental Capacity Act

- The trust had an up to date policy for the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Staff were aware of the policy and how they could access it.
- Members of the MCA team chaired complex best interests' meetings. There were 83 safeguarding/MCA champions across the trust who could be consulted by staff for support with safeguarding or Mental Capacity Act issues
- The trust had best interest assessors across the trust who acted for the supervisory body to assist families and carers to ascertain patients' wishes, based on feelings, culture and history.
- As at 31 March 2017, the trust-wide compliance rate for staff training in the Mental Capacity Act was 83%, against a trust target of 95%. The renewal timeframe for this training course is every three years. This course is mandatory for both community and inpatient staff.
- All core services failed to achieve the trust target of 95% compliance. Child and adolescent wards had the highest compliance rate of 87%.
- The two core services with the lowest level of compliance were long stay/rehabilitation mental health wards for working age adults with 73% and acute wards for adults of working age with 55% compliance.
- The trust identified low levels of compliance with Mental Capacity Act training during the last CQC inspection, completed in December 2015. Whilst some improvement was noted, the trust had continued to fail to achieve its target of 95% compliance for this training.
- Staff understood the Mental Capacity Act and its guiding principles. Staff supported people to make decisions and involved families and carers in order to ascertain people's wishes, feelings culture and history.
- However, within the inpatient wards for older people, capacity assessments were not decision specific and forms included more than one decision. One patient was receiving covert medication without the appropriate capacity assessment; meaning medication was administered outside of the Mental Capacity Act Code of Practice.

Requires improvement

Are services effective?

- Within the community team for patients with learning disabilities or autism, staff did not record mental capacity assessments consistently. We found old assessments used to formulate decisions and not all assessments were decision specific.
- Within the crisis teams, managers had identified that improvements to assessment of capacity needed to be made; specifically to assess the capacity of informal patients' agreement to admission and treatment. Managers had made this decision following a serious incident.
- The trust provided information around the Deprivation of Liberty Safeguards applications made between 1 January 2016 and 31 December 2016. The trust stated they made 141 Deprivation of Liberty Safeguards (DoLS) applications during this time. Forty-two of these were approved at the time of inspection. The trust has advised that six of these were sent to CQC, however only five reports were extracted from the CQC systems. All DoLS applications received by CQC during this time were within older people wards.
- Wards for older people with mental health problems had the most applications made with 134 (95%). Forty of these were approved (30%). The highest number of applications made within a month was 18, in March 2016.
- There was one application made by the long stay/ rehabilitation mental health wards for working age adults during this time (made in July 2016) but this was not approved.

Good

Are services caring?

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

Summary of findings

We rated Lincolnshire Partnership NHS Foundation Trust as good for caring because:

- Throughout the trust, staff treated patients with kindness, dignity and respect. Consistently staff attitudes were helpful, compassionate and understanding. Staff used appropriate language patients would understand. The style and nature of communication was kind, respectful and compassionate. Staff showed strong therapeutic relationships with their patients and clearly understood their needs. Staff offered guidance and caring reassurance in situations where patients felt unwell or distressed, confused or agitated.
- Patients told us staff were kind and caring and were consistently positive about staff and the support they had received from services.
- Staff encouraged patients to give feedback about their care. Staff offered patients the chance to give feedback in a variety of ways.
- Senior managers told us that patients were involved in projects across the organisation. This included recruiting and interviewing staff. The trust had a patient involvement group that was well attended by patients from the mental health pathway.
- The trust employed peer support workers, which allowed people with lived experience of mental illness to mentor and support current patients.
- There were numerous examples of patient involvement in care plans, in risk assessments and patient participation in meetings. Staff encouraged patients, wherever possible, to maximise their independence during their treatment.

Our findings

Kindness, dignity, respect and support

- We found staff treated patients with dignity, respect and compassion. We observed specific areas of good practice, for example within the community services for children and young people and community services for patients with learning disabilities or autism. Teams consistently demonstrated a detailed understanding of the patients in their care and spoke in compassionate terms during team and multidisciplinary meetings. We were impressed with the level of knowledge of the needs of patients by staff across all services.
- Staff involved carers and families in the care of patients across all services.
- The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment. The trust scored between 2% and 8% higher than the England average for recommending the trust as a place to receive care for each of the six months in the period June to November 2016. Both June and November 2016 saw the highest per cent of patients who would recommend the trust as a place to receive care with 95%, and each month in the period scored above 89%. Additionally, the trust was below the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in all six months.
- The staff Friends and Family Test was launched in April 2014. It asks staff whether they would recommend their service as a place to receive care, and whether they would recommend their service as a place of work. The percentage of staff who would recommend the trust as a place to receive care was the same as the England average at 80%. The percentage of staff who would not recommend the trust as a place to receive care is below the England average at 4% compared to the England average of 6%.
- PLACE assessments are self-assessments undertaken by NHS and private/ independent health care providers, and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as

supporting non-clinical services. In relation to privacy, dignity and wellbeing, the 2016 PLACE score for the trust was 82%, which was below the England average of 90%. Ashley House scored the same as the England average at 90% for mental health and learning disabilities trusts, in the assessment. The other nine scored below the England average, with a low of 67% at Discovery House.

- For the 2016 CQC community mental health survey, a questionnaire was sent to 850 people who received community mental health services. Responses were received from 265 people at the trust. The trust scored 'about the same' as other mental health trusts in nine of the ten questions, however 'changes in who you see' was worse when compared to other trusts. Regarding the 'changes in who you see' question, the trust specifically scored worse for continuity of care (six out of ten) and information about knowing who was in charge of their care when this had changed in the last 12 months (four out of ten).
- The trust's organisational risk register showed one risk which concerned poor patient satisfaction within working age and older adult mental health community services, as evidenced within the annual community mental health survey, indicating that services are not achieving the required levels of quality.
- Ten out of 173 complaints (6%) were regarding attitude of staff. Three of these related to community adult teams. Six of these referred specifically to the attitudes of clinical staff and included feelings of being dismissed and not listened to.

The involvement of people in the care they receive

- Patients and carers generally participated in care planning and assessment. Care plans showed details of patient's views and demonstrated that patients had been involved in formulating their plans, including their goals and aspirations. However, within the inpatient wards for older people, there was little evidence of patient participation in care plans and risk assessments and within the community teams for patients with learning disabilities or autism, when staff completed care plans there was no evidence of patients or carers receiving a copy in any records reviewed.
- Patients had access to regular community meetings across inpatient services, Patients were able to express their opinions and any concerns. We saw a variety of issues discussed and addressed in these meetings, such as maintenance issues and suggestions for activities.
- Patients had access to regular multidisciplinary team meetings. Staff encouraged patients, where ever possible, to maximise their independence during their care. Carers and patients were invited into wards rounds and clinical meetings to discuss care. Patients told us they were involved in decisions, and given choices about treatments.
- Within the acute wards for adults of working age, we saw families and carers were involved in care and treatment where appropriate. The trust had an email account set up for families and carers. This enabled them to email and express their opinions, if for example they could not attend a multidisciplinary meeting.
- Families were able to access the dementia café and could access carers groups and referral for a carer's assessment. Cognitive stimulation therapy was also available to families and carers. A volunteer facilitated a carers group at Spalding and carers were encouraged to meet informally outside of services.
- On the Fens, long stay rehabilitation ward, the manager facilitated a weekly 'brew break' where patients could drop in for an informal chat. Managers had developed advanced plans with patients, which detailed how patients wanted staff to treat them in difficult situations. This approach had decreased the number of restrictive interventions required.
- Patients were able to give feedback through 'You said, we did', community meetings and patient forums.
- The trust ran a number of number of carers groups.
- Patients had access to advocacy services and information, such as contact details, were available across all services. Staff supported patients where needed to access these services. The independent mental health advocates told us they had been invited to attend community meetings.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated Lincolnshire Partnership NHS Foundation Trust as good for responsive because:

- The trust had robust systems for recording, investigating and learning from complaints. Patients and families were provided with outcomes and received timely apologies when required.
- The trust used information about the local population when planning service developments and delivering services. The trust had effective working relationships with commissioners and other stakeholders.
- The majority of services had a range of rooms and equipment to support care and treatment. Patients had good access to quiet areas on wards and access to improved outside space.
- Patients had access to information on treatments, local services, patients' rights and how to complain across all services. We saw evidence of information available to patients on how to access interpreters should they need one.
- Crisis teams were meeting commissioned targets for contacting patients within four hours. As of February 2017, 99% of patients were contacted within this time.
- All inpatient services had activities programmes for patients. There was access to activities over a seven day period. Each ward had timetables visible so that patients knew what was on offer.
- Patients could personalise their bedrooms and lockable storage for their possessions.

However:

- The majority of beds within the adult acute admission wards were located in bays sleeping either four or five patients. These areas offered limited space and privacy.
- The trust could not always provide a bed locally for patients who required admissions to acute mental health wards, resulting in significant numbers of patients transferred outside of the trust locality to access treatment. Bed occupancy rates were above 100% for acute wards for adults of working age. We saw that patient numbers exceeded the number of beds available on wards. Therefore, there were no beds available if patients returned from leave.
- The trust did not have psychiatric intensive care beds. Therefore, if a psychiatric intensive care unit bed was required, patients were placed out of area. However, the trust is opening a psychiatric intensive care unit for males in the summer of 2017 and has plans to provide further provision for females.
- 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.
- Within acute inpatient services, 55% of patients did not have a discharge care plan.

Our findings

Service planning

- The trust used information about the local population when planning service developments and delivering all services. The trust had effective working relationships with commissioners and other stakeholders. There were close links with the commissioners and on-going discussions about developments to improve services.
- The trust had built a new psychiatric intensive care unit for males. This was due to open in the summer of 2017. The trust had further plans to built a similar unit for females.
- The commitment of staff to service development, and their willingness to embrace responsibility for being involved in change, is essential when expecting services

to respond to the challenges experienced currently. The Board have made real efforts to embed this principle within their interactions with staff, and this was demonstrated at a local level.

Access and discharge

- We reviewed how quickly patients could access services when needed. 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. Staff offered flexibility with appointment times and we saw crisis teams prioritised urgent home visits to manage immediate risk issues.
- Crisis teams were meeting commissioned targets for contacting patients within four hours. As of February 2017, 99% of patients were contacted within this time.
- The trust had not developed a mental health crisis helpline, since our last inspection.
- Within the community teams for older adults, all teams met the trust target for assessment to onset of treatment. Overall, 95% of patients should be seen within 18 weeks. However, non-urgent referrals could be waiting up to 20 weeks to be seen. Patients were advised to phone accident and emergency during evenings and weekends.
- The trust provided details of bed occupancy rates for five core services between 1 January 2016 and 31 December 2016. All bed occupancy rates supplied included periods of patient leave. The trust wide average bed occupancy over the last 12 months was 98%. All of the core services had average bed occupancies throughout the 12 months of 95% and above. The core service with the highest average bed occupancy was acute wards for adults of working age with 106%, meaning the trust was admitting patients into beds vacated by patients utilising periods of leave from the wards. Staff might have difficulties identifying an appropriate bed for the patient on their return from leave to admit patients.
- When acute or psychiatric intensive care beds were needed, beds were sourced by bed managers who located available beds for patients and organised transfers at the earliest opportunity. The bed managers worked between nine and five Monday to Friday. Outside of these hours the crisis home treatment team sourced acute and PICU beds. However, it was not guaranteed that this would be during the day. Between January 2015 and 31 December 2016, staff transferred four patients after 22:00hrs.
- The trust did not have sufficient inpatient beds within the acute wards for adults of working age to meet patient need. The trust identified the lack of adequate provision of inpatient acute beds within the organisation risk register. Identified actions included working with commissioners on a full review of the inpatient pathway to improve patient flow, reviewing local capacity and reducing out of area placements. The risk register identified capital funding had been agreed for a clinical decisions, 72-hour assessment unit and a new Section 136 facility, offering two beds, had recently opened. The trust identified difficulties in accessing suitable beds for patients diagnosed with personality disorder as an on-going concern.
- Between March 2016 and March 2017, there were 306 out of area placements from the trust to other providers of acute adult inpatient care. Trust data showed between August and November 2016, this equated to an average of 36 patients nursed out of area per day.
- As of 04 March 2017, 40 acute patients remained placed out of area. The largest proportion of patients at 12 (30%) were placed into a hospital in Harrogate 83 miles from Lincoln. Two patients were placed in a hospital in West Sussex (202 miles) and five patients were placed in Norfolk (100 miles).
- The trust did not have psychiatric intensive care unit provision. Data provided between February 2016 and February 2017, showed the trust transferred 63 patients to other providers when psychiatric intensive care was required. Of these, 48 were male and 18 female. At the point of discharge, six patients were transferred back to services within the trust, 25 transferred to independent hospitals and nine were discharged to their home address. On 4 March, six PICU patients remained out of area.
- The trust transferred patients considerable distances to access out of area psychiatric intensive care placements when local beds were not available, the closest being

Good

Are services responsive to people's needs?

Bradford, 77 miles and the furthest being West Sussex at 202 miles. Patients' families and carers might find difficulty in maintaining contact during these admissions and access to local care provision might be compromised. However, the trust had systems in place to liaise with these hospitals for weekly updates on patients, and notification about any community leave or discharge.

- The trust had completed the build of a ten bed psychiatric intensive care unit, which was due to open in the summer of 2017. However, this facility is for males only. The trust would continue to secure out of area placements for females requiring psychiatric intensive care. However, the trust's draft operational plan for 2017/18 and 2018/19 detailed plans to create a new ten bed psychiatric intensive care unit for female patients. The trust had identified a facility and plans were detailed in Lincolnshire's sustainability and transformation plan. The trust hoped to open the unit by the end of 2018.
- The trust had identified insufficient acute inpatient beds, leading to admission delays, increased risk is to individuals' safety and wellbeing caused by delays in accessing mental health beds, and poor patient experience when placed out of county on their organisational risk register. Other risks identified included the risk of the trust experiencing accident and emergency department 12 hour breaches, assaults against staff whilst patients awaited psychiatric intensive care placements, and the additional risk of difficulties in accessing out of county beds for informal patients. More recently, this has also included accessing out of area beds for patients with personality disorder diagnoses.
- 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 in accident and emergency departments longer than needed, for example 12 occasions in September 2016 when patients waited over 12 hours.
- The trust advised that where a patient declined the offer of an out of area bed, they were supported intensively by one of the four crisis teams. This was supported in records reviewed.
- 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, if required. This was to ensure patients who required admission; following assessment under Section 136 of the Mental Health Act did not remain longer than 24 hours in the place of safety.
- Five out of 173 complaints (3%) concerned admissions, discharge and transfer arrangements. Two of these were from the family of a service user who would like them transferred closer to home.
- Between 1 January and 31 December, discharged patients had average lengths of stay ranging from 42 days to 523 days across all services. The average length of stay of patients over the 12 months was 76 days. The forensic secure inpatient ward had the highest average length of stay with 523 days, followed by long stay/ rehabilitation mental health wards with 251 days. Acute wards for adults of working age and psychiatric intensive care units had the shortest average length of stay with 42 days across the period.
- Within the crisis and home treatment teams, managers were reviewing discharge processes for inpatients to ensure they did not remain in hospital longer than was needed. For example, reviewing the use of the crisis house and improving communication with discharge coordinators and bed managers
- The trust reported 47 readmissions within 28 days, between 1 January 2016 and 31 December 2016 across nine wards. The highest number of readmissions within 28 days were to Conolly Ward with 14, and Ward 12A with 12. Both of these wards are acute wards for adults of working age. The majority of readmissions within 28 days occurred from discharges from acute wards for adults, with 32 of 47 (68% of all readmissions within 28 days).
- Trust data showed out of 47 readmissions within 28 days, 22 (47%) of patients were readmitted to the same ward from which they had been discharged. There were no cases where patients were readmitted on the day of discharge.
- The trust reported 367 delayed discharges between 1 January 2016 and 31 December 2016. There were 929 discharges within the same period. The core services with the highest number of delayed discharges were

wards for older people, with 165 and long stay/ rehabilitation mental health wards with 100. However, data collected related to the number of episodes of delayed discharge and not individual patient numbers. Over the 12 months, the most prominent reasons were: awaiting residential home placement or availability (102 patients delayed, accounting for 32%) followed by awaiting a nursing home placement or availability (50 patients delayed, accounting for 16%). Over the 12 months, the most prominent reasons were: awaiting residential home placement or availability (102 patients delayed, accounting for 32%) followed by awaiting a nursing home placement or availability (50 patients delayed, accounting for 16%).

- The trust identified the services they measure by 'referral to initial assessment' and 'assessment to treatment'. The trust reported there were no services with a referral to initial assessment or assessment to treatment wait longer than 18 weeks. Additionally, the trust also advised they met the target of 75% of patients to be seen within six weeks from initial assessment to onset of treatment. There was a national target for assessment to treatment times which states 75% of patients should have commenced treatment within six weeks of assessment, 95% within 18 weeks. The average number of days for referral to initial assessment was 20 days, with the longest wait being 59 days for the countywide child and adolescent mental health core service team. The average wait for assessment to treatment was 17 days, with the longest wait being 52 days for the adult clinical psychology and psychotherapies service.
- The trust's quarterly mental health community teams' activity return collects data on the number of patients on care programme approach followed up within seven days of discharge from psychiatric inpatient care. The trust recorded 92% of patients were followed up within seven days after discharge between October and December 2015. This was below the England average of 97% and below the trust target of 95%. However, between January and September 2016, the trust was above or equal to the England average. However,
- Information from April 2016 to March 2017 showed 242 patients 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.
- Overall, staff working within the crisis teams 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 was not met.
- The trust reported 12 out of 173 complaints (7%) concerned outpatient appointment delays or cancellations. Eight of these were within community adults. The main trust wide themes related to cancellation of appointments, long waiting lists and lack of support from community mental health teams.

The facilities promote recovery, comfort, dignity and confidentiality

- The majority of beds within the adult acute admission wards were located in bays sleeping either four or five patients. These areas offered limited space and privacy.
- Across all inpatient services we found patients could personalise their bedrooms. However space was limited within the bed bays on the adult acute wards. Patients were provided with facilities to store their possessions safely. On the inpatient ward for children and young people, patients could choose from a choice of bedding.
- All services had a range of rooms and equipment to support care and treatment. Patients had access to quiet areas on wards and access to outside space. Rochford unit (older adult inpatient ward) did not have a dedicated garden area, however, staff supported patients to access communal garden areas within the hospital as well as visiting the hospital café.
- All inpatient wards accepting both males and females had separate female lounges available.
- Wards had dedicated and well equipped clinic rooms.
- The health based place of safety had two rooms for patients. There was space for professionals to talk privately. Patients had access to fresh air, a telephone, clean clothes and a washing machine.
- The trust had updated outside courtyard areas across the three acute admission wards to improve the environment and promote patient and staff safety. The outside space at Ash Villa was large and well equipped for the client group.
- Patients had access to drinks and snacks and staff assisted patients to make food and encouraged patients to use therapy kitchens if appropriate.

Good

Are services responsive to people's needs?

- Staff facilitated 1:1 sessions and care co-ordinator sessions in private rooms to maintain confidentiality.
- In community teams, staff saw patients in private interview rooms. However, at the Grantham crisis and home treatment team, it was possible to hear a conversation in the reception area room.
- PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness.
- In relation to ward food, the 2016 PLACE score for Lincolnshire Partnership NHS Foundation Trust is 91.1%. This is slightly below the England average of 91.9%. Of the ten sites that this assessment related to, five scored above the trust average, of which, four scored above the England average (Department of Psychiatry at Pilgrim Hospital, Francis Willis Unit, Rochford Unit at Pilgrim Hospital and Ash Villa). The remaining three scored below the trust average. No figures were provided for Ashley House or Maple Lodge. The lowest scores were at the Peter Hodgkinson Centre (87.5%) and the Manthorpe Centre (86.9%).
- The trust provided a choice of food to meet dietary requirements of different religions and ethnic groups. In the inpatient service for children and young people, the ward had dedicated kitchen staff that worked with patients to develop menus. Patients within the long stay rehabilitation wards were provided with the opportunity to attend certified courses, for example in food hygiene, however, at Ashley House the food fridge temperatures were consistently above the acceptable range. Managers explained this was due to patients accessing the fridges frequently.
- All inpatient services had activities programmes for patients. There was access to activities over a seven-day period. Each ward had timetables visible so that patients knew what was on offer. Examples of activities included cooking; art; badminton, film night and a trip out to a local garden centre. Within the inpatient service for children and young people, patients worked with the activity coordinator to plan activities that they would like to do.

Meeting the needs of all people who use the service

- All services had suitable adjustments for patients requiring disabled access and facilities.
- Staff had access to interpreters and hearing loops and sign language interpreters if required. 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.
- The trust had systems in place to access interpreters for patients whose first language was not English.
- The trust provided food to meet dietary requirements, for example for patients of differing religious and ethnic groups.
- Staff ensured patients had access to spiritual support. On the acute wards for adults of working age, each ward had a spirituality room for the use of patients. These rooms had various different religious literature, prayer mats, a compass, and provided a quiet private space. On the long stay rehabilitation wards, here was a multi-faith room available on one of the wards and staff described how they had accessed spiritual support in the community for one patient. Patients admitted to the inpatient ward for children and young people could use a quiet room to practice their faith. Chaplaincy services were also available across services.

Listening to and learning from concerns and complaints

- The trust had a robust governance structure in place to manage, review and give feedback from complaints. Performance against complaints compliance was reported to public board of directors or to the private section of the board meeting due to the sensitive nature of content.
- Staff in services, knew the process to support patients to make a complaint. Staff gave patients information on how to do this where appropriate, and information was readily available on ward notice boards and in welcome packs. Managers investigated complaints promptly and patients and carers received outcomes and written apologies, where appropriate.
- The trust operated a quarterly complaints review panel until July 2016 chaired by a non-executive director with carer governor and operational management

Good

Are services responsive to people's needs?

representation, which formally reviewed the handling of complaints. In December 2016, the trust engaged in a contract with an external provider to gain feedback from complainants regarding their experience and satisfaction of the complaints process.

- The trust received 173 complaints with 109 fully or partially upheld (63%) during the last 12 months from 1 January to 31 December 2016.
- Fourteen complaints were referred to the Ombudsman, none of which were upheld. One complaint within the acute wards for adults of working age core service was still under investigation.
- Community based services for adults had the most complaints received with 58 (34%). This service also had the most complaints fully or partially upheld with 35 (60% of all complaints).
- Child and adolescent wards had the least complaints received during this time with one. This was partially upheld.
- The most complaints (93, accounting for 54% of complaints) received fell under the category of 'all aspects of clinical treatment'. Twenty-five of these complaints were from patients or family members making general statements about being unhappy with the care received. Seven of these came from community-based mental health services for adults of working age.
- The second largest numbers of complaints at 39 (23%) were regarding communication / information to patients (both written and oral). Fifteen of these complaints came from the community adults' core service.
- Within the crisis service, '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.
- The trust received 2,014 compliments during the last 12 months from January to December 2016.
- Specialist community mental health services for children and young people received the highest number of compliments with 574 (29%). Forensic inpatient/ secure wards received the lowest number of compliments with one (0.5%).
- The Trust has identified that the review of compliments requires additional development and an action plan is in place to address and support this.

Good

Are services well-led?

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

Summary of findings

We rated Lincolnshire Partnership NHS Foundation Trust as good for well led because:

- Trust board members interviewed were clear about the trust's vision and strategy. Senior clinicians were clear about their role and the trust's direction. The vision and values were on display in the trust and were available on the intranet.
- Staff demonstrated the trust's stated values in their behaviour and attitude. Staff we spoke with were passionate about helping patients with mental illness.
- Staff knew who senior managers in the trust were and said they were visible. Staff reported positive morale and job satisfaction. They reported good relationships with managers and felt empowered in their roles.
- Frontline staff took part in some of the clinical audits. This gave staff the opportunity to be involved in the development of the service.
- Staff knew the trust's whistle blowing policy and said they could raise concerns without fear of victimisation.
- Staff participated in team meetings, reflective practice, sharing skills and supporting each other to help improve the health of the patients in their service.
- The trust utilised a values based recruitment checklist during their interview process and revisited this during staff induction. The trust also operated a rewards and recognition systems, including individual and team recognition, thank you cards, heros' awards and annual awards ceremonies.
- The trust had good processes for report and recording complaints. Complaints files we viewed were detailed and showed evidence of investigations, outcomes and action plans, where needed.
- The trust used an electronic system for reporting incidents. Staff knew what incidents needed to be reported and how to report them. Managers monitored the reporting and recording of incidents and gave feedback to staff on lessons learned.
- Staff had a process in place to submit concerns and issues to the individual ward risk registers which fed in to the trust risk register where appropriate.
- We found the board of directors worked well together, both internally and externally.
- The trust reported a drop in staff sickness rates. In December 2015, staff sickness was reported as 5.1%. In February 2017, this had reduced to 4.5% as a 12-month average.

However:

- The trust data on compliance with both clinical and managerial supervision variable. Not all staff had received supervision in line with trust policy.
- Mandatory training compliance was low in some areas.
- The trust had made changes to improve their governance processes; however, these were not yet fully embedded. For example, the trust had established a recovery college, based on trust premises, which had led to people accessing services now acting as peer support workers. However, this development was not linked to the national research project (a set of mental health system performance indicators for facilitating mental health recovery).

Good

Are services well-led?

Our findings

Vision, values and strategy

- The trust had a clear set of visions and values:
- To enable people to live well in their communities" and to make a difference to the lives of people with mental health, substance misuse problems and learning disabilities. As well as promoting recovery and quality of life through effective, innovative and caring mental health and social care services.
- Putting people first
- Developing and supporting our staff
- Respecting people's differences
- Behaving with compassion and integrity
- Having pride in our work
- Working in partnership
- Being recovery focused and making a positive difference.

The trust's behaviour framework states the below relating to the organisation's behaviours:

- We constantly strive to deliver exceptional levels of personalised service.
- We are genuine and honest with people and patients.
- We positively interact with colleagues and patients.
- Trust board members were clear about the trust's vision and strategy. The vision and values were on display in the trust and were available on the intranet. The majority of staff knew and understood the values of the trust. We were told that the board views the importance of staff involvement and co-ownership of the responsibility for developing services as a key value. It was clear from discussions with staff during the inspection that this was actively being embraced and acted upon. For example, we spoke with staff at Ash Villa, the children's inpatient unit, who, together with the people accessing the service, had been instrumental in making plans to improve the environment for the benefit of patients. Staff were able to talk about how the plans had developed and changed, in line with their thinking and that of the people accessing the service, and how these had been accepted and approved by the senior leadership. The finance director showed us how plans had been costed and funding identified for the coming year to make improvements.
- The trust advised their visions and values were disseminated to staff utilising a new appraisal process and training, translating the organisation's vision to individual priorities and including a behavioural framework, which is assessed on a 1-4 Likert scale (a scale used to represent people's attitudes to a topic).
- The trust utilised a values based recruitment checklist during their interview process and revisited this during staff induction. The trust also operated a rewards and recognition systems, including individual and team recognition, including thank you cards, hero's awards and annual awards ceremonies.
- The director of nursing and quality provided executive leadership for quality improvement and quality assurance. The trust regularly held a number of key assurance meetings with both internal and external involvement to support the quality governance process, including regular ward/team meetings, monthly operational division management team meetings, board meetings and operations clinical quality and governance group. These committees held bi-monthly organisational development / legislative / patient safety and experience which in turn reported to the quarterly quality committee chaired by a non-executive director. The trust also provided assurance regarding its quality governance via the quarterly quality review meeting chaired by the executive nurse of the trust's lead commissioning clinical commissioning group.
- The chief executive had identified positive indicators in the recently-published staff survey as wider evidence that this value had been embedded across the organisation
- We found staff were committed to service development. They showed willingness to embrace responsibility for involvement in change to their services. We found the board had made real efforts to embed this principle within their interactions with staff, and this was demonstrated at a local level.

Good governance

Good

Are services well-led?

- We considered the processes by which the board assured itself were sufficiently sighted on the strategic risks faced by the organisation.
- We reviewed the board assurance framework, which focused on strategic risk, and the corporate risk register, which focused on operational risk. We spoke with relevant directors regarding the trust's approach to managing strategic and operational risk. We found that the board assurance framework could be more acutely focussed on the strategic risks faced by the trust, for example, those risks potentially posed by sustainability and transformational plan decisions.
- We were told that the trust anticipated 'making a small surplus' in the financial year 2016/2017, indicating that it was acting within its financial constraints and delivering to an operational plan which had been set a year earlier and agreed with the trust's regulators.
- The finance director discussed both the achievement of the plans for the financial year 2016 to 2017 and the process for arriving at the operational plan for 2017 to 2018. The latter would provide for service developments in line with the Trust overall strategy and meet the financial targets set by the trust's regulator. These detailed plans included proposals for making 'efficiency savings' and the director of finance outlined the arrangements which meant services had agreed with the targets set for them, and the process for ensuring that savings were not made where there was potential for quality to be compromised.
- The documentation we reviewed, together with the discussions we had, and also observed, confirmed there was a robust arrangement in place to meet the requirement for financial stability whilst not compromising the quality of service experienced.
- We spoke with all members of the board of directors and also with the council of governors. We found all directors, both executive and non-executive had sufficient understanding of the breadth and depth of the agenda and that they could discuss issues, including those outside their immediate portfolio.
- Executive directors and non-executive directors demonstrated their ability to work with appropriate constructive challenge. There was mutual understanding of the experience individual directors brought and a sense that, collectively, they were able to harness these for the benefit of the people who accessed the service.
- The board realised that, in order to continue to develop and improve, board members needed to look outside the organisation, both locally and nationally. For instance, we were told about a recent presentation at a national event that could have beneficial implications for one local service, and a visit to another provider of mental health services to review clinical record systems.
- We sought evidence of good working arrangements between the board and the council of governors. We were told by the non-executive directors that there was a greater degree of confidence that governors held non-executive directors to account for the performance of the executive directors and for delivery of the trust's strategic objectives, than at our last inspection.
- The processes for budget-setting, including quality-assurance of savings plans and the on-going scrutiny of delivery against the plan, are essential elements in assurance that Trusts will meet plans and targets. The documentation we reviewed, together with the discussions we had and also observed, confirmed there was a robust arrangement in place to meet the requirement for financial stability whilst not compromising the quality of service experienced.
- 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
- All services had sufficient staff for safe care and treatment of patients. The trust employed bank and agency staff to fill shifts when needed. However, whenever possible teams used regular bank staff that were known to patients, for continuity of care. However, within the acute wards for adults of working age, staffing levels dropped over the weekends. Patients and staff told us staff were not always able to facilitate periods of leave during these times.
- The trust had reviewed its mandatory training requirements, reducing the number of courses to

statutory and role specific training. The trust had good systems for monitoring compliance and staff received notifications via the electronic staff record system when training was due. Overall compliance with mandatory training across the trust as at March 2017 was 92%, against the trust target of 95%. However, compliance with some mandatory training, for some teams, was low.

- Staff had access to role specific specialist training. For example, inspirational leadership, suicide prevention, and dementia training. Ward and team managers and deputies were encouraged to undertake leadership development courses. Within the community team for children and young people, 17 clinicians had completed child and patients improving access to psychological therapies training and within the forensic inpatient secure service, the forensic services, substance misuse and reinforce the appropriate and implode the disruptive (RAID) training had been provided for front line staff.
- The trust had systems for monitoring compliance with annual appraisals for all staff. As at March 2017, compliance with appraisals for both medical and non-medical staff was 92%, against a trust target of 95%.
- The trust had recently changed its recording system for management and clinical supervision. However, we found significant variance in compliance across the trust in both the recording and delivery of sessions. The trust did not supply data on compliance with management supervision; however, the trust policy clearly defined the different aims, objectives and required compliance between the two. Some staff did not understand the difference between management and clinical supervision and told us supervision did not always take place, especially when services were busy. Data provided for compliance with clinical supervision showed the trust had not consistently achieved its target and records viewed across core services were poor in quality
- 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.
- The trust had good processes for report and recording complaints. Complaints files were detailed and showed evidence of investigations, outcomes and action plans, where needed. Staff ensured they kept patients informed throughout the process and responded with outcomes in a timely way in accordance with trust policy.
- The trust used an electronic system for reporting incidents. Staff knew what incidents needed to be reported and how to report them. Managers monitored the reporting and recording of incidents and gave feedback to staff on lessons learned.
- The trust had a policy for the management of patients in seclusion in accordance with the Mental Health Act Code of Practice. The trust employed a physical interventions team leader who held responsibility for the development of Trust policies in relation to prevention and management of violence and aggression and observations and for providing detailed reports on behalf of the trust to the quality committee and trust board. The post holder was a member of the trust quality and patient experience committee. Over the 12-month period to December 2016, the trust had completed audits, in accordance with National Institute for Health and Care Excellence, in challenging behaviour in learning disabilities and supervised confinement (seclusion).
- We met eight hospital managers (members of a committee authorised to consider the discharge of patients detained under certain sections of the MHA). The managers had a variety of skills, experience and qualifications. The trust secretary had led a recent drive to recruit more managers. The managers confirmed that they had received an induction, which included shadowing panels. They had also received relevant information and training. The managers reported the quality of the reports sent to their panels, by medical and nursing staff, had significantly improved over past three years.
- A legislative committee had formed early in 2017, and had met on a monthly basis thereafter. This was chaired by the director of nursing or medical director, and attended by a non-executive director, safeguarding/MCA champion, divisional managers and leads, and either the principle social worker or the trust MHA lead. The trust board was provided with a safeguarding and MCA report three times a year and produced and published an annual report.

Good

Are services well-led?

- The trust had an equality strategy 2016-2018 which included the trust's obligations under the Equality Act 2010 and Equality Duties 2011. The document incorporated the NHS Equality Delivery System 2 (EDS2) and Workforce Race Equality Standard (WRES). The strategy showed local population demographics, taken from the 2011 census and detailed how the trust planned services to meet the needs of the local population.
- Staff had a process in place to submit concerns and issues to the individual ward risk registers which fed in to the trust risk register where appropriate.
- The trust completed all national statutory and mandatory audits. The results were published in the quality account. The trust had a clinical audit policy and clinical audit plan in place, signed off by the quality committee. The trust completed 40 clinical or local audit projects between 24 January 2016 and 23 January 2017. Of the 40 audits, 28 were clinical, five financial, five were workforce or corporate with the remaining two relating information management or governance. Clinical staff routinely participated in clinical audit including use of anti-psychotic medication in patients with dementia, health and safety audit, safeguarding audits and ligature audit for premises where patients were seen.

Fit and proper persons test

- The trust provided their policy and procedures relating to fit and proper person's requirement checks. We reviewed the files for two recently appointed directors and found the trust had met these requirements and had ongoing monitoring for regular reviews of fit and proper person's requirement.

Leadership and culture

- At the time of our last inspection (December 2015) several members of the senior management team were new in post. The director of nursing had joined shortly after the last inspection. All directors were still in post. The trust had restructured the management and governance arrangements and had embarked on a programme of quality improvement. During this inspection, we found significant improvements in governance arrangements and the trust was able to demonstrate clear plans and vision for ongoing improvements.
- We found that the trust had moved away from a transactional, compliance based approach to a more enabling, transformational culture. This cultural shift had enabled the board to show stronger and more charismatic leadership. The relatively new chair, director of nursing and chief executive were particularly praised by senior staff as being inspirational leaders.
- Staff knew who senior managers in the trust were and said they were visible. Staff reported positive morale and job satisfaction. They reported good relationships with managers and felt empowered in their roles.
- We found some good local leadership in services and considerable improvements in the functioning of the board; with movement away from a transactional, compliance based model to a more enabling and transformational model. We found a more externally focused board and organisation that expanded the trust's vision. However, we found that systems had not yet fully embedded into practice in some areas.
  The trust reported a drop in staff sickness rates. In December 2015, staff sickness was reported at 5.1%. In February 2017, this had reduced to 4.5% as a 12 month average.
- From the 2016 NHS staff survey for mental health and learning disability trusts, the trust had 12 key findings that were better than the England average and three key findings below the average. For example, the trust was above the England average regarding questions related to staff reporting errors, near misses or incidents they had witnessed in the previous month, percentage of staff
- The trust scored equal to the average for mental health and learning disability trusts for staff agreeing they would feel secure raising concerns about unsafe clinical practice, for staff recommending the organisation as a place to work or receive treatment, the percentage of staff feeling unwell due to work related stress in the last 12 months, and for staff reporting good communication between senior management and staff.
- The trust scored lower than the England average for quality of non-mandatory training, learning or development, fairness and effectiveness of procedures for reporting errors, near misses and incidents and percentage of staff able to contribute towards improvements at work.

Good

Are services well-led?

- The trust delivered mandatory training to all staff on equality and diversity. As at 31 March 2017, 91% of staff across services were compliant with this training.
- We spoke with staff from the black minority ethnic (BME) executive and senior staff who led on BME issues within the trust. The trust had four current active staff network groups, relating to equality and diversity standards: LGBT (lesbian, gay, bisexual and transgender), MAPLE (mental and physical lived experience), black and minority ethnic staff and carers in the workplace. All of these staff networks included allies and met on a quarterly basis. Members of the executive team were sponsors of staff networks and there were visible senior leaders. The associate director of nursing and quality was awarded the role model of the year title during Midlands 2015 workforce equality index awards.
- The trust's workforce race equality standard 2016 action plan showed under-representation of BME staff within the workforce at bands 3-6 and 8a and under representation in non-clinical posts at almost all bands. Eighty-seven percent of staff were classified as white and 4% as other. However, there had been an increase in representation of BME staff within the overall workforce profile, having increased from 5% in 2014 to 2015 to 9% in 2015 to 2016. This compared to a 2% BME population within Lincolnshire, as taken from the 2011 census.
- The trust advised that 63% of their BME staff were medical staff and, therefore, had included this as part of their medical meeting to capture the views of these staff. There was no BME representation at board level.
- Some of the questions in the NHS staff survey 2016 provided circumstantial evidence about equality and diversity standards. 29% percent of white staff from the trust experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months, against the England average for white staff of 31%. This compared to 36% of BME staff, against the England average for BME staff of 38%. The 2016 workforce related standards action plan quoted 38% for BME staff and 27% for white staff for these same indicators and recorded a 20% rise in reports from BME staff on the previous year.
- Nineteen percent of white staff from this trust experienced harassment, bullying or abuse from staff in the last 12 months (against the England average for white staff of 22%). This was compared to 26% of BME staff (which is equal to the England average for BME staff of 26%). The 2016 workforce related standards action plan quoted 23% for BME staff and 21% for white staff for these same indicators and recorded a 10% rise on the previous year.
- The trust had responded to these concerns in a number of ways. For example, hosting the BME conference for black history month in October 2016, in conjunction with local NHS providers and a review of the trust behaviour framework to ensure that race equality was sufficiently addressed. The trust included a section about equality and diversity on the website, including a diversity pledge from the Board of Directors. The trust received internal and external feedback on the equality strategy in March and April 2016 and documented their responses and actions.
- Eighty-eight percent of white staff from this trust agreed that the organisation provided equal opportunities for career progression (89% England average for white staff) compared to 76% of BME staff (79% England average for BME staff). Six percent of white staff (7% England average for white staff) personally experienced discrimination at work from manager/team leader or other colleagues compared to 9% of BME staff (14% England average for BME staff).
- The 2016 workforce related standards action plan quoted 13% for BME staff and 8% for white staff for these same indicators and recorded a slight decrease on the previous year. However, the trust acknowledged a disparity between the experiences of staff, requiring further action.
- From the staff friends and family test, the percentage of staff who would recommend the trust as a place to work is above the England average at 68%, compared to the England average of 64%. The percentage of staff who would not recommend the trust as a place to work is below the England average at 13%, compared to the England average of 18%.
- The trust produced an annual equality report which contained ten specific objectives, including continued implementation of the workforce race equality

standards, establishing infrastructure for black minority ethnic disability and carer equality, and identifying any gaps or areas of concern within the equality data for both patients and staff.

- The trust's strategic goals have been aligned to those in the national equality delivery system 2 in the equality strategy. Each goal had specific outcomes for which work within the trust was ongoing, and included:
  - better health outcomes - five outcomes listed, two are "achieving" and three are "developing".
  - improved patient access and experience - four outcomes listed two are "achieving" and the other two are "developing".
  - a representative and supported workforce - six outcomes listed under it, five are "achieving" and one is "developing"
  - inclusive leadership at all levels - three outcomes listed under it, one "achieving" and two are "developing".
- The trust recently signed up to support a national pledge to improve employment of people with learning disabilities in the NHS, helping to create a diverse workforce.
- The trust had received an award by the Ministry of Defence in recognition of continuing support for members of the Armed Forces.
- The trust had ongoing recruitment processes in place. The assessment of candidates included the use of a values based recruitment toolkit; which included mandatory equality and diversity question for all interviews that took place within the Trust. The trust advised this had been included to ensure that successful appointees demonstrated the appropriate values related to equality and diversity to values based recruitment. The equality and diversity section of recruitment and selection training was updated during 2015 to 2016 to cover discrimination and unconscious bias.
- The trust board encouraged candour, openness and honesty from staff. Staff knew how to whistle-blow and the majority of staff felt able to raise concerns without fear of victimisation. Staff we spoke with were aware of their responsibilities to be open and honest with patients and families if things went wrong.
- The trust had an interim Freedom to Speak up Guardian, with a newly appointed Guardian due in post from May 2017. The trust had reviewed their whistleblowing processes to encourage staff to report issues and concerns without fear of victimisation, for example producing a leaflet with a case study and including outcomes from whistleblowing in the lessons learned bulletin.
- The trust reported that historically whistleblowers had chosen to remain anonymous. However, staff were now more comfortable being identified and each member of staff received a letter from the chief executive acknowledging their concerns. Staff could elect to receive feedback via anonymous email accounts if this was preferred. The trust reported an increase in staff whistleblowing over the past two years, suggesting that staff felt supported to raise concerns. Staff had access to confidential support helplines and an employee assistance programme.
- Following one whistleblowing report, related to staffing levels, caseload and patient safety in a community mental health team, an investigation was commissioned and completed by the director of nursing and quality and the director of operations. An apology letter was sent to the staff, accepting the concerns raised, and the concerns were added to the corporate risk register and board assurance framework.
- Managers addressed poor performance when required and support was available from the human resources department. The trust policy supported managers to address poor performance. Between January 2016 and January 2017, there were 10 cases where staff were suspended.
- There were four cases where staff were moved, suspended briefly and then moved or redeployed under supervision. Older people wards accounted for half of all suspensions or supervisions (seven of 14), three were band five staff. Band five had the highest number of suspensions/moves with six. Of all 14 cases, 11 were concluded, including four from the community teams for patients with learning disabilities or autism, four on the inpatient wards for older people and two for staff within other specialist services. Three staff on older people wards remained suspended at December 2016.

Good

Are services well-led?

- Staff across all services reported good team working and said they were able to raise issues with their line managers.
- Overall, we found staff morale had improved. However, staff working in the Louth crisis team told us morale was lower than within other crisis teams due to increased work due to the community mental health teams and difficulty accessing medical cover.

Engagement with the public and with people who use services

- The trust had an involvement strategy for 2016-2018, which detailed how the views of patients, carers and families would be involved in planning and evaluating trust services. The principle was supported by the NHS England Five Year Forward View for Mental Health.
- The trust employed a public and patient engagement lead into a recently established post. The trust kept a database containing details of 150 patients and carers involved in various training and trust events and had delivered a series of workshops across Lincolnshire involving patients, carers, staff, and community stakeholders.
- The trust had signed up to the triangle of care (a therapeutic alliance between service users, staff and carers that promoted safety, supports recovery and sustains wellbeing).
- The trust employed peer support workers across the adult community mental health teams. Peer support workers are workers with a lived experience of mental illness who offer mentoring and support to patients currently receiving treatment. At the time of our inspection, eight posts had been created and five peer support workers were in post across five community teams. The trust had visited neighbouring trusts to see how these roles had progressed, in order to further develop this service.
- The trust participated in the friends and family test. The friends and family test is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.
- Carers had access to a number of carers' forums across the core services. We attended two carers' groups at the child and adolescent inpatient unit, Ash Villa and community-based mental health services for older people at Witham Court. We also attended patient and carer forums at the community-based mental health services for adults at Gainsborough, Carhome Court and Sleaford. Carers and patients were positive about the car they received from all services. However, some patients raised concerns about lengthy waits for psychology; reported as being up to two years.
- As part of the Steps2Change programme, the trust held patient involvement groups titled 'Voice2Change'. At the time of our inspection, Voice2Change patient groups ran across the county, in Boston, Grantham, Skegness, Sleaford and Spalding.Voice2change members worked with staff and were involved in supporting the development of the service, suggesting ideas for new ways of working, reviewing and critiquing new ideas, helping to recruit new staff and enabling patients to share their views of services. The trust operated a dedicated email address for patients and carers to share their views, managed by the involvement team.
- The trust encouraged patient involvement in staff recruitment. Patients received training to understand the trust recruitment process. At the time of our inspection, the trust had just completed the second intake of patients on this training.

Quality improvement, innovation and sustainability

- The trust was committed to the principle of continuous quality improvement. For example, we had observed staff members taking responsibility for service development and change, as a practical illustration of the quality Improvement programme, introduced in the past year.
- The trust employed six clinical research staff working under the associate director of research and effectiveness. Four consultant psychiatrists worked across each division as research leads.
- There were good examples of national research undertaken, with good outcomes for patients. For example, research completed with primary care partners resulted in a web based tool to support patients at home, following research completed into persistent accident and emergency attendance.
- Whilst we found evidence of both clinical audit and research activity, it appeared that little of this was being

used to inform either further development or the systematic dissemination of learning across the organisation. For example, the trust had established a recovery college, based on trust premises, which had led to people accessing services now acting as peer support workers. Peer support refers to a situation where people with experience of mental health problems are offering each other support based on their lived experience. However, this development was not linked to the national research project (a set of mental health system performance indicators for facilitating mental health recovery). We found there was potential for the audit and research activity to be more actively focussed on both identifying outcomes for people accessing the service and for ensuring that learning was disseminated widely

- Senior managers told us there had been much organisational change and transformation of care within the trust. Staff told us they felt supported by the board to work with change and felt able to provide feedback about their experiences.
- The trust provided details on their participation in national service accreditation and peer-review schemes. In total, 14 schemes were identified, for example:

- Accreditation for inpatient mental health service (AIMS): acute wards for adults of working age (Charlesworth and Conolly wards – under review). Ward 12 was currently under self-review. Long stay / rehabilitation mental health wards for working age adults
- ECT accreditation service (ECTAS): acute wards for adults of working age (Charlesworth and Conolly wards).
- Accreditation for the quality networks for community mental health services (ACOMHS): community mental health services for people with learning disabilities or autism.
- Accreditation for the home treatment accreditation scheme (HTAS): mental health crisis services and health-based places of safety.
- Accreditation for the quality network for community child and adolescent mental health services (QNCC): specialist community mental health services for children and young people.
- Accreditation for the quality network for inpatient child and adolescent mental health services (QNIC): Specialist community mental health services for children and young people.
- The Quality Network for Perinatal Mental Health Services: other Specialist Services.

- Quality initiatives included staff nomination and internal recognition awards for the trust. The Lincoln crisis and health based place of safety staff had received a trust 'heros' award in 2016 and the team leader at the Boston crisis team had received a trust 'heros' award in 2016 for inclusive leadership.

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 11 HSCA (RA) Regulations 2014 Need for consent • **The trust had not ensured formal capacity assessments and best interest's decisions were fully recorded within the care records.** This was in breach of regulation 11

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The trust had not ensure patients admitted to the acute inpatient wards had a risk assessment, completed by a registered nurse, prior to using section 17 leave. • The trust had not ensured that patients admitted to the adult acute admission wards had specific care plans for staff to follow, during periods of seclusion. • The trust had not ensured that patients admitted to the adult acute inpatient wards had appropriate care plans in place to address physical health needs. This was a breach of regulation 12

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 • The trust must ensure that all staff receive clinical and management supervision, in accordance with trust policy, and that recording systems are robust.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 18