MH – Long stay/rehabilitation mental health wards for working age adults

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Long Leys Road	The Fens	15	Male
Long Leys Road	The Vales	15	Female
Long Leys Road	The Wolds	15	Mixed
Beaconfield Centre	Ashley House	15	Mixed
Maple Lodge Site	Maple Lodge	15	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they found.

Staff had adequate observation of all patients in all parts of the wards.

Safety of the ward layout

All wards except Ashley House followed single sex guidance, though the manager at Ashley House was aware of the issue and had reported it and dealt with it accordingly. While Ashley House and Maple Lodge were mixed sex accommodation Vales, Wolds and Fens wards were single sex accommodation.

Over the 12-month period from 1 November 2018 to 31 October 2019 there were no same sex accommodation breaches within this service.

There were detailed ligature and environmental risk assessments for all wards. All potential ligature points had adequate mitigation and staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

There were ligature risks on all five wards within this service. All five wards had a ligature assessment within the 12 month period for which data was provided.

Ward / unit name	Briefly describe risk	High level of risk? Yes/ No	Summary of actions taken
The Wolds	The 'Clinical Area Profile' describes the assessment of risk areas in relation to the patient profile, clinical area and potential ligature point(s)	No	Local management of risk areas is described within the wards Assessment and Management of ligature Risks folder. No action required following ligature audit.

Ward / unit name	Briefly describe risk	High level of risk? Yes/ No	Summary of actions taken
The Vales	The 'Clinical Area Profile' describes the assessment of risk areas in relation to the patient profile, clinical area. Doors to all rooms where patients have free access and isolate themselves. Potential ligature point(s) Disabled bathrooms. Toilet seats	Yes	Local management of risk areas is described within the wards Assessment and Management of ligature Risks folder. Revised observation policy and observation documentation with the inclusion of environmental checks in addition to individual patient's clinical risk assessment, Disability Discrimination Act (DDA) bathrooms and individual toilet seats have local management plans in place to minimise risks. Estates to review if alternatives are available for DDA bathrooms
The Fens	The 'Clinical Area Profile' describes the assessment of risk areas in relation to the patient profile, clinical area and potential ligature point(s). Toilet seats, DDA bathroom sink and taps	No	No action required following ligature audit. Each ward has a clinical area profile in situ and details of how to manage each area on the ward. individual toilet seats have local management plans in place to minimise risks
Maple Lodge	The 'Clinical Area Profile' describes the assessment of risk areas in relation to the patient profile, clinical area and potential ligature point(s).	No	Local management of risk areas is described within the wards Assessment and Management of ligature Risks folder.
Ashley House	The 'Clinical Area Profile' describes the assessment of risk areas in relation to the patient profile, clinical area and potential ligature point(s) Staff toilet area to be secured	No	Local management of risk areas is described within the wards Assessment and Management of ligature Risks folder.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

At time of inspection all ward areas were clean, well maintained, well-furnished and fit for purpose.

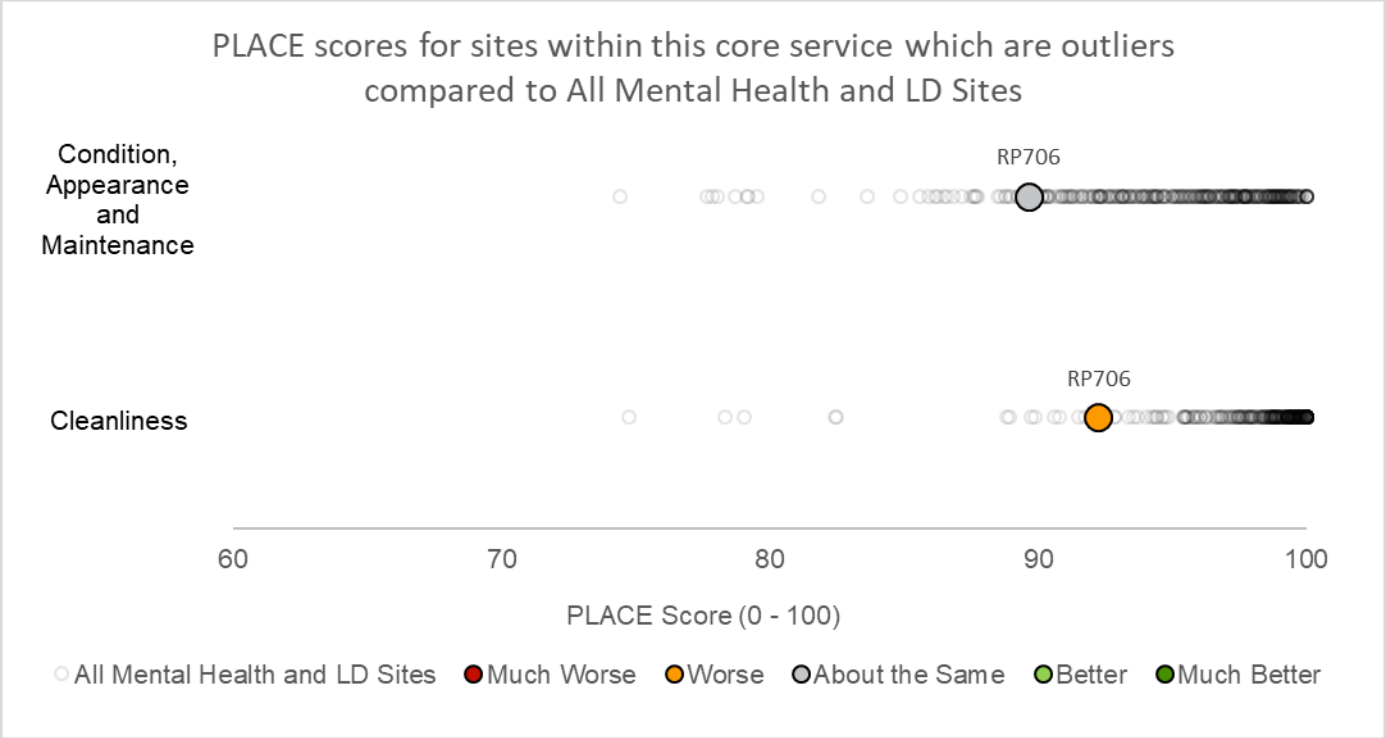
PLACE assessments aim to provide a clear message from patients on how the care environment may be improved. They are undertaken by teams of local people alongside healthcare staff and assess privacy and dignity, food, cleanliness, building maintenance and the suitability of the environment for people with disabilities and dementia.
For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), Ashley House scored worse than the average for cleanliness. However, the manager at Ashley House showed us a PLACE audit dated December 2019 where they had scored 98.7%.

The scores for this site are shown in the table below and in Figure 1. In Figure 1 the site is shown as larger circles and their rating compared to similar sites is indicated by the colour. Other sites of the same type are shown as smaller white circles for context.

The scores for the other sites were found to be about the same as the England average when compared to sites of a similar type and as such have not been included in the table or Figure 1.

Site name	Cleanliness	Condition appearance and maintenance
Ashley House	92.3%	89.7%
Trust overall	**98.0%**	**93.6%**
England average (Mental health and learning disabilities)	**98.4%**	**95.4%**

Figure 1



Except for Maple Lodge and Ashley House all wards had cleaning records. Staff made sure cleaning records were up to date and the premises were clean. At Ashley House and Maple lodge there were only kitchen cleaning records available.

Staff followed infection control policy, including handwashing

Seclusion room

Only Vales and Fens wards had a seclusion room. The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock.

Clinic room and equipment

Staff ensured clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

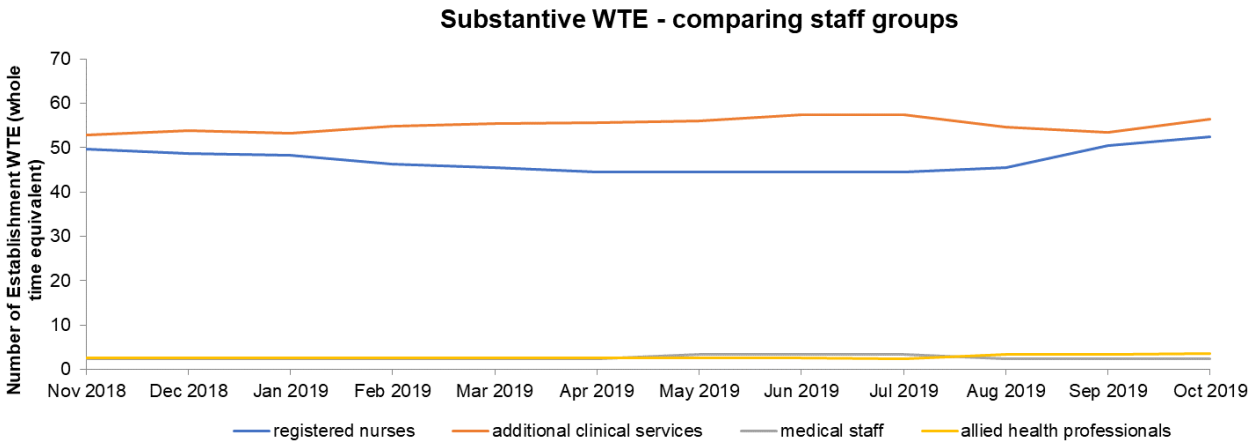
Safe staffing[1]

The service had enough nursing and medical staff, who knew the patients and received mandatory training to keep people safe from avoidable harm.

All wards had enough nursing and support staff to keep patients safe, and managers could request more staff to cover enhanced observations and ward rounds.

The below chart (Figure 2) shows the breakdown of staff in post WTE in this core service from 1 November 2018 to 31 October 2019.

Figure 2



The below table covers staff fill rates for registered nurses and care staff during May, June and July 2019.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	May 2019				**June 2019**				**July 2019**			
The Fens	105	100	102	110	103	99	100	104	109	100	102	132
The Vales	99	110	103	123	102	108	101	126	98	117	108	166
The Wolds	100	98	100	97	99	108	97	102	108	97	100	100
Maple Lodge	108	94	103	103	101	106	100	100	97	103	100	110
Ashley House	109	93	100	100	106	98	101	100	95	96	100	100

[1] Staffing Analysis Safe Staffing Vacancy Benchmarking Turnover Benchmarking Sickness Benchmarking

The Vales had above 125% of the planned nursing assistants for night shifts in June and July 2019. The Fens had above 125% of the planned nursing assistant for night shifts in July 2019. This was due to the higher than expected levels of enhanced patient observations needed.

Annual staffing metrics

The service had average vacancy rates for nursing staff of 10% but high vacancy rates for allied health professionals at 33%.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

The service had low rates of agency nurses, but high rates of bank nurses.

The service had reducing rates of bank and agency additional clinical services.

The service had reducing turnover rates.

While levels of sickness were reducing for nursing staff at 6.9% they remained high for allied health professionals at 28%. Managers supported staff who needed time off for ill health.

Although managers calculated and reviewed the number and grade of nurses, and healthcare assistants for each shift in line with core establishment; one qualified nurse and two healthcare support workers per day shift; one qualified nurse and one healthcare support worker per night shift; plus, one twilight shift, staff told us they frequently struggled to meet all their patient's needs. In addition, at Maple Lodge and Ashley House there were insufficient occupational therapy staff to meet patient's needs. The existing band 6 occupational therapist at Maple Lodge was covering both units in the absence of an occupational therapist at Ashley House. However, the manager informed the inspection team that a newly qualified band 5 occupational therapist had been recruited but had not started work on the ward. This had been reported on at our previous inspection of this core service.

The ward managers told us that as a temporary measure to address this issue they could adjust qualified nurse and support worker staffing levels according to the observation needs of the patients, and to ensure that the service had enough staff on each shift to carry out any physical interventions safely.

While patients had regular one to one session with their named nurse, and escorted leave was rarely cancelled, staff shortages and the lack of occupational therapy meant staff had cancelled or postponed ward based, and community recovery programs.

Staff shared key information to keep patients safe when handing over their care to others.

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

	Core service annual staffing metrics (1 November 2018 – 31 October 2019)

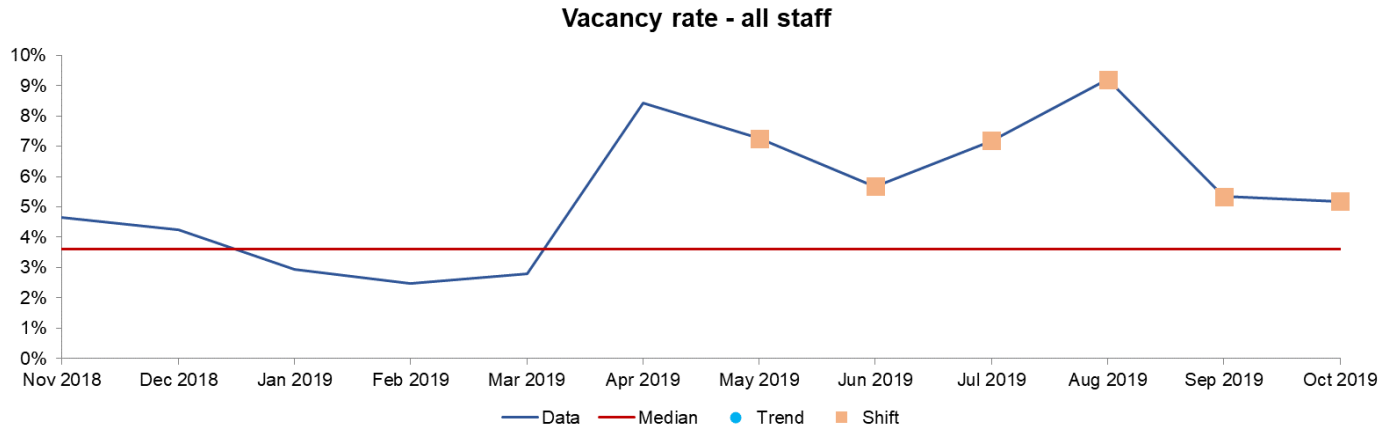
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual "unfilled" hours (% of available hours)
All staff	254	5%	7%	8.5%			
Registered nurses	74	10%	9%	6.9%	12,062 (20%)	0 (0%)	238 (<1%)
Additional clinical services	146	2%	5%	9.4%	25,517 (25%)	398 (<1%)	1,915 (2%)
Medical staff	3	0%	38%	0.7%	0 (0%)	89 (4%)	1,999 (96%)
Allied Health Professionals	5	33%	14%	28.1%			

Vacancy

The average vacancy rates for all staff and medical staff were in the lowest 25% when compared to other similar core services nationally.

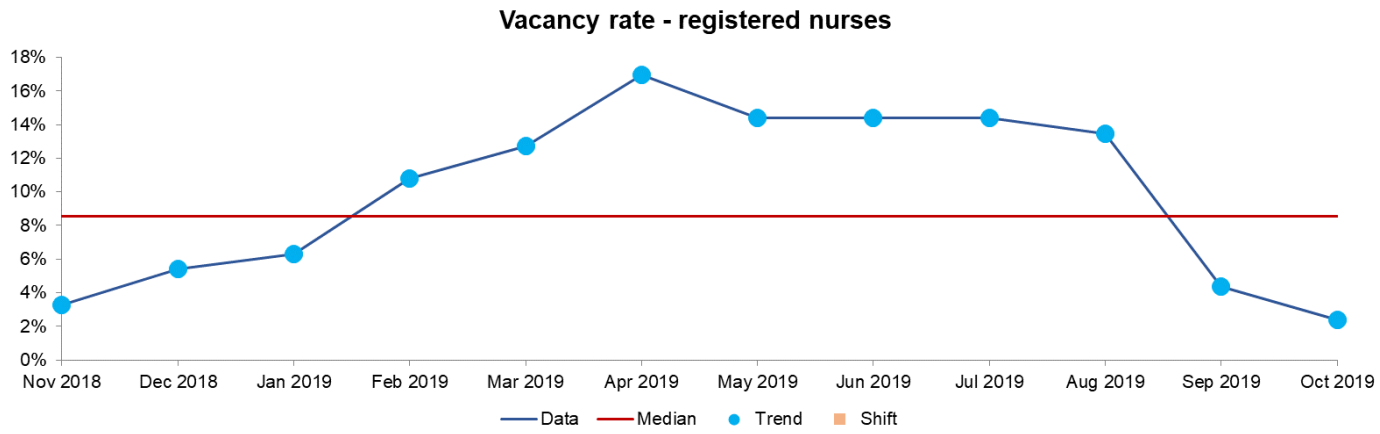
The average vacancy rate for allied health professionals was in the highest 25% when compared to other similar core services nationally.

Figure 3



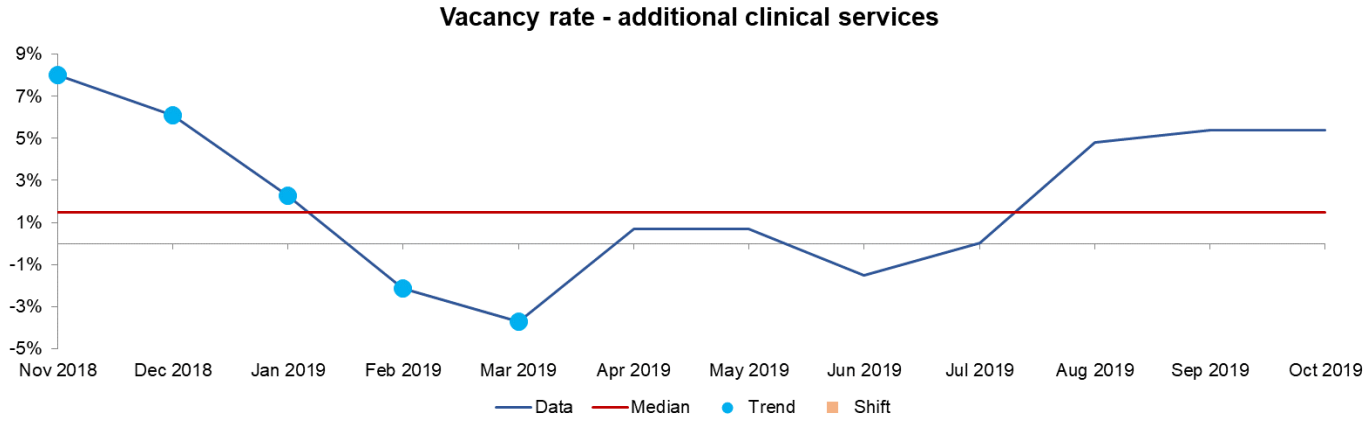
Monthly vacancy rates over the last 12 months for all staff showed an upward shift from May 2019 to October 2019 (see Figure 3). Managers felt this could be due to some staff uncertainty about the outcome of the rehabilitation service transformation.

Figure 4



Monthly vacancy rates over the last 12 months for registered nurses showed an upward trend from November 2018 to April 2019 followed by a downwards trend from April 2019 to October 2019 (see Figure 4).

Figure 5



Monthly vacancy rates over the last 12 months for additional clinical services showed a downward trend from November 2018 to March 2019 (see Figure 5).

Turnover

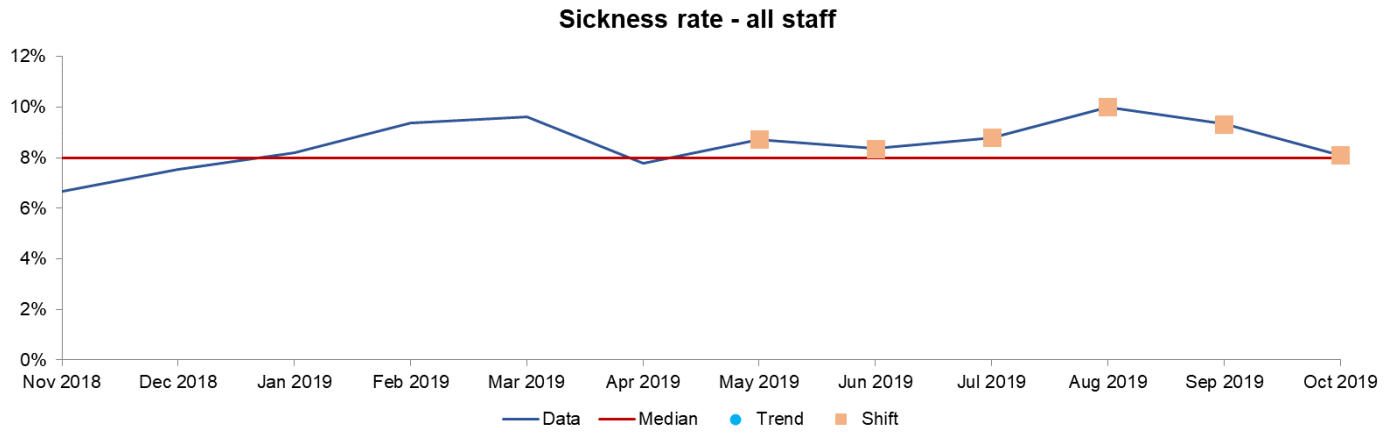
The annual turnover rate for medical staff was in the highest 25% when compared to other similar core services nationally.

The annual turnover rate for allied health professionals was in the lowest 25% when compared to other similar core services nationally.

Sickness

The average sickness rates for all staff, additional clinical services and allied health professionals were in the highest 25% when compared to other similar core services nationally.

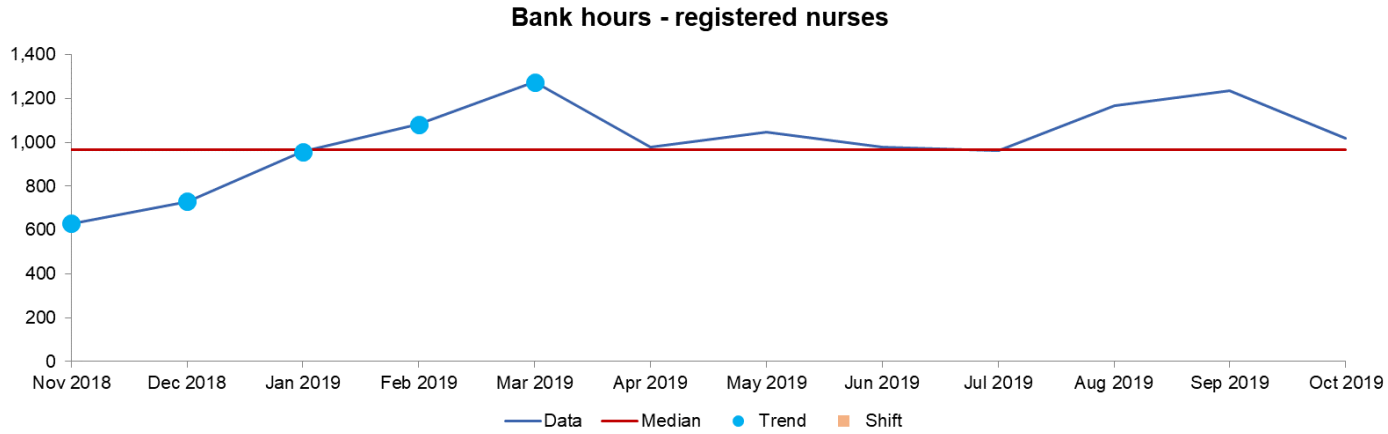
Figure 6



Monthly sickness rates over the last 12 months for all staff showed an upward shift from May 2019 to October 2019 (see Figure 6).

Bank and agency

Figure 7



Monthly bank use over the last 12 months for registered nurses showed an upward trend from November 2018 to March 2019 (see Figure 7).

Mandatory and statutory training

The trust set a target of 90% for completion of statutory training.
The compliance for mandatory training modules at 31 October 2019 was 82%. Of the training modules for which data was provided, 11 achieved compliance and 18 failed to reach the trust target of 90%.

Eleven failed to score above the CQC recommended minimum threshold of 75% as outlined below.

The trust advised that training data is reported on a rolling month on month basis.

The training compliance reported for this core service during this inspection was higher than the 77% reported in the previous year.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✘	**Higher** ↑	**No change** →	**Lower** ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (<75%)	Trust Target Met	Compliance change when compared to previous year
Mental Capacity Act - Level 3	123	90	73%	✖	→
Safeguarding Children (Level 3)	123	89	72%	✖	↓
Physical Healthcare Training	113	80	71%	✖	↓
Personal Safety Breakaway - Level 1	29	20	69%	✖	↓
Person Centred Care Planning	116	77	66%	✖	N/A
Moving and Handling - Level 2 - 1 Year	17	11	65%	✖	↑
Mental Health Act	115	74	64%	✖	↑
Rapid Tranquilisation	54	31	57%	✖	↓
Medicine management training	46	26	57%	✖	↑
Food Hygiene	113	48	42%	✖	↓
Mental Health Clustering Training	58	2	3%	✖	N/A
Total	**3,332**	**2,719**	**82%**	✖	↑

* no eligible staff for previous year

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff took part in the provider's restrictive interventions reduction programme.

Assessment of patient risk

We reviewed 16 patient risk assessments. Staff completed risk assessments for each patient on admission using a recognised risk assessment tool, and reviewed this regularly, including after any incident.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff could either see patients in all areas of the wards or followed procedures to minimise risks where they could not easily see patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions had reduced over the twelve months prior to inspection.

This service had 143 incidences of restraint (25 different service users) and 11 incidences of seclusion between 1 November 2018 and 31 October 2019.
The below table focuses on the last 12 months' worth of data: 1 November 2018 to 31 October 2019.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
The Fens	0	21	8	1 (5%)	6 (29%)
The Vales	11	116	12	19 (16%)	34 (29%)
The Wolds	0	2	2	0 (0%)	0 (0%)
Maple Lodge	0	1	1	0 (0%)	0 (0%)
Ashley House	0	3	2	0 (0%)	0 (0%)
Core service total	**11**	**143**	**25**	**20 (14%)**	**40 (28%)**

Staff took part in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

There were 20 incidences of prone restraint, which accounted for 14% of the restraint incidents. Over the 12 months, incidences of prone restraint ranged from none to five per month. The number of incidences (20) had decreased from the previous 12-month period (23). Mangers told us, and records confirmed that where prone restraint had occurred, usually when a patent had gone down on their front, this was for the shortest period until staff could turn the patient safely.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed National Institute of Clinical and Healthcare Excellence guidance when using rapid tranquilisation.

There were 40 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from none to nine per month. The number of incidences (40) had decreased from the previous 12-month period (54).

There have been no instances of mechanical restraint over the reporting period. The number of incidences (none) was the same as the number of incidences from the previous 12-month period (none).

When staff placed patients in seclusion they kept clear records and followed best practice guidelines.

There have been 11 instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from none to five per month. The number of incidences (11) had decreased from the previous 12-month period (18).

If staff placed patients in long term segregation they followed best practice, including guidance in the Mental Capacity Act Code of Practice.

There have been no instances of long-term segregation over the 12-month reporting period. The number of incidences (none) was the same as the previous 12-month period (none).

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff received the right training on how to recognise and report abuse for their role.

Staff kept up to date with their safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or adult at risk from abuse. Recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or adult at risk, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made six safeguarding referrals between 1 November 2018 and 31 October 2019, of which all six concerned adults.

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
MH - Long stay/rehabilitation mental health wards for working age adults	6	0	6

The number of adult safeguarding referrals in month ranged from none to two per month.

Managers took part in serious case reviews arising from safeguarding reports and made changes based on the outcomes. Examples of changes made following serious incident review the introduction of sexual safety huddles twice daily for staff to share any concerns or questions about patient's general safety on the wards.

The trust has submitted details of no serious case reviews commenced or published in the last 12 months (1 November 2018 to 31 October 2019) that relate to this service.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. 22 of the 35 staff we spoke with, and who made comment on this matter, said they could access the records they needed quickly.

When patients transferred to a new team, there were no delays in staff accessing their records.

Staff stored records securely.

Although the service continues to use some paper records such as Mental Health Act paperwork recovery star and therapy assessments, we saw how these documents were usually uploaded to the electronic system in a timely manner. Except for some Capacity assessment decisions and some physical health records on Ashley House, staff made sure records were up to date and complete.

Medicines management

We reviewed 26 patient prescription charts and eight physical healthcare records. The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and gave specific advice to patients and carers about their medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy.

Where patients were self-administering their medicines (SAM), there were clear risk assessments in place with documented reviews. However, not all wards were using the trust paperwork to record when patients attended to access their medicines which would have meant this information was not always available to support their progression with the SAM programme.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure that staff did not control patient's behaviour by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute of Health and Care Excellence guidance. However, at Ashley House we found one record for a patient who was on high dose antipsychotic medication where the record did not reflect whether staff had completed the necessary physical health checks or not.

Track record on safety

The service had a good track record on safety.

Between 1 November 2018 and 31 October 2019 there were four serious incidents reported by this service.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with four reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

	Number of incidents reported				
Type of incident reported (SIRI)	**Slips/trips/ falls**	**Substance misuse whilst inpatient**	**Abuse/alleged abuse of adult patient by staff**	**Pressure ulcer**	**Total**
Ashley House	1	0	1	0	**2**
The Wolds	0	1	0	0	**1**
The Vales	0	0	0	1	**1**
Total	**1**	**1**	**1**	**1**	**4**

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that staff had made changes because of feedback. Protected times for medication administration, laptop availability in the clinic room to ensure staff could update notes immediately and without distraction.

Managers shared learning with their staff about never events that happened elsewhere. Through e-mail shots, sexual safety huddles, staff handovers, team meetings and the trusts safety matters news bulletin.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Lincolnshire Partnership NHS Foundation Trust. However, in December 2019 there had been a patient death on Maple ward. The manager had reported this and completed a full investigation.

Is the service effective?

Assessment of needs and planning of care

We reviewed 16 patient healthcare records. Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which staff reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and while they were personalised, and holistic they did not clearly reflect recovery orientated goals or recovery focussed interventions.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patient's needs changed.

While care plans were personalised, and holistic they were not recovery orientated. It was difficult to see what recovery orientated goals the patient had identified and what recovery focussed interventions the patient could expect as part of their care and treatment.

Best practice in treatment and care

Staff provided a range of, but not all, treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives.

We saw limited use of recognised rating scales to assess and record severity and treatment outcomes. There was no clearly defined model of rehabilitation or recovery focussed intervention at Ashley House or Maple Lodge. Staff we spoke with could not describe their model of care and did not routinely use recognised rating scales to assess and record severity and outcomes. Managers said they used recovery star, however, we found staff were not using it consistently or correctly, apart from Fens ward. Therefore, staff could not rely on this as an effective model or outcome measure.

Ashley House did not have enough occupational therapy staff to meet patient's needs. This led to patients not being fully assessed for their rehabilitation needs, rehabilitation care plans and programs were not comprehensive and there was little evidence of evaluation of the plans that were in place. CQC reported on the lack of occupational therapy and staff in the previous inspection report.

Not all wards had access to the full range of specialists needed to meet the needs of patients on the ward. Maple Lodge had limited access to psychological input and Ashley House had no

occupational therapist and limited access to psychological input. Patients at Ashley House and Maple Lodge had to rely on staff referring them to psychology services rather than receiving an automatic assessment for psychology.

At Ashley House, Maple Lodge and to a lesser degree on Vales ward there was little evidence that senior managers had reviewed the core staffing establishment in the light of acknowledged changes to the patient group. Staff and managers acknowledged that their patient groups were more complex and acute than the rehabilitation patients the establishment was originally intended for. This had affected patients care and treatment and staff said they could not meet all patient's rehabilitation needs. Staff told us they prioritised containment of patient's distress, safety on the ward and patients' section 17 leave, at the expense of ward and community-based activity and recovery programs. Staff felt they did not have the time and skills to motivate and support current patients to engage in meaningful rehabilitation or recovery focussed activity.

Staff delivered nursing care in line with best practice and national guidance National Institute of Health and Care excellence.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as needed.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in smoking cessation, healthy diet and wellbeing programmes or giving advice on living healthier lives.

Staff used some technology to support patients care including healthy living apps on mobile devices.

Qualified staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers told us they were keen for all staff to attend the trusts quality improvement training so more of them had confidence to be involved in quality improvement projects.

Managers used results from audits to make improvements. Examples included development of the occupational therapy hub and an occupational therapy clinic on Vales ward, as well as those listed below.

This service participated in nine clinical audits as part of their clinical audit programme 2018 – 2019.

Audit name	**Audit scope**	**Audit type**	**Date completed**	**Key actions following the audit**
Physical Health Reviews and Time-frames of completion	Ashley House	Local	December 2018	As this audit concluded there are some areas missing from the new inpatient admissions physical health review when compared to the expected standard. To improve current practice a check list or a clerking Proforma could be introduced, where the staff can check specific requirements, their period for completion and

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
				mark when they are performed and recorded on the system. Also, a clear split of tasks between the doctors and the nursing staff as of who should complete which aspects of the new admission clerking could be printed out for each of the new admissions and documented in notes. Such clerking check list can be distributed to junior doctors at Ashley house. After a period of 3 months or several sufficient new admissions audit can be repeated to see if there's been any improvement in completion of physical health reviews.
CQUIN 9 – Preventing Ill Health by Risky Behaviours (Alcohol and Tobacco)	Charlesworth ward Conolly ward Ward 12 Francis Willis unit Hartsholme Centre Ashley House Maple Lodge The Fens The Vales The Wolds Rochford unit	Clinical	Quarterly audits	All new staff to undergo the alcohol and tobacco training as part of local induction. All new starters to be shown how to complete the electronic physical health check document. Business manager to send out weekly compliance report to service managers. Service managers to monitor and address at ward level
CQUIN 3 – Improving physical healthcare to reduce premature mortality in people with serious mental illness 3a – cardio metabolic assessment and treatment for patients with psychoses	Hartsholme centre The Vales The Wolds Maple Lodge Francis Willis unit Brant ward Langworth ward Rochford unit Manthorpe centre CMHT Boston CMHT Lincoln CMHT Louth CMHT Grantham/Sleaford CMHT	Clinical	Annual March 2019 (Q4)	The Physical Health Improvement Learning In Practice (PHILIP) course is mandatory for all frontline nursing and AHP staff, and has been developed and delivered by the physical healthcare team, supported by the Trust Learning and Development team.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
	Stamford/Spalding CMHT Gainsborough			
CQUIN 3 – Improving physical healthcare to reduce premature mortality in people with serious mental illness 3b – collaboration with primary care clinicians	Charlesworth ward Conolly ward Ward 12 Maple Lodge The Wolds Rochford unit Hartsholme centre Brant ward Langworth ward CMHT Stamford/Spalding CMHT Gainsborough CMHT Boston CMHT Skegness CMHT Louth CMHT Lincoln CMHT Grantham/Sleaford Community Forensic	Clinical	Annual - Q3 (October 2018)	None of the criteria showed above 78% compliance. Improvements required across both inpatient and community settings
Seclusion	Charlesworth ward Conolly ward Ward 12 Francis Willis Unit Hartsholme Centre The Fens The Vales The Wolds	Local	November 2018	The Prevention Management of Violence and Aggression (PMVA) Team will commence theory sessions with the Junior Doctors highlighting the seclusion policy and Seclusion paperwork. Liaison was carried out with the Medical Education Coordinator however it was found that the current induction does not allow for any flexibility. The PMVA Team will complete a further Seclusion Audit July 2019 of all incidents of Seclusion. The Seclusion Audit tool will be reviewed before the next Audit to enhance accurate information gathering. The PMVA team will work with staff teams to promote effective care planning during an incident of seclusion and clarifying incidents of seclusion that last over 8 hours. The PMVA team will monitor that risk assessments are

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
				completed within 48 hours from the termination of Seclusion and evidencing that a plan of care for the reintegration of the patient onto the ward was completed. Seclusion template will be developed on RIO for use by all clinical staff. Action: formulation of a RiO template will be discussed as part of the agenda for the new PMVA working group. Clinical systems have been consulted about the feasibility of developing the template.
Seclusion	Charlesworth ward Conolly ward Ward 12 Francis Willis Unit Hartsholme Centre The Fens The Vales The Wolds	Local	August 2019	Following verbal feedback of this audit to the Patient Safety and Executive committee held on 23rd July 2019 a quality initiative project will be undertaken to review the results of this audit to ensure a structured formal approach to improve practice is implemented across all wards. Corporate and clinical representation will be invited to the initial QI project meeting to be held on 12th August 2019.
Seclusion	Charlesworth ward Conolly ward Ward 12 Francis Willis Unit Hartsholme Centre The Fens The Vales The Wolds	local	October 2019	Findings from this audit will be reviewed by the Quality Committee and actions will be addressed accordingly. The Interim Director of Nursing, Quality Improvement & Assurance Lead and the PMVA Team Leader met to discuss the audit outcome on 5th November 2019. The outcome of the meeting was the formulation of the action plan.
Monitor High Dose Antipsychotic Therapy (HDAT) in line with Risk Management Guideline	The Vales	Local	June 2019	To increase staff awareness about HDAT, handy leaflets distributed and added to the board in the clinic room and nursing office. To encourage nursing staff to

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
				participate actively in calculating Anti-psychotic doses and identify patients who are on HDAT.
Practice of Observations audit	All Inpatient Wards	Local	September 30th 2019	Patient Audits commenced/Focus groups with teams to understand issues and pressures/CQI Project across divisions

Skilled staff to deliver care

Supervision rates remained low across the service, CQC had reported on both issues at a previous inspection. The supervision rate for the service was 66% this was below the expected target for the trust which was 85%. Data produced at the time of inspection showed supervision compliance ranged from 88% managerial on Wolds to 40% managerial at Maple Lodge, and 100% clinical on Fens to 11% clinical at Maple Lodge.

Managers provided an induction for new staff and supported staff with appraisals, and opportunities to update and further develop their skills.

We found very few staff we spoke with had undertaken specialist training relating to rehabilitation or recovery such as recovery focussed interventions, motivational interviewing, recovery star or wellness recovery action plans (WRAP). Neither could all staff explain what was meant by recovery in mental health.

Managers ensured staff had the right basic skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff, however, they did not necessarily recruit staff from rehabilitation or recovery focussed backgrounds.

Managers supported staff through regular, constructive appraisals of their work. However, compliance rates for appraisals on Vales, Fens and Maple Lodge at 30 November 2019 were lower than they had been in the previous 12 months. Managers told us this was due in part to changes in the ward management teams.

The trust's target rate for appraisal compliance is 85%. At the end of last year (1 April 2018 to 31 March 2019), the overall appraisal rate for non-medical staff within this service was 80%. This year so far, the overall appraisal rate was 78% (as at 30 November 2019). The wards with the lowest appraisal rate at 30 November 2019 were Maple Lodge with an appraisal rate of 50% and The Fens at 76%.

Ward name	Total number of permanent non-medical staff needing an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 30 November 2019)	% appraisals (previous year 1 April 2018 - 31 March 2019)
The Wolds	23	22	96%	96%
Ashley House	21	18	86%	75%

Ward name	Total number of permanent non-medical staff needing an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 30 November 2019)	% appraisals (previous year 1 April 2018 - 31 March 2019)
The Vales	38	30	79%	80%
The Fens	50	38	76%	79%
Maple Lodge	20	10	50%	68%
Core service total	**152**	**118**	**78%**	**80%**
Trust wide	**1,885**	**1,610**	**85%**	**87%**

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work.

The trust's target rate for appraisal compliance is 85%. At the end of last year (1 April 2018 to 31 March 2019), the overall appraisal rate for medical staff within this service was 60%. This year so far, the overall appraisal rates was 80% (as at 30 November 2019). The ward with the lowest appraisal rate at 30 November 2019 was Ashley House with an appraisal rate of 0%, although it was worth noting that this ward only has one medical member of staff.

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 30 November 2019)	% appraisals (previous year 1 April 2018 - 31 March 2019)
The Wolds	4	4	100%	50%
Ashley House	1	0	0%	100%
Core service total	**5**	**4**	**80%**	**60%**
Trust wide	**122**	**89**	**73%**	**59%**

The trust's target of clinical supervision for non-medical staff is 85% of the sessions required. Between 1 November 2018 and 31 October 2019, the average rate across all nine teams in this service was 66%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

At the time of inspection staff recorded clinical and managerial supervision separately. Data provided by managers showed that supervision compliance on Vales was 78% for management and 66% for clinical; Fens 80% management and 100% for clinical; Wolds 95% managerial and 88% clinical; Ashley House 66% clinical we could not show what the exact managerial rate was; and Maple Lodge 40% managerial and 11% clinical. Some managers told us they did not think these figures correct because not all staff were recording their supervision correctly, and as the graph below shows in November 2019 rates for clinical supervision were higher than at the time of this inspection. CQC had reported on supervision compliance being below the trusts target rate, in the previous inspection report. At that time managers thought this was because staff were not

recording supervision accurately on the electronic recording system and told us they would ensure that all staff understood the importance of supervision and how to record it correctly.

Team name	Clinical supervision sessions required	Clinical supervision delivered	% of sessions delivered
GACZPSA Adult Recovery Psychology	1	1	100%
The Fens	284	250	88%
Rehab Psychology	47	41	87%
IRI Adult Recovery Psychology	7	6	86%
The Wolds	231	164	71%
Ashley House	181	125	69%
The Vales	332	175	53%
Maple Lodge	172	77	45%
Team Leader Rehabilitation	50	19	38%
Core service total	**1,305**	**858**	**66%**
Trust Total	**13,343**	**9,837**	**74%**

Managers supported non-medical staff through regular, constructive clinical supervision of their work.

The trust stated that: 'medics clinical supervision is not recorded on an electronic system. Junior doctors are supervised weekly by their consultants and this is recorded within their individual portfolios. Senior grade doctors receive peer supervision and frequency ranges from monthly to quarterly. During peer group supervision one patient case is presented for the group to consider and peer supervision is recorded on appraisal documentation'.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. Wherever possible they supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

As of 31 October 2019, 64% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is non-mandatory for all inpatient and community-based staff and renewed every three years.

The training compliance reported during this inspection was higher than the 22% reported for the previous year.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up to date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and staff automatically referred patients who lacked capacity to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary following the Mental Health Act Code of Practice and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when a Responsible Clinician and /or Ministry of Justice agreed.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. However, not all staff we spoke with understood how the Mental Capacity Act 2005 affected on their work with patients. While staff assessed and recorded capacity clearly for patients who might have impaired mental capacity – staff did not always record the decision-making process correctly.

While staff received and kept up to date with training in the Mental Capacity Act they told us this was an on line non-mandatory training and the quality of the training was not good. Sixteen out of the 35 staff we spoke with did not fully understand all five principles of the Act. CQC had reported on staff training compliance with the Mental Capacity Act following the services previous inspection. However, staff knew where to get correct advice on the Mental Capacity Act and deprivation of liberty safeguards when they needed it.

As of 31 October 2019, 73% of the workforce in this service had received training in the Mental Capacity Act level 3. The trust stated that this training is non-mandatory for all inpatient and community-based staff and renewed every three years.

The training compliance reported during this inspection was the same as the 73% reported for the previous year.

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 November 2018 and 31 October 2019.

While there was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff knew how to access, the policy was out of date and managers should have reviewed the policy in October 2019.

Staff gave patients all support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they told us they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. However, in five of the eight Mental Capacity Act records we looked at staff had not recorded the decision-making process correctly, and in six of the eight records we reviewed staff had not stored the assessments in the correct part of the electronic record.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and checked the progress of these applications.

Although staff audited how they applied the Mental Capacity Act, identified and acted when they needed to make changes to improve, staff had not picked up the errors we found during these audits.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care, treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help. Patients said staff gave them information and help to access other services.

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

While managers at Ashley House had measures in place to comply with same sex accommodation due to the layout and position of the male toilet and bathroom facilities there had been an incident in November 2019, when a gentleman's privacy and dignity had been compromised. The manager was aware of the issue and had reported it accordingly. In addition,

the manager had discussed and consulted with patients about proposed plans to reduce the chances of a similar thing happening again. Community meeting minutes showed that patients had rejected the plans and any further attempts to reduce the likelihood of this happening again were on hold. We were concerned that not taking any action could lead to a further incident occurring.

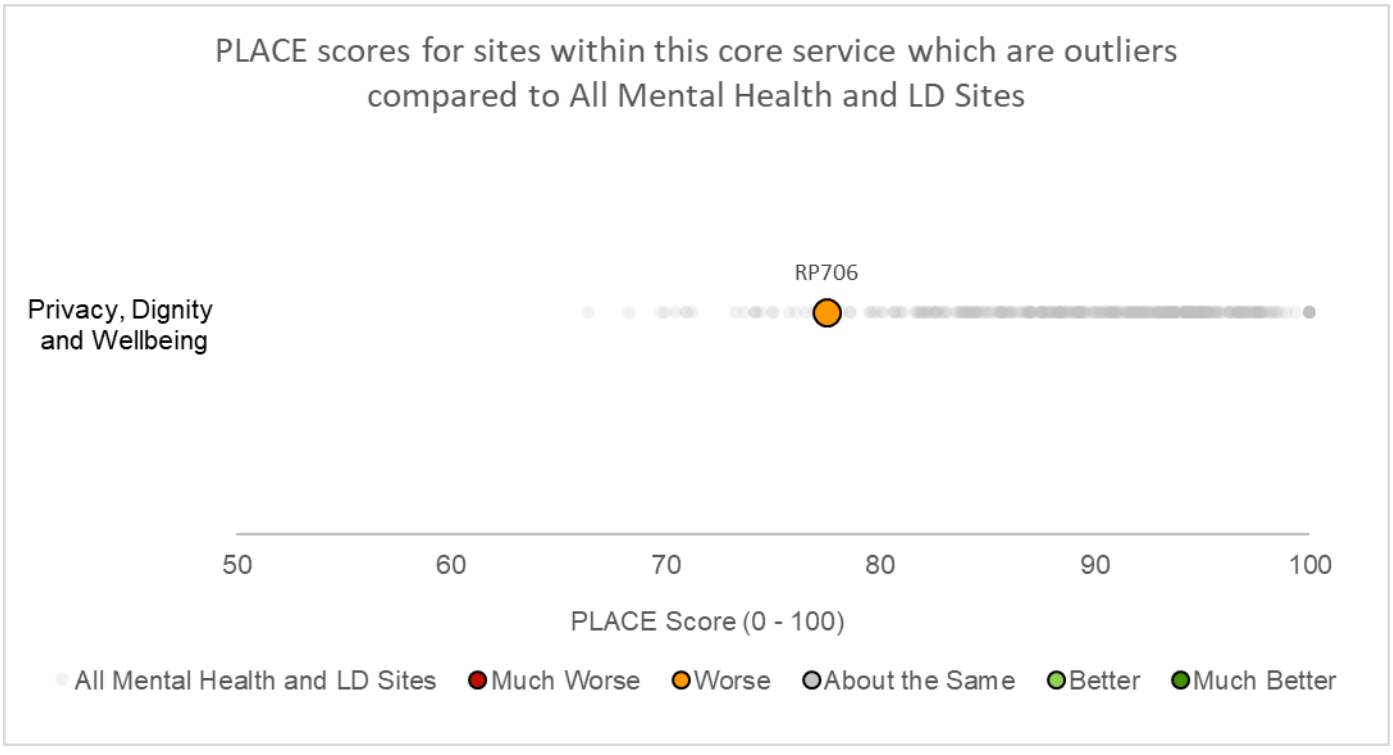
Staff followed policy to keep patient information confidential.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), Ashley House scored worse than the average for privacy, dignity and wellbeing. The scores for this site are shown in the tables below and in Figure 8. In Figure 8, the site is shown as larger circles and their rating compared to similar sites is indicated by the colour. Other sites of the same type are shown as smaller white circles for context.

The scores for the other sites were found to be about the same as the England average when compared to sites of a similar type and as such have not been included in the table or Figure 1.

Site name	Privacy, dignity and wellbeing
Ashley House	77.5%
Trust overall	**85.8%**
England average (mental health and learning disabilities)	**91.0%**

Figure 8



Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Patients could give feedback on the service and their treatment and staff supported them to do this through patient focus groups and regular ward community meetings.

Staff made sure patients could access advocacy services.

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning. and risk assessments.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Staff involved patients in decisions about the service, when appropriate.

Involvement of families and carers

Staff supported, informed and involved families or carers.

Staff helped families to give feedback on the service through feedback forms and carers forums.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Access and discharge

Staff managed beds well. A bed was available when needed and staff did not move patients between wards unless this was for their benefit. Staff rarely delayed discharge for other than clinical reasons.

Bed management

Bed occupancy was often above the national average of 85% however managers were holding regular bed meetings to ensure they were making good use of the beds available. At the time of inspection there were two out of area placements and one patient who had been waiting two weeks to be admitted.

The trust provided information regarding average bed occupancies for five wards in this service between 1 November 2018 – 31 October 2019.

All five wards within this service reported average bed occupancies ranging above the national benchmark of 85% over this period.

Ward name	**Average bed occupancy range (1 November 2018 – 31 October 2019)**
Ashley House	87% - 99%
Maple Lodge	57% - 99%
The Fens	99% - 100%
The Vales	74% - 100%
The Wolds	85% - 100%

Patient length of stay (LOS) is an important indicator of the quality of patient care and the effectiveness of the care pathway. Having a clear expected length of stay is a marker of the degree to which a service adopts a recovery orientation.

Data relating to length of stay provided at the time of inspection was as follows:-

Average length of stay across the service was 516 days. The trust said their maximum length of stay should be 547 days. This is within the Longer-term High Dependency Rehabilitation services guidelines of 1-3 years (364 to 1,092 days).

The shortest stay was Fens ward at 43 days, the longest stay was Ashley House at 1,645 days. Though we heard how a bespoke care package had now been secured to allow this patient to move on. The next longest stay patient was 856 days. Again, we heard of the plans that were in place to secure a move on placement for this patient in the following two months.

Managers acknowledged that on Fens ward the average length of stay was an upward trend and thought this was due to the increased demand for beds for patients transferring from acute and forensic services in the trust to rehabilitation beds. Of all five wards Fens ward tended to take the more complex rehabilitation patients.

Key:

Variation			
			
Common cause - no significant change	Data is not stable and may be subject to ongoing change	Special cause - concern due to upward trend/ shift/ outlier	Special cause - improvement due to downward trend/ shift/ outlier

Trust data on active inpatient length of stay (1 November 2018 – 31 October 2019)

Ward name	Expected minimum LOS (days)	Expected maximum LOS (days)	Average LOS of inpatients (days)*	Change over time	Commentary
Ashley House	90	547	257		Patient LOS is not stable and may be subject to ongoing change
Maple Lodge	90	547	123		Patient LOS is not stable and may be subject to ongoing change
The Fens	90	547	428		Increasing trend from April 2019 to October 2019 and upward shift from May 2019 to October 2019, which could be an indicator of deterioration
The Vales	90	547	509		Common cause - no significant change

The Wolds	90	547	194		Common cause - no significant change

* Weighted average of monthly figures

This service reported no out-area placements between 1 November 2018 to 31 October 2019.

Managers and staff made sure they did not discharge patients before they were ready. We also saw evidence of how staff and managers had worked hard to facilitate comprehensive and bespoke packages of care for some patients whose needs were such that regular community social and healthcare would not be enough to meet their needs.

This service reported no readmissions within 28 days between 1 November 2018 and 31 October 2019.

When patients went on leave there was always a bed available when they returned.

Staff did not move or discharge patients at night or very early in the morning.

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends.

Discharge and transfers of care

Staff managed discharges and transfers of care well. All patients had discharge care plans. The service followed national standards for transfer.

Between 1 November 2018 and 31 October 2019 there were 52 discharges.

Delayed discharges across the 12-month period was 16 and ranged from none to two per month.

At the time of inspection, we heard of two delayed discharges across the wards. This was a reducing number since October 2019. Managers monitored the number of delayed discharges.

The only reasons for delaying discharge from the service were clinical.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Except for Ashley House and Maple Lodge each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. Patients could personalise their bedrooms. At Ashley House and Maple Lodge females had en-suite bedrooms but males did not.

There were quiet areas for privacy. The food was of good quality, staff encouraged and supported patients to self-cater whenever possible and all patients could make hot drinks and snacks at any time.

Staff used a full range of rooms and equipment to support treatment and care. The service had quiet areas and a room where patients could meet with visitors in private, and patients could make phone calls in private.

Each ward had outside space that patients could access easily. However, staff had locked the access door to the rear garden at Wolds ward and categorised the rear garden as a high-risk ligature area. There was no evidence that staff had reviewed this restriction in the previous three months. Staff mitigated this potential blanket restriction by opening a second garden area on the ward for patients use, however this limited patients choice as to which garden they could go to.

The sites which deliver mental health -In this case Long stay/rehabilitation mental health wards for working age adults within Lincolnshire Partnership NHS Foundation Trust were compared to other

sites of the same type and the scores they received for ‘ward food’ were found to be about the same as the England average.

Patients’ engagement with the wider community

Whenever staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. However, at Ashley House staff told us that they only had very limited occupational therapy input and did not always have enough staff with the right experience and knowledge of the patients to assess for work and educational opportunities or to facilitate all the activity’s patients would have liked to do off site.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and keep relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service supplied a variety of food to meet the dietary and cultural needs of individual patients. Staff encouraged and supported patients to self-cater as part of their ongoing rehabilitation programmes.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), Ashley House, Discovery House and Maple House scored worse than the average for the environment being dementia friendly and Ashley House scored worse than the average for the environment supporting those with disabilities. The scores for these sites are shown in the table below and in Figures 9, 10 and 11. In Figures 9, 10 and 11, the sites are shown as larger circles and their rating compared to similar sites is indicated by the colour. Other sites of the same type are shown as smaller white circles for context.

Site name	Dementia friendly	Disability
Ashley House	64.3%	61.1%
Discovery House	64.7%	72.4%
Maple House	65.9%	85.2%
Trust overall	**70.5%**	**80.4%**
England average (Mental health and learning disabilities)	**88.3%**	**87.7%**

Figure 9 (Ashley House)

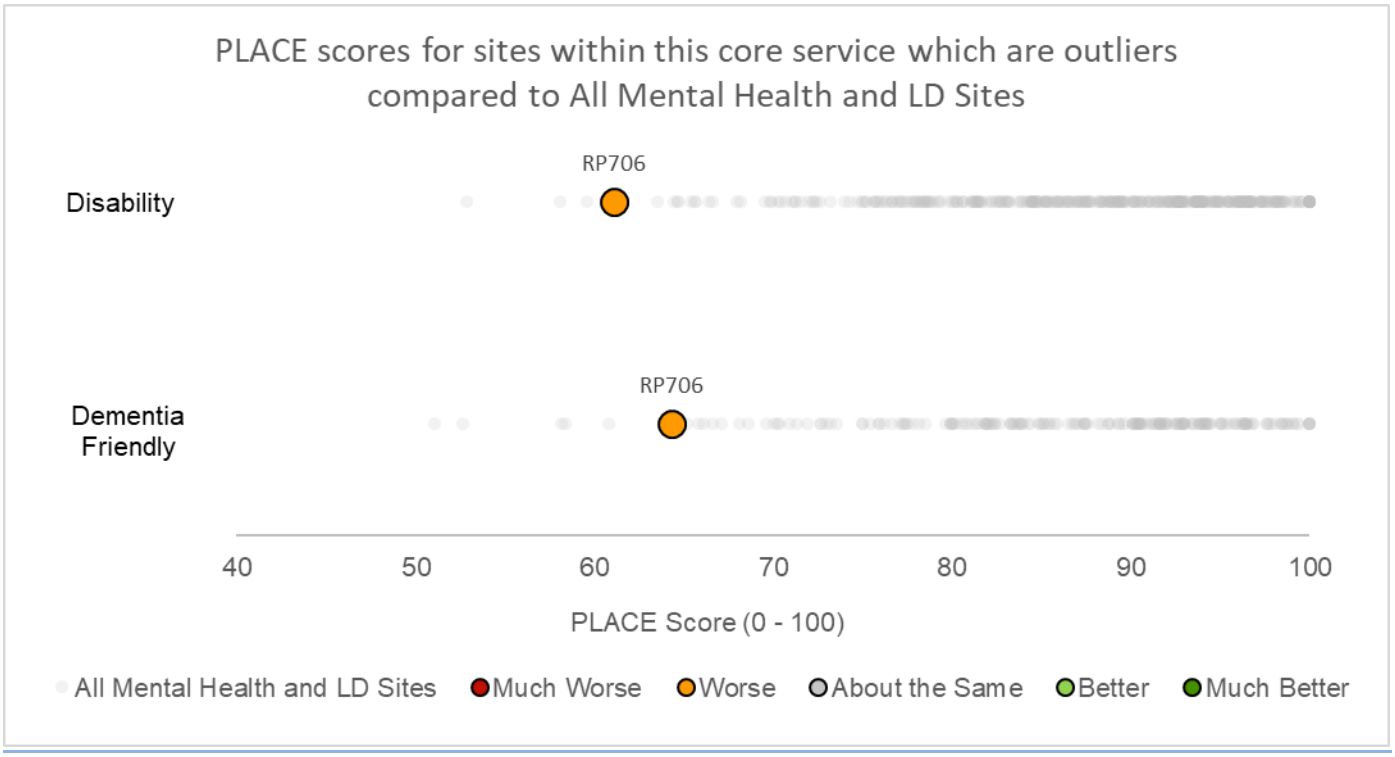


Figure 10 (Discovery House)

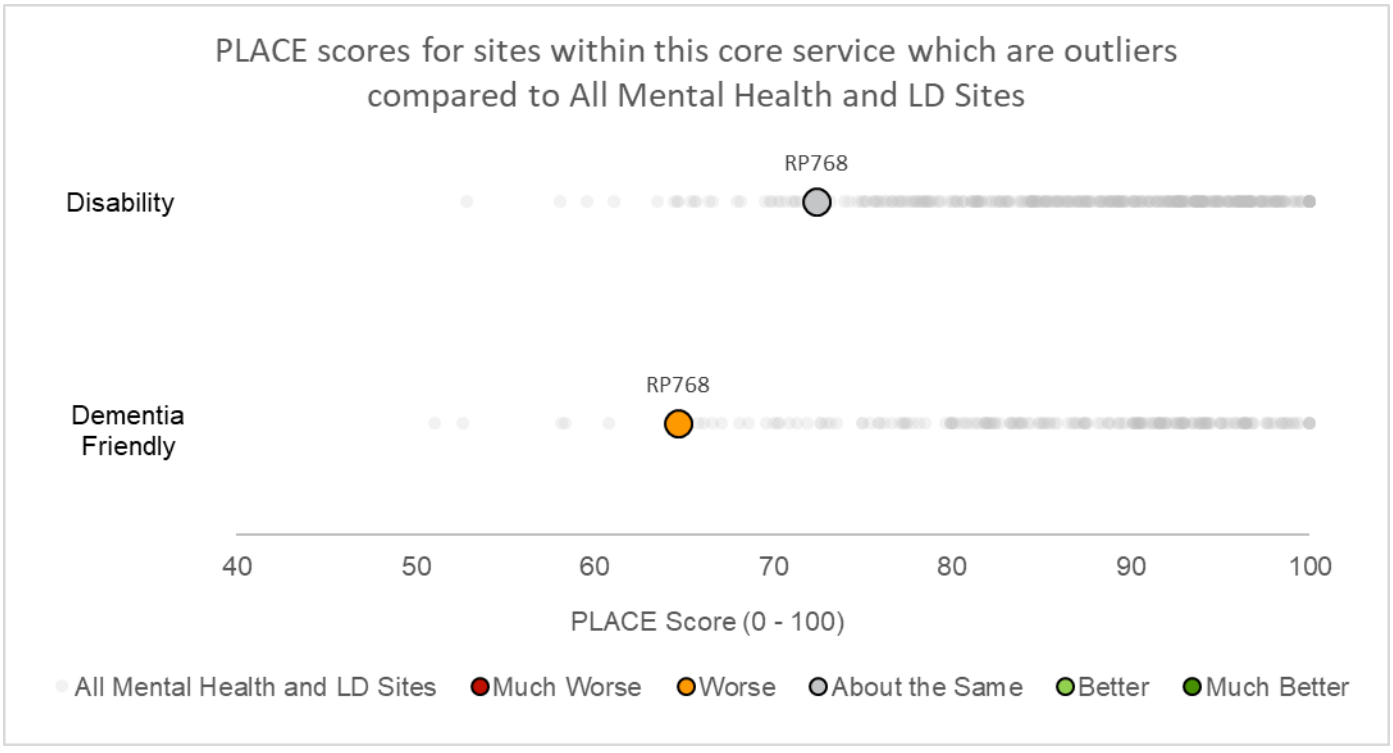
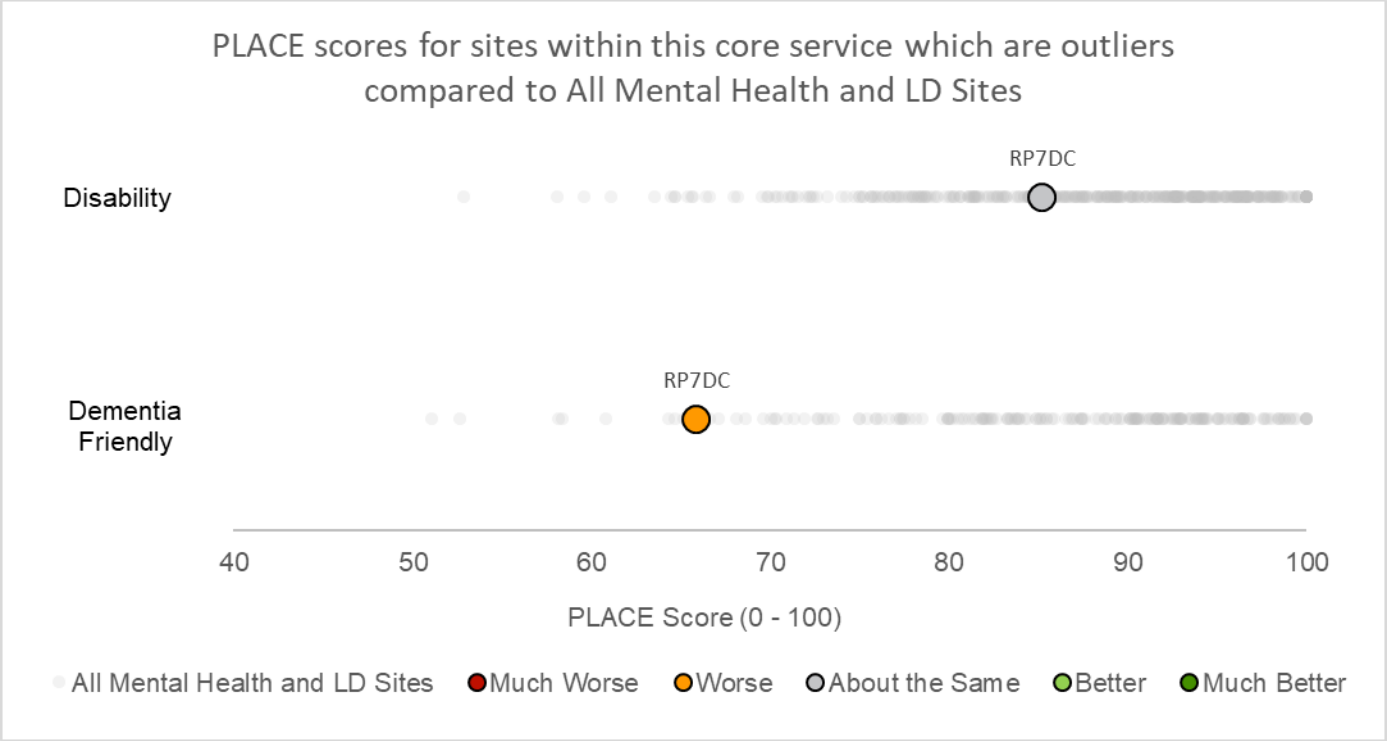


Figure 11 (Maple Lodge)



The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed.

Staff made sure patients could access information on treatment, local services, their rights and how to complain.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

This service received four complaints between 1 November 2018 and 31 October 2019. One of these was upheld, two were partially upheld and one was not upheld. None were referred to the Ombudsman.

Ward name	**Total Complaints**	**Fully upheld**	**Partially upheld**	**Not upheld**
Maple Lodge	**2**	1	0	1
The Fens	**1**	0	1	0
The Wolds	**1**	0	1	0

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld
Total	**4**	**1**	**2**	**1**

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and used the learning to improve the service.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

The service used compliments to learn, celebrate success and improve the quality of care.

This service received 189 compliments during the last 12 months from 1 November 2018 to 31 October 2019 which accounted for 3% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. They were visible in the service and supported staff to develop their skills and take on more senior roles.

Vision and Strategy

Staff were unable to clearly articulate the current model of rehabilitation being provided across the five wards. Staff showed a lack of clarity about the future of the inpatient service. While the managers vision for the future of rehabilitation and recovery services was clear, and we recognised that the trust was focusing on a transformation of the rehabilitation service which will include both inpatient and community rehabilitation. We found limited evidence and were not assured that these plans had been shared fully or understood by the staff delivering the rehabilitation programme.

Culture

Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear.

Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. Managers ensured they dealt with risks at the proper level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

Information Management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The service had integrated and secure information systems.

Engagement

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage services. It collaborated with partner organisations to help improve services for patients.

Learning, continuous improvement and innovation

All staff were committed to continually improving services and had a good understanding of quality improvement methods. Leaders encouraged innovation and participation in research.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	**Service accredited**
AIMS - Rehab (Rehabilitation wards)	Maple Lodge, Boston (October 2019) The Fens, Lincoln (October 2018) The Vales, Lincoln (October 2018) The Wolds, Lincoln (October 2019) Triangle of Care awarded from Carers Trust (May 2019)