Lincolnshire Partnership NHS Foundation Trust

Evidence appendix

Trust Headquarters, St. George's
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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

The trust had nine locations registered with the CQC (on 20 August 2018

Registered location	Code	Local authority
Trust Headquarters	RP7X3	Lincolnshire
Witham Court	RP7CG	Lincolnshire
Mental Health Unit, Lincoln County Hospital Site	RP7EV	Lincolnshire
Mental Health Unit	RP7LA	Lincolnshire
Maple Lodge	RP7DC	Lincolnshire
Manthorpe Centre	RP7RV	Lincolnshire
Long Leys Road	RP705	Lincolnshire
Beaconfield Centre	RP7MB	Lincolnshire
Ash Villa	RP7MA	Lincolnshire

The trust had 247 inpatient beds across 15 wards, 13 of which were children's mental health beds. The trust also had 10 outpatient clinics a week and 12 community clinics a week.

Total number of inpatient beds	**247**
Total number of inpatient wards	15
Total number of day case beds	0
Total number of children's beds (MH setting)	13
Total number of children's beds (CHS setting)	0
Total number of outpatient clinics a week	10
Total number of community clinics a week	12

Is this organisation well-led?

Leadership

The trust had a senior leadership team in place with the appropriate range of skill, knowledge and experience to perform its role. Whilst there had been recent changes to the executive team this had been strategically planned to ensure that the changes were implemented effectively with minimal impact on the running of the trust. The executive board members were proactive, accomplished, open and responsive to feedback and passionate about improving the organisation.

The chief executive had been in post since July 2014 and the chair since May 2015. There were six non- executive directors who had a wide range of previous and suitable experience. The board had ensured that the non-executive directors terms had been appraised and roles reviewed to align with the Single Oversight Framework.

The trust leadership team had a comprehensive knowledge of current priorities and challenges across all sectors and acted to address them. The board were supportive to the wider health and social care system, with the chair, chief executive and executive team having key roles in the local system including the Sustainability and Transformation Plan. The trust was in a strong position within the system to influence care for all the people in the county.

Under the leadership of the new chief pharmacist the trust were actively involved in the medicines works streams of the Lincolnshire sustainability and transformation partnership to ensure mental health therapies were considered across the area.

The chief executive was experienced with over 20 years of leadership in mental health medical practice. He has an extensive career history of managerial roles before joining the trust as medical director in 2011 and then gaining the role of chief executive in 2014. The director of finance has held several senior finance roles within the NHS for the past 14 years. She joined the trust as deputy director of finance in April 2015 and was appointed as director of finance in April 2017. The director of nursing, allied health profession and quality was appointed to the current position in January 2016. She has worked in the NHS for over 30 years in nursing and senior leadership roles. To her credit she has received several awards and scholarships. When the chief executive leaves the trust at the end of the year, she will become the interim chief executive. The trust chair has had a career in several senior leadership roles within the third sector. These included chief executive and non-executive director positions. Several executive members had mental health clinical experience, physical health clinical experience whilst only one had experience working within commissioning and the acute sectors.

The trust board and senior leadership team displayed integrity and the values of the trust on an ongoing basis. The trust's non-executive members of the board were challenging, holding the executive team to account to improve the performance of the trust. The trust leadership team had

a comprehensive knowledge of current priorities and challenges and took action to address them. The leadership team had worked hard not only to model behaviours and practices that underpin the values of the trust but to ensure that these behaviours were embedded across the trust.

The workplan for the trust medicines management team aligns with the trust priorities and is based on national guidance for medicines management in mental health. The new chief pharmacist has completed a scoping document which covered all aspects of medicines optimisation in the trust. From this medicine optimisation priorities and risks have been identified as well as an overall view of pharmacy team staffing to support developments.

The trust is defined by NHS Improvement as a 'segment 1' organisation (providers with maximum autonomy: no potential support needs identified. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance). NHS Improvement defined segmentation as: 'level of support needed across the five themes. The segment in which a provider is placed is determined by the extent and nature of the issues they need to address, and the level of support we have decided is appropriate'. This had increased since the last inspection in 2017.

When senior leadership vacancies arose the recruitment team reviewed capacity and capability needs. The trust had a robust appointment process for all board directors, with strong focus on the changing environment and skill sets required. The chief executive is leaving the trust at the end of December however, the trust had appointed an interim chair, that has worked in the trust since 2016 in the role of The Director of Nursing, Allied Health profession and Quality. The medical director left the trust in October 2018. An interim medical director had been appointed. The interim medical director has worked at the trust since 2015 as the clinical director of adult inpatient services. Three non-executive director posts are currently being recruited to. The boards' plan is to appoint in advance of the current non-executives in those posts departing, to enable a handover period. The trust completed exit interviews on resignation/end of term of office for both executive and non-executive directors.

The board of directors and governors completed a programme of board visits to services, with a focus on talking to staff on the ground. In the last 12 months there had been 400 executive visits throughout the trust. Across all services, staff told us that leaders were approachable, their local managers were supportive and senior leaders were visible within their services. Staff across all services spoke highly of the executive team and chair without exception.

The trust had a lead for child and adolescent mental health, learning disability and autism.

Fit and proper persons checks were in place. We reviewed the personnel files of senior staff and found that checks were carried out, disclosure and barring checks were completed on appointment and within the last three years. There was an annual declaration of interests and records maintained of professional qualifications and registrations with expiry dates present. Appraisals were completed, with actions identified.

The trust demonstrated a strong focus on leadership development. As part of the NHSI Culture and Leadership Programme delivery phase three. The trust had developed 'living the values as a leader in LPFT' programme which will be rolled out imminently. The trust offered a variety of leadership programmes for all grades of staff which focussed attention on leaders and leadership development through training, coaching, mentoring, support and listening to feedback. The programmes had all been aligned to national leadership directives and aligned with the STP and the 5 Year Forward View to ensure that the trust was developing forward thinking leadership capabilities and fit with the continuous quality improvement ethic. We heard about the positives

effects of these schemes from staff throughout all levels of the organisation. The board had undertaken significant board development, and this was valued by all board members.

The trust demonstrated succession planning at board level. The trust people strategy outlined the key aims over the next four years and identified that internal talent needed to be recognised to support succession planning in to key roles. To achieve this the trust have worked closely with Health Education England and the local action workforce boards to support all aspects of workforce planning.

The executive board had 0% black, minority ethnic (BME) members, and 31% women.

The non-executive board had 8% BME members and 8% women.

	BME %	BME (Number)	Female %	Female (Number)
Executive	0%	0	31%	4
Non-executive	8%	1	%	1
Total	8%	1	39%	5

Vision and strategy

The trust had a clear vision and set of values with quality and sustainability as the top priorities. These had been co-produced with staff at all levels and patients. The trust vision was, 'Making a difference to support people to live well in their communities'. The values that underpinned the vision were:

- Compassion – Acting with kindness
- Pride – Being passionate about what we do
- Integrity – Leading by example
- Valuing everybody – using an inclusive approach
- Innovation – Aspiring for excellence in all we do
- Collaboration – Listening to each other and working together.

Values were embedded throughout the trust through recruitment, new initiatives, staff appraisals and staff wellbeing. The leadership team and the staff we spoke with during the inspection of services were able to discuss the values and what they meant to the service they provided. In addition to the vision and values the trust had identified specific behaviours that aligned with each value so they close alignment within their services. Each individual team across the trust had taken time to ensure that they understood what the values and behaviours meant for their individual teams and the patients that they provided care for. At board and committee meetings discussions were consistently linked to the values. The values, vision and behaviours were visible on the trust website, intranet and notice boards across all services.

The trust had a robust and realistic strategy for achieving trust priorities and developing good quality, sustainable care.

The strategy is also highlighted via the 'Inspirational Leadership Events'. The events were held quarterly and attended by all staff Band 7 and above. Messages were cascaded down to staff at all levels through this forum. The Trust also used its Annual General Meeting as a showcase for the trust, which is a full day event at the Learning and Development Centre.

The trust promoted and upheld their values through their presenting staff with awards and publishing the 'Book of Brilliance' which shares learning, external awards and trust services successfully accredited. In the last 12 months 258 nominations had been made for recognition of staffs' dedication and commitment. We were impressed how well the vision and values were considered in all areas across the trust including aspects of care provided to patients and included service re-design.

We observed that the trust's vision and values were embedded at board level and informed how the senior leadership team operated. This was also evident throughout the services we inspected. The board culture was open, collaborative, positive and honest. All trust board meetings begin with the patients' voice or a presentation from a team of staff to share their experiences or innovative ways of providing care. It was pleasing to see that the board had an exclusive approach, valued their patient and staff voices and worked alongside them.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. The trusts intention is to improve the sustainability of care provided by the system as a whole, including involvement in the Acute Services Reconfiguration and Out of Hospital Care reviews currently taking place in Lincolnshire.

The Trust maintains an open dialogue with its regulators on the challenges it faces. It has communicated clearly with NHSI on the financial risks and operational challenges it is managing. In 2017/18 the Trust achieved a financial surplus of £1.143m. This was £595k better that their financial control total, (excluding sustainability transformation fund). For 2018/19, the Trust had accepted its control total of a £242k surplus (excluding provider sustainability fund). At month six end 2018/19 the trust is resubmitted a revised plan showing an improved outturn position of a £581k surplus.

A key challenge for the Trust is the ability to recruit substantively to some consultant posts. The Trust has taken action to identify workforce priorities and is reviewing its establishment. In 2017/18 the Trust did not deliver its agency ceiling of £2.14m, it was exceeded by £834k.

The trust had a robust and realistic strategy for achieving trust priorities and developing good quality, sustainable care. The trust had identified key priorities that supported their vision of enabling people to live well in their communities. The strategy and vision for high quality, sustainable care is set out in its operational business plan. The operational plan clearly outlined that patients, staff and working in partnership with other organisation to develop clinical and financially sustainable health care services for the people of Lincolnshire. The plan embedded a culture of co-production, both internally and externally, by developing people, working collaboratively with partners and to strive for continuous learning to ensure that the services they provided were the best they can be, and the patients, staff and stakeholders had the best possible outcomes and experience of care. The operational plan was aligned to the trust clinical strategy and the local sustainability and transformation plan. The strategy had been promoted within the organisation and is visible to staff throughout the organisation.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about trust strategy through a robust plan of engagement, especially where there were plans to change services.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local places. This was communicated to staff, patients and external partners in a co-ordinated manner using newsletters, intranet, blogs, social media and personal visits.

Local providers and people who use services had been involved in developing the strategy. Throughout the redevelopment of the strategy the trust consulted staff, council members, key stakeholders, including the clinical commissioning groups, local authorities, governors, the CQC and the voluntary sector.

The trust was responsive to challenge and worked collaboratively with stakeholders, other local NHS trusts and the third sector to deliver services to patients. This was confirmed by commissioner and other stakeholders throughout the inspection process.

A pharmacy and medicines optimisation workplan has been developed with priorities and timescales for delivery. The trust were expanding their pharmacist team to include a full time Community Mental Health Team pharmacist and planned to use this resource to address some of the inconsistencies in CMHT prescribing across the trust localities. In addition, a lead for development and training was appointed on a fixed term contract which will now be substantive. This supports the trusts strategy to improve the training and competence of the pharmacy team to support retention and recruitment as well as provide an enhanced clinical service. The trust has accessed Health Education England funding to provide mental health diploma training for pharmacists. Staff we spoke to are clear on their role in delivering the priorities for medicines optimisation, pharmacy team interventions were monitored and staff are supported to identify ways of achieving longer term goals.

The trust had a strategy for meeting the physical healthcare needs of inpatients with mental health needs. The strategy had been developed in partnership with patients and staff and underpinned by best practice and aligned with the trusts quality priorities. This was confirmed by our findings during the inspection of the core services where patients' physical health care needs were assessed and responded to appropriately. 428 staff had completed the physical healthcare improvement and learning in practice training.

Culture

The trust's strategy, vision and values underpinned a culture which was patient centred. We were particularly impressed with the caring and compassionate attitudes of staff across all services we visited. Staff consistently demonstrated that patients were at the heart of every interaction. This included working collaboratively with families, carers and outside agencies to achieve their desire of providing first class patient care.

Leaders showed an inspiring positive culture with a shared purpose towards the vision, values and strategy. Leaders modelled and encouraged compassionate, inclusive and supportive relationships between all grades of staff. Leaders at every level lived the vision and prioritised high quality sustainable and compassionate care. Staff showed pride and talked passionately about their roles.

Staff and leaders demonstrated a culture of putting the patient first and co-production. The trust had a patient engagement programme which supports on going involvement of patients to support the transformation of the trust. In the child and adolescent service, learning disability service, adult community team and specialist rehabilitation wards the trust had employed peer support workers, experts by experience and clinical apprentices to strengthen the voice and the participation of the patients. The trust had invested in these patients and provided training and mentorship to them.

The trust had recently employed carers lead to promote the involvement of carers within the trust. This role has supported the community mental health teams and the wards to hold carers groups on a monthly basis.

Staff felt respected, supported and valued. Across all services staff told us that the relationships they have with colleagues and local managers were very supportive and that they staff would go the extra mile to support colleagues. Staff showed pride and spoke passionately about their roles and working for the trust, their personal progression, opportunities to access specialist training and open and transparent relationships with senior colleagues. We were impressed at how the culture had been embedded and promoted an arena across the trust for shared learning and encouragement of staff to offer ideas to improve service delivery and patient experience.

Staff received annual appraisals and used this time to discuss their learning and career development needs. Staff we spoke with stated that they all had regular supervision. Whilst we recognised since the last inspection the trust had taken action in order to promote staffs experience of and the reporting of clinical supervision, the recording of supervision remained an issue. However, we note the compliance figures were on an upward trajectory and were confident that this would continue to increase.

The chief pharmacist did a lot of team building and demonstrating effectiveness work when she joined the trust 14 months ago. Improving communication in the pharmacy team was identified as a key priority. This is being achieved through regular meetings and group supervision sessions. All pharmacy staff have had an annual appraisal and retention rates have improved within the team. All the staff we spoke to were positive about working in the pharmacy team for this trust. This work had facilitated a re-purposing of the pharmacy team to better meet the needs of the trust.

Managers addressed poor performance of staff where needed. Staff and leaders reported that the level of disciplinary actions taken against staff had reduced by 75% in the last twelve months. Due to the revision of the disciplinary policy to include lessons learnt, pre and post investigation, the culture had moved from what was perceived by staff as a culture of blame to one that was based on a lesson learnt approach. The trust had designed the holistic approach and staff were given the opportunity to learn and develop in a supportive framework to become the best that they can be through further development or retraining.

The board supported leaders across the trust and held them to account in a fair and supportive way. The trust had implemented a mediation service managed by the human resources team. This service advocated the use of mediation scheme for the maintenance of high quality employment relationships between all staff and to manage conflict solutions. The trust had trained ten mediators that were able to be deployed to carry out mediation across the trust.

The trust worked appropriately with trade unions. Staff side representatives held monthly meetings with the human resources department, attended by the deputy directors and were involved in consultations when the trust planned changes to services or provisions.

The trust encouraged staff to feel confident to raise concerns openly. Staff we spoke to all felt able to raise concerns without fear of retribution and knew how to use the whistle blowing procedure and about the role of the Speak up Guardian. A freedom to speak up guardian had been in place for eighteen months and the trust had provided them with sufficient resources and support to help staff raise concerns. Freedom to speak up guardians are intended to provide impartial and independent advice to NHS workers, and to foster a culture of safety and learning. The trust had a raising concerns and whistleblowing policy. The policy met the standards set out in the national ‘Freedom to speak up: raising concerns (whistleblowing) policy for the NHS (NHS Improvement April 2016).

In services across the trust there were speaking up champions to support and signpost staff when needed. From June 2017 to June 2018 33 concerns were raised. A small proportion of these were raised indirectly but the vast majority came directly from staff members. The staff members who

raised concerns represented a wide range of professions (where disclosed). This highlighted that all staff groups had accepted the responsibility to speak up when needed. As a result of staff raising concerns the trust took appropriate action, learnt lessons and made 13 positive improvements across the organisation.

The freedom to speak up guardian produced an annual report to ensure the board that the policy and the systems are up to date and robust in line with the recommendations of the national guardian's office. They also produced a bi monthly report to the audit committee so that themes, trends and opportunities to learn were shared across the trust and up to the board when required.

The trust applied Duty of Candour appropriately and we saw good examples of this in practice.

The trust had effective systems in place for learning from incidents. Action plans arising from when things went wrong, raised through incidents or complaints, were monitored and reported on. The trust followed a robust process when investigating deaths and there was a specific mortality governance group in place. The trust complied with and exceeded the national guidance on learning from deaths in that they reported all deaths in addition to minimum national expectations. We saw that the trust contacted families and carers for their views and kept them informed. The trust reported all deaths to the CQC and held monthly mortality review meetings, where all deaths are discussed. We reviewed 14 serious incidents of which some result in the death of a patient. All were fully completed, with lessons learnt and upheld duty of candour.

The trust had a clear oversight and had promoted the importance of wellbeing amongst their workforce. The wellbeing service demonstrated the responsiveness of the organisation to support the wellbeing of staff. The service had a dedicated psychological and occupational therapy service which included a dedicated counsellor support for staff experiencing domestic abuse. The service ran gender specific health and wellbeing workshops, for example, man matters and menopause. Sleep groups were in place to promote healthy sleeping patterns for staff. Physical activities were a high priority and the service ran yoga and Zumba classes and 100-day steps challenges. Clinical members of the board were actively involved in administering the flu vaccination to 79% of clinical facing staff. Staff we spoke with throughout the inspection spoke highly of the wellbeing service and acknowledged that the trust had worked hard to deliver a service that met the diverse needs of the staff that worked across the trust.

The trusts equality strategy had been revised and been in place for the last two years. The strategy had been produced to clarify the intentions and obligations of the trust and to openly show their commitment to equality and diversity. It had been ratified by the board in May 2018. The equality and diversity annual report demonstrated the trusts compliance within the Public Sector Equality Duty (2011).

The trust had three active staff networks, meetings took place quarterly:

- MAPLE (Mental And Physical Lived Experience) and Allies Staff Network
- LGBT (Lesbian, Gay, Bisexual and Transgender) and Allies Staff Network
- BAME (Black, Asian and Minority Ethnic) and Allies staff network

These staff network groups provided a platform for staff to voice their opinions and support the trust to improve working practices and services. Each staff network has an executive sponsor, whereby an executive director had committed to championing that group at board level and attending at least one meeting a year to understand the issues being raised by that group. Staff networks also have visible leaders. Visible leaders were people who identified with an equality area and were willing to champion that area and talk about their own experiences.

Diversity champions with Stonewall took part in the annual workplace equality index (WEI) to access how inclusive the trust were for LGBT+ staff. The trust was ranked 148th out of 434 organisations who took place. The trust is one the only organisation in Lincolnshire to be members of the Stonewall and complete the WEI which highlights their commitment to promote the diversity and the equality of their staff. In addition to this the trust is a member of the inclusive employers, employers network for equality and inclusion. The trust is a level two, disability confident employer and had set a two year target to become a level three leader.

Throughout the year the trust had held equality Conferences to raise awareness of equality areas, jointly with Lincolnshire NHS providers and internal staff networks.

The trust was proud to share with us the progression of the multi-agency LGBT+ conference. This year the conference welcomed 210 delegates from 50 organisations, including the voluntary and community sector.

The workforce race equality standard (WRES) was owned by the black and asian and minority ethnic staff network group. This staff network group consider the results of the WRES and set actions based on feedback and real life experiences of staff working across the trust. As a result of this plan, the reverse mentoring initiative was implemented. The executives had all participated in a reverse mentoring programme.

The trust was continuously taking action to improve a culture of high quality sustainable care through innovations and responding to the changes in requirements. They held discussions with commissioners around the sustainability of certain services. The historic financial performance of the trust was supportive of sustainable care, however given the trust's size and scale, the financial position is vulnerable to commissioning changes.

In the 2017, NHS Staff Survey the trust had better results than other similar trusts in 18 key areas:

Key finding	Trust score	Similar trusts average
KF1. Staff recommendation of the trust as a place to work or receive treatment	3.77	3.67
KF2. Staff satisfaction with the quality of work and patient care they are able to deliver	3.94	3.83
KF3. % of staff agreeing that their role make a difference to patients	89%	88%
KF4. Staff motivation at work	3.96	3.91
KF5. Recognition and value of staff by managers and the organisation	3.64	3.59
KF6. % reporting good communication between senior management and staff	42%	36%
KF8. Staff satisfaction with level of responsibility and involvement	3.93	3.88
KF14. Staff satisfaction with resourcing and support	3.43	3.35
KF16. % working extra hours	70%	72%
KF19. Organisation and management interest in action on health and wellbeing	3.91	3.77
KF20. % experiencing discrimination at work in the last 12 months	10%	14%
KF22. % of staff experiencing physical violence from patients, relatives or the public in the last 12 months.	18%	22%
FK23. % of staff experiencing physical violence from staff in last 12 months	2%	3%

KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	26%	32%
KF26. % experiencing harassment, bullying or abuse from staff in last 12 months	18%	21%
KF28. % witnessing potentially harmful errors, near misses or incidents in last month	19%	27%
KF31. Staff confidence and security in reporting unsafe clinical practice	3.76	3.71
KF32. Effective use of patient/service user feedback	3.76	3.72

In the 2017, NHS Staff Survey: the trust had worse results than other similar trusts in one key area.

Key finding	Trust score	Similar trusts average
KF29. % reporting errors, near misses or incidents witnessed in the last month	91%	93%

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 1% and 6%, higher than the England averages for patients recommending it as a place to receive care for five of the six months in the period (January to June 2018). Both March and April 2018 saw the highest percentage of patients who would recommend the trust as a place to receive care with 95%, for each month.

The trust scored lower than 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.

	Trust wide responses				England averages	
	Total eligible	Total responses	% that would recommend	% that would not recommend	England average recommend	England average not recommend
Jun 2018	3737	573	93%	2%	89%	4%
May 2018	3595	617	89%	2%	89%	4%
Apr 2018	3738	534	95%	1%	89%	4%
Mar 2018	20	437	95%	1%	89%	4%
Feb 2018	3283	490	90%	2%	89%	4%
Jan 2018	3555	519	91%	2%	88%	4%

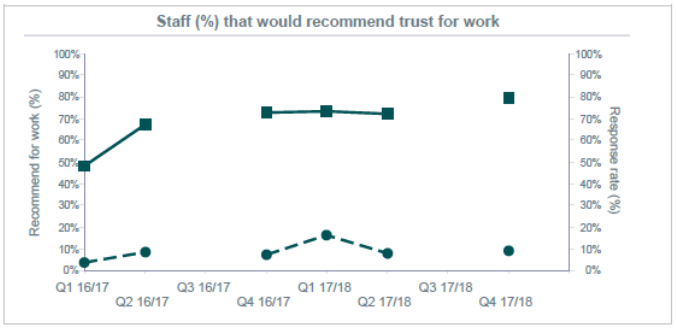
The Staff Friends and Family Test asks staff members whether they would recommend the trust as a place to receive care and also as a place to work.

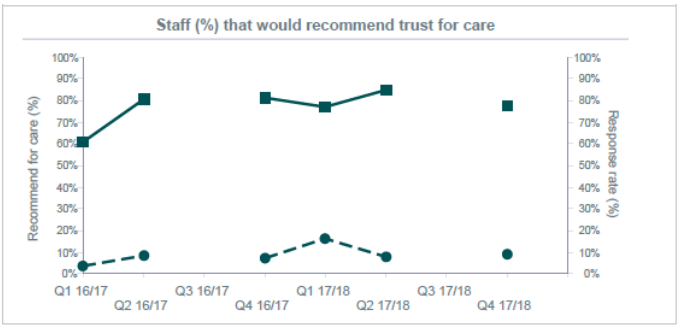
The percentage of staff that would recommend the trust as a place to work in Q4 17/18 increased when compare to the same time last year.

The percentage of staff that would recommend the trust as a place to receive care in Q4 17/18 stayed the same when compared to the same time last year.

Response rates were the lowest in these quarters and are therefore less likely represent the staff views overall.

There is no reliable data to enable comparison with other individual trusts or all trusts in England.





This trust Response rate for this trust

Please note: Data is not collected during Q3 each year because the Staff Survey is conducted during this time

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 30 April 2018	257.4	N/A
Total number of substantive staff leavers	1 May 2017 – 30 April 2018	30.2	N/A
Average WTE* leavers over 12 months (%)	1 May 2017 – 30 April 2018	12%	N/A
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 30 April 2018	172.2	N/A
Total vacancies overall (%)	At 30 April 2018	10%	N/A
Total permanent staff sickness overall (%)	Most recent month (At 30 April 2018)	4%	4.5%
	At 30 April 2018	5%	4.5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 30 April 2018	549.4	N/A
Establishment levels nursing assistants (WTE*)	At 30 April 2018	605.4	N/A
Number of vacancies, qualified nurses (WTE*)	At 30 April 2018	66.3	N/A
Number of vacancies nursing assistants (WTE*)	At 30 April 2018	43.6	N/A
Qualified nurse vacancy rate	At 30 April 2018	12%	N/A
Nursing assistant vacancy rate	At 30 April 2018	7%	N/A
Bank and agency Use			
Bank staff filled to cover sickness, absence or vacancies (qualified nurses) (Hours)	1 May 2017 – 30 April 2018	40081.3 (9%)	N/A
Agency staff to cover sickness, absence or vacancies (Qualified Nurses) (Hours)	1 May 2017 – 30 April 2018	4217.8 (1%)	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 May 2017 – 30 April 2018	144727.5 (31%)	N/A
Bank staff to cover sickness, absence or vacancies (Nursing Assistants) (Hours)	1 May 2017 – 30 April 2018	100481.1 (23%)	N/A

Agency staff to cover sickness, absence or vacancies (Nursing Assistants) (Hours)	1 May 2017 – 30 April 2018	45806.9 (4%)	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	61265.4 (14%)	N/A

*Whole-time Equivalent

As at 31 May 2018, the training compliance for trust wide services was 87% against the trust target of 85%. Of the training courses listed four failed to achieve the trust target and of those, one failed to score above 75%.

The training compliance data is reported on an ongoing monthly basis. Statutory training is reported as part of the monthly board report dashboard produced by workforce and a separate dashboard is provided by the Learning and Development team for all other courses classified by the trust as role essential.

The training compliance reported for the trust during this inspection was lower than the 92% reported at the last inspection (3 April 2017).

Key:

Below CQC 75%	Met trust target	Not met trust target	Higher	No change	Lower	Error
	✓	✗	↑	→	↓	N/A

YTD (Current Period)	Target	Number of staff eligible	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults - Level 1 - 3 Years	85%	1700	1588	93%	✓	↓
Health, Safety and Welfare - 3 Years	85%	1700	1550	91%	✓	↓
Information Governance - 1 Year	95%	1700	1543	91%	✗	↓
Safeguarding Children (Version 2) - Level 1 - 3 Years	85%	1700	1548	91%	✓	↓
Equality, Diversity and Human Rights - 3 Years	85%	1700	1526	90%	✓	↓
Moving and Handling - Level 1 - 3 Years	85%	1700	1518	89%	✓	↓
Domestic Violence	85%	1700	1459	86%	✓	↑
Resuscitation - Level 2 - Adult Basic Life Support - 3 Years	85%	1007	856	85%	✓	↑
Infection Prevention and Control - Level 1 - 1 Year	85%	976	782	80%	✗	↑
Fire Safety - 1 Year	85%	1700	1319	78%	✗	↑
LSGCB - Female Genital Mutilation	85%	1211	895	74%	✗	↑
Core service total		**16794**	**14584**	**87%**	✗	↑

The trust's target rate for appraisal compliance is 85%. As at 31 May 2018, the overall appraisal rates for non-medical staff was 87%.

Eight of the 12 teams achieved the trust's appraisal rate. The core services failing to achieve the trust's appraisal target were 'Wards for people with mental health problems with 83%, 'Other' with 81%, 'Secure wards/forensic inpatient' with 78% and 'Long stay/rehabilitation mental health wards for working age adults' with 72%.

The rate of appraisal compliance for non-medical staff reported during this inspection is lower than the 92% reported at the last inspection (3 April 2017).

Core Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% of non-medical staff who have had an appraisal
MH - Child and adolescent mental health wards	42	41	98%
MH - Specialist community mental health services for children and young people	133	127	95%
MH - Community mental health services for people with a learning disability or autism	82	75	91%
MH - Community-based mental health services for older people	81	74	91%
MH - Other Specialist Services	318	290	91%
MH – Acute wards for adults of working age & psychiatric intensive care units	187	166	89%
MH - Mental health crisis services and health-based places of safety	140	121	86%
MH - Community-based mental health services for adults of working age.	191	163	85%
MH - Wards for older people with mental health problems	177	147	83%
Other	124	101	81%
MH – Secure wards/Forensic inpatient	32	25	78%
MH - Long stay/rehabilitation mental health wards for working age adults	141	102	72%
Total	**1648**	**1432**	**87%**

The trust's target rate for appraisal compliance is 85%. As at 31 May 2018, the overall appraisal rates for medical staff was 76%.

Three of the nine teams achieved the trust's appraisal rate. The core services failing to achieve the trust's appraisal target were 'Specialist community mental health services for children and young people' with 80%, 'Community based mental health services for adults of working age' with 76%, Long stay/rehabilitation mental health services for adults of working age' with 75%, Other specialist services with 75%, Mental health crisis services and health based places of safety' with 50% and 'Other' with 50%.

The rate of appraisal compliance for medical staff reported during this inspection is lower than the 88% reported at the last inspection.

Core Service	Total number of permanent medical staff who have had an appraisal within the last 12 months	Total number of permanent medical staff who have not had an appraisal in the last 12 months	% appraisals
MH – Acute wards for adults of working age & psychiatric intensive care units	2	2	100%

MH - Community mental health services for people with a learning disability or autism	4	4	100%
MH - Community-based mental health services for older people	12	11	92%
MH - Specialist community mental health services for children and young people	5	4	80%
MH - Community-based mental health services for adults of working age.	21	16	76%
MH - Long stay/rehabilitation mental health wards for working age adults	4	3	75%
MH - Other Specialist Services	8	6	75%
MH - Mental health crisis services and health-based places of safety	2	1	50%
Other	10	5	50%
Total	**68**	**52**	**76%**

The trust does not have a target for clinical supervision. As at 30 April 2018, the overall clinical supervision compliance was 54%.

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

The core services with the lowest compliance were 'Acute wards for adults of working age and psychiatric intensive care units' with 16% and 'Other' with 12%.

Core Service	Formal supervision sessions each identified member of staff had in the period	Formal supervision sessions should each identified member of staff have received	Clinical supervision rate (%)
MH - Community-based mental health services for adults of working age.	2713	3075	113%
MH - Community-based mental health services for older people	887	573	65%
MH - Community mental health services for people with a learning disability or autism	716	430	60%
MH - Secure/Forensic wards	332	198	60%
MH - Specialist community mental health services for children and young people.	2023	1075	53%
MH - Child and adolescent mental health wards	403	169	42%
MH - Mental health crisis services and health-based places of safety	813	324	40%
MH - Other Specialist Service	1130	447	40%

MH - Wards for older people with mental health problems	1505	467	31%
MH - Long stay/rehabilitation mental health wards for working age adults	1417	296	21%
Provider wide	308	66	21%
MH - Acute wards for adults of working age and psychiatric intensive care units	1405	221	16%
Other	25	3	12%
TOTAL	**13677**	**7344**	**54%**

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

	In Days	Current Performance
What is your internal target for responding to* complaints?	3	3
What is your target for completing a complaint?	25	25
If you have a slightly longer target for complex complaints please indicate what that is here	45-60	45-60

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

	Total	Date range
Number of complaints resolved without formal process* in the last 12 months**	217	1 May 2017 to 30 April 2018
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	0	1 May 2017 to 30 April 2018

**Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example, PALS resolved or via mediation/meetings/other actions

This trust received 2,600 compliments during the last 12 months from 1 May 2017 to 30 April 2018. This was higher than the 2,014 reported at the last inspection.

'Specialist community mental health services for children and young people' had the highest number of compliments with 24% (617), followed by 'Other specialist services' with 23% (601) and 'Other' with 12% (321).

Governance

The trust had comprehensive and effective structures, systems and clearly articulated processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures. Ratification of decisions made were taken by the board and the council of governors working collaboratively. This meant that the board had oversight of local challenges, developments and successes.

Non-executive and executive directors were clear about their areas of responsibility. The trust used the organisational risk register and as its board assurance framework to support good governance.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information that were shared publicly on the trust website.

The trust had reviewed the appropriateness of the governance arrangements in relation to the Mental Health Act administration and compliance. They had recognised that this was a key area to strengthen to ensure the best possible outcomes for patients detained under the Mental Health Act. This review led to the implementation of a policy document and flowchart being devised and implemented in both clinical division and corporate teams to highlight the correct procedure for the administration of the Act. Heat maps were produced to identify to teams the proactive reading of patients' rights, reviews of sections and the completeness of the detention paperwork. Audits for Mental Health Act and Community Treatment Orders were clearly documented. The legislative committee had been identified as the committee to oversee the governance arrangements and this committee fed back progress to the board.

The pharmacy team was effectively integrated into trust governance structures. The chief pharmacist, in line with their statutory roles, had direct reporting lines to the trust board. The drug and therapeutic committee had clinical representation and is chaired by the medical director. This demonstrated and assured clinical engagement in medicines management in the trust.

The trust had a medicines supply contract with a local community pharmacy chain. This had been well planned to ensure adequate coverage across the large geographic area of the trust and was managed via three monthly review meetings. The trust contracts manager chaired these. KPIs around timeliness and accuracy of supply are monitored and recent work has identified a focus on shared learning from events.

Individual directorates were held to account by the board on financial, performance and quality. Business portfolios were well defined and owned by an executive director. Risk registers were analysed and reviewed at the relevant performance or quality committees, which fed into the board assurance framework. Risks, risk levels and risk owners were identified. Each identified risk had clear detail of controls, assurances and key actions.

The board oversaw and assured the trusts financial performance at monthly board meetings. Any investments were reviewed by the trust's investment appraisal framework, which required sign off firstly by the operational delivery team and then by the strategic delivery team. The strategic delivery team can sign off up to £1m, anything above this the decision would be taken to the quarterly finance and performance committee meetings before going to board for ultimate sign off. Anything capital related must go through the trust's capital Investment Team for approval first.

Exceptional finance and performance committee meetings were held to approve investments as per the trust's investment framework. For any items to be approved they must meet the trust's seven seals of approval, which include; Finance, Quality, deliverability and Reputational impact.

The delivery of the financial efficiency programme (CIP) is monitored weekly by the trust leadership team and tracked quarterly through finance committee. Regular updates regarding CIPs were provided to NHS Improvement by the Trust.

A partnership arrangement was in place for the provision of psychiatric liaison services. This was supported by the mental health, older adult, child and adolescent, and learning disability liaison teams. Staff in these teams were employed by the trust and worked directly in the accident and emergency department of the local acute hospital. We reviewed the governance arrangements

were in place for these services and found that they were appropriate. In addition to this the governance structure in relation to physical healthcare were robust and reviewed in line with trust strategy.

The trust have provided their board assurance framework, which details any risk scoring 15 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The three strategic principles with 10 sub priorities outlined by the trust relating to this core service are as follows:

1. Improving service quality:
    a. More people will have good mental health
    b. More people will have a positive experience of care and support
    c. More people with mental health and learning disability problems will have good physical health.
    d. Fewer people will suffer avoidable harm
    e. Promote recovery and independence
2. Using resources more effectively:
    a. Support our people to be the best they can be
    b. Maximise NHS response
    c. Ensure our estate is fit for modern healthcare delivery
3. Retaining and developing the business:
    a. People will have better access to LPFT services
    b. Support integrated health and social care in Lincolnshire

The trust provided a document detailing its highest profile risks. Each of these had a current risk score of 15 or more

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Last review date
69	Inability to achieve financial control targets in 2018/19	15	15	6	11/05/2018
74	Ash Villa will be going out for tender. There is a risk that Lincolnshire will not have an inpatient resource in Lincolnshire to meet the needs of very complex children and young people with mental health needs if LPFT do not win the tender. Children & Young people will then have to go out of county to receive this treatment	12	16	4	04/05/2018
70	Sec 75 Social care Operational delivery – service user safety and quality of care due to limited	20	16	12	14/05/2018

	staffing. Sec 75 contractual obligations will not be met				
63	Silverlink clinical system is difficult to navigate and to find clinical information in an effective way. The system is also end of life and unless a new system is implemented, LPFT runs the risk of not having a viable operational clinical system.	16	16	8	10/05/2018
20	Reduction in service provision for patients on Clozapine leading to reduced monitoring	20	20	8	14/08/2018
21	There is a risk of the trust being hit with a Cyber-attack. This could lead to a loss of data and damage to our reputation. Any loss of systems due to Cyber-attack would also have an impact on the day to day running of the trust	15	20	10	10/05/2018
19	Difficulties in recruiting substantive consultant and SAS medical staff: We are employing agency and fixed term trust contract Locum Psychiatrists on a regular basis which whilst maintains safe staffing potentially leads to a lack of consistency in patient care.	16	16	8	16/05/2018
18	Patient safety could potentially be compromised due to staff shortages, unfilled shift and over reliance on agency staff	16	16	8	02/05/2018

The trust has provided a document detailing their 10 highest profile risks. Each of these has a current risk score of 15 or higher.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Last review date
69	Inability to achieve financial control targets in 2018/19	15	15	6	11/05/2018
77	Currently there is a lack of parity in the provision of Psychology between Lincoln and Boston in patient services, there is a WTE in Lincoln covering Conolly and Charlesworth	15	15	2	No date

	and no cover for ward 12 with maple lodge only receiving one day per week for 15 patients. This contravenes standard 1 for AIMS accreditation and creates disparity for treatment localities.				
70	Sec 75 Social Care Operational Delivery - ***** Service user safety and quality of care due to limited staffing. Sec 75 contractual obligations will not be met.	20	16	8	15/06/2018
18	Patient safety could potentially be compromised due to staff shortages, unfilled shift and over reliance on agency staff	16	16	8	26/06/2018
19	Difficulties in recruiting substantive consultant and SAS medical staff: We are employing agency and fixed term trust contract Locum Psychiatrists on a regular basis which whilst maintains safe staffing potentially leads to lack of consistent in patient care	16	16	8	16/05/2018
62	There is no current long term SLA with AGEMs and the contract is a rolling monthly contract. This presents risks to the trust of AGEM supporting the trusts strategic priorities. AGEMs capacity and capability exposes the trust to non-delivery in key areas, such as replacement of clinical systems and cyber security	16	16	4	10/05/2018
63	Silverlink clinical system is difficult to navigate and to find clinical information in an effective way. The system is also end of life and unless a new system is implemented, LPFT runs the risk of not having a viable operational Clinical System.	16	16	8	10/05/2018
74	Ash Villa will be going out for tender. There is a risk that Lincolnshire will not have an inpatient resource in Lincolnshire to meet the needs of very complex children and young people with mental health needs if LPFT do not win the tender. Children & young people will then have to go out of county to receive this treatment.	12	16	4	25/05/2018
21	There is a risk of the Trust being hit with a Cyber Attack. This could lead to a loss of data and damage to our reputation. Any loss of systems due to a Cyber-attack would also have an	15	20	10	10/05/2018

	impact on the day-to-day running of the Trust.				
28	Reduction in service provision for patients on Clozapine leading to reduced monitoring.	20	20	8	14/05/2018

Lincolnshire Partnership NHS Foundation Trust has submitted details of two external reviews commenced or published in the last 12 months [1 May 2017 to 30 April 2018].

1. Long leys court internal review of services to patients from January 2013 – November 2015
2. NHS England commissioned mental health homicide review - not yet completed.

Key outcomes: Areas for improvement found care planning, effective case managers, and effective clinical decision making a referral criteria, documentation and multi-professional record keeping. Physical case management of people with a learning disability who are currently being cared for within a community setting.

Management of risk, issues and performance

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts. Safety and governance teams regularly reviewed the systems. Senior management committees and the board reviewed performance reports and board members actively encouraged challenge on issues. Leaders regularly reviewed and improved the processes to manage current and future performance.

There was a comprehensive trust wide internal audit plan in place, agreed by the executive board and overseen by the audit committee. Quarterly internal audits on data quality reviews were included in the internal audit plan on an annual basis. Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed.

The trust had established a multidisciplinary medicine safety group and medicines alerts were managed by this group with actions reported to the trust safety group to close the loop on any actions taken. The pharmacy team produced an annual audit plan which was approved by the clinical effectiveness group to ensure it aligned with trust priorities and conclusions for further work were appropriately disseminated. The trust was taking part in the POMH-UK audits and has completed data collection for both clozapine and rapid tranquilisation. The nation results were not yet available. The chief pharmacist was very pleased at the uptake for the Clozapine audit as two thirds of patients were recruited and this demonstrated the commitment by the trust to understand the value of their Clozapine prescribing and monitoring programme.

The Trust has a robust risk assessment and risk register process in place to identify both clinical and non-clinical risks at local, directorate/service and organisational levels. The board of directors reviewed all risks on the organisational risk register where they were scored 16 or above. Each identified risk had an executive director ownership who ensured that each risk was reviewed and updated monthly. Staff had access to the risk register either at a team or divisional level and could effectively escalate concerns as needed. Significant risks were escalated to the organisational risk register/board of directors.

The pharmacy risk register had been reviewed following the move to a local community pharmacy for supply of medicines, we were pleased that the supply of medicines is no longer considered a risk for the trust. Clozapine remains on the risk register as the locality based clinics were being established but the severity has been reduced. Recruitment remains on the risk register until the

trust pharmacy team is at full establishment and a new risk relating to the impact of the Falsified Medicines Directive had been added.

The trust had plans in place for emergencies and other unexpected or expected events. For example, adverse weather, a flu outbreak or a disruption to business continuity.

The Trust met key financial and operating targets in 2017/18 and continues to do so in 2018/19. Achievement of these targets is indicative of effective processes for managing risks and delivering target performance. However, the trust use of agency staff remained a risk. Whilst the trusts use of agency had marginally decreased over the last year. It remained above the budget of medical agency expenditure to cover consultant vacancies. Due to the trust meeting its budget in 2017/18 for this year (2018/19) the trust had its agency ceiling reduced to £1.99 million. At the month six end, the trust had forecasted to reduce the spend on agency staff and expects to be under spent by £100k. This is largely due to the development of plans to reduce the agency spend including the move to a direct engagement model, which helped the trust to reduce long term placements and the increase in the use if medical bank staff.

Where cost improvements were taking place, there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. Leaders challenged business development proposals if the impact on the trust was less than positive. Where cost improvements were taking place, the focus was on not compromising patient care. One example was the boards awareness of the limitation imposed by much of the trusts estate, particularly in relation to dormitory style inpatient wards. The trust reviewed each inpatient unit using the NHS England same-sex accommodation toolkit. The outcome of this review led to the trust to produce an extensive estate strategy to address the medium and long term estate issues. We were pleased to see at the time of the inspection this work had begun. Brant Ward for older people had been closed and the refurbishment work was due to commence in the new year. To ensure that patients care was not impacted negatively the trust procured the staff from the ward and developed a home treatment team for older people in the community to provide care for the patients.

The trust reported an increase in the use physical interventions (restraint). However, the trust had a new psychiatric intensive care unit, not inspected previously, which accounted for much of this increase. In the last year the trust had employed a restrictive intervention lead to ensure that staff were trained and using the correct restrictive interventions where necessary and to reduce use of restrictive interventions. This post has led to the recording and reporting of the use of restrictive interventions not only to increase, due to staffs expanded knowledge but the reporting is now more accurate and reflects more details of the actual restrictive intervention techniques that were used. The newly adapted reporting systems were accredited to the increase too.

Since the last inspection there has been a significant decrease in patients placed out of area. The opening of the male psychiatric intensive care unit (PICU) contributed to this. Since it opened in July 2017 no male patients requiring this service have been placed out of county. The number of occupied bed days for male PICU has remained at zero since October 2017, when all out of county male PICU patients had finally been discharged or repatriated. Female patients requiring a PICU bed have also decreased significantly. The trusts dashboard showed there was one female patient in a PICU bed out of county. Ten women had been placed out of area requiring an acute in-patient bed. The trust had now began planning how it will address the current out of area rehabilitation activity. The implementation delivery plan which has been agreed with the commissioners highlighted the need to develop a community personality disorder service. The trust were in the process of writing an additional business case for the transformation of the rehabilitation services, to include a community rehabilitation service offer.

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of identifying an incident.

Between 1 May 2017 and 30 April 2018, the trust reported 83 STEIS incidents. The most common type of incident was 'Apparent/actual/suspected self-inflicted harm meeting SI criteria' with 49. Twenty-nine of these incidents occurred in Community bases mental health services for adults of working age.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Lincolnshire Partnership NHS Foundation Trust reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the same period on their incident reporting system. The number of the most severe incidents was broadly comparable with the number the trust reported to STEIS.

From the trust's serious incident information, there were no unexpected deaths reported.

Type of incident reported on STEIS	MH - Acute wards for adults of working age and psychiatric intensive care units	MH - Community-based mental health services for adults of working age.	MH - Community-based mental health services for older people	MH - Mental health crisis services and health-based places of safety	MH - Other Specialist Services	MH - Wards for older people with mental health problems	Other	Total
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1	29	1	11	6	1		49
Abuse/alleged abuse of adult patient by staff	6	1				2		9
Slips/trips/falls meeting SI criteria						8		8
Pending review (a category must be selected before incident is closed)	1	2			1	1		5
Disruptive/ aggressive/ violent behaviour meeting SI criteria	1	2						3
Apparent/actual/suspected homicide meeting SI criteria		1		1	1			3
Confidential information leak/information governance breach meeting SI criteria		1					1	2
Commissioning incident meeting SI criteria	1							1
Pressure ulcer meeting SI criteria						1		1
Medication incident meeting SI criteria						1		1
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria						1		1

Total	**10**	**36**	**1**	**12**	**8**	**15**	**1**	**83**

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. They do not report staff incidents, health and safety incidents or security incidents to NRLS.

The highest reporting categories of incidents reported to the NRLS for this trust for the period 1 May 2017 to 30 April 2018 were Self-harming behaviour, Patient abuse (by staff/third party) and Medication. These three categories accounted for 2057 of the 3557 incidents reported. Other accounted for 61 of the 63 deaths reported.

Ninety-six percent of the total incidents reported were classed as no harm (77%) or low harm (19%).

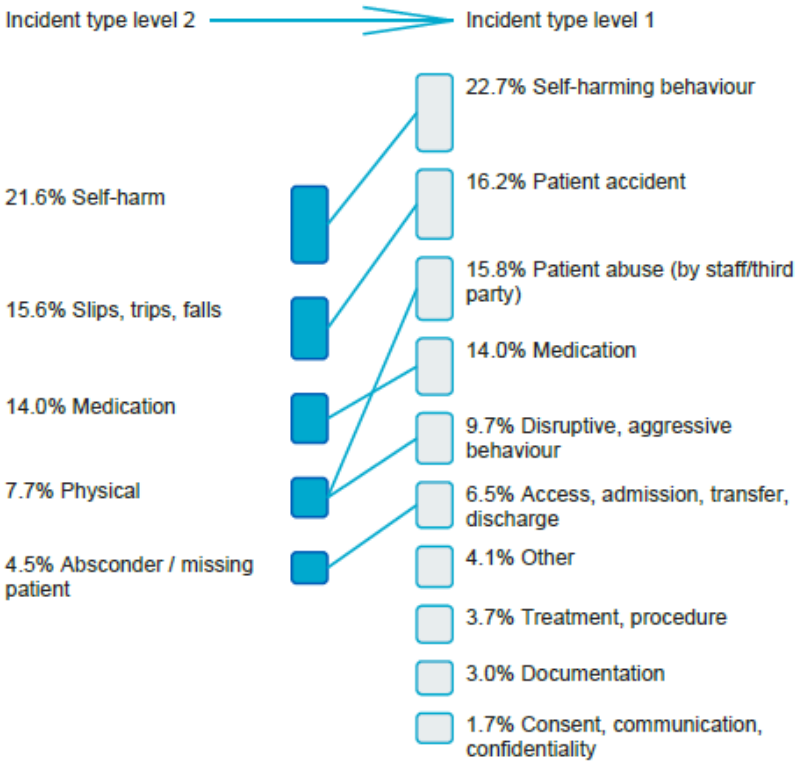
Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Self-harming behaviour	726	237	37		2	1002
Patient abuse (by staff / third party)	437	125	17	1		580
Medication	456	16	3			475
Patient accident	263	133	12			408
Disruptive, aggressive behaviour (includes patient-to-patient)	276	88	5			369
Access, admission, transfer, discharge (including missing patient)	170	16	4			190
Treatment, procedure	94	31	8	1		134
Other	52	11	1	4	61	129
Documentation (including electronic & paper records, identification and drug charts)	118					118
Consent, communication, confidentiality	79	4				83
Implementation of care and ongoing monitoring / review	16	8	3			27
Infrastructure (including staffing, facilities, environment)	21	2	1			24
Medical device / equipment	13	1				14
Infection Control Incident	2	1				3
Clinical assessment (including diagnosis, scans, tests, assessments)		1				1
Total	**2723**	**674**	**91**	**6**	**63**	**3557**

According to the latest six-monthly National Patient Safety Agency Organisational Report (April 2017 to September 2017), the trust was in the middle 50 of reporters nationally for similar trusts.

Self-harming behaviour and Patient accident accounted for a higher proportion of the total number of incidents reported compared to similar trusts.

Do you understand your most frequently reported incident types?

Figure 5: Your most frequently reported incident types, April 2017 to September 2017



Actions for your organisation

- Do you understand what is being reported locally for these incident types?
- Are improvement efforts underway for all these safety issues?
- Have you investigated your local incident type data to see if you can improve your reporting to us? It may be possible to reduce the proportion of incidents reported to the NRLS as 'Other'.
- The top 5 level 2 incidents excludes 311 level 2 incidents categorised as 'Other', this represents 24.8% of incidents reported in April 2017 to September 2017.

Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

Lincolnshire Partnership NHS Foundation Trust reported more incidents from 1 May 2017 to 30 April 2018 compared with the previous 12 months. When compared to the previous 12 months, the number of moderate incidents increased from 36 to 91, severe incidents increased from one to six and death incidents increased from nine to 63 for the current period.

Level of harm	1 May 2016 – 30 April 2017	1 May 2017 – 30 April 2018 (most recent)
No harm	1002	2723
Low	477	674
Moderate	36	91
Severe	1	6
Death	9	63
Total incidents	**1525**	**3557**

Information management

The board received holistic information on service quality and sustainability via the integrated performance report. This report provided the board with the trust level metrics and key points summary as the main indicators currently not being met together with the trust level reporting for quality and safety, patients experience and safe staffing. Each division across the trust provided performance summaries which highlighted when they were under the required target performance and detailed action plans to give the board assurance that these issues were being addressed within the division. The fiancé report gave the current financial position in line with the trust forecasted plan. The final section of the report was the assurance alert mechanism (early warning tool) indicated areas that may require further attention from the board. The Information in the report was in an accessible format, timely, accurate and identified areas for improvement.

The trust had identified that they needed to improve their quality and validity of their data. Board members requested support from NHS Improvement to develop in this area. They attended a session which focussed on the dangers associated with using RAG reports as an assurance tool and the benefits of using a technique called statistical process control. The use of which supports more effective decision making. Within a month of the board attending this session the trust had radically improved their integrated performance report using the statistical process control. In addition to this the trust is the first to have incorporated NHS Improvements summary icons to indicate the type if variation seen for each of their reporting indicators and also the capability of an indicator to achieve the trust set target. This positive change has enabled the board to focus on changes in performance which merit discussion and potential interventions required. We were especially pleased that due to this impressive piece of work NHS Improvement have repeatedly used their integrated performance report in presentations when sharing best practice with other organisations.

Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Staff said they had access to all necessary information and were encouraged to challenge its reliability. Although staff we spoke with stated that they felt confident that the information was accurate due the changes that had taken place.

The KPIs for the pharmacy team in the trust had previously focussed on data collections relating to audit and interventions. There is now a focus on developing quality related KPIs in line with the Carter report. The management and oversight of the data is now reported via the Quality and safety report which the pharmacy team have input to so this information has not been lost.

Team managers had access to a range of information to support them with their management role. The divisional integrated reports were reviewed monthly by managers who would identify themes or trends in the data and a commentary that offered the board assurance. This included information on the performance of the service, staffing and patient care.

The trust had a robust system for the internal recording of staffs' appraisals and mandatory training compliance. The system provides staff and senior managers with accurate data of performance. However, the system in place for clinical supervision was not robust and did not accurately capture the amount of supervision staff were receiving. The trust is fully aware of this issue and whilst we could clearly see there had been some improvement in it the trust still had further work to complete to ensure that the system is accurately capturing staffs' uptake of supervision across the trust.

The trust had a senior information risk owner and a Caldecott guardian. The senior information risk owner was accountable for how the trust managed information and provided a focal point for managing risks and incidents.

Systems were in place to collect data from wards/service teams and this was not over burdensome for front line staff.

Staff had access to the IT equipment and systems needed to do their work. IT systems and telephones were working well, and they helped to improve the quality of care.

The trust had robust information governance systems in place including the confidentiality of patient records in line with best practice. Front line staff knew the importance of managing patient confidential personal information securely. Access to electronic patient care and treatment records was via smart cards and password protected.

The board had invested in a new electronic clinical information system in response to staff feedback on the previous system. Access to information was difficult for staff on the previous system due to multiple care options and different places to key patient documentation m including Mental Health Act paperwork. The new system went live in September 2018. To support staff with the new system training was provided and a helpline was set up for the first months the system was in use. The trust welcomed staff to feedback any issues that they had with the system. We saw a 'you said, we did' document that highlighted that the trust had listened to feedback from staff about the new system and had taken action to improve it. For example, the community teams reported that they found it difficult to see their team caseloads in numbers. The trust responded and built a caseload report which calculated the number of patients within each community team. Staff we spoke with were pleased with the new system and felt the trust had delivered quality training to support them to use it. Whilst they acknowledged that it was still early days using the system they had all noted that the system was a vast improvement and supported them in their day to day work.

The trust had completed the information governance toolkit assessment. An independent team had audited it and the trust took action where needed. The information toolkit had achieved compliance of 96%.

The trust provided financial information to NHS Improvement regularly and timely to meet with imposed deadlines. The trust communicated with NHS Improvement in an open and prompt manner. There were regular meetings with NHS Improvement through scheduled progress review meetings or by exception.

The trust continuously identified efficiency opportunities which is highlighted by benchmarking themselves against similar organisations and were using the model hospital database. Continuous improvement plans for 2018/19 built on the analysis of this model to deliver financial efficiency saving.

Leaders submitted notifications to external bodies as required.

The trust had systems in place to identify and learn from data security breaches. They had invested in the upgrades to its IT security structures. The finance and performance committee reviewed all data security issues on a quarterly basis. To date there have been no incidents that have required to be reported to the ICO as level 2 information governance serious incident requiring investigation. The trust was one of the top three trust in the country for compliance and were assessed as being level two on the information governance toolkit. They have an action plan in place to complete the data protection and security tool kit. Lesson learnt from 'WannaCry' and security breaches were shared to the board via the finance and performance committee and communicated with all staff via the intranet. The investment in new electronic patient record will further strengthen barriers to, and audit of inappropriate subject access.

Engagement

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. For example, the trust had a recovery college which supported individuals with experience of mental health difficulties to live the life they want to lead and become experts in their own self-care. All courses were co-produced and co-delivered by people with lived experience of mental health difficulties and mental health professionals, providing a shared learning environment. Courses were open to service users, their carers, friends and family and trust staff.

The trust's latest staff survey results showed as 'very good', with the trust being rated as the 7th best mental health trust in the country. There was an above average response to the take up of the survey and only one key area out of 32 had below average results. The trust utilises both a qualitative as well as quantitative approach to their revision of the survey.

The trust encouraged staff to be fully engaged in the financial improvement programme through agreement, delivery and accountability for divisional CIP schemes. Two operational steering groups hold meetings monthly; the operational delivery team, which is formed of business managers and operational leads, and the strategic delivery team, which is formed of heads of service, clinical leads and deputy directors. The outcomes of the operational delivery team meeting feeds into the strategic team meeting, with the chair of ODT sitting on both groups. Once a year the two groups are merged to form the panel for the quality impact assessment process.

Patients and the public are engaged and involved in the trust strategy through consultation processes related to service changes and trust communications. The trust holds board of directors' meetings every month and these meetings are open to the public. Dates for future board meetings, together with agendas and approved minutes from previous meetings are available on the trust's website.

The trust involvement strategy confirms the trusts commitment to involving patients, carers, staff, volunteers, the public and stakeholders in the development of its services by encouraging active participation in the decision making process about what services are provided, how those services are developed and how those services are delivered. For example, the learning disabilities engagement event was held to discuss the proposals for closing learning disabilities inpatient beds. Strategic Change Committee gained assurance on participation through quarterly reports.

In the last year the involvement charter had been launched across the trust. The charter was based on the NSUN4Pi standards for involvement: principles, purpose, presence, process and impact. The trust worked with their service users, carers and staff to develop a set of standards. These can be seen clearly displayed across the trust.

The trust works closely with the sustainability and transformation programme and had strong links with other local trusts pharmacy teams and the chief pharmacists regional mental health network. The chief pharmacist was on the Council of the CMHP (College of Mental Health Pharmacy). This ensured the trust was kept abreast of developments in mental health medicines optimisation.

The trust pharmacy team offer face to face support for in-patients of the trust to provide guidance and information relating to their medicines. Some wards have trialled specific dates and times for drop in sessions although this has not proven effective on all wards. Pharmacist now plan to tie in with the occupational health programme on each ward to maximise this opportunity for patients. The pharmacy team intend to use a patient surgery for in-patients to determine the value of the face to face offer. Where a member of the pharmacy team has spoken to a patient about their medicines we saw that this was recorded on RIO. The trust used the 'choice and medication'

website to access medicines information and print this off for patients. Members of the pharmacy team take part in evening information sessions for carers and there is a plan to provide medicines training for the trust peer support workers to improve concordance with therapy.

The trust had a dedicated involvement lead committed to ensuring service users, members and carers are properly consulted and involved in how the trust is run. Their role was to encourage and enable patients and carers to be actively involved in a number of opportunities, for example, focus groups, patient led assessment of the care environment (PLACE) inspections and working groups and staff recruitment selection processes.

We saw numerous examples of co-production where patients and staff worked together. The trust had signed up to the Triangle of Care. This approach had created a therapeutic alliance between service users, staff and carers that promotes safety, supports recovery and sustains wellbeing. It had been developed by carers and staff seeking to improve carer engagement in all inpatient services and home treatment services.

The trust had improved and strengthen the patients voice by employing peer support workers, experts by experience and clinical apprentices to strengthen the voice and the participation of the patients. These roles were in place in the child and adolescent service, learning disability service, adult community team and specialist rehabilitation wards the trust had. The trust had invested in these patients and provided training and mentorship to them.

In the last year 1027 people had attended and participated in 22 trust engagement events. 73 people attended learning disability engagement events.

Senior staff and team leaders at all levels showed active engagement with local and national stakeholders to improve the delivery of projects and safe care to patients. This included CCG's, local authorities [and governing bodies of healthcare. Trust staff attended meetings and volunteered to pilot projects in the trust to ensure they were ahead of innovation in healthcare.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The trust sought to actively engage with people and staff in a range of equality groups.

Learning, continuous improvement and innovation

The trust actively sought to participate in national improvement and innovation projects. Staff and patients were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented.

The trust progress on continuous quality improvement had been good over the last year. An executive led on an active programme of continuous quality improvement which covers seven areas:

- Improving the collection of quality and use of data and information
- Supporting developing our people
- Treating and caring for people in a safe environment and protecting then form avoidable harm
- Strategic change for mental health and learning disability by 2020

- Developing clinical skills
- Improving the environment for patients and staff
- Patient experience.

This overview of continuous quality improvement across the trust highlighted some positive initiatives, many of which have received national recognition through publication and shortlisted for several national awards. For example, the trust had been involved the NHS improvement carter improvement programme around staffing, e-rostering and agency and bank use. As a result, this work has led to a drop in nursing agency use, and the trust case study has been used in Carter Report (Lord Carter's review into unwarranted variations in mental health and community health services, May 2018). The trust won a CCA National Good Practice Award. The project was aimed at improving awareness and quality of managing risk issues in patients utilising secondary mental health services, and the project won in the category of 'Innovation to Support Service Development'.

The trust had a planned approach to take part in national audits and accreditation schemes and shared learning with other organisations.

The trust had set aside funds in for the innovation scheme and awarded funding to support good ideas in teams across the trust. In addition to this the trust has improved on recognising and celebrating staffs successes through the 'Local LPFT Heroes' and Staff Excellence Awards.

Research was acknowledged as an asset in the trust. For the first time in 2018 the research annual report and outcomes was published highlighting the excellent work done across the organisation. The trust was proud of the national institute for health research that was being intervention for severe mental health, RADAR: research into antipsychotic discontinuation and reduction. The trust held a research and innovation conference which was attended by nearly 100 attendees. The conference aim to encourage staff to take their first step on research and understand what research can mean for them.

The trust had improved their focus and the attention that they paid to innovation in the last 2 years. On the trust intranet there is a "I've got an idea" option for staff to put forward good ideas. The trust had developed a continuous quality improvement, celebrating success programme on social media were staff share their projects and learning. An example of co-produced innovation was the patients and staff at the North East Lincolnshire CAMHS team had co designed and produced a Wellbeing Passport. This passport allows the young person and their families to provided details about them prior to the initial assessment so that the staff can more effectively meet their needs. This initiative had been shortlisted for the Nursing Times Awards this year.

The chief pharmacist is on the CMHP council and had presented work from the trust at the annual CMHP conference related to the delivery of the induction programme by pharmacy technicians.

The clozapine clinics had been an opportunity to combine a near patient testing service with physical health monitoring. This was being developed further and a proposal to run a physical exercise intervention group for Clozapine patients is to be taken to the trust quality improvement group. It has been identified that there are current staffing and equipment resources that could be used. A patient survey related to the Clozapine clinic has demonstrated that patients are positive about the new service.

The trust had recently been involved in addressing concerns in primary care relating to the transfer of care for dementia patients receiving medicines for their condition. The chief pharmacist had produced a document titled 'prescribing arrangements for dementia medications', this was designed to assist GPs in prescribing these medicines and provide assurance of the support

available from the trust. This document was currently going through external stakeholders to ensure it meets the needs of clinicians in the CCG areas covered by the trust.

There were effective systems were in place to identify and learn from unexpected deaths. The had adapted the royal college of psychiatrist mental health version of the structure judgement review tool to review all deaths. The tool supports the trust to learn lessons from deaths and critically review the patients record and specific phases of clinical care. The trust has engaged with events relating to the national mortality agenda alongside other trusts within the east midlands region and leading the planning and hosting of a regional learning event for mental health providers. Additionally, the trust clinical specialist (mortality) had engaged and taken an active part within the Lincolnshire Provider and CCG Mortality Collaborative.

The trust engaged with peers in providing support to the local system (STP) across a variety of areas where improvement was required: financial, operational and quality. They attended regional network improvement events such as the NHS Improvement Director of Finance meetings, as well as various other leadership and financial events, such as those held by the Healthcare for Financial Management Association (HFMA).

	Historical data		Projections	
Financial Metrics	Previous financial year (2 years ago) A April 2016 to 31 March 2017	Last financial year (1 April 2017 to 31 March 2018)	This financial year (1 April 2018 to 31 March 2019)	Next financial year (1 April 2019 to 31 March 2020)
Actual income	£98,079,000	£104,023,000	£104,956,000	19/20 plan not yet defined
Actual surplus (deficit)	£1,639,000	£1,168,000	£1,076,000	19/20 plan not yet defined
Actual costs/ expenditure -full	£96,440,000	£102,855,000	£103,880,000	19/20 plan not yet defined
Planned budget or (budget deficit)	£754,000	£721,000	£1,076,000	19/20 plan not yet defined

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed.

The table below shows services across the trust awarded an accreditation (trust-wide only) and the relevant dates.

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
AIMS – WA (Working Age Units)	Acute ward for adults of working age and psychiatric intensive care units	-	Obtained 2011, renewal date 2019
AIMS – PICU (Psychiatric Intensive Care Units)	Acute ward for adults of working age and psychiatric intensive care units	-	Hartsholme - Plan for completion of AIMS accreditation in Autumn 2018
AIMS – OP (Wards for older people)	Wards for older people with mental health problems	Brant ward and Longworth ward have undertaken the peer review	-

AIMS – Rehab (Rehabilitation wards)	Long stay/rehabilitation mental health wards for working age adults	AIMS accredited in October 2014:- Maple Lodge, Boston Ashley House, Grantham The Fens, The Vales and The Wolds, Lincoln. Triangle of Care awarded from Carers Trust	-
Quality Network for Inpatient CAMHS (QNIC)	Child and adolescent mental health wards	-	Waiting to hear following the submission of additional information requested.
Quality Network for Perinatal Mental Health Services (QNPMH)	N/A	Peer review process due in November/December 2018	-
ECT Accreditation Scheme (ECTAS)	-	Obtained in 2010, renewed in 2017	-
Psychiatric Liaison Accreditation Network (PLAN)	-	Boston Mental Health Liaison Team	A peer review took place in March 2017, a royal college full assessment in June 2017, we had to supply further evidence to RCP by 24th November 2017 to gain accreditation but due to the A&E safe interview room the service could not complete. Given further time to submit which ended in March 2018 but this deadline was not achieved for the room to be completed in time as it is still at the planning stage. No further funding has been allocated to support PLAN
Accreditation for Community Mental Health Services (ACOMHS)	Community based MH services for adults of working age	-	Grantham CMHT awaiting sign off; Lincoln South CMHT Team signed up; Spalding CMHT team signed up
HTAS Accreditation	Core Services - Mental Health Crisis and Home Treatment services	-	Grantham and Lincoln CRISIS Teams are credited and Boston team currently working towards accreditation.
Stonewall Diversity Champion	-	-	Obtained June 2017, Renewal June 2018
Stonewall Workplace Equality Index 148th/434 employers	-	-	Obtained January 2018, submission Sept 2018/results Jan 2019
ENEI (Employers Network for Equality an Inclusion)	-	-	Obtained January 2018, renewal January 2019
ENEI (Employers Network for Equality and Inclusion) e-quality benchmarking diversity 2017	-	-	July 2017 awarded Silver Standard Employer
Inclusive Employers	-	-	Obtained March 2018, renewal March 2019
Disability Confident Level 2 Employer	-	-	Obtained December 2017, working towards level 3 in the next 2 years

Learning Disability Employment Pledge	-	-	Signed pledge of commitment in October 2016. Trying to progress to the next stage. Working group set up.
Dying to Work' Charter	-	-	Signed October 2016, no renewal date
Silver award winner from Armed Service Covenant (MOD)	-	-	Obtained September 2016, No renewal date
National Health Education England, improving perceptions of nursing and midwifery	-	Nursing across The Trust from all services, May 2018	Won national award for a hackathon, innovative ideas and practice.
Aging Workforce Charter	-	-	Nov-17

Mental health services

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

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Mental Health Unit, Lincoln County Hospital site, Peter Hodgkinson Centre (RP7EV)	Charlesworth Ward	20	Female
Mental Health Unit, Lincoln County Hospital site, Peter Hodgkinson Centre (RP7EV)	Conolly Ward	22	Male
Long Leys Road Site, Lincoln (RP7QS)	Hartsholme Centre	10	Male
Pilgrim Hospital Site, Department of Psychiatry (RP7LA)	Ward 12	20	Mixed

Is the service safe?

Safe and clean environment

Safety of the ward layout

Nursing staff undertook daily visual risk assessments of the wards to ensure that safety of patients, staff and visitors. This entailed staff walking around each ward, checking fire exits, any potential hazards, and the general condition of the ward areas.

Staff had access to alarms across the service so that assistance could be sought from additional staff if necessary in emergencies. There was always staff present in communal areas, and an allocated staff member undertook routine observations. Therefore, patients could summon help if needed.

Over the 12 month period from 1 May 2017 to 30 April 2018 there were no mixed sex accommodation breaches within this core service.

The number of same sex accommodation breaches reported in this inspection was better than the 21 reported at the time of the last inspection (3 April 2017).

There were ligature risks on four wards within this core service. The trust had undertaken recent (from 7 July 2017 onwards) ligature risk assessments at three locations. No wards had not had a ligature risk assessment in the last 12 months.

One of the wards presented a high level of ligature risk due to ‘the fixtures and fittings in the disabled toilet’. Three wards presented a lower risk due to the left wing top of a bay partition, which had been identified as needing to be removed. There were also gaps between bathroom furniture and walls, as well as small gaps behind radiators and lockers in bedrooms.

The trust had taken actions to mitigate ligature risks and had produced colour coded maps of the ward environment identifying high risk areas, these were displayed in ward offices.

Maintenance, cleanliness and infection control

Wards appeared clean, had appropriate, modern furnishings that were well maintained. We saw a dedicated team of housekeeping staff cleaning the wards throughout the inspection. Housekeepers worked flexibly over the seven day period and worked to a schedule to ensure all ward areas were cleaned. Staff supported patients to keep their bedrooms clean and tidy.

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. Staff had control measures in place to prevent the spread of infection for example, protective clothing such as aprons and gloves. Staff had adequate hand washing facilities and hand gel on each ward. The service completed infection control audits and any associated actions were completed.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) assessment (2017 the locations scored lower than the similar trusts for all four aspects overall. The trust received a score lower than other similar trusts for cleanliness scoring 95.8% compared to 98% nationally, condition, appearance and maintenance scoring 93.1% compared to 95.2% nationally, dementia friendly scoring 68.2% compared to 84.8% nationally and in disability (81.6% compared to 86.3% nationally).

Two locations scored lower than similar trusts for the Dementia friendly and Disability aspects of the care environment.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
Peter Hodgkinson Centre	Acute wards for adults of working age and psychiatric intensive care units Mental health crisis services and health based places of safety MH – Other Specialist Services Secure wards/Forensic inpatient	99.5%	91.2%	65.3%	82.7%
Pilgrim Hospital	Acute wards for adults of working age and psychiatric intensive care units MH – Other Specialist Services Wards for older people with mental health problems Mental health crisis services and health based places of safety Community based mental health services for older people	97.5%	93.4%	66.7%	84.8%
Trust overall		**95.8%**	**93.1%**	**68.2%**	**81.6%**
England average (Mental health and learning disabilities)		**98.0%**	**95.2%**	**84.8%**	**86.3%**

Seclusion room (if present)

The service had four seclusion rooms across three sites. The seclusion rooms at Charlesworth and Conolly wards were compliant with the Mental Health Code of Practice, in terms of having clear observation; two-way communication, had toilet facilities and a clock. However, on Ward 12 whilst the patient could be seen in the seclusion room's ensuite area, via a mirror and window, if the patient was crouched under the sink, staff would be unable to observe the patient fully. We drew this to the attention of the ward manager who told us they had reported this to the trust maintenance team.

In the Hartsholme centre's seclusion room's ensuite area, we saw the coating of the wall surface was damaged (it was peeling from the wall). This created small, sharp debris which could potentially be used by the patient to self-harm (for example, to lacerate or ingest). The ward manager informed us the matter had been raised with the maintenance team and they were awaiting sealant from an approved supplier.

Clinic room and equipment

Clinic rooms were fully equipped with examination couches and accessible resuscitation equipment. Emergency medicines were available; however, they were locked in the drug cupboard which may have caused a delay in administration. Nursing staff recorded that they checked medical equipment and emergency medicines regularly. Staff cleaned clinical equipment daily such as blood pressure monitors and recorded this on "this is clean" stickers.

Safe staffing

Nursing staff

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	30 April 2018	172.9	N/A
Total number of substantive staff leavers	1 May 2017 – 30 April 2018	26.3	N/A
Average WTE* leavers over 12 months (%)	1 May 2017 – 30 April 2018	16%	N/A
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	30 April 2018	25.5	N/A
Total vacancies overall (%)	30 April 2018	13%	N/A
Total permanent staff sickness overall (%)	Most recent month (30 April 2018)	5%	4.5%
	1 May 2017 – 30 April 2018	5%	4.5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	30 April 2018	63.2	N/A
Establishment levels nursing assistants (WTE*)	30 April 2018	96.5	N/A
Number of vacancies, qualified nurses (WTE*)	30 April 2018	15.7	N/A

Number of WTE vacancies nursing assistants	30 April 2018	11.5	N/A
Qualified nurse vacancy rate (%)	30 April 2018	25%	N/A
Nursing assistant vacancy rate (%)	30 April 2018	12%	N/A
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 May 2017 – 30 April 2018	7719.5 (12%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 May 2017 – 30 April 2018	1665.5 (3%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 May 2017 – 30 April 2018	7449.5 (12%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	29650.9 (25%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	6729.8 (7%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	12125.6 (12%)	N/A

*Whole-time Equivalent

This core service reported an overall vacancy rate of 25% for registered nurses at 30 April 2018.

The vacancy rate for registered nurses was higher than the 2% reported at the last inspection (3 April 2017).

This core service reported an overall vacancy rate of 12% for registered nursing assistants.

The vacancy rate for nursing assistants was higher than the 10% reported at the last inspection (3 April 2017).

This core service has reported a vacancy rate for all staff of 13% as of 30 April 2018. This was higher than the rate reported at the last inspection (5%) (between 1 January 2016 and 31 December 2016).

During inspection, we were told that staff recruitment had been an ongoing priority. Some vacancies had been recruited into, and staff had start dates. We were told that each ward had the following vacancies outstanding: Ward 12, three registered nurses and one nursing assistant; Hartsholme centre, four registered nurses and one nursing assistant; Conolly ward, one nursing assistant post and Charlesworth ward, four registered nursing vacant posts.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
274 IA2 Psychiatric Intensive Care Unit (PICU) L21219	5.3	14.5	37%	4.8	17.5	27%	10.4	40.9	25%
274 IAILD Porters Recharge L20903	0	0	0	0	0	0	0.23	1.03	22%
274 IAIBA Ward 12 L21521	4.1	15.6	26%	3.9	23.7	16%	7.2	41.9	17%

274 IAILC Charlesworth Ward L21212	3.2	14.6	22%	1.6	20.9	8%	4.8	37.5	13%
274 IA Divisional Manager Inpatient L60020	1.1	2.1	51%	0.6	1.6	38%	0.7	5.7	12%
274 IAIBG Pilgrim Admin L60503	0	0	0	0.4	3.4	12%	0.4	3.4	12%
274 IAILG PHC Admin L60220	0	0	0	0.4	4.6	8%	0.39	4.64	8%
274 IAILH PHC Medical Secretaries L64210	0	0	0	0.2	3.2	6%	0.2	3.23	6%
274 IAILB Conolly Ward L21211	2.0	13.4	15%	-0.4	19	-2%	1.7	35.0	5%
274 IAIBF Pilgrim Medical Secretaries L60502	0	0	0	0.0	2.0	2%	0.0	2.0	2%
274 IAIBD Pilgrim OT L50550	0	0	0	0	0	0	0.0	1.5	0%
274 IAILA Team Leader Inpatient L21210	0	0	0	0	0.5	0%	0.0	2.5	0%
274 IAILF HTT LIAISON PHC L21224	0.0	3.0	0%	0	0	0	0	4	0%
274 IAILI PHC Domestics L73210	0	0	0	0	0	0	0.04	10.51	0%
274 IAIBE Pilgrim Domestic L60458	0	0	0	0	0	0	-0.2	6.4	-2%
274 LCAH Medical PICU L15219	0	0	0	0	0	0	-0.3	1.4	-21%
Core service total	**15.7**	**63.2**	**25%**	**11.5**	**96.5**	**12%**	**25.5**	**201.4**	**13%**
Trust total	**66.3**	**549.4**	**12%**	**43.6**	**605.4**	**7%**	**172.2**	**1756.0**	**10%**

NB: All figures displayed are whole-time equivalents

Between 1 May 2017 and 30 April 2018, bank staff filled 12% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 3% of shifts for qualified nurses. Twelve percent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Total Hours	Bank use (hours)	Agency use (hours)	Total hours unfilled by bank or agency staff
Charlesworth	14497.3	2505.1 (17%)	0 (0%)	2155 (15%)
Conolly	15740.8	1503.9 (105)	0 (0%)	1015 (6%)
PICU	14037.9	2292.9 (16%)	1665.5 (12%)	3854 (27%)
Ward 12	19310.3	1417.6 (7%)	0 (%)	426 (2%)
Core service total	**63586.4**	**7719.5 (12%)**	**1665.5 (3%)**	**7449.5 (12%)**
Trust Total	**469050.1**	**40081.8 (9%)**	**4217.8 (1%)**	**144727.5 (31%)**

*****Percentage of total shifts

Between 1 May 2017 and 30 April 2018, bank staff to cover sickness, absence or vacancy for nursing assistants filled 29% of shifts.

In the same time period, agency staff covered 7% of shifts. Twelve percent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Total Hours	Bank use (hours)	Agency use (hours)	Total hours unfilled by bank or agency staff
Charlesworth	26274.2	10259.3 (39%)	2861.8 (11%)	2557 (10%)
Conolly	28410.3	5432.8 (19%)	1434.5 (5%)	1940 (7%)
PICU	25192.1	9411.9 (37%)	2178.5 (9%)	6341 (25%)
Ward 12	22527.7	4547 (20%)	255 (1%)	1287.9 (6%)
Core service total	**102404.2**	**29650.9 (29%)**	**6729.8 (7%)**	**12125.6 (12%)**
Trust Total	**443457.4**	**100481 (23%)**	**15807 (4%)**	**61265.39 (15%)**

***** Percentage of total shifts

This core service had 26.3 (16%) staff leavers between 1 May 2017 and 30 April 2018. This was higher than the 11% reported at the last inspection (from 3 April 2017).

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
274 IAILF HTT LIAISON PHC L21224	4	1	71%
274 IAIBF Pilgrim Medical Secretaries L60502	1	1	54%
274 IA2 Psychiatric Intensive Care Unit (PICU) L21219	30.5	10.93	36%
274 IAILH PHC Medical Secretaries L64210	3.03	0.6	20%
274 IAILC Charlesworth Ward L21212	32.67	5.2	19%
274 IAILG PHC Admin L60220	3.25	0.53	18%
274 IAILA Team Leader Inpatient L21210	2.5	0.5	14%
274 IAILB Conolly Ward L21211	32.29	3.6	13%
274 IAILI PHC Domestics L73210	10.47	1	10%
274 IAIBE Pilgrim Domestic L60458	6.51	0.37	6%
274 IAIBA Ward 12 L21521	34.72	1.6	5%
274 IA Divisional Manager Inpatient L60020	5	0	0%
274 IA1 Nurse Consultant L00093	0	0	0%
274 IAIBD Pilgrim OT L50550	1.49	0	0%
274 IAIBG Pilgrim Admin L60503	3	0	0%

274 IAILD Porters Recharge L20903	0.8	0	0%
274 LCAH Medical PICU L15219	1.7	0	0%
Core service total	**172.9**	**26.3**	**16%**
Trust Total	**1474.6**	**162.2**	**12%**

Managers had calculated the number and grade of nurses and nursing assistants required per ward. We examined staffing rotas and found that the number of nurses and nursing assistants matched this number on most of the shifts.

Each ward manager adjusted staffing levels daily as required, to meet patient needs. When necessary, bank and agency staff were sought to maintain safe staffing levels. Staff could be deployed from other acute wards within the service on occasions to meet safe staffing numbers at short notice. The service used bank staff where possible, and agency staff who were familiar with the service. Bank and agency staff who were unfamiliar with the service received a ward induction.

We observed staff in communal areas of the ward during the inspection. Staff and patient's, we spoke with said that one to one time with staff was occasionally cancelled due to staffing levels.

Staff shortages rarely resulted in staff cancelling escorted leave. If this occurred, staff re-arranged at the earliest opportunity. Activities were available throughout the seven day period, facilitated by both occupational therapy and nursing staff.

The service had enough staff to carry out physical interventions, such as restraint, or seclusion safely. Each ward had a designated "responder", who attended wards when the alarm sounded to offer support. Staff received training before they used any physical interventions, and were updated regularly.

The sickness rate for this core service was 5% between 1 May 2017 and 30 April 2018. The most recent month's data [30 Apri1 2018] showed a sickness rate of 5%. This was similar to the sickness rate of 6% reported at the last inspection in 3 April 2017.

Ward/Team	**Total % staff sickness (at latest month)**	**Ave % permanent staff sickness (over the past year)**
274 IAIBF Pilgrim Medical Secretaries L60502	0%	29%
274 IAILI PHC Domestics L73210	5%	7%
274 IAILC Charlesworth Ward L21212	5%	6%
274 IA2 Psychiatric Intensive Care Unit (PICU) L21219	11%	5%
274 IAIBA Ward 12 L21521	7%	5%
274 IAILB Conolly Ward L21211	2%	5%
274 IAILA Team Leader Inpatient L21210	0%	3%
274 IAILF HTT LIAISON PHC L21224	1%	3%

274 IAIBG Pilgrim Admin L60503	0%	2%
274 IAILG PHC Admin L60220	0%	2%
274 IA Divisional Manager Inpatient L60020	0%	1%
274 IA1 Nurse Consultant L00093	0%	1%
274 IAIBE Pilgrim Domestic L60458	0%	1%
274 IAILH PHC Medical Secretaries L64210	1%	1%
274 IAIBD Pilgrim OT L50550	0%	0%
274 IAILD Porters Recharge L20903	0%	0%
274 LCAH Medical PICU L15219	0%	0%
Core service total	**5%**	**5%**
Trust Total	**4%**	**5%**

The below table covers staff fill rates for registered nurses and care staff during December 2017, January and February 2018.

Charlesworth ward had less than 90% registered nurses for day shifts in January and February 2018.

Ward 12 and Conolly ward had less than 90% care staff for day shifts in January 2018 and Hartsholme unit had less than 90% care staff for day shifts in December 2017.

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 (%)
	Feb 18				**Jan 18**				**Dec 17**			
Conolly Ward	98.8	99.0	93.3	103.8	92.4	89.8	99.8	95.3	112.7	92.6	100.4	110.3
Charlesworth ward	86.2	98.5	90.8	108.1	86.6	91.8	60.7	91.0	94.8	108.2	83.5	117.0
Ward 12	93.7	99.4	83.6	116.0	103.4	88.3	100.0	98.4	89.1	111.4	100.3	113.4
Hartsholme Unit	101.5	98.0	101.6	103.2	109.3	92.2	98.2	96.0	123.1	84.7	101.8	106.8

Medical staff

There was adequate medical cover throughout the day, and an on-call rota in place throughout the night. Doctors could usually attend the ward quickly in the event of an emergency.

Between 1 May 2017 and 30 April 2018, bank staff to cover sickness, absence or vacancy for medical locums filled 0% of shifts.

In the same time period, agency staff covered 4% of shifts. Less than one percent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Total Hours	Bank use (hours)	Agency use (hours)	Total hours unfilled by bank or agency staff
Adult Inpatient	42940.8	0 (0%)	3640 (8%)	80 (0.2%)
General Adults	45849.6	0 (0%)	280 (1%)	0 (0%)
Core service total	88790.4	0 (0%)*	3920 (4%)*	80 (0.1%)*
Trust Total	475881.6	1902 (0.4%)*	21784 (5%)*	968 (0.2%)*

***** Percentage of total shifts

Mandatory training

The compliance for mandatory and statutory training courses at 31 May 2018 was 84%. Of the training courses listed eight failed to achieve the trust target and of those, one failed to score above 75%.

The training compliance data is reported on an ongoing monthly basis. Statutory training is reported as part of the monthly board report dashboard produced by workforce and a separate dashboard is provided by the Learning and Development team for all other courses classified by the trust as role essential.

The training compliance reported for this core service during this inspection was higher than the 83% reported at the last inspection.

Key:

Below CQC 75%	Met trust target	Not met trust target	Higher	No change	Lower	Error
	✓	✗	↑	→	↓	N/A

YTD (Current Period)	Target	Number of staff eligible	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Information Governance - 1 Year	95%	185	168	91%	✗	↓
Health, Safety and Welfare - 3 Years	85%	185	167	90%	✓	↑
Safeguarding Adults - Level 1 - 3 Years	85%	185	166	90%	✓	↓
Safeguarding Children (Version 2) - Level 1 - 3 Years	85%	185	163	88%	✓	↓
Moving and Handling - Level 1 - 3 Years	85%	185	160	86%	✓	↓
Equality, Diversity and Human Rights - 3 Years	85%	185	155	84%	✗	↓
Resuscitation - Level 2 - Adult Basic Life Support - 3 Years	85%	154	124	81%	✗	↑
Domestic Violence	85%	185	146	79%	✗	↑
Fire Safety - 1 Year	85%	185	145	78%	✗	↑
Infection Prevention and Control - Level 1 - 1 Year	85%	152	118	78%	✗	↑
Female Genital Mutilation	85%	128	94	73%	✗	↑

Core service total	**1914**	**1606**	**84%**	✘	↑

Assessing and managing risk to patients and staff

Assessment of patient risk

We examined 29 care records. Staff completed a risk assessment of every patient upon admission to the wards. These included the patients historical and current risks. Nursing staff updated these regularly, including following incidents. The trust used their own risk assessment tool.

Management of patient risk

Staff were aware of any specific physical risk issues for individual patients and managed these effectively. For example, on Ward 12, we saw that one patient was at risk of falling. Staff had implemented a care plan specifically around this, which was reflected in the risk assessment.

The trust had a policy in place for the use of observations which staff were aware of, and adhered too. We examined a sample of observation documentation, and found that staff undertaking patient observations completed documentation as expected, and in a timely way.

The searching of patients and property was undertaken by staff in line with the trust policy. Staff undertook searches of patients based upon individual risk assessments.

Staff had actively looked to reduce any blanket restrictions upon patient's freedom. Any restrictions were justified, incorporated into care plans, and based upon risk. Staff discussed any restrictions with the patients and imposed these for the shortest time possible.

The trust encouraged patients to stop smoking. Nicotine replacement therapy was offered where applicable and could use e-cigarettes in outside areas.

Staff regularly explained to informal patients their rights, which included being able to leave the ward.

Use of restrictive interventions

This core service had 282 incidents of restraint (on 174 different service users) and 119 incidents of seclusion between 1 May 2017 and 30 April 2018.

The range of incidences of restraint was between 11 and 38 per month.

The below table focuses on the last 12 months' worth of data: 1 May 2017 to 30 April 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Charlesworth Ward	29	107	58	32 (30%)	24 (22%)
Conolly Ward	39	59	45	27 (46%)	18 (31%)
Ward 12	15	35	22	14 (40%)	8 (23%)
Hartsholme Centre	36	81	49	36 (44%)	31 (38%)
Core service total	119	282	174	109 (39%)	81 (29%)

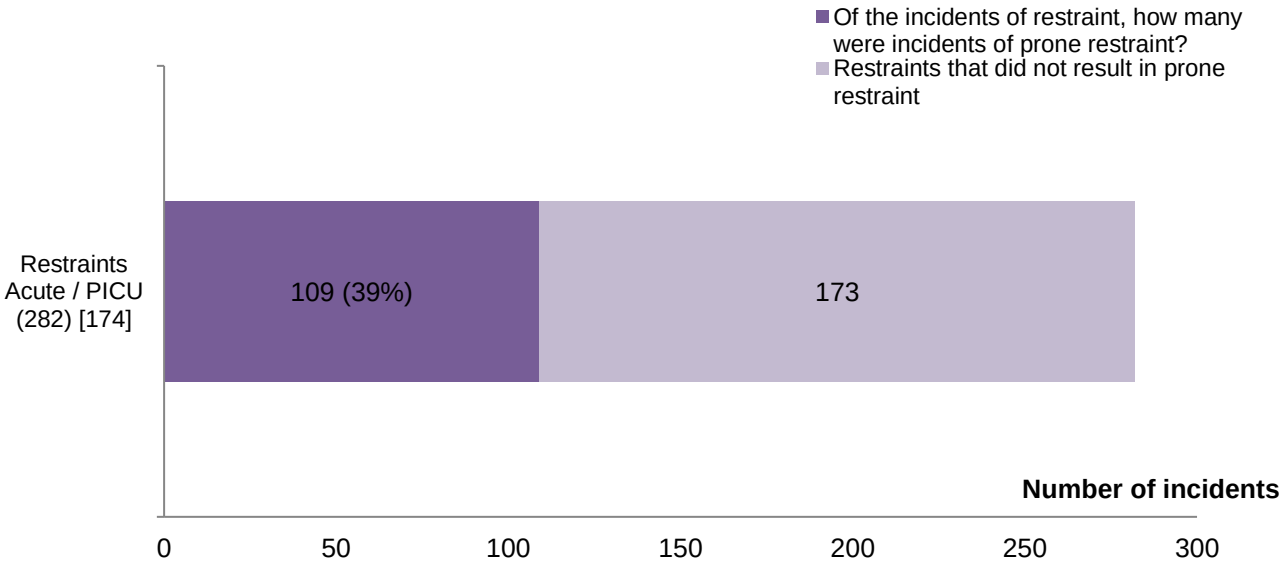
There were 109 incidents of prone restraint, which accounted for 39% of the restraint incidents. Staff were aware that prone restraint should be avoided where possible. Staff were trained to turn a patient over at the earliest opportunity when prone restraint did occur. Senior managers and staff reported that prone restraint was predominantly used to administer medication, and to exit seclusion safely.

There were 81 incidents resulting in rapid tranquilisation for this core service, ranging between two and 13 incidents per month.

There have been no instances of mechanical restraint over the reporting period.

The number of restraint incidents reported during this inspection was higher than the 209 reported at the time of the last inspection (3 April 2017). The trust had a new psychiatric intensive care unit, not inspected previously, which accounted for much of this increase.

Number of incidents of restraint and prone restraint for this core service over the 12 months

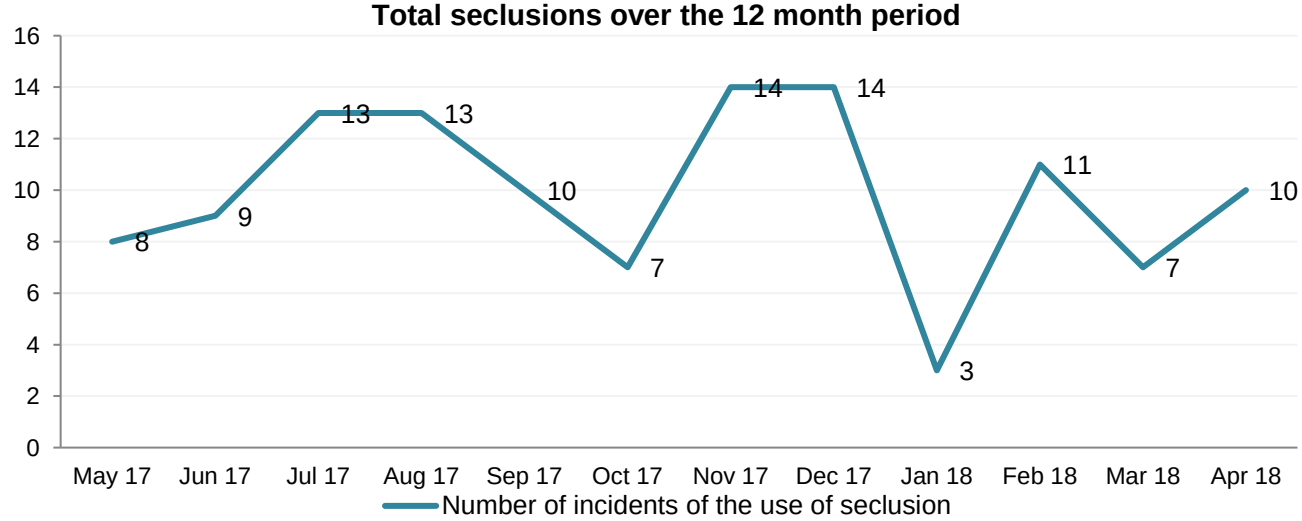


Please note the figures in square brackets ,after the total number of restraints, are the number ofdifferent service users restraint was used on during this time period.

The range of incidences of seclusion was between three and 14 per month.

The number of seclusion incidents reported during this inspection was higher than the 92 reported at the time of the last inspection (3 April 2017).

Total seclusions over the 12 month period



We reviewed 41 seclusion records across the four wards. We found that seclusion documentation was not always fully completed.

Of the 41 records reviewed, 18 (46%) of patients did not have a medical review within one hour of their episode of seclusion commencing, 22% of patients did not have a nursing review by two

nurses every two hours throughout seclusion. Staff did not always include their designation on the relevant forms, thus it was sometimes unclear if two nurses had completed the nursing review.

17% of patients did not have continuing medical reviews every four hours until the first internal multi-disciplinary team review.

In one patient's case, the reasons for their seclusion was unclear. In another patient's case the recording of the reasons for seclusion did not demonstrate that the patient was a danger to others.

Staff had not recorded what the patient took into the seclusion room on 68% of the records we reviewed.

Not all patients had a care plan relating to seclusion, nine (24%) of the records examined did not have a specific seclusion care plan. The care plans on Conolly, Charlesworth and Ward 12 were of a standardised format, whereas the care plans on the Hartsholme centre were personalised to the patients' individual needs.

There have been zero instances of long-term segregation over the 12-month reporting period.

The number of segregation incidents reported during this inspection was equal to the zero reported at the time of the last inspection (3 April 2017).

Safeguarding

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 vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

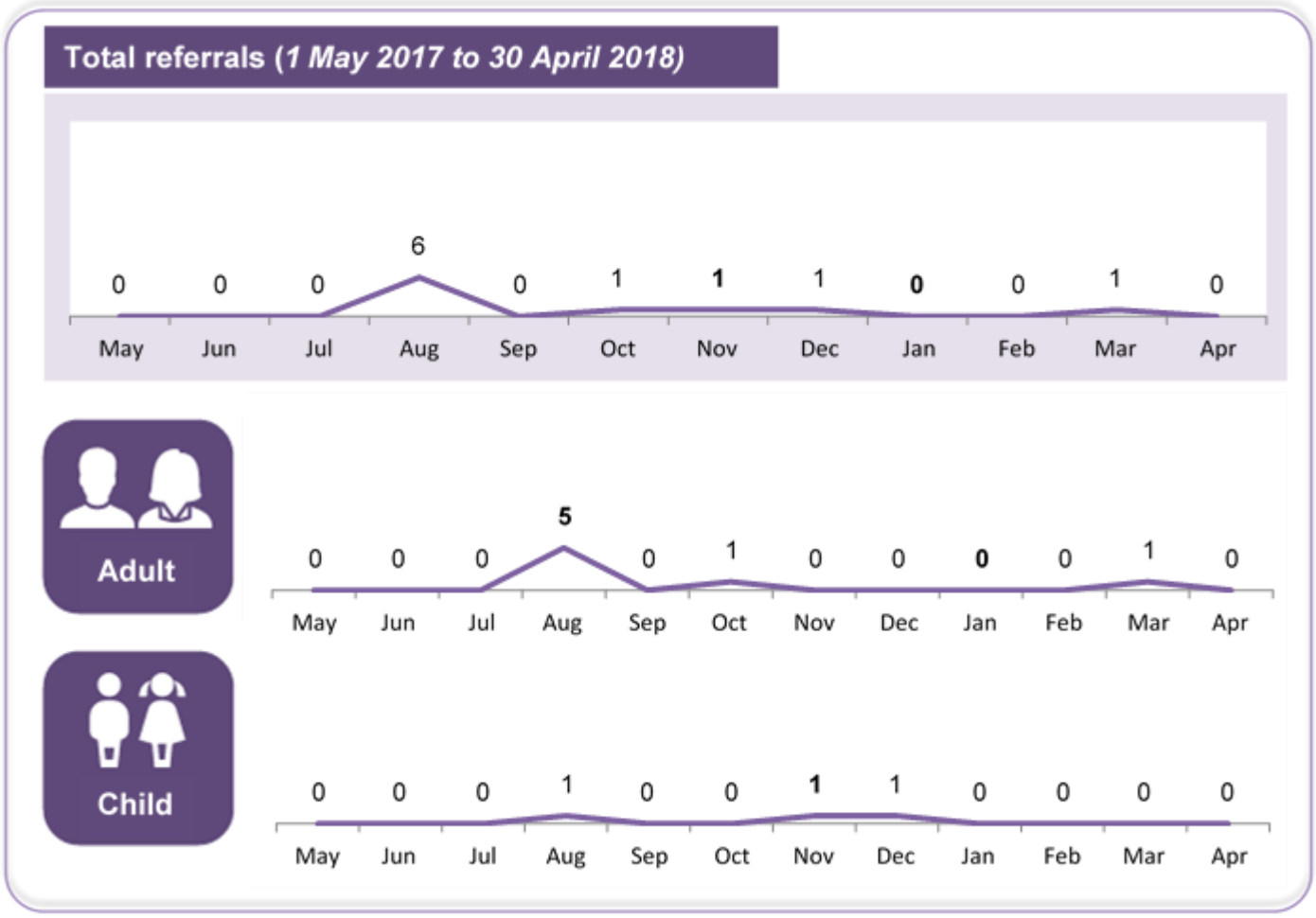
Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine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

This core service made 10 safeguarding referrals between 1 May 2017 and 30 April 2018, of which seven concerned adults and three children.

The number of safeguarding referrals reported during this inspection was lower than the 13 reported at the last inspection (3 April 2017).

Referrals		
Adults	**Children**	**Total referrals**
7	**3**	**10**

The reported numbers of adult referrals show a narrow range: between zero and one per month. The reported numbers of child referrals also show a narrow range: between zero and one per month. This indicates a stable system.



Staff were trained in safeguarding and knew how to make a referral. We saw that nursing staff had raised safeguarding concerns appropriately, and in a timely way. Care plans included protection plans and vulnerabilities where applicable. Staff could give examples of how to protect patients from harassment or discrimination; including protected characteristics under the Equality Act. Staff worked with other agencies where appropriate to keep patients safe. We saw an example of this when staff had made a children's safeguarding referral, due to concerns around their parents who were receiving treatment.

The service followed safe procedures for children visiting patients. Each ward had a designated room for this purpose.

Lincolnshire Partnership NHS Foundation Trust has submitted details of two serious case reviews commenced or published in the last 12 months [1 May 2017 to 30 April 2018], however they do not relate to this core service.

Staff access to essential information

The trust had recently introduced a new electronic patient record system. Staff reported that the implementation had been trouble free and they had received the appropriate level of training. All patient information was accessible to all staff working on the wards, as and when they needed it. This included when patients transferred between wards.

Medicines management

Medicines were stored safely and securely and were only accessible by authorised staff. Controlled drugs were appropriately stored and managed, however, emergency medicines were locked in the drug cupboard which may have caused a delay in administration. Refrigerator and room temperatures were monitored and were maintained within the recommended limits. All medications were available, within date, and suitable for use.

Patients detained under the Mental Health Act (MHA) received medicines that were duly authorised and administered in line with the MHA Code of Practice. Staff had access to T2 (consent to treatment) and T3 (record of second opinion) for reference when administering medication for patients.

Staff reviewed the effects of patients' physical health regularly. We saw that, where required, patients received daily monitoring of blood pressure, pulse, temperature and blood glucose monitoring. Staff monitored physical health in line with the National Institute for Health and Care Excellence guidance in relation to high dose anti-psychotic medications and mood stabilisers in four out of five cases we examined. We saw that doctors had entered discussions with female patients about the risks of pregnancy whilst taking certain medications, and potential complications.

Track record on safety

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of an incident being identified.

Between 1 May 2017 and 30 April 2018 there were 10 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was *Abuse/alleged abuse of adult patient by staff* with six. No unexpected deaths were reported for this core service.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

The number of serious incidents reported during this inspection was lower than the 18 reported at the last inspection (3 April 2017).

	Number of incidents reported			
Type of incident reported on STEIS	Charlesworth	PICU	Ward 12	Total
Abuse/Alleged abuse of patient by staff	3	1	1	6

Apparent/actual/suspected self-inflicted harm meeting SI criteria			1	1
Disruptive/aggressive/violent behaviour meeting SI criteria			1	1
Commissioning incident meeting SI criteria		1		1
Pending review (a category must be selected before incident is closed)	1			1
Total	**4**	**2**	**3**	**10**

Reporting incidents and learning from when things go wrong

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.

Staff knew what incidents to report, and how to report them, in line with Trust policy. Staff interviewed spoke about the importance of being open and transparent with patients. Staff were aware of, and demonstrated the duty of candour placed on them to inform people who use the services of any incident affecting them.

Staff received feedback from investigations of incidents, both internal and external to the service. Staff relayed examples of learning, and were aware of when incidents were discussed, and in what forum. Staff gave us examples of changes to practice following incidents specifically in the way patients would be managed, for example ensuring certain patients were never in the same space as each other following aggressive outbursts towards each other.

Managers had systems in place for dissemination of information, which included discussions at team meetings, during reflective practice meetings, through emails and alerts which were sent out centrally to staff, and during multi-disciplinary meetings.

Staff were supportive of one another following incidents. All staff we spoke with who had been involved in an incident had received a de-brief and support from the trust wellbeing service.

Is the service effective?

Assessment of needs and planning of care

We examined 29 care records. Staff completed a mental health assessment of patients upon, or shortly after admission. This included, where possible an assessment of the patients' physical health needs. Staff implemented care plans which reflected the patient's needs following initial assessment and 24 out of the 29 care records inspected were personalised, holistic and recovery orientated. Nursing staff updated care plans when necessary and following multidisciplinary discussions and included estimated dates of discharge.

The trust had implemented interactive technology at the Hartsholme centre which enabled patients to have access to their care plans in electronic form in their bedroom.

Best practice in treatment and care

This core service participated in one clinical audit as part of their clinical audit programme 2017 – 2018.
Managers we spoke with whilst on site said they had participated in audits around controlled drugs, care plans, physical healthcare, alcohol and smoking cessation and the ward round template.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Audit of Physical Health among acute inpatients in Charlesworth Ward	Charlesworth Ward	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	01/08/2017	Going forward: ensure training is provided at regular intervals. Ensure staff are regularly updated with statistics to ensure high-standards are maintained. MDT to optimise physical healthcare outcomes for service users, especially for inpatient ward, community and GPs.

Skilled staff to deliver care

The teams included a range of specialists required to meet the needs of the patients. Teams included doctors; nurses; nursing assistants; occupational therapists; psychologists; social workers; bed managers and discharge facilitators. Other specialists, such as a speech and language therapist or dieticians, could be accessed via a referral.

Staff had various levels of experience and qualifications. Training given supported staff to meet the needs of the patients. Nursing assistants undertook care certificates and national vocational qualifications. These enabled them to develop professionally, with opportunity for promotions. Some nursing assistants were undertaking nurse training while working part time for the trust. Qualified nurses were encouraged to attend additional training and conferences.

New staff received an appropriate induction to the service. This consisted of a corporate induction, mandatory training, and learning about the ward and trust policies and protocols. Staff then spent time orientating themselves to the ward allocated, alongside staff, before working as part of the team.

Staff had the opportunity to reflect and learn from practice; seek out personal and peer support; and discuss issues around work performance. Each ward held regular team meetings, or team days.

Ward managers dealt with poor staff performance promptly. Support from human resources was readily available, via telephone, or face to face.

The trust's target rate for appraisal compliance is 85%. As at 31 May 2018, the overall appraisal rates for non-medical staff within this core service was 89%.

The wards/teams failing to achieve the trust's appraisal target were Pilgrim medical secretaries with an appraisal rate of 50% and Pilgrim domestics at 63%.

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 83% reported at the last inspection (3 April 2017).

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
274 IA Divisional Manager Inpatient L60020	5	5	100%
274 IAIBD Pilgrim OT L50550	2	2	100%
274 IAIBG Pilgrim Admin L60503	4	4	100%
274 IAILA Team Leader Inpatient L21210	3	3	100%
274 IAILB Conolly Ward L21211	33	33	100%
274 IAILD Porters Recharge L20903	1	1	100%
274 IAILF HTT LIAISON PHC L21224	3	3	100%
274 IAILG PHC Admin L60220	6	6	100%
274 IAILH PHC Medical Secretaries L64210	4	4	100%
274 IAILC Charlesworth Ward L21212	36	35	97%
274 IAILI PHC Domestics L73210	13	12	92%
274 IAIBA Ward 12 L21521	36	28	78%
274 IA2 Psychiatric Intensive Care Unit (PICU) L21219	31	24	77%
274 IAIBE Pilgrim Domestic L60458	8	5	63%
274 IAIBF Pilgrim Medical Secretaries L60502	2	1	50%
Core service total	**187**	**166**	**89%**
Trust wide	**1648**	**1432**	**87%**

The trust's target rate for appraisal compliance is 85%. As at 31 May 2018, the overall appraisal rates for medical staff within this core service was 100%.

The rate of appraisal compliance for medical staff reported during this inspection was higher than the zero reported at the last inspection (3 April 2017).

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
274 LCAH Medical PICU L15219	2	2	100%
Core service total	**2**	**2**	**100%**
Trust wide	**68**	**52**	**76%**

Between 1 May 2017 and 30 April 2018 the average rate across all six teams in this core service was 16% of the trust's average of 54%.

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

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Conolly Ward	348	93	27%
Charlesworth Ward	326	72	22%
Psychiatric Intensive Care Unit	273	32	12%
Acute Therapy Team	70	5	7%
Ward 12	372	19	5%
Boston OT's	16	0	0%
Core service total	**1405**	**221**	**16%**
Trust Total	**13677**	**7344**	**54%**

Whilst on site managers told us that supervision compliance rates had improved. Staff and managers, we spoke with said they had regular supervision with wellbeing staff, matrons and peers. Although the recording of staff supervision remained an issue. Whilst we recognise since the last inspection the service had taken action in order to improve in this area the recording systems were not robust and did not capture staffs' compliance with supervision. Supervision rates were at 70%, this was below the trust target of 85% for this service.

Multidisciplinary and interagency team work

Staff attended multidisciplinary team meetings. Patients were encouraged to participate and share their views; one patient said that too many people attended the meeting that they found this quite intimidating. We observed one multi-disciplinary meeting, and found this to be very thorough, and included any potential leave or discharges.

Occupational therapists and activity coordinators workers worked as part of the team and we saw that they worked closely with patients. The patients we talked with spoke positively about the support they received.

We attended one handover meeting. Staff provided details including each patient's level of observations, risks, and Mental Health Act status. Staff received information on diagnosis, current presentation, and activities for the day and physical health care, as appropriate.

Ward managers reported they had good relationships with community mental health teams and the local authority.

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

As of 31 May 2018, 87% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is non-mandatory for all core services for inpatient and all community staff and is a one off course.

The training compliance reported during this inspection was the same as the 87% reported at the last inspection (3 April 2017).

Staff understood their roles and responsibilities under the Mental Health Act 1983, Code of Practice and the guiding principles. Staff told us they had access to Mental Health Act administrators, who provided support and legal advice. Staff completed audits of detention paperwork.

The trust had relevant policies and procedures in place relating to the Mental Health Act, and informal patients. Staff could access policies and procedures easily when required, and they incorporated the most recent guidance.

Staff displayed information around the ward about independent mental health advocacy. Staff assisted patients with accessing the service.

Nursing staff regularly explained patients' rights under the Mental Health Act and recorded this in the electronic patient record.

Nursing staff accommodated patients escorted Section 17 leave, when granted. (Section 17 refers to detained patients having permission to leave the hospital for a specified length of time) Staff reported that on occasions, leave had been delayed or rescheduled, due to the activity levels on the wards. Section 17 leave forms clearly included terms and conditions for leave, including a risk assessment.

Doctors requested an opinion from a second opinion appointed doctor when necessary, when detained patients had not consented to medications, in line with the Mental Health Act.

Staff stored detention paperwork electronically so that all staff had access to them. Original paper copies were stored with the Mental Health Act administrator.

Each ward displayed notices to tell informal patients that they could leave the ward freely, and to discuss with nursing staff.

Good practice in applying the Mental Capacity Act

As of 31 May 2018, 42% of the workforce in this core service had received training in the Mental Capacity Act. The trust stated that this was essential training mandatory for all clinical staff and is refreshed every 3 years.

The training compliance reported during this inspection was lower than the 55% reported at the last inspection (3 April 2017).

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 May 2017 and 30 April 2018.

CQC received 22 direct notifications from Lincolnshire Partnership NHS Foundation Trust between 1 May 2017 and 30 April 2018[1]. However, none pertained to this core service.

The number of DoLS applications made during this inspection was lower than the six reported at the last inspection (3 April 2017).

Staff had a broad understanding of the Mental Capacity Act and knew where they could find relevant information including an up to date policy. Staff assumed patients had the capacity to make specific decisions.

Staff encouraged patients to make decisions for themselves where possible. Staff completed capacity assessments for specific decisions, if they believed a patient had impaired capacity.

[1] PAN01 Notifications

When a patient lacked capacity, staff made decisions in their best interests. Staff also considered and documented the patients' capacity to consent to care plans.

Staff had support from the safeguarding and Mental Capacity team for guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at both core service location(s) scored lower when compared to similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Peter Hodgkinson Centre	Acute wards for adults of working age and psychiatric intensive care units Mental health crisis services and health based places of safety MH – Other Specialist Services Secure wards/Forensic inpatient	89.7%
Pilgrim Hospital	Acute wards for adults of working age and psychiatric intensive care units MH – Other Specialist Services Wards for older people with mental health problems Mental health crisis services and health based places of safety Community based mental health services for older people	84.2%
Trust overall		**86.4%**
England average (mental health and learning disabilities)		**90.6%**

We observed positive interactions between staff and patients. Staff were responsive to individual need during our inspection. Staff understood individual needs of patients and knew the patients well. This included cultural, social and religious needs. Of the 20 patients we spoke with, 17 were positive about the staff. Patients felt that staff were kind and supportive and treated them with dignity and respect.

Three out of the 20 patients we spoke with, were negative about the staff. One patient said staff could be impatient and spoke sharply. Two patients told us that on occasions staff dismissed them and were late in giving them their medication.

Staff said they could raise concerns about any discriminatory, disrespectful or abusive behaviour or attitudes towards patients, without fear of reprisal.

Staff maintained the confidentiality of patients. Sensitive conversations with patients took place in private. Staff were mindful of other patients being in communal areas and ensured that any conversations about patients between staff could not be overheard by others.

Involvement in care

Involvement of patients

Patients were orientated to the ward upon admission. Staff showed patients around and introduced them to other staff and patients. Staff provided patients with welcome packs upon admission. This contained information about the ward generally and the patients' rights, whether detained or informal, this was available in electronic format at the Hartsholme centre.

Some patients were involved in care planning across the service, which was demonstrated in care records. However, five (25%) told us they were not aware of their care plans. Staff offered patients a copy of their care plans, which was usually reflected in care records.

Staff communicated effectively with patients and used language that they understood.

Patients across all wards had the opportunity to attend regular community meetings. During these meetings, patients could give their views of the service, and make suggestions of how things could be improved, or done differently. One example of change following feedback, was in relation to activities on the ward. Patients were given extended time to access activities room and equipment.

Patients had access to advocacy services on the wards and information and contact details were contained in patient admission packs and on posters and leaflets available on the wards.

Involvement of families and carers

Staff told us they informed and involved families and carers appropriately and provided them with support when needed if the patient had consented to this. 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.

Staff described how they would support carers to access a carer's assessment.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for four wards in this core service between 1 May 2017 and 30 April 2018.

Three of the wards within this core service reported average bed occupancies ranging above the national recommended minimum benchmark of 85% over this period.

We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Bed management processes were effective and included daily bed management meetings. Mangers said they would endeavour to ensure a bed was available for patients on return from leave.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds, for example a transfer to the psychiatric intensive care ward.

When patients were transferred or discharged, this occurred wherever possible at appropriate times of the day.

Ward name	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	Total
12A	0	0	1	0	0	0	0	0	0	0	0	0	**1**
CONOLLY WARD	0	0	0	0	0	2	0	1	0	0	0	0	**3**
HARTSHOLME PICU	0	0	1	0	0	0	0	1	0	1	2	1	**6**
Core service total	0	0	**2**	**0**	**0**	**2**	**0**	**2**	**0**	**1**	**2**	**1**	**10**

There were no patients awaiting a psychiatric intensive care bed. Ward managers told us that they had no waiting lists, and usually met patient need for beds.

Staff across the service worked on admissions and discharges. Bed managers, social workers and discharge co-ordinators all worked collaboratively to ensure appropriate flow of movement across the acute and psychiatric intensive care units.

Ward name	Average bed occupancy average (1 May 2017 – 30 April 2018) (current inspection)
12A	104.08
CHARLESWORTH WARD	102.62
CONOLLY WARD	97.71
HARTSHOLME PICU	75.82

The trust provided information for average length of stay for the period 1 May 2017 to 30 April 2018.

We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	Average length of stay range (1 May 2017 – 30 April 2018) (current inspection)
12A	15-56
CHARLESWORTH WARD	25-53
CONOLLY WARD	18-38
HARTSHOLME PICU	5-30

This core service reported 344 current out area placements between 1 May 2017 and 30 April 2018.

As of 10 June 2018, this core service had six ongoing out of area placements.

There was one placement that lasted less than one day, and the placement that lasted the longest amounted to 318 days.

Of the 344 current out of area placements for this core service, 280 were due to the patient being placed with another provider due to capacity issues; while 61 placements were because the patient was received from another provider. Three were due to the patient being placed with another provider due to this better suiting their care or personal needs.

The number of out of area placements reported during this inspection was higher, than the 219 reported at the time of the last inspection (3 April 2017).

Managers told us that the number of out of area placements had reduced significantly over recent months. They said that the provision of the 10 psychiatric intensive care beds had contributed to the reduction of patients receiving care out of area. The trust produced a daily dashboard of patients in out of area placements which was monitored and arrangements for patients to return to local beds was discussed. At the time of the inspection we were informed there were 21 out of area placements with four patients due to be transferred back to the trust within the next two days.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Number due to being received from another provider	Range of lengths (completed placements)	Number of ongoing placements
344	3	280	61	0- 318	6

This core service reported 71 readmissions within 28 days between 1 May 2017 and 30 April 2018.

Of the readmissions 31 (44%) were readmissions to the same ward as discharge.

The average of days between discharge and readmission was 15 days. There were no instances whereby patients were readmitted on the same day as being discharged but there were four instances where patients were readmitted the day after being discharged.

At the time of the last inspection, for the period 1 January 2016 to 31 December 2016, there were 32 readmissions within 28 days. Of these, 16 were readmissions to the same ward (50%) and the average days between discharge and readmission was 14 days.

Therefore, the number of readmissions within 28 days has increased between the two periods and the average time between discharge and readmission has remained static.

Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
71	31	44%	1-30	15

Discharge and transfers of care

Between 1 May 2017 and 30 April 2018, there were 721 discharges within this core service. This amounts to 64% of the total discharges from the trust overall (1127). Of the 721 discharges seven (1%) were delayed for this core service.

The proportion of delayed discharges reported during this inspection was better than the 17% reported at the time of the last inspection (3 April 2017).

The trust has identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

The core service did not meet the referral to assessment target in the one target listed.

The core service did not meet the assessment to treatment target in the one target listed.

The number of days from referral to initial assessment and assessment to treatment during this inspection was worse than that reported at the time of the last inspection (six and six).

Name of hospital site or location	Name of in-patient ward	Service Type	Days from referral to initial assessment		Days from assessment to treatment	
			Target	Actual (mean)	Target	Actual (mean)
Long Leys Road Site, Lincoln (RP7QS)	Hartsholme Centre	General Psychiatry	0.16	8	1	15

Facilities that promote comfort, dignity and privacy

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the locations scored higher than similar trusts. There was one location – Pilgrim Hospital (79.9%) that scored lower when compared to other similar trusts for ward food.

Site name	Core service(s) provided	Ward food
Peter Hodgkinson Centre	Acute wards for adults of working age and psychiatric intensive care units Mental health crisis services and health based places of safety MH – Other Specialist Services Secure wards/Forensic inpatient	94.7%
Pilgrim Hospital	Acute wards for adults of working age and psychiatric intensive care units MH – Other Specialist Services Wards for older people with mental health problems Mental health crisis services and health based places of safety Community based mental health services for older people	79.9%
Trust overall		**91.5%**
England average (mental health and learning disabilities)		**91.5%**

Patients at the Hartsholme centre had single ensuite bedrooms and patients could personalise their room. Charelsworth, Conolly and Ward 12 had dormitory areas, however patents could display personal items such as posters and photographs.

Patients had somewhere safe to store their possessions. There were lockable cupboards or drawers in bedrooms, and patients could store items in a separate locked area, if needed.

Staff and patients had access to a full range of rooms and equipment to support treatment and care. Each ward had space utilised for activities, clinic rooms and de-escalation rooms. In addition to this, outside space was available for fresh air. The service also had gyms for patient use, following an appropriate induction.

Each ward had quieter areas where patients could receive visitors and private areas to make phone calls., if they required a ward telephone. Staff undertook risk assessments for the use of mobile phones on the ward. We saw many patients throughout the inspection using their own mobile phones.

Patients had access to outside space, although staff had to supervise the use of outdoor areas, due to risks, including blind spots.

Patients could make hot drinks and snacks throughout the 24-hour period. Generally, the kitchen areas were locked by staff throughout the night. However, if patients requested something to eat or drink, staff facilitated this.

Patients' engagement with the wider community

Staff supported patients to maintain contact with friends and family members where appropriate. If patients wanted families or carers involved in their care, this was encouraged. Patients told us that family members had been into ward rounds when requested.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients. Each ward had appropriate access to premises for patients who may require a wheelchair, or who had limited mobility. We saw that special beds and mattresses, and hoists had been sourced as and when required for patients.

Patients had access to a wide range of information through leaflets displayed on each ward. This included information on treatments, patients' rights, how to complain, how to contact advocacy, as well as information about local services, for example housing or drug and alcohol support groups.

Information provided was in a variety of languages. Staff could obtain information in different languages spoken by patients. Easy read versions of leaflets could also be sourced for those patients who had a learning disability.

Ward staff had access to interpreters and signers. We spoke with some staff who spoke different languages, and who had helped patients interpret during multi-disciplinary meetings.

Patients were given a choice of foods to meet individual dietary requirements of religious and ethnic groups. Patients at the Hartsholme centre had recently taken part in a "tasting session" to decide which foods would be part of the new menu choices.

The trust provided a chaplaincy service that provided patients with access to support from a variety of religions and faiths.

Listening to and learning from concerns and complaints

This core service received 14 complaints between 1 May 2017 and 30 April 2018. None of these none were upheld, nine were partially upheld and five were not upheld. None were referred to the Ombudsman.

The number of either partially or fully upheld complaints reported during this was higher than the five reported at the last inspection.

Ward/Team	Patient Care	Values & behaviours (staff)	Communications	Other (Specify in comments)	Admissions and discharges (excluding delayed discharge due to absence of care package)	Prescribing	Grand Total
Conolly Ward (Inpatient)	2	1		1	1	1	**6**
Ward 12 (Inpatient)	6						**6**
Charlesworth Ward (Inpatient)	1						**1**

Hartsholme (PICU)			1				**1**
Core service total	**9**	**1**	**1**	**1**	**1**	**1**	**14**

We saw thank you cards from patients and relatives during the inspection.

Patients we spoke with were aware of how to make a complaint, and who to approach in the first instance.

Staff managing the complaint usually fed back the findings to the patients. This could be face to face, if the patient was on the ward, or through a letter.

Staff knew how to handle complaints appropriately, and knew how to escalate, where to record, and who to report too.

Staff received feedback on the outcome of the investigation of complaints during team meetings. One example of learning from a complaint, resulted in the ward information leaflet being updated.

This core service received 35 compliments during the last 12 months from 1 May 2017 to 30 April 2018, which accounted for 1% of all compliments received by the trust as a whole.

Is the service well-led?

Leadership

Managers had the skills, knowledge and experience to perform their roles. Ward managers had a good understanding of the wards they managed and were aware of how well the team was performing.

We saw that ward managers were visible throughout the inspection, attended multidisciplinary meetings, patient meetings, and were available generally for staff and patients. Staff reported that they could approach the ward managers, who would make time to speak with them as required. Staff on the wards knew who the service managers and senior leaders were.

Ward managers and senior nurses had been given the opportunity to undertake leadership development.

Vision and strategy

Staff could tell us the vision and values of the trust. The trusts vision and values were dedicated to making a positive difference and aimed to provide care with compassion. Ward teams had used the template of the trust values to describe their work against these values. Throughout the inspection, we saw staff demonstrated these values in their day to day work with patients.

There was evidence in the notes from recent service development days that ward managers contributed to discussions about strategy of the service and new initiatives and different ways of working. We heard from staff that there had been lots of discussions around developing the acute care pathway.

Staff interviewed were keen to give all patients a positive experience of being in hospital, with emphasis upon recovery and returning to the community.

Manager's explained how they were working to deliver high quality care within the budget available.

Culture

During the reporting period, there was one case where staff have been suspended.

The case involved Band 3 staff group.

The number of staff placed under supervision, suspended or moved ward during this inspection was worse than those reported at the last inspection (none reported).

Caveat: Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

Ward name	Suspended	Under supervision	Ward move	Total
Hartsholme Unit	1	**0**	**0**	1

Staff felt respected, supported and valued by team members and senior staff. Staff were proud to be working for the trust and enjoyed their roles on the wards.

Staff felt able to raise any concerns about patient care and treatment without any fear of retribution. Staff were familiar with the whistle blowing process and the role of the Speak up Guardian.

Ward managers dealt with poor staff performance when needed. Managers were supported by senior staff and the human resource department when required. Staff followed the trust policy for any misconduct to ensure a fair process for staff.

Ward teams worked well together and provided mutual support. Staff felt able to speak with the ward managers or service director if there were any difficulties within the teams.

Staff appraisals included conversations about career development, and how this could be supported.

Staff were supported with wellbeing and were encouraged to look after both their physical and emotional health needs. Staff described recent free yoga and Zumba sessions.

The trust recognised staff and team success within the service. We saw individual staff had received staff awards, which were displayed.

Staff sickness rate across this service was 5% between 1 May 2017 and 30 April 2018.This was higher than the national average, which was 4%.

Governance

The trust have provided their board assurance framework, which details any risk scoring 15 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The three strategic principles with 10 sub priorities outlined by the trust relating to this core service are as follows:

1. Improving service quality:
    a. More people will have good mental health
    b. More people will have a positive experience of care and support
    c. More people with mental health and learning disability problems will have good physical health.
    d. Fewer people will suffer avoidable harm
    e. Promote recovery and independence
2. Using resources more effectively:
    a. Support our people to be the best they can be

b. Maximise NHS response
c. Ensure our estate is fit for modern healthcare delivery

3. Retaining and developing the business:
    a. People will have better access to LPFT services
    b. Support integrated health and social care in Lincolnshire

There were governance processes in place. Managers attended monthly quality meetings. Ward issues, such as incidents, safeguarding and staffing concerns were discussed with other managers across the service. Ward managers participated in daily meetings to review patient admissions, leave and discharges.

Wards had set agendas of what needed to be discussed at team level, in team meetings. This included learning from incidents, ward issues, security and environmental issues, and documentation. Staff took minutes of meetings so that those who could not attend knew what was discussed. Minutes were emailed to staff.

We saw that staff had implemented recommendations from the learning of incidents and complaints. Information had been successfully cascaded to staff at ward level.

Staff undertook clinical audits on the wards.

Staff understood the importance of working with external teams and individuals, to meet the needs of the patients. Care records demonstrated effective joint working with others.

Management of risk, issues and performance

The trust has provided a document detailing their 10 highest profile risks. Each of these has a current risk score of 15 or higher. The following relate to this core service.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Last review date
77	Currently there is a lack of parity in the provision of Psychology between Lincoln and Boston in patient services, there is a WTE in Lincoln covering Conolly and Charlesworth and no cover for ward 12 with maple lodge only receiving one day per week for 15 patients. This contravenes standard 1 for AIMS accreditation and creates disparity for treatment localities.	15	15	2	No date
18	Patient safety could potentially be compromised due to staff shortages, unfilled shift and over reliance on agency staff	16	16	8	26/06/2018

Staff had access to the risk register at ward level. Senior staff regularly reviewed this. Staff at ward level could escalate any concerns through the ward manager.

The service had plans for emergencies, such as a flu outbreak, information technology failure or adverse weather.

Information management

Systems were in place to manage information. The trust used electronic systems to collect data from wards. These included an electronic system to record incidents and risks, and a system to record staff training, sickness, supervision and appraisals. The trust used this data to provide monthly compliance reports, which enabled managers to review and act.

Staff had access to information technology needed to complete their work. Staff reported that generally the electronic recording system worked well, was easy to navigate and they had sufficient support and training prior to its introduction.

Staff adhered to confidentiality of patient records.

Staff made notifications to external bodies when appropriate, such as the local authority and the Care Quality Commission.

Engagement

Wards had information boards detailing the staff on duty and staffing levels. These informed patients of the staff available for care and treatment for that day.

Manager's and staff facilitated weekly community meetings, these allowed patients and carers, where appropriate to raise concerns and provide feedback about the wards. The minutes of the meetings showed that actions had been taken following the meetings.

Patients were actively involved in choosing food for the ward menus at the Hartsholme centre.

Learning, continuous improvement and innovation

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 core service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
AIMS – WA (Working age units)	Hartsholme	Obtained 2011, renewal date 2019
AIMS – PICU (Psychiatric Intensive Care Units)		Plan for completion of AIMS accreditation in Autumn 2018

Community-based mental health services for adults of working age

Facts and data about this service

Location site name	Team name	Number of clinics	Service user group (male, female, mixed)
Long Leys Road Site, Lincoln (RP7QS)	Adult Community Mental Health Team (Lincoln South Team)	-	-
Long Leys Road Site, Lincoln (RP7QS)	Adult Community Mental Health Team (Lincoln North Team)	-	-
Beaconfield Site, Grantham (RP7MB)	Adult Community Mental Health Team (Beaconfield Site)	-	-
Beech House, Boston (RP7DD)	Adult Community Mental Health Team (Beech House)	-	-
Holly Lodge, Skegness (RP7DG)	Adult Community Mental Health Team (Holly Lodge)	-	-
Johnson Hospital, Spalding (RP7RK)	Adult Community Mental Health Team (Johnson Hospital)	-	-
Stamford Resource Centre (RP7RH)	Adult Community Mental Health Team (Stamford Resource Centre)	-	-
Windsor House, Louth (RP774)	Adult Community Mental Health Team (Windsor House)	-	-
Trinity House, Gainsborough (RP727)	Adult Community Mental Health Team (Trinity House)	-	-
Long Leys Road Site, Lincoln (RP7QS)	Early Intervention Team	-	-

Is the service safe?

Safe and clean environment

Staff did regular risk assessments of the care environment.

Most of the interview rooms had emergency call alarms and there were staff on site to respond to the alarms. Where rooms did not have alarms, staff used personal alarms.

Although clinic rooms were well-equipped with the necessary equipment to carry out physical examinations, staff did not have direct access to emergency equipment at the team base. While this is good practice, rather than a requirement, and the trust had risk assessed the situation, we did not think the timeframes the trust had stated, of between three and five minutes to access emergency equipment from neighbouring wards, or calling an emergency ambulance, were realistic in all situations.

Areas were clean, had good furnishings and were well-maintained. Cleaning records were up to date and showed that staff cleaned the premises regularly.

Staff adhered to infection control principles, including handwashing.

Staff maintained equipment and kept it clean, and ‘clean’ stickers were visible and in date.

Safe staffing

Definition

Substantive – All filled allocated and funded posts.

Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 30 April 2018	177.3	N/A
Total number of substantive staff leavers	1 May 2017–30 April 2018	16.1	N/A
Average WTE* leavers over 12 months (%)	1 May 2017–30 April 2018	9%	N/A
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 30 April 2018	30.6	N/A
Total vacancies overall (%)	At 30 April 2018	14%	N/A
Total permanent staff sickness overall (%)	Most recent month (At 30 April 2017)	4%	4.5%
	1 May 2017–30 April 2018	5%	4.5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 30 April 2018	84	N/A
Establishment levels nursing assistants (WTE*)	At 30 April 2018	74.2	N/A
Number of vacancies, qualified nurses (WTE*)	At 30 April 2018	14.7	N/A
Number of vacancies nursing assistants (WTE*)	At 30 April 2018	9.5	N/A
Qualified nurse vacancy rate	At 30 April 2018	17%	N/A
Nursing assistant vacancy rate	At 30 April 2018	13%	N/A
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 May 2017–30 April 2018	2752.7 (4%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 May 2017–30 April 2018	2552.3 (3%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 May 2017–30 April 2018	30578.8 (40%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 May 2017–30 April 2018	99.5 (0.3%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 May 2017–30 April 2018	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 May 2017–30 April 2018	15900.5 (53%)	N/A

*Whole-time Equivalent

This core service reported an overall vacancy rate of 17% for registered nurses at 30 April 2018, though at the time of inspection, and following a successful recruitment drive, this core service reported an overall vacancy rate for all staff at 12%. This was lower than the rate reported at the last inspection.

The vacancy rate for registered nurses was higher than the 5% reported at the last inspection (3 April 2017)

This core service reported an overall vacancy rate of 13% for registered nursing assistants.

The vacancy rate for nursing assistants was lower than the 15% reported at the last inspection (3 April 2017).

This core service has reported a vacancy rate for all staff of 14% as of 30 April 2018. This was similar to the rate reported at the last inspection (between 1 January 2016 and 31 December 2016).

	Registered nurses			Health care assistants			Overall staff figures		
Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
274 LCAF Senior Medical Adult East L15501	0	0	0%	0	0	0%	1.85	2	93%
274 GAC2A S75 Best Interest Assessors L75040	0.4	5	8%	1	1.5	67%	9.57	16.67	57%
274 GACCB1 Boston EI L21606	1	2	50%	0	0	0%	1	2	50%
274 GACS Spalding CMHT (Health) L21564	4	8	50%	6.18	11.41	54%	10.18	20.41	50%
274 GACS1 Spalding EI L21608	1	2	50%	0	0	0%	1	2	50%
274 GACCB Boston CMHT (Health) L21562	4.8	11.6	41%	6.36	11.47	55%	11.16	23.07	48%
274 GACLS5 Lincoln South Med Sec L64360	0	0	0%	0.67	1.67	40%	0.67	1.67	40%
274 GAC2 S75 AMHP Social Inclusion L75024	0	0	0%	-0.5	0	0%	1.3	3.8	34%
274 GACLN4 Lincoln North CMHT (Health) L21360	3.76	11.36	33%	3.47	8.47	41%	6.83	19.83	34%
274 GAC2B S75 Management L75050	0	0	0%	2.2	3	73%	2.8	8.6	33%
274 LCAE Senior Medical Adult North East L15330	0	0	0%	0	0	0%	0.5	1.5	33%
274 GACC2 Early Intervention Psychology L53255	1	3	33%	0	0	0%	2.2	7	31%
274 GACG Grantham CMHT (Health) L21588	4.2	11.88	35%	-0.17	9.18	-2%	4.23	23.06	18%
274 GACLS Lincoln South CMHT (Health) L21220	1.4	12	12%	1.25	7.05	18%	1.65	19.05	9%
274 GAC Divisional Manager Community L60010	0	1	0%	0	2.8	0%	0.7	9	8%
274 GACL Louth CMHT (Health) L21333	0.34	7.78	4%	0.8	5.7	14%	1.14	13.48	8%
274 LCCOC Med CMHT Lincoln L15220	0	0	0%	0	0	0%	0.4	4.9	8%
274 GACG2 Grantham Medical Secretaries L60586	0	0	0%	0.17	2.8	6%	0.17	2.8	6%
274 GACL2 Louth Medical Secretary L64333	0	0	0%	0.04	2.1	2%	0.04	2.1	2%
274 GAC2D S75 South Team L75410	0	0	0%	0	0	0%	0.08	7	1%
274 GACC Team Leader Assertive Outreach L21503	-1	0	0%	0	0	0%	0	1	0%
274 GACC1 Team Leader South West L60410	0	0	0%	0	0.49	0%	0	0.49	0%
274 GACCB5 Skegness CMHT (Health) L21565	-3.2	0	0%	-4.3	0	0%	-7.5	0	0%

274 GACG3 Grantham EI L21609	0	2	0%	0	0	0%	0	2	0%
274 GACLN Gainsborough CMHT (Health) L21310	-2	0	0%	-3.64	0	0%	-5.64	0	0%
274 GACLN3 Gainsborough Medical Secretary L64310	0	0	0%	0	1	0%	0	1	0%
274 GACLN5 Lincoln North EI L21601	0	3	0%	0	0	0%	0	4	0%
274 GACLN7 Lincoln North Medical Secretary L64220	0	0	0%	0	1	0%	0	1	0%
274 GACLS1 Lincoln South EI L21602	0	3	0%	0	0	0%	0	2.4	0%
274 GACOEL6 Louth EI L21603	0	1	0%	0	0	0%	0	1	0%
274 GACS6 Stamford CMHT (Admin) L60542	-2	0	0%	0	1	0%	0	1	0%
274 GACS7 Stamford Medical Secretaries L64542	0	0	0%	0	1	0%	0	1	0%
274 LCCOB Med CMHT Louth L15330	0	0	0%	0	0	0%	-1	0	0%
274 LCCOE Med Community Boston L15562	0	0	0%	0	0	0%	0	3.9	0%
274 GACS4 Stamford CMHT (Health) L21592	0	0	0%	-4	0	0%	-6	0	0%
274 GACCB4 Med Sec Boston L64562	0	0	0%	0	0	0%	-0.02	2.51	-1%
274 LCCOF Med Community Grantham L15588	0	0	0%	0	0	0%	-0.1	1.9	-5%
274 LCCOD Med Community Spalding L15542	0	0	0%	0	0	0%	-0.9	2.3	-39%
274 GAC2C S75 North Team L75408	0	0	0%	0	0	0%	-4.4	8	-55%
274 LCA Senior Medical Adult North L15210	0	0	0%	0	0	0%	-1.3	2.3	-57%
Core service total	**14.7**	**84.0**	**17%**	**9.5**	**74.2**	**13%**	**30.6**	**225.7**	**14%**
Trust total	**66.3**	**549.4**	**12%**	**43.6**	**605.4**	**7%**	**172.2**	**1756.0**	**10%**

NB: All figures displayed are whole-time equivalents

The trust had decided safe staffing levels by calculating the number and grade of members of the multidisciplinary team required using a systematic approach.

The number, profession, and grade of staff in post matched the provider's staffing plan.

While managers assessed the size of the caseloads of individual staff regularly and helped staff manage the size of their caseloads some early intervention team members and the doctor's caseloads were higher than national guidelines suggested they should be. Staff in the early intervention team told us this was a temporary situation until new staff had completed their training and induction, to take on the excess numbers on their caseloads. Doctors told us they did not feel confident that there were enough or appropriate resources either within or external to the service to enable them to discharge more service users safely.

The service used very little bank and agency staff. Managers used existing team resources to cover sickness, leave and vacant posts without undue pressure on existing staff. This ensured the safety and consistency of treatment for service users. Therefore, while the figures quoted below for unfilled shifts appears high this is misleading.

Between 1 May 2017 and 30 April 2018, bank staff filled 4% of shifts to cover sickness, absence, or vacancy for qualified nurses.

In the same period, agency staff covered 3% of shifts for qualified nurses. Forty percent of shifts were unable to be filled by either bank or agency staff.

Team	Total Hours	Bank use (hours)	Agency use (hours)	Total hours unfilled by bank or agency staff
CMHT Boston	9132.7	494.7 (5%)	0 (0%)	2627.7 (29%)
CMHT Gainsborough	4084.6	43.3 (1%)	112 (3%)	4235.3 (104%)
CMHT Grantham	14639.0	40 (0.3%)	0 (0%)	6356.7 (43%)
CMHT Lincoln North	10812.6	1700 (16%)	0 (0%)	4893.4 (45%)
CMHT Lincoln South	14157.7	112.8 (1%)	0 (0%)	4703.7 (33%)
CMHT Louth	9794.8	0 (0%)	699 (7%)	2942.8 (30%)
CMHT Skegness	5213.4	361.5 (7%)	72 (1%)	3276.9 (63%)
CMHT Spalding	9374.4	0 (0%)	1669.3 (18%)	1542.4 (16%)
Core Service Total	**77209.1**	**2752.2 (4%)***	**2552.3 (3%)***	**30578.8 (40%)***
Trust Total	**469050.1**	**40081.8 (9%)**	**4217.8 (1%)***	**144727.5 (31%) ***

*****Percentage of total shifts

Between 1 May 2017 and 30 April 2018, bank staff to cover sickness, absence or vacancy for nursing assistants filled less than 1% of shifts.

In the same time period, agency staff covered 0% of shifts. Fifty-three percent of shifts were unable to be filled by either bank or agency staff.

Team	Total Hours	Bank use (hours)	Agency use (hours)	Total hours unfilled by bank or agency staff
CMHT Boston	6058.4	0 (0%)	0 (0%)	1408.5 (23%)
CMHT Gainsborough	927.15	0 (0%)	0 (0%)	1576.5 (170%)
CMHT Grantham	6015.1	0 (0%)	0 (0%)	2311.5 (38%)
CMHT Lincoln North	4822.35	0 (0%)	0 (0%)	1638.4 (34%)
CMHT Lincoln South	1314.6	96.5 (7.3%)	0 (0%)	231.3 (18%)
CMHT Louth	4393.3	0 (0%)	0 (0%)	2547.5 (58%)
CMHT Skegness	3395.4	3 (0.1%)	0 (0%)	4076.0 (120%)
CMHT Spalding	2913	0 (0%)	0 (0%)	2111.0 (72%)
Core Service Total	**29839.3**	**99.5 (<1%)***	**0 (0%)***	**15900.5 (53%)***
Trust Total	**443457.4**	**100481 (23%)***	**15807 (4%)***	**61265.39 (14%)***

*Percentage of total shifts

This core service had 16.1 (9%) staff leavers between 1 May 2017 and 30 April 2018. This was higher than the 5% reported at the last inspection (from 3 April 2017).

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
274 GACCB2 Boston Assertive Outreach L21615	0	1	150%
274 GACS6 Stamford CMHT (Admin) L60542	1	1	150%
274 GACC Team Leader Assertive Outreach L21503	1	1	86%
274 GAC2B S75 Management L75050	5.8	4.6	69%
274 GACCB1 Boston EI L21606	1	1	63%
274 LCAF Senior Medical Adult East L15501	0	1.5	38%
274 GACCB4 Med Sec Boston L64562	2.53	0.51	22%
274 GAC2C S75 North Team L75408	9.4	1.6	17%
274 GACCB Boston CMHT (Health) L21562	11.31	1.65	11%
274 GAC2A S75 Best Interest Assessors L75040	7.1	0.8	9%
274 GACS Spalding CMHT (Health) L21564	10.23	1	6%
274 GACG Grantham CMHT (Health) L21588	18.33	0.42	2%
274 GAC Divisional Manager Community L60010	6.8	0	0%
274 GAC2 S75 AMHP Social Inclusion L75024	2.5	0	0%
274 GAC2D S75 South Team L75410	6.92	0	0%
274 GACC1 Team Leader South West L60410	0.49	0	0%
274 GACC2 Early Intervention Psychology L53255	4.8	0	0%
274 GACG1 Grantham Assertive Outreach L21618	0	0	0%
274 GACG2 Grantham Medical Secretaries L60586	2.63	0	0%
274 GACL Louth CMHT (Health) L21333	11.34	0	0%
274 GACL2 Louth Medical Secretary L64333	2.06	0	0%
274 GACLN Gainsborough CMHT (Health) L21310	5.64	0	0%

274 GACLN3 Gainsborough Medical Secretary L64310	1	0	0%
274 GACLN4 Lincoln North CMHT (Health) L21360	10.4	0	0%
274 GACLN5 Lincoln North EI L21601	4	0	0%
274 GACLN6 Lincoln North Assertive Outreach L21610	0	0	0%
274 GACLN7 Lincoln North Medical Secretary L64220	1	0	0%
274 GACLS Lincoln South CMHT (Health) L21220	16.2	0	0%
274 GACLS1 Lincoln South EI L21602	2.4	0	0%
274 GACLS2 Lincoln South Assertive Outreach L21611	0	0	0%
274 GACLS5 Lincoln South Med Sec L64360	1	0	0%
274 GACS1 Spalding EI L21608	1	0	0%
274 GACS2 Spalding Assertive Outreach L21617	0	0	0%
274 GACS7 Stamford Medical Secretaries L64542	1	0	0%
274 LCAG Senior Medical Adult South West L15551	0	0	0%
274 GACOEL6 Louth EI L21603	1	0	0%
274 GACG3 Grantham EI L21609	2	0	0%
274 LCA Senior Medical Adult North L15210	1.6	0	0%
274 GACCB5 Skegness CMHT (Health) L21565	7.1	0	0%
274 GACS4 Stamford CMHT (Health) L21592	5.8	0	0%
274 LCCOB Med CMHT Louth L15330	1	0	0%
274 LCCOC Med CMHT Lincoln L15220	3	0	0%
274 LCCOD Med Community Spalding L15542	2.9	0	0%
274 LCCOE Med Community Boston L15562	2	0	0%
274 LCCOF Med Community Grantham L15588	2	0	0%
Core service total	**177.3**	**16.1**	**9%**
Trust Total	**1474.6**	**162.2**	**12%**

The sickness rate for this core service was 5% between 1 May 2017 and 30 April 2018.

This was similar to the sickness rate of 6% reported at the last inspection in 3 April 2017.

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
274 GACS6 Stamford CMHT (Admin) L60542	12%	33%
274 GACS1 Spalding EI L21608	0%	28%
274 GACS4 Stamford CMHT (Health) L21592	17%	17%
274 GACLN6 Lincoln North Assertive Outreach L21610	23%	12%
274 GACC Team Leader Assertive Outreach L21503	0%	11%
274 LCAG Senior Medical Adult South West L15551	0%	11%
274 GAC2C S75 North Team L75408	2%	9%
274 GACCB1 Boston EI L21606	10%	9%
274 GACCB4 Med Sec Boston L64562	39%	9%
274 GAC2A S75 Best Interest Assessors L75040	1%	7%
274 GACL Louth CMHT (Health) L21333	5%	7%
274 GACLN4 Lincoln North CMHT (Health) L21360	6%	7%
274 LCA Senior Medical Adult North L15210	2%	7%
274 GAC2D S75 South Team L75410	2%	6%
274 GACCB Boston CMHT (Health) L21562	6%	5%
274 GACG Grantham CMHT (Health) L21588	1%	5%
274 GACS Spalding CMHT (Health) L21564	3%	5%
274 GACLN5 Lincoln North EI L21601	0%	4%
274 GACLS Lincoln South CMHT (Health) L21220	5%	4%
274 GAC2 S75 AMHP Social Inclusion L75024	4%	3%
274 LCCOD Med Community Spalding L15542	3%	3%
274 GAC2B S75 Management L75050	0%	2%

274 GACC2 Early Intervention Psychology L53255	0%	2%
274 GACCB5 Skegness CMHT (Health) L21565	0%	1%
274 GACG2 Grantham Medical Secretaries L60586	0%	1%
274 GACLS1 Lincoln South EI L21602	0%	1%
274 GACLS2 Lincoln South Assertive Outreach L21611	0%	1%
274 GACLS5 Lincoln South Med Sec L64360	0%	1%
274 LCAF Senior Medical Adult East L15501	0%	1%
274 GAC Divisional Manager Community L60010	0%	0%
274 GACC1 Team Leader South West L60410	0%	0%
274 GACCB2 Boston Assertive Outreach L21615	0%	0%
274 GACG1 Grantham Assertive Outreach L21618	0%	0%
274 GACG3 Grantham EI L21609	0%	0%
274 GACL2 Louth Medical Secretary L64333	0%	0%
274 GACLN Gainsborough CMHT (Health) L21310	0%	0%
274 GACLN3 Gainsborough Medical Secretary L64310	0%	0%
274 GACLN7 Lincoln North Medical Secretary L64220	0%	0%
274 GACOEL6 Louth EI L21603	0%	0%
274 GACS2 Spalding Assertive Outreach L21617	0%	0%
274 GACS7 Stamford Medical Secretaries L64542	0%	0%
274 LCAE Senior Medical Adult North East L15330	0%	0%
274 LCCOC Med CMHT Lincoln L15220	0%	0%
274 LCCOE Med Community Boston L15562	0%	0%
274 LCCOF Med Community Grantham L15588	0%	0%
Core service total	**4%**	**5%**

Trust Total	4%	5%

Medical staff

The service used known medical locums appropriately. This ensured consistency of treatment for service users and assurance for staff that they could access a psychiatrist quickly if needed.

Between 1 May 2017 and 30 April 2018, bank staff to cover sickness, absence or vacancy for medical locums filled 0% of shifts.

In the same time period, agency staff covered 5% of shifts. Less than one percent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Total Hours	Bank use (hours)	Agency use (hours)	Total hours unfilled by bank or agency staff
Adult Community	78134.4	0 (0%)*	3760 (5%)*	32 (0.04%)*
Core service total	78134.4	0 (0%)*	3760 (5%)*	32 (0.04%)*
Trust Total	475881.6	1902 (0.4%)*	21784 (5%)*	968 (0.2%)*

***** Percentage of total shifts

Mandatory training

Staff were up to date with appropriate mandatory training.

The compliance for mandatory and statutory training courses at 31 May 2018 was 88%. Of the training courses listed five failed to achieve the trust target and of those, one failed to score above 75%.

The training compliance data is reported on an ongoing monthly basis. Statutory training is reported as part of the monthly board report dashboard produced by workforce and a separate dashboard is provided by the Learning and Development team for all other courses classified by the trust as role essential.

The training compliance reported for this core service during this inspection was lower than the 92% reported at the last inspection (3 April 2017).

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓	Error N/A

YTD (Current Period)	Target	Number of staff eligible	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults - Level 1 - 3 Years	85%	212	200	94%	✓	↓
Moving and Handling - Level 1 - 3 Years	85%	212	195	92%	✓	↓
Safeguarding Children (Version 2) - Level 1 - 3 Years	85%	212	195	92%	✓	↓
Domestic Violence	85%	212	192	91%	✓	↑
Health, Safety and Welfare - 3 Years	85%	212	193	91%	✓	↓
Information Governance - 1 Year	95%	212	193	91%	✗	↑
Equality, Diversity and Human Rights - 3 Years	85%	212	187	88%	✓	↓

Resuscitation - Level 2 - Adult Basic Life Support - 3 Years	85%	95	79	83%	✗	↓
Female Genital Mutilation	85%	129	104	81%	✗	↑
Fire Safety - 1 Year	85%	212	160	75%	✗	↓
Infection Prevention and Control - Level 1 - 1 Year	85%	79	59	75%	✗	↑
Core service total		**1999**	**1757**	**88%**	✓	↓

Assessing and managing risk to patients and staff

We reviewed 49 service user risk assessments and 47 of these were complete and updated in a timely manner.

Assessment of patient risk

Staff completed a risk assessment of every service user at initial triage/assessment and updated it regularly, including after any incident. Staff used recognised risk assessment tools, including the historical clinical risk management 20, suicide assessment scales and hospital and anxiety and depression ratings. When appropriate, staff created and make good use of crisis plans and advance decisions.

Management of patient risk

Staff responded promptly to sudden deterioration in a service user's health. Staff monitored service users on waiting lists to detect and respond to increases in level of risk. Duty staff made telephone contact with all service users on their waiting lists weekly and offered them support and advice as needed.

The service had developed good personal safety protocols, including lone working practices, and there was evidence that staff followed them.

Safeguarding

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 vulnerable adult 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. If a concern is raised regarding a child or vulnerable adult, 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.

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate. Staff could give examples of how to protect service users from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm. That included working in partnership with other agencies.

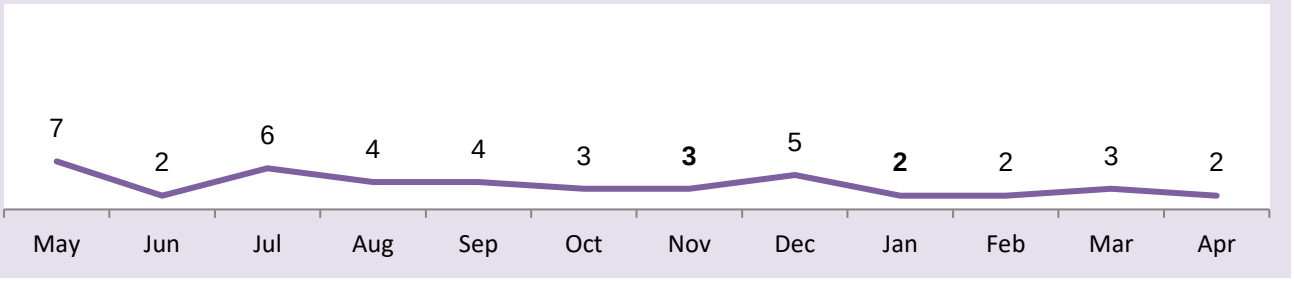
This core service made 43 safeguarding referrals between 1 May 2017 and 30 April 2018, of which 28 concerned adults and 15 children.

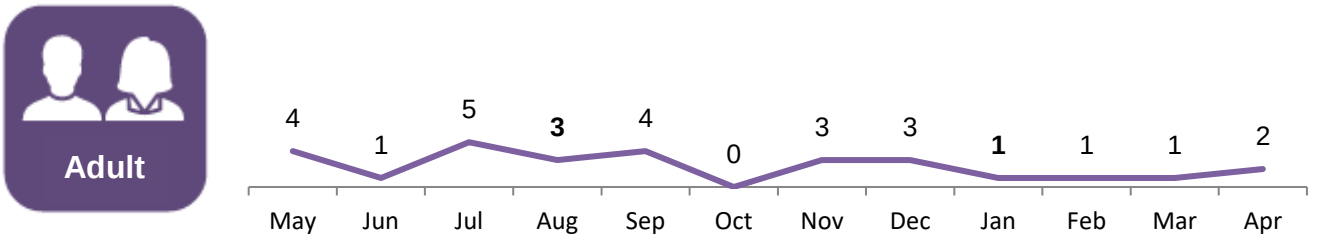
The number of safeguarding referrals reported during this inspection was higher than the 37 reported at the last inspection.

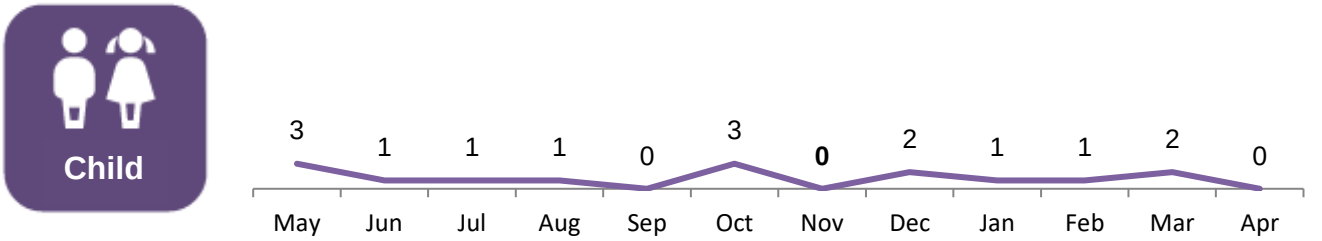
Referrals		
Adults	**Children**	**Total referrals**
28	15	**43**

The reported numbers of adult referrals show a narrow range: between zero and five per month. The reported numbers of child referrals also show a narrow range: between zero and three per month. This indicates a stable system.

Total referrals (*1 May 2017 to 30 April 2018)*







Lincolnshire Partnership NHS Foundation Trust has submitted details of one external case review commenced or published in the last 12 months (1 May 2017 to 30 April 2018) that relate to this core service.

CQC Core Service	SCR/SAR Ref Number	Team/Ward Unit	Recommendation	Actions taken	Outstanding actions
MH - Community-based mental health services for adults of working age.	Thematic Review 19 TH19 7576 STEIS 2014/37580	Grantham iCMHT, CRHT & inservice user units	Trust recommendations - mental capacity workshops / review AOT service model / review safeguarding Lincolnshire together role / support LSAB in developing procedures re S42	All internal complete except safeguarding Lincolnshire together / LSAB had several and the ones relevant to all agencies are recording perpetrator detail / clinical system with chronology facility /	Safeguarding Lincolnshire Together (MASH model) being developed currently

Staff access to essential information

The service had recently transferred to a new electronic record system, and staff had access to extra training and support as needed to help them use the systems.

All information needed to deliver service user care was available to all relevant staff, including agency staff, when they needed it and in an accessible form. This included when service users moved between teams.

Medicines management

Although staff administered medicines in line with national guidance on medicines management, such as transport, storage, dispensing, administration, recording, and disposal, we found one team base where staff were not checking and recording the clinic room refrigerator temperatures correctly. When this was pointed out to the team manager the situation was at once rectified.

The trust had risk assessed, the need for staff to carry emergency adrenaline when off site, and based on overall safety, they had decided that staff would not carry emergency adrenaline for administration in an emergency when off site. While the need to carry adrenaline for this purpose is not a requirement, it is good practice.

Staff reviewed regularly the effects of medication on service users' physical health. This included review of service users prescribed antipsychotic medication or lithium. These reviews were in line with guidance from the National Institute for Health and Care Excellence.

Track record on safety

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of an incident being identified.

Between 1 May 2017 and 30 April 2018 there were 36 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was category with Apparent/actual/suspected self-inflicted harm meeting SI criteria. There were no unexpected deaths for this core service.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

The number of serious incidents reported during this inspection was higher than the 19 reported at the last inspection (3 April 2017).

	Number of incidents reported						
Type of incident reported on STEIS	Apparent/actual/ suspected self-inflicted harm meeting SI criteria	Pending review (a category must be selected before incident is closed)	Disruptive/ aggressive/ violent behaviour meeting SI criteria	Abuse/alleged abuse of adult service user by staff	Apparent/actual/suspected homicide meeting SI criteria	Confidential information leak/information governance breach meeting SI criteria	Total

Lincoln South CMHT	5						**5**
Spalding CMHT	4						**4**
Grantham CMHT	2	1					**3**
Lincoln North CMHT	3						**3**
Louth CMHT	1	1			1		**3**
Outpatient users - Grantham	1			1		1	**3**
Gainsborough CMHT	2						**2**
Outpatient users - Lincoln	2						**2**
Skegness CMHT	2						**2**
Boston CMHT	1						**1**
Early Intervention - Boston			1				**1**
Outpatient users - Boston	1						**1**
Outpatient users - Louth	1						**1**
Outpatiient users - Spalding	1						**1**
Psychotherapy - Lincoln	1						**1**
Sleaford CMHT	1						**1**
Social Care - Stamford	1						**1**
Stamford CMHT			1				**1**
Total	**29**	**2**	**2**	**1**	**1**	**1**	**36**

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff reported all incidents that needed to be reported.

Staff understood the duty of candour. They were open and transparent, and explained to service users and families when something went wrong.

Staff received feedback from investigation of incidents both internal and external to the service. Managers provided this information in different formats including verbal report, lessons learned newsletters and via e mail. Staff met to discuss that feedback. Team minutes and communication books confirmed this was happening, and staff confirmed they had received debrief and support after serious incidents.

There was evidence of staff making changes because of feedback from serious incidents. Changes included discussion and sharing of internal referrals at multidisciplinary interface meetings, discharge letters to service users to include what they should do if they become unwell after discharge and making clear notes of who the liaison person was when joint working with other agencies.

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.

Is the service effective?

Assessment of needs and planning of care

We reviewed 49 service users care records, 23 of which were using the newly introduced recovery service user focussed care plans. Forty-three of the 49 records we reviewed were complete and in date. Care records, particularly those using the new format, were personalised, holistic, and recovery focussed.

The care records showed that staff completed a comprehensive mental health assessment of each service user. Staff ensured that service users' annual physical health checks were completed.

Staff developed care plans that met the needs identified during assessment and updated the care plans when necessary. Care plans included assessment scales such as Health of the Nation Outcome Rating Scales, clustering, and care pathway identification.

Best practice in treatment and care

We reviewed 49 service user care records. All care records showed good practice in the areas reported on below.

Staff provided a range of care and treatment interventions suitable for the service user group. The interventions were those recommended by and delivered in line with National Institute for Health and Care Excellence guidance. This included medication, psychological therapies, support for employment, housing and benefits, and interventions that enabled service users to gain living skills.

We saw examples of innovative practice delivered by peer support workers. Examples included a bespoke researched and designed, psycho-educational group program for people with bi polar disorder, effective use of the care pathways and the employment peer support worker, to help a service user through the pathway and onto voluntary work within the trust.

Staff ensured that they met service users' physical healthcare needs, including their need for an annual health check. Where the GP handled this, staff assured themselves that it was done at the correct time. Some teams had primary and acute care liaison nurses who held clinical sessions in GP practices. This helped to support GP's and ensured community mental health staff delivered mental health and physical healthcare close to the service users home.

Staff supported service users to live healthier lives. For example, through participation in smoking cessation schemes, acting on healthy eating advice, managing cardiovascular risks, and dealing with issues relating to substance misuse.

Staff used recognised rating scales and other approaches to rate severity and to monitor outcomes for example, Health of the Nation Outcome Scales, and clustering by diagnosis. This enabled staff to allocate service users to one of the following care pathways. Common mental disorder; psychosis, trauma, and personality disorder; or longer-term care. Each care pathway identified relevant National Institute for Health and Care Excellence guidelines and recommended psychological skills packages. Staff had written this information in a way that service users could understand and explained what treatment options they could expect from the service.

Staff used technology to support service users effectively, for example, online access to therapies and other resources, timely access to blood test results.

Staff took part in clinical audit, benchmarking, and quality improvement initiatives, and audit processes were embedded in routine practice.

This core service took part in one clinical audit as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
National clinical audit of Psychosis	Adult community	MH - Community-based mental health services for adults of working age.	Clinical	Oct - Nov 2017 (Data collected) Awaiting a report from the Royal College of Psychiatrists	Awaiting NCAP recommendations

Skilled staff to deliver care

The team included, or had access to, the full range of specialists needed to meet the needs of service users. As well as doctors and nurses, occupational therapists, clinical psychologists, social workers, and peer support workers. The trust had developed a range of specialist posts including employment support workers, liaison nurses and advanced nurse practitioners.

Staff had the experience, qualifications, skills, and knowledge to meet the needs of the service user group.

Managers provided new staff with induction, using the care certificate standards as the benchmark for healthcare assistants. Managers recruited volunteers when required and trained and supported them for their roles.

Managers provided staff with clinical and managerial supervision to discuss case management, to reflect on and learn from practice, and for personal support and professional development and appraisal of their work performance, and managers dealt with poor staff performance promptly and effectively through the supervision process.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers ensured that staff received the necessary specialist training for their roles.

Managers ensured that staff had access to regular team meetings.

The trust’s target rate for appraisal compliance is 85%. As at 30 April 2018, the overall appraisal rates for non-medical staff within this core service was 85%. As at the 12 October 2018 this figure had risen to 89% for this core service, and we found no teams in the adult community mental health service were below the trusts target of 85%.

The teams failing to achieve the trust’s appraisal target were Divisional manager community with an appraisal rate of 78%, Louth CMHT with 77%, Lincoln North with 75%, S75 North Team with 55%, S75 South team with 25% and Stamford CMHT (Admin) at 0% (two people eligible).

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 93% reported at the last inspection (3 April 2017).

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
274 GAC2 S75 AMHP Social Inclusion L75024	2	2	100%
274 GAC2B S75 Management L75050	6	6	100%
274 GACC Team Leader Assertive Outreach L21503	1	1	100%
274 GACC1 Team Leader South West L60410	1	1	100%
274 GACC2 Early Intervention Psychology L53255	5	5	100%
274 GACCB Boston CMHT (Health) L21562	15	15	100%
274 GACCB1 Boston EI L21606	1	1	100%
274 GACCB4 Med Sec Boston L64562	3	3	100%
274 GACCB5 Skegness CMHT (Health) L21565	7	7	100%
274 GACG2 Grantham Medical Secretaries L60586	4	4	100%
274 GACG3 Grantham EI L21609	2	2	100%
274 GACL2 Louth Medical Secretary L64333	3	3	100%
274 GACLN Gainsborough CMHT (Health) L21310	7	7	100%
274 GACLN3 Gainsborough Medical Secretary L64310	1	1	100%
274 GACLN7 Lincoln North Medical Secretary L64220	1	1	100%
274 GACLS1 Lincoln South EI L21602	3	3	100%
274 GACLS5 Lincoln South Med Sec L64360	1	1	100%
274 GACOEL6 Louth EI L21603	2	2	100%
274 GACS1 Spalding EI L21608	1	1	100%
274 GACS7 Stamford Medical Secretaries L64542	1	1	100%
274 GACS Spalding CMHT (Health) L21564	11	10	91%
274 GACLS Lincoln South CMHT (Health) L21220	18	16	89%
274 GAC2A S75 Best Interest Assessors L75040	8	7	88%
274 GACG Grantham CMHT (Health) L21588	17	15	88%
274 GACLN4 Lincoln North CMHT (Health) L21360	16	14	88%
274 GACS4 Stamford CMHT (Health) L21592	7	6	86%
274 GAC Divisional Manager Community L60010	9	7	78%
274 GACL Louth CMHT (Health) L21333	13	10	77%
274 GACLN5 Lincoln North EI L21601	4	3	75%
274 GAC2C S75 North Team L75408	11	6	55%
274 GAC2D S75 South Team L75410	8	2	25%
274 GACS6 Stamford CMHT (Admin) L60542	2	0	0%
Core service total	**191**	**163**	**85%**
Trust wide	**1648**	**1432**	**87%**

The trust's target rate for appraisal compliance is 85%. As at 30 April 2018, the overall appraisal rates for medical staff within this core service was 76%.

The teams failing to achieve the trust's appraisal target were senior medical adult North with an appraisal rate of 75%, Med community Spalding with 67%, Med CMHT Lincoln with 60% and Senior Medical Adult East at 50%.

The rate of appraisal compliance for medical staff reported during this inspection was lower than the 100% reported at the last inspection (3 April 2017).

Team name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
274 LCCOB Med CMHT Louth L15330	1	1	100%
274 LCCOE Med Community Boston L15562	4	4	100%
274 LCCOF Med Community Grantham L15588	2	2	100%
274 LCA Senior Medical Adult North L15210	4	3	75%
274 LCCOD Med Community Spalding L15542	3	2	67%
274 LCCOC Med CMHT Lincoln L15220	5	3	60%
274 LCAF Senior Medical Adult East L15501	2	1	50%
Core service total	**21**	**16**	**76%**
Trust wide	**68**	**52**	**76%**

Between 1 May 2017 and 30 April 2018, the average rate across all 18 teams in this core service was 113% of the trust's target.

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

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Steps2Change Boston	108	218	202%
Steps2Change Lincoln	243	477	196%
Steps2Change Gainsborough	123	202	164%
Adult Clinical Psychology	351	549	156%
Complex and Forensic Community	142	201	142%
Steps2Change Louth	133	184	138%
Steps2Change Sleaford	74	102	138%
EIP	48	63	131%
Steps2Change Spalding	114	138	121%
Adult CMHT Lincoln South	144	167	116%
Steps2Change Skegness	90	103	114%
Steps2Change Stamford	118	125	106%

Adult CMHT Grantham / Sleaford	159	164	103%
Adult CMHT Lincoln North / Gainsborough	253	134	53%
Adult CMHT Louth	145	76	52%
Adult CMHT Boston / Skegness	211	98	46%
Steps2Change Grantham	99	42	42%
Adult CMHT Spalding / Stamford	158	32	20%
Core service total	**2713**	**3075**	**113%**
Trust Total	**13677**	**7344**	**54%**

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary team meetings. Staff shared information about service users at effective handover meetings within the team, for example, when staff went on holiday.

The community mental health teams had effective working relationships, including good handovers, with other teams both within and external to the organisation. For example, community to crisis team, and community to primary care, and social services. We heard how teams had recently started to be more proactive with traditionally difficult to engage service users such as those experiencing substance misuse and homelessness.

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

As of 30 April 2017, 91% of the workforce had received training in the Mental Health Act. The trust stated that this training is non-mandatory for all core services for in service user and all community staff and undertaken once.

The training compliance reported during this inspection was lower than the 97% reported at the last inspection (3 April 2017).

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. The trust had recently appointed Mental Health Act administrators to the service, and staff knew who these colleagues were.

The trust had relevant policies and procedures that reflected the most recent guidance, and code of practice, and staff had easy access to this information.

Where the teams worked with service users subject to community treatment orders, staff did regular audits to ensure that the Mental Health Act was applied correctly and there was evidence of learning from the audits. Staff explained to service users their rights in a way that they could understand, repeated the information as needed and recorded that they had done so. Service users had easy access to information about independent mental health advocacy services.

We reviewed 32 community treatment order (CTO) records. We found that while staff stored records correctly, and most of records were complete and up to date, four records were either incomplete or had errors. We told managers about the errors and they were putting in place measures to rectify the records, and prevent similar errors occurring in future. Despite these errors this was significant improvement since our last inspection.

Good practice in applying the Mental Capacity Act

As of 30 April 2017, 75% of the workforce had received training in the Mental Capacity Act Level 1, 100% had received training in Level 2, 100% had received training in Level 3 and 72% had received training in Level 4. The trust stated that this was essential training mandatory for all clinical staff and is refreshed every 3 years.

The provider had a policy on the Mental Capacity Act. Staff were aware of the policy and had access to it. Staff knew where to get advice from within the provider about the Mental Capacity Act.

Staff gave service users every possible assistance to make specific decisions for themselves before they assessed the service user's capacity related to a particular decision.

For service users who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. When service users lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture, and history.

The service had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and acted on any learning that resulted from it.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with service users showed that they were discreet, respectful, and responsive, providing service users with help, emotional support, and advice at the time they needed it.

Staff supported service users to understand and manage their care, and treatment.

Staff directed service users to other services when appropriate and, if required, supported them to access those services.

Service users said staff treated them well and behaved appropriately towards them. Staff understood the individual needs of service users, including their personal, cultural, social, and religious needs.

Staff said they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards service users without fear of the consequences. Staff maintained the confidentiality of information about service users.

Involvement in care

Involvement of patients

Staff involved service users in care planning and risk assessment, as evidenced in care plans. We saw service user's participation in Care Programme Approach reviews, and service users had a copy of their care plan. We also saw copies of information folders, given to each new service user at the time of admission, this explained what they could, and should expect from the service, and how they would be involved in all aspects of their care and treatment.

Staff communicated with service users so that they understood their care and treatment, including finding effective ways to communicate when service users had communication difficulties. We heard of an example of where a doctor had decided to produce minutes during his consultation with a service user who had difficulties remembering details. The doctor had recognised how the service users' inability to remember detail had caused excessive anxiety for the service user who was then unable to fully engage in the consultation process. The doctor gave the minutes to the service user at the end of each consultation and then used them again at the start of the next consultation.

Staff involved service users, when appropriate, in decisions about the service – for example, in the recruitment of staff, and through service user groups.

Staff enabled service users to give feedback on the service they received via surveys. Staff enabled service users to make advance decisions (to refuse treatment, sometimes called a living will) when appropriate. Staff ensured that service users could access advocacy.

Service users we spoke with were very positive about the service and staff they had been working with.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed.

Staff enabled families and carers to give feedback on the service they received for example, via surveys or carers support meetings.

Staff gave carers their own information folder at the point of admission, this included information about how to access a carer's assessment.

Carers and family members, we spoke with were very positive about the care and treatment their relative or friend had received from the service.

Is the service responsive?

Access and waiting times

The service had clear admission criteria for service users, and where waiting lists were used, who could be placed on them. The criteria did not exclude service users who needed treatment and would benefit from it.

The provider had set target times from referral to triage/assessment, and from assessment to treatment. This included allocation to a key worker, based on the Health of the Nation Outcome Scales diagnostic cluster into one of the three care pathways.

Following our last inspection, and to reduce the waiting lists for psychological interventions, the trust had applied a temporary cap on the number of referrals teams could make to the psychology service. During this time the trust had also trained community mental health team staff to provide low level psychological interventions, as a result, the waiting lists for psychology had reduced significantly. The cap was lifted a few weeks prior to our inspection.

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

There were no targets for the number of days for referral to initial assessment, however, the Community Mental Health Team (Johnson Hospital) reported the most number of days with 34 and

the least number of days to assessment was reported by the Adult community Mental Health Team (Beaconsfield Site) with six days.

The core service met the assessment to treatment target (126 days) in all of the targets listed. The Community Mental Health Team (Johnson Hospital) reported the most number of days with 101 and the least number of days to onset of treatment was the Adult Community Mental Health Team (Lincoln South Team) with 12 days

Name of hospital site or location	Ward/team	CCQ core service	Days from referral to initial assessment			Days from referral to treatment		
			Target	Is this target national or local?	Actual (median)	Target	Is this target national or local?	Actual (median)
Beaconfield Site, Grantham (RP7MB)	Adult Community Mental Health Team (Beaconfield Site)	MH - Community-based mental health services for adults of working age.			6	126	National	22
Beaconfield Site, Grantham (RP7MB)	Adult Community Mental Health Team (Beaconfield Site)	MH - Community-based mental health services for adults of working age.			17	126	National	44.5
Beech House, Boston (RP7DD)	Adult Community Mental Health Team (Beech House)	MH - Community-based mental health services for adults of working age.			28	126	National	49
Beech House, Boston (RP7DD)	Adult Community Mental Health Team (Beech House)	MH - Community-based mental health services for adults of working age.			19	126	National	43
Holly Lodge, Skegness (RP7DG)	Adult Community Mental Health Team (Holly Lodge)	MH - Community-based mental health services for adults of working age.			24	126	National	55
Johnson Hospital, Spalding (RP7RK)	Adult Community Mental Health Team (Johnson Hospital)	MH - Community-based mental health services for adults of working age.			12	126	National	21.5
Johnson Hospital, Spalding (RP7RK)	Adult Community Mental Health Team (Johnson Hospital)	MH - Community-based mental health services for adults of working age.			34	126	National	101

Long Leys Road Site, Lincoln (RP7QS)	Adult Community Mental Health Team (Lincoln North Team)	MH - Community-based mental health services for adults of working age.	7	126	National	20
Long Leys Road Site, Lincoln (RP7QS)	Adult Community Mental Health Team (Lincoln South Team)	MH - Community-based mental health services for adults of working age.	14	126	National	29
Long Leys Road Site, Lincoln (RP7QS)	Adult Community Mental Health Team (Lincoln South Team)	MH - Community-based mental health services for adults of working age.	8	126	National	17
Long Leys Road Site, Lincoln (RP7QS)	Adult Community Mental Health Team (Lincoln South Team)	MH - Community-based mental health services for adults of working age.	12	126	National	12
Long Leys Road Site, Lincoln (RP7QS)	Adult Community Mental Health Team (Lincoln South Team)	MH - Community-based mental health services for adults of working age.	23	126	National	52
Stamford Resource Centre (RP7RH)	Adult Community Mental Health Team (Stamford Resource Centre)	MH - Community-based mental health services for adults of working age.	29	126	National	56
Trinity House, Gainsborough (RP727)	Adult Community Mental Health Team (Trinity House)	MH - Community-based mental health services for adults of working age.	23	126	National	56
Windsor House, Louth (RP774)	Adult Community Mental Health Team (Windsor House)	MH - Community-based mental health services for adults of working age.	28	126	National	36
Windsor House, Louth (RP774)	Adult Community Mental Health Team (Windsor House)	MH - Community-based mental health services for adults of working age.	23.5	126	National	56

Between 1 May 2017 and 30 April 2018, the average wait times for a follow up appointment for the core service was 7.1 weeks.

The team was able to see urgent referrals quickly and non-urgent referrals within an acceptable time.

The team responded promptly and adequately when service users telephoned the service.

The team tried to engage with people who found it difficult or were reluctant to engage with mental health services.

The team tried to make follow-up contact with people who did not attend appointments.

Where possible, staff offered service users flexibility in the times of appointments.

Staff cancelled appointments only when necessary and when they did, they explained why and helped service users to access treatment as soon as possible. Appointments usually ran on time and staff kept people informed when they did not.

Staff supported service users during referrals and transfers between services – for example, if they needed temporary treatment in an acute hospital, and support workers who contacted service users on the acute wards prior to them transferring to the community mental health team.

Facilities that promote comfort, dignity and privacy

The service had a range of rooms and equipment to support treatment and care such as clinic rooms to examine service users, enough chairs in the waiting areas, and therapy rooms. There were magazines and relevant information displayed in waiting areas, and staff upheld service users' privacy and dignity at all times.

Patients' engagement with the wider community

When appropriate, staff ensured that service users had access to education and work opportunities. Staff supported service users to maintain contact with their families and carers.

Staff encouraged service users to develop and keep relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

The service made adjustments for disabled service users – for example, by ensuring disabled people's access to premises and by meeting service users' specific communication needs.

Staff ensured that service users could obtain information on treatments, local services and service users' rights.

Staff could print and translate information, so it was accessible to service users, for example, in large font, and easy-read form for people with a learning disability.

Staff made information leaflets available in languages spoken by service users, upon request.

Managers ensured that staff and service users had easy access to interpreters and/or signers.

The service had liaison workers to link with and carry out joint work with homeless organisations. Managers were beginning to introduce similar practice with the substance misuse teams.

Listening to and learning from concerns and complaints

Service users knew how to complain or raise concerns. When service users complained or raised concerns, they received feedback.

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

Staff knew how to handle complaints appropriately.

Managers feedback to staff the outcome of investigation of complaints and and ensures any findings were acted upon.

This core service received 69 complaints between 1 May 2017 and 30 April 2018. Seventeen of these were upheld, 19 were partially upheld and 31 were not upheld and two still open. Two were referred to the Ombudsman.
The number of either partially or fully upheld complaints reported during this was higher than the 58 reported at the last inspection.

Ward/team	Not upheld	Partially upheld	Upheld	Open	Grand Total
Integrated Community Mental Health Team (ICMHT - Boston and Skegness)	6	5	2	2	**15**
In patient service user Department Lincoln	8	2	5		**15**
Integrated Community Mental Health Team (ICMHT - Spalding and Stamford)	4	3	3		**10**
In patient service user Department Louth	4		2		**6**
In patient Department Boston	2	3			**5**
Integrated Community Mental Health Team (ICMHT - Lincoln North)	3		1		**4**
Integrated Community Mental Health Team (ICMHT - Gainsborough)	1	2			**3**
Integrated Community Mental Health Team (ICMHT - Grantham/Sleaford)	1	1	1		**3**
Integrated Community Mental Health Team (ICMHT - Lincoln South)		1	2		**3**
In patient Department Gainsborough	1	1			**2**
Integrated Community Mental Health Team (ICMHT - Louth & East Sector)	1				**1**
Inpatient Department Horncastle			1		**1**
Inpatient Department Spalding		1			**1**
Grand Total	**31**	**19**	**17**	**2**	**69**

This core service received 234 compliments during the last 12 months from 1 May 2017 to 30 April 2018, which accounted for 9% of all compliments received by the trust as a whole.

Is the service well-led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles.

Leaders had a good understanding of the services they managed. They could explain how the teams were working to provide high quality care.

Leaders were visible in the service and approachable for service users and staff.

Leadership development opportunities were available, including opportunities for staff below team manager level.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied in the work of their team.

The trust senior leadership team had successfully communicated the trust vision and values to the frontline staff in this service.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff felt respected, supported, and valued. They felt positive and proud about working for the trust and their team.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.

Managers dealt with poor staff performance when needed. During the reporting period, there were no cases where staff have been either suspended or placed under supervision.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

Staff appraisals included conversations about career development and how managers could support those goals.

Staff reported that the provider promoted equality and diversity in its day-to-day work and gave opportunities for career progression. Managers had enabled staff to develop enhanced psychological skills to meet the needs of the service user group. The trust had supported nurses to obtain advanced nurse practitioner status, and recently introduced opportunities for healthcare support workers to do their nurse training.

The service's staff sickness and absence rates were average for the trust.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff we spoke with spoke highly of the trusts wellbeing service, an easily accessible and confidential health and counselling service offering support and advice for trust staff.

The trust recognised staff success within the service through staff award schemes.

Governance

There was a clear framework of what was to be discussed at a ward, team, or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared, and discussed.

Staff had implemented recommendations from reviews of deaths, incidents, complaints, and safeguarding alerts.

Managers demonstrated a good overarching understanding of their service, as well as their teams' strengths and challenges.

Managers felt the trust had kept them informed of trust level performance and the detail behind the decisions the trust board had made Managers had opportunity to share good practice and learn from each other through regular governance meetings.

The trust provided its Board assurance framework. This detailed any risk scoring 15 or higher and gaps in the risk controls that affect strategic ambitions. The trust outlined three strategic principles with 10 sub priorities:

4. Improving service quality:
    a. More people will have good mental health
    b. More people will have a positive experience of care and support
    c. More people with mental health and learning disability problems will have good physical health.
    d. Fewer people will suffer avoidable harm
    e. Promote recovery and independence
5. Using resources more effectively:
    a. Support our people to be the best they can be
    b. Maximise NHS response
    c. Ensure our estate is fit for modern healthcare delivery
6. Retaining and developing the business:
    a. People will have better access to LPFT services
    b. Support integrated health and social care in Lincolnshire

The trust has provided a document detailing their 10 highest profile risks. Each of these have a current risk score of 15 or higher. The following relate to this core service.

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Last review date
70	Sec 75 Social Care Operational Delivery - ***** Service user safety and quality of care due to limited staffing. Sec 75 contractual obligations will not be met.	20	16	8	15/06/2018
18	Service user safety could potentially be compromised due to staff shortages, unfilled shift and over reliance on agency staff	16	16	8	26/06/2018
19	Difficulties in recruiting substantive consultant and SAS medical staff: We are employing agency and fixed term trust contract Locum Psychiatrists on a regular basis which whilst maintains safe staffing potentially leads to lack of consistent in patient care	16	16	8	16/05/2018
63	Silverlink clinical system is difficult to navigate and to find clinical information in an effective way. The system is also end of life and unless a new system is implemented, LPFT	16	16	8	10/05/2018

	runs the risk of not having a viable operational Clinical System.				
28	Reduction in service provision for service users on Clozapine leading to reduced monitoring.	20	20	8	14/05/2018

Management of risk, issues and performance

Staff maintained and had access to the risk register either at a team or directorate level and could escalate concerns when required from a team level.

Staff concerns matched those on the risk register.

The service had plans for emergencies, for example, adverse weather or a flu outbreak.

Where cost improvements were taking place, they did not compromise service user care.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well, and helped to improve the quality of care. The trust had introduced additional training for staff to use the new electronic recording system, and there was a champion in each team to support colleagues with the systems day to day use.

Information governance systems included confidentiality of service user records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and service user care. Managers could use the trusts governance dashboard to retrieve essential information on request.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed.

Engagement

Staff, service users and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, newsletters and so on.

Service users and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

Managers and staff had access to the feedback from service users, carers and staff and used it to make improvements.

Service users and carers were involved in decision-making about changes to the service.

Service users and staff could meet with members of the provider's senior leadership team and governors to give feedback.

Directorate leaders engaged with external stakeholders – such as commissioners and Healthwatch.

Learning, continuous improvement and innovation

Managers gave staff time and support to consider opportunities for improvements and innovation and this led to changes. Staff, including peer support workers, had opportunities to take part in research.

Innovations, as described above, were taking place in the service. The trust had recently introduced several innovative roles and strategies for improving discharge rates and liaison with acute hospitals to improve the service user experience. New roles included Inpatient Liaison and Discharge Lead, and Advanced Nurse Practitioner

Staff used quality improvement methods and knew how to apply them. For example, promoting service user and carer engagement forums and feedback, investing in developing a continuous learning culture, and using solution focussed problem solving throughout the service.

Although they did not always realise it, staff routinely took part in national audits relevant to the service and learned from them.

The teams took part in accreditation schemes relevant to the service and learned from it.

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 core service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
Accreditation for community mental health services (ACOMHS)		Grantham CMHT awaiting sign off Lincoln South CMHT Team signed up Spalding CMHT team signed up

Community mental health services for people with a learning disability or autism

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Long Leys Road Site, Lincoln (RP7QS)	Learning Disabilities Community Hub, West Lincoln	-	-
Long Leys Road Site, Lincoln (RP7QS)	Learning Disabilities CHAT Team	-	-
Beaconfield Site, Grantham (RP7MB)	Learning Disabilities Community Hub, South West Grantham	-	-
Beech House, Boston (RP7DD)	Learning Disabilities Community Hub Team, East Team	-	-
Johnson Hospital, Spalding (RP7RK)	Learning Disabilities Community Mental Health Team, South Team	-	-

Is the service safe?

Safe and clean environment

Staff completed and regularly updated thorough risk assessments of most areas accessed by patients and removed or reduced any risks they identified. However, at the south west team hub the fire risk assessment available during our visit was dated September 2016, the trust advised that this was due for a review in October 2018. The actions identified at the last fire risk assessment had been completed. The team had recently moved to this building (Sycamore House) and were in the process of putting together a health and safety folder with relevant documents.

Staff supported each other to keep safe through a lone workers buddy system and carried personal alarms. The west team building, unit five at Lincoln had been fitted with an alarm system and fobs had been ordered for this. In the meantime, staff would only see patients in pairs and the patient would also have a carer or support worker with them at all times.

The service did not have clinic rooms. All areas were clean and well maintained, with suitable furnishings and the premises were cleaned regularly. Staff minimised the risks of slips, trips and falls by ensuring environments met the mobility needs of patients.

Staff always followed infection control guidelines, including handwashing.

Safe staffing

The community hub teams had enough staff with the right skills, qualifications and experience.

Managers ensured there were sufficient staff to meet patient needs. Managers had calculated staffing numbers to meet the service specification laid down by commissioners in consultation with stakeholders, including patients and carers. The teams were geographically aligned to the clinical commissioning group boundaries. The number of hours to be provided by each discipline in each team was based on learning disability population. Managers had adjusted staffing as required to meet the changing needs of the local population.

The number and grade of staff matched the provider's staffing plan.

Staff at the community and home treatment team told us that referrals to the service had increased over the last few months and that if this continued they would struggle to provide the support required.

Staff from the hub teams told us that new patients were allocated on a capacity basis and a full time worker usually had a caseload of between 20 and 26 patients. Managers regularly assessed caseloads in supervision. Staff in specific roles, for example, speech and language therapy had higher caseloads of approximately 36 patients. Managers were working with consultants to reduce their caseloads. The west team consultant had a case load of 185 that they had inherited from their predecessor. They were gradually reducing this. The south team consultant had reduced their caseload from 190 to 90 patients.

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	30 April 2018	78.1	N/A
Total number of substantive staff leavers	1 May 2017 – 30 April 2018	5	N/A
Average WTE* leavers over 12 months (%)	1 May 2017 – 30 April 2018	7%	N/A
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	30 April 2018	11.7	N/A
Total vacancies overall (%)	30 April 2018	13%	N/A
Total permanent staff sickness overall (%)	Most recent month (At 30 April 2018)	4%	N/A
	1 May 2017 – 30 April 2018	7%	N/A
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 30 April 2018	29.1	N/A
Establishment levels nursing assistants (WTE*)	At 30 April 2018	32.3	N/A
Number of vacancies, qualified nurses (WTE*)	At 30 April 2018	4.4	N/A
Number of vacancies nursing assistants (WTE*)	At 30 April 2018	3.7	N/A
Qualified nurse vacancy rate	At 30 April 2018	15%	N/A

Nursing assistant vacancy rate	At 30 April 2018	11%	N/A
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 May 2017 – 30 April 2018	345.8 (4%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 May 2017 – 30 April 2018	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 May 2017 – 30 April 2018	626.7 (8%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	306.5 (3%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	557.7 (6%)	N/A

*Whole-time Equivalent

This core service reported an overall vacancy rate of 15% for registered nurses at 30 April 2018.

The vacancy rate for registered nurses was higher than the 6% reported at the last inspection (3 April 2017).

This core service reported an overall vacancy rate of 11% for registered nursing assistants.

The vacancy rate for nursing assistants was higher than the 4% reported at the last inspection (3 April 2017).

This core service has reported a vacancy rate for all staff of 13% as of 30 April 2018. This was not comparable to the rate reported at the last inspection (3 April 2017).

	Registered nurses			Health care assistants			Overall staff figures		
Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
274 SLDCA LD Team East L22452	2	6	33%	2.4	6	40%	7.03	20.5	**34%**
274 SLDC LD Team West L22451	2.61	6.61	39%	0	7.3	0%	3.36	20.35	**17%**
274 SLDCB LD Team South L22453	0.75	2.25	33%	-0.43	4.5	-10%	1.02	10.78	**9%**
274 SLDCD LD CHAT Team L22455	0.51	8	6%	1	8	13%	1.51	16	**9%**
274 SLDCE LD Recovery College L22456	0	0	0%	0	2	0%	0	2	**0%**
274 LCSB Med LD Boston L15620	0	0	0%	0	0	0%	0	1	**0%**
274 LCSD Med LD Spalding L15640	0	0	0%	0	0	0%	0	1	**0%**
274 LCSA Med LD Lincoln L15610	0	0	0%	0	0	0%	0	1	**0%**
274 LCSC Med LD Grantham L15630	0	0	0%	0	0	0%	0	1	**0%**
274 SLDCC LD Team South West L22454	-0.85	2.25	-38%	0.7	4.5	16%	-0.7	12.14	**-6%**

274 SLD LD Team Leader L60515	-0.61	4	-15%	0	0	0%	-0.51	7	**-7%**
Core service total	**4.4**	**29.1**	**15%**	**3.7**	**32.3**	**11%**	**11.7**	**92.8**	**13%**
Trust total	**66.3**	**549.4**	**12%**	**43.6**	**605.4**	**7%**	**172.2**	**1756.0**	**10%**

NB: All figures displayed are whole-time equivalents

The service was recruiting to vacant posts, with staff due to start within the next two months. Managers had created additional roles to provide a liaison between the service and other health providers. The east team manager reported difficulties with recruiting due to the isolated location of the team. The team manager for the south and south west hubs told us that staffing was shared across the two teams.

Between 1 May 2017 and 30 April 2018, bank staff filled 4% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 0% of shifts for qualified nurses. Eight percent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Total Hours	Bank use (hours)	Agency use (hours)	Total hours unfilled by bank or agency staff
CHAT	7759.6	345.8 (4%)	0 (%)	626.7 (8%)
Core service total	7759.8	345.8 (4%)	0 (%)	626.7 (8%)
Trust Total	**469050.1**	**40081.8 (9%)**	**4217.8 (1%)**	**144727.5 (31%**

*****Percentage of total shifts

Between 1 May 2017 and 30 April 2018, bank staff to cover sickness, absence or vacancy for nursing assistants filled 3% of shifts.

In the same period, agency staff covered 0% of shifts. Six percent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Total Hours	Bank use (hours)	Agency use (hours)	Total hours unfilled by bank or agency staff
CHAT	9843.8	306.5 (3%)	0 (0%)	557.7 (6%)
Core service total	9843.8	306.5 (3%)	0 (0%)	557.7 (6%)
Trust Total	443457.4	100481 (23%)*	15807 (4%)*	61265.4 (14%)

***** Percentage of total shifts

Managers made arrangements to cover staff sickness and absence. Staff would usually cover for each other for any planned absences.

Managers limited their use of bank and agency staff and requested staff who knew the service, to ensure continuity of care.

This core service had five (7%) staff leavers between 1 May 2017 and 30 April 2018.

This was lower than the 16% reported at the last inspection (from 3 April 2017).

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers

274 SLDC LD Team West L22451	16.99	3	16%
274 SLDCA LD Team East L22452	12.47	2	15%
274 SLD LD Team Leader L60515	7.51	0	0%
274 SLDCB LD Team South L22453	9.76	0	0%
274 SLDCC LD Team South West L22454	10.84	0	0%
274 SLDCD LD CHAT Team L22455	14.49	0	0%
274 SLDCE LD Recovery College L22456	2	0	0%
274 LCS Senior Medical Adult Learning Dis L15400	0	0	0%
274 LCSA Med LD Lincoln L15610	1	0	0%
274 LCSB Med LD Boston L15620	1	0	0%
274 LCSC Med LD Grantham L15630	1	0	0%
274 LCSD Med LD Spalding L15640	1	0	0%
Core service total	**78.1**	**5**	**7%**
Trust Total	**1474.6**	**162.2**	**12%**

Three of the teams reported low turnover rates. The east team reported a high turnover rate, the manager advised staff had been relocated to the east team following the closure of inpatient services but had left due to the long distances they had to travel. The manager was in the process of recruiting to these posts.

The sickness rate for this core service was 7% between 1 May 2017 and 30 April 2018.

This was similar to the sickness rate of 6% reported at the last inspection in (3 April 2017).

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
274 SLD LD Team Leader L60515	13%	15%
274 SLDCB LD Team South L22453	4%	13%
274 SLDC LD Team West L22451	7%	7%
274 SLDCC LD Team South West L22454	4%	5%
274 SLDCA LD Team East L22452	0%	4%
274 SLDCD LD CHAT Team L22455	1%	3%

274 LCS Senior Medical Adult Learning Dis L15400	0%	2%
274 SLDCE LD Recovery College L22456	5%	2%
274 LCSA Med LD Lincoln L15610	0%	0%
274 LCSB Med LD Boston L15620	0%	0%
274 LCSC Med LD Grantham L15630	0%	0%
274 LCSD Med LD Spalding L15640	0%	0%
274 SLDCF LLC Central Costs L22410	0%	0%
Core service total	**4%**	**7%**
Trust Total	**4%**	**5%**

Managers supported staff who needed time off for ill health and helped to keep sickness rates low. Staff had access to support from human resources and occupational health when off on long term sickness absence.

Medical staff

Between 1 May 2017 and 30 April 2018, bank staff to cover sickness, absence or vacancy for medical locums filled 0% of shifts.

In the same period, agency staff covered 8% of shifts. Zero percent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Total Hours	Bank use (hours)	Agency use (hours)	Total hours unfilled by bank or agency staff
Specialist Services	7680	0 (0%)*	640 (8%)*	0 (0%)*
Core service total	7680	0 (0%)*	640 (8%)*	0 (0%)*
Trust Total	475881.6	1902 (<1%)	21784 (5)*	968 (0.2%)*

***** Percentage of total shifts

The service had enough medical staff and staff could get support from a psychiatrist quickly when they needed to.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

The service could get support from a psychiatrist quickly when they needed to.

Mandatory training

The compliance for mandatory and statutory training courses at 31 May 2018 was 92%. Of the training courses listed, two failed to achieve the trust target and of those, none failed to score below 75%.

The training compliance data is reported on an ongoing monthly basis. Statutory training is reported as part of the monthly board report dashboard produced by workforce and a separate dashboard is provided by the Learning and Development team for all other courses classified by the trust as role essential.

The training compliance reported for this core service during this inspection was higher than the 91% reported at the last inspection (3 April 2017).

The mandatory training programme met the needs of staff and patients in the service.

Key:

Below CQC 75%	Met trust target	Not met trust target	Higher	No change	Lower	Error
	✓	✗	↑	→	↓	N/A

YTD (Current Period)	Target	Number of staff eligible	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Resuscitation - Level 2 - Adult Basic Life Support - 3 Years	85%	15	15	100%	✓	↑
Information Governance - 1 Year	95%	86	83	97%	✓	↑
Health, Safety and Welfare - 3 Years	85%	86	82	95%	✓	↑
Domestic Violence	85%	86	81	94%	✓	↑
Safeguarding Adults - Level 1 - 3 Years	85%	86	81	94%	✓	↓
Equality, Diversity and Human Rights - 3 Years	85%	86	80	93%	✓	↓
Moving and Handling - Level 1 - 3 Years	85%	86	79	92%	✓	↓
Safeguarding Children (Version 2) - Level 1 - 3 Years	85%	86	78	91%	✓	↓
Female Genital Mutilation	85%	67	59	88%	✓	↑
Fire Safety - 1 Year	85%	86	73	85%	✗	↑
Infection Prevention and Control - Level 1 - 1 Year	85%	52	42	81%	✗	↑
Core service total		**822**	**753**	**92%**	✓	↑

Managers kept track of staff and their mandatory training and alerted staff so they knew when to update or complete training modules.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed a risk assessment for each patient when they were admitted and reviewed this regularly. We reviewed 37 patient records and 35 had a completed risk assessment.

Staff used a risk assessment tool developed within the service to meet the needs of the patient group. Psychologists completed historical clinical risk-20 and specialist learning disability sex offenders risk assessments.

Staff devised advance decision and crisis plans jointly with other providers and GP's. Staff also devised positive behaviour support plans with other providers and supported them in their understanding and use.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Staff told us that they would contact the patient's GP with any physical health concerns. Staff told us they would inform the mental health liaison nurse and the mental health community team of any mental health deterioration.

The community and home treatment team facilitated 'local area emergency protocol' meetings to support patients who were very unwell. The purpose of these meetings was to try to support the patient in the community, if possible. From October 2017 to end of September 2018 the service had held 18 meetings and prevented eight admissions to hospital.

Staff followed clear personal safety protocols, including the trusts lone working policy.

Safeguarding

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 vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

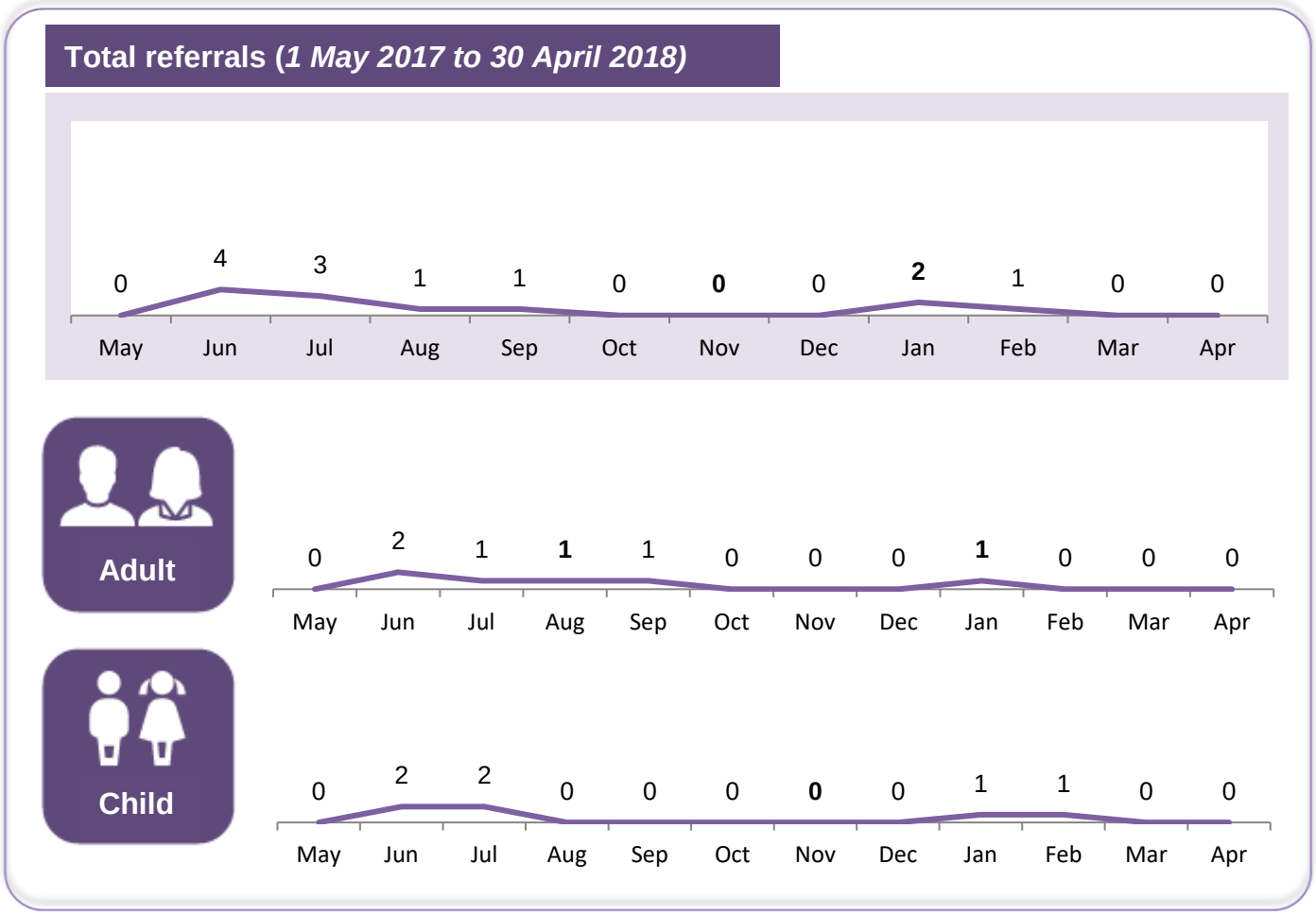
Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine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

This core service made 12 safeguarding referrals between 1 May 2017 and 30 April 2018, of which six concerned adults and six children.

The number of safeguarding referrals reported during this inspection was lower than the 13 reported at the last inspection (3 April 2017).

Referrals		
Adults	**Children**	**Total referrals**
6	**6**	**12**

The reported numbers of adult referrals show a narrow range: between zero and two per month. The reported numbers of child referrals also show a narrow range: between zero and two per month. This indicates a stable system.



Lincolnshire Partnership NHS Foundation Trust has submitted details of two external case reviews commenced or published in the last 12 months. However, they do not relate to this core service.

Staff received training in safeguarding that was appropriate for their role.

Staff showed us an initial safeguarding screening tool they would use to identify any signs of abuse, for example, bruises or changes in behaviour.

Staff knew how to recognise adults and children at risk of, or suffering harm and worked with other agencies to protect them. Staff told us about a safeguarding situation where they had involved the police and social services to ensure the safety of a patient following concerns raised by a family member.

Staff spoken with knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that there is no multi-agency safeguarding hub in Lincolnshire and that the local authority safeguarding team do not always feedback the outcomes of referrals made to them.

Staff access to essential information

Patient notes were comprehensive. The trust had recently transferred to a new electronic record system. At the time of our inspection there were three systems in use; the new system, the previous system and a temporary system to bridge the two. Staff were able to access information but not always in a timely manner. We found no evidence that this had impacted on patient care.

When patients transferred to a new team within the trust there were no delays (other than those reported above) in staff accessing their records.

Medicines management

The service did not keep or administer any medicines for patients.

Staff reviewed the effects of each patient's medication on their physical health according to the National Institute of Health and Care Excellence guidance. The service had a STOMP (stopping over medication of people) lead. STOMP is a national project aimed at reducing the use of psychotropic medication for people with a learning disability or autism. The service STOMP lead covered patients in the west area. The lead would devise STOMP care plans for patients on their case load. The lead shared positive outcomes that had been achieved for patients through reducing the use of psychotropic medication, which included increased mobility and a reduction in side effects. The service facilitated regular STOMP meetings, which included a pharmacy overview.

Track record on safety

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of an incident being identified.

Between 1 May 2017 and 30 April 2018 there were zero STEIS incidents reported by this core service.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

The number of serious incidents reported during this inspection was the same to the zero incidents reported at the last inspection (3 April 2017).

Reporting incidents and learning from when things go wrong

Staff reported all the incidents they should.

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

Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service. We observed a team meeting and the manager shared learning from incidents that had occurred elsewhere in the trust.

Managers and staff made changes to practice as a result of incidents and feedback. Examples included alerting staff following an incident at another provider and introducing a checklist to ensure cupboards and doors are kept locked following an information governance breach.

Staff met to discuss feedback and look at improvements to patient care. We observed two formulation meetings, which evidenced this.

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.

Is the service effective?

Assessment of needs and planning of care

Staff completed comprehensive assessments of each patient. We reviewed 37 patient records and all had a comprehensive initial assessment.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. The service had developed an ‘annual health check booklet’ and this had been promoted by the service experts by experience to encourage patients to visit their GP to ensure they have an annual physical health check.

Staff developed a comprehensive care plan for most patients that met their mental and physical health needs. Staff developed these plans after formulation meetings. We reviewed 37 patient records and 29 had comprehensive care plans. Out of eight records reviewed at the west team, four had no care plans. Out of six records reviewed at the south team, two had no care plans and out of ten records reviewed at the south west team, two had no care plan.

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

Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for the patients in the service. Different disciplines within the teams provided specific interventions, for example, speech and language therapists would provide support with communication and eating and drinking. occupational therapists would access specific equipment to support patients, for example, hoists. Behaviour of concern nurses would support patients with behaviours that challenge through the implementation of positive behaviour support plans. The psychology team provided a range of therapies including trauma therapy, bereavement counselling, cognitive behavioural therapy, eye movement desensitization and reprocessing, cognitive analytic therapy, acceptance and commitment therapy.

Staff delivered care in line with best practice and national guidance (from relevant bodies, for example, the National Institute of Health and Care Excellence). The service was on a transformation programme, in line with the governments transforming care agenda. The service followed National Institute of Health and Care Excellence guidance for challenging behaviour and cognitive behavioural therapy.

Staff ensured patients received care and treatment for their physical health needs, either from their GP or community services. The service had a physical health lead who supported staff to ensure patients received the support they needed for physical health care. The service employed an acute liaison nurse who supported patients when they accessed acute health care services. Staff told us about supporting a patient with terminal cancer, the occupational therapist provided home adaptations and the psychologist provided counselling to help them come to terms with their condition. Staff devised care plans for patients’ specific healthcare needs, for example speech and language therapy plans for patients who required support with eating and drinking.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. This included encouraging patients to visit the GP for their annual health check, promoting healthy eating and exercise and encouraging patients to have the flu vaccination.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. The community and home treatment team used an outcome measure tool, the quality of life scale, to assess patients at the beginning and end of receiving care and treatment. Patients would assess themselves on a scale from ‘awful’ to ‘brilliant’. The

service also used psychometric tests to assess patient conditions, these included; Behavioural Assessment for Dysexecutive Syndrome; Rivermead Behavioural Memory Test; Weschler Adult Intelligence Scale; Family relations test; Social-moral assessment tool. Staff used the health of the nation outcomes scales for learning disabilities and 'people at risk of admission' tool to assess the severity of patients' conditions.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff had supported the STOMP lead by collating outcomes for patients, staff audited their case files within management supervision and the audit lead had completed an audit of the service against NHS improvement standards.

This core service participated in no clinical audits as part of their clinical audit programme 2017 – 2018.

Skilled staff to deliver care

The service had access to a full range of specialist staff to meet the needs of the patients in the service. This included psychiatrists, nurses, psychologists, occupational therapists, speech and language therapists, physiotherapists, behaviour support nurses, intervention workers, mental health liaison, physical health liaison and social workers.

Staff had the right skills, qualifications and experience to meet the needs of the patients in their care.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work.

The trust's target rate for appraisal compliance is 85%. As at 30 April 2018, the overall appraisal rates for non-medical staff within this core service was 91%.

The team failing to achieve the trust's appraisal target was SLDC Team West with an appraisal rate of 83%.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
274 SLDCB LD Team South L22453	10	10	100%
274 SLDCD LD CHAT Team L22455	15	15	100%
274 SLDCE LD Recovery College L22456	2	2	100%
274 SLDCA LD Team East L22452	14	13	93%
274 SLDCC LD Team South West L22454	16	14	88%
274 SLD LD Team Leader L60515	7	6	86%
274 SLDC LD Team West L22451	18	15	83%
Core service total	**82**	**75**	**91%**
Trust wide	**1648**	**1432**	**87%**

Managers supported medical staff through regular, constructive appraisals of their work.

The trust's target rate for appraisal compliance is 85%. As at 30 April 2018, the overall appraisal rates for medical staff within this core service was 100%.

Team name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
274 LCSA Med LD Lincoln L15610	1	1	100
274 LCSB Med LD Boston L15620	1	1	100
274 LCSC Med LD Grantham L15630	1	1	100
274 LCSD Med LD Spalding L15640	1	1	100
Core service total	**4**	**4**	**100%**
Trust wide	**68**	**52**	**76%**

Between 1 May 2017 and 30 April 2018 the clinical supervision compliance rate across all five teams in this core service was 60%.

Whilst on site managers told us that supervision compliance rates had improved. We requested more up to date data from the trust. The overall compliance rate from 1 May 2018 to 30 October 2018 was 76%. The west team hub reported the lowest rate at 56% and the south team reported the highest at 93%. Staff told us that they had access to supervision but it was not always being recorded.

The trust had introduced clinical supervision passports for staff to record their clinical supervision notes. Managers had recently implemented peer group supervision for intervention workers. This was also helping to develop band five and six leadership skills.

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

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
LD Integrated Community Team East CCG	121	104	86%
LD Integrated Community Team South CCG	96	77	80%
CHAT	152	79	52%
LD Integrated Community Team SW CCG	121	59	49%
LD Integrated Community Team West CCG	226	111	49%
Core service total	**716**	**430**	**60%**
Trust Total	**13677**	**7344**	**54%**

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We observed two team meetings and reviewed minutes of team meetings for this year.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Staff told us about training courses they had attended, these included training in the following; Makaton, epilepsy, physical healthcare, associate practitioner diploma, applied behaviour therapy diploma, learning

disabilities, mental health, non-medical prescribers course and hydrotherapy.

Managers recognised poor performance, identified the causes and responded appropriately.

Multidisciplinary and interagency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed two multi-disciplinary meetings and a formulation meeting which confirmed this.

Staff shared clear information about patients and any changes in their care during handover meetings. We reviewed handover sheets used by the crisis and home treatment team to ensure actions required were passed on to the next shift.

Staff had effective working relationships with other teams in the organisation. This included the mental health teams and child and adolescent services.

Staff had effective working relationships with external teams and organisations. This included with the local authority, the acute hospital, schools and other providers. Representatives from the local authority attended hub team multi-disciplinary meetings. The service had developed a joint protocol with the local acute hospital trust for supporting patients with learning disabilities. We observed a visit to a patient in a care home by the speech and language therapist. We observed effective working with the care home staff and patient to ensure the patient's needs were met.

The east team had provided a presentation on effective multi-disciplinary working to the trust board.

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

As of 31 May 2018, 89% of the workforce had received training in the Mental Health Act. The trust stated that this was essential training mandatory for all clinical staff and is refreshed every 3 years.

The training compliance reported during this inspection was higher than the 85% reported at the last inspection (3 April 2017).

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

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

Only one patient, using this service, had a Community Treatment Order in place. We checked this record noting the paperwork was complete in relation to the patient's Community Treatment Order under the Mental Health Act. However, we noted that one of the conditions on the Community Treatment Order included the patient is required "to reside with her husband". This condition did not appear to be in line with the Code of Practice, paragraphs 29.28 to 29.32. We noted, in part three of the Community Treatment Order "Section 20A – community treatment order: report extending the community treatment period" form, that the professional had not specifically stated their profession, as required by the form. We raised these issues with the Trust's legal services manager.

Good practice in applying the Mental Capacity Act

As of 31 May 2018, 76% of the workforce had received training in the Mental Capacity Act. The trust stated that this training is non-mandatory for all core services for inpatient and all community staff and is a one off course.

The training compliance reported during this inspection was lower than the 87% reported at the last inspection (3 April 2017).

Most staff received training in the Mental Capacity Act and had a good understanding of the five principles. Staff told us that they presume capacity unless there are any concerns and then capacity would be assessed on decision specific basis. The trust had facilitated masterclasses for clinical staff and their managers on application of the Mental Capacity Act. Managers had discussed mental capacity with their teams during away days.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act.

Staff had completed mental capacity assessments in 36 of 37 records reviewed. This was a significant improvement from the last inspection when staff had not completed mental capacity assessments in 21 out of 28 records reviewed. However, in records at the South West hub, the assessments that were in place were not detailed. Staff told us it was difficult to record mental capacity assessments on the new electronic system. The service had introduced a new initial assessment form, which included a section on mental capacity, this was in use for new patients.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so, by completing a two stage capacity assessment.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We observed staff making a best interest decision in a formulation meeting regarding a specific intervention being proposed for a patient. Staff advocated for the least restrictive option.

The service monitored how well it adhered to the Mental Capacity Act and made changes to practice when necessary. The trust had recently commissioned an external agency to review application of the Mental Capacity Act in the service. The report had concluded that the trust paperwork for recording mental capacity needed to be improved. We observed a meeting, where the trust lead nurse for Mental Capacity discussed the findings of the report and asked staff for feedback on what would help to improve.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Patients and carers told us that staff were discreet, respectful, and responsive.

Patients and carers told us that staff gave patients help, emotional support and advice when they needed it.

Patients and carers told us that staff supported patients to understand and manage their own care, treatment or condition.

Carers told us that staff directed patients to other services and supported them to access those services if they needed help, for example, day care centres.

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff followed policy to keep patient information confidential.

Involvement in care

Involvement of patients

Staff involved patients and gave them access to their care plans.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). One carer told us that staff had provided their relative with a communication passport. Another carer told us that staff used visual aids to communicate with their relative.

Staff supported patients to make advanced decisions on their care. This would be done with other providers, for example care homes and GP's.

Staff made sure patients could access advocacy services. We observed a meeting where the county wide advocacy service gave a talk to staff on what services they could offer.

Experts by experience were involved in the recruitment of staff to the service.

Involvement of families and carers

Staff supported, informed and involved families or carers. We spoke with six carers who told us that staff were fantastic, approachable, friendly, caring and thoughtful. They told us that staff go above and beyond and they couldn't expect a better service. Staff provided training sessions for carers, these included sessions on recognising learning disabilities, health risks for people with learning disabilities, diagnostic difficulties in learning, reasonable adjustments, rescue medication.

Staff helped families to give feedback on the service through the friends and family test and expressions of satisfaction. From April 2018 to September 2018, 95% of respondents to the friends and family test said they were highly likely or likely to recommend the service.

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

Is the service responsive?

Access and waiting times

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

The core service met the referral to assessment target in four of the targets listed.

The core service met the assessment to treatment target in four of the targets listed.

The trust stated that the Learning disability services are working to under a 12-week assessment from referral however, there is a longer wait reported due to the high demand for adult autistic spectrum disorder diagnostic assessments, which is part of the specialist contract.

Name of hospital site or location	Name of in-patient ward or unit	CCQ core service	Days from referral to initial assessment	Days from referral to treatment	Comments, clarification

			Target	Is this target national or local?	Actual (median)	Target	Is this target national or local?	Actual (median)	
Beaconfield Site, Grantham (RP7MB)	Learning Disabilities Community Hub, South West Grantham	MH - Community mental health services for people with a learning disability or autism	84	local	21		no target	33	Learning Disability Services are working to under a 12-week assessment from referral however, there is a longer wait reported due to the high demand for adult autistic spectrum disorder assessments, which is part of the specialist contract.
Beech House, Boston (RP7DD)	Learning Disabilities Community Hub Team, East Team	MH - Community mental health services for people with a learning disability or autism	84	local	19		no target	37	Learning Disability Services are working to under a 12-week assessment from referral however, there is a longer wait reported due to the high demand for adult autistic spectrum disorder assessments, which is part of the specialist contract.
Johnson Hospital, Spalding (RP7RK)	Learning Disabilities Community HubTeam, South Team	MH - Community mental health services for people with a learning disability or autism	84	local	47		no target	63	Learning Disability Services are working to under a 12-week assessment from referral however, there is a longer wait reported due to the high demand for adult autistic spectrum disorder assessments, which is part of the specialist contract.
Long Leys Road Site, Lincoln (RP7QS)	Learning Disabilities CHAT Team	MH - Community mental health services for people with a learning disability or autism			0			0	
Long Leys Road Site, Lincoln (RP7QS)	Learning Disabilities Community Hub, West Lincoln	MH - Community mental health services for people with a learning disability or autism	84	local	18		no target	28	Learning Disability Services are working to under a 12-week assessment from referral however, there is a longer wait reported due to the high demand for adult autistic spectrum disorder assessments, which is part of the specialist contract.

Between 1 May 2017 and 30 April 2018, the average waiting times for a follow up appointment (based on 12 months' worth of data) for this core service was 13.3 weeks.

The service had clear criteria to describe which patients they would offer services too and offer patients a place on waiting lists. The service did not have a waiting list for access to the hub teams and crisis and home treatment team at the time of the inspection. There was a waiting list to access speech and language therapy as the service had been unable to recruit to vacant posts. There was an identified gap in service provision for people with autism spectrum disorders and attention deficit hyperactivity disorder. The trust provided a service that diagnosed autism spectrum disorders, but did not offer any support. The service had inherited a waiting list for this, which was at 211 at the time of our visit.

The trust set and the service met the target times seeing patients from referral to assessment and assessment to treatment.

Staff responded to referrals in a timely manner. The team saw urgent referrals quickly and non-urgent referrals within the trust target time.

The crisis team had skilled staff available to contact patients within four hours of a referral being received and carried out a face to face assessment within 24 hours. Over a 12 month period only one call had been received for out of hours support. The service was trialling a new system for out of hours support whereby patients would be signposted via an answer phone message.

The hub teams held weekly referral meetings to review new referrals. We observed one of these meetings, referrals were received from GP's, other providers, the local authority and other trust teams. Staff decided as a multi-disciplinary team whether the referral met the service criteria and it was then allocated to the discipline of staff best placed to meet the patients' needs.

Patients had some flexibility and choice in the appointment times available.

Staff worked hard to avoid cancelling appointments and when they had to they gave patients clear explanations and offered new appointments as soon as possible.

Appointments ran on time and staff informed patients when they did not.

Staff supported patients when they were referred, transferred between services, or needed physical health care.

Facilities that promote comfort, dignity and privacy

Teams only saw patients occasionally at three of the sites visited. These sites had rooms available when required. The south west hub team had a separate waiting room for patients with sensory needs.

Interview rooms in the service had sound proofing to protect privacy and confidentiality. However, we noted at the South team hub, that the receptionist could be heard talking on the phone by anyone in the waiting area. We raised this with managers for the service.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities for education and work, and supported patients. These included; supporting patients to access work as an expert by experience, accessing the gym, swimming, horse riding, learning activities of daily living, money management and relationship skills.

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

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

Meeting the needs of all people who use the service

The service could support and make adjustments for people with disabilities, communication needs or other specific needs.

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

The service provided information in a variety of accessible formats so the patients could understand more easily. The service provided information in line with accessible information standards.

Managers made sure staff and patients could get hold of interpreters or sign language interpreters when needed.

Listening to and learning from concerns and complaints

This core service received four complaints between 1 May 2017 and 30 April 2018. Two of these were upheld, none were partially upheld and two were not upheld. None were referred to the Ombudsman.
The number of either partially or fully upheld complaints reported during this was lower than the seven reported at the last inspection (3 April 2017).

Ward/team	Not upheld	Upheld	Grand Total
Learning Disabilities - Community Hub South West Team	1	1	2
Learning Disabilities - Community Hub East Team		1	1
Learning Disabilities - Community Hub West Team	1		1
Grand Total	2	2	4

Staff provided patients with an easy read leaflet telling them how they could share their experiences of the service. Carers spoken with said they knew how to complain but had not needed to.

Staff understood the policy on complaints and knew how to handle them. Staff would forward any complaints to the team manager. The trust had a central complaints team that dealt with all complaints.

The service received a low number of complaints reflecting that patients were satisfied with their care.

Staff received feedback from managers after investigations. We reviewed minutes of team meetings, where managers had discussed findings from a complaints investigation.

The service received a high number of compliments reflecting patients were satisfied with their care. We reviewed compliments received via the expressions of satisfaction, examples included; thanks for accessible information, thanks for support provided and thanks for specific interventions that have improved the lives of patients.

This core service received 173 compliments during the last 12 months from 1 May 2017 to 30 April 2018, which accounted for 7% of all compliments received by the trust as a whole.

Is the service well-led?

Leadership

Leaders had the right skills, knowledge and experience to lead their teams.

Leaders had a clear understanding of the service they managed and knew how their teams worked to provide high quality care.

Patients and staff knew who the leaders were, could approach them and saw them often in the service.

The trust gave opportunity for leaders to develop their skills and for other staff to develop leadership skills. Managers told us they had accessed the trust leadership programme which had been developed in consultation with band 7 staff and a management skills toolkit and band 7 development course.

Vision and strategy

Staff knew and understood the trust's visions and values and could describe how they applied to their work. Staff told us they had discussed the trust vision and values and how they applied to the service at their recent away days.

The senior leadership team had successfully communicated the trust's visions and values to staff at all levels of the service.

Staff could contribute to discussions about the service's strategy and changes to the service.

Culture

Leaders ensured staff felt respected, supported and valued by their team and wider management. The trust provided initiatives to support staff wellbeing, these included access to physiotherapy, yoga classes, zumba classes, boxercise, counselling and wellbeing clinics. Staff told us that managers supported them to achieve a healthy work life balance through flexible working arrangements.

Staff demonstrated high levels of satisfaction and were proud of the trust as a place to work and spoke highly of the culture. Staff told us there had been a positive culture change in the trust over the past few years that had been led from the top. Staff were empowered by the leadership team to innovate and make changes.

Staff could raise concerns without fear.

Staff understood the whistle-blowing policy and who their speak up guardian was.

Managers identified and supported staff who needed it to perform their jobs well. The trust provided mentors for staff to support their development.

Teams worked well together and their managers dealt with any difficulties when they happened.

Managers had facilitated away days for their teams to encourage better team working.

Managers supported staff during their appraisals and discussed career progression and development.

The trust promoted equality and diversity.

The trust supported their staff with access to occupational health services.

The trust recognised staff success and innovation. The east team had won a team award following a quality review.

During the reporting period, there were no cases where staff have been either suspended, placed under supervision or were moved to a different team.

Governance

Staff implemented recommended changes following reviews of the service.

Staff undertook or participated in local clinical audits and acted on the results.

Staff understood the trust's arrangements for working with other teams both inside and outside the trust.

The trust provided its Board assurance framework. This detailed any risk scoring 15 or higher and gaps in the risk controls that affect strategic ambitions. The trust outlined three strategic principles with 10 sub priorities:

7. Improving service quality:
    a. More people will have good mental health
    b. More people will have a positive experience of care and support
    c. More people with mental health and learning disability problems will have good physical health.
    d. Fewer people will suffer avoidable harm
    e. Promote recovery and independence
8. Using resources more effectively:
    a. Support our people to be the best they can be
    b. Maximise NHS response
    c. Ensure our estate is fit for modern healthcare delivery
9. Retaining and developing the business:
    a. People will have better access to LPFT services
    b. Support integrated health and social care in Lincolnshire

The trust has provided a document detailing their 10 highest profile risks. Each of these has a current risk score of 15 or higher. None pertained to this core service.

Management of risk, issues and performance

Managers were able to put items onto the divisional risk register, these would be discussed at the learning disabilities steering group. The service had clear plans for dealing with emergencies and staff understood these.

Managers made sure that cost improvements did not compromise patient care.

Information management

The systems to collect team and directorate data did not create extra work for frontline staff.

Staff told us that they were experiencing issues with accessing information following the trusts recent move to a new patient records system. Patient records were stored in three different locations and were not easily accessible.

Information governance systems clearly stated policy on confidentiality of patient records.

Team managers had access to information that supported them. The trust provided managers with dashboards that gave an overview of their team's performance, with areas that could be accessed to give more detail.

All information was accessible, accurate and identified areas for improvement.

Staff notified and shared information with external organisations when necessary, seeking patient consent when required to do so.

Engagement

Staff, patients and their carers could access up to date information about the services they use and the trust as a whole. The service had recently introduced a service newsletter, co-produced by an expert by experience and staff.

Patients and carers could give feedback about their care and in ways that reflected their individual needs. The service collected feedback from patients and carers, using the friends and family test and expressions of satisfaction surveys.

Patients and staff could meet with the senior leadership team to give feedback. We observed a wellbeing event for experts by experience and staff, which was attended by the service manager.

Learning, continuous improvement and innovation

Leaders inspired staff to continuously improve and innovate.

The service had developed training packages to help other providers and agencies to support patients more effectively. These included; recognising learning disabilities, epilepsy, health risks for people with learning disabilities, reasonable adjustments, vulnerability of population, reducing the use of psychotropic medications, importance of positive behaviour support.

Managers recruited, trained and supported experts by experience to work with patients and staff in the service. The service employed six experts by experience, all of whom had used learning disability services previously. The experts by experience were used to support staff recruitment, promote the service to external agencies and increase awareness of learning disabilities.

Staff knew about quality improvement methods and could apply them. Staff told us about their involvement in the trust's continuous quality improvement process. The east team manager had arranged quality improvement workshop with colleagues from the mental health and child and adolescent teams to encourage more integrated working. Some staff had recently attended a national learning disabilities conference. Staff from the east team had attended a quality improvement science workshop and were working on projects to develop with support from the trust quality improvement team. The community and home treatment team had presented their model of service to another trust.

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.

There was no information pertaining to this core service.