Lincolnshire Partnership NHS Foundation Trust

Quality Report

Trust Headquarters,
Units 8 & 9 The Point,
Lions Way
Sleaford,
Lincolnshire,
NG34 8GG
Tel: 01529 222200
Website: www.lpft.nhs.uk

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Mental Health Unit, Lincoln County Hospital Site	RP7EV
Acute wards for adults of working age and psychiatric intensive care units	Mental Health Unit, Pilgrim Hospital	RP7LA
Child and adolescent mental health wards	Ash Villa	RP7MA
Forensic inpatient/ secure	Francis Willis Unit, Mental Health Unit, Lincoln County Hospital Site	RP7EV
Wards for older people with mental health problems	Witham Court	RP7CG
Wards for older people with mental health problems	Manthorpe Centre	RP7LP
Wards for older people with mental health problems	Pilgrim Hospital	RP7LA
Inpatient rehabilitation wards	Ashley House, Beaconfield	RP7MB
Inpatient rehabilitation wards	Discovery House, Long Leys Court	RP7QS
Inpatient rehabilitation wards	Maple Lodge	RP7DC

Summary of findings

Community-based mental health services for adults of working age	Trust Headquarters	RP7HQ
Specialist community mental health services for children and young people	Trust Headquarters	RP7HQ
Community-based mental health services for older people	Trust Headquarters	RP7HQ
Community mental health services for people with learning disabilities and autism.	Trust Headquarters	RP7HQ
Mental health crisis services and health-based places of safety	Trust Headquarters	RP7HQ
Substance misuse services	Trust Headquarters	RP7HQ

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for services at this Provider	Requires improvement 
Are services safe?	**Inadequate** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

We rated Lincolnshire Partnership NHS Foundation Trust as Requires Improvement overall because:

- Not all services were safe or effective and the board needs to take action to address areas of improvement.
- Some of the wards did not provide an environment that was safe or that preserved patients' dignity or privacy. The layout of some wards and ward garden areas meant that staff could not easily observe patients who might be at risk. We were concerned about the design of the place of safety and seclusion facilities at some units. Some wards had fixtures and fittings that people at risk of suicide could use as a ligature anchor point; the trust had not addressed these risks adequately. Not all wards met the requirements of single sex accommodation guidance or the Mental Health Act (MHA) code of practice. Some seclusion rooms and dormitory areas did not promote privacy and dignity.
- Restrictive practices that amounted to seclusion were not reported or safeguarded appropriately.
- Staff on the acute, forensic and child and adolescent wards imposed blanket restrictions that were not based on an assessment of the risks of individual patients.
- Some wards in the rehabilitation, forensic and children's mental health services had too few staff on duty at times to keep patients safe and others relied heavily on the use of bank and agency staff.
- Staff were not always receiving supervision in line with the trust policy.
- We were concerned that information management systems did not always ensure the safe management of people's risks and needs.
- Access arrangements needed improvement. There was a lack of availability of acute beds. There were delays for assessment from community adult teams and there was limited access to psychological therapy.
- While performance improvement tools and governance structures were in place these had not always brought about improvement to practices.
- While the board and senior management had a vision with strategic objectives in place, morale was found to be poor in some areas, particularly community teams, and some staff told us that they did not feel engaged by the trust.

However:

- Staff showed us that they wanted to provide high quality care, despite the challenges of staffing levels and some poor ward environments. We observed some very positive examples of staff providing emotional support to people.
- Services were clean with good infection control practices.
- There had been significant work on reducing restrictive intervention.
- Procedures for incident management and safeguarding where in place and well used. The trust was meetings its obligations under Duty of Candour regulations.
- The trust had participated in a range of patient outcome audits, research and accreditation schemes.
- The trust had an involvement policy which set out the trust's commitment to working in partnership with service users. The trust told us about a number of initiatives to engage more effectively with users and carers.
- Complaint information was available for patients and staff had a good knowledge of the complaints process.
- Overall we saw good multidisciplinary working and generally people's needs, including physical health needs, were assessed and care and treatment was planned to meet them.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Inadequate

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

- Some of the wards did not provide an environment that was safe or that preserved patients' dignity or privacy. The layout of some wards and ward garden areas meant that staff could not easily observe patients who might be at risk. We were concerned about the design of the place of safety and seclusion facilities at some units. Some wards had fixtures and fittings that people at risk of suicide could use as a ligature anchor point; the trust had not addressed these risks adequately.
- Not all wards met the requirements of single sex accommodation guidance or the Mental Health Act code of practice. Some seclusion rooms and dormitory areas did not promote privacy and dignity.
- Restrictive practices that amounted to seclusion were not always reported or safeguarded appropriately. There were some blanket restrictions within acute, forensic and children and adolescent mental health services.
- Some wards in the rehabilitation, forensic and children's mental health services had too few staff on duty at times to keep patients safe and others relied heavily on the use of bank and agency staff. We were concerned about medical arrangements in the rehabilitation service.
- We were concerned about the levels of training in some teams for restrictive intervention, health and safety, safeguarding, Mental Capacity Act, Mental Health Act, clinical risk assessment and food hygiene.
- Not all clinical risk assessments in the older people's wards and at Maple Lodge and Ashley House had been undertaken or reviewed meaning patients risks and needs were not always known or addressed.
- The trust had processes in place for the safety of lone workers but emergency call systems were not being used consistently in community teams.
- There were some concerns about the effective prescribing, management and storage of medication at community services.
- There was not always clear evidence of learning and improvements to practice following incidents and learning was not always shared across services.

However:

Summary of findings

- Services were clean, with good infection control practices.
- There had been significant work on reducing restrictive intervention.
- Incidents were reported and investigated. The trust was meetings its obligations under Duty of Candour regulations.
- The trust has contingency plans in place for in the event of an emergency.

Are services effective?

Requires improvement

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

- There were a large number of concerns about information sharing systems at the trust. A number of electronic record systems were in operation as well as paper records. This made it difficult to follow information and meant that the trust could not ensure that people's records were accurate, complete and up to date.
- Care plans were not always in place or updated were people's needs changed in the community adults, rehabilitation and older people's services. Peoples' involvement in their care plans varied across the services.
- Patients had to wait a long time to receive specialist psychological interventions.
- Not all staff had received specialist training or supervision.
- Original detention paperwork was stored in general files on the wards and not all documents could be located.
- There were poor levels of training in and procedures were not always followed in the application of the Mental Capacity Act.

However:

- People's needs, including physical health needs, were usually assessed and care and treatment was planned to meet them.
- Generally people received care based on a comprehensive assessment of individual need but not all services used evidence based models of treatment.
- The trust had participated in a range of patient outcome audits.
- Generally we saw good multidisciplinary working.
- Overall, systems were in place to ensure compliance with the Mental Health Act (MHA) and the guiding principles of the Mental Health Act MHA Code of Practice.

Are services caring?

Good

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

Summary of findings

- Staff showed us that they wanted to provide high quality care, despite the challenges of delivering care from some poor ward environments. We observed some very positive examples of staff providing emotional support to people.
- Most people we spoke with told us they were involved in decisions about their care and treatment and that they and their relatives received the support that they needed.
- We heard that patients were well supported during admission to wards and found a range of information available for service users regarding their care and treatment.
- The trust had an involvement policy which set out the trust's commitment to working in partnership with service users. The trust told us about a number of initiatives to engage more effectively with users and carers.
- Results from the friends and family test indicated a good level of satisfaction with the service.

Are services responsive to people's needs?

Good

We rated Lincolnshire NHS Foundation Trust as good for Responsive because:

- The inpatient environments were clean and maintained and most were conducive for mental health care and recovery.
- Complaint information was available for patients and staff had a good knowledge of the complaints process.
- A good range of information was available for people in appropriate languages.
- The trust was meeting the cultural, spiritual and individual needs of patients.

However:

- Bed occupancy rates were high across the trust and over 100% in acute services. This meant that the trust used acute leave beds for new admissions.
- In acute and older peoples services some beds were situated in bays. Patients told us they did not always feel safe and these areas lacked privacy.
- In adult community services target times for assessment were not met.
- Food was not always at the standard required by patients.

Are services well-led?

Requires improvement

We rated Lincolnshire Partnership NHS Foundation Trust as requires improvement overall for well-led because:

Summary of findings

- We were concerned that the trust had not always delivered safe and quality care. Our findings indicate that that there is room for improvement to ensure that lessons are learned from quality and safety information and are embedded in to practice.
- Risk registers for the trust and directorates did not include all of the concerns that we found during this inspection.
- Staff morale was poor in some areas and some and not all staff felt heard.
- The trust had failed to improve on the previous year's staff survey results.
- Leadership was not always clearly visible.

However:

- The trust board had developed a vision statement and values for the trust and most staff were aware of this.
- The trust had undertaken positive engagement action with service users, carers and partner agencies.
- The trust had undertaken a range of audit and research. Accreditation had been attained for most inpatient services.
- There was some innovative and outstanding practice.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell, Chief Executive of Oxford Health NHS Foundation Trust.

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

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

The team included 3 CQC inspection managers, 17 mental health inspectors, 2 pharmacy inspectors, 8 Mental Health Act reviewers, support staff, a variety of specialists, and experts by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting.

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

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

When we inspect, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before visiting, we reviewed a range of information we hold about Lincolnshire Partnership NHS Foundation Trust and asked other organisations to share what they knew.

We carried out an announced visit between 30 November to 4 December 2015. Unannounced inspections were also carried out on the 16 December 2015.

Prior to and during the visit the team:

- Held service user focus groups and met with local user forums.
- Met with more than 25 local stakeholders and user groups.
- Held focus groups with 23 different staff groups.
- Talked with more than 250 patients and 50 carers and family members.
- Collected feedback using comment cards.
- Observed how staff were caring for people.
- Attended 39 community treatment appointments.
- Attended 30 multi-disciplinary team meetings.
- Looked at the personal care or treatment records of more than 300 patients and service users.
- Looked at patients' legal documentation including the records of people subject to community treatment.
- Interviewed more than 350 staff members.

- Interviewed senior and middle managers.
- Attended an executive team meeting.
- Met with the Mental Health Act hospital managers
- Reviewed information we had asked the trust to provide.

We inspected all mental health inpatient services across the trust including adult acute services, rehabilitation wards, secure wards, older people's wards, and specialist wards for and children and adolescents. We looked at the trust's places of safety under section 136 of the Mental Health Act. We inspected a sample of community mental health services including the trust's crisis services, children and adolescents services, learning disability services, older people's and adult community teams.

We also visited three locations where community substance misuse services are provided.

Information about the provider

Lincolnshire Partnership NHS Foundation Trust offers a number of mental health services to adults, older adults and children including community, inpatient, specialist, substance misuse and learning disability services across Lincolnshire and North Lincolnshire.

Lincolnshire Partnership was authorised with foundation trust status 1 October 2007.

At April 2015, the trust served a population of almost 990,000 and employed almost 2,100 staff including nursing, medical, psychology, occupational therapy, social care, administrative and management staff. It had a revenue income of £99 million for the period of April 2014 to March 2015.

The trust provides integrated health and care services for people aged 18-64 under a section 75 agreement with Lincolnshire County Council.

The trust is a partner in Lincolnshire Health and Care which aims to provide residents with access to safe and good quality services, closer to home and avoid, where possible, a lengthy hospital stay.

Lincolnshire Partnership NHS Foundation Trust operates from 79 sites across almost 2,500 square miles and had a total of 12 locations registered with CQC. The trust had 274 inpatient beds the majority of which are on the main sites in Lincoln, Grantham and Boston.

It had been inspected 30 times since registration in April 2010. At the time of this inspection, there were no breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Good practice

In the acute service we observed excellent care provided to a terminally ill patient on Charlesworth Ward. Staff were dedicated, compassionate and caring. Appropriate capacity assessments were in place to ensure the patient's rights were protected and specialist staff were employed to meet care needs. We felt staff were to be commended for the dignified and compassionate care they provided for this patient, under unusual and difficult circumstances.

The introduction of street triage had improved access to assessments for people who came to the attention of the police. The triage car was staffed by paramedics and qualified mental health professionals from the trust. Information from the trust showed that out of 178 referrals to the triage car in the period from April to October 2015, 59 were resolved with follow up offered, 30 were resolved with no follow up needed, 18 received mental health home treatment, five were detained under section 136 Mental Health Act MHA and 32 were detained under the Mental Health Act MHA.

The substance misuse service had started to provide a breathalyser for people to take home to monitor their alcohol use. Staff implemented this as a modern alternative to paper drink diaries, used to record an individual's alcohol intake. Staff supported people to monitor their intake and recognise a reduction in drinking as a positive achievement and motivation to continue to reduce intake.

The community learning disability assertive service (CAST), greenlight team, psychology, speech and language therapy, and medical staff provided flexible input into each "pod", as required. Patients' needs were met quickly and effectively, when and where patients wanted to be seen.

The CAST team had won the trust's service recognition award for 'team of the quarter', and was nominated for 'team of the year award'. The team had won this award for being responsive to patients and carers needs, and embracing new ways of working.

On the Rochford unit an ex-patient volunteer was working on the ward, positively engaging with, and supporting patients. The volunteer told us they had taken part in staff recruitment panels for employing nursing assistants and nurses for the Rochford unit.

The trust is heavily involved and committed to dementia research and was actively taking part in or applying for a multitude of research projects to improve dementia care across their services.

The CAMHS community service was actively involved in research and developing areas of best practice. Staff within the trust had developed "outcomes orientated child and adolescent mental health service". This evidence based model focussed on the outcomes for young people and had been recognised in NHS innovation awards. This demonstrated clear positive outcomes for young people using the service. Other CAMHS services were adopting this model.

Within the North East Lincolnshire CAMH service a research assistant had been employed to help with a piece of work evaluating services response to young people in crisis. This aimed to use qualitative and quantitative data from young people and their carers, the CAMHS service, police, emergency departments and other agencies.

The CAMH inpatient service had employed a therapy dog as a member of the team on the unit. We heard about numerous examples from young people and staff of how the dog defused and de-escalated situations. We saw that young people responded positively to the dog and it helped them engage with their care.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all ligature risks are identified on the ligature risk audit and that they do all that is reasonably practicable to mitigate any such risks.
- The trust must ensure that all mixed sex accommodation meets guidance and promotes safety and dignity.
- The trust must ensure that seclusion facilities are safe and appropriate and that seclusion is managed within the safeguards of the Mental Health Act Code of Practice
- The trust must ensure there are sufficient and appropriately qualified staff at all times to provide care to meet patients' needs.
- The trust must ensure that all risk assessments and care plans are updated consistently in line with changes to patients' needs or risks.
- The trust must ensure effective systems for management of medication.
- The trust must ensure that there are not significant delays in treatment and that access is facilitated to psychological therapy in a timely way.
- The trust must that food meets the standard required by patients.
- The trust must ensure that there are systems in place to monitor quality and performance and that governance processes lead to required and sustained improvement.

- The trust must ensure that learning and improvements to practice are made following incidents.

Action the provider SHOULD take to improve

- The trust should review its procedures for maintaining records, storage and accessibility.

The trust should ensure all staff including bank and agency staff have completed statutory, mandatory and where relevant specialist training, and are supervised.

Lincolnshire Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

A Mental Health Act committee had overall responsibility for the application of the Mental Health Act and the Mental Capacity Act. The Mental Health Act committee received information and assurance through the Mental Health Act manager.

We visited all of the wards at the trust where detained patients were being treated. We also reviewed the records of people subject to community treatment and people who had been assessed under section 136 of the Mental Health Act. We also looked at procedures for the assessment of people under the Mental Health Act. We found that there was some detention paperwork missing from the patient files on the wards. Where detention paperwork was available this had usually been completed correctly.

Overall Mental Health Act training compliance was below the trust targets in some services. Despite this most staff had an awareness of the Mental Health Act.

We reviewed practice under section 136 of the Mental Health Act MHA in detail. Staff were aware of their responsibilities around the practical application of the Act. The relevant legal documentation was completed appropriately in those records reviewed. However, some staff were mistaken about the point of time that a person was detained under section 136. Some staff believed this was the time when the person arrived at the health based place of safety rather than at the emergency department where they had first been taken by the police.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust has a policy in place on the application of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). Reporting to the board the Mental Health Act committee had overall responsibility for the application of the MCA.

The trust told us that training rates for staff in the MCA were poor with between 62 and 68% (dependent on the required level of training), of staff trained at October 2015. Despite this most staff had an awareness of the MCA and the DoLS. However, in the children's inpatient team not all staff could demonstrate their understanding of the MCA and Fraser competency.

Generally, at inpatient units' people's capacity had been assessed and details were recorded. In most community services staff had a clear understanding of their responsibilities in relation to the MCA. Most were able to differentiate between ensuring decisions were made in the best interests of people who lacked capacity for a particular decision and the right of a person with capacity to make an unwise decision.

Inadequate

Are services safe?

Inadequate

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

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

- Some of the wards did not provide an environment that was safe or that preserved patients' dignity or privacy. The layout of some wards and ward garden areas meant that staff could not easily observe patients who might be at risk. We were concerned about the design of the place of safety and seclusion facilities at some units. Some wards had fixtures and fittings that people at risk of suicide could use as a ligature anchor point; the trust had not addressed these risks adequately.
- Not all wards met the requirements of single sex accommodation guidance or the Mental Health Act code of practice. Some seclusion rooms and dormitory areas did not promote privacy and dignity.
- Restrictive practices that amounted to seclusion were not always reported or safeguarded appropriately. There were some blanket restrictions within acute, forensic and children and adolescent mental health services.
- Some wards in the rehabilitation, forensic and children's mental health services had too few staff on duty at times to keep patients safe and others relied heavily on the use of bank and agency staff. We were concerned about medical arrangements in the rehabilitation service.
- We were concerned about the levels of training in some teams for restrictive intervention, health and safety, safeguarding, Mental Capacity Act, Mental Health Act, clinical risk assessment and food hygiene.
- Not all clinical risk assessments in the older people's wards and at Maple Lodge and Ashley House had been undertaken or reviewed meaning patients risks and needs were not always known or addressed.
- The trust had processes in place for the safety of lone workers but emergency call systems were not being used consistently in community teams.
- There were some concerns about the effective prescribing, management and storage of medication at community services.
- There was not always clear evidence of learning and improvements to practice following incidents and learning was not always shared across services.

However:

- Services were clean, with good infection control practices.
- There had been significant work on reducing restrictive intervention.
- Incidents were reported and investigated. The trust was meetings its obligations under Duty of Candour regulations.
- The trust has contingency plans in place for in the event of an emergency.

Our findings

Safe and clean environments and equipment

Inadequate

Are services safe?

The trust undertook an annual programme of environmental health and safety checks.

Ligature risk assessments were reviewed as part of this programme. The programme was overseen by the quality and safety team. All ligature related issues were also reported to the patient safety group and the quality committee on a regular basis. Prior to the inspection the trust told us that all inpatient units had received a ligature assessment in the previous 12 months and that there were no high level risks relating to ligatures identified.

Some wards had few potential ligature points and measures were in place to minimise the risk to patients, including the use of nursing observations and alterations to furnishings. However, in a number of acute, forensic, rehabilitation, older people's and children's mental health wards there were ligature risks which we highlighted on the visit that had not been previously noted in the assessments, or were noted by the trust but had not been addressed. We were particularly concerned about ligature risks within Ward 12 in Boston, at the acute and forensic wards in Lincoln and the children's mental health unit. Some potential ligature anchor points were located within garden areas adjacent to the wards. We were told that the trust did not routinely assess ligature risks within the outside areas.

Generally staff were aware of the risks to patients' safety caused by the environment and had assessed patients' individual risks and increased their observation level as needed. However, this was not always the case in the rehabilitation wards.

In some instances patients, including those not detained under the Mental Health Act, had their access to fresh air restricted due to environmental concerns within gardens. Since the inspection, the trust has told us that they have taken appropriate action to address this.

The seclusion facilities at the Francis Willis Unit and on the three acute wards did not meet required standards.

At the Francis Willis Unit the ward had one seclusion room in use. This was located away from the main ward, however the viewing panel could be seen from the main corridor by other patients.

The seclusion rooms on Conolly and Charlesworth wards were opposite the bed bays which affected the privacy and dignity of patients. On Ward 12, the seclusion room toilet contained ligature risks. The trust had identified these on the ligature risk audit in January 2015, with plans to replace bathroom fittings and door hinges. The trust had not completed this work and there was no recorded management plan to support staff in the interim. Staff could not observe the toilet area from outside the seclusion room and told us they needed to enter the seclusion room if patients wished to use the toilet, to ensure safety. This affected the privacy and dignity of patients and was a risk to both patients and staff.

Staff told us there had been occasions when male patients had been secluded on Charlesworth ward, when the seclusion room on Conolly ward was in use or out of action. We were concerned that this did not promote privacy of both male and female patients.

The layout of the wards generally allowed clear lines of sight for staff to observe patients. Where this was not the case the trust had usually installed observation mirrors or CCTV to mitigate this risk. However, this was not the case at the Rochford unit which did not allow staff to observe an area outside the manager's office. Within the garden areas at the Francis Willis Unit and Ash Villas we also noted areas that could not be easily observed by staff.

Prior to the inspection the trust told us that there had been no breaches of single sex accommodation in adherence to guidance from the Department of Health and the Mental Health Act Code of Practice. On the majority of wards there were clear arrangements for ensuring that there was single sex accommodation. However, within rehabilitation services at Ashely House and Maple Lodge, bathroom arrangements were not clearly delineated as single gender and frequently used by both genders. At the older peoples service at Langworth ward two female bedrooms set off a male corridor, without ensuite facilities. This meant that female patients had to cross the area used by male patients to access the bathrooms. We immediately raised our concerns with the trust.

Within older people's services, the dormitories on Brant ward and Rochford unit and at the acute services at Peter Hodgkinson Centre did not allow for patients' privacy and dignity, with curtains separating beds in some bay bedrooms. Staff told us there were no plans to address this.

The health-based places of safety did not meet all of the environmental requirements of the Royal College of Psychiatrists' national standards. Environmental risks

identified in our previous Mental Health Act monitoring visit in May 2015 remained. The room was small and only had one door which created a risk that staff would not be able to exit the area quickly if needed. Staff were not able to maintain line of sight observation in all areas. The furniture in the suite was not weighted. There was nowhere for professionals to talk privately. A new place of safety was being built to address these concerns at the time of this inspection. In the interim staff had increased staffing levels to manage this better.

Fire procedures and equipment were in place at all services. Staff had received fire safety training and were aware of what to do in an emergency. However, we were concerned to find inappropriate electrical equipment in the clinic room at Ash Villas, which was a potential fire hazard because of the heat it gave off. We also found oxygen stored in the same location.

The trust had an infection control committee that oversaw a programme of audit for this work. Hand hygiene and infection control audits were regularly undertaken across services and showed that staff demonstrated good hand hygiene. Staff received infection control practice as part of mandatory training. There was good levels of completion for this training. Regular trust-wide cleanliness audits were undertaken.

Infection control procedures were being followed by staff. Hand gels and other equipment was readily available and in use. There was information available to patients and families around good practice and advice to prevent the spread of infection. Inpatient services were found to have hand-washing facilities readily available and we observed staff adhering to the trust's 'bare below the elbow' policy where appropriate. Staff washed their hands at the nurses' station.

The trust had performed better overall than the national average with regard to its score for cleanliness (98.4%) in the patient-led assessment of the care environment (PLACE) programme. However, Ashley House, Francis Willis Unit and the Manthorpe Centre had fallen short of the average score. The trust had performed worse overall for the condition, appearance and maintenance of the environment (89.6%) with Francis Willis, the Manthorpe Centre, Pilgrim Hospital, Peter Hodgkinson Centre and Ash Villas being of particular concern. All of the services we visited were clean and most were well maintained. Patients told us that they were happy with the standards of cleanliness. Most services were able to provide cleaning records however these were not available at some community mental health teams or substance misuse services.

All clinic rooms we visited appeared clean and most were fit for purpose. However, we were concerned with safety aspects of the clinic at Ash Villas.

Inpatient services had systems in place to ensure equipment was serviced and electrically tested. Equipment was labelled with testing dates which were current. Staff told us about the procedure in place to clean equipment between patients. Generally, necessary equipment to carry out physical examinations and for emergency life support were in place, regularly serviced and checked by staff.

Patients had access to appropriate nurse call systems on most wards. However, there was limited access to nurse call systems in the dormitories on Brant ward. One nurse call bell was shared between four patients and was not easy to locate. These meant patients would not find them accessible in an emergency. In the community teams most staff had access to emergency alarms where required.

Safe staffing

In 2014 the trust reviewed and set staffing levels for all inpatient services. Since April 2014 the trust had published actual staffing levels as a percentage of planned staffing on their website. The board reviewed overall staffing levels on a monthly basis as part of the integrated performance board report. Where fill rates fall below 90% and above 115% these were highlighted as hot spots and further assurance was sought.

The head of workforce told us that further work was underway to review safe staff levels for all inpatient areas. The trust was moving towards implementing the Hurst Model which is a specialist mental health service tool that includes measures for patient acuity.

Figures provided indicated that during October 2015 overall inpatient staffing had generally met the trust's target with an average of 99% of planned day shifts and 101% of planned night shifts filled across inpatient services throughout the month. However, it was noted that staffing had not met the trust's target of 90% at the acute service in Boston during the day were there had been only 86.5% of shifts filled.

Inadequate

Are services safe?

Ward and team managers confirmed that processes were in place to request additional staff where required.

The trust told us that increased staffing above 20% by bank staff is only undertaken to fulfil an increase in clinical observation. The trust was implementing a monitoring system called 'Safe Care' which will give oversight of bank and agency usage across the trust which will allow areas of high usage of bank and agency staffing to be better monitored.

At the time of our inspection in December 2015 staffing was generally sufficient on the wards. However, we found that staffing while meeting the trust target was low at night within the forensic, some rehabilitation and the children's mental health units. We were concerned about these units due to their location, as they were not near to other services, so could not rely on support from additional staff should an emergency arise. In addition some wards, particularly in older people's services, were using very high levels of bank and agency staff to meet their staffing targets. In the previous three months 687 shifts had been filled in older people wards by bank or agency staff.

Within community adult services, vacancies and sickness were adversely affecting staffs' ability to deliver the services. Caseloads within these teams were above the Royal College of Psychiatrists' recommended levels. At the time of our visit the vacancy rate stood at 22%. Of particular concern was the team in Skegness with vacancies at 45%. During our inspection 43% of clinical staff were on sick leave. Other community teams were better staffed through the use of bank and agency staff.

The trust had identified on the older adult risk register in 2013 that excessive service and staff caseload size within older adult's CMHT. Since then there have been progressive attempts to reduce the case load for nurses and band 4 workers throughout 2014 and 2015 but their caseloads still remained high.

The trust confirmed that they had an overall vacancy rate of 3% in August 2015. For registered nurses this stood at 5.7%. For nursing assistants this stood at 19.8%. Staff turnover stood at 14% in August 2015. However, some services had notable high turnover at 29% in community forensic services, 22% in adult community services and 19% in forensic wards. Specific teams with high staff turnover were the rapid response team at 280%, the adult ILT at 43% and the single point of access at 39%. All community adult teams had high turnover at an average 22%.

The trust acknowledged challenges regarding recruitment and retention particularly given Lincolnshire's rural isolation but told us that they are working hard to address this issue. We saw a recruitment strategy, action plans and positive information about recruitment initiatives.

We met with a number of doctors of different grades at the trust. We were told that medical cover was decreasing and the role was becoming increasingly challenging. The trust told us they are undertaking a medical workforce review and acknowledged they were having problems recruiting doctors. The trust was looking at how to make better use of nurse prescribers and to employ more physical health nurses to relieve some burden from the medical staff. Medical cover was generally acceptable across inpatient and community services when we visited. However, we were concerned that there were insufficient consultants within the rehabilitation service.

The trust required staff to attend a variety of mandatory training courses. These included courses in the Mental Capacity Act, restrictive intervention, food hygiene, autism awareness, medication management, immediate life support, hand decontamination, children's safeguarding and clinical risk management. In addition, display screen equipment, falls, infection control, inoculation incidents, records management, manual handling, PREVENT and diversity awareness was mandatory for some staff. The trust had recently increased their training target to 95% (previously this was 90%). Training records showed that 84% of staff had attended their mandatory training at October 2015. However, we were concerned that a low proportion of staff had undertaken some of the courses considered mandatory. These included: level 3 children's safeguarding at 68%, Mental Capacity Act training at between 62% and 68% dependant on the required level of training, Mental Health Act at 73%, restrictive intervention at 71%, health and safety at 50% and food hygiene at 50%.

The trust gave us differing accounts of whether safeguarding adults' training was or was not mandatory. The trust initially supplied us with information that did not include this as part of the core training. Staff in some services also told us that it was not mandatory. Subsequent submissions did include this as mandatory

training. Overall compliance stood at 87%. We heard at a large number of services that this was due to staff being unable to book on to courses which were delivered by the local authority.

Assessing and monitoring safety and risk

We looked at the quality of individual risk assessments across all the services we inspected. Usually these addressed risks in most inpatient and community mental health services. However, in the older people's wards and at Maple Lodge and Ashley House we found that some risk assessments were not completed or available. We were particularly concerned that at Witham court, three out of the six sets of care records we looked at did not have risk assessments on file and could not be found by the staff. In addition, at some community and substance misuse services the quality of risk assessments varied and not all had been updated to address patients' current needs.

The trust had an observation policy in place. Training on observation practice was included within the clinical risk management mandatory training. Generally, staff were aware of the procedures for observing patients. Ward managers indicated that they were able to request additional staff to undertake observations.

Safeguarding

The trust had policies in place relating to safeguarding procedures. Additional guidance was available to staff via the trust's intranet. We were told that the trust's internal and the local authorities' safeguarding teams were also accessible and available to staff for additional advice. Most teams had a lead nurse for safeguarding.

A number of staff had not received their mandatory safeguarding training. However, most staff we spoke with knew about the relevant trust-wide policies relating to safeguarding. Most staff were able to describe situations that would constitute abuse and could demonstrate how to report concerns.

Managers and staff told us of occasions where they had raised urgent issues of concern. We heard about a number of positive actions as a result of this.

A governance process was in place that looked at safeguarding issues at both a trust and at directorate levels on a regular basis.

Restrictive practice, seclusion and restraint

The director of nursing was executive lead for restrictive practice. Restrictive interventions steering group had been set up to oversee a work programme to meet the Department of Health's 'Positive and Proactive Care: reducing the need for restrictive interventions'. This programme included the six key reduction strategies Work undertaken had included a review of all relevant policies and training delivery, benchmarking against other services, development of supportive behaviour plans, and involvement in the safe wards initiative. Training had been developed to ensure that supine interventions were taught as the safest way to intervene on the floor and prone restraint was only used as a last resort. The trust had also developed a restrictive intervention section on the internal website to provided staff the opportunity to read national guidelines and standards, and access restrictive intervention tools.

The trust told us that they had made amendments to the reporting structure, improved audit procedures and data collection of restrictive intervention data. The extraction of restrictive intervention data was performed manually due to IT challenges however work was planned to commence in January 2016 to support a more efficient way of data extraction.

Policies and procedures were in place and had been updated covering the management of aggression, physical intervention, seclusion and segregation. These policies had been reviewed to reflect latest guidance regarding the safe management of patients in a prone position and addressed the specialist needs of children or people with a learning disability, autism or a physical condition. The seclusion and segregation policies had been reviewed to reflect the updated Mental Health Act Code of Practice.

The lead for physical intervention confirmed that this work programme continues to ensure that restrictive practice is minimised.

The use of restraint and seclusion were defined as reportable incidents at the trust. Incidents were monitored at the restrictive interventions steering group and the quality committee meetings. An annual report on restrictive practice was presented to the board in August 2015.

Prior to the visit we asked the trust for restraint and seclusion figures. Restraint was used on 275 occasions in the six months to July 2015. Of these face down (prone)

restraint was used on 29 occasions. This equated to almost 11% of all restraints. It was noted that 11 of these (38%) had resulted in rapid tranquilisation. The majority of all restraints had occurred at Long Leys Court, a ward for people with a learning disability that closed in November 2015, at 78 incidents equating to 28%. The three acute wards together had used restraint on 81 occasions equating to 29%. These wards also had the majority of prone restraints at 10 incidents equating to 34%.

The trust reported that seclusion was used on 90 occasions during the same period. The trust stated that there had been no uses of long term segregation. The majority of episodes of seclusion had occurred at Long Leys Court, a ward for people with a learning disability that closed in November 2015, at 41 incidents equating to 46%. The three acute wards together had used seclusion on 45 occasions equating to 50%. We had some concerns that not all episodes of seclusion had been captured in data at the older people's wards.

We observed a number of examples of staff managing patients' aggressive behaviour effectively with an emphasis on de-escalation techniques.

We reviewed seclusion practice across the trust. We had concerns about the safety of a number of seclusion facilities as outlined above under environment. We also found in the older peoples wards staff used de-escalation rooms, which staff described as comfort rooms. Staff told us that patients would be taken to this room if they were distressed, and supported with de-escalation techniques until they calmed down. Patients were being cared for away from others and were unable to leave of their own free will. This practice was observed to amount to seclusion. We were concerned that this practice was not viewed by staff as seclusion and therefore not recorded as such. We were told that these incidents were recorded on the incident recording system however we were unable to locate most of these incidents. Further, we were concerned that these incidents were not reviewed through the procedural safeguards set out in the Mental Health Act code of practice. Staff also told us there had been occasions when male patients had been secluded on the female ward Charlesworth, when the seclusion room on Conolly ward was in use or out of action. We did not find a protocol for this.

Generally we found that staff did not restrict patients' freedom and that informal patients understood their status and knew how, and were assisted, to leave the wards. However, at the acute services at the Peter Hodgkinson Centre, patients who were informal were not allowed to go out at night into the garden for fresh air without a staff escort. In addition staff told us that detained patients could not access outside space during the night, regardless of risk assessment. The trust's operating protocol for managing patient access to designated garden areas within adult acute care areas did not stipulate when access to this area should cease.

Most patients were not subject to blanket restrictions. However, in forensic services there was a restriction regarding meal times. Patients were given only 15 minutes to attend the dining room before food thrown away. Young people at Ash Villa had restricted access to the garden, drinks and snacks. In addition the young people's duvets had plastic covers, which meant covers constantly slipped off. This concern had been raised by young people, with the ward response being that it was necessary for infection control.

Medicines management

The medicines management policy had been updated in December 2014 and was supported by all necessary procedures.

The trust told us that the trust had made the elimination of medicines errors one of its quality priorities and had made a commitment under to reduce medication incidents in patient areas. Standard Operational Procedures have been developed to strengthen the governance process. Locality medicines management subgroups have been set up to disseminate the actions locally. The matron for forensic and adult services has led on a medication incidents review and had ensured that both local and trust wide learning has taken place.

Arrangements were in place to ensure that medicine incidents were documented and investigated. Medicine errors were reported directly to the medicine quality group and the serious incident review group. The quality group also received a monthly report regarding prescribing and any medicine related issues. The trust told us that the rapid tranquilisation policy was currently being reviewed to make this clearer. This was in response to an incident.

The trust confirmed that there had been recent recruitment and that the pharmacy team was now well staffed. Pharmacy teams had begun to work throughout the trust

to give a presence on the wards and at most community teams. Nursing staff told us that the pharmacy teams were a good support and if they had any medicine queries they always had access to pharmacist advice.

Medicines, including those requiring cool storage, were usually stored appropriately and controlled drugs were stored and managed appropriately at most services. However, we did have some concerns. There was no medicine storage in the place of safety. Medicines were being stored at 26 degrees Celsius in the Boston crisis resolution team which is above the recommended temperature for safe storage of medicines. There were a number of issues with prescribing in the substance misuse team. Medication was not managed effectively on Manthorpe ward and Rochford Unit. We found errors when we looked at medication records and a wound swab was found in the drugs fridge. Staff had not accurately recorded in medicines charts for patients being discharged. Staff did not know how to obtain medicines if they did not stock them. In substance misuse services staff did not see clients, accessing a prescription every 12 weeks, to review their medication and ensure clients were safe to continue with this. Staff did not always review people's recovery plans when a lapse had occurred and they used illicit drugs but continued to prescribe medication. Doctors did not follow guidelines for prescribing diamorphine, as described in the Drug Misuse and Dependence: UK Guidelines on Clinical Management (2007).

Emergency medicines were available, were appropriate and there was evidence that these were regularly checked.

Within inpatient services most patients were receiving their medicines when they needed them and that these were correctly recorded. In rehabilitation services some patients administered their own medication which they felt promoted their independence

Track record on safety

We reviewed all information available to us about the trust including information regarding incidents prior to the inspection. A serious incident known as a 'never event' is where it is so serious that it should never happen. The trust had reported no 'never events' between September 2014 and August 2015 through STEIS (Strategic Executive Information System). We did not find any other incidents that should have been classified as never events during our inspection.

Since 2004, trusts have been encouraged to report all patient safety incidents to the National Reporting and Learning System (NRLS). Since 2010, it has been mandatory for trusts to report all death or severe harm incidents to the CQC via the NRLS. Between September 2014 and August 2015 the Trust had reported 2425 incidents to the NRLS. There were 35 incidents categorised as death during the period and a further 4 had resulted in severe harm.

There were 110 serious incidents which required further investigation reported by the trust between April 2014 and June 2015. The majority of these were 'unexpected or avoidable death' at 34 incidents or severe harm at 57 incidents.

This was within the expected range of incidents for a trust of this type and size. Overall, the trust had improved its reporting rates and had been a good reporter of incidents during 2014/15 when compared to trusts of a similar size. It was noted that the overall rate of severe, moderate and no harm incidents decreased during the reporting period. Overall incidents reported had also decreased throughout the period.

The trust was in the lowest quintile of mental health trusts for suicides rates. The trust was aiming for a zero tolerance of suicide and had commissioned an external report into deaths and deliberate self-harm with intent to die. The trust was launching a public consultation on its draft Suicide Prevention Strategy in September 2015.

The National Safety Thermometer is a national prevalence audit which allows the trust to establish a baseline against which they can track improvement. The trust participates in this initiative within older adult services. The harms that are relevant for the trust include rates for new pressure ulcers, new cases of catheter and urinary tract infections, new venous thrombolytic embolisms (VTE) acquired whilst under the trust's care and falls resulting in harm. The target for compliance is 95%. At November 2015 the trust had scored 94.4%. It was noted that the levels of harm free care had fluctuated throughout the 12 months to November 2015 with some improvement in the final quarter.

The Ministry of Justice publishes all 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. No concerns had been raised about the trust between August 2014 and August 2015.

Inadequate

Are services safe?

Learning from incidents

The staff survey 2015 had indicated that incident reporting was below average at the trust. It also indicated that staff did not always feel they would be supported following a report or thought that procedures were fair and effective.

Arrangements for reporting safety incidents and allegations of abuse were in place. Staff had access to an online electronic system to report and record safety incidents and near misses. Staff had received mandatory training which included incident reporting and were able to describe their role in the reporting process. All staff felt that there was clear guidance on incident reporting.

The trust told us that they were developing a new post within the quality and safety team of a serious incident senior practitioner and this role will take oversight of all serious incident investigations. The team reported directly to the serious incident review group (SIRG) and to the quality committee. Meeting minutes confirmed that the board also received monthly updates about actions undertaken as a result of serious incidents via the quality report.

Generally staff told us that they were encouraged to report incidents and near misses and felt supported by their manager following any incidents or near misses. Some staff told us that the trust encouraged openness. However, some staff approached us before and during the inspection and told us that they had not been supported following incidents. In addition staff in the rehabilitation services told us that they did not feel supported following serious incidents. Most staff felt that they got feedback following incidents they had reported.

Where serious incidents had happened we saw that investigations were carried out. The trust had a group of trained staff to undertake serious incident investigations. The majority of investigations were carried out within the timescales required. The investigatory process was robust and followed the National Patient Safety Agency guidelines for incident investigation.

Ward and team managers told us clinical and other incidents were reviewed and monitored through trust-wide and local governance meetings and shared with front line staff through team meetings. The trust produced a bi-monthly learning lessons bulletin to share and disseminate key learning points. Staff received alerts following learning from incidents in other parts of the trust. Most staff knew of relevant incidents and were able to describe learning as a result of these.

Most managers told us that serious incident action plans were devised within the services following investigation completion. However, in community adult teams information we saw did not detail whether actions were completed. A senior manager confirmed that monitoring of individual serious incident investigation action plans took place outside of the community teams, at trust level. The community teams were not routinely involved in the development of action plans for their service.

Managers in other services were able to describe learning as a result of past incidents and how this had informed improvements or service provision. However, at Maple Lodge there had been three serious incidents of assaults on staff including the attempted strangulation of medical staff and we saw was no evidence of learning from these incidents.

We were also concerned that learning was not always adopted across services. For example, following an incident in the crisis service a protocol had been introduced to be followed when people did not attend or were not available for their appointment. This had been implemented across the four crisis resolution teams but had not been adopted in adult community teams were there was no overall monitoring or written protocol for teams to follow for engaging with patients who did not attend appointments. In acute services lessons learnt had not been shared across the site. For example, changes to ward protocols made on one ward, following a serious incident, were not replicated on another.

There had been a number of serious incidents across children's mental health services. The trust had investigated each incident and identified learning from each individual incident and swiftly implemented changes. However, there had not been a coordinated review of all the incidents to see if there were any themes.

Duty of candour

In November 2014 a CQC regulation was introduced requiring NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong.

Inadequate

Are services safe?

The trust had taken a number of actions to meet this requirement. These included training for the executive and managers, information for staff and a review of all relevant policies and procedures. Duty of candour considerations had been incorporated into the serious investigation framework, tools and report, and complaints procedures. The trust told us that they were about to appoint an investigation lead who will also be the trust's Duty of Candour guardian. The board were sighted each month via the integrated performance report on any concerns were duty of candour considerations have been included.

Duty of candour consideration had been include in trust induction training and training for incident investigators. Staff were aware of the duty of candour requirements in relation to their role.

We examined case records where patients had experienced a notifiable event to check that staff had been open and honest in their dealings with patients and carers. We found that the trust was meeting its duty of candour responsibilities.

Anticipation and planning of risk

Systems were in place to maintain staff safety in the community. The trust had lone working policies and arrangements. Most staff in community teams told us that they felt safe in the delivery of their role. However some staff undertook initial assessments alone and that they felt unsafe at times. Other staff, particularly staff in the crisis teams, reported that mobile phone coverage was poor in some areas. As a result some staff had been issued with skyguard electronic devices but these were not being used consistently. The trust was developing IT that would provide a safety app to staff in the future.

The trust had necessary emergency and service continuity plans in place and most staff we spoke with were aware of the trust's emergency and contingency procedures. Staff told us that they knew what to do in an emergency within their specific service. The trust told us that they had tested their arrangements when the floods had affected the Boston area of Lincolnshire in winter 2013.

Emergency resuscitation equipment was available and regularly checked across most inpatient services. Equipment, including resuscitators, were well-maintained, clean and checked regularly. However, this was not the case in the forensic ward where the defibrillator had not been serviced for 20 months. This had not been picked through staff equipment checks. Most staff had received life support training and could describe how they would use the emergency equipment and what the local procedures were for calling for assistance in medical emergencies. However, at the place of safety staff while had access to resuscitation equipment, only 50% had had training in immediate life support.

Most community services staff had been trained in basic life support, and informed us that if a patient deteriorated or had a cardiac arrest at community team bases, they would start resuscitation and call the emergency services through 999.

Requires improvement

Are services effective?

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

Summary of findings

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

- There were a large number of concerns about information sharing systems at the trust. A number of electronic record systems were in operation as well as paper records. This made it difficult to follow information and meant that the trust could not ensure that people's records were accurate, complete and up to date.
- Care plans were not always in place or updated were people's needs changed in the community adults, rehabilitation and older people's services. Peoples' involvement in their care plans varied across the services.
- Patients had to wait a long time to receive specialist psychological interventions.
- Not all staff had received specialist training or supervision.
- Original detention paperwork was stored in general files on the wards and not all documents could be located.
- There were poor levels of training in and procedures were not always followed in the application of the Mental Capacity Act.

However:

- People's needs, including physical health needs, were usually assessed and care and treatment was planned to meet them.
- Generally people received care based on a comprehensive assessment of individual need but not all services used evidence based models of treatment.
- The trust had participated in a range of patient outcome audits.
- Generally we saw good multidisciplinary working.
- Overall, systems were in place to ensure compliance with the Mental Health Act (MHA) and the guiding principles of the Mental Health Act MHA Code of Practice.

Our findings

Assessment of needs and planning of care

The Care Quality Commission community mental health survey 2015 found that overall the trust was performing about the same as other trusts in all areas. On average, the trust was scored as 7.5 (out of 10) for the questions about how involved respondents were in planning their care (on a scale of 0 to 10, where 10 out of 10 is the most positive). On average, the trust was scored as 6.3 (out of 10) for holding formal meetings with respondents to discuss how their care was working in the last 12 months. On average, the trust was scored as 6.2 (out of 10) for information about who to contact out of hours if they have a crisis. However the trust scored worse than other trusts for feeling that they have seen mental health services often enough for their needs in the last 12 months.

People were usually appropriately assessed at admission and relevant treatment had been put in place. However, we were concerned that some patients at Maple Lodge had not been formally assessed and that two patients in older people's services had not had their eye care needs fully assessed or met.

Generally we found the care plans were detailed, individualised to the patients' needs and showed the patients' involvement in the care planning process. In the majority of mental health services, people's care needs and risks were assessed and care plans had been put in place. However, this was not the case at some of the rehabilitation service, community adult and older peoples' services where gaps in care plans. In addition, at these services the quality of care plans varied and some lacked sufficient detail. In the majority of services, care plans had been reviewed following changes to people's needs, and

risk assessments had been updated. Most care plans reviewed indicated the involvement of the patient. This was not the case within children's inpatient and some rehabilitation services. However, we did find that patients were knowledgeable about their care.

Within services patients' physical health needs were usually identified. Patients had a physical healthcare check completed by the doctor on admission and their physical healthcare needs were being met. Physical health examinations and assessments were usually documented by medical staff following the patients' admission to the ward. Ongoing monitoring of physical health problems was taking place. However, in community mental health teams records did not show that patients received regular physical healthcare examinations.

There were a large number of concerns about information sharing systems at the trust. A number of electronic record systems were in operation as well as paper records. Some teams used just the electronic system; others used partial electronic and partial paper notes. This made it difficult to follow information and meant that the trust could not ensure that people's records were accurate, complete and up to date. At the community adult teams staff used mostly electronic patient records. However, these were not compatible with other systems used by teams within the trust. In substance misuse services staff recorded a person's contemporaneous case notes in three places: two paper files and an electronic system. This made the care records difficult to navigate to ensure that staff saw clients and supported them appropriately. In learning disability services there were two electronic recording systems in operation that did not interface with each other. Staff had to access both systems in order to get all the risk assessment information. This resulted in staff not always having complete or readily available information before providing care and treatment.

We also heard from a large number of staff that access to records systems was difficult meaning that they often worked outside of core hours to ensure records were complete. The trust acknowledged that records systems was one of their main challenges and had been working to make improvement to the systems. This included looking at remote working solutions.

Best practice in treatment and care

Services were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) or other relevant guidelines.

Generally people in mental health services received care based on a comprehensive assessment of individual need and usually outcome measures were considered using the Health of the Nation Outcome Scales (HoNOS) or other relevant measures. In older people's services healthcare assessments were routinely carried out using recognised tools such as the malnutrition universal screening tool and the modified early warning system. Forensic services were using HoNOS secure and HCR-20 (the historical clinical risk management tool). However, rehabilitation services were not all using measures to gauge patient's outcomes.

Staff within the community children's mental health team had developed "outcomes oriented CAMHS". This evidence based model focussed on the outcomes for young people and had been recognised in NHS innovation awards. Other CAMHS services were considering adopting this model.

However, in some services there were potentially high levels of prescribing, outside of British National Formulary (BNF) guidelines. For example, there were 13 patients across the acute service who had doses prescribed that were over British National Formulary (BNF) limits. The substance misuse service did not support people in line with Drug Misuse and Dependence: UK Guidelines on Clinical Management (2007), when individuals were receiving diamorphine prescriptions. In the rehabilitation service there were no audits to evaluate the outcomes of the interventions used at Maple Lodge.

Across services, there was a shortage of psychology staff meaning that not all services were able to offer psychological therapies in line with NICE guidance. The adult mental health psychology service was not meeting the key performance indicators (KPIs) set by commissioners in relation to 'access targets'. In December 2014, there were approximately 1100 people waiting to access a specialist psychological therapist within the service. The trust told us this had reduced to just fewer than 700 people by the time of our inspection in response to a number of actions including a review of the waiting list. At the time of our visit some people were waiting 56 weeks for a psychology team assessment.

The older adult community teams only had access to one psychologist across the six teams. Staff told us there was a

12-18 month waiting list for access to a psychologist. In CAMH community teams there was good access to psychology and therapy however there was no family therapy. There was limited access to psychology in the CAMH inpatient service, with one clinician providing the majority of the interventions.

During 2014, the trust participated in the national audit of schizophrenia (NAS). The audit had found that a high proportion of service users were receiving more than one antipsychotic medication at a time or a higher dose than normally expected. The trust did not participate in the national audit of psychological therapies. The trust also participated in POMH audits in antipsychotic prescribing for young people, and prescribing anti-dementia drugs. The learning disabilities services contributed to the POMH (Prescribing Observatory for Mental Health) anti psychotics in learning disabilities audit. The trust also participated in the National CQUIN for improving physical health care to prevent premature mortality in people with serious mental illness.

In the past 12 months the trust had conducted patient outcome audits against NICE guidance for: anorexia nervosa and bulimia nervosa, pharmacological treatment of epilepsy by seizure type, general anxiety disorder, posttraumatic stress disorder. Other audits included: audit of NICE quality standards for dementia, medication prescribing in patients diagnosed with dementia, lithium monitoring in learning disabilities psychiatry, and the completion of in-patient physical healthcare assessment tool (baseline audit).

A report summarising the findings of all audits was included in the quarterly audit highlight report which was reported to the board via the quality committee, and results from this specific parts of the audits informed the bi-monthly heat map.

The trust had undertaken a trust-wide audit using the Green Light Toolkit in 2009. This audit aims to assess whether services are appropriate for people with a learning disability. A further full audit with all teams was planned for 2016. The trust was working in partnership with commissioners to undertake a full service review and redesign of LD and ASD services at the time of our inspection. Since the initial audit the trust had set up a small greenlight team made up of three mental health nurses, and two outreach nurses who worked with the National Autistic Society. The team work with other teams and directly with service users to facilitate access, and ensure reasonable adjustments in mainstream services and supported mainstream mental health services and colleagues who had people with learning disability and/or autism on their caseload. The team were also active members of the ASD and LD partnership boards. All trust staff are trained in autism awareness through an e-learning programme as part of the mandatory training.

Skilled staff to deliver care

In the 2015 NHS Staff Survey, the trust scored worse than average for 16 key measures. These included staff recommending the trust and job satisfaction, feeling valued and involved, quality of appraisal and training experiencing violence, bullying and stress, incident reporting and communication with managers. Overall the trust had decreased its position across 6 relevant indicators against the 2014 survey results. This particularly related to communication, feel safe to report issues and staff recommending the trust.

New permanent staff underwent a formal induction period. This involved attending a corporate induction, learning about the service and trust policies and a period of shadowing existing staff before working alone. In most services bank and agency staff received a local induction and where appropriate mandatory training.

The trust had been an early implementer of the national care certificate which is available to nursing assistants and other unqualified staff. Some specialist training to meet the needs of the client group was available such as autism awareness, best interests' assessor training and training to become a nurse prescriber. Most managers had also been able to access leadership training. In learning disability and CAMH services staff told us that they could access specialist training for their roles. However we spoke with a large number of staff across services who said that they could not get the development they needed for their job. Staff in older people teams stated that they did not get access to dementia training. Staff in the single point of access had not had access to specialist training for their role. Suicide prevention training was planned for January 2016. In substance misuse services there was no evidence to show that staff had completed appropriate training for this type of work.

The trust told us that 89% of staff had received an appraisal in the previous 12 months. However, the figures for some

community and crisis teams were significantly lower. Not all staff we met had receive clinical and management supervision on a regular basis. Local records supported this concern. At Maple Lodge in the rehabilitation service we found that only 8% of staff had received supervision in the previous three months.

In substance misuse services managers did not keep organised staff files. They stored supervision notes, correspondence, sickness records and other documentation in loose-leaf document wallets. These were not organised, making it difficult to review how managers supported and monitored staff.

A total of 50 medical staff had been revalidated in 2014/2015 with a 100% revalidation and appraisal rate.

Multi-disciplinary and inter-agency team work

At most mental health units we saw input from doctors, occupational therapists, psychologists, and pharmacy. Usually where required there was also input from physiotherapists, speech and language therapists and nutritionists. However, in the learning disability service there was not sufficient provision of speech and language therapy. There was a long waiting list for this service and the 18 week assessment target had been breached on five occasions in the previous four weeks. Staff could only carry out limited assessments and interventions for those referred. Most community services had input from social workers and social care staff however the crisis teams did not have access to the full range of mental health professional backgrounds. There was also a shortage of psychology staff in all core services. This had some impact on the multidisciplinary process.

There was a strong commitment to multidisciplinary team working across all services. On the wards we visited we usually saw good multidisciplinary working, including ward meetings and regular multidisciplinary meetings to discuss patient care and treatment.

We saw documentary evidence of a multidisciplinary approach to discharge planning. Community teams usually attended discharge planning meetings making the process of leaving the wards more effective. Generally we saw that the community teams worked well with inpatient teams to meet people's individual needs.

Community mental health teams had effective inter-agency working in assessing and supporting those people subject to detention. There were effective links between the approved mental health professionals (AMHPs), the acute services, the police and the trust nursing team. In community older peoples teams there was an allocated 'neighbourhood team' member whose responsibility was to attend the Lincolnshire health and care meeting. This initiative has been developed with the support of the local Clinical Commissioning Groups to help support older adults living in the community and is aimed at promoting independence.

Schools, social workers in the community and those providing residential care described the CAMH service as very responsive and confirmed good partnership working. Within Lincolnshire, there was a drop in clinic for social workers to get advice and support regarding the work of CAMHS, and in ways of supporting a young person suffering from mental illness. The local authority had nominated the CAMH service in Lincolnshire for awards twice for their work and support.

At most wards there were effective handovers with the ward team at the beginning of each shift. These helped to ensure that people's care and treatment was co-ordinated and the expected outcomes were achieved.

Adherence to the MHA and MHA Code of Practice

A Mental Health Act committee had overall responsibility for the application of the Mental Health Act and the Mental Capacity Act.

The Mental Health Act committee received information and assurance through the Mental Health Act manager. The Mental Health Act committee was moving away from focussing on trends and statistics and are going to look at impact on clinical decisions. An example of this would be the recent focus on medication management.

We met with the hospital managers and were informed that they link with the Mental Health Act manager. We were told that the hospital managers receive a rolling programme of training that ensured that they had the knowledge and skills to undertake the role effectively.

We visited all of the wards at the trust where detained patients were being treated. We also reviewed the records of people subject to community treatment and people who had been assessed under section 136 of the Mental Health Act. We also looked at procedures for the assessment of people under the Mental Health Act.

Requires improvement

Are services effective?

We reviewed a range of files covering a variety of sections of the Mental Health Act MHA over a range of detention locations. We were concerned that original detention paperwork was being kept in the patient files on the wards. We found that there was some detention paperwork missing from the patient files on the wards. Where detention paperwork was available this had usually been completed correctly.

Overall Mental Health Act training compliance was below the trust targets in some services. Despite this most staff had an awareness of the Mental Health Act.

In most units we saw good evidence of regular testing of capacity to consent for treatment, however not all patients in older people services had their capacity recorded initially for assessment or on an ongoing basis.

Generally patients had received their rights under the Mental Health Act MHA. However, records did not show that patients had their rights regularly explained to them when subject to a community treatment order (CTO).

Advocates, including independent mental health advocates, were available to people, and in most cases their use was actively promoted. A standardised system was in place for authorising and recording section 17 leave of absence.

We reviewed practice under section 136 of the Mental Health Act MHA in detail. Staff were aware of their responsibilities around the practical application of the Act and we found that the relevant legal documentation was completed appropriately in those records reviewed. However, some staff were mistaken about the point of time that a person was detained under section 136. Some staff believed this was the time when the person arrived at the health based place of safety rather than at the emergency department where they had first been taken by the police.

We noted the section 136 units visited had patient information readily available for and everyone was given a leaflet about the powers and responsibilities of section 136 of the Act.

Good practice in applying the MCA

The trust has a policy in place on the application of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). Reporting to the board the Mental Health Act committee had overall responsibility for the application of the MCA.

The trust told us that training rates for staff in the MCA were poor with between 62 and 68% (dependent on the required level of training), of staff trained at October 2015. Despite this most staff had an awareness of the MCA and the DoLS. However, in the children's inpatient team not all staff could demonstrate their understanding of the MCA and Fraser competency.

Generally, at inpatient units' people's capacity had been assessed and details were recorded. However, for one patient we found that the patient had been subject to DoLS and treated with frequent medical interventions, but their care records indicated that the use of the Mental Health Act might have been more appropriate. We drew this to the attention of clinicians during our inspection.

In most community services staff had a clear understanding of their responsibilities in relation to the MCA. Most were able to differentiate between ensuring decisions were made in the best interests of people who lacked capacity for a particular decision and the right of a person with capacity to make an unwise decision. However, in the older people's community services 27 out of 39 records did not detail the person's capacity. In these cases it was not clear whether the person had been assessed but was deemed to have capacity or whether or not an assessment had actually occurred.

Good

Are services caring?

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

Summary of findings

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

- Staff showed us that they wanted to provide high quality care, despite the challenges of delivering care from some poor ward environments. We observed some very positive examples of staff providing emotional support to people.
- Most people we spoke with told us they were involved in decisions about their care and treatment and that they and their relatives received the support that they needed.
- We heard that patients were well supported during admission to wards and found a range of information available for service users regarding their care and treatment.
- The trust had an involvement policy which set out the trust's commitment to working in partnership with service users. The trust told us about a number of initiatives to engage more effectively with users and carers.
- Results from the friends and family test indicated a good level of satisfaction with the service.

Our findings

Kindness, dignity, respect and support

Assessments undertaken under the patient-led assessment of the care environment (PLACE) reviews in 2015 identified that the trust scored worse than average at 88.3% for the privacy, dignity and well-being element of the assessment against an England average of 90.7%. Seven operational inpatient services, Francis Willis Unit, Ashley House, Ash Villa, Rochford Unit, Maple Lodge, Peter Hodgkinson Centre and Witham Court scored significantly below the average at below 89%. However, inpatient services at the Manthorpe Centre, Discovery House and the Pilgrim Hospital scored above the average.

We observed some very positive examples of staff providing emotional support to people across all services visited. We saw that staff were kind, caring and compassionate in their response to people. We observed many instances of staff treating patients with respect and communicating effectively with them. We saw staff working with patients to reduce their anxiety and behavioural disturbance. Staff demonstrated that they wanted to provide high quality care and were knowledgeable about the history, possible risks and support needs of the people they cared for.

We were impressed with the care provided on Charlesworth ward where staff were looking after a patient suffering from terminal illness. We observed that staff interactions and management plans were excellent and all required nursing interventions were in place, which included Macmillan nurse support.

We found the care provided by young people's community mental health teams outstanding. Staff were positive and enthusiastic about their roles and were committed to the young people. All staff, both clinical and nonclinical, displayed a passion to meet young people's needs. All feedback including surveys collected by the trust was consistently positive about the way staff treated the young people.

Almost all of the patients and relatives we spoke with told us that staff were kind and supportive, and that they or their loved one were treated with respect. We received particularly positive comments in older people's services. We heard some negative comments about staff attitudes in the acute and forensic services.

We were told that staff respected people's personal, cultural and religious needs. We saw some very good examples of the trust attempting to deliver services in line with peoples' cultural needs.

Confidentiality was understood by staff and maintained at all times. Staff maintained privacy with people, who were asked if they would like their information shared with their relatives or whether they wanted their relatives present during assessments. Information was stored securely, both in paper and electronic format.

The involvement of people in the care they receive

Good

Are services caring?

Inpatient services oriented people to the ward on admission. At most services we found welcome packs that included detailed information about the ward philosophy, the staff present on the ward, ward activities, Mental Health Act information and how to complain Notice boards on the wards held a variety of information for patients and carers. A range of information leaflets about the services were available. Almost all patients we spoke with told us that they were given good information when they were admitted to the wards. Some patients told us that staff had taken time to clearly explain ward procedures when they had been unclear or confused. Most detained patients told us that staff had explained their rights under the Mental Health Act.

Patients had access to advocacy including an independent mental health advocate (IMHA). There was information on the notice boards at most wards on how to access these services. Arrangements were also in place to access independent mental capacity advocates (IMCA) and we saw examples of where this was actively promoted. However, we received mixed feedback from patients in acute services about involvement with advocacy services. Most patients were aware of advocacy but not all had used the service. Posters containing advocacy information and contact details were visible on wards.

Across most services we generally found good involvement of patients in their care. Almost all care plans and records reviewed demonstrated the person's involvement. However, this was not the case in the acute service and CAMHs inpatient services. In all services we found that there was an opportunity for patients to attend care planning meetings. In CAMHs services we saw innovative practice to engage young people in their care planning meetings.

We found a number of examples of relatives being involved in care planning where this was appropriate. We observed that where a patient was unable to be actively involved in the planning of their care, or where they wanted additional support, staff involved family members with the patients' consent.

Patients told us that they had opportunities and were encouraged to keep in contact with their family where appropriate. Visiting hours were in operation within inpatient services. We found at most services there was a sufficient amount of dedicated space for patients to see their visitors. At most services there were specific children's visiting areas. However, this was not available at the forensic service.

The trust had a service user involvement policy. This with the clinical strategy priorities 2016/2017 set out a commitment for engagement with service users, carers and wider stakeholders. The trust was in the process of updating this work into an involvement strategy. The trust had recently appointed a head of patient and public engagement who worked closely with the membership, quality and risk teams. The trust told us about work undertaken on this agenda however recognised the need to formalise arrangements. This work was overseen by a trust wide involvement committee. A patient experience report was collated quarterly to inform the quality committee, collating feedback from a range of sources. Work undertaken on this agenda had included increased partnerships with voluntary and community groups and involvement in developing the strategy and clinical priorities. The head of patient and public engagement also supported a range of user and carer groups across the county.

The trust told us that patient experience was also captured by a web based tool. The tool accepts input via the website, through kiosks, and via paper, telephone and SMS. Within Inpatient units tablets were used to collect feedback, within community services other channels were used.

The trust had also led on the establishment of two county wide community support networks; one for mental health and one for dementia.

Prior to the inspection we spoke with a number of user groups, community support organisations and advocacy services. Generally we heard of positive relationships with the trust and of opportunities to be involved in providing feedback on how services are run or planned.

The trust had a number of carers' forums and inpatient services had community meetings to engage patients in the planning of the service and to capture feedback. In most services this meeting was chaired by patients and was attended by relevant ward staff. Minutes were usually taken and we saw evidence of actions that were raised being completed. Patients told us they felt able to raise concerns in the community meetings and that they usually felt listened to.

Good

Are services caring?

In community CAMH services, 'CHI-ESQ' was used to measure young people and families' experience of care. There was a high rate of return which demonstrated an overall satisfaction from young people discharged from the service.

The older adult community teams used the "making experiences Count" (MEC) patient feed-back questionnaire. There was a high level of returns at 935 with an overall satisfaction rate of 98.36% for 2015.

The trust had used the Friends and Families Test (FFT) since 2014. At November 2015 the results indicated that 77% of patient respondents were likely or extremely likely to recommend the trust services. The response to the test demonstrated a fluctuating picture of satisfaction during the 12 months before our inspection at between 77 and 98%. However, all months were higher than the trust's own target of 71%. There had been a good participation rate by former inpatients at between 45 and 63%. However, there was poor response from former community patients at between 7 and 16% during the period.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated Lincolnshire NHS Foundation Trust as good for Responsive because:

- The inpatient environments were clean and maintained and most were conducive for mental health care and recovery.
- Complaint information was available for patients and staff had a good knowledge of the complaints process.
- A good range of information was available for people in appropriate languages.
- The trust was meeting the cultural, spiritual and individual needs of patients.

However:

- Bed occupancy rates were high across the trust and over 100% in acute services. This meant that the trust used acute leave beds for new admissions.
- In acute and older peoples services some beds were situated in bays. Patients told us they did not always feel safe and these areas lacked privacy.
- In adult community services target times for assessment were not met.
- Food was not always at the standard required by patients.

Our findings

Access, discharge and bed management

The single point of access provided a first point of contact for people aged 18 and over who wished to access mental health and learning disability services in Lincolnshire. The team provided advice and guidance through a triage process, where the urgency of care required was assessed. The service had recently been restructured to become part of the function of the Grantham crisis resolution team. Staff told us that the process had deteriorated in the two weeks prior to our inspection. Since the teams had received referrals which appeared not have been screened appropriately. Staff had to gain further information to assess if patients were suitable for assessment or not, and to determine the urgency. Feedback had been given to managers and the trust was addressing this.

The trust has set the target for crisis teams to see people within 4 hours at 95%. At October 2015 the trust had only met this target in 82% of cases. However, at the time of our inspection this was improving and the trust had met the national target at 95% of admissions to acute wards being gate-kept by crisis teams. Workloads had increased in the crisis teams recently as they were also providing assessments for people who presented with a mental health need in the emergency departments of the local acute hospitals. New services for people presenting in emergency departments were being introduced by the trust.

There was no mental health crisis helpline available. The crisis teams were taking telephone calls from members of the public and other health professionals which were not always relevant to a crisis resolution team but did need a response. Staff told us that crisis plans for people using other mental health services provided by the trust often included the crisis resolution team's phone number as no other was available. This was confirmed by staff in other services. In addition general practitioners often referred directly to crisis resolution teams rather that referring through the single point of access. Staff told us that this impacted on their ability to respond to people needing the crisis resolution team. The Lincolnshire mental health crisis care concordat plan contained an action to scope the provision of a 24/7 helpline number for people in mental health crisis, but this had not yet concluded.

The introduction of street triage had improved access to assessments for people who come to the attention of the police. The triage car was staffed by paramedics and qualified mental health professionals from the trust. Information from the trust showed that out of 178 referrals to the triage car in the period from April to October 2015. 59 were resolved with follow up offered, 30 were resolved with no follow up needed, 18 received mental health home treatment, five were detained under section 136 Mental Health Act and 32 were detained under the Mental Health Act.

Good

Are services responsive to people's needs?

People detained under section 136 were usually transported to the health based place of safety by police rather than by ambulance. This could create delays in the person being admitted to hospital. The trust had recently contracted a secure transport provider with a two hour response rate to reduce these delays.

In community mental health teams there were delays in providing patient assessments and treatment. There was a risk that community services were not meeting patients' needs in a timely manner. Average waiting times for December 2014 to November 2015 showed the average waiting time for referral to assessment was 9 weeks. The waiting time for the early intervention service was 5 weeks. The standard for providing a service was 50% of referrals seen in two weeks, which the trust had not met for October 2015. The average waiting time for referral to treatment was 12.8 weeks.

There was not a care pathway for people with a personality disorder. This had led to the crisis teams experiencing difficulties in discharging people who were ready to move onto other mental health services. This was acknowledged by the trust.

In CAMH community services some parents raised that it was difficult to get an initial referral to the service from schools or GP's but once in the service were happy with the response times and service provided. One specialist school in Lincolnshire also raised concern about access due to changes in commissioning thresholds. Commissioners were clear that thresholds were appropriate and that more work needed to be done for other services such as schools to understand the work that tier three CAMHS provided.

In older adult services patients remained with the community teams without discharge for an average of 50 weeks with the patients under medication reviews due to the long-term monitoring requirements, staying up to a maximum of 110 weeks. Staff told us they found this difficult to manage and added an additional pressure to their ability to care for the patients. This issue had been escalated to the older adult risk register and there was a process of review in place with the local clinical commissioning groups to address this issue.

Within community learning disability services with the exception of the speech and language therapy service, the teams were meeting these targets. The speech and language therapy service was struggling to meet its referral to assessment targets of two weeks for urgent referrals and 18 weeks for routine referrals. There were 53 patients on the waiting list, five of whom had breached the 18 week target. The service was only able to offer urgent dysphagia assessment two days per week.

Staff told us that there was often a problem finding beds for patients who needed an admission. Between February 2015 and July 2015 the average bed occupancy rate for the trust was 89%. It is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients. Wards within acute, rehabilitation, forensic and CAMH services had bed occupancy over 85%. Acute wards had an average occupancy of 105%.This confirmed that the trust was using leave beds for admissions. At the time of our inspection there were 27 patients placed outside of Lincolnshire in acute beds.

The trust was not commissioned to provide a psychiatric intensive care unit (PICU) but recognised the need for this type of facility. Detailed discussions had taken place with commissioners and the trust had plans to provide this facility in the near future. The trust referred patients who required a PICU service to other hospitals. Staff told us there could be delays securing a PICU bed, because of funding and transport. At the time of the inspection, 11 patients were receiving care and treatment in a PICU outside the county. The trust told us that from the point of admission, they work closely with the local CCG to repatriate the patient as soon as a local bed becomes available. Staff in the trust kept in contact with the patient throughout the out of area placement.

Supporting data showed that 16 patients were transferred between different acute wards during a single admission in a six-month period. Senior staff told us these transfers were on clinical grounds, for example, to a single sex facility or to nurse the patient closer to their home. We considered these transfers to be appropriate.

The trust told us that they were about to appoint a bed manager who will be responsible for overseeing all admissions and discharges within the organisation.

The mental health ward teams told us that they worked closely with both crisis services and community teams to ensure continuity of care when patients were discharged from hospital. We observed that at all inpatient services' staff worked with other services to make arrangements to

transfer or discharge patients. Generally there was evidence of different groups working together to ensure that patients' needs continued to be met when they moved between services.

Between February 2015 and July 2015 there had been 20 delayed discharges across wards. The majority of delayed discharges were in acute services. The trust told that this mainly related to people waiting for residential home placement or suitable housing. This also was due to delays in accessing home care packages.

At the time of our inspection the trust had met their target for percentage of patients on CPA followed up within 7 days of discharge at 95% but had not in October 2015.

The service environment optimises recovery, comfort and dignity

During 2015 patient-led assessments of the care environment (PLACE) visits had taken place to a number of inpatient services. This is a self-assessment process undertaken by teams including service users and representatives of Healthwatch. The trust had performed better than the national average with regard to its overall score for cleanliness (98.3%) and worse for condition, appearance and maintenance of the environment (89.6%). Francis Willis, the Manthorpe Centre, Pilgrim Hospital, Peter Hodgkinson Centre and Ash Villas were of particular concern.

All of the services we visited were clean and most were well maintained. Patients told us that they were happy with the standards of cleanliness. Most services were able to provide cleaning records however these were not available at some community mental health teams or substance misuse services. A number of the buildings were old and required updating. This was acknowledged by the trust. Most wards had room for activities, space for quiet and a place to meet visitors.

We found that most inpatient services had access to grounds or outside spaces. However we were concerned about the garden areas at some wards. The Rochford unit was situated on the first floor and accessed via a staircase or lift. The ward manager told us that patients had previously had access to a garden area but this had been identified for building work. The manager had raised concerns about this on the ward risk register. In acute, forensic, rehabilitation and children's mental health services we had concerns about the safety of outside areas.

Wards we visited had a telephone available for patients' private use. However, at the Manthorpe centre patients were unable to make phone calls in private. There was no payphone and patients would have to ask staff to use the office phone.

Most inpatient services had lockable storage available to patients. However in acute and older people's services patients did not have the keys for such storage and had to approach a member of staff. This was not based on assessed risk. In longer stay services we found that people were able to personalise their bedroom space. Within older peoples services the dormitories on Brant ward and Rochford unit and at the acute services at Peter Hodgkinson Centre did not allow for patients' privacy and dignity, with curtains separating beds in some bay bedrooms. Staff told us there were no plans to address this.

Overall the trust was performing worse than other trusts for the food score in the PLACE 2015 survey at 83.9%. 7 out of 9 wards scored below the England average of 90% for 'food and Hydration' overall. All words scored below the England average of 90% at 85.5% for the 'organisation food' element of the score. 6 scored better than the average for other food available on the ward. We heard a large number of complaints about the quality and availability of food across inpatient services. In acute services there was no hot meal in the evening. Patients told us they disliked having sandwiches every evening. In forensic services patients reported that the food was of a poor quality and they had to attend the small dining room within 15 minutes of service otherwise food would be thrown away. This was in line with trust policy however patients said that at these times alternative food was not available. At the rehabilitation service Discovery House patients told us the food was of very poor quality.

Most wards had facilities for drinks and snacks outside of meal times. In the majority of cases these were open to patients as appropriate.

We found the quality of community team bases varied. In older people's services most of the services we visited were not very welcoming and not considered to be dementia friendly with poor signage, a lack of colour and low furniture. There was a more 'user friendly' reception area at the Johnson Community Hospital as it is a much more modern building.

Meeting the needs of all people who use the service

Good

Are services responsive to people's needs?

Inpatient and community services were mainly provided from facilities that were equipped for disability access. In environments where this was not possible arrangements were in place to ensure alternative access to the service. However, in older people's services and the CAMH service at Gainsborough a lack of space meant poor disability access.

We found a wide range of information available for service users regarding their care and treatment both within services and via the trust website. Some of the leaflets viewed were available in other languages and formats. However, in community learning disability services there was limited easy read information across the service.

From the Census 2011 figures, 'White Other' is the largest ethnic minority group in Lincolnshire at 4% across the whole county. With the figures being markedly higher in Boston (12.5%), Lincoln (5.3%) and South Holland (7.3%) district areas. 93% of the population of Lincolnshire are White British. The trust told us that the population in Lincolnshire was changing with increased with increased Eastern European populations that have settled in Lincolnshire. They said they had worked hard to meet the increasing needs of people from minority ethnic communities.

In 2014 they were ranked 123rd out of 397 in the Stonewall Workplace Equality Index 2014. This had been a significant rise of 145 places. In February 2015 the trust had hosted a conference on 'Improving Care through Understanding' for staff which took place in LGBT History Month. At most inpatient services we saw that multi-faith rooms were available for patients to use and that spiritual care and chaplaincy was provided. We saw that generally there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs. Staff told us that interpreters were available via local interpreting service and language line and were used to assist in assessing patients' needs and explaining their care and treatment.

Listening to and learning from concerns and complaints

The trust provided details of all complaints received during in the twelve months prior to our inspection. There had been 262 complaints. Of these 161 had been formal and 101 informal complaints. The service area receiving most complaints was adult community mental health at 111 complaints. Most of these related to access to services, care and treatment and communication. The trust informed us that during the period 30% of formal complaints had been upheld or partially upheld.

During the period no complaints had been referred to the Parliamentary and Health Service Ombudsman.

The trust also provided information about the complaint issues and the actions they had taken as a result of the findings. We reviewed this information and saw some good examples of learning from complaints.

The trust also provided information regarding compliments received. This indicated there had been over 895 in the previous 12 months.

The trust provided details of their formal complaints process. This set out arrangements for response, investigation and ensuring lessons were learned and shared. We found that complaints were logged on the trust's incident management system and were notified to the trust complaints team. Complaints information was discussed at local governance meetings and was reviewed by the complaints review committee and the quality committee. The board received an overview of all complaints and compliments as part of the monthly integrated performance report and details of serious complaints and any relevant actions.

Staff received training about the complaints process during their induction and an ongoing basis. Staff were generally aware of the complaints process. The trust told us that they had worked with patient and carer groups to develop a 'Top Tips for Complaint Handling' training tool for staff development. Staff told us they that were aware of complaints raised in the service and usually heard of the outcome and any learning this raised. We saw that staff discussed the learning from complaints at a number of team meetings we observed.

At the inpatient services most patients told us that they were given information about how to complain about the service. This was usually contained within the ward information pack and included information about how to contact the patients' advice and liaison service. Information about the complaints process was usually displayed at the wards. All patients knew how to complain

Good

Are services responsive to people's needs?

and most felt they would be listened to. At most community teams we found that complaints information was displayed and that additional information was available. Most community patients knew how to complain.

Complaints information was also looked at some of the services we visited. Reports usually detailed the nature of complaints and a summary of actions taken in response. Generally complaints had been appropriately investigated and included recommendations for learning. We saw examples of where the outcome of the complaint had included duty of candour considerations. At some units we saw actions that had occurred as the result of complaints.

Requires improvement

Are services well-led?

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

Summary of findings

We rated Lincolnshire Partnership NHS Foundation Trust as requires improvement overall for well-led because:

- We were concerned that the trust had not always delivered safe and quality care. Our findings indicate that that there is room for improvement to ensure that lessons are learned from quality and safety information and are embedded in to practice.
- Risk registers for the trust and directorates did not include all of the concerns that we found during this inspection.
- Staff morale was poor in some areas and some and not all staff felt heard.
- The trust had failed to improve on the previous year's staff survey results.
- Leadership was not always clearly visible.

However:

- The trust board had developed a vision statement and values for the trust and most staff were aware of this.
- The trust had undertaken positive engagement action with service users, carers and partner agencies.
- The trust had undertaken a range of audit and research. Accreditation had been attained for most inpatient services.
- There was some innovative and outstanding practice.

Our findings

Vision, values and strategy

While the board and senior management had a vision with strategic objectives in place, some staff did not feel fully engaged in the improvement agenda of the trust.

The trust board had developed a vision statement and values for the trust in 2010. The vision was stated as: "To make a difference to the lives of people with mental health problems and learning disabilities. To promote recovery and quality of life through delivering effective, innovative, and caring mental health, and social care services." The trust values were confirmed as: "putting people first, respecting people's differences, behaving with compassion and integrity, having pride in our work, working in partnership, developing our staff, being recovery focused and making a positive difference."

The trust gave us a copy of their strategic priorities for 2015 to 2020. This included the overarching trust objectives. These were: improving service quality, using resources more efficiently, retaining and developing the business. Underpinning this are the clinical priorities 2016/17 which sets out more detailed objectives to meet this plan, as well as arrangements to monitor progress. The objectives included:

- "Ensure organisational learning is embedded and sustained.
- Improve record keeping, ensuring compliance with CQC essential standards of quality and safety.
- Improve safety thermometer outcome; measure triggers of potential/ actual harm from medication errors.
- Improve the overall experience of service users and carers.
- Increase service user and carer involvement in service planning, workforce development and delivery of care.
- Improve responsiveness to service user, carer, staff and partnership agencies feedback.
- Improve the Early Detection of Risk.
- Invest in staff leadership development and improve staff engagement.
- Increase in external accreditation, participation in research, and benchmarking of new and existing services."

The trust board, executive team and quality committee reviewed performance against the strategy on a monthly basis via the integrated performance report. This included a dashboard and heat maps that indicate where possible risks may be. Performance against annual objectives was also published within the quality account.

Requires improvement

Are services well-led?

Across all directorates we found an inconsistent level of staff knowledge and awareness of the trust's vision and strategy. Some staff confirmed that they had seen a copy of the vision and values. Other staff did not have an understanding of the vision, values and strategy. Staff demonstrated that they usually had a better understanding of directorate and service level objectives than of the trust wide objectives.

We were told that the strategy was developed following detailed engagement with service users, staff and commissioners. The trust told us that they were in the process of refreshing the vision and values. The trust had held focus groups in all areas led by clinicians and staff to ensure wide ownership of the vision

Good governance

The trust has a board of directors who were accountable for the delivery of services and sought assurance through its governance structure for the quality and safety of the trust. Reporting to this are committees for quality, audit, and planning and investment. The trust managed all quality governance through the quality committee. Reporting to this were sub-committees for patient safety, safeguarding, health and safety, operational governance, operational business and the Mental Health Act. Reporting in to these there were also committees for infection control, serious incidents, medicines management, emergency planning, complaints, and information management. These committees had terms of reference, defined membership and decision making powers.

The trust told us that improvements in quality and safety were their highest priority. The trust had an integrated board assurance framework and risk register which was reviewed monthly by the board. Risk registers were also in place, held at different levels of the organisation which were reviewed at directorate and locality meetings.

The integrated performance report acted as a performance report against key indicators and an early warning system for identifying risks to the quality of services. The performance report was being continuously improved and included a number of measures such as: waiting times, targets for clinical outcomes, staffing and workforce effectiveness, patient experience, complaints, serious incidents, access and waiting time targets, bed occupancy, as well as staffing measures such as vacancies, sickness, turnover and training rates.

The Mental Health Act committee had overall responsibility for the application of the Mental Health Act and the Mental Capacity Act. We met with the hospital managers and found that they provided a regular annual report to the board, to inform of performance in this area. The board also received further information and assurance regarding the Mental Health Act through the board committee structure. We found that some concerns we had raised through previous Mental Health Act MHA monitoring visits such as the design of the place of safety and missing detention documents due to being filled on the wards had not all been fully acted upon.

Staff demonstrated they were aware of their responsibilities in relation to governance. Most staff told us that they were aware of the governance structure and had access to performance information and meeting minutes. Most staff told us that they would escalate any risks they were aware of.

Team managers confirmed that they were involved in governance groups and that they were able to raise issues through the risk register and operational groups. Some managers told us that they did not think that the performance measures were currently accurate. These were under further development at the time of our inspection.

During this inspection we found some practices and resources that required improvement.

We had some concerns about the robustness of the arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. Whilst ligature risk assessments and action plans were in place, they did not address all ligature risks and a number of ligature risks remained on the wards.

We were concerned about the environments in Ash Villas, Ashley house and Maple Lodge. We found breaches of single sex accommodation that had not been raised by the trust prior to our inspection.

The trust had responded well to some individual incidents. However, following a series of serious incidents in the children's service the trust had not instigated a thematic review to look at whether there were any themes or learning points to consider.

Requires improvement

Are services well-led?

We found high bed occupancy in acute services and that the trust was using leave beds to manage this. The trust was not meeting its targets for assessment and treatment in some community teams and there were very long waits for psychology.

We reviewed the performance reports for the previous year's objectives. We noted that while some progress had been made, some objectives had not been fully met or sustained such as improvements to staff survey results, training and appraisal rates.

Other issues of concern included under compliance of supervision, staffing levels, high use of bank and agency staff and poor staff morale.

We are concerned that the trust's own governance system had not highlighted all of these issues.

We reviewed the risk registers for the trust and directorates and saw that some but not all risks that we identified through this inspection had been included in the risk register. This showed that further work was required to ensure that all risks were fully captured and understood by the board.

While performance improvement tools and governance structures had been put in place, our findings indicate that that there is room for improvement to ensure that lessons are learned from quality and safety information and are imbedded in to practice.

Fit and proper persons test

In November 2014 a CQC regulation was introduced requiring NHS trusts to ensure that all directors were fit and proper persons. As a consequence of this the trust had checked that all senior staff met the necessary requirements. The trust had set up policies and procedures to ensure that all future senior staff had the relevant checks. During the inspection the trust provided us with details of all the checks they had undertaken to meet this regulation.

Leadership and culture

The trust senior management team was relatively new. The chief executive, medical director, director of operations and chair had been appointed in the previous 18 months. Since, the trust had begun to restructure the management and governance arrangements and had embarked on a programme of service improvement. At the time of our inspection the leadership team was just beginning to challenge long established practices and bring about necessary change. Some of that change had been difficult for staff. The trust recognised this as a key challenge and was working to address this.

Morale was poor in some areas and some staff told us that they did not feel engaged by the trust. In crisis and community adult services staff morale was generally low following significant organisational change. Some staff were concerned at the future impact of these changes on the availability of services for people who needed them. Several transformation projects, such as those within community teams, had taken place to look at workload and use of resources. This had impacted on staffing and regrading of posts. A number of the staff we spoke with were unhappy with the restructuring of the service and told us they did not feel communicated with or listened to by senior trust staff.

Most staff told us they knew their immediate management team well and most felt they had a good working relationship with them. Many staff were aware of, and felt supported by the trust's directorate management structures. Some staff were aware of who the senior management team were at the trust and told us about initiatives to engage with them. However, some staff, particularly in community teams, felt a disconnect from the senior management team. Staff told us that senior managers within the trust had not visited the service and in some cases staff could not state who the leaders were. Some staff we spoke with did not feel supported by senior managers and said their concerns, such as the lack of a crisis helpline, were not being addressed.

In the 2015 NHS Staff Survey, although the trust was ranked about average overall, it was below average in relation to 16 items. These included staff recommending the trust and job satisfaction, feeling valued and involved, quality of appraisal and training, experiencing violence, bullying and stress, incident reporting and communication with managers. Overall the trust had decreased its position across 6 relevant indicators against the 2014 survey results. This particularly related to communication, feel safe to report issues and staff recommending the trust.

We looked at data available about staffing. Sickness absence rates had increased slightly in the six months prior to our inspection and were above target at 6% in October 2015. Sickness rates were significantly higher in community

teams and during our inspection 43% of clinical staff were on sick leave in the community teams. The trust confirmed that they had an overall vacancy rate of 3.4% in August 2015. For registered nurses this stood at 5.7%. For nursing assistants this stood at 19.8%. Staff turnover stood at 14% in August 2015. However, some services had notable high turnover at 29% in community forensic services, 22% in adult community services and 19% in forensic wards. Specific teams with high staff turnover were the rapid response team at 280%, the adult ILT at 43% and the single point of access at 39%. All community adult teams had high turnover at an average of 22%.

The trust told that they had undertaken a range of initiatives to engage staff. These included the chief executive 'roadshows' where the executive team took time to meet staff from around the trust. Staff had received regular emails and a newsletter including 'the weekly word' to inform them of trust updates. A staff wellbeing service had been set up. Regular sessions had been held for all teams called 'making a difference'. These were used to inform the 'cultural barometer'. The trust had re-launched the staff recognition strategy and introduced an electronic process to allow all staff to nominate individuals and teams who deserved extra recognition. Leadership development training had also been provided.

Trust clinical staff were committed to ensuring that they provided a good and effective service for people who used the services. Most, but not all, staff felt able to influence change within the organisation. However, staff in the community teams and CAMHs services told us that they did not know the long term plans from the trust and could not influence change.

Staff were aware of their role in monitoring concerns and assessing risks. They knew how to report concerns to their line manager and most felt they would be supported if they did. We found some good examples of staff feeling that learning from past incidents was informing planning of services or service provision. However, a few staff told us they had not been supported by their managers and they felt unable to raise concerns, or if they did raise concerns these would not be appropriately dealt with.

During this inspection we also looked at the trust application of the Workforce Race Equality Standard (WRES). This requires all NHS organisations to demonstrate progress against a number of indicators of workforce equality. The trust had published its 'equality delivery system 2 report' and objectives for 2015-16. This included nine measures for workforce equality. The trust had declared that actions were required to meet seven of the indicators. These actions were ratified by the board however it is not clear that the planned actions were robust to meet the required changes. The trusts equality and diversity council meets infrequently and we found no evidence that the committee had discussed or monitored the WRES or workforce equality issues.

Throughout and immediately following our inspection we raised our concerns with the trust. The trust senior management team informed us of a number of immediate actions they had taken to address our concerns.

Engagement with the public and with people who use services

The trust had a service user involvement policy. This with the clinical strategy priorities 2016/2017 set out a commitment for engagement with service users, carers and wider stakeholders. The trust was in the process of updating this work into an involvement strategy. The trust had recently appointed a head of patient and public engagement who worked closely with the membership, quality and risk teams. The trust told us about work undertaken on this agenda however recognised the need to formalise arrangements. This work was overseen by a trust wide involvement committee. A patient experience report was collated quarterly to inform the quality committee, collating feedback from a range of sources. Work undertaken on this agenda had included increased partnerships with voluntary and community groups and involvement in developing the strategy and clinical priorities. The head of patient and public engagement also supported a range of user and carer groups across the county.

The trust told us that patient experience was also captured by a web based tool. The tool accepts input via the website, through kiosks, and via paper, telephone and SMS. Within Inpatient units tablets were used to collect feedback, within community services other channels were used.

The trust had also led on the establishment of two county wide community support networks; one for mental health and one for dementia.

The trust had a number of user and carers' forums and inpatient services had community meetings to engage patients in the planning of the service and to capture

feedback. Minutes were usually taken and in most cases we saw evidence of actions that were raised being completed. However, this was not always the case in older people's services. Patients told us they felt able to raise concerns in the community meetings and that they usually felt listened to.

In community CAMH services, 'CHI-ESQ' was used to measure young people and families' experience of care. There was a high rate of return which demonstrated an overall satisfaction from young people discharged from the service.

The older adult community teams used the "making Experiences Count" (MEC) patient feed-back questionnaire. There was a high level of returns at 935 with an overall satisfaction rate of 98.36% for 2015.

The trust had used the Friends and Families Test (FFT) since 2014. At November 2015 the results indicated that 77% of patient respondents were likely or extremely likely to recommend the trust services. The response to the test demonstrated a fluctuating picture of satisfaction during the 12 months before our inspection at between 77% and 98%. However, all months were higher than the trust's own target of 71%. There had been a good participation rate by former inpatients at between 45% and 63%. However, there was poor response from former community patients at between 7% and 16% during the period.

Since 2013 'Patient-Led Assessments of the Care Environment' (PLACE) visits had taken place to a number of inpatient services. This is a self-assessment process undertaken by teams including service users and representatives of Healthwatch.

Prior to the inspection we spoke with a number of user groups, community support organisations and advocacy services. Generally we heard of positive relationships with the trust and of opportunities to be involved in providing feedback on how services are run or planned. Many patients told us that they felt listened to and their requests were usually acted upon.

Quality improvement, innovation and sustainability

The trust told us that external accreditation, participation in research, and benchmarking were key priorities.

The trust had participated in a number of applicable Royal College of Psychiatrists' (RCPsych) quality improvement programmes or alternative accreditation schemes. All acute and rehabilitation wards were accredited as excellent for the accreditation for inpatient mental health services (AIMS) programme. The forensic service, at the Francis Willis Unit was part of the quality network for forensic mental health services. The crisis teams in Stamford and Grantham held the home treatment accreditation scheme (HTAS) accreditation. The ECT suite at the Peter Hodgkinson Centre was accredited as excellent by the RCPsych. The trust was in the process of applying for accreditation for the memory services, and for both inpatient and community CAMH services. We found that facilities in the health-based place of safety did not meet all guidance issued by the RCPsych.

The trust had a research strategy in place and had participated in a wide range of clinical research. There was a dedicated research team in place and through its website provided detailed information on research projects. The trust works in partnership with the University of Lincoln and the East Midlands Clinical Research Network and is supported by a research and innovation patient and public involvement group.

In the past 12 months the trust had conducted a wide range of clinical effectiveness and quality audits across all inpatient areas, CAMHS community teams, older adult community teams and integrated community mental health teams. Topics included: safeguarding practice, medicines management, prescribing, compliance with NICE guidance, suicide prevention, clinical outcomes, physical healthcare, care planning, record keeping, consent and capacity, Mental Health Act administration and patient satisfaction.

We found a number of innovative practices:

In the acute service we observed excellent care provided to a terminally ill patient on Charlesworth Ward. The circumstances were unusual for this environment but staff were dedicated, compassionate and caring. Appropriate capacity assessments were in place to ensure the patient's rights were protected and specialist staff were employed to meet care needs. We felt staff were to be commended for the dignified and compassionate care they provided for this patient, under unusual and difficult circumstances.

The introduction of street triage had improved access to assessments for people who came to the attention of the police. The triage car was staffed by paramedics and qualified mental health professionals from the trust.

Requires improvement

Are services well-led?

Information from the trust showed that out of 178 referrals to the triage car in the period from April to October 2015, 59 were resolved with follow up offered, 30 were resolved with no follow up needed, 18 received mental health home treatment, five were detained under S136 Mental Health Act MHA and 32 were detained under the Mental Health Act MHA.

The substance misuse service had started to provide a breathalyser for people to take home to monitor their alcohol use. Staff implemented this as a modern alternative to paper drink diaries, used to record an individual's alcohol intake. Staff supported people to monitor their intake and recognise a reduction in drinking as a positive achievement and motivation to continue to reduce intake.

The community learning disability assertive service (CAST), greenlight team, psychology, speech and language therapy, and medical staff provided flexible input into each "pod", as required. Patients' needs were met quickly and effectively, when and where patients wanted to be seen.

The CAST team had won the trust's service recognition award for 'team of the quarter', and was nominated for 'team of the year award'. The team had won this award for being responsive to patients and carers needs, and embracing new ways of working.

On the Rochford unit an ex-patient volunteer was working on the ward, positively engaging with, and supporting patients. The volunteer told us they had taken part in staff recruitment panels for employing nursing assistants and nurses for the Rochford unit.

The trust is heavily involved and committed to dementia research and was actively taking part in or applying for a multitude of research projects to improve dementia care across their services.

The CAMHS community service was actively involved in research and developing areas of best practice. Staff within the trust had developed "outcomes orientated child and adolescent mental health service". This evidence based model focussed on the outcomes for young people and had been recognised in NHS innovation awards. This demonstrated clear positive outcomes for young people using the service. Other CAMHS services were adopting this model.

Within the North East Lincolnshire CAMH service a research assistant had been employed to help with a piece of work evaluating services response to young people in crisis. This aimed to use qualitative and quantitative data from young people and their carers, the CAMHS service, police, emergency departments and other agencies.

The CAMH inpatient service had employed a therapy dog as a member of the team on the unit. We heard about numerous examples from young people and staff of how the dog defused and de-escalated situations. We saw that young people responded positively to the dog and it helped them engage with their care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The trust are not effectively ensuring that care and treatment is provided in a safe way for patients, by assessing the risks to the health and safety of patients of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. • The trust must ensure that all ligature risks are identified on the ligature risk audit and that they do all that is reasonably practicable to mitigate any such risks. • The trust must ensure that all mixed sex accommodation meets guidance and promotes safety and dignity. • The trust must ensure that seclusion facilities are safe and appropriate and that seclusion is managed within the safeguards of the Mental Health Act Code of Practice • The trust must ensure that all risk assessments and care plans are updated consistently in line with changes to patients' needs or risks. • The trust must ensure effective systems for management of medication. • The trust must ensure that there are not significant delays in treatment and that access is facilitated to psychological therapy in a timely way. **Regulation 12 (1)(2) (a)(b)(d)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients who may be at risk which arise from the carrying on of the regulated activity, and systems to assess, monitor and

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Requirement notices

improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services), are not operating effectively.

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

Regulation 17 (2)(b)(f)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The trust must meet any reasonable requirements of a service user for food and hydration arising from the service users' preferences. • The trust must ensure that patients' dietary preferences are met, where reasonable. **Regulation 14 (1)(4)(c)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust did not deploy sufficient numbers of suitable qualified, competent, skilled and experienced staff to make sure they could meet people's care and treatment needs. **Staffing**

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Requirement notices

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

This was in breach of regulations 18 (1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The trust must that food meets the standard required by patients. **This is a breach of Regulation 13.**