Annual Quality Report
2017/18

Lincolnshire Partnership NHS Foundation Trust
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Glossary

Appraisal
Performance appraisals are an opportunity for individual employees and those involved with their performance, typically line managers, to engage in a dialogue about their performance and development, as well as agreeing the support required from the manager and the Trust. This will include a review of the past year’s objectives and the employee’s performance against these, setting new objectives for the coming year and reviewing the employee against their competency framework.

Audit Commission
An independent body responsible for ensuring that public money is spent economically, efficiently and effectively, to achieve high quality local and national services for the public.

C Difficile
Clostridium Difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics.

CAHMS (Child and Adolescent Mental Health Service) also known as CYPMHS – Children and Young Peoples Mental Health Services
CAMHS/CYPMHS is used as a term for all services that work with children and young people who have difficulties with their emotional or behavioural wellbeing.

Cardio Metabolic Assessment
An assessment of key cardio metabolic parameters (as per the 'Lester tool'): smoking status, lifestyle (including exercise, diet alcohol and drugs), Body Mass Index, blood pressure, glucose regulation (HbA1c or fasting glucose or random glucose as appropriate) and blood lipids.

Care Act 2014
The Care Act was first published as a Bill in the House of Lords on 9 May 2013, following legislative scrutiny. The legislation, which aims to modernise adult social care law, received Royal Assent on the 14 May 2014, becoming the Care Act (the Act).

Care plan/wellbeing plan
A written document that describes the treatment and support being provided, and should be developed jointly between the healthcare provider and the person receiving care.
Carer
Refers to a family member or close friend who provide a variety of emotional and practical support. This caring is generally unpaid and carried out on a voluntary basis. However, some carers will receive statutory benefits such as a carer allowance, direct payment or a personal budget.

Care Programme Approach (CPA)
Describes the framework that was introduced in 1990 to support and co-ordinate effective mental health care for people using secondary mental health services. Although the policy has been revised over time, the CPA remains the central approach for co-ordinating the care for people in contact with services who have more complex mental health needs and who need the support of a multi-disciplinary team.

Care Quality Commission (CQC)
This is the independent regulator of health and adult social care in England. Its purpose is to make sure hospitals, care homes, dental and GP surgeries, and other care services in England provide people with safe, effective, compassionate and high quality care, and encourage them to make improvements. Its role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and to publish findings, including performance ratings to help people choose care.

Clinical Audit
Is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

CMHT (Community Mental Health Team)
There are both adult and older adult CMHTs within the Trust they support people living in the community who have complex or serious mental health problems. Different mental health professionals work in a CMHT.

Commissioner
An NHS commissioner, known as a 'Clinical Commissioning Group' (CCG), is responsible for planning and purchasing healthcare services for its local population.
Complaints
Within the NHS, the term ‘concern’ or ‘complaint’ refers to any expression of dissatisfaction that requires a response. A person’s right to complain about the care or treatment they have received is embedded in the NHS Constitution and are subject to strict set of process and procedures.

Community mental health services
Provide care and treatment for people who require care over and above what can be provided in primary care. Services are provided through a wide range of service models, and through a broad range of interventions. People using these services may receive support over a long period of time or for short-term interventions.

Council of Governors (CoG)
All NHS Foundation Trusts are required to have an elected CoG which is the ‘voice’ of local people and helps set the direction for the future of the hospital and community services, based on members’ views.

CQUIN (Commissioning for Quality and Innovation)
The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers’ income to the achievement of local quality improvement goals.

Data quality
A perception, or an assessment of data's fitness to serve its purpose in a given context.

Datix
Web-based software that helps organisations manage their risks, incidents, service user experience and CQC Standards compliance.

Early Intervention in Psychosis
Is a clinical approach to those experiencing symptoms of psychosis for the first time usually provided to people aged between 14 and 25.

Francis report
Following an extensive inquiry into failings at Mid-Staffordshire NHS Foundation Trust, Robert Francis QC published his final report on 6 February 2013. The 1,782 page report had 290 recommendations with major implications for all levels of the health service across England, and called for a whole service, patient centred focus.
Friends and Family Test (FFT)
This is a national feedback tool that asks people if they would recommend the services they have used and offers a range of responses.

Fundamental standards of quality and safety
The fundamental standards were introduced as part of the government's response to the Francis Inquiry’s recommendations and define the basic standards of safety and quality that should always be met, and introduce criminal penalties for failing to meet some of them. The standards are used as part of the Care Quality Commission’s (CQC’s) regulation and inspection of care providers, and are enshrined in the Health and Social Care Act 2012 (amended 2014).

GP (General Practitioner)
A medical doctor who treats acute and/or chronic illnesses and provides preventive care, and health education to patients.

IG (Information Governance) Toolkit
An online system which allows NHS organisations and partners to assess themselves against the Department of Health's Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit assessments.

Information governance
Ensures necessary safeguards for the appropriate use of patient and personal information.

Learning disability
This is a reduced intellectual ability and difficulty with everyday activities, for example household tasks, socialising or managing money, which affects someone for their whole life.

LeDeR (Learning Disabilities Mortality Review Programme)
Aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially modifiable factors associated with a person's death, and works to ensure that these are not repeated elsewhere.

Ligature
Any item which can be used to self-strangulate and cause asphyxiation.
**Ligature point**
Any fixed point a ligature may be attached to.

**Mandatory training**
Training identified by the Trust as an essential requirement for the safe conduct of the Trust's activities.

**MDT (Multi-Disciplinary Team)**
Is a group of health care workers and/or social care professionals who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programs for people accessing services.

**Mental health**
A person’s condition with regard to their psychological and emotional wellbeing.

**MHA (Mental Health Act)**
Is an Act of the Parliament of the United Kingdom which applies to people in England and Wales. It covers the reception, care and treatment of people with mental health difficulties, the management of their property and other related matters.

**MH5YFV (Mental Health Five Year Forward View)**
The Five Year Forward View for Mental Health is an independent and far-reaching overview of what modern mental health services should be.

**MHSDS (Mental Health Service Data Set)**
Is a patient level, output based, secondary uses data set which delivers robust, comprehensive, nationally consistent and comparable person-based information for children, young people and adults who are in contact with Mental Health Services

**MRSA Bacteraemia**
A blood stream infection caused by the presence of methicillin resistant staphylococcus aureus.

**National community mental health survey**
This is a mandatory annual survey run by the Care Quality Commission (CQC). Service users aged 18 and over are eligible for the survey if they were receiving specialist care or treatment for a mental health condition.
National Confidential Inquiry into Suicide and Homicide (NCISH)
The Inquiry examines suicide and homicides committed by people who had been in contact with secondary and specialist mental health services in the previous 12 months. It also examines the deaths of psychiatric inpatients which were sudden and unexplained. Previous findings of the Inquiry have informed national mental health strategies, and continue to provide definitive figures for suicide and homicide related to mental health services in the UK.

National NHS Staff Survey 2016
This is recognised as an important way of ensuring that the views of staff working in the NHS inform local improvements and input into local and national assessments of quality, safety, and delivery of the NHS Constitution.

NHS (National Health Service)
This is a publicly funded healthcare system, primarily funded through central taxation, in the United Kingdom. It provides a comprehensive range of health services, the vast majority of which are free at the point of use for people legally resident in the United Kingdom.

NHS Improvement (NHSI)
Supports foundation trusts and NHS Trusts to give patients consistently safe, high quality, compassionate care within local health systems, that are financially sustainable.

NICE (National Institute for Health and Care Excellence)
NICE provides national guidance and advice to improve health and social care.

National Institute for Health Research (NIHR)
Aims to improve the health and wealth of the nation through research.

National Reporting and Learning System (NRLS)
A comprehensive database of patient safety information used nationally.

PALS (Patients Advice and Liaison Service)
A service that offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and carers.
Payment by Results (PbR)
This is the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient’s healthcare needs.

PDSA
Plan, Do, Study, Act is an iterative four stage problem solving model used as part of the Model for Improvement to support the testing and implementation of change/quality improvement.

Prescribing Observatory for Mental Health (POMH)
The national POMH aims to help specialist mental health trusts/healthcare organisations improve their prescribing practice. It identifies specific topics within mental health prescribing and develops audit-based Quality Improvement Programmes (QIPs).

Pressure ulcer (PU)
An area of skin that breaks down when something keeps rubbing or pressing against the skin. Good nursing care and pressure area management are essential to the prevention and management of pressure ulcers.

PSEC (Patient Safety and Experience Committee)
A standing committee of the Trust Board. Its over-arching responsibility is to provide the Board with assurance that high standards of care are provided by the foundation trust and in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust.

Quality report
A report about the quality of services provided by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector and are available to the public.

Recovery
This is about being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual’s recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process.
Safeguarding adults
Aims to support adults at risk to retain independence, wellbeing and choice, and to be able to live a life that is free from abuse and neglect.

Safeguarding children
The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully.

SBAR
Situation, Background, Assessment, Recommendation is a communication technique which allows for short, organized and predictable flow of information between professionals.

SI (Serious Incident)
The definition of a serious incident (SI) extends beyond those incidents which impact directly on patients and includes incidents which may indirectly impact on patient safety or an organisation’s ability to deliver on-going healthcare services in line with acceptable standards. The Trust adopts the definition of SI as set out by the Serious Incident Framework (2015).

Social care
The provision of social work, personal care, protection or social support services to children or adults in need or at risk or adults with needs arising from illness, disability, old age or poverty.

Sustainability and Transformation Partnership (STP)
Brings together organisations involved in the planning and provision of health and care services across the region. This includes CCGs, acute hospital trusts, mental health, community services, and local authorities.

THRIVE Model of Care
THRIVE is a conceptual framework of person-centred care for child and adolescent mental health with strong theoretical foundations. It enables care to be delivered according to the needs and preferences of children and young people and their families.
Part 1: Statement on quality from the Chief Executive Officer and the Chair, Lincolnshire Partnership NHS Foundation Trust

1.1 Statement on quality from the Chief Executive Officer and the Chair

We, at Lincolnshire Partnership NHS Foundation Trust (the Trust), are delighted to present our ninth annual quality report for the financial year April 2017 to March 2018.

We remain focussed on our core purpose, which is to ensure our service users/patients and carers have a positive experience of high quality evidence based care, which delivers improved outcomes, the best level of recovery possible and results in an enhanced quality of life. To achieve and sustain this we engage and promote good partnership working and strong effective governance processes. Working in partnership with our service users/patients, carers, staff, governors and key stakeholders is critical to achieving the highest standards of patient safety, patient experience and clinical effectiveness. We recognise that our services will only ever be as good as the dedicated and skilled workforce we have and that we invest in.

This report provides an overview of the quality governance arrangements that we have in place for monitoring, identifying risks and trends to ensure the Trust works safely and continuously improves. We are immensely proud of our achievements over this last year and are passionate about making improvements going forward, wherever possible. Our quality report highlights our successes and strengths, areas we need to improve upon and our quality plans for 2018 to 2019.
Our purpose
To enable people to live well in their communities.

Our vision
To make a difference to the lives of people with mental health needs and learning disabilities. To promote recovery and quality of life through effective, innovative and caring services.

Our core values
- Putting people first
- Developing and supporting our staff
- Respecting people’s differences
- Behaving with respect, compassion and integrity
- Having pride in our work
- Working in partnership
- Being recovery-focused and making a positive difference

Development of our Quality Report
We have developed our Quality Report in consultation with the Trust’s governors, service users/patients, carers, staff and key stakeholders. We have continued to focus on quality during a time of economic constraints which has seen significant changes across both our own organisation and those of our key partners (health, social care and voluntary sector). We are working hard with our local partners developing the Lincolnshire Sustainability and Transformation Partnership (STP) to ensure service users/patients and carers continue to receive high quality, safe, responsive and effective care services at this time and moving forward into future years.

The quality report forms part of the Trust’s annual report, which also includes a summary of our financial accounts for 2017/18.

Our continued focus in 2017/18 on working in partnership with service users/patients, carers and staff more effectively, has resulted in many positive initiatives, many of which are discussed in more detail within this report. Our staff engagement through areas our Inspirational Leadership Programme and Continuous Quality Improvement team along with feedback tools such as our cultural barometer, ensure our staff in every part of the organisation have a voice, are kept up-to-date and feel valued and motivated in their work.
A strong continued focus on service user/patient, carer and staff engagement will remain a high Trust priority in 2018/19 in our continuous journey to provide the highest standards of healthcare within Lincolnshire.

Mr Paul Devlin      Dr John Brewin
Chair                  Chief Executive

24 May 2018

Declaration
There are a number of inherent limitations in the preparation of quality accounts which may impact the reliability or accuracy of the data reported. These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.
- Data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to re-analyse historic data.

The Trust including its Board has sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above. Following these steps, to the knowledge of the Chief Executive and Chair, the information in the document is accurate.
1.2 Our services

The Trust is the principal provider of NHS adult mental health, learning disability and social care services in Lincolnshire. It provides the full spectrum of mental health and social care services including:

<table>
<thead>
<tr>
<th>Adult community mental health division</th>
<th>Specialist services division</th>
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<tbody>
<tr>
<td>• Adult community mental health</td>
<td>• Learning disabilities</td>
</tr>
<tr>
<td>• steps2change (improving access to psychological therapies)</td>
<td>• Community child and adolescent mental health services (CAMHS)</td>
</tr>
<tr>
<td>• Recovery College</td>
<td>• CAMHS inpatient unit</td>
</tr>
<tr>
<td>• Volunteers</td>
<td>• Lincolnshire Secure Unit (LSU) healthcare services</td>
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<tr>
<td>• Section 75: including direct social care</td>
<td>• Eating disorders</td>
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<tr>
<td>• Best interest assessors</td>
<td>• Wellbeing Service</td>
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<tr>
<td>• Complex and forensic community mental health services</td>
<td></td>
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<tr>
<td>• Psychology</td>
<td></td>
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<tr>
<td>• Specialist psychology</td>
<td></td>
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<tr>
<td>• Perinatal services</td>
<td></td>
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<tr>
<td>• Ministry of Defence and veteran services</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Adult mental health inpatient division</th>
<th>Older adult mental health division</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Single point of access (SPA)</td>
<td>• Community and inpatient services for people with dementia</td>
</tr>
<tr>
<td>• Acute inpatient wards</td>
<td>• Specialist older adult mental health services – community and inpatient</td>
</tr>
<tr>
<td>• Crisis resolution and home treatment</td>
<td>• Mental health hospital liaison</td>
</tr>
<tr>
<td>• Mental health triage car</td>
<td>• Neuropsychology</td>
</tr>
<tr>
<td>• Sexual assault referral centre (SARC)</td>
<td>• Psycho-Oncology</td>
</tr>
<tr>
<td>• Independent sexual violence adviser</td>
<td>• Chronic fatigue syndrome/ME</td>
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<tr>
<td>• Mental health rehabilitation</td>
<td></td>
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<tr>
<td>• Low secure mental health</td>
<td></td>
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<tr>
<td>• Health Based Place of Safety</td>
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<tr>
<td>• Psychiatric Intensive Care Unit (PICU)</td>
<td></td>
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<tr>
<td>• Psychiatric Clinical Decisions Unit (PCDU)</td>
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<table>
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<tr>
<th>Pan Trust</th>
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<tbody>
<tr>
<td>• Community support networks</td>
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<td>• Pharmacy support</td>
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Further information about these services can be found via [www.lpft.nhs.uk](http://www.lpft.nhs.uk)
1.3 Our commitment to service users/patients and carers

The trust developed an Involvement Strategy working with the National Survivor User Network (NSUN) and signing up to the 4Pi National Involvement Standards. 4Pi is a simple framework on which to base standards for good practice, and to monitor and evaluate involvement.

The framework builds on the work of many people: mental health service users and carers and others who have lived and breathed involvement and shared their experiences in various ways, both written and unwritten.

The Charter sets out what is important to the organisation about how it involves patients, staff, the public and others in the work that we do and in making decisions about what we do.

The way we involve people and the principles we follow in doing this are an important illustration of how seriously we take involvement. It demonstrates to our staff teams the importance of getting this right and how we can support our services to do this.

The Charter has been co-produced by Governors working with patient representatives, carers and the LPFT Involvement Team. It is important to acknowledge the contribution of the patients who were involved in producing this and whose input was valued as was the commitment in time they gave. This was done using a co-production workshop, which involved several patients and service users.

**Involvement Standards**

| Principles: | How do we relate to each other? Principles and values are the rules or beliefs that influence the way we behave, the choices we make and the way that we relate to other people. |
| Purpose: | Why are we involving people? Why are we becoming involved? |
| Presence: | Who is involved? Are the right people involved in the right places? |
| Process: | How are people involved? How do people feel about the involvement process? |
| Impact: | What difference does involvement make? How can we tell that we have made a difference? |
Our Mental Health Involvement Charter

Together we believe we can make a real difference for everyone affected by mental health difficulties in Lincolnshire.

Connecting with others and your Community

Respect

- Listen to Others
- No Judging
- Safe place to have your say

Involving everyone in our Service

Patients, Carers, Staff

Making a difference together

Have your Say

You: Be part of the jigsaw

Working and Learning Together

Improved services

Good patient Experience

Your Local contact for Involvement:

For further information and to find out how you can get involved please contact:

Engagement Team

T: 01529 222722 or 01529 222333
E: involvement@lplt.nhs.uk
Part 2: Priorities for improvement and statements of assurance from the Board of Directors

2.1 Quality improvement priorities

Strategic principles

The Trust is passionately committed to improving quality and safety; and recognises the importance of being able to evidence this by positive treatment outcomes and continuously improving services. As such improving service quality remains the Trust's primary strategic priority, thus supporting the embedding of quality in all aspects of the Trust's practice and business. The Trust is committed to working in partnership with service users/patients, carers, governors, staff and stakeholders to ensure delivery of high quality services, underpinned by recovery principles. The Trust is committed to the earliest identification and needs of carers, as required by the Care Act 2014, as 'partners-in-care' in the implementation of each of its priorities in the coming year 2018/19.

The following strategies and plans define the ambition of the organisation for each strategic priority:
Quality – a set of quality priorities, quality strategy and clinical strategy to improve quality in clinical services. These are informed by service users/patients, carers, governors, stakeholders and our clinical teams and reflect our ambition for our services.

Resources – an involvement strategy, people and organisational development strategy, financial plan, estates plan and information management and technology strategy that support the delivery of high quality clinical services and the best possible experience for the people who use our services.

Business - an Integrated Business Plan that consolidates the existing services provided by the Trust and protects them into the future. It also supports the Trust’s ambition for growth and positioning local and national healthcare system and that enables the Trust to continue to operate effectively in a regulatory environment.

2.1.1 Approach to quality improvement

The Director of Nursing, Allied Health Professionals (AHPs) and Quality (DoNAQ) provides executive leadership for quality improvement and quality assurance. A number of key assurance meetings with both internal and external involvement are regularly held to support the quality governance process including regular ward/team meetings, monthly operational division management team meetings, Board meetings and Operations Performance and Clinical Governance Meeting, and also four committees held bi-monthly - Organisational Development / Legislative / Patient Safety and Experience / Mortality Surveillance which in turn report to the bi-monthly Quality Committee chaired by a non-executive director (NED). The Trust also provides assurance regarding its quality governance via the quality contract review meetings chaired by the executive nurse of the Trust's lead commissioning CCG.

The Trust’s Board Assurance and Escalation Framework details the Trust’s clinical governance and risk management processes, including the committee structure that ensures risk and compliance concerns are reported and escalated as appropriate to the Board.

The Trust’s capacity and capability for quality improvement will be further developed and refined throughout 2018/19 drawing from the available evidence base and supporting an open and innovative culture led by those staff and patients at the front end of service provision. A formal structure of quality improvement was introduced during 2017/18 and will be sustained during 2018/19 to further support the development of innovative and effective local improvements.

The Trust’s continuous quality improvement (CQI) focusses upon key national and local priorities, taking account of the STP, the Mental Health Five Year Forward View and the
Trust’s comprehensive CQC inspection (April 2017) findings. The improvements will be supported by the CQI team and driven by the most appropriate service areas and individuals collaboratively with patients/service users, carers and other key stakeholders. Priorities and some examples of relationships are provided in the table below. (Please refer to section 2.1 ‘The Big Picture’ to linked quality priority).

<table>
<thead>
<tr>
<th>CQI aims</th>
<th>Key national and local priorities</th>
<th>Examples of local delivery</th>
<th>Linked 2018/19 quality priority (Q)</th>
</tr>
</thead>
</table>
| Improving the collection, quality and use of data and information to support delivery of care. | • Sustainability and Transformation Plan (STP)  
• Mental Health Five Year Forward View (MH5YFV) | • External review of clinical system and decide upon future system.  
• Implementation of Lincolnshire CarePortal. | Q4  
Q5 |
| Supporting and developing our people.                                   | • STP  
• MH5YFV                                                             | • Develop clear standard operating procedures.  
• Team building and role development. | Q4  
Q5 |
| Treating and caring for people in a safe environment and protecting them from avoidable harm. | • CQC comprehensive inspection  
• STP  
• MH5YFV                                                             | • Ongoing improvement of collaborative risk assessment and care planning.  
• Co-location of teams. | Q1  
Q2  
Q3  
Q6 |
| Strategic change for mental health and learning disability services by 2020. | • STP  
• MH5YFV                                                             | • Configuration of support services to maximise quality.  
• Configuration of services that realigns investment into the MH5YFV. | Q1 - 6 |
2.1.2 Our quality priorities for 2017/18: review of achievement

The Trust identified six quality priorities for 2017/18 and achievement against these is summarised within this section.

<table>
<thead>
<tr>
<th>Quality Priority</th>
<th>Baseline data</th>
<th>Measures for improvement</th>
<th>Progress to achievement</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health for people with Severe Mental Illness (Relates to Adult Inpatient wards/units, Community Mental Health and Early Intervention in Psychosis Teams).</td>
<td>2017/18 - Baseline identified from 2016/17 achievement. Inpatient: 22% of submitted sample (n=50) had complete data against the required criteria*. Community: 11% of submitted sample (n=100) had complete data against the required criteria*. *Description of data can be found at: <a href="http://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17">www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17</a></td>
<td>Inpatient: 50% of submitted sample will have complete data against the required criteria*. Community: 40% of submitted sample will have complete data against the required criteria*.</td>
<td>Of the sample submitted the Trust achieved 29.40% (53.12% with 95% Confidence Interval applied) completion for inpatient and 10.30% for community (excluding EIP). Contributing to this outcome may be that in an effort to promote local engagement and ownership the Trust adopted a different approach to data collection than in previous years; sharing 200 forms with medical and nursing colleagues for completion. Unfortunately only 99 were returned in time to meet the submission deadline for inclusion in the National Audit of Psychosis which is where the sample is selected by the Royal College of Psychiatrists (RCPsych) for audit. The Trust have reviewed the method of data collection employed this year and anticipate that the same sample selection process will be employed by the RCPsych in 2018/19. With this in mind the clinical effectiveness team and CQUIN lead are working with clinical teams to ensure an improved number of returns for the coming year.</td>
<td>Partially achieved with application of Confidence Interval to inpatient results.</td>
</tr>
</tbody>
</table>
**Q2**

* Improved ligature* risk assessment, management and understanding for inpatient areas.

Each inpatient area has a completed ligature risk assessment and management audit held within a folder (hard copy and electronic). 2 ligature risk assessment and management workshops have been held during 2016/17.

Evidence of joint working between Estates team (health and safety), Quality and Safety Team and ward areas to ensure any required actions are completed within identified time frames. 4 ligature risk assessment and management workshops delivered each year. Each inpatient area to maintain accurately their ligature risk assessment and management folder.

Risks and prioritisation supported between the key areas for clear identification of works required post audits. The estates and quality and safety team have worked towards a more aligned audit process to ensure that any identified actions did not present new risks. Positive feedback has been received from employees who have attended ligature workshops regarding their skills and knowledge development. The quality and safety team are revising the ligature audit process to further enhance its effectiveness into 2018/19.

* please refer to glossary

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**Patient experience**

<table>
<thead>
<tr>
<th>Quality Priority</th>
<th>Baseline data</th>
<th>Measures for improvement</th>
<th>Progress to achievement</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q3</strong> Improving services for people with Mental Health needs who present to A and E.</td>
<td>The total number of attendances to A and E of a cohort of 25 individuals with a mental health flag more than 10 times. Baseline figure of cohort identified as 497 attendances.</td>
<td>Reduce by 20% the number of attendances to A&amp;E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.</td>
<td>A lead coordinator was jointly appointed In June 2017 to lead on this work stream for Year 1 where the main focus was care-coordinator activities for the targeted cohort. 25 patients were identified within the cohort for year 1 with a combined attendance of 497 in 2016/17. This cohort reduced to a combined attendance of 215 in 2017/18 and represents a total reduction of 56.74% against a target reduction of 20%.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Ensure the overall experience of patients/service users, carers and staff is positive and consistent across all Trust services.

2017/18 baseline is 7.5/10 reported in 2016 survey.

Improvement in the Community mental health services patient survey indicator score with regard to a patient's experience of contact with a health or social care worker.

The community mental health survey was published in November 2017 and the rating for a patients experience of contact with a health or social care worker was 7.2/10 (required 7.6 to evidence improvement). The stretch target has not been achieved this rating is 'about the same' as other mental health Trusts.

2017/18 baseline taken from 2016/17 achievement is 79%.

The Trust's recruitment and selection process to evidence the involvement of service user and/or carers in 80% of appointments. (This can include a range of options).

The Trust has achieved its target for SU and Carer involvement. To ensure that the target is achieved in 18/19, the number of training sessions has increased for both SU and Carers. Out of hours Carer sessions have been held twice and with positive feedback from participants. Specific sessions for SU have also been undertaken when requested specifically from services. " The staff survey results will not be published until February 2018.

2017/18 baseline is questions from 2015 staff survey. 2018/19 baseline will be 2016 survey.

Achieving a 5 percentage point improvement over the 2 years in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress. The two questions do not have to be pre-selected before the staff survey results.

The format in which the data is presented in the annual staff survey generates challenge in identifying a percentage increase in one of the three areas available for selection. The individual outcome of the three areas is that:

KF17: no change in percentage
KF18: 2% reduction (positive reduction)
KF19: 0.07 increase (not reported as a percentage value).

Work will continue via specific work streams during 2018/19 to achieve the overall 5% improvement.

Partially
<table>
<thead>
<tr>
<th>Quality Priority</th>
<th>Baseline data</th>
<th>Measures for improvement</th>
<th>Progress to achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5 Develop and implement a robust Quality Improvement methodology.</td>
<td>The Trust had no formalised structure of quality improvement methodology to baseline.</td>
<td>For each operational Division to have run or have running 3 quality improvement projects within the year.</td>
<td>Continuous Quality Improvement (CQI) events have been very well attended by a range of employees. The Model for Improvement is being shared for wider rollout across the Trust. The Trust have utilised the services of NHS Elect to run 4 QI masterclasses for a cohort of staff. Highlights of Divisional QI projects are presented at section 3.10.</td>
</tr>
<tr>
<td>Q6 Preventing ill health caused by the use of alcohol and tobacco (Relates to Adult Inpatient wards only).</td>
<td>The Trust baseline data across the identified areas for 2017/18 was identified following audit at the end of quarter 1.</td>
<td>Improving performance across the indicators (data*) at each quarter of 2017/18.</td>
<td>The majority of staff across the wards have been trained to offer brief smoking cessation and alcohol reduction advice. Staff record all activity associated with this via Audit C and the Lincs Health Questionnaire. Unfortunately the Trust has not been able to sustain a consistent improvement in the monitoring of assessment and onward referral during the year.</td>
</tr>
</tbody>
</table>
2.1.3 Choosing our quality priorities 2018/19

In 2017 the Trust Board agreed six key quality priorities for 2017/18 and 2018/19, two in the domain of patient safety, two in the domain of patient experience and two in the domain of clinical effectiveness. The quality priorities were selected taking account of a number of sources including the following:

- Patient, carer, governor and staff feedback.
- Department of Health’s national priorities.
- CQC comprehensive inspection 2015 and MHA visits feedback since that time.
- National patient and staff surveys.
- NHSI reporting requirements.
- Commissioners requirements and feedback.
- Sustainability and Transformation Plan (STP).
- Equality Delivery System 2.
- Healthwatch Lincolnshire feedback.
- Serious incidents, complaints, coroner and serious case review feedback (local and national).

Stretch targets for performance in respect of all the quality priorities were developed collaboratively; and have been closely monitored throughout 2017/18. Revised targets for 2018/19 will be developed using data from 2017/18 as the baseline where identified. Ongoing measurement throughout the year will assist in monitoring our progress; and in developing the understanding and embedding from ward/team to Board of the Trust’s quality priorities.

Ongoing support for the agreed quality priorities started in November 2017, with an interactive presentation within the Joint Board of Directors and Council of Governors meeting; and continued through papers and presentations to the Quality Committee and Council of Governors’ meetings.

Progress to achieve the identified quality priorities 2018/19 will be monitored through the quality and safety team; and reported three times a year to the Patient Safety and Experience Committee a sub-committee of the Quality Committee.
<table>
<thead>
<tr>
<th>Quality priority</th>
<th>Priority continuation</th>
<th>Why this is important for us</th>
<th>How will we measure and monitor it</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q1.</strong> Physical health for people with severe mental illness (Relates to adult inpatient wards/units, community mental health and early intervention in psychosis teams)</td>
<td>This is priority a continuation aligned to a CQUIN which will be in its fourth year.</td>
<td>This priority builds on previous work to improve physical health care for people with severe mental illness (SMI) in order to reduce premature mortality in this patient group. Collaborative working with partner agencies supported by neighbourhood teams will ensure parity of esteem for this patient group.</td>
<td>Measures will align with those required of the CQUIN (Further information about CQUINs can be found at section 2.2.3). Our physical healthcare group will monitor progress and a report will be presented to the Patient Safety and Experience Committee three times a year. Service users with a serious mental illness (SMI) will have comprehensive cardio metabolic risk assessments; the necessary treatments and the results are recorded and shared with the patient and treating clinical teams.</td>
</tr>
<tr>
<td><strong>Q2.</strong> Improved ligature risk assessment, management and understanding for inpatient areas</td>
<td>This is a priority continuation.</td>
<td>This priority supports the ongoing work of the Trust in the reduction and management of ligature risks for our patients. It will ensure this area remains a high priority for the Trust and levels of safety are improved. The identification and management of both fixed and unfixed ligatures in our inpatient areas enhances the culture of safe and responsive services.</td>
<td>Measures will be qualitative evidence of improved ligature risk assessment, management and understanding for inpatients. Our Director of Operations has overall lead for this work and our Patient Safety and Experience Committee will continue to monitor and receive progress reports on improvements which will include audits of compliance.</td>
</tr>
<tr>
<td>Quality priority</td>
<td>Priority continuation</td>
<td>Why this is important for us</td>
<td>How will we measure and monitor it</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------</td>
<td>-----------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>Q3.</strong> Improving services for people with mental health needs who present to A&amp;E</td>
<td>This is a quality priority continuation aligned to a CQUIN</td>
<td>Working together with partners to ensure that people presenting at A&amp;E with primary or secondary mental health needs have these needs met more effectively through an improved, integrated service offer. The prevention and early intervention for patients in mental health crisis reduces unnecessary hospital admissions and out of area placements.</td>
<td>Measures will align with those required of the CQUIN. A report will be presented to the Patient Safety and Experience Committee three times a year. Accessing the right service at the right time benefits the patient experience which in turn is clearly linked to improved clinical outcomes.</td>
</tr>
<tr>
<td><strong>Q4.</strong> Ensure the overall experience of patients/service users, carers and staff is positive and consistent across all Trust services</td>
<td>This is a quality priority continuation.</td>
<td>Patients and carers need to be valued and respected, listened to and communicated with effectively with information in accessible formats. Staff engagement is a measure of employees’ emotional attachment to their job, colleagues and organisation which influences their experience at work and their willingness to learn and develop.</td>
<td>Measures will be improved patient/service user and staff experience surveys. Patient and carer experience will be monitored by the Patient Safety and Experience Committee. Data will also be presented to the Board via the integrated performance report (Friends and Family Test, complaints, PALS). Staff feedback will be monitored by the Organisational Development Committee and also reported to the Board via staff survey and cultural barometer reports.</td>
</tr>
<tr>
<td>Quality Priority</td>
<td>Priority continuation</td>
<td>Why this is important for us</td>
<td>How will we measure and monitor it</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------</td>
<td>-----------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>Clinical effectiveness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Q5. Develop and implement a robust quality improvement methodology</strong></td>
<td>This is a quality priority continuation.</td>
<td>Establishing a quality improvement culture which is led collaboratively by front line employees and patients will ensure that sound improvements are identified and made where they are needed, when they are needed and by those who can own and influence the change.</td>
<td>Measures will be evidence of QI methodology being implemented. This will be monitored by the Patient Safety and Experience Committee with quarterly reporting of roll out of training and support in addition to divisional reports of local quality improvement developments.</td>
</tr>
<tr>
<td><strong>Q6. Preventing ill health caused by the use of alcohol and tobacco (relates to adult inpatient wards/units)</strong></td>
<td>This is a quality priority continuation aligned to a CQUIN.</td>
<td>This priority seeks to help deliver on the objectives set out in the 2016 Department of Health document - Five Year Forward View for Mental Health (5YFV), particularly around the need for a ‘radical upgrade in prevention’ and to ‘incentivising and supporting healthier behaviour’.</td>
<td>Measures will align with those required of the CQUIN. Our physical healthcare group will monitor progress and a report will be presented to the Patient Safety and Experience Committee quarterly.</td>
</tr>
</tbody>
</table>
2.1.4 Service development and improvement plans 2017/19

The following provides a brief summary of key clinical service development and improvement plans for the Trust in 2017/19. The Trust has kept the plan to a small number of large scale projects, rather than a large number of small scale projects, as has been done in the past.

In some cases, plans will be subject to business case development, consultation and governance, identified funding and/or Board of Directors/Council of Governors approval. Greater detail on the clinical service transformation plans is provided within the Trust’s Operational Plan (2017/18 and 2018/19).

<table>
<thead>
<tr>
<th>Key planned developments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community CAMHS</strong></td>
</tr>
<tr>
<td>Mobilisation of the North East Lincolnshire CAMHS contract with the service evolving to deliver the THRIVE model of care.</td>
</tr>
<tr>
<td><strong>Adult Integrated CMHTs</strong></td>
</tr>
<tr>
<td>Develop greater integration by aligning psychology and medical into CMHTs, transforming care into a ‘one stop’ clinic model rather than separate outpatient clinics.</td>
</tr>
<tr>
<td><strong>Electronic prescriptions and medical administration system</strong></td>
</tr>
<tr>
<td>Implementation of an electronic prescriptions and medical administration system will give a significant quality improvement, financial cost savings and provide operational efficiencies.</td>
</tr>
<tr>
<td><strong>Expanded early intervention service</strong></td>
</tr>
<tr>
<td>Following a decision to de-commission the psycho-dynamic psychotherapy service, Commissioners have agreed to reinvest this budget into the early intervention service. This became operational from Q1 2017/18 and enters the second phase of expansion in 2018/19.</td>
</tr>
<tr>
<td><strong>Reduction of out of area placements</strong></td>
</tr>
<tr>
<td>As a key national strategic objective, the trust will develop plans with commissioners to re-design local services and pathways in order to reduce the number of patients required to travel out of county for non-specialist mental health care. This is likely to focus on adult acute and rehabilitation pathways during 2018/19.</td>
</tr>
<tr>
<td><strong>Older adults service transformation</strong></td>
</tr>
<tr>
<td>The older adults division will undertake a large scale transformation programme to ensure that optimal patient care pathways are adopted in line with clinical best practice.</td>
</tr>
</tbody>
</table>
2.2 Statements of assurance from the Board

The Trust's Board of Directors is required to satisfy itself that the Trust's annual quality report is fairly stated. In doing so, the Trust is required to put in place a system of internal control to ensure that proper arrangements are in place based on criteria specified by NHSI, the independent regulator of NHS Foundation Trusts. The Trust has appointed a member of the Board, the Director of Nursing and Quality, to lead and advise on all matters relating to the preparation of the Trust's annual Quality Report.

To ensure that the Trust's Quality Report presents a properly balanced view of performance over the year, the Trust's Quality Committee, accountable to the Board of Directors, provides scrutiny and challenge. The Quality Committee ensures robust challenge, review and the provision of assurance to the Board in respect of quality and risk initiatives and reports, including escalating risks if required, as per the Trust's Board Assurance and Escalation Framework (2017).

The Trust held quarterly quality review meetings with its lead commissioner until September 2017 following which they became monthly, and has shared the draft quality report with governors, commissioners, the local Health Scrutiny Committee and Healthwatch Lincolnshire for comment.

During 2017/18 the Trust provided and/or sub-contracted two relevant health services, these services being mental health and learning disabilities.

The Trust has reviewed all the data available to them on the quality of care in two of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2017/18.
2.2.1 Participation in clinical audits and national confidential enquiries

Participation in clinical audits 2017/18

During 2017/18, seven national clinical audits and one national confidential enquiry covered relevant health services that the Trust provides.

During the period the Trust participated in 88% of the national clinical audits and 100% of national confidential enquiries.

The national clinical audits and national confidential enquiries that the Trust was eligible to and participated in during 2017/18 are as follows:

- 2 POMH (UK)
- 4 National CQUINs
- 1 National Clinical Audit of Psychosis (NCAP)
- 1 National confidential enquiry into patient outcome and death (NCEPOD) – young people’s mental health (case note extracts).

The reports of 20 local clinical audits were reviewed by the provider in 2017/18 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- Disseminate audit results to all relevant clinicians and staff.
- Develop and monitor action plans to address shortfall in service provision.
- Carry out re-audits where necessary to monitor compliance.

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.
<table>
<thead>
<tr>
<th>Audit</th>
<th>Status</th>
<th>Date</th>
<th>Number of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>*CQUIN 3a Cardio metabolic</td>
<td>Inpatient - completed</td>
<td>See National Clinical Audit of Psychosis (NCAoP) below</td>
<td>Not known as the sample is drawn from the NCAoP by the RcPsych.</td>
</tr>
<tr>
<td>(Inpatient/Community/EIP)</td>
<td>Community - completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>EIP - completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQUIN 3b GP Correspondence</td>
<td>Inpatient - completed</td>
<td>February 2018</td>
<td>50 (100% of eligible cases agreed with CCGs)</td>
</tr>
<tr>
<td>(Inpatient/Community)</td>
<td>Community - completed</td>
<td>February 2018</td>
<td>75 (100% of eligible cases agreed with CCGs)</td>
</tr>
<tr>
<td>CQUIN 5 Transitions out of Children and</td>
<td>Completed</td>
<td>March/April 2018</td>
<td>100% of all eligible cases</td>
</tr>
<tr>
<td>Young Peoples MH Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQUIN 9 Preventing Ill Health by Risky</td>
<td>Completed</td>
<td>Quarterly - April 2017 / March 2018</td>
<td>100% of all eligible cases</td>
</tr>
<tr>
<td>Behaviours (Alcohol and Tobacco)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Inpatients only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*National Clinical Audit of Psychosis</td>
<td>Completed</td>
<td>Inpatient/Community EIP</td>
<td>200 (100% of expected returns)</td>
</tr>
<tr>
<td>(Inpatient/Community/EIP)</td>
<td></td>
<td></td>
<td>120 (100% of eligible cases)</td>
</tr>
<tr>
<td>**National Confidential Enquiry - Young</td>
<td>Completed</td>
<td>June 2017</td>
<td>** Not known</td>
</tr>
<tr>
<td>People’s Mental Health Study</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>POMH(UK) Topic 17 - the use of depot/long</td>
<td>Completed</td>
<td>May/June 2017</td>
<td>31 patients submitted (100% of returned eligible cases)</td>
</tr>
<tr>
<td>acting antipsychotic medication for relapse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>purposes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>POMH(UK) Topic 16 - rapid tranquilisation</td>
<td>Underway</td>
<td>Prospective data collection: March to June 2018</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

*Data was collected for the 3a CQUIN as part of the National Audit of Psychosis and submitted to NHS England by Royal College of Psychiatrists where cases met the CQUIN criteria. Actual numbers meeting the criteria and submitted for the CQUIN are not known by the clinical audit dept.

**Data for the NCE audit was forwarded directly to NCEPOD by the identified clinicians and therefore the number of cases submitted is not known by the clinical audit dept.
NICE guidance implementation 2017/2018

The Trust has developed systems and processes in line with recommendations from NICE to ensure that all implementation of their guidance has a clear process. The overall co-ordination, planning and monitoring of NICE implementation within and across services is carried out in accordance with principals set out in this policy. The Trust currently has 10 NICE technology appraisals and 47 clinical guideline implementation projects in progress. Compliance with implementation is detailed in the tables below for clinical guidelines, technology appraisals and public health guidelines respectively.

Technology appraisals:

<table>
<thead>
<tr>
<th>Technology appraisals</th>
<th>Total</th>
<th>Compliant</th>
<th>Partially compliant</th>
<th>Under review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Clinical guidelines and public health guidelines

<table>
<thead>
<tr>
<th>Clinical guidelines and public health guidelines</th>
<th>Total</th>
<th>Compliant</th>
<th>Partially compliant</th>
<th>Under review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>46</td>
<td>0</td>
<td>19</td>
<td>27</td>
</tr>
</tbody>
</table>

Quality standards

<table>
<thead>
<tr>
<th>Quality standards</th>
<th>Total</th>
<th>Compliant</th>
<th>Partially compliant</th>
<th>Under review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>39</td>
<td>8</td>
<td>18</td>
<td>13</td>
</tr>
</tbody>
</table>

Where our status is ‘partially compliant’, meaning there are elements of non-compliance with the guidance, we will undertake a baseline audit to establish areas where improvements are needed to achieve full compliance. From the results of baseline audits, individual action plans will be developed detailing implementation requirements over varying timescales.

NICE permits flexibility when implementing clinical guidelines as it is recognised that in some instances it may take varying periods of time to fully implement the guidance. However, it is the expectation, unless otherwise noted, that NICE technology appraisals should be implemented within 12 weeks of publication. The function of the Trust’s research, innovation and effectiveness team is to audit and monitor progress against agreed action plans with the aim to achieve full implementation over time.
The Trust is working hard to ensure that for those areas of NICE guidance relevant to our patients/service users and services we have a robust system of assessment and implementation embedded.

**Participation in research 2017/18**

The number of service users/patients receiving relevant health services, provided or sub-contracted by the Trust, that were recruited during this period to participate in research approved by a research ethics committee was 428 (Clinical Research Network East Midlands, partner summary report, March 2018).

For the year April 2017 to March 2018, the Trust achieved 100% of local NHS permissions within NIHR 30 day performance indicators.

Trust NIHR network funded staff supported NIHR studies hosted within the Trust. The Trust used national systems to manage the studies in proportion to risk. All studies were managed under national model agreement and research passport guidance.

The Trust’s research and development operational capability statement (RDOCS) was reviewed by the Trust Board in 2017 and is uploaded to the NIHR Clinical Research Network website and published on the Trust’s website.

**Examples of NIHR work undertaken by the Trust in 2017-18:**

**Responding to the Dementia Challenge**

A key area for action within the Dementia Challenge is improving research; the Trust’s research department is working with Trust clinical staff to increase access to dementia studies in Lincolnshire and offer our staff, service users and carers valuable opportunities to help shape improvements in dementia care through participation in research. In 2017-18 the Trust continues to drive forward two national initiatives that have been developed as part of the Dementia Challenge:

**ENRICHT – Enabling Research in Care Homes**

Developed by the NIHR, the ENRICHT toolkit draws on work from the NIHR School for Social Care Research (SSCR). Whilst focusing on dementia the toolkit has been designed to be applicable to other disease areas and conditions, and information provided can be used to support the promotion of all high-quality research. There are over 18,000 care homes in England providing homes and care for over 386,000 people. The ENRICHT programme aims to support increasing the amount of research from its current levels in order to improve the
quality of life and quality of care for all care home residents especially people with dementia

Join Dementia Research (JDR)
JDR is a national service that offers individuals the chance to register their interest in taking part in dementia research, find suitable studies in their area, and let researchers know that they might be interested in taking part in their research. The service’s development is being funded by the Department of Health and is delivered in a partnership with the NIHR Clinical Research Network, Alzheimer’s Research UK and the Alzheimer’s Society.

JDR was launched nationally in early 2015 and the Trust has registered as a whole organisation JDR Champion – the first NHS Trust in the country to achieve this:

Clinical Research - Workforce Development Award 2017-18
The Trust Research Team strive to be active enablers of research, to remove barriers and provide a broad range of opportunities. We realise the need to offer professional development to clinical staff who want to remain in clinical practice but to increase their expertise in clinical research.

We have collaborated with National Institute for Health Research Clinical Research Network East Midlands (NIHR CRN EM) to pilot the Clinical Research Workforce Development Award 2017-18.

- Flexible to the needs of recipient and seconding clinical division
- Negotiable hours/days – to fit with clinical work
- Non-medical healthcare professionals
- Internal opportunity B4-6 – advertised for internal expressions of interest
- Backfilled at existing banding and pay point
- Travel and expenses paid
- Completed in 2017-18 financial year
- Mentored by the Research Team
- Learning - NIHR studies/initiatives/training
- Actively work on NIHR studies/initiatives
- Evaluation - annual opportunity
This year’s recipient is a Community Psychiatric Nurse (CPN) within our Older Adult division. Award given 1 September 2017-31 March 2018; two days a month – backfilled to seconding team budgets.

- Induction – attended team meeting and introduced to wider Trust research team; regional and national teams/context
- Identify - learning needs
- Training - Good Clinical Practice (attended face to face training)
- Learning – Join Dementia Research (training session provided by Dementia Challenge Project Manager, CRN EM)
- Studies – information on relevant NIHR studies; now promoting recruitment to all studies relevant to clinical area
- Agreeing – workload and opportunities
- Support – present independently at team meetings (studies and JDR)
- Reporting – progress to research team and via LPMS
- Mentor – regular meetings to support, plan, review
- Long-term – identify ways to embed research culture and opportunities within Older Adult division

We have just opened a study in Older Adult division – a randomised controlled trial of an intervention for people in the early stages of dementia. The award recipient has been able to follow negotiation and set-up of the trial, is supervising the staff who will be delivering the intervention in Lincolnshire and as such has received training from the sponsor site. Working alongside the research nurse to recruit, take informed consent and collect data. This is an opportunity to be fully involved in how we deliver NIHR research in the Trust.

Performance information on the initiation and delivery of clinical research

The Government wants to see a dramatic and sustained improvement in the performance of providers of NHS services in initiating and delivering clinical research. The Government’s Plan for Growth, published in March 2011, announced the transformation of incentives at local level for efficiency in initiation and delivery of clinical research.

The Department of Health (DoH), via the new NIHR contracts with providers of NHS services, requires the publication on a quarterly basis information regarding: the 70-day benchmark for clinical trial initiation; and the recruitment to time and target for commercial contract clinical trials.
Providers of NHS services are required to publish information for initiating clinical research (ie the 70-day benchmark) on a publicly available part of their website. Providers of NHS services are also required to publish information regarding commercial contract clinical trials, to meet the transparency commitment for delivering clinical research to time and target on a publicly available part of their website. The Trust publishes data on initiating and delivering clinical research quarterly basis; this information is published on the Trust website: www.lpft.nhs.uk/research

2.2.2 Commissioning for Quality and Innovation (CQUIN) payment framework

What are CQUINs and what do they mean for the Trust?
The CQUIN payment framework was introduced in 2009 to make a proportion of providers’ income conditional on demonstrating improvements in quality and innovation in specified areas of care. Whether the Trust receives its CQUIN payments is dependent on achieving certain quality measures. This means that some of the Trust’s income is conditional on achieving certain targets that are agreed between the Trust and our commissioners.

2.2.3 Performance in CQUINs 2017/18

A proportion of the Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body the Trust entered into a contract, agreement or arrangement with for the provision of relevant health services, through the CQUINs payment framework. Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at: www.lpft.nhs.uk

The 2017/18 CQUINs are detailed below:

- There were six CQUINs within the standard contract. There were three NHS England (NHSE) low secure CQUINs; two NHSE CAMHS CQUINs; one ‘Incentive Payment’ for NEL CAMHS and one LCC tier 3 CAMHS CQUINs.
- The overall monetary total for income in 2017/18 conditional upon achieving quality improvement and innovation goals was £1.85 million. The monetary total value of the CQUINs 2016/17 was £1.84 million.
- The CQUINs for 2017/18 have been rated on a RAG (red – no payment, amber – partial payment, green – full payment) basis dependent on achievement to date as detailed in the following tables:
Lincolnshire Clinical Commissioning Groups

<table>
<thead>
<tr>
<th>Goal No.</th>
<th>CQUIN targets and topics</th>
<th>RAG rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH1a(B)</td>
<td>The introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with muscular skeletal (MSK) issues.</td>
<td></td>
</tr>
<tr>
<td>MH1b</td>
<td>Healthy food for NHS staff, visitors and patients.</td>
<td>N/A</td>
</tr>
<tr>
<td>MH1c</td>
<td>Improving the uptake of flu vaccinations by frontline clinical staff.</td>
<td></td>
</tr>
<tr>
<td>MH3a</td>
<td>Improving physical healthcare to reduce premature mortality in people with SMI: <strong>cardio metabolic assessment and treatment for patients with psychoses.</strong></td>
<td></td>
</tr>
<tr>
<td>MH3b</td>
<td>Improving physical healthcare to reduce premature mortality in people with SMI: <strong>communication with general practitioners.</strong></td>
<td></td>
</tr>
<tr>
<td>MH4</td>
<td>Improving mental health services at A&amp;E</td>
<td></td>
</tr>
<tr>
<td>MH5</td>
<td>CAHMS inpatient transitions to adult care.</td>
<td></td>
</tr>
<tr>
<td>MH9</td>
<td>Preventing ill health from the use of tobacco and alcohol.</td>
<td></td>
</tr>
</tbody>
</table>

NHS England low secure

<table>
<thead>
<tr>
<th>Goal No.</th>
<th>CQUIN targets and topics</th>
<th>RAG rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH2</td>
<td>Recovery Colleges for Medium and Low Secure Patients</td>
<td></td>
</tr>
<tr>
<td>MH3</td>
<td>Reducing restrictive practices within Adult Low and Medium Secure Services</td>
<td></td>
</tr>
<tr>
<td>MH4</td>
<td>Discharge and Resettlement</td>
<td></td>
</tr>
</tbody>
</table>

North East Lincolnshire (NEL) CAMHS (incentive payments)

<table>
<thead>
<tr>
<th>Goal No.</th>
<th>Incentive payment targets and topics</th>
<th>RAG rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>TARGET 1</td>
<td>Transition from CAMHS to AMHS</td>
<td></td>
</tr>
</tbody>
</table>
NHS England TIER 4 CAMHS

<table>
<thead>
<tr>
<th>Goal No.</th>
<th>CQUIN targets and topics</th>
<th>RAG rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH4</td>
<td>Discharge and resettlement from specialised mental health inpatient services.</td>
<td>Green</td>
</tr>
<tr>
<td>MH5</td>
<td>CAHMS inpatient transitions to adult care.</td>
<td>Green</td>
</tr>
</tbody>
</table>

Lincolnshire County Council - Lincolnshire community CAMHS

<table>
<thead>
<tr>
<th>Goal No.</th>
<th>CQUIN targets and topics</th>
<th>RAG rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMHS1</td>
<td>Transition from CAMHS to adult mental health services</td>
<td>Green</td>
</tr>
</tbody>
</table>

2.2.4 CQUINs 2018/19

All CQUINs were nationally mandated for the contract period 2017/19 with an option for any additional CQUINs to be agreed by providers and commissioners locally. We have worked closely and effectively with our commissioners, our lead commissioner being South West Lincolnshire Clinical Commissioning Group, to identify that our CQUINs align well with our quality priorities and support the promotion of further quality improvements as such agreement was made to add no further local CQUIN to those mandated.

The overall monetary total for income in 2018/19 conditional upon achieving quality improvement and innovation goals is £1.85 million inclusive of STP and risk reserve monies.

The Trust’s services span inpatient and community provision and are detailed within this report. With our commissioners we have identified how we will meet the stretching targets set nationally for quality improvements across our services, with the shared goal of evidencing improved outcomes for those using our services.

- The CQUINs remain as those described in section 2.2.3 with revised milestones for achievement details of which are available at: www.lpft.nhs.uk
2.2.5 CQC - including the intelligent monitoring and comprehensive inspection

The Trust is required to register with the CQC and its current registration status is fully registered. The Trust has no conditions on registration.

The CQC has not taken any enforcement action against the Trust during 2017/18.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust has been registered to carry out the following regulated activities:

- Treatment of disease disorder or injury
- Assessment and medical treatment of persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures

The CQC make sure health and social care services provide people with safe, effective, compassionate, high-quality care and they encourage care services to improve.

The CQC role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety; they publish their finding, including performance ratings to help people choose care. They have introduced a new surveillance model which is built on a suite of indicators that relate to the five key questions inspectors will ask of all services – are they safe, effective, caring, responsive, and well led.

The Trust is also subject to periodic Mental Health Act reviews by the CQC and a number of our units have been visited during 2017/18; and any actions identified are monitored and assurance given to the CQC on completion of these actions.

During 2017/18 the Trust received the following CQC Mental Health Act visits to its sites:

<table>
<thead>
<tr>
<th>Mental Health Act visits</th>
<th>Date of Inspection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hartsholme Centre (Psychiatric Intensive Care Unit)</td>
<td>07/11/2017</td>
</tr>
<tr>
<td>Ward 12, Boston</td>
<td>25/01/2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CQC comprehensive re-inspection</th>
<th>Date of inspection</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust received a re-inspection of its services following their original comprehensive inspection in December 2015.</td>
<td>03/04/2017-07/04/2017</td>
</tr>
</tbody>
</table>
The Trust is fully compliant in respect of MHA visits; and has promptly addressed any feedback and actions identified. CQC visit related action plans are monitored through the Trust’s Operational Governance and Quality Group, with assurance reported to the Legislative Committee.

The Trust’s compliance assurance mechanisms include a schedule of quality governance visits to clinical areas in both inpatient and community settings. Non-executive directors and directors also carry out scheduled and non-scheduled visits to clinical areas throughout the year, reporting findings to the Board.

2017 CQC comprehensive inspection

The Trust had a re-inspection following the 2015 comprehensive inspection during the week of 4\textsuperscript{th} April 2017; the published ratings grid and key areas described in the report are presented in the table overleaf; the full report is available on the CQC website at: www.cqc.org.uk
There were ten individual service line reports published by the Care Quality Commission that related to services provided by Lincolnshire Partnership NHS Foundation Trust. In addition, there was an overall provider report. All “must do” and “should do” actions from these reports have been included in a comprehensive action plan.

A clear process is in place to monitor the action plan and check progress, working with operational managers and clinical leads. The action plan is presented monthly, in the public session, to the Board of Directors meeting.
Further work to improve the patient experience and the experience of staff in the organisation is supported through the development of a continuous quality improvement programme, containing four significant strands of work:

- Supporting and developing our people
- Improving the collection, quality and use of data and information
- Treating and caring for people in a safe environment and protecting them from avoidable harm
- Strategic change for Mental Health and Learning Disability Services by 2020

### 2.2.6 Statement on quality of data, governance assessment report score and clinical coding

The Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient’s valid NHS number was:
  - 99.2% for admitted patient care.
  - 100% for outpatient care

The percentage of records in the published data:

- Which included the patient’s valid General Medical Practice Code was:
  - 100% for admitted patient care
  - 100% for outpatient care

In addition the Trust continues to upload monthly returns for:

- The Mental Health Services Dataset (MHSDS)
- IAPT minimum dataset (IAPT MDS)

The Trust’s Information Governance Assessment Report overall score for 2017/18 was 96% and was graded green (satisfactory).

The Trust reports information governance (IG) toolkit progress in year, on a quarterly basis, to the Trust Board through its committees and also submits this into the IG toolkit portal.

The Trust has maintained compliance against the previous year’s position, taking into consideration the year on year increase in requirement to attain level two and above in each of the 45 standards.
# IG toolkit assessment summary report

## Information governance management

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Stage</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Not relevant</th>
<th>Total req'ts</th>
<th>Overall score</th>
<th>Self-assessed grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version 14.1 (2017-2018)</td>
<td>Published</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>100</td>
<td>Satisfactory</td>
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</table>

## Confidentiality and data protection assurance

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Stage</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Not relevant</th>
<th>Total req'ts</th>
<th>Overall score</th>
<th>Self-assessed grade</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1</td>
<td>7</td>
<td>1</td>
<td>9</td>
<td>95%</td>
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</table>

## Information security assurance

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Stage</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Not relevant</th>
<th>Total req'ts</th>
<th>Overall score</th>
<th>Self-assessed grade</th>
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</thead>
<tbody>
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<td>1</td>
<td>14</td>
<td>0</td>
<td>15</td>
<td>97%</td>
<td>Satisfactory</td>
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</table>

## Clinical information assurance

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Stage</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Not relevant</th>
<th>Total req'ts</th>
<th>Overall score</th>
<th>Self-assessed grade</th>
</tr>
</thead>
<tbody>
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<td>0</td>
<td>0</td>
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<td>4</td>
<td>0</td>
<td>5</td>
<td>93%</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

## Secondary use assurance

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<tr>
<th>Assessment</th>
<th>Stage</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Not relevant</th>
<th>Total req'ts</th>
<th>Overall score</th>
<th>Self-assessed grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version 14.1 (2017-2018)</td>
<td>Published</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>0</td>
<td>8</td>
<td>95%</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

## Corporate information assurance

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Stage</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Not relevant</th>
<th>Total req'ts</th>
<th>Overall score</th>
<th>Self-assessed grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version 14.1 (2017-2018)</td>
<td>Published</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>88%</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

## Overall

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Stage</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Not relevant</th>
<th>Total req'ts</th>
<th>Overall score</th>
<th>Self-assessed grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version 14.1 (2017-2018)</td>
<td>Published</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>39</td>
<td>1</td>
<td>45</td>
<td>96%</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>
The Trust is also working on data quality and completeness issues and has appointed a Senior Business Intelligence and Data Quality Lead to support the launch of a new Data Quality Strategy, recognising that best quality data can be one of the fundamental pillars of the continuous quality improvement environment all staff are working to create.

The strategy aims to provide an overarching framework to ensure that the Trust operates with high quality data in order to achieve its clinical and quality priorities.

Our 2021 Data Quality Vision is that our data will be a valuable asset to our services and patients. The Strategic Priorities that will facilitate us to achieve our vision are:

**Single Source of the Truth**
A Business Intelligence tool will be the primary source for operational, performance management and income reporting.

**Automation**
Automate the current processes of information provision in order to improve accuracy and use resources more effectively.

**Kite Marking**
Develop a visual indicator backed up by an assurance process that makes an explicit assessment of our data quality.

**Data stewardship**
All staff will understand that data quality is an organisational priority. Through training and development they will understand how their actions directly affect the validity of data and the potential to use data to promote better patient outcomes.

**Simple**
Empower staff with simplified data collection and validation processes, reducing the need for manual reconciliation.

**Business Rules**
Develop a shared understanding for all staff of the language used to describe our services and performance reporting.

**Sustainable**
All of our data quality improvement efforts will be linked to a central work plan and clear governance structure.
2.2.7 Payment by results (PbR)

The Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

References to the Audit Commission are now out of date because it has closed. From 2014 responsibility for coding and costing assurance transferred to Monitor and then NHSI. From 2016/17 this programme has applied a new methodology and there is no longer a standalone ‘coding audit’ with error rates as envisaged by this line in the regulations.

2.2.8 Learning from deaths

2.2.8.1

Data presented within this section is for learning within the Trust and is not comparable with any other Trusts (Acute, Community and Mental Health) published data, it should not be used to provide organisational benchmarking or presented as comparators in any onward reports.

The Trust Board of Directors (BoD) is responsible for assuring itself and the public that they are reporting and reviewing deaths of patients where appropriate, and any learning that can be identified is acted upon. This ensures information regarding any deaths of patients are appropriately escalated to the BoD, supported in this role by an effective sub-committee structure, in particular the Mortality Surveillance Committee (MSC) and Quality Committee. This process is aligned to recommendations made from the National Quality Board: Learning from Deaths.

Whilst numbers are reported here it is important to remember that every death involves the loss of a loved one from family and friends lives. This is often a difficult and distressing time for those close to the person and as such the Trust aims to support and further develop strong family engagement. Through this we will ensure that value is gained from learning from deaths and openness and transparency is central to this process.

The total number of deaths reported in this section include:

- People open to Trust services at the time of their death;
- People who died within 6 months of discharge from Trust services;
- Peoples deaths that are referred for Learning Disabilities Mortality Review (LeDeR);
- Death investigated as Serious Incidents.
2.2.8.2
During 2017/18, 1320 of the Trusts patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 269 in the first quarter; 272 in the second quarter; 376 in the third quarter; 403 in the fourth quarter.

The figures above include people open to the Trust at the time of their death and also those who died within 6 months of contact with the Trust. Only 2 deaths occurred within a Trust inpatient unit.

2.2.8.3
By 31/03/2018, 8 case record reviews and 37 investigations have been carried out in relation to 1320 of the deaths included in item 2.2.8.2.

In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 9 in the first quarter; 8 in the second quarter; 9 in the third quarter; 19 in the fourth quarter.

2.2.8.4
0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 0 representing 0% for the first quarter; representing 0% for the second quarter; 0 representing 0% for the third quarter; 0 representing 0% for the fourth quarter. These numbers have been estimated using the Trusts Structured Judgement Review (SJR) tool. The tool is utilised by a clinician to obtain a detailed account of care and service delivery, this is subsequently presented and given further analysis by Committee members. As part of this analysis grading is allocated via a 4 tier system:

0. Unavoidable death, no suboptimal care;
1. Unavoidable death, suboptimal care but different management would not have affected the outcome;
2. Suboptimal care, but different management might have affected the outcome (possibly avoidable death);
3. Suboptimal care, different care would reasonably be expected to have affected the outcome (probable avoidable death).
2.2.8.5
The Trust aims to mature and enhance the process of reviewing deaths within the scope of the learning from deaths framework however a number of key areas for system improvement have been identified from the review and investigation process:

- The Trust will support employees to engage with patients/service users, families and carers regarding Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) at an earlier stage in care to ensure choice and involvement.
- Managers to be aware that when staff members are not at work at the time of a patient’s death, for example sickness, that this needs to be sensitively communicated to them on their return to work.
- When reviewing capacity the first step is to assume capacity for the decision and document the findings. Staff may need to explore mental capacity in relation to physical healthcare issues. Declining assessment or treatment could meet the mental capacity assessment criteria, in all such cases staff must consider and record whether capacity is an issue in relation to the specific decision. If the patient/service user is found to lack capacity upon assessment then best interest decision making processes should be followed.

Learning from case specific, positive practice has also been highlighted, including;
- Good liaison with GP and other agencies,
- Employees supporting and engaging well with family members of the deceased.

2.2.8.6
Lessons are identified within the monthly Mortality Surveillance Committee meeting and also as part of SI investigations. Appropriate leads for any actions that need to be implemented are identified to oversee and ensure their completion. Information is also shared with the Trust though the bi-monthly Lessons Learnt Bulletin for wider sharing.

2.2.8.7
As the Trust is currently undertaking the actions identified in 2.2.8.6 we look forward to reporting any impact upon the safety and experience of patients to future Board of Directors meetings and quality report.
2.2.8.8

0 case record reviews and 10 investigations completed after 31/03/17 which related to
deaths which took place before the start of the reporting period.

2.2.8.9

0 representing 0% of the patient deaths before the reporting period, are judged to be more
likely than not to have been due to problems in the care provided to the patient. This number
has been estimated using the Serious Incident investigation reports into each case to
support review with the tiered mortality grading system.

2.2.8.10

0 representing 0% of the patient deaths during quarter 4 of 2016/17 are judged to be more
likely than not to have been due to problems in the care provided to the patient.

2.2.9 Performance against core quality account indicators

Since 2012/13 the Trust has been required to report performance against a core set of
indicators using data made available to the Trust by NHS Digital. This feeds the hospital
episode statistics and the mental health minimum data set.

For each indicator the number, percentage, value, score or rate (as applicable) for at least
the last two reporting periods is presented below. Where available, for each indicator, the
rate for the last six reporting periods is presented. In addition, where the data is made
available by the NHS Digital, a comparison is made of numbers, percentages, values, scores
or rates of each of the Trust’s indicators with: the national average for the same; and those
NHS trusts and NHS foundation trusts with the highest and lowest for the same.

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<tr>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CPA seven day follow-up (threshold 95%)</td>
<td>96.2%</td>
<td>96.5%</td>
<td>98.7%</td>
<td>95.9%</td>
<td>97.7%</td>
<td>96.6%</td>
<td>95.2%</td>
</tr>
</tbody>
</table>

Benchmark: NHS average is 95.4%
(Source: NHS Digital)

- The Trust considers that this data is as described for the following reason: reports are validated
  against the source system (NHS Digital website).
- The Trust will be taking the following actions to improve data quality: completing in year quality
  audits of CPA seven day follow-up entries and ensuring any identified actions are promptly
  followed up.
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</tr>
</thead>
<tbody>
<tr>
<td>Admissions to inpatient services have had access to crisis resolution home treatment teams (threshold 95%)</td>
<td>91.7% (threshold 90%)</td>
<td>96.3%</td>
<td>96.7%</td>
<td>99.8%</td>
<td>99.8%</td>
<td>96.8%</td>
<td>97.9%</td>
</tr>
</tbody>
</table>

Benchmark: NHS average is 98.5% (Source: NHS Digital)

- The Trust considers that this data is as described for the following reasons: reports are run, manually reviewed and uploaded to the Department of Health via the Unify system quarterly.
- The Trust will be taking the following actions to improve data quality: continuing an assertive focus in work to improve its data quality systems.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>(From April 2011 – March 2017 28-day) re-admission (threshold 10%)</td>
<td>&lt;15yrs old</td>
<td>11.1%</td>
<td>9.4%</td>
<td>8.1%</td>
<td>8.7%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>&gt;16yrs old</td>
<td>10.4%</td>
<td>8.3%</td>
<td>9.6%</td>
<td>8.79%</td>
<td>3.97%</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

Source: Trust systems

- The Trust considers that this data is as described for the following reasons: admission and discharge data is manually reviewed monthly to capture data on all re-admissions within the Trust.
- The Trust will be taking the following actions to improve data quality: continuing an assertive focus in work to improve its data quality systems.
<table>
<thead>
<tr>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Staff recommendation of the organisation as a place to work or receive treatment.</td>
<td>Not available</td>
<td>3.25 (below national average)</td>
<td>3.55 (national average)</td>
<td>3.58 (above national average)</td>
<td>3.36 (below national average)</td>
<td>3.58 (equal to national average)</td>
<td>3.77 (above the national average)</td>
</tr>
</tbody>
</table>

Benchmark: Mental Health Trusts average 3.67
(Source: NHS Staff Survey)

- The Trust considers that this data is as described for the following reason: reports are published on the CQC website.
- The Trust will be taking the following actions to improve data quality: delivery of initiatives including the Trust’s staff engagement programme, ‘Making a Difference through CQI’ and a wide range of leadership events and training.

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</tr>
</thead>
<tbody>
<tr>
<td>Community mental health services patient survey indicator score with regard to a patient’s experience of contact with a health or social care worker</td>
<td>8.9/10 (better than national average)</td>
<td>8.7/10 (about the same as national average)</td>
<td>8.7/10 (about the same as national average)</td>
<td>7.6/10 (about the same as national average)</td>
<td>7.2/10 (about the same as national average)</td>
<td>7.5/10 (about the same as national average)</td>
<td>7.2/10 (about the same as national average)</td>
</tr>
</tbody>
</table>

Benchmark: Each Trust received a rating of Better, About the same or Worse on how it performs on each question (within the survey) compared with most other Trusts
(Source: CQC)

- The Trust considers that this data is as described for the following reason: reports are published as part of the national community mental health patient survey.
- The Trust will be taking the following actions to improve data quality: maintaining the work programme to achieve Accreditation of Community Mental Health Services.
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>The number and rate of patient safety incidents reported within the Trust; and the number and % of such patient safety incidents that resulted in severe harm or death.</td>
<td>Not available</td>
<td>5,024 incidents (total). 1,520 reported to NRLS of which 50 (3%) resulted in severe harm or death</td>
<td>4,169 incidents (total). 2,074 reported to NRLS of which 36 (1.7%) resulted in severe harm or death</td>
<td>5,025 incidents (total). 2,174 reported to NRLS of which 23 (1%) resulted in severe harm or death</td>
<td>5,570 incidents (total). 2,390 reported to NRLS of which 47 (2%) resulted in severe harm or death</td>
<td>5,981 incidents (total). 1,997 reported to NRLS of which 20 (1%) resulted in severe harm or death</td>
<td>6,918 incidents (total). 4,299 reported to NRLS of which 50 (1.2%) resulted in severe harm or death</td>
</tr>
</tbody>
</table>

Benchmark: Severe harm or death mental health Trust average 1%
(Source: NHSI)
(Trust data correct as of 06/04/18)

- The Trust considers that this data is as described, as incident reports are submitted to the CQC and to the National Reporting and Learning Service (NRLS) where incidents result in severe harm or death.
- The Trust will be taking the following actions to improve data quality: daily review and monitoring of emerging themes and/or trends via the Trust’s quality and safety team, with reporting to the Board and the Trust’s Patient Safety and Experience Committee. The Trust’s implementation of duty of candour and wide dissemination of learning lessons bulletins across the Trust.

### 2.2.10 Quality of information

The Trust generates monthly performance reports, with dashboard summaries of the Trust’s position against key performance indicators. These provide validated performance information on a monthly basis, which are shared with the Board of Directors, services and commissioners; and are included in the Board of Directors’ monthly reports.

Where the Trust has included relevant indicators and performance thresholds within this section (part two of the quality report), in accordance with the quality accounts regulations, it has not reported these again in part three of the quality report.
To review progress and prepare for the completion of a director’s statement in the published quality report in 2017/18, the Trust has engaged its external auditors to:

- Review the arrangements put in place to ensure the quality report framework is robust.
- Review the data accuracy of the proposed mandated performance measures, which are EIP access and out of area admissions and the local indicator for medication management.
- Identify the requirements of good practice internal control systems for data quality.
- Provide recommendations to put these best practice arrangements in place in advance of the 2017/18 published audit opinion.
- The Trust will manage the implementation of the action plan, generated by its external auditors, through the Board committee structure.
- Review progress against the locally mandated indicator and the mandated indicators.
Part 3: Other information

The Quality Account Regulations specify that part three of the quality account should be used to present other information relevant to the quality of the relevant health services provided or sub-contracted by the Trust during 2017/18.

Unless otherwise stated, all data for local quality indicators is gathered and reported internally.

3.1 Indicators selected by the Board in consultation with stakeholders

As per the requirements for a NHS Foundation Trust, the following is presented:

- An overview of the quality of care offered by the Trust, based on performance in 2017/18 against indicators selected by the Board, in consultation with stakeholders, with an explanation of the underlying reason(s) for selection. The indicator set selected includes:
  - Three indicators for patient safety.
  - Three indicators for clinical effectiveness.
  - Three indicators for patient experience.
- Historical data and benchmarked data, where available, so the reader can understand progress over time and performance compared to other providers.
- Reference to the data sources for the indicators, including whether the data is governed by standard national definitions.
- Confirmation is made that seven indicators for 2017/18 are the same as those reported in the Trust’s 2016/17 quality report; and confirmation is made that the data reported has been checked to ensure consistency with the 2016/17 report.
- Two new indicators were added in 2017/18
  - Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral
    Chosen to ensure the best evidence based practice is provided to our patients / service users to promote the best possible outcomes.
  - Inappropriate out-of-area placements for adult mental health services
    Chosen to ensure that patients/service users receive the correct care as near to their home, friends and family as possible.
• For each core indicator the number, percentage, value, score or rate (as applicable) for the last two reporting periods is the minimum required; and the Trust has presented data, where available, for the last six reporting periods.

• Limited data has currently been made available by the NHS Digital but, where this is available, a comparison for previous reporting periods has been made of the numbers, percentages, values, scores or rates of each of the Trust’s indicators with:
  o The national average for the same; and
  o Those NHS trusts and NHS foundation trusts with the highest and lowest for the same.

The table below details the selected indicators and includes performance against the two mandated indicators (EIP access to care and Inappropriate out of area admissions). The local mandated indicator performance is shown afterwards.

The source for the following data is from Trust systems unless otherwise stated.
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>CPA seven day follow-up (threshold 95%)</td>
<td>96.2%</td>
<td>96.5%</td>
<td>98.7%</td>
<td>95.9%</td>
<td>97.7%</td>
<td>96.6%</td>
<td>95.2%</td>
</tr>
<tr>
<td>Benchmark: NHS average is 75.5% (year to date);</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Highest 100%; Lowest: 0%</td>
<td></td>
<td></td>
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<tr>
<td>Source: NHS Digital</td>
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<td></td>
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<tr>
<td>Number of inpatient ligation incidents (of which</td>
<td></td>
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</tr>
<tr>
<td>from a fixed point</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>2011/12</td>
<td>51</td>
<td>50</td>
<td>147</td>
<td>164</td>
<td>204</td>
<td>245</td>
<td>217</td>
</tr>
<tr>
<td>2012/13</td>
<td></td>
<td></td>
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<tr>
<td>2013/14</td>
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<tr>
<td>2014/15</td>
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<tr>
<td>2015/16</td>
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<tr>
<td>2016/17</td>
<td></td>
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</tr>
<tr>
<td>2017/18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection control no. of MRSA bacteraemia and</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 C Diff</td>
<td>0</td>
</tr>
<tr>
<td>C Diff infections (threshold: a de minimis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0 MRSA</td>
<td>0</td>
</tr>
<tr>
<td>applies)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical effectiveness</td>
<td>91.7%</td>
<td>96.3%</td>
<td>96.7%</td>
<td>99.8%</td>
<td>99.8%</td>
<td>96.8%</td>
<td>97.9%</td>
</tr>
<tr>
<td>Admissions to inpatient services have had access</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>to CRHT teams (threshold 95%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(From April 2011 to March 2017 28-day)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2017/18 30-day re-admission (threshold 10%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15yrs old</td>
<td>11.1%</td>
<td>9.4%</td>
<td>8.1%</td>
<td>8.7%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>&gt;16yrs old</td>
<td>10.4%</td>
<td>8.3%</td>
<td>9.6%</td>
<td>8.79%</td>
<td>3.97%</td>
<td>4.2%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Early intervention in psychosis (EIP): people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>experiencing a first episode of psychosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>treated with a NICE-approved care package</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>within two weeks of referral</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Inappropriate out-of-area placements for adult</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>mental health services (Average number of bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>days per quarter)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 16yr olds admitted onto adult wards</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Delayed transfers of care to be kept at a minimal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>level (threshold 7.5% or below)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Target: 7.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual: 0.9%*</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Target: 7.5%</td>
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<tr>
<td>Actual: 3.9%</td>
<td></td>
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<tr>
<td>Target: 7.5%</td>
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<tr>
<td>Actual: 2.5%</td>
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<tr>
<td>Target: 7.5%</td>
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<tr>
<td>Actual: 1.9%</td>
<td></td>
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<tr>
<td>Target: 7.5%</td>
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<tr>
<td>Actual: 2.3%</td>
<td></td>
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<tr>
<td>Target: 7.5%</td>
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<td></td>
</tr>
<tr>
<td>Actual: 11.9%</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Target: 7.5%</td>
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<tr>
<td>Actual: 2.6%</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

55
The Trust considers that their data is as described, as reports are validated against the source system and where evidence from the NHS Digital available, reports are validated against this.

Data quality within the Trust is coordinated through the data quality group by the Business Intelligence and Data Quality Lead. Data quality dashboards on identifier and priority metrics are provided monthly. During 2016/17 data quality monitoring was changed by NHSI from data completeness measures as part of the MHSDS to identifier and priority metrics as specified in the Single Oversight Framework. Compliance for identifier metrics was 99.6% and priority metrics was 85.1%.

### 3.2 Local indicator 2017/18

The Trust identified medicines management for its local indicator in 2017/18, the aim being that 95% of reported medication errors result in no harm across all inpatient and community areas of the Trust and evidence how, and to whom, those incidents are attributed.

The continued reduction of medication errors that cause harm is an ongoing priority for the Trust. Following several years of intensive and focussed work within our inpatient wards a ‘statistical plateau’ has been achieved resulting in limited impact upon a reduction of incidents with harm. In 2016/17 this was 1.6% of errors caused harm.

The current indicator broadens the work to include our community teams to ensure that community patients receive the same level of medication safety as those in our inpatient areas. Work has been undertaken by our pharmacy team along with community teams to support improved and accurate reporting of medication errors and this will continue into 2017/18 with the Matron (Adult Inpatient) supporting the community Divisional Quality Leads and Service Managers development of Community Team Medicine Management Processes. The data for medication errors from April 2017 to March 2018 is presented below by reporting area: community (all teams) and inpatient (all teams), the total percentage of errors which resulted in no harm is 95%.

<table>
<thead>
<tr>
<th>Division</th>
<th>Total Number of Errors</th>
<th>Number and level of harm Caused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Community</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>Older Adults</td>
<td>41</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1 moderate and 3 low harm)</td>
</tr>
<tr>
<td>Adult Inpatients</td>
<td>125</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(low harm)</td>
</tr>
<tr>
<td>Specialist</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(low Harm)</td>
</tr>
</tbody>
</table>
3.3 Performance against core indicators

NHSI targets not reported in this table are detailed in section 2.2.7

The Trust has continued to focus upon delayed transfers of care and implemented a number of strategies into the pathway which have successfully reduced their occurrence.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>CPA patients having a formal review within 12 months (threshold 95%)</td>
<td>Red</td>
<td>Green</td>
<td>Green</td>
<td>96.9%</td>
<td>95.5%</td>
<td>96.7%</td>
<td>96.3%</td>
</tr>
<tr>
<td>Minimising delayed transfers of care (no more than 7.5%) * Target reduced to 3.5% November 2017</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>1.57%</td>
<td>5.2%</td>
<td>11.9%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Improving access to psychological therapies (IAPT) - People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral (target 75%). New for Q3 2015/16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>97%</td>
<td>85.5%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Improving access to psychological therapies (IAPT) - people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral (target 95%). New for Q3 2015/16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
<td>98.8%</td>
<td>98.8%</td>
</tr>
<tr>
<td>Early intervention in psychosis (EIP): people experiencing a first episode treated with a NICE-approved care package within two weeks of referral</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>71.4%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Certification against compliance with requirements regarding access to healthcare for people with a learning disability</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
3.4 Patient experience

3.4.1 Complaints

The Trust is proactive in encouraging service user/patient feedback, recognising that service user/patient feedback, comments and complaints are effective measures of services delivered, what is needed to improve those services, changing trends/demands and necessary learning. As a learning environment the Trust welcomes this feedback as a way to continually improve the services we offer. The information assists the Trust to:

- Recognise standards of service delivery and continue to ensure service improvement.
- Understand the patient experience, perspective and expectations.
- Identify any problematic areas.
- Identify actions needed.

On receipt of a complaint, a risk assessment is undertaken to identify any action that need to be taken in respect of immediate healthcare/safeguarding needs. This can offer resolution to the concerns raised, for example, contact with the care coordinator, reviewing waiting times, offering an appointment, a second opinion or a change of consultant.

Irrespective of whether a complaint is upheld or not, the Trust demonstrates its responsiveness to that person’s individual experience and offers an explanation from the Trust’s perspective and an apology for any errors which occur, and for the experiences that people have of services provided by the Trust. The Trust also evidences any changes made as a result of a complaint and tracks the progress of these changes.

Data contained within the complaints section of the quality report is data correct as of 27th April 2018.

<table>
<thead>
<tr>
<th>Complaint outcomes</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upheld</td>
<td>33</td>
<td>19%</td>
</tr>
<tr>
<td>Partially upheld</td>
<td>38</td>
<td>22%</td>
</tr>
<tr>
<td>Not upheld</td>
<td>43</td>
<td>26%</td>
</tr>
<tr>
<td>In process</td>
<td>57</td>
<td>33%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>171</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
### Subject of complaint (elements)

<table>
<thead>
<tr>
<th>Subject of complaint (elements)</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and treatment</td>
<td>55</td>
<td>32.2%</td>
</tr>
<tr>
<td>Access to services</td>
<td>24</td>
<td>14%</td>
</tr>
<tr>
<td>Communication</td>
<td>19</td>
<td>11.1%</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>21</td>
<td>12.3%</td>
</tr>
<tr>
<td>Medication</td>
<td>11</td>
<td>6.4%</td>
</tr>
<tr>
<td>Appointments</td>
<td>10</td>
<td>5.8%</td>
</tr>
<tr>
<td>Patient safety</td>
<td>9</td>
<td>5.3%</td>
</tr>
<tr>
<td>Detention under MHA</td>
<td>4</td>
<td>2.3%</td>
</tr>
<tr>
<td>Discharge</td>
<td>5</td>
<td>2.9%</td>
</tr>
<tr>
<td>Code of Openness</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>3</td>
<td>1.8%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>3</td>
<td>1.8%</td>
</tr>
<tr>
<td>Policies and procedures</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Direct payments</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Patient property</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Breach of confidentiality</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Total</td>
<td>171</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Lessons learned from complaints:

<table>
<thead>
<tr>
<th>You said</th>
<th>We did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient complained about their treatment from services since their discharge from an inpatient setting. They wanted to see a CPN more regularly and the have their consultant appointment brought forward.</td>
<td>Apology given for their experiences. Team coordinator confirmed with staff to contact out of area patients weekly and will monitor in supervisions. Working with medical secretaries to ensure outpatient appointments are prioritised for recently discharged patients.</td>
</tr>
<tr>
<td>Complaint made by family member regarding support from mental health services for their relative.</td>
<td>Face to face meeting arranged with senior management team and clinical staff. Apology given to complainant and her daughter for their experiences and action plan devised to address issues raised.</td>
</tr>
<tr>
<td>Complaint received regarding diagnosis being changed and CPN cancelling appointments at short notice.</td>
<td>Response letter written by medical director. Second opinion arranged. Apology given for cancelled appointments and staff member to attend a course around accurate and timely record keeping, appointments to be audited by team coordinator.</td>
</tr>
</tbody>
</table>
Patient told he could not have a phone charger on the ward as this could be a ligature risk. They felt this was unfair.

Lockers purchased with inbuilt phone chargers (these also charge electronic vapes). These are lockable.

There had been a number of complaints regarding telephone messages not being passed on at a particular Trust location.

Team coordinator and Quality Lead reviewed current process-urgent messages are passed immediately to the appropriate person, carbonated message slips are used and a plan for folders for messages

Complaint from relative regarding prescription management by the Trust.

Face to face meeting arranged, action plan agreed including changing prescription management to GP for ease of collection.

### 3.4.2 Inpatient element of the Friends and Family Test (FFT)

The Trust continues to actively seek FFT feedback and has successfully rolled out patient experience feedback questionnaires, including the FFT question, across inpatient and community teams. In October 2017 NHS England clarified that a target response rate is no longer published nationally and following a review undertaken by NHS England the Lead Official for Statistics has concluded that the characteristics of the Friends and Family Test (FFT) mean it should not be classed as Official Statistics. The real strength of the FFT lies in the follow up questions that are attached to the initial question and LPFT use this rich source of feedback to locally highlight and address concerns.

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How many would recommend %</td>
<td>82</td>
<td>96</td>
<td>88</td>
<td>84</td>
<td>85</td>
<td>83</td>
<td>84</td>
<td>81</td>
<td>85</td>
<td>96</td>
<td>81</td>
<td>88</td>
</tr>
</tbody>
</table>
3.4.3 Community element of the FFT and community mental health patient survey 2017

The FFT question is asked within community services using the ‘Making your experience count’ leaflet.

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How many would recommend %</td>
<td>93</td>
<td>93</td>
<td>92</td>
<td>91</td>
<td>91</td>
<td>92</td>
<td>94</td>
<td>91</td>
<td>94</td>
<td>90</td>
<td>92</td>
<td>89</td>
</tr>
</tbody>
</table>

2017 annual community mental health patient survey results

The Care Quality Commission use national surveys to find out about the experiences of people who receive care and treatment. At the start of 2017, a questionnaire was sent to 850 people who received community mental health services. Responses were received from 241 people at Lincolnshire Partnership NHS Foundation Trust, a 30% response rate. The Trust is pleased to see further year on year positive improvement in 13 of the 32 areas in the report. The Trust’s final scores mean we are performing about the same as most other trusts that took part in the survey. Of the questionnaires returned fifty five per cent were returned from adult mental health service users and the remaining forty five per cent from those in receipt of older adult community mental health services.

<table>
<thead>
<tr>
<th>Patient survey</th>
<th>Patient response</th>
<th>Compared with other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and social care workers</td>
<td>7.2/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Organising care</td>
<td>8.3/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Planning care</td>
<td>6.7/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Reviewing care</td>
<td>7.4/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Changes in who people see</td>
<td>6.2/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Crisis care</td>
<td>6.2/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Treatments</td>
<td>7.0/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Support and wellbeing</td>
<td>4.6/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Overview of care and services</td>
<td>6.9/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Overall experience</td>
<td>6.8/10</td>
<td>About the same</td>
</tr>
</tbody>
</table>

Some of the areas of improvement in the report include that 98% of patients know who to contact if they have a concern about their care, with 85% feeling that care coordinators organise the care and services needed. Patients felt informed about any changes in the
people they see and knowing who is in charge during any changes. Patients feel they are treated with respect and dignity. People know who to contact out of hours in a crisis.

There are however, particular areas where the Trust would wish to improve the experience for our service users/patients, these themes include:

- People feeling listened to
- Support to find or keep work
- Supporting patients to participate in local activities
- Frequency of appointments and time at these to discuss their needs
- Information about the treatment and medications available and discussions and involvement in making these decisions.

Much of the Community Mental Health Survey is relevant to the Trust’s Continuous Quality Improvement work. Of particular relevance is the joint review of care and risk assessment. A working group has been established to consider the work programme, notable to improve the policies, tools and training to support staff in being able to effectively and efficiently undertake, and record care planning and risk assessment.

The Adult Community Division has commenced work towards achieving the Royal College or Psychiatrists’ College Centre for Quality Improvement (CCQI), Accreditation for Community Mental Health Services (ACOMHS).

The Adult Community Division has embraced ACOMHS and linked each of the Community Mental Health survey questions to one or more of the standards. The project has been in progress for six months, initially working to meet all standards and achieve accreditation in the Grantham Community Mental Health Team, with a view to sharing the learning and agreed standards across the division on a team by team basis. Some agreed common standards, such as information leaflets and standard letters for service users and carers have already progressed through a process of agreement and rolled out to teams as the shared standard.

In addition to ACOMHS, the Adult Community Division has a range or other initiatives aimed at improving and clarity to all stakeholders around the role of the community mental health:

- ‘Enhancing the Quality of Services Users Involvement in Practice’ (EQUIP) initiative
- Triangle of Care – accreditation of the Trust’s work with carers
- Care pathway development – towards having a much clearer service offering and training staff to deliver against robust care pathways
- Physical healthcare monitoring and service provision
There are two questions in the survey that relate to crisis services and these remain an ongoing issue for the adult inpatient division to address. It is not possible to identify if any of the responses about crisis services come from the older adult population, for which there no crisis services are commissioned.

The relevant results relate to patients who state they ‘know who to contact in a crisis’ which is relatively positive at 70%. Unfortunately, only 53.7% stated that they received an appropriate response when they contacted the team. The service managers of the CMHTs and Crisis teams are working together to improve working relationships and communication between the two services. A clear process for joint working has been developed, which is demonstrating improvements. The Trust is part of the Crisis Care Concordat for Lincolnshire and is now actively involved in a Lincolnshire wide review of Crisis Services, led by Lincolnshire County Council. This review is planned to be completed by April 2018 and will produce a number of recommendations for future service development.

Within the Older Adult Services Division, work to improve service user and carer experience has been progressing for some time and a number of actions have been completed since the survey was undertaken; a number of actions are ongoing and some are still being developed:

- All service users are now provided with a clear LPFT Care Plan folder
- CMHT letters re-drafted with service user focused content including clear statement of staff roles and care plan
- Development and implementation of electronic letters to support timely communication with GP and service user around diagnosis and treatment in Memory Assessment and Management Services (MAMS)
- Post-diagnosis information packs provided and discussed as part of MAMS pathway
- Service information leaflets developed and outline service remit and expectation/local contact information.
- Care pathway development, including:
  - Dementia Clinical Pathway
  - Psychosis and Anxiety Pathway
- CMHT protocol: with clear service standards of review and service user communication
- Development of Non-Medical Prescriber role within division to enhance access to medications and expand delivery options
- Recovery College development of new pathways and promotion of recovery and self-care for older adults
- Provision of LPFT medication leaflets for all medicines prescribed via CMHT
- Direct referral pathway in place for referral to support/by Dementia Family Support Services (Alzheimer's Society)
- Development of multi-agency dementia working group looking at better alignment and integration of care pathways
- Development and implementation of bespoke physical healthcare and facility screen for all older adult referrals at appoint of referral/initial assessment
- Work to deliver the current physical health care CQUIN including implementation of cardio-metabolic assessment and health promotion requirements
- All CMHT staff undertaking physical health PHILIP training and provision of required physical health care equipment for community based use
- ACHOMS is commencing for older adult services – first site Louth CMHT. Roll-out will support boarder standardisation of service standards against national best-practice and have benefits to all areas or service user contact and experience.

Patient experience is critically important, not only as a measure of the quality of the Trust’s services in its own right, but due to the direct relationship between patient experience and the effectiveness of the service delivered. In other words, patients will achieve better outcomes if they have positive experiences of the services provided.

### 3.5 Patient safety

#### Serious incidents
Whenever a serious incident (SI), such as an attempted suicide, suicide, serious assault or injury, occurs within Trust services, it is investigated thoroughly so that the risk of such an incident happening again can be reduced or removed and lessons can be learned. Good communication and involvement, where appropriate, with families and/or service users/patients concerned in incidents is essential. The Trust works hard to ensure this is a part of all SI investigation processes and continually explores ways to strengthen involvement in investigation processes; including better establishing what outcomes are important for those most closely impacted by SI incidents.

During 2017/18 the Trust invested in the training of up to 50 staff in bespoke Duty of Candour for Mental Health Trusts. This is to ensure that the support, transparency and engagement provided to the relevant person affected by an incident is both effective and compassionate whilst meeting our statutory duty (further information can be found in section 3.11).
Patient safety incidents resulting in severe harm or death 2017/18

The most recently published national reporting and learning system (NRLS) data for mental health Trusts (March 2018) has been used to benchmark the Trust’s level of severe harm incidents. The Trust has consistently had below the national mental health Trust average of 0.3% of severe harm incidents within this report, with current levels at 0.1%.

The Trust has robust systems in place to ensure all serious incidents, including severe harm and death, are reported externally onto the national database the strategic external information system (STEIS). All incidents are investigated within the national target of 60 working days from when the incident occurred, with associated reports submitted to commissioners. Financial penalties are incurred for reports that do not achieve the deadline.

It is mandatory for NHS Trusts to report all serious patient safety incidents to the CQC. All incidents resulting in severe harm or death are reported to the NRLS who in turn report them to the CQC. Whilst this is not a mandatory process, the Trust reports all patient safety incidents to the NRLS to assist with learning both locally and nationally. Whilst it is common practice for most NHS trusts to report to NRLS it is recognised that there are different approaches to reporting and validation of the categories of patient safety incidents. The Trust monitors and validates all incidents of severe harm or death via the quality and safety team.

For the year 2017/18 there were a total of 6,918 incidents reported by the Trust, of which 4,299 were reported to the NRLS as patient safety incidents. Of these, 4 were reported as severe harm; and 16 were reported by the Trust as initial cause of death being suspected suicide. Cause of death (such as suicide) confirmed by coroner conclusions, can take several months due to the required investigative and coronial processes. This delay, whilst entirely understandable, can be particularly difficult for families affected. In 2018/19 the Trust is keen to strengthen processes and seeks to better inform and support families at these often difficult times.

The Trust monitors and proactively responds to findings and trends in respect of harm (domains of Safety Thermometer), violence/abuse/harassment incidents, medication incidents; and falls. There is close working between the Trust’s quality and safety team, team leader for restrictive interventions, the matrons, divisional managers and quality assurance and improvement leads to highlight trends and to ensure any required actions are completed. This includes the clinical lead for restrictive interventions making visits to the ward areas to discuss individualised care planning, preventative advice; and to ensure staff, service users/patients and families are supported. The clinical lead for restrictive interventions also takes professional lead responsibility for developing a specific restrictive
interventions care plan for individuals as required. The Trust is very aware that some of the
most vulnerable service users/patients within our care are within the specialities with the
highest number of reported incidents of violence, aggression and harassment (older adult
inpatients). Incidents are reviewed, where appropriate, with the Trust’s safeguarding team,
ensuring those appropriate for safeguarding are promptly referred for safeguarding
investigation. The Trust takes violence, abuse and harassment incidents extremely
seriously; and works to ensure all preventive actions possible are put in place so service
users/patients and their carers are safe, and feel safe, whilst under the care of the Trust’s
inpatient services.

All absconding and absent without leave (AWOL) incidents and trends are monitored at the
Trust’s Patient Safety and Experience Committee, with recommended actions being
identified and disseminated by the matron with responsibility for AWOLs.

**Safety thermometer - Harm free care**
The Trust reports monthly to the NHS classic safety thermometer on the performance of its
inpatient older adult wards in respect of the four domains measured in harm free care (falls
resulting in any degree of harm, urinary tract infections in patients with in-dwelling catheters,
a new venous thrombo-embolism whilst under the Trust’s care, and pressure ulcers acquired
anywhere). Due to the low number of older adult inpatient beds within the Trust a small
variation can impact significantly upon the percentage of harm free care achieved.
The prevention of falls remains a patient safety priority area and the matron for older adults
and consultant occupational therapist lead on falls prevention. Further detailed analysis is
carried out by the matron and consultant occupational therapist including times of falls and
whether they were witnessed or unwitnessed. This work is reported to the patient safety
group, where falls trends and incidents are monitored along with the efficacy of all equipment
used.

The use of telecare bed alerts (assistive technology) continues. Systems are in place to
capture data in respect of findings, which are reported via the patient safety group. All
equipment, currently procured to support the reduction and prevention of falls is available to
the older adult inpatient wards.
3.6 Staff engagement including the 2017 NHS staff survey performance

Staff survey 2017

In October 2017, the national NHS staff survey was launched. The Trust received a 59% response rate which was above average for mental health trusts. The survey as before looked at 32 key findings (KFs).

<table>
<thead>
<tr>
<th>Response rate</th>
<th>2016/17 Trust</th>
<th>2017/18 (current year) Trust</th>
<th>Mental health/learning disability Trusts average</th>
<th>Trust improvement/deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response rate</td>
<td>59%</td>
<td>59%</td>
<td>52%</td>
<td>No change</td>
</tr>
</tbody>
</table>

The responses from staff pointed to positive improvements from 2016, both locally and nationally when compared to other mental health and learning disability organisations. The results were:

**National comparison**

18 key findings are above average (an increase of 6 on 2016).
13 key findings are average (a decrease of 4 on 2016).
1 key finding is below average (a decrease of 1 on 2016).

**Local changes**

5 key findings have increased significantly.
27 key findings have not changed.

**Top five ranking scores**

KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
KF19. Organisation and management interest in and action on health and wellbeing
KF20. Percentage of staff experiencing discrimination at work in the last 12 months
KF2. Staff satisfaction with the quality of work and care they are able to deliver
Bottom five ranking scores

KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month
KF11. Percentage of staff appraised in last 12 months
KF7. Percentage of staff able to contribute towards improvements at work
KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months

Where staff experience has improved

KF6. Percentage of staff reporting good communication between senior management and staff
KF13. Quality of non-mandatory training, learning or development
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents
KF1. Staff recommendation of the organisation as a place to work or receive treatment
KF31. Staff confidence and security in reporting unsafe clinical practice

3.7 Workforce planning

The Trust undertakes a robust approach to workforce planning by which it ensures that we have the right number of people in the right place and with the right skills at the right time. Our approach to workforce planning is to make sure that we align the workforce to the work, not the other way round.

In terms of nursing recruitment, 2017 was a very successful year, where nurse vacancy levels reduced from 16% to 2%. However due to service expansion it is becoming more difficult to recruit into our services.

The Trust workforce of registered and unregistered professionals expanded considerably during 2017 due to the opening of 4 newly commissioned services. These were the Psychiatric Intensive Care Unit, Healthy Minds Lincolnshire, Psychiatric Clinical Decisions Unit; and the expanded Home Treatment Team, where a total of 95 additional staff were recruited between July – December 2017.

Additionally, 32 newly qualified nurses were appointed from Universities across the region, including Lincoln, Staffordshire, Sheffield, Nottingham and Hull. This was a result of a dedicated recruitment campaign in October 2016, which was repeated in October 2017, to
secure newly qualified nursing staff for a start date of September 2018. To date, 44 ‘Conditional’ job offers have been accepted.

The planning of the workforce for now and the future is a Trust priority and a number of projects are currently underway to address shortfalls in key professional areas and also the risks around our ageing workforce. The Trust is also working closely with Health Education England and the STP in the development of new roles across our services including:

Physician Associate – LPFT is piloting 3 roles within inpatient areas and assuming these roles are a success, looking across the Trust’s 14 inpatient areas, it would be reasonable to look at an expansion to 14 by 2021.

Medical assistants - LPFT is recruiting to 3 posts within inpatient areas as a pilot. Again assuming these roles are a success, there would be 14 by 2021.

Non-medical prescribers (NMP) - The Trust employs nurses with NMP status however there are discussions on dedicated NMP roles across our services and plans are currently being finalised to confirm where the posts will be located.

The Trust is finding it difficult to recruit medical staff and uses a large number of agency and bank Doctors. The vacancy rate currently stands at 20%. However LPFT has acknowledged that the attraction and retention of our medical workforce is a risk and has implemented a number of incentives, including the payment of a home to work travel premium to Speciality Doctors and Consultants. To address the recruitment problem, LPFT is exploring overseas recruitment but this is at an early stage.

LPFT continues to work as part of the local workforce action board (LWAB) with the Head of Workforce Planning & Recruitment chairing the attraction strategy project group. The group has participated as a ‘NHS Lincolnshire Collaborative’ in several national recruitment events which have been beneficial in attracting both medical and non-medical staffing to enquire further about opportunities in Lincolnshire.

The Trust, as part of the East Midlands collaborative, was awarded a pilot site for the implementation of the new Nursing Associate role (from January 2017). The Trust sponsored five non-registered staff to commence as trainee Nursing Associates from January 2017 and is delighted to have sponsored a further five to commence their Nursing Associate training from January 2018. There is considerable work underway within clinical divisions’ workforce planning to support the successful integration of the Nursing Associate role from January 2019, when the first trainees will register with the NMC. In addition, the
Trust has continued to invest in its nurse training secondment scheme, sponsoring a further five healthcare support workers to undertake their nurse training with the University of Lincoln during 2017/18.

The Trust’s Bank Staffing Unit (BSU) is now well established and works closely with clinical divisions to recruit Nursing, AHP and health care support workers to the Bank; and to provide a reliable effective service aligned to NHSI agency rules. Increasingly the BSU, Healthroster and the clinical divisions are using intelligence to better anticipate staffing needs and plan cover as early as possible. This work has been supported by the Trust’s involvement in a number of NHSI programmes and pilots over the past year, including Care Hours per Patient Day (CHPPD), rostering; and early work with the Mental Health Model Hospital.

The nursing workforce, who represent the largest single professional group within the Trust, successfully implemented nurse revalidation from April 2016, since which time no staff in scope have failed to meet the revalidation requirements. The Trust continues to have an active Nursing Workforce Council, a representative voice of nursing and care staff (all bandings), which supports consultation, embedding and celebration of nursing and care initiatives. The Trust also has an active and highly valued Allied Health Professional (AHP) workforce; and was delighted to host a highly successful AHP conference in 2017.

Safe staffing levels on inpatient wards continues to be a high Trust priority, with safe staffing reviews ensuring a high level of multi-disciplinary engagement and professional judgement. The Trust has continued to invest in a safe care system, which supports the monitoring of safe staffing aligned to patient acuity using the mental health staffing framework guidance model developed by Dr Keith Hurst.

3.8 Leadership

There is considerable work taking place in relation to Leadership and Organisational Development within the Trust. Attendance for the lower banding programmes continues to be low and we will explore the reasons for this and adjust our offering accordingly. In the next 12 months, work on the design and delivery phase of NHSI Culture and Leadership Programme will be a priority for the Leadership team; as will developing and embedding an approach to service improvement. As part of this work we are reviewing the Trust’s vision, values and behaviour framework and our approach to appraisal’s and talent management. We now have robust benchmark data in place so that we can start to measure ourselves annually, to demonstrate impact and return on investment as our team continues to respond to the need of the organisation and wider STP requirements. Focussing on reducing turn over and sickness will be a priority for OD/HR in the next 12 months.
This year we moved away from masterclass provision, to dedicated leadership cohort training, as from the data and feedback collected from staff this was the approach that was needed. Below is a detailed summary of each of the programmes including attendance and evaluations.

**Bands 2-4 Development Programme**
2 programmes - 12 attendees. Overall people felt more motivated, confident and knowledgeable to perform their roles, with a significant rise in their knowledge and confidence.

**Band 5 Development Programme**
4 programmes - 30 attendees. Overall the delegate’s motivation, confidence, skills and knowledge increased significantly.

Again low numbers have been identified and discussion held at ODC in November 2017 and a decision made to reduce this programme to 2 a year for 2018.

**Ready Now B7 Programme**
3 cohorts run with 45 attendees. Those currently in B7 roles are prioritised for this programme.

**Coaching**
We have 10 trained coaches within LPFT and an internal website informing staff of advantages of coaching, personal biographies of our coaches and the various tools, techniques and resources available for coaches and coachees. Coaching is coordinated through the leadership team and this year we have had 39 people access this. Break down by division below:

<table>
<thead>
<tr>
<th>Division</th>
<th>Corporate</th>
<th>Adult Community</th>
<th>Adult Inpatient</th>
<th>Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist</td>
<td>16</td>
<td>7</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Adult Inpatient</td>
<td>7</td>
<td></td>
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</table>

**Mary Seacole Course - Local**
Lincolnshire is one of 3 sites within the East Midlands chosen as a pilot to deliver the National Leadership Academy’s programme at a local level. This is a pan- Lincolnshire Health and Social care offer. We are now on cohort 7 within Lincolnshire and are being recognised nationally for the successful roll out of this programme. Our 96% success rate is significantly higher than the national average of 80%.
**Team Development**
The Leadership team have facilitated 10 team development days throughout 2017, capturing 116 staff.

Teams we have facilitated:

<table>
<thead>
<tr>
<th>Learning disabilities</th>
<th>Pharmacy team</th>
</tr>
</thead>
<tbody>
<tr>
<td>North CAMHS</td>
<td>Quality and safety team</td>
</tr>
<tr>
<td>The Vales</td>
<td>The Wolds</td>
</tr>
<tr>
<td>Brant ward</td>
<td>Bank staffing unit (BSU)</td>
</tr>
<tr>
<td>Social workers</td>
<td>Older adults</td>
</tr>
</tbody>
</table>

We have worked with them on issues such as innovation, service redesign, role clarity, team objectives & team dynamics.

**Appraisal Training**
We have facilitated 5 training days and these are split into training for managers and staff. 57 staff have attended this.

**Service Improvement**
Using service improvement methodology as an approach to continuous quality and safety has widely been recognised as an essential component of Health and Social Care. To support the Trusts quality priority 2 work streams are in place:

1. We are providing a series of workshops to staff from across the 5 divisions to consider useful tools and more importantly consider how we will create the capacity and culture to embed service improvement.

2. Secondly, we have drawn down on the apprenticeship levy, as it is currently being underutilised, to provide a 12 month certificated programme to 20 of our staff, to ensure that we are building capability in our workforce. This training starts in April 2018 and the attendees will be determined by the above group.

**NHSI Culture and Leadership Programme**
A major piece of work undertaken by the OD and Leadership department this year has been the NHSI Culture and Leadership programme. As a result of this we are now in the Design phase, which involves, reviewing and co-producing our vision, values and behaviour framework and the appraisal process, with staff, patients/service users and carers. The outcomes of which will be embedded in values based recruitment, induction, all training and during annual appraisal reviews. Enabling people to have more meaningful conversations around service user care, performance and behaviours.
We are also looking at what skills all our leaders need in the organisation, given the variation in leadership competencies identified. We will then be devising a range of interventions to equip our leaders in these areas.

3.9 Restrictive intervention (RI) reduction

There has been investment by the Trust Board of an RI Team Leader to lead the strategic and operational requirements for the Trust in respect of reducing the need for RI and this post was appointed to in June 2017. The Trust’s RI Team now consists of the RI Team Leader and a Clinical Lead for RI. These roles manage the operational component of a network of seventeen instructors across the Trust. The instructors have full-time jobs within the Trust and as part of their work have also trained as RI instructors. The RI instructors’ practice is affiliated to General Services Association, one of the leading providers of RI training.

Early priorities for the RI Team Leader have been identified as follows;
To ensure Trust policies relating to RI are fully aligned to a strong and current evidence base. The CQC in its comprehensive inspection of Trust services (April 2017) identified some minor actions in respect of this. This priority is now complete with amendments made to existing policy to reflect the CQC requirements. A further priority for the year 2018 / 2019 is to completely review the existing policies to align with a reflective and positive behavioural philosophy.

To develop a Trust-wide Restrictive Intervention Working Group (RIWG) to progress actions relating to this work stream within operational divisions. This priority is complete with an RIWG meeting on a monthly basis.

To progress a number of pieces of work through the RI Team and through the Trust-wide RIWG including:

- Reviewing RI related Datix incidents and identification of trends, including supporting learning related lessons. A full review of the Datix reporting system for RI has been carried out and early indicators are that the data quality is improving which will enable more efficient and accurate compilation of trends.
- Reviewing of RI training, including alternatives to current modelling and strategies to support full training compliance across clinical in-patient teams. To date risks and
issues relating to the current model have been included in a presentation to the Quality Committee.

- Reviewing of RI trainers’ structure to ensure adequate resource is available.
- Working to embed Positive Behavioural Support Plans, or the equivalent, in line with the Mental Health Act Code of Practice (Revised 2015).
- Reviewing the current debrief Trust process and establishment of a more robust process and structure. Funding has been secured to enable Debrief Training to be provided to designated professionals.
- Developing the RI site on Trust’s intranet site to ensure it is easily accessible and kept up-to-date.

The priorities relating to reducing the need for RI in the Trust are driven, and underpinned, by NICE Guidance NG10, The Mental Health Act 1983 (Revised 2015), CQC Regulations and Department of Health Positive and Proactive Care: Reducing the Need for Restrictive Intervention (2014).

Reducing the need for RI should support a number of positive impacts including the following:

- Patient and staff therapeutic relationships.
- Patient and staff safety due to the promotion of a more collaborative approach and a reduction in incidents of conflict, with the potential risk of injury.
- Patient experience of the services provided, resulting in a reduction of complaints and more positive feedback including through the Friends and Family Test.
- Staff experience of their roles due to improvement in the therapeutic approach and environment.
- Recruitment and retention of staff due to an enhanced job satisfaction and a reduction in anxieties experienced in volatile environments.
- Financial impacts due to a reduction in claims for damages, both physical and environmental; and due to staff sickness and bank and agency use due to staff absence and vacancies.
- The reputation of the Trust locally and nationally.
- Improvement in inspection outcomes, such as CQC.
- A culture of learning from incidents with a structure through which best practice can be cascaded and facilitated.
It is fully expected that an adjunct to the work, as it progresses, will be an increase in incidents reported. The impact of a healthy reporting culture is regarded by The National Patient Safety Agency as:

Trusts that report incidents regularly suggest a stronger organisational culture of safety. They take all incidents seriously and link reporting with learning.

Progress of identified priorities will be reported quarterly to the Patient Safety and Experience Committee, with highlights and exceptions to the Quality Committee where appropriate.

### 3.10 Divisional teams quality improvement

**Adult Inpatient Division**

*Improving patient experience of, and engagement with, observations within inpatient units.*

The aim of the project was to deliver an improved experience for the most vulnerable hospital inpatients, to measure and monitor the cost of one to one care, and to improve the quality and patient experience of one to one care.

The project team initially focused on trying to reduce the frequency and duration of observations but after working through a couple of weeks' worth of data we realised that we needed to shift our focus. We began to look at the quality of engagement when people are on observations and developed two surveys; one for staff and one for service users who have been involved in observations. This would help us to focus our project on training as most staff identified that they did not feel they received enough training to prepare them for undertaking observations. We filmed a short training video for staff which will be rolled out for use on induction and also can be sent as a link for staff to watch on their smartphone or desktop computer.

Alongside this, we also looked at improving the resilience of the workforce. One of the wards in particular were having a high level of 1:1 observations and they are now having weekly debriefs facilitated by a member of staff from outside the ward. We have also arranged safewards training to ensure that all staff have the awareness needed to develop this culture on the wards.
Plans for further development:

- We are hoping to be involved in piloting an observation review tool which has been developed by another Trust (2gether Trust) which will help to inform when a service users observation levels are reduced.
- We would like to develop lanyards with information about engagement on them for staff undertaking observations as a guide to the kind of activities they might engage a service user in and where to find them (useful for bank staff.)
- We will need to revisit the surveys periodically to ensure that we are making improvements and to capture any other opportunities for improvement.

Improving patient experience – Supporting individuals to receive the care they need closer to home

The division has opened 2 new services and expanded the existing Bed Managers Service over the last 9 months with the combined aim of reducing the number of out of area placements so that patients are supported to receive the treatment they need closer to their homes. A Psychiatric Intensive Care Unit (PICU) for male patients opened to patients in June 2017 and the Psychiatric Clinical Decisions Unit opened to patients in January 2017. The reduction in out of area admissions is illustrated below (2 data areas are missing due to i. failed inputting and ii. National cyber-attack upon IT systems):

![Graph showing reduction in patients receiving treatment in out of area beds](image)

The reduction in male patients being admitted to out of area PICU beds is illustrated in the graph below (1 data area is missing due to the National cyber-attack upon IT systems):
Learning From, and Improving, Carer Experience

The Trust has a keen desire to improve and sustain its relationship with carers and wanted a systematic and process focused way to address the needs of carers.

The introduction of the Care Act 2014 and the required need to offer Carers Assessments was recognised as one of the areas that the Trust needed to improve upon and feedback from Carers recognised that they were not always routinely involved in their loved ones care.

By joining the Triangle of Care the Trust was afforded the opportunity to engage in a process that included Carers routinely as part of the patient journey and afforded Carers a voice in the transformation and development of practice.

Stage one of the Triangle of Care was successful within inpatient wards and crisis teams across the Trust and we were awarded our first star in April 2017. This does not mean that the work and progress is not continued and the work continues in trying to successfully engage carers in the patient journeys. The second stage of the Triangle of Care is now ongoing in the Community teams within the Trust and the Steering groups for inpatients and crisis teams continue across the Trust to build on the work we have already done as there is an expectation that when the Community teams submit their evidence to gain the second star that Inpatients and Crisis teams will also submit their evidence of their continued progress.

Progress so far:

- The roll out of the Carer Awareness e learning/DVD package to all teams across the Inpatient and Crisis teams and this to be shown on Inductions to the Trust for new staff.
- The roll out of the new Information packs for all inpatient wards to be disseminated and sent out to all Carers currently in inpatient services or crisis services.
• Changes to recording systems to include special carer circumstances
• New Carer group started in the Boston area has had sporadic attendance so enhanced advertising required and engagement of Community teams to promote this.
• Carer Governor and Director of Nursing giving Strategic lead to the Triangle of Care across the whole Trust
• More formalised Carer feedback from wards to be sought as little returns from questionnaires. Consideration to be given to uploading feedback form onto the ward iPads.

The framework provided by the Triangle of Care has given the wards and crisis teams a standard to aspire to and uniform some of the approaches and information given

Older Adults Division

The older adult services are undertaking a number of quality improvement projects across the division and progress is reported through community and inpatient meetings with overall monitoring through service wide divisional management meeting.

<table>
<thead>
<tr>
<th>Making the patient journey safe; recognizing and responding to increased distress in patients with dementia through use of a sensory toolkit</th>
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<tbody>
<tr>
<td><strong>Background:</strong> Violence and Aggression (V&amp;A) across the older adult wards had been on the increase with the service rating in the top 5 across the country. Bank and Agency spend to support 1:1 due to violence and aggression was increasing; staff burn out and turnover was high due to ‘burden’ of caring. Research and evidence outlines that a person centered approach and care planning can reduce the incidences of violence and aggression through targeted interventions, support and environmental changes.</td>
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<tr>
<td><strong>AIM:</strong> To reduce V&amp;A on older adult wards by 20%. Commencing with Langworth ward.</td>
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<tr>
<td><strong>Methodology:</strong> Base line audit developed for V&amp;A; sickness and staff turn over Development of driver diagram with clinical team to set priorities Ward Engagement team developed to support buy in and sustainability.</td>
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<tr>
<td><strong>Expected or actual Outcomes:</strong> Reduction in violence and aggression; Bank Staff/Agency spend reduced; Improved engagement in meaningful activity; Improved patient experience, positive carer feedback and impact on complaints; Improved retention and staff satisfaction.</td>
</tr>
<tr>
<td><strong>Updates:</strong> Overall reduction in violence and aggression on Langworth ward which is monitored monthly; reduction in bank and agency spend; Nomination for national and local awards. Project revisited through inpatient working group to support and monitor embedding of actions and outcomes. Project has now been rolled out to Manthorpe Unit as a PDSA cycle with some refinement in the methodology</td>
</tr>
</tbody>
</table>
A change in culture; Safe and Effective Handovers to support care in older adults

**Background:** Nursing handovers remain an important traditional ritual in nursing. Timely and effective handover of critical information ensure continuity of patient care and safe delivery. Nurses rely heavily on information gathered from handover sessions to prioritise and make clinical decisions that impact patient care. A review of Serious Incidents outlined that issues remained with quality of information being handed over and that tasks were not being completed in a timely manner resulting in unnecessary delays in care. Anecdotal feedback on wards also highlighted dissatisfaction in some areas and variance in tools and style across the division.

**Aim:** To improve quality in nursing handover – demonstrated improvements against baseline audit and post follow up audit; (Improvements in efficiency (time); comprehensiveness of information; consistency)

**Methodology:** Meeting with ward managers to define main concerns and establish top 5 priorities for quality improvement

Driver diagram developed with ward managers

Pre- audit data was developed to establish a base line against which project can be evaluated using survey monkey for each individual ward e.g (snap shot of Langworth ward. A total of 70 staff have participated in the audit giving a good baseline to monitor improvement outcomes.

Base line audit of the time for handover was undertaken in each of the inpatient wards using a simple flip chart paper in handover room to record time; interruptions and number of staff handed over to.

Inpatient working group established to support improvements and ownership at local level

Development of SBAR tool based on staff feedback and comments

Implementation plan developed to support roll out

**Expected or Actual Outcomes:** Development of handover tool across OA division

Improved staff satisfaction with handover process; reduction in number of interruptions

Development of expected standards to support qualified staff and new starters

**Update on Progress:** project ongoing; SBAR tool developed and currently out with ward teams for consultation and refinement; PDSA pilot for one week planned once tool agreed before full roll out; Senior nurse engagement at ward level to support roll out and embedding; Further review at 3 months using base line measurements to monitor progress

**Seeing the patient as a person; Development of person centred care planning within older adult wards**

**Background:** Creating the care plan with the person or their chosen representative keeps the focus on what is important to that individual and will enable their care and support to reflect this. There are national drivers calling for person centred care. In 2013, the Department of Health and all the system leading bodies across health and social care in England declared a shared commitment to making ‘person-centred coordinated care’ the norm. A recent report by National Voices entitled Person-centred care in 2017; Evidence from service users’ (2017) concluded that there was little or no evidence nationally to suggest that this was embedded or that family and carer engagement was central to care planning processes. Research shows that people who understand their health conditions
and who are actively involved in decisions about their own care are more likely to value
treatment programmes and have better outcomes. Recent CQC reports highlighted that
this was absent in older adult services highlighting the need to make improvements to
support the patients voice and goals being key to in their inpatient journey. Baseline
patient and carer audit demonstrate lack of person-centred care planning and patient
engagement.

**AIM:** For every older adult inpatient to have a person centred care plan which actively
involves them and their support systems

**Base line measures put into place; Pre Project:** staff feedback on care planning skills
confidence and time (process measure); 5 questions to carers/patients –engagement
(outcome measure). Base line care plan audit (outcome measure); 1:1 audit and review
(outcome measure)

**Post Project:** staff feedback questionnaire; care plan audit; CQC feedback; 1;1 audit and
MDT audit (Process measure); patient survey
Implementation plan developed to support staff engagement through workshops and
person centred care planning sessions across the service

**Expected or Actual outcomes outcomes:**
Every patient to have a person centred care plan in place at post audit;
Evidence through outcome measures of patient/carer engagement through patient and
carer feedback sessions;
Evidence of service protocol for expected service standards for care planning;
Triangulation of care planning into MDT and handover –(through audit);
Improvement on baseline audits.

**Update:** Staff feedback has been completed looking at current care planning process and
skills and confidence. Patient and carer sessions completed across all 4 wards to review
engagement and understanding of care planning. Draft care plan template developed on
feedback focusing on strengths of patients. Next step is to take template back out to staff
and seek feedback. Gain feedback from carers and service users on template. Pilot on
one dementia and one function ward as a PDSA process. Review, amend and roll out
across the service.

**Implementing a bespoke band 6 leadership programme to support clinical
leadership focusing on quality improvement within inpatient services**

**Background:** Leadership within older adults had been picked up within previous CQC
reports and quality themed visits through lack of understanding. The Francis Report ‘The
treatment the team receives from their leaders will have a strong impact on how they treat
other people’. Recent HR investigations within the division highlighted an absence of
clinical leadership behaviors at ward level and lack of clarity in respect to roles.
**Aim:** Strengthen leadership at ward level.

**Methodology:** base line ‘360 degree’ appraisals with all band 6 leaders to support
identifying areas of development. Established starting point with each and 6 by leadership
team and to be reviewed post project whether goals have been achieved. Each member of
staff has a quality improvement project to identify at the beginning of the project

**Baseline measures:** This will be evidenced by attendance; % of supervision compliance
as this incorporates a review of risk assessment and care planning reviews; Sickness
**Performance; number of signed off Datix; Ward Manager feedback; 360 Appraisals; Initial QI project plans; Records Management Audit**

**Outcome Measures:** Ward Manager Feedback; Candidates feedback; Programme Evaluation; QI project outcomes; Records Management Audit to demonstrate improvement in service KPIs; Coaching and mentoring for each band 6

**Expected or actual outcome:** Clearer clinical leadership at ward level; Improvement in patient journey; Identification of future ward managers. On-going band 6 reflective peer support group

**Update/Progress:** Leadership programme has commenced in January; Base line assessments completed; Positive engagement from Band 6 leaders; ‘360 degree’ appraisals completed; QI projects identified at first meeting; Band 6s invited to inpatient quality improvement meeting Monthly for ongoing support and mentoring. Coaches identified across the organisation for staff.

**Other Quality Improvement Projects currently being scoped:**
- Therapeutic engagement and 1:1 time
- Clinical Pathway development across functional pathways
- Role of named/associate nurse
- Implementation of post fall huddles
- Nurse Led MDT approaches
- Weekly board Huddles to support patient journey
- Increasing carer engagement across the service
- Third sector engagement in clinical pathways

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**Specialist Services Division**

In 2016 NICE released guidance for the use of antipsychotic medication in people with behaviour that challenges which reinforced the national 2015 STOMP agenda (Stopping over-medication of people with a learning disability, autism or both). In line with the national agenda the learning disabilities service looked to initiate work to reduce antipsychotic medication. The East team hub put themselves forward as an early implementer of this initiative. A baseline audit was undertaken by a Consultant Psychiatrist and the East team to investigate if the total dose of these medications, for challenging behaviour without any comorbid psychiatric disorder, could be reduced.

The target was to reduce by 50% the total dose of antipsychotic medication prescribed in 50% of this population over a one year period. Though this target was not reached, significant progress was made: a reduction in dose was made in 49% (39) of the Consultant Psychiatrist's eligible patients, and a 50% reduction was made in 27% (21) of the patients. Antipsychotics were successfully completely withdrawn in 6 patients. The multi-disciplinary approach within this project has been instrumental in maintaining people within their own homes and community setting, supporting both patients and families to make the reductions in medication, whilst establishing more appropriate ways to address behaviours of concern.
Progress with reducing these medications continues, and it is anticipated that the numbers having a reduction/cessation will continue to rise with time.

Following the success of this quality improvement initiative, the service is now working on a roll out project across the other 3 hubs within the county. The service currently has a Band 7 NMP post out to advert in order to support this initiative moving forward across the county, providing increased capacity within the system to achieve the outcome aim.

Improving mental capacity act (MCA) processes has been a major target area of the Learning Disabilities services during the past year. Ensuring that the assessment paperwork is fit for purpose is a key focus of this work. The assessment tool has been redesigned to ensure that it is fit for purpose for all disciplines within the services. A fundamental part of the redesign was to ensure that the capacity to consent to treatment is clearly documented at the first contact with the service user. Further to this, the development of the staff group has been supported by LPFT’s safeguarding team in the form of four focussed masterclasses in mental capacity and best interest assessment (BIA).

A baseline audit has been undertaken focussing on both the quality and completeness of MCA assessments and subsequent BIA paperwork with the Learning Disabilities service. The outcome of the audit was fed back to staff at the LD away day in February. Workshops at the away day will have a further focus on MCA to reinforce the masterclasses and use of the new paperwork. A six month follow-up audit is planned for June 18 to ensure embeddedness of the process.

The inpatient CAMHS service has commenced a piece of work to look to reduce the number of self–injurious behaviours that occur whilst an inpatient on the unit. The number of incidents currently occurring are the highest of all inpatient units within the Trust. Whilst the staff do an excellent job of managing these presenting behaviours the service would like to see a reduction in the number and frequency of these incidents. A piece of work has been established to gain baseline data as a part of an improvement project with the aim of reducing these incident types. A process of thematic review of incidents is being utilised to start to produce ‘line plots graphs’ of the time of incidents, ‘measles chart maps’ to identify whereabouts of incidents and ‘cluster graph’ for incident types. Once this baseline data is fully established, the service will utilise the information to test improvement initiatives under the CQI approach during 2018-19.

The division successfully recruited a peer support and involvement project lead within Lincolnshire community CAMHS service which commenced in July 2017. A key outcome for
this role was to establish a paid peer role to work within the community CAMHS service. Early work took place to establish a clear job role for people who had recent lived experience of receiving a CAMHS service. An essential element of the development was building the training and support that would underpin the employment of young peers to ensure the role would be a success. A project group was formed to ensure that the project gained the expertise from the right departments within the Trust and Workforce, HR and the Learning and Development teams provided their experience and support to the group. The development of an attractive and clear job description, combined with targeted marketing of the job advert led to the project lead receiving 150 applicants for four whole time equivalent posts. The mammoth task was undertaken to short list from such a large volume of worthy candidates and this recruitment process concluded in employing six individual people, with combination of full time and part time positions making up the four whole time equivalent posts. All the post successfully commence in employment in November 17 with a full and robust induction and training plan. The peers are currently just commencing face to face working and establishing their roles within the CAMHS teams. Accredited training is booked for both the peers and their supervisors, which will take place during Q4.

North East Lincolnshire (NEL) CAMHS were successful in attracting Trust innovation monies to create a user friendly Wellbeing Passport. The Passport pulls together the information that a young people wishes to know about them at the same time as acting as being a tool to plan their care, ambitions and successful exit from service. The plan is designed to be owned by the young person and become a tool that they can use beyond CAMHS if they wish. The two NEL staff that successfully won the innovation monies facilitated a working group of young people to design the passport. The passport is currently in a trail stage within the team with a planned full role out in Q4. The paper passport was intended to be only phase one in the design and the service is hoping to attract further monies to develop this into an ‘app’ during 2018-19.

The establishment and launch of the young person emotional and wellbeing service for Lincolnshire, Healthy Minds, has proved to be a great success and has been received very positively by partner children’s services and stakeholders. The early demand for the service outstripped expectation with 745 referral for children, young people and their families since 16th October 2017. Positive and proactive leadership within the service has supported this newly established workforce to cope well with the demand. The planned staged rollout of the service will see the introduction of training programmes for teachers and other professionals working with children and young people over the coming months.
Adult Community Division

ACOMHS- Accreditation for Community Mental Health Teams

ACOMHS is an accreditation service for teams that provide treatment and care for people with a spectrum of mental health problems, ranging from common and limited conditions through to those that are complex, enduring and severe. The inception of community mental health teams and centres in the early 1980s brought a new way to deliver care and treatment to people in, or close to, their own homes. Since that time there has been a dearth of standard-setting specific to community mental health teams. The ACOMHS standards now offer a means to support benchmarking and quality improvement.

These standards are designed for adult community mental health teams and can also be applied to specialist community mental health teams such as those for older adults, forensic settings, people with intellectual disabilities, rehabilitation and so on. They form a ‘core’ based on the shared qualities and attributes of these teams. For example, all services are concerned with providing timely access to assessment, care and treatment delivered by competent, caring and compassionate staff.

The Grantham CMHT have signed up to undertake the accreditation process and have been preparing evidence to meet the standards. The standards cover thirty-one areas which include the care pathway through services, collaborative and inclusive practice, service user and carer participation, staffing, team working, training and supervision, and audit and service evaluation. The standards endeavour to reflect exemplary practice in mental health care by drawing on new policy and recent insights into best practice such as; promoting physical health, working within a recovery ethos, and providing psychological and psychosocial therapies.

We have produced the following newsletter which is sent out to all of the CMHT’s which gives examples of changes in practice to meet the standards:
We have gathered sufficient evidence for the following:-

| NO | STANDARD | | GOOD NEWS |
|----|----------| | | |
| 1.2 | Clear information is made available, in paper and/or electronic format to service users, carers and healthcare practitioners | | The waiting list for assessment in GRANTHAM was 80 days, this has been reduced to individuals being assessed within three weeks. |
| 1.3 | A clinical member of staff is available to discuss emergency referrals during working hours. | | | |
| 1.4 | Where referrals are made through a single point of access e.g. triage, these are passed on to the community team within one working day | | A new template letter for assessments has been created by staff and service users, to be used by all staff within CMHT. |
| 1.5 | Outcomes of referrals are fed back to the referrer, service user and carer (with the service users consent). If a referral is not accepted, the team advises the referred, service user and carer on alternative options | | The CMHT page on the intranet has been updated in line with current processes |
| 1.6 | Acceptance to the service is based on need and risk, the services not use specific exclusion criteria | | The CMHT service leaflet has been updated with clear information for service users and carer. |
| 1.7 | There is sufficient car parking for visitors to the service | | | |
| 1.8 | Everyone is able to access the service using public transport or transport provided by the service. | | |
Under this standard, we can provide evidence for:

<table>
<thead>
<tr>
<th>No</th>
<th>STANDARD</th>
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<tbody>
<tr>
<td>4.1</td>
<td>Service users have a comprehensive assessment which includes their-</td>
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<tr>
<td></td>
<td>1. Mental Health and medication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Psychosocial needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Strengths and weaknesses</td>
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<tr>
<td>4.4</td>
<td>An assessment of practical problems of daily living is recorded.</td>
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<td>4.5</td>
<td>Service users have a risk assessment that is shared with relevant agencies (with consideration for confidentiality) and includes a comprehensive assessment of</td>
<td></td>
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<tr>
<td></td>
<td>1. Risk to self (including self-neglect)</td>
<td></td>
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<tr>
<td></td>
<td>2. Risk to others</td>
<td></td>
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<tr>
<td></td>
<td>3. Risk from others</td>
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<tr>
<td>4.6</td>
<td>The team discussed the purpose and outcome of the risk assessment with the service user and a management plan is formulated jointly.</td>
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<td>4.7</td>
<td>The service user is asked if they have a carer and if so, the carer's name is recorded.</td>
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<tr>
<td>4.8</td>
<td>Any dependants are identified and recorded, including their wellbeing, needs and any childcare issues.</td>
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<tr>
<td>4.9</td>
<td>Staff members are easily identifiable (for example, by wearing appropriate identification)</td>
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<tr>
<td>4.10</td>
<td>Staff members address service users using the name and title they prefer</td>
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The ACOMHS accreditation programme is designed to work with staff to assure and improve the quality of community mental health services for people with mental health problems, and their carers. It engages staff in a comprehensive process of review, through which good practice and high quality care are recognised, and teams receive support to identify and address areas for improvement.
These standards have been developed in consultation with a range of professionals, carers and service users. The process of creating the standards was guided by staff from the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). The names of the individuals involved are listed overleaf and we are incredibly grateful for the input, enthusiasm and support they have given to the programme. The Grantham CMHT are expecting the Peer Review on the 4th May 2018. There are a further two CMHT’s who have now signed up for the accreditation Spalding and Lincoln South.

3.11 Sign up to safety

Sign up to Safety is a national patient safety campaign that was announced in March 2014 by the Secretary of State for Health with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The ambition was to halve avoidable harm in the NHS over the subsequent three years, and save 6,000 lives as a result. Sign up to Safety applies to every part of the NHS in England.

Organisations who Sign up to Safety commit to strengthen patient safety by:

1. Setting out the actions they will undertake in response to the five sign up to safety pledges and agree to publish this on their website for staff, patients and the public to see.
2. Committing to turn their actions into a safety improvement plan (including a driver diagram) which will show how organisations intend to save lives and reduce harm for patients over the next three years.

The five Sign up to Safety pledges are:

1. **Putting safety first.** Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans.
2. **Continually learn.** Make our organisation more resilient to risks, by acting on feedback from patients and staff and by constantly measuring and monitoring how safe our services are.
3. **Being honest.** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
4. **Collaborating.** Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
5. **Being supportive.** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.
The Trust’s safety improvement plan was developed in partnership with our lead Commissioners (South West Lincolnshire Clinical Commissioning Group) and in consultation with our clinical services.

This is the final year of the Trust’s original safety plan and as such completeness and accuracy of data will be reviewed at the end of quarter 4 2017/18 and presented within the final version of this report.

The 3 areas are outlined below.

**Action area 1**
Seven day follow up of patients on CPA

**Measure:** Increase over three years the % of patients seen within 48 hours of discharge.
Target is increase by 10%.

The graph below shows the % of patients seen within 48 hours of discharge from the 3 adult inpatient wards (excluding S140 beds). The year average is 55% compared to 58% in 2016-2017.

The quality and safety team leader and crisis home treatment service manager have further reviewed data and identified that a significant number of cases which were not followed up within 48 hours were due to DNAs, clinical system and data inputting issues and patients transferring/staying with relatives out of area. The bed management team support both the wards and the crisis teams in ensuring that all 7 day follow ups are proactively perused. Data
reported earlier within this report (section 2.2.9) evidences that seven day follow-up target thresholds continue to be achieved. Work is being undertaken with Acute and Crisis service team managers to review current pathways and identify any further strategies that can be utilized when patients do not wish to engage with the crisis team.

**Action area 2**

**Risk assessment in CRHT teams** – Improve the consistency and collaboration with patients and/or carers in quality of risk assessments care planning for patients under CRHT teams.

**Measure:** Increase over three years by 10% the number of risk assessments and care plans for patients under CRHT that evidence patient involvement.

All 4 CRHT teams have continued to demonstrate a sustained improvement during 2017/2018. Audits were undertaken in Quarter 1 and Quarter 4 and evidenced 87.5% and 100% respectively of patient involvement in risk assessment and risk management plans.

**Action area 3**

**Inpatient medication errors and issues** - Safe administration of medication in inpatient areas, so preventing potential patient harm.

**Measure:** To achieve 10% reduction) in number of inpatient medication errors and issues.

The numbers of medication incidents which have caused harm have decreased for the third consecutive year, from 9 moderate incidents reported during 2015/2016, to 3 moderate incidents reported during 2016/2017 and 1 moderate incident in 2017/2018. The total number of medication errors reported Trust wide has increased from 184 in 2016/2017 to 196 in 2017/2018. All incidents have been reported to National Reporting and Learning System (NRLS). Ongoing work continues Trust wide and the Modern Matron for adult Inpatient is leading on medication errors and issues. Bi monthly locality medicines management meetings are taking place with Adult, Older Adult and Specialist inpatient services. In addition, quarterly meetings with all inpatient service nursing and pharmacy colleague’s is supporting the reviewing of incidents, identification of trends, themes and learning lessons. EPMA implementation is pending and will significantly support a reduction in the number of medication errors and issues.
3.12 Duty of candour

Every healthcare professional must be open and honest with service users/patients. Every NHS trust, since November 2014, has a statutory duty of candour.

Candour is defined by Sir Robert Francis as: ‘The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made’.

The being open principles and ethical duty of openness apply to all incidents and any failure in care or treatment. The duty of candour applies to incidents whereby moderate harm, severe harm or death has occurred.

The Trust wants to make this duty a reality for people who come into contact with our services. We want to ensure there is clear, strong organisational support for staff to follow their ethical responsibility in being open and honest with service users/patients. While the duty applies to organisations, not individuals, it is clear that individual NHS staff must cooperate with it to ensure the duty is met.

Our approach to candour underpins a commitment to providing high quality of care, understanding and sharing the truths about harm at an organisational as well as an individual level, and learning from them. It is about our organisational values being rooted in genuine engagement of staff, our clinical leadership building on professional accountability, and on every member of staff’s personal commitment to the safety of service users/patients.

During 2017/18 the Trust commissioned bespoke training for up to 50 employees to support further understanding and commitment to the statutory requirement in relation to mental health.

The statutory requirement has been met for all incidents meeting the threshold.
3.13 Involvement of the Trust’s governors

The Trust’s governors continue to take an extremely valuable and active role in providing the Trust with views and opinions on the services and contributing to the planning of future services. During 2017/18 developments in respect of governors’ involvement include:

- Listening to members of the Trust and the wider public’s issues and working with Trust officers to provide responses to the issues raised.
- Input to public sessions on transformation of mental health and learning disability services.
- Holding the Board to account for the quality standards by receiving regular reports and challenging performance results.
- Contributing the views of members and content to the Trust's clinical strategy, the forward plan and the involvement charter.
- Contributing to the equality and diversity work across the Trust including attendance at related conferences and meetings.
- Receiving training and development in the roles and responsibilities of governors to ensure an effective performance in the role.
- Taking part in the Trust’s 15 steps /quality governance visits as part of inspection teams.
- Engagement with the Trust’s continuous quality improvement work streams through joint Council and Board meetings.
- Contributing to staff recruitment processes
- The Lead Governor is Chair of the Trust’s governors’ Representation Committee.
- Contributing to cost improvement programmes through involvement with quality impact assessment panels.
- Selecting and appointing the external auditors

3.14 Board assurance

The Trust Board is accountable for ensuring all Trust services genuinely and consistently meet the essential compliance standards for quality and safety. The Trust Board ensures it remains well informed and visible across its services. The Board receives detailed quality and risk reports, Board members visit clinical areas and Board members seek additional assurance where there are residual concerns for quality and service user/patient safety. The Board has a robust assurance and escalation process, which ensures its members are promptly informed of any high risk concerns across services. In practice, the Board ensures its accountability for quality and service user/patient safety through mechanisms including the following:
• Setting strategy and policy that is in line with best practice and statutory requirements.

• Ensuring focussed Board time is dedicated to discussion on quality and service user/patient safety issues.

• Effectively monitoring the quality of care provided across all Trust services through critically reviewing internal and external quality and risk reports, including those evidencing benchmarking of the Trust’s services locally and nationally.

• Proactively scrutinising high level risks to quality and instructing prompt mitigating action if required.

• Challenging poor performance or variation in quality and actively recognising quality improvement.

• Supporting critical reviews to identify root causes to both poor and exceptional performance, so ensuring better understanding of factors affecting quality and service user/patient safety.

• Leading effective partnership working with other health and social care organisations, including the STP.

• Role modelling a culture of listening, transparency, visibility and accountability.

• Provide executive sponsorship to all equality and diversity staff forums.

• Actively listening and responding to concerns to ensure early detection of problems, including to allegations of abuse, so reducing the likelihood of serious failings.

• Being accountable for the quality and safety of care provided, so reducing the likelihood of missing early indicators of serious risk.

• Proactively engaging with service users/patients, carers, governors and staff to support good communication from Board level to ward / team level and vice versa.

• Continuing to prioritise hearing service user/patient/carer and staff stories at the Board and proactively seeking any associated assurance required.

• Ensuring the Trust provides its staff with good and safe working environments, where they are free from discrimination or bullying. The Board remains committed to ensuring all staff have clear job descriptions, with defined expectations and work in environments where they are supported to achieve the very best possible for themselves and those they care for.

• Utilising and adhering to the operating principles within the national quality board’s framework to assess the quality impact of cost improvement plans, ensuring that the service user/patient always comes first.

• Undertaking annual appraisals to ensure Board members remain up-to-date, supported and well equipped to undertake their role responsibilities in leading the Trust.
3.15 Highlights of the year

From innovative service transformations to national awards and recognition, the past year has seen many highlights for the Trust:

Achievements

- Following an inspection by the Care Quality Commission (CQC) in early April the Trust was rated Good overall for the services it delivers. This was a result of real focus on continuous quality improvement and positive cultural changes within the organisation. The improvements made have also been showcased in two national reports published by the Care Quality Commission (CQC) looking at the state of care in England’s mental health services and driving improvements in mental health services.
- A brand new 10-bed male psychiatric intensive care unit, the Hartsholme Centre, opened in Lincoln in the summer of 2017.
- Opened the new Psychiatric Clinical Decisions Unit and expanded home treatment teams and bed manager provision to better support patients experiencing severe episodes of mental ill health or crisis and reduce the need for out of area hospital care.
- Healthy Minds Lincolnshire - a new emotional wellbeing service for children and young people launched in October 2017. The service offers support for young people, parents and carers as well as training for professionals in education and children's services.
- Awarded the contract to provide healthcare services as part of a new three year agreement with the 12 bed local authority secure children’s home (Lincolnshire Secure Unit). Which provides services to young people placed via the courts for youth justice or welfare reasons.
- A new team of mental health nurses has been deployed in Lincolnshire Police’s control room to help frontline officers deal with incidents involving mental health issues.
- More staff were vaccinated for the flu than ever before this winter, with around 79% of frontline staff protected. LPFT was the second most improved trust for staff flu vaccination rates.
- For the second year running the Trust achieved a significant improvement on its national NHS staff survey, placing the Trust in the top 10 mental health and learning disability trusts for sustained improvement and performance on staff satisfaction.
- Launched a new Involvement Charter co-produced in partnership with service users, carers, providers, governors and staff. The charter presents how we encourage people to get involved.
Awards

- North East Lincolnshire child and adolescent mental health service (CAMHS) won the specialist service category at the HSJ Value in Healthcare Awards. The learning disability service was also shortlisted for their joint working with South West Lincolnshire Clinical Commissioning Group on their service redesign.

- North East Lincolnshire child and adolescent mental health service was shortlisted in the national Children and Young People’s Mental Health Awards (Positive Practice Awards 2018) for the crisis services award, which recognises a service providing exceptional support and intervention to children/young people and their families at a time of crisis.

- The Lincolnshire Allied Health Professionals (AHP) Strategic Forum, which the Trust has formed with other partners, was a finalist in the first Chief Allied Health Professions Awards.

- Langworth Ward was shortlisted in the national Patient Safety Awards for the team’s personalised sensory toolkit programme and was recognised as good practice in the care for older people category.

- The Trust’s work with carers to implement Triangle of Care in inpatient services was recognised with a Carers Quality Award from Every–One (former Lincolnshire Carers and Young Carers Partnership). The Triangle of Care was also shortlisted for a Nursing Times Awards in the nursing in mental health category.

- Shortlisted in three categories in the HSJ Awards. Langworth Ward was shortlisted for the most effective adoption and diffusion of best practice. North East Lincolnshire CAMHS crisis and intensive home treatment team was a finalist in the specialist services redesign, while Anne-Maria Newham, Director of Nursing, Allied Health Professionals (AHPs) and Quality was a finalist in clinical leader of the year category.

- Zoë Rowe, LGBT+ Visible Leader and Associate Director of Nursing and Quality, was shortlisted in the Employer’s Network for Equality and Inclusion (ENEI) Awards.

- Five staff were nominated by University of Lincoln nursing students for Mentor Excellence Awards. In appreciation to the mentors who helped, supported and taught students whilst on their course.

- Langworth Ward won a Positive Practice in Mental Health Award in the older people’s mental health and dementia category for their innovation project - the personalised sensory toolkit. North East Lincs CAMHS were also highly commended for crisis and intensive home treatment team in the innovation in children and young people’s mental health category for the crisis and home treatment care they provide.

- Payroll shared services won the Rewards 2017 – public sector payroll team of the year.

- Carolyn Wright, an Independent Sexual Violence Advisor, was awarded a Lincolnshire Police Commendation for her work on a rape case that resulted in successful conviction.
The first ever Lincolnshire Media Health Awards were a great success for LPFT staff with payroll shared service winning non-clinical team of the year; Hannah Clements, Specialist Clinical Psychologist winning therapist of the year and Ali Young, Community Support Worker winning healthcare assistant of the year. Langworth Ward was also highly commended in the clinical team of the year category, and Paula Jelly, Veterans Lead was a finalist in the nurse of the year category.

The Ministry of Defence awarded the Trust a Silver Award in recognition of our continuing support for members of the Armed Forces.

Five staff were shortlisted in the national Unsung Hero Awards - Helen McDonald, CAMHS Service Lead Administrator, shortlisted for the everyday hero award. Nick Overton, Head of Capital Projects and Compliance, shortlisted for the leader of the year award. Amy Poole, Apprentice for the Executive Admin Team, and Claudia Richardson, Administrator for the Veterans Service were also both shortlisted for the apprentice of the year award and Rachel-Michelle Jones, Peer Support Worker was shortlisted for the patient's choice award.

North East Lincolnshire CAMHS crisis team was highly commended in the crisis services category at the national Children and Young People’s Mental Health (CYPMH) Awards 2017.

The Trust held its eighth Staff Excellence Awards and recognised 18 individuals and 10 teams at the ceremony in Lincoln.

Zoë Rowe and Tracy Ward made up two of the three finalists on the shortlist for mental health nurse of the year at the 2018 British Journal of Nursing (BJN) Awards. In addition, Jane Lord was shortlisted for infection prevention nurse of the year and Langworth Ward was a finalist for the innovation award.

The Trust’s mental health practitioners, based in the Lincolnshire Police force control room were recognised at the High Sherifff of Lincolnshire’s annual awards, following their nomination by the Police and Crime Commissioner.

Anna Black, Team Leader for Grantham crisis team and the single point of access, received royal recognition at Buckingham Palace for her services to local NHS services.

Kirsty Johnson, Health and Safety Advisor was shortlisted in the Safety and Health Excellence Awards in the rising star of the year category.
Accreditations

- The Trust’s Triangle of Care initiative in inpatient services passed the first stage assessment and was awarded its first star of achievement.
- The Lincoln crisis resolution and home treatment team successfully met standards for the Royal College of Psychiatrist’s Home Treatment Accreditation Scheme (HTAS).
- In recognition of the Trust’s work on employing people with disabilities, it has been awarded a Level 2 Disability Confident Employer mark.

3.16 What service users/patients, carers and the public say

The process for hearing people’s views

There are a number of formal and informal ways service users/patients, carers and the public are able to give their views, get involved; and provide feedback. These include:

- Service user/patient feedback questionnaires (including FFT responses and free text answers).
- Group of 1,000.
- Complaints, concerns, comments and compliments.
- Care Opinion website.
- National community surveys.
- Expressions of satisfaction.
- Views of the membership and Council of Governors.
- Patient Advisory Liaison Service (PALS).
- MP enquires.
- Healthwatch Lincolnshire feedback.
- Investigations, including SI investigations.
- Capturing of feedback from service user/patient involvement events/mental health listening events.
- Capturing of feedback that is service specific through consultations, service user/patient/ carer meetings, announced and unannounced 15 Steps / mock CQC / non-executive director and Board member visits; and CQC inspection visits to clinical areas.
- Suggestion boxes.
- Patient reported outcome measures.
- Complaints learning forum.
- Internal audits.
- Hospital managers’ hearings.
Please note that some aspects of service user/patient feedback have been reported earlier within this report, including the community patient survey results (2017).

**Care Opinion**

The Trust has maintained its contract with the web-based Care Opinion, a national independent feedback platform for health services. The non-profit making website allows for a conversation between service users/patients, carers and health service bodies, by allowing people to:

- See what others are saying about the healthcare that each Trust is providing.
- Share their story so that others can learn from their experience.
- See how health services have responded to comments from others.

Care opinion provides a mechanism for the Trust and healthcare professionals to listen and respond to the experiences of people using this platform. All published opinions go to the CQC and are republished on NHS Choices.

The Trust had 44 stories posted on Care Opinion during Q3 in 2017/18, all of which received responses, examples of which are over leaf.

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**Amazing, we are so fortunate to have this..**

I, for the 1st time had problems with stress due to a work related issue. Not only did I receive wonderful CBT and counselling, I also had the expertise of an extremely competent employment advisor. My case was very complex and very daunting, the employment expert and the team made it a smoother less stressful process which allowed me to continue with issues against my company and we reached a successful agreement. I personally would like to thank all the team at the … as I feel privileged to have had access to their absolutely 1st class services.

Keep up the great work!

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**Patient experience coordinator response**

Thank you for taking the time to post your kind comments. I have passed your feedback onto the team and they are so glad that you have benefitted from our service and we wish you well for the future.

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**Not worth the time**

After assignment felt let down, how can I recommend something with so many failings? I left feeling far worse than when I went in, you may as well try and sort yourself out, given leaflets. This is when I struggle to take in what has been said to me, how can I understand this?
Patient experience coordinator response

1st response: I am so sorry to hear about your experiences. The patient experience team will pass these comments onto the service, and ask them to respond to you via this site. If you want to speak to somebody in the meantime, please contact us on:………. 

Please can I apologise for the delay in responding to you, this is due to the I.T issues within the NHS this week.

2nd response: …….Service Manager, ……. team apologises that you did not find the information you were given helpful. She understands that whilst being assessed it must be very difficult to process all the information you are given or told. She has asked that you please contact the local team (you should have been given a telephone number when you had your assessment) and they will be able to help you with any questions you have. If you do not have a contact number please ring the Patient Experience team on …….. and we will put you in touch with the right team.

I was mended

I was involved in individual as well as group counselling group and I had a number of appointments with a Psychiatrist. I am impressed with every single aspect of care given. Reception staff are extremely kind, polite and always willing to help. Psychiatrist I was dealing with demonstrated tremendous understanding in depth of my problems and respected all my personal choices. I can understand that some people cannot engage a positive relation with therapist. However I have very positive experience and indeed desirable outcomes. My therapist was simply brilliant and possessed a real person orientated approach as well as good savvy. After group session with two lovely therapists and incredibly supportive participants I managed to gather the strength and completely change my life by implementing thought mindfulness techniques. Everything may sound like a massive cliché but all I want to say is that they are literally life savers.

If it comes to a negative opinion... it is sorry to hear that but I believe it is much easier to complain about something bad rather than make an effort to give praise. Thank you for everything you ever did to me guys!

Lincolnshire Partnership NHS Foundation Trust response

Thank you so much for your lovely feedback and I am so pleased that you benefited from the support you received. We really value all feedback but, as you say, it is so satisfying to hear praise for our staff who work hard to deliver excellent patient care. Good luck with your continued recovery and thank you again for your kind words.
A sample of quotes taken from service user/patient feedback via the various patient surveys:

- I cannot praise your services enough. The group has been my salvation as a carer. The staff have been wonderful and proactive; any concerns have been addressed promptly. The choice of speakers was spot on; the doctor has been most helpful and reassuring. The group has been an experience for my husband. Thank you for a quality experience.
- At one point dropped through the net. However since he was picked up he has had brilliant care. …. is brilliant, thank you.
- Dr.…. was very easy to talk to, very friendly and we would like to thank her so much. We were listened to and helped.
- Such a shame you have to go through the criminal justice system to get decent, fit for purpose, mental health services.
- The team in my experience are a vital part of the NHS. I could never thank them enough for the support they gave me at the lowest point in my life; the staff I met were all caring and genuine people.
- Could be more supportive before being hospitalised.
- For the first time in 55 years I feel alive.
- Professional/sympathetic, listened and took notice of the effect of PTSD.
- This is such daft question - I wouldn't wish mental illness on anyone and the question suggests that there is an element of choice where people go to get help.
- I spent a lot of time talking to the staff who are lovely and spent time with other patients who I made friends with because I was very low in mood and depressed but my stay in the ward made me better and happy again.
- It was fun apart from the lady at the desk she was miserable.
- The service was amazing. I am so grateful for the help I received and could not have got through it without…….She was fab and everything I needed and sorted me out straight away.
Annex 1A: Statement from South West Lincolnshire Clinical Commissioning Group on behalf of NHS Lincolnshire (Commissioner)

NHS South West Lincolnshire Clinical Commissioning Group (the commissioners) welcomes the opportunity to review and comment on the Lincolnshire Partnership NHS Foundation Trust (the trust) Draft Annual Quality Report 2017 – 18.

The Quality Report provides comprehensive information on the quality priorities that the trust has focussed on during the year and it is pleasing to see the work undertaken in delivering the management of ligature risks and improving the experience of patients who use the trusts services.

Looking forward to the 2018 – 19 Quality Priorities the commissioner is assured that the patient’s physical healthcare is again a key focus as this has been raised as a concern by the commissioner over the past two years through a variety of reporting mechanisms. The remaining quality priorities are targeted to improve the patient safety and patient experience agenda as well as supporting the delivery of the coming years CQUIN (Commissioning for Quality & Innovation) schemes. The commissioner supports these priorities and would urge the trust to deliver as many of these priorities to achieve care closer to home for the patients. The commissioner can confirm that up to the end of quarter three the trust has achieved 36% of the years CQUIN monies to date. The commissioner cannot confirm the final quarter 4 position at this moment as the joint commissioner and trust review; verification and approval process is scheduled for May 2018. However the expected end of year position as detailed in the report does align with the commissioners expectations.

The Quality Report has numerous examples of the good work undertaken by the trust over the past year but the commissioner believes the following items are of particular note:

- The joint work undertaken with the United Lincolnshire Hospitals NHS Trust to enhance mental health care in the Emergency Departments of the hospital
- The “Involvement charter” on page 15 encouraging patients, carers and staff to become involved in the services offered and developed by the trust to ensure the patients’ needs are met
- Information Governance Toolkit, the Trust was the second highest scoring mental health trust in England and the third highest scoring compared to all mental health, acute and ambulance trusts. The commissioners are particularly pleased to note this achievement as previously concerns have been raised with the trust

The commissioners are concerned at the number of NICE Quality Standards and Guidance which have not achieved completion and compliance. This has been identified at each of the commissioner and provider quality review meetings during this current year and during the 2016 – 17 year. Whilst incremental progress is being made by the trust there is a need for a greater focus on this subject over the coming year.
The commissioner believes that the national and local audit information presented would benefit from a greater level of detail as whilst the title and number of audits is given the recommendations are generic and do not give a sense of changes to practice to improve the care given. The trust is undertaking some very good work and this will no doubt be reflected in the clinical audits undertaken and presented within the trust.

The commissioner confirms that to the best of our knowledge the accuracy of the information presented within the working draft of the Quality Report submitted is a true reflection of the quality delivered by Lincolnshire Partnership NHS Foundation Trust based upon the information submitted to the Quality Contract Meetings.

The commissioner can confirm that this Quality Report has been critically appraised against the 2010 Quality Account Regulations and subsequent additions to the regulations in 2017 and 2018. The results of this appraisal have been issued to the trust.

The commissioner looks forward to working with the Trust over the coming year to further improve the quality of services available for our population in order to deliver better outcomes and the best possible patient experience.

Pamela Palmer
Chief Nurse
NHS South West Lincolnshire Clinical Commissioning Group
Statement on Lincolnshire Partnership Foundation Trust

Quality Report for 2017/18

This statement has been prepared by the Health Scrutiny Committee for Lincolnshire.

Presentation of Information
We are pleased to see the inclusion of a glossary, which will aid the accessibility of the document to the public. The layout and presentation are clear and make the document easy to read.

Progress with Priorities for 2017-18
We acknowledge the Trust's progress with its priorities for 2017/18, which has seen the attainment or partial attainment of its six targets; and there is a clear indication of whether the target has been achieved.

We would like to highlight the priority Q2 (Ligature Risk Assessment and Management), where the target has been achieved, which should lead to reduced risk of self-harm and suicide.

Progress with priority Q2 (Improving A&E Services for People with Mental Health Needs) has also been good with the 20% reduction in the number of A&E attendances having been achieved. Providing community support for individuals is an important priority and we are pleased to see this carried forward into 2018-19.
Priorities for 2018-19
In 2017, the Health Scrutiny Committee for Lincolnshire supported the Trust's approach of adopting six priorities for both 2017-18 and 2018-19, to allow substantial progress to be made. The Health Scrutiny Committee supports the continuation of the six priorities for a second year, and looks forward to continued progress being made. The Committee understands that the targets will be set once the final figures for 2017-18 are confirmed.

Care Quality Commission Rating
We note that an inspection by the Care Quality Commission (CQC) took place in the week beginning 3 April 2017, following which the CQC published its report and rated the Trust overall as good. We would like to record the Committee's congratulations on the CQC rating. This includes an outstanding rating for specialist mental health services for children and young people.

Performance in CQUINS
We note that the Trust has met its CQUIN targets for 2017/18, with the additional income derived from this achievement totalling £1.85 million.

Learning from Deaths
The draft version of the document which we reviewed referred to 1,321 of the Trust's patients dying during 2017/18. We requested some context for this figure in terms of the overall number of patients treated by the Trust. We urge the Trust to continue with this analysis, so that improvements can be made.

Engagement with the Health Scrutiny Committee for Lincolnshire
The Trust readily engages with the Health Scrutiny Committee when requested to do so. There have been three items considered during the last year, where representatives from the Trust have attended. In the first instance, the Trust attended to present the outcome of the Care Quality Commission inspection. The Committee also provided advice to the Lincolnshire STP on learning disabilities consultation, with the Committee suggesting that targeted engagement with patients and their families would be preferable to a full consultation. This was because changes had been implemented, which had so far received the full support of patients and their families.

Accreditations and Achievements
We would particularly highlight the section of the report on the accreditations and achievements which the Trust has received. Of these achievements, we are impressed by the opening of the ten-bed Psychiatric Intensive Care Unit, known as the Hartsholme Unit,
for male patients in June 2017. The benefit of this Unit is that many patients with a severe mental health are no longer placed out-of-county for these services.

We would also like to highlight the reduction in waiting times for patients accessing services provided by the Trust, as a significant achievement.

Involvement of Governors and Patient Groups
The Committee note that the Council of Governors and patient groups have been consulted on the content of the document. We note that arrangements are in place to monitor progress with the priorities in the coming year.

Conclusion
We are grateful for representatives from the Trust taking the time to present the draft Quality Account to us. This provided us with an opportunity to provide immediate feedback on certain aspects of clarity and presentation of the document. This also enabled us to seek clarification of particular points, which was welcome.

We look forward to the Trust delivering improvements in quality in the coming year.
Annex 1C: Statement from Healthwatch Lincolnshire

Wednesday 9 May 2018

Lincolnshire Partnership Foundation Trust, Presented by Mark Halsall

Healthwatch Lincolnshire Quality Account Working Group: Sarah Fletcher (CEO), John Bains (Board Chair), Clive Green (Trustee), Pauline Mountain (Trustee), Nicola Tallent (Partnership & Development Manager), Pam Royales (PA Administrator)

Healthwatch Lincolnshire would like to thank Mark for presenting the LPFT Quality Account and meeting with our representatives. We acknowledge the work you have done over the past 12 months to improve the overall performance and on behalf of patients, carers and service users, would like to thank your staff for their hard work and dedication in achieving this.

Healthwatch Lincolnshire share all relevant patient experiences we receive with LPFT and thank you for responding generally within 20 working days. Your responses are shared in turn with the patient, carer or service user who raised the issue, in many cases this provides them with a level of closure they may not otherwise receive. We believe learning through patient feedback and experiences is an essential part of any service improvement and acknowledge your Trust’s work to better assess what has occurred. We consider it important to also include any actions that are being implemented by your Trust which demonstrates how this learning is being used and would welcome this addition in future.

During the past year we have recognised a reduction in the number of issues and concerns about LPFT services being shared with Healthwatch Lincolnshire, we believe this is a positive benchmark. However, our general feeling is that where comments are being made, those that concern us most include access to community services, this does appear to be one of the biggest issues currently being raised.

We welcome the extension of your priorities being extended from 1 to 2 years and believe this enables a much better environment in which to achieve positive performance results and maximise learning.

One concern we have is with the significant number of CQUINs not being achieved. Clarification is also required as to why the Trust adopts a CQUIN that states the transition from CAMHS to Adult Care is 16-17 years, particularly as the NICE guide states 13-14 years.
Whilst we notice that patient safety is rising and you tell us that this is due to better reporting, we are keen to know what is being done as a result?

Learning from deaths – we believe that a better explanation of what has been learnt and what the figures relate to i.e. seasonal, should be included in the narrative for future years.

Mental Health patients attending A&E – we are aware this is not just an LPFT achievement and therefore would like to see more context as to how this has been achieved, including any partnership working.

While we agree that 98% patients knowing who to contact with regards to their care is positive, we would welcome move context i.e. figures in numbers rather than percentages, as we believe this would be much more informative.

We believe where your Quality Account highlights (staff satisfaction) an underreporting of ‘Near misses or incidents’ this may be due to staff culture or reluctance due to the environment staff work in. Healthwatch Lincolnshire are keen to see this area improved.

Healthwatch Lincolnshire would like to express concerns about the impact of STP on LPFT services. In particular, the Trust’s involvement in Care Portal; Integrated Neighbourhood Working; Service Transformation, Inter-organisational working etc and it would be helpful to see this reflected in future quality accounts. In fact, we were concerned to see STP was not included as a priority for 2018/19.

Finally, we consider our relationship with LPFT is very positive. This includes an invitation to include a Healthwatch Trustee on your Council of Governors (who considers they are well supported and valued by LPFT in this role), along with the many inter-staff relationships we have built up over the past five years, which all lead to excellent working relationships.
Dear Board of Directors

Council of Governors’ Opinion on the Annual Quality Report 2017/18

The Council of Governors is grateful to Mark Halsall, the Head of Quality & Safety, for attending the Council of Governors’ meeting on 19 April 2018 to present the draft report, which provided Governors with an update on the process for the final publication of the Trust’s Quality Report 2017/18.

At the Council of Governors’ meeting in January 2018, Governors discussed and agreed the mandated and local performance indicators for 2018/19, however, since that date, NHS Improvement (NHSI) had published the finalised detailed guidance for quality reports and this mandated that two national indicators must be selected, from a list of four, in a specified order of preference. This meant that those indicators selected in January 2018 were no longer valid.

Governors were informed, and agreed to support, that in order for the Trust to comply with the mandatory requirements of the new list, the following indicators had been selected for testing:

1) Early intervention in psychosis: people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral, and
2) Inappropriate out of area placements for adult mental health services.

The Council noted that the Trust’s external auditors would be testing and reporting on the indicators and, where necessary, making any recommendations for improvement. The Council of Governors would welcome a report on performance in due course.

Governors were grateful to receive additional time to individually review the report and provide further feedback and comments, via the Trust Secretary’s office. It is pleasing to see that the report has included revisions and suggestions made by the Governors.

Governors noted that the Information Governance (IG) toolkit assessment summary report has rated each element as green, which is described as only being satisfactory. The Council was informed that this was the highest level of grading. The Head of Quality & Safety would establish if the ‘satisfactory with improvement plan’ grade should be green, as indicated.

The Council of Governors is pleased to note that carers are being mentioned more frequently in this document and other forums. Referring to the section ‘Learning From, and Improving, Carer Experience, the Council recommended that the Trust could consider monitoring this improvement with the use of figures and graphs. The Trust’s work on the Triangle of Care initiative is commended and Governors were pleased to hear the proposal from the Head of Quality & Safety that ongoing monitoring and reporting to the Patient Safety & Experience Committee would be continued.

The Council did hear representation regarding a lack of support for carers of patients who had been discharged from community mental health teams (CMHTs), particularly in the East of the county, and the Trust Chair acknowledged this as a challenge for the Trust, particularly regarding stretch and ambition. It would be important to consider this further and also the apparent disparity in carer support in different areas. It is suggested that the Trust should record the numbers attending the carer support group.

The Council of Governors was encouraged to hear the Chief Executive confirm that the Trust was working hard to develop its service offering outside the organisation, eg the Managed Care Network, the Recovery College and the offer of a network across the county, but acknowledged that there was still much to do.

In last year’s letter we expressed concerns over low uptake of flu vaccinations and delayed transfer of care rates being so high, at 11.9%. The Council of Governors, through the receipt of performance assurance reports provided by the Non-Executive Directors, has monitored the remarkable improvements in the quality performance between 2016/17 and 2017/18. The dramatically increased flu vaccination rates and the near eradication of
delayed transfer of care are improvements which have significantly improved the safety of our staff and service users and enhanced the quality of service user and carer experience.

Yours sincerely

Carrie Forrester
Lead Governor 2017/18

David Bray
Deputy Lead Governor 2017/18 & Lead Governor wef 25 May 2018
Independent auditor’s report to the council of governors of Lincolnshire Partnership NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Lincolnshire Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of Lincolnshire Partnership NHS Foundation Trust’s quality report for the year ended 31 March 2018 (the ‘quality report’) and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Lincolnshire Partnership NHS Foundation Trust as a body, to assist the council of governors in reporting Lincolnshire Partnership NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Lincolnshire Partnership NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- proportion of people experiencing first episode psychosis or ‘at risk mental state’ who wait two weeks or less to start a National Institute for Health and Care Excellence recommended package of care; and
- average monthly number of total bed days patients have spent in inappropriate out-of-area placements.

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the ‘NHS foundation trust annual reporting manual’ issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the ‘NHS foundation trust annual reporting manual’ and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified below:
  o Board Minutes for the period April 2017 to March 2018;
  o Papers relating to the quality report reported to the board over the period April 2017 to March 2018;
  o Feedback from Commissioners dated 11 May 2018;
  o Feedback from Governors on the quality report dated 15 May 2018;
  o Feedback from local Healthwatch organisations dated 9 May 2018
  o Feedback from Overview and Scrutiny Committee dates 10 May 2018
  o The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 6 April 2018;
  o The latest National Patient Survey results dated 15 November 2017;
  o The latest National Staff Survey 2017 results dated 6 March 2018;
Annex 1E: Deloitte limited assurance statements

- the Head of Internal Audit’s annual opinion over the Trust’s control environment dated 12 April 2018; and
- Care Quality Commission Inspection Report published 9 June 2017.

- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the ‘NHS foundation trust annual reporting manual’ and the six dimensions of data quality set out in the ‘Detailed guidance for external assurance on quality reports’.

We read the quality report and consider whether it addresses the content requirements of the ‘NHS foundation trust annual reporting manual’ and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the documents listed above and specified in the detailed guidance for external assurance on Quality Reports (collectively the ‘documents’).

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the documents. Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the ‘NHS foundation trust annual reporting manual’ to the categories reported in the quality report; and
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.
Annex 1E: Deloitte limited assurance statements

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';

- the quality report is not consistent in all material respects with the sources specified in 2.1 of the 'NHS Improvement Detailed requirements for external assurance for quality reports 2017/18' for foundation trusts; and

- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

Deloitte LLP
Birmingham
United Kingdom
24 May 2018
Annex 2: Statement of directors’ responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2017 to March 2018
  - papers relating to quality reported to the Board over the period April 2017 to March 2018
  - feedback from commissioners dated 11/05/2018
  - feedback from governors dated 15/05/2018
  - feedback from local Healthwatch organisations dated 09/05/2018
  - feedback from Overview and Scrutiny Committee dated 10/05/2018
  - the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 06/04/2018
  - the national patient survey 15/11/2017
  - the national staff survey 06/03/2018
  - the Head of Internal Audit’s annual opinion of the Trust’s control environment dated 12/04/2018
  - CQC inspection report dated 09/06/2017
- the Quality Report presents a balanced picture of the NHS Foundation Trust’s performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
• the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

• the Quality Report has been prepared in accordance with NHS Improvement’s annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Paul Devlin
Chair

Dr John Brewin
Chief Executive

24 May 2018