Independent Quality Assurance Review

Lincolnshire Partnership NHS Foundation Trust and NHS Lincolnshire CCG

Final Report

6 July 2022

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July 2022

Independent Quality Assurance Review, Lincolnshire Partnership NHS Foundation Trust and NHS Lincolnshire CCG

Please find attached our Final Report of 6 July 2022 in relation to an independent quality assurance review of the implementation of recommendations resulting from the independent investigation into the care and treatment of a mental health service user in Lincolnshire (report dated February 2020).

This report is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose. The scope of our work has been confined only to provide an assessment of the implementation of the organisations' resultant action plans against the Niche Investigation and Assurance Framework (NIAF) review. Equally, events which may occur outside of the timescale of this review will render our report out of date.

Our report has not been written in line with any UK or other auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

This report is for the attention of the project sponsor and stakeholders. No other party may place any reliance whatsoever on this report as this report has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final signed version of this report should be regarded as definitive.

Yours sincerely,

Kate Jury

Niche Health and Social Care Consulting Ltd

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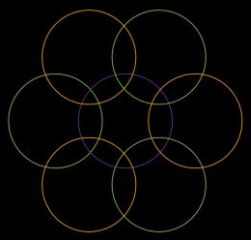

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1. Method

1. Background and context for this review

NHS England and NHS Improvement, Midlands and East of England commissioned Niche Health and Social Care Consulting Ltd (Niche) to undertake an assurance review using the Niche Investigation Assurance Framework (NIAF). This is intended to provide an assessment of the implementation of the actions developed in response to recommendations from the Niche independent investigation into the care and treatment of a mental health service user who killed his grandson in December 2014.

This is a high-level report on progress to NHS England, undertaken through desktop review only, without site visits or interviews.

1.2 Implementation of recommendations

This review focused on the implementation of actions by Lincolnshire Partnership NHS Foundation Trust ('the Trust' or LPFT) and NHS Lincolnshire CCG (the CCG).

The Niche independent investigation into the care and treatment provided by the Trust and CCG made 15 recommendations for LPFT, two of which involved the CCG, and were grouped into three priorities:

Priority One: the recommendation is considered fundamental in that it addresses issues essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.

Priority Two: the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of service user but identifies important improvements in the delivery of care required.

Priority Three: the recommendation addresses areas that are not considered important to the achievement of systems or process objectives. The area of concern relates to minor improvements in the quality of service provision.

The action plan developed from these recommendations included the desired outcome, individual actions, the action lead and target completion dates. A narrative picture of the progress against each recommendation was provided.

For clarity of process, this assurance review lists the recommendations by priority level assigned.

1.3 Review method

Our work comprised a desktop review of documents provided by LPFT and the CCG. These included policies, procedures, action plans, audits meeting minutes and staff communications.

The assurance review focusses on the actions that have been progressed and implemented in response to the recommendations made in the independent investigation report. We set out our summary of findings in relation to the progress of each agency.

We have not reviewed any health care records because there was no requirement to re-investigate the incident in the review terms of reference. The information provided to us has not been audited or otherwise verified for accuracy.

2. Assurance overview (summary)

The Niche Investigation Assurance Framework

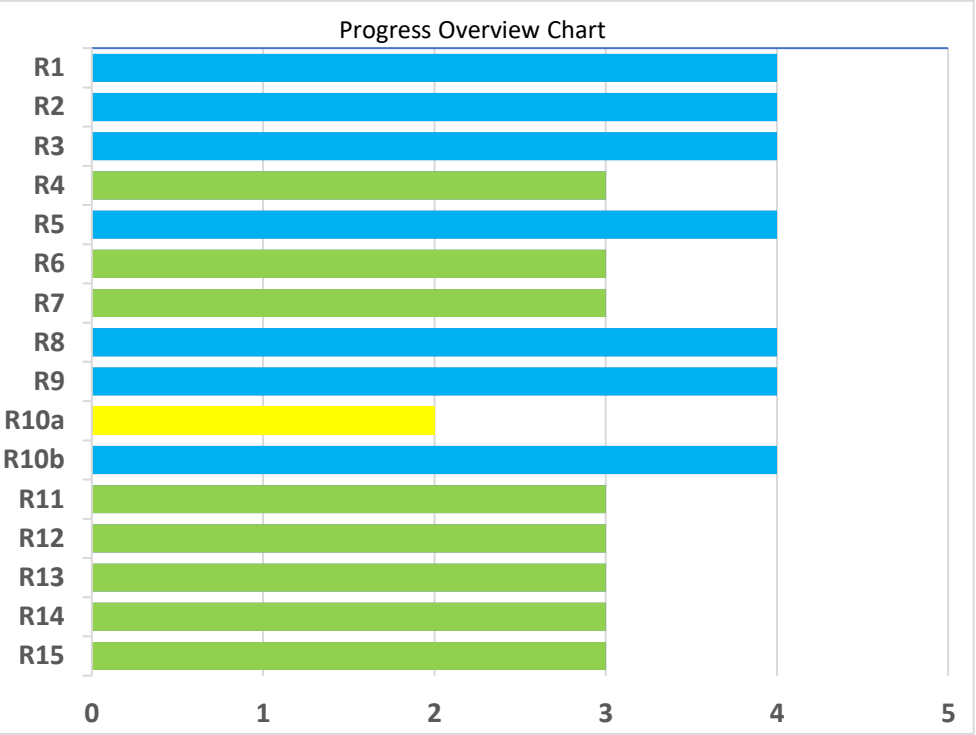
The assessment is meant to be useful and evaluative, and we adopt a numerical grading system to support the representation of 'progress data'. This is intended to help organisations focus on the steps they need to take to move between the stages of completed, embedded and impact sustained. An improvement which has been 'sustained' is the best available outcome and response to the original recommendation. Our measurement criteria include:

Score	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action completed, tested, but not yet embedded
5	Can demonstrate a sustained improvement

There were 15 recommendations in total, two of which include actions for Lincolnshire CCG in collaboration with LPFT.

Implementation of recommendations

We have rated the progress of the actions which were agreed from the 15 recommendations made. Our findings are summarised opposite:



Summary

The recommendations have been completed in most cases; however, evidence to support action completion for Recommendation 10a was more limited. Where relevant we have provided examples of further assurance required to demonstrate actions are complete, tested, embedded and/or sustained as appropriate.

2. Assurance overview (Priority One recommendations)

	Recommendation	Niche rating	Key findings
10a	The Trust must ensure that when: • family members are either expected to play a key role in a patient's care and treatment; and/or • have previously expressed concern about their own safety in relation to the patient those family members are involved in the decision making about discharge and informed about the patient's discharge prior to it taking place.	2	The requirement for engagement with family members/carers is referenced in a number of policy documents and work has been undertaken to strengthen carer involvement in the care, treatment and discharge of service users. However, recognising the impact and restrictions imposed by Covid-19, further assurance is required in relation to the identification of family members who might be at risk and how they are being supported.
10b	The Trust must ensure that any plans for discharge from an inpatient unit are planned with the patient, GP and all relevant community services. There must be a clearly documented structured plan which sets out roles, responsibilities and timescales.	4	The Trust has evidenced progress with this recommendation although guidance to staff regarding the involvement of GPs in the discharge planning process could be strengthened. From the data seen, we note varied compliance with this discharge process. Further assurance and testing is required.
11	The Trust must assure itself and its commissioners that they involve patients and their families (where appropriate) in decisions about transferring patients to other units.	3	The requirement for engagement with service users and carers is referenced in a number of policy documents and work has been undertaken to strengthen carer involvement in the care, treatment and discharge of service users; however, further assurance and testing is required to ensure carers are involved in decisions about transferring service users to other units.
12	The GP practice must ensure that when the practice is informed that a patient has been admitted to hospital, a review of that patient's appointments and repeat medications is undertaken.	3	The GP practice has a suite of policies aimed at safeguarding patients, with processes in place to check on vulnerable patients if they fail to collect their medications or do not attend booked appointments. GPs have been reminded of their responsibilities in relation to this and testing of processes and compliance in this area will be incorporated into routine audits of GP surgeries by the CCG quality team .
13	The GP practice must ensure that prior to removing a patient from a surgery list, the surgery has considered all information in their possession regarding the possible whereabouts of that patient and they clearly document in the records the basis or rationale for that removal with details and/or a copy of the information upon which the decision is based.	3	The Policy for Removal of Patients has been refreshed and national guidance regarding the de-registration of patients has been re-circulated to all local GP Practices. Testing of processes and compliance in this area will be incorporated into routine audits of GP surgeries by the CCG quality team.

2. Assurance overview (Priority Two recommendations)

	Recommendation	Niche rating	Key findings
5	The Trust must ensure that appropriate action is taken when a clinician has advised that a review of a patient's medications is required.	4	Medication guidelines are available which include requirements for review although the Antipsychotic Guidelines could be strengthened by having minimum timeframes stated. An audit has been completed but with a limited question set and selection of a small sample size. Further testing is required.
6	The Trust must assure itself and its commissioners that medications are prescribed in accordance with best practice and that timely reviews of the ongoing appropriateness of the dose are undertaken.	3	Medication prescribing guidelines are available in local policy and service standards. Audits, including those referenced in the Medicine Management Policy, are required to ensure that medications are being prescribed in accordance with best practice.
7	The Trust must ensure that there is a clear rationale provided when changing a diagnosis and that the appropriate associated treatment plans are described and implemented.	3	This recommendation has been progressed but testing is now required to ensure that rationales for changes in diagnosis are fully documented with treatment plans described and implemented. The Trust will also want to ensure that patients and GPs are aware of any diagnosis changes that are made.
9	The Trust must ensure that the correct registered GP details are held on file, regularly checked and updated (where required) and present on discharge documentation.	4	Procedural and policy documents require staff to ensure the correct GP details are held for service users admitted to the Trust. Further testing is required to ensure that these details are updated when required and present on discharge documentation.
15	The Trust must ensure that a clear focus is maintained on the reasons and purpose of admission throughout any internal ward transfers.	3	Procedural and policy documents require staff to document the reasons for admission. However, we have not been provided with evidence to confirm that the Trust is monitoring whether the reasons and purpose of admission (including through internal ward transfers) are clearly documented and retained.

2. Assurance overview (Priority Three recommendations)

	Recommendation	Niche rating	Key findings
1	The Trust must ensure that staff complete incident forms at the earliest opportunity and that staff are clear about when this is.	4	This recommendation has been progressed. Compliance is monitored through Datix reports, however, findings indicate that incidents are not consistently being reported within required timeframes and further improvements are required.
2	The Trust must ensure that guidance is in place for staff completing serious incident investigation reports, that they use plain English and that report templates include section numbering, page numbering and a table of contents.	4	Guidance is in place for the investigation of incidents and there is evidence that the format of serious incident reports and the language used has improved although evidence of training for staff involved in these investigations is required. Patient Safety Incident Investigators have recently been appointed to ensure improvements are sustained going forward.
3	The Trust must assure itself and its commissioners that recommendations in internal reports are fully implemented and that the actions provide sufficient evidence of the effectiveness of the changes made.	4	Actions resulting from investigations are tracked by the Patient Safety Team. Further assurance is required to ensure that revised monitoring mechanisms can evidence that changes in practice are having the required impact and sustained improvements.
4	The Trust must assure itself and its commissioners that staff use every opportunity to triangulate information about clients from all reasonably available sources.	3	The actions supporting this recommendation have been progressed. A cycle of audits or other monitoring mechanisms are required to ensure that information about service users is obtained from all relevant sources.
8	The Trust must ensure that a communication protocol with the police is developed and implemented when the police are involved in a patient's management.	4	A new police liaison protocol has been developed and there is evidence of good working relationships being developed. Although staff have worked from home and were not regularly based in the police control room during the pandemic, implementation of this action has resulted in prompt notification of significant events. Further monitoring will be required to ensure improvements are sustained.
14	The Trust must ensure that service changes are properly monitored in the post-implementation phase. Analysis should include governance success indicators, staff satisfaction assessments, patient experience scores and overall performance rates.	3	The standard Business Case Template has been revised and some assurance was provided that the Trust has taken steps to ensure the impact of service changes are being monitored but further testing is required to ensure this recommendation is embedded in practice.

Detailed assurance review findings
Priority One recommendations

Detailed Review – *Priority One Recommendations (Trust)*

Recommendation 10a: The Trust must ensure that when:
• family members are either expected to play a key role in a patient's care and treatment; and/or
• have previously expressed concern about their own safety in relation to the patient

those family members are involved in the decision making about discharge and informed about the patient's discharge prior to it taking place.

Desired outcome (as agreed by the Trust): *Family members are involved in decision making about patient/service user discharges. There is a victim safety plan for family members who have been identified as at risk.*

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
1. Adult Inpatient and Urgent Care (AIUC) wards to ensure that carers pack is issued at point of first contact with family/carers or on admission	'All About Me' and the Inpatient Communication Plan have a series of questions for the service user to answer in relation to whether and how they would like their carer/s involved and how to contact them. 'Making you part of the triangle of care: Information for carers' includes that carers have a right to pass on their thoughts and/or information to the nursing and medical team involved in the care of their loved one and involved in their care planning. Triangle of Care self-assessment tool summary results for 2020 include results for eight wards/Community Mental Health Teams (CMHTs)/Home Treatment Teams (HTTs). The May 2022 Triangle of Care Progress Report includes that the Trust has implemented a Carers Strategy which aims to ensure that carers feel informed and engaged in the care of the person or people that they support, and that relevant NICE guidelines are met. A number of supporting initiatives have been introduced which are captured in carer newsletters. The Trust achieved Stage 2 of the Triangle of Care in May 2022 (i.e., it completes self-assessments for all community services). Carer involvement in inpatient older adult services audits (various) include feedback from carers. Carer Communication Audits include a question that asks if there is evidence of carer contact by the ward in the patient notes.	Carers leaflets have been revised (see overleaf). The Triangle of Care self-assessment tool summary results for 2020 included that 6/8 teams were rated green for 'access to advice' (i.e. carers assessed to see if they would like any support and, should they consent, provided with a carers pack). The May 2022 Triangle of Care Progress Report evidences sustained achievements although risks and areas requiring further development have also been identified. Carer involvement in inpatient older adult services audits identified some variance in carers being contacted by ward staff and being provided with information about the service user's admission to the ward. The Carer Communication Audit results also evidence carer contact by the ward; however, 'evidence of carer contact' does not allow an insight into the frequency or quality of this contact.

Detailed Review – *Priority One Recommendations (Trust)*

Recommendation 10a: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
2. Older People and Frailty Division (OPFD) to coproduce a carers leaflet about how to be involved in OPFD services.	The 'Making you part of the triangle of care: Information for carers' leaflet and the 'Information for Carers: Working Together' leaflets for Inpatient Older Adult services - these include a section on how carers can be involved in the service user's care and how they can access support including a carers assessment. It also highlights how if the service user does not consent to their involvement, they as a carer, can still meet a member of staff to discuss any information or concerns they wish to share with the clinical team. Celebrating Feedback Friday poster – this includes carer and professional feedback.	The 'Making you part of the triangle of care: Information for carers' leaflet has been co-produced by the Triangle of Care Steering Group and Lincoln's Discovery House Carers Group. The 'Information for Carers: Working Together' does not include that it was co-produced with carers but is a good practice document and easy to read. This action has been completed.
3. Each MDT meeting will evidence carer/family involvement where appropriate. This will be recorded on the MDT template.	Information about Carer Champions – these postholders are based on Charlesworth and Connolly wards. A copy of their job plan has been shared with confirmation regarding the tasks which they are required to undertake. Evaluation of Carer Champion forms (various) include good practice and areas for learning. 'All About Me' has a series of questions for the service user to answer in relation to whether and how they would like their carer/s involved and how to contact them. This includes the time of the doctor's rounds and any MDT meetings. An MDT proforma has been introduced by the OPFD and AIUC. The Carer Communication Audit includes a question that asks if carers views have been captured in MDT meetings. The division received 153 complaints of which 19 were in relation to communication with relatives/ carers (although we are unaware if these were upheld).	We have seen evidence of positive feedback about the Carer Champion role and in the evaluation reports the majority of respondents said they were invited to join the ward round and were telephoned 48 hours after their relative's discharge. However, these postholders only cover two wards. The MDT proforma is good practice and allows carer attendance and involvement within the meetings to be recorded. However, the Carer Communication Audit results indicated that (where applicable) a number of carers had not had their views captured in the MDT meeting. Carer Champion evaluation reports similarly confirm that a small number of carers did not feel their views were heard and listened to during ward rounds. While some progress has been made, we cannot be assured on the basis of the evidence provided that this action is embedded in practice.

Detailed Review – *Priority One Recommendations (Trust)*

Recommendation 10a: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
4. Complete DASH [Domestic Abuse, Stalking and Honour Based Violence] assessments and/or adult safeguarding tool for all family members who are identified as at risk.	The Clinical Risk Assessment and Management Framework (which is detailed within the Clinical Care Policy 2021) requires staff to ensure that service users and their carers/families (where appropriate) are involved in risk assessments and formulations. Completed DASH risk assessments (undated spreadsheet). Care Audits include a question about completion of the Safeguarding Tool. Divisional Data for Safeguarding Screening Tool Completion March 2021. Trust Data for Safeguarding Screening Tool Completion May 2022. Inpatient care audits (various) consist of an audit of five service users on the following wards; Charlesworth, Conolly and Ward 12, plus three from Hartsholme Ward. The Safeguarding team in-reach to the acute wards to support them with the concerns relating to all safeguarding, public protection and mental capacity issues. This involves advice around domestic abuse and family members.	The DASH risk assessment spreadsheet is undated and contains raw data which has not been interpreted by the Trust. Care Audits evidence completion of the Safeguarding Tool (although some were marked for children and also adults). The divisional data from March 2021 indicates that 16% of adult community service users did not have their safeguarding adult and child screening tools completed at assessment, and a further 35% were overdue their six-month review. Trust data from May 2022 indicates improved compliance, with 93% completion for adult assessments. Service level detail is available such that 'hotspot' areas of concern can be monitored, and improvements facilitated. Safeguarding audits have been undertaken; however, the adult screening tool which guides on domestic abuse is about risk to the service user not risk from the service user to family and there is little evidence to support the identification of family members who might be at risk and how they are being supported. We have seen no evidence of victim safety plans for family members who have been identified as at risk and we cannot be assured that this action is complete.

Detailed Review – *Priority One Recommendations (Trust)*

Recommendation 10a: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
5. Ongoing audit of risk assessment and formulation frameworks to evidence family and carer involvement where appropriate.	The OPFD 'This Is Me Care Plan' has a section on family views on relapse signs and risks. Carer involvement in risk assessment (email dated 6th November 2020) includes two examples of redacted extracts of care plans. Carer communication audits include questions which ask about carer involvement in care plans and risk assessments. Care Audits (various) include questions about risk assessments and care planning. The Clinical Care Policy 2021 describes the guidance for family/carer involvement in risk assessment, formulation and discharge. Carers survey free text raw feedback data in spreadsheet. Clinical Risk Audit March 2021 includes data from 18 service users about their first and last risk assessment. Local Carers Survey Report April July 2021 includes responses from 40 carers for the inpatient wards, dementia service, and HTT.	Two redacted extracts demonstrate examples of carer views of risk being captured in the 'This is Me Care Plan'. Audits indicate that carers were mostly involved in care plans but had less involvement with risk assessments. We also note that the qualitative free text response data from carers was not thematically analysed or triangulated with the quantitative data. In the Brant Ward Clinical Risk Audit (March 2021), 11/18 service users had their first and last risk assessments reviewed within stipulated time frames; however, five were due for review and two were out of date. There was some positive feedback from carers in the December 2020 Carer Audit, with initial contact confirmed by 8/10 carers; but continued communication, information sharing and involvement in care and treatment plans reduced as the patient stay progressed. The Local Carers Survey Report indicated that 23/24 carers felt that staff listened to the if they had a concern; however, six said they were not consulted or involved in discussions about the person they cared for as much as they would have liked. Audits have been undertaken but there is a need to continue monitoring and testing to ensure compliance with the requirements for family and carer involvement where appropriate.

Detailed Review – *Priority One Recommendations (Trust)*

Recommendation 10a: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
6. Discharge care plans to evidence that family/carers are aware of arrangements	The Clinical Care Policy describes the guidance for family/carer engagement and their involvement in discharge planning. The Care Champion job list includes the requirement for Carer Champions to contact carers 48 hours after the service user's discharge to check if they have any questions/concerns. OPFD have family meetings within dementia units to support discharge planning. Three Discharge Care Plans – these have a section where the views of carers can be captured. Discharge Care Plan Audits include if there was family/carer involvement and contact, and whether a discharge care plan was completed. Carer communication audits include questions which ask about carer involvement in discharge plans. Care audits also include questions about carer involvement in discharge and discharge risk assessments. Care Champion Evaluations (various) include responses from carers about their engagement and involvement. Carers 'You said, we did' poster (undated).	We have seen no policy which describes the requirement for carers to be contacted 48 hours after discharge although we have been told this will be included in the next Standard Operating Procedure. Carer Champion Evaluation reports indicate, however, that the majority of relatives were telephoned 48 hours after their relative was discharged. We note that significantly fewer were offered a carer's assessment. The Discharge Care Plan Audits are brief in terms of the descriptors applied, and it is unclear how samples have been selected. It would appear that for the majority of service users listed, carers were involved (although it is not stated how these care plans were devised). Care communication audits have been undertaken but sample sizes for the question about involvement in discharge care plans are small. Care audits have also been undertaken and these evidence varying levels of carer involvement in discharge/transfers from the team or discharge risk assessments. The Carers 'You said, we did' poster includes that carers were not always clear about what happens after discharge and what to do if the service user's health deteriorated. It states there will be a trial of Safety Plans on one of the wards, with roll out to other services if successful. While progress has been made, there is a need to continue the cycle of testing and improvement actions.

Detailed Review – *Priority One Recommendations (Trust)*

Recommendation 10b: The Trust must ensure that any plans for discharge from an inpatient unit are planned with the patient, GP and all relevant community services. There must be a clearly documented structured plan which sets out roles, responsibilities and timescales.

Desired outcome (as agreed by the Trust): *There is a structured plan in place for all discharges that includes the GP and other services which were previously involved in the patient/service user's care.*

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
No stated action.	The Clinical Care Policy 2021 includes guidance for making the decision to discharge a service user via the MDT, ward round, or CPA review meetings. It requires staff to have a pre-discharge meeting with the nominated community-based co-ordinator/lead professional, service user, their relative/carer if appropriate. Members of the multi-disciplinary team involved in the inpatient care and for discharge plans to be shared as required. 'Discharge audit' (undated) includes 33 discharge process questions for 17 service users. 'Discharge plans 1-3 and 'discharge follow-up' spreadsheets include raw data about family involvement/contact, whether the patient was aware of 48 hour follow-up arrangements, and the discharge plan completed.	Discharge summaries are sent at the point of discharge to known GPs although we note that the Clinical Care Policy does not specifically include a requirement for GPs to be involved in discharge planning processes, or informed prior to discharge, to ensure that primary care services can appropriately step into care provision when service users return home. The audit data evidenced 17-100% compliance with discharge processes for the 17 service users audited. All had a comprehensive structured discharge plan and decisions made to discharge a service user had been made with the patient, care coordinator, MDT and carer/family member. Also, 94% of discharges had been discussed and communicated with the relevant GP, PC or CMHT and 88% had timescales agreed for their first initial follow up within 72 hours of discharge. 94% of service users had a clear plan for ongoing care that contained details of the next visit scheduled by community mental health services. However, this audit was undated and it is unclear how the sample was selected. The audit indicated that only 18% of care coordinators had attended a pre-discharge MDT meeting. There remains work to be completed to reach 100% compliance with this target. The 'discharge plan' data is 'raw' and similarly undated and there is no evidence of an 'output paper' that would help staff to understand areas where further improvements are required. We are unaware of any repeat audits being undertaken to further test compliance with this recommendation.

Detailed Review – *Priority One Recommendations (Trust)*

Recommendation 11: The Trust must assure itself and its commissioners that they involve patients and their families (where appropriate) in decisions about transferring patients to other units.

Desired outcome (as agreed by the Trust): *Family members are involved in decision making about discharges.*

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
1. Each MDT meeting will evidence carer/family involvement where appropriate for patient transfers. This will be recorded on the MDT template.	The Clinical Care Policy May 2021 describes the requirements for the views of families, carers and others, if appropriate, to be fully considered when taking decisions about care, support and treatment. It also requires a pre-discharge meeting to be organised by the named nurse in liaison with the nominated community-based co-ordinator/lead professional and that this meeting should include the service user, their relative/carer if appropriate, and all members of the multi-disciplinary team involved in the inpatient care. MDT proforma includes the estimated discharge date and carers' views. 'MDT evidence' (excel spreadsheet) includes data on ten service users from ward 12 (April 2021) and centres on whether actions from the ward round were fed back to the patient and their carer including in relation to discharge or transfer. Also see evidence for Recommendation 10a including the Triangle of Care documentation.	The Clinical Care Policy is a lengthy (600 page) document. There is a section on patient transfers which includes the requirement for service users to be involved and informed of the decision to transfer, but does not include the requirements for carers. The MDT evidence contains raw data but there is no indication of how the ten service users were selected (from a sample size of 17) to ensure appropriate representation. We can see no evidence of further/additional audits being undertaken. We have only seen one completed MDT template where discharge but not transfer is referenced, and we can see no evidence of rolling audits aimed at patient transfers to confirm that this action is embedded in practice..

Detailed Review – *Priority One Recommendations (Trust)*

Recommendation 11: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
2. Quarterly review of patient family and carer feedback in relation to inpatient areas and involvement in care.	Summary Report – Inpatient/CMHT Service User / Carer Surveys Experience of Care During COVID – includes feedback from surveys of 16 service users and two carers on the support they had received from the wards and CMHTs. Evaluation of Carer Champion forms include examples of feedback from service users around interventions they found most useful, whether anything else could have been done to improve their experience, contact with the Carer's Champion, receipt of the carers pack, contributions to ward rounds, and contact after discharge. Example of a Patient Experience Report to the Patient Safety and Experience Committee July 2020 provides an overview of feedback from service users, carers and relatives, and identifies themes and improvement priorities. Friends and Family Test Service Report April-October 2020 includes feedback for ward 12. Adult Inpatient & Urgent Care, Complaints Analysis 2019, includes analysis of 77 complaints received in 2019.	The experience of care during COVID report demonstrated positive results from the service users and carers who returned their surveys. Feedback gained through the Carer Champion evaluations is also largely positive although there are some areas where further improvements are required. The Patient Experience Report and the Complaints Analysis identify communication as one of the top three themes from patient feedback. This same causal analysis is good practice; however, these reports do not include improvement actions. This action is complete, but reviews of patient feedback need to include actions to be undertaken as a result of the analysis, and monitoring mechanisms to ensure implementation.

Detailed Review – *Priority One Recommendations (CCG)*

Recommendation 12: The GP practice must ensure that when the practice is informed that a patient has been admitted to hospital, a review of that patient's appointments and repeat medications is undertaken.

Desired outcome (as agreed by the Trust): The GP practice reviews all appointments and medications after being informed of a hospital admission. Lincolnshire CCGs will brief all relevant GP surgeries on the learning from this investigation.

CCG action plan	CCG response and evidence submitted	Niche comments and gaps on assurance
No stated action.	The Missing Patient Policy 2021 includes guidance about how to deal with queries from carers about vulnerable family members who are reported missing. The Did Not Attend Policy May 2021 provides guidance to staff about actions to take in the event of a service user not attending a planned appointment including those who are deemed to be 'at risk' or vulnerable. In May 2021 the CCG Safeguarding Lead re-circulated a copy of the Niche investigation report published in November 2019 to all local GP Practices. Further communications have also been issued via quarterly newsletters. The CCG has advised that it is more common for GP Practices to be informed of admissions to hospital at the point of discharge. However; there are plans for the CCG's Quality Leads to visit GP Practices to undertake targeted quality audits. These will include compliance with the above mentioned policies and also whether necessary adjustments have been made to medications and appointments if the GP surgery is informed that a patient has been admitted to hospital (and is still an inpatient).	The GP Practice does not have a specific policy for what should be done when they are advised a patient has been admitted to hospital (and is still an inpatient). There is, however, national guidance which covers aspects of this and there are processes in place to check on vulnerable patients if they fail to collect medication or do not attend booked appointments. A programme of audits, undertaken by the Quality Leads, has been planned to test compliance with this recommendation.

Detailed Review – *Priority One Recommendations (CCG)*

Recommendation 13: The GP practice must ensure that prior to removing a patient from a surgery list, the surgery has considered all information in their possession regarding the possible whereabouts of that patient and that they clearly document in the records the basis or rationale for that removal with details and/or a copy of the information upon which the decision is based.

Desired outcome (as agreed by the Trust): *The GP surgery documents the information that is reviewed before any surgery list removals, and the reasons for removal are documented. Lincolnshire CCGs will brief all relevant GP surgeries on the learning from this investigation.*

CCG action plan	CCG response and evidence submitted	Niche comments and gaps on assurance
No stated action.	The Policy for Removal of Patients From Practice List (version 5 published May 2021). Patient Deduction Policy May 2021 provides guidance to staff about actions to take when correspondence is sent from a central services agency to a patient and is returned to them undelivered. In May 2021 the CCG Safeguarding Lead re-circulated a copy of the Niche investigation report that had been published in November 2019 to GP Practices and included a reminder of the guidance available (i.e. British Medical Association Guidance for GPs and the General Medical Council Good Medical Practice) regarding the deregistration of patients and asking them to ensure they have a policy and auditable system in place. This information was also included in a quarterly newsletter in April 2022. An audit of the deduction of patients has taken place and a total of three patients have been removed from this GP practice since the event. All three were due to zero tolerance behaviours and were reported to the police.	The Policy for Removal of Patients From Practice List has been refreshed. This does not contain specific information on the steps to be taken when the GP practice is told that a patient has moved away from the area, but national guidance which is linked to this has been re-circulated to all local GPs. We have been informed that there has been an audit of patient removals but numbers were small and we have not had sight of the information collected or output document. However, the CCG safeguarding team are in the process of forward planning the General Practice Assurance Framework, which will include an audit of the de-registration of patients.

Detailed assurance review findings
Priority Two recommendations

Detailed Review – *Priority Two Recommendations (Trust)*

Recommendation 5: The Trust must ensure that appropriate action is taken when a clinician has advised that a review of a patient's medications is required.

Desired outcome (as agreed by the Trust): *All agreed reviews of changes in medication must be actioned.*

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
1. The Trust will develop and implement a system that ensures requests for medication reviews are followed up. This will include clear guidance for the prescribing and monitoring of medication after a patient has been assessed. 2. The Trust will develop a system whereby any requested reviews are followed up within a set time frame to monitor their completion.	The 2019 Antidepressant Treatment Guidelines were updated in April 2022 and these include a Drug Treatment Algorithm which stipulates timeframes for reviews. Antipsychotic Guidelines March 2021 require clinicians to document their review dates and to reassess the patient in the event of adverse reactions. An audit of five service user clinical care records for each of four wards in February 2022 has found that medications were reviewed as part of the multi-disciplinary team meeting with documentation on the MDT proforma and a written entry in the progress notes. It also found that a pharmacy review had been requested for half (10) of the service users.	The Antipsychotic Guidelines require medication review dates to be documented 'at regular intervals'. More specific or minimum timeframes should be included. A medication audit was undertaken in February 2022 but this did not include whether the requests for pharmacy review were actioned. Further testing is required to ensure that medications are reviewed at appropriate intervals and action taken (within a defined timeframe) when a review has been requested.

Detailed Review – *Priority Two Recommendations (Trust)*

Recommendation 6: The Trust must assure itself and its commissioners that medications are prescribed in accordance with best practice and that timely reviews of the ongoing appropriateness of the dose are undertaken.

Desired outcome (as agreed by the Trust): *Prescribing and reviews must be carried out in line with best practice guidance.*

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
1. The Trust will ensure an MDT approach to engagement with Prescribing Observatory for Mental Health UK (POMH-UK).	Drugs and Therapeutics Committee Terms of Reference. This focuses on promoting the rational use of medicines, safety and quality. Medication Safety Group reports to the Drugs and Therapeutics Committee. Terms of Reference require the meeting to review medication error related data from a range of sources including incidents and audits.	The Drugs and Therapeutics Committee has a multi-disciplinary membership including GP and terms of reference include liaison with the POMH-UK local group as required. There has been an increase in medical participation in meetings where POMH audits are discussed. This action is complete.
2. The Trust will engage with relevant National POMH-UK audits as identified by the pharmacy team and agreed through the Clinical Effectiveness Group.	Rapid Tranquilisation in the context of the pharmacological management of acutely disturbed behaviour POMH-UK October 2018. Early Intervention in Psychosis Spotlight national Clinical Audit and Improving the quality of valproate prescribing in adult mental health POMH-UK audit (2020-21). Medical staff at the Trust are currently collecting data for a POMH-UK clozapine audit. Clinical Effectiveness Group Terms of Reference. Audit results are disseminated by the Medical Director in quality reports to the Medicines Advisory Committee and through the Patient Safety and Experience Report. Results are also discussed in action planning meetings (which are attended by members of the MDT) and in the Clinical Effectiveness Group. Local audits and re-audits have been undertaken including rapid tranquilisation, prescribing in the pandemic, use of anti-psychotics with challenging behaviour, psychotropic medication use for individuals with a diagnosis of emotionally unstable personality disorder (EUPD).	During the period from 1st April 2020 through to 31st March 2021 the Trust was eligible for, and participated in POMH-UK audits. However, there was inconsistent compliance with standards being monitored through the Rapid Tranquilisation clinical audit. The March 2021 POMH-UK report on the quality of valproate prescribing in adult mental health services shows that there are inconsistent prescribing and monitoring processes for this medication. This action is complete but further assurance is required to ensure that actions are implemented to address non-compliances identified in audits.

Detailed Review – *Priority Two Recommendations (Trust)*

Recommendation 6: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
3. Spot check audits undertaken of prescription charts and clinical records to identify areas for improvement and good practice.	Prescription Writing Standards were revised in May 2021. Clinical Pharmacy Service Standards June 2021 include the expected minimum number of ward visits by the pharmacist. The Medicine Management Policy states that the number of pharmacist interventions will be measured six monthly by the clinical pharmacist, and prescribing incidents will be reported quarterly by the Matrons to the Drug and Therapeutics Committee. Monthly medication incident review reports include incidents within the divisions, causation and planned actions. The Medicines Safety Group reviews an action tracker for medication incidents. Five community-based mental health specialist pharmacists have been recruited. These post-holders aim to facilitate good prescribing in community teams and to maintain links with GPs for continuity of patient care. The Trust has provided training to LPFT and GP practice staff on LPFT psychotropic prescribing guidelines for the treatments of depression, psychosis and treatments of anxiety and insomnia. The frequency of attendance at MDTs by pharmacy staff has been increased and new discharge paperwork has been developed to provide GPs with accurate discharge medication records.	One redacted patient record shows evidence of a medication review at an MDT but further audits are required to provide assurance that pharmacists have been attending MDTs and wards at the required frequency. Clinical Pharmacy Service Standards require outcomes to be measured through drug chart audits. Prescription charts are screened regularly, but the required audits have not been completed, and we can see no collation of information or learning resulting from errors noted within the drug chart reviews. The action tracker from the Medicines Safety Group indicates a number of areas where ongoing improvements are required. While medication incidents are now seen to be reducing, the evidence supplied for this action is limited and we cannot be assured that this action has been fully progressed.

Detailed Review – *Priority Two Recommendations (Trust)*

Recommendation 15: The Trust must ensure that a clear focus is maintained on the reasons and purpose of admission throughout any internal ward transfers. ***Desired outcome (as agreed by the Trust):*** *Transfers must be clearly documented, with rationale and care plans in place.*		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
The Trust will review its admission documentation along with the clinical risk assessment and formulation data collection tool and include a clear section which describes the purpose of a patient's admission.	The Clinical Care Policy 2021 requires the reason for, and expected outcome of the admission to be clearly documented and to travel with the patient during their inpatient stay. "All about me" includes information about the service user (gained from the service user, carer(s) and relevant others) and forms a basis for their care plan. Inpatient model flow chart describes the various treatment location options available to service users in hospital and within the community. MDT meeting record form records the type of meeting, the people involved in care, diagnosis, risk assessment, care planning and the views of carers (where applicable). Three examples of patient and carer admission goals forms. These include information from the patient and carer perspective regarding the reasons and purpose of admission. Adult Acute Inpatient Referral Forms include 'purpose/objective of admission'. Rehabilitation Referral Forms include purpose of referral. Supplementary evidence: examples of PICU referrals and rehabilitation assessments.	The Clinical Care Policy and patient/carer admission goals forms require staff to document and retain the reasons for admission. Inpatient referral forms also require the purpose of admission to be confirmed but we have seen no auditing to ensure compliance.

Detailed assurance review findings
Priority Three recommendations

Detailed Review – *Priority Three Recommendations (Trust)*

Recommendation 1: The Trust must ensure that staff complete incident forms at the earliest opportunity and that staff are clear about when this is.
Desired outcome (as agreed by the Trust): *All incident forms must be completed within (the policy guidance deadline).*

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
1. Notification to refresh peoples' knowledge of the required time frame will be distributed via the Trust's Safety Matters Bulletin. .	Datix Incident Reviewer Guidance (Version 3, May 2017) states that incidents should be reported on Datix within one working day. 'Patient Safety – Datix and Incident Reporting' training package (undated) guides all staff to complete incident report forms 'within 24 hours' . Page 19 of 5b Reporting and Management of Risk Policy (incidents, complaints and claims) states that whenever possible, incidents are to be reported within one working day. 'Incidents reported over 24 hours after occurrence' word document, (undated). For more significant events the allocation of a nurse in the police control room ensures prompt notification of incidents which include LPFT service users. Compliance in this area has risen from 75% of incidents reported to Datix within 24hrs in 2018/19 to 100% in 2019-21. Safety Matters Bulletin July 2021, including learning from incidents and the required timeframes for reporting.	The 'Patient Safety- Datix and Incident Reporting' training package gives clear examples of the types of incidents that need reporting; for example, instances of self harm, violence and aggression. As of May 2022, more than 80 staff had received this training. Staff have been notified via policy documents and the Safety Matters Bulletin of the required timeframe to complete incident forms. For the last two years, all incidents in the police control room have been reported to Datix within 24hrs. This action is complete; however, the Trust will need to ensure that staff continue to be reminded of the timeframes required for reporting incidents.

Detailed Review – *Priority Three Recommendations (Trust)*

Recommendation 1: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
2. Ongoing monthly spot check audits will be undertaken, and compliance reported to the Divisional Management Team/quality leads meetings as part of the regular Quality and Safety communications	Incident Reporting Review, Grant Thornton (May 2020), found staff were aware that they are required to report an incident within 24 hours of it occurring. However, in 6/10 serious incidents reviewed, they were not reported within 24 hours. Audit of the incident date vs. incident reported onto Datix conducted by the Safety team (undated). A separate monitoring document with data regarding the "Reporting of incidents" contains the date of when incidents occurred, versus when they were reported, with ongoing analysis through a statistical process control tool.	In May 2020, Grant Thornton found that improvements were required to meet the internal timeframe of incidents being reported on Datix within 24 hours and proposed action points to address them; they have now marked these as complete. Undated audit findings evidenced that 861/5418 (16%) incidents were not reported within 24 hours of the incident occurring and that further improvement was needed to meet this internal timeframe. As an outcome to the review, the following recommendation was made: *'The Quality & Safety Team should continue to monitor compliance with reporting of incidents against each of the prescribed timeframes. Non-compliance with reporting timeframes should be reviewed to identify any common themes and action taken to resolve this*". Ongoing monitoring information supplied in 2022 similarly shows that for 2020 and 2021, 5641 of 6380 incidents (88%) were reported within one working day.

Detailed Review – *Priority Three Recommendations (Trust)*

Recommendation 2: The Trust must ensure that guidance is in place for staff completing serious incident investigation reports, that they use plain English and the templates include section numbering, page numbering and a table of contents.

Desired outcome (as agreed by the Trust): *All serious incident reports must be completed within appropriate policy expectations, with an assurance process in place.*

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
No stated action.	Reporting and Management of Risk Policy (including incidents, near misses, complaints and claims) September 2020 includes some guidance on the management of serious incidents. Three anonymised serious investigation reports. The Trust described how their Serious Incident processes were subject to review in 2016 and aligned to the requirements of the Serious Incident Framework (2015). Subsequent revisions have been made to keep up to date with the local changes. As an interim measure (commenced in February 2019), the internal 'Learning from Deaths Lead' was partially 'acted-up' into a senior position, to lead on 'more complex investigations'. Patient Safety Incident Investigators 'Business Case' (29 January 2021) identified that the Trust had experienced inconsistencies with the quality of serious incident investigations mainly attributed to limited training and experience in root cause and system-based analysis. The Business Case proposed different options to address this with the overarching aim of having a designated investigation team. The Trust considered joining the Royal College of Psychiatrists serious incident investigation accreditation scheme but decided not to proceed in view of NHS England's introduction of the Patient Safety Incident Response Framework.	The Reporting and Management of Risk Policy includes guidance on the completion of investigations, and references the need to ensure that employees undertaking investigations are provided with the appropriate training to enable them to undertake this role. The three samples of anonymised serious incident investigations submitted were written in plain English that included: section numbering, page numbering and a table of contents to meet this recommendation. However, we have not seen evidence of investigation training rates or assurance that investigations are undertaken by staff who have been appropriately trained. Following submission of the Business Case, a Patient Safety Review Team consisting of three investigators and one overall lead, was approved and the team has since been established.

Detailed Review – *Priority Three Recommendations (Trust)*

Recommendation 3: The Trust must assure itself and its commissioners that recommendations in internal reports are fully implemented and that the actions provide sufficient evidence of the effectiveness of the changes made.

Desired outcome (as agreed by the Trust): *All SI action plans are actioned, tracked, signed off and closed at appropriate levels.*

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
1. The safety team will produce a clear process map which details the current serious investigation (SI) pathway from initiation to recommendation action completion.	Action Plan tracker, excel sheet. The Action Plan tracker identifies the number of times a recommendation by theme and year has arisen. It also sets out the actions. It allows the Trust to monitor recommendations by themes per year. Action Plan process, word document (undated). The Trust has produced a one-page diagram summarising the Action Plan process. It covers the relevant steps.	The Trust has set out the process for the Serious Incident pathway and completed Action 1.
2. The clinical audit team will undertake an audit each quarter of 1 SI action plan which is no less than 1 year old.	Monthly Quality & Safety Reports include recommendations resulting from incidents and the number of action plans with overdue actions. Narrative file note states that this action has been revised. A meeting was established in May 2022 to capture learning from SIs but also other data sources such as incidents, complaints, claims, mortality and learning from death reviews. This is aligned to implementation of the Patient Safety Incident Review Framework which will replace the 2015 Serious Incident Framework.	Action plan implementation will be monitored thematically through a recently established meeting, the effectiveness of which will need to be tested after a defined period.
3. Internal audit (Grant Thornton) to complete an audit of 10 randomly selected serious incident investigations and their action plans.	Incident Reporting Review, Grant Thornton (May 2020), reviewed the Trust's arrangements for identifying, reporting and learning from serious incidents. They tested a sample of ten serious incidents to see whether the resultant action plan sufficiently addressed the issues raised from the investigation, whether their management adhered to Trust policy and whether the timeframes had been met. They also interviewed Trust staff to assess how learning from a serious incident investigation had been communicated throughout Trust services. There are minutes 22/04/2021 of Council of Governors Meeting where the findings of Grant Thornton's review of Clinical Care Policy were reviewed.	Grant Thornton have marked the actions from their audit as complete.

Detailed Review – *Priority Three Recommendations (Trust)*

Recommendation 4: The Trust must assure itself and its commissioners that staff use every opportunity to triangulate information about clients from all reasonably available sources.

Desired outcome (as agreed by the Trust): *Admission and assessment documents are comprehensive and document sources used.*

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
1. The Trust to ensure that admission checklist/ documentation clearly evidences agencies/ individuals who have been contacted as part of the history taking and assessment process.	Brant Ward Risk Audit Tool (08/01/2021). Risk Assessment Audit Toolkit. Preventing Suicide Audit-Older Adults Home Treatment Team (15/01/2021). An audit was undertaken of five sets of service user case notes from each clinical setting /team. Older Adults HTT audit (05/05/2021). Five service users were audited. These confirmed a carer had been identified, their contact details and that a risk assessment was present.	It is unclear how the samples were selected for the audits provided and sample sizes are too small to draw conclusions about whether the findings are reflective of the team/wider service. Further rolling audits or audits with larger samples are required to provide assurance that this action is complete.
2. The Trust will review its Person-Centred Care training and ensure that the importance and rationale of obtaining history/information from relevant sources is included.	Page 35 of the Trust's Clinical Care Policy 2021 describes best practice for Clinical Risk Assessment and Management. Page 36 describes the risk assessment process. Person-Centred Care Planning & Risk Assessment' training package (2018-2021). The importance of service user and carer involvement is covered in the training and the importance of obtaining history/ information from relevant sources.	As of August 2021, 464 staff have attended the "Person-Centred Care Planning and Risk Assessment training". Training is on-going. This action is complete, but audits are required to ensure that history/information from relevant sources is collected as part of the risk assessment process.

Detailed Review – *Priority Three Recommendations (Trust)*

Recommendation 8: The Trust must ensure that a communication protocol with the police is developed and implemented when the police are involved in a patient's management. ***Desired outcome (as agreed by the Trust):*** *A police liaison protocol is in place for inpatient units.*		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
No stated action.	A Memorandum of Understanding and operational protocol for Section 135/136 Mental Health Act procedures was developed in September 2018 between Lincolnshire Police, Lincolnshire County Council, East Midlands Ambulance Service NHS Trust, United Lincolnshire Hospitals NHS Trust, South-West Lincolnshire CCG and LPFT. The Action Plan confirms that a meeting took place between LPFT and Lincolnshire Police in July 2017. It was agreed that the existing protocol was working "much better" on acute inpatient units and should be rolled out across all LPFT mental health units and refreshed across all organisations. The Action Plan states that the operational protocol should be updated in line with "National Partnership Protocol for Managing Risk and Investigating Crime in Mental Health Settings". NHS Protect (March 2017) by LPFT and Lincolnshire Police disseminated trust wide. The Trust now has an excellent working relationship with the Lincolnshire Police which is strongly built from the member of Trust staff based within the Police control room. LPFT's safeguarding team are also based within Lincolnshire Police's Protecting Vulnerable Peoples hub which improves communication and risk assessment/public protection. There are now regular Police Liaison meetings where issues can be addressed promptly. Minutes of the Police Liaison Meeting dated 18/03/2021 were shared. The Agenda for the Police Liaison Meeting dated 15/04/2021 was also shared.	A liaison protocol has been developed regarding Section 135 and 136. The minutes of the monthly Police Liaison Meeting dated 18/03/2021 demonstrate there is a system in place to discuss compliance with this. Nursing staff are currently working from home due to the pandemic and not based in the Police control room but audit results support the prompt reporting of significant events (see recommendation 1). Minutes of the Police Liaison Meeting dated 18/03/2021 show joint working with the police. The minutes evidence that monthly meetings are being held and several Trust services are represented. This action is complete and has been tested but the Trust will need to ensure that improvements are sustained going forward.

Detailed Review – *Priority Three Recommendations (Trust)*

Recommendation 14: The Trust must ensure that service changes are properly monitored in the post-implementation phase. Analysis should include governance success indicators, staff satisfaction assessments, patient experience scores and overall performance rates.

Desired outcome (as agreed by the Trust): *The implementation of service developments are monitored.*

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
1. All planned service changes will include from the outset clear metrics for analysis post implementation including (but not limited to) areas such as: a) Staff satisfaction assessments b) Patient experience scores c) Overall performance rates	The Investment Appraisal Framework has been updated and includes the need for a post implementation/submission lessons learned review. It states an evaluation should be undertaken within six months on all major transactions/investments especially where significant risks are identified as part of the investment. This will be established through the newly implemented Business Case Review Team (BCRT) which launched in March 2020 and is detailed within the group's Terms of Reference (ToR). Business cases are now required to produce a post project report to detail benefits realisation. The standard business case template has been revised to include a benefits realisation section for the business case author to complete. The author must: describe how they will measure the impact of the recommended change; outline the key indicators, information, data that will be collected and how will this be gathered; clarify what will be used as a baseline to measure change against; and propose a time for benefit realisation and lessons learned report to be completed. The Trust has started the process of recalling business cases which have been approved by BCRT/Strategic Delivery Team from April 2020 to provide a benefits realisation report in line with the Trust's Investment Appraisal Framework. A copy of the "XXX Temporary Accommodation six-month review April to August 2020".	The Investment Appraisal Framework sets out the expectation that an evaluation will be conducted within six months on major transactions/ investments. One example was shared with us. The "XX Temporary Accommodation Six Month Review Report" provides evidence that a review of this new service was undertaken, including measurement of the impact on service users and staff. Further evidence of the impact of other service developments are not yet available. The revised standard business case template also requires inclusion of how service changes will be monitored post implementation. This provides some assurance that there will be a consistent approach going forward. We did not receive evidence that any tenders which the Trust has secured include key performance indicators which can be used to monitor the impact of the new service on staff, service users and carers.

Appendices

Appendix A – Glossary of terms

AIUC	Adult Inpatient and Urgent Care
BCRT	Business Case Review Team
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CRHTT	Crisis Resolution Home Treatment Team
DASH	Domestic abuse, stalking and honour based violence risk assessment.
EUPD	Emotionally unstable personality disorder
GMC	General Medical Practice
GP	General Practitioner
HTTs	Home Treatment Teams
KPIs	Key Performance Indicators
LPFT	Lincolnshire Partnership NHS Foundation Trust
MDT	Multi-disciplinary team
NIAF	Niche Investigation and Assurance Framework
OPFD	Older People and Frailty Division
POMH-UK	National Prescribing Observatory for Mental Health UK
PSIRF	Patient Safety Incident Response Framework
RCPsych	Royal College of Psychiatrists
QIP	Quality Improvement Programme
Q2	Quarter two of the year (April-June)
RiO	Electronic patient record system
SI	Serious incident
SOP	Standard Operating Procedure
TOR	Terms of Reference

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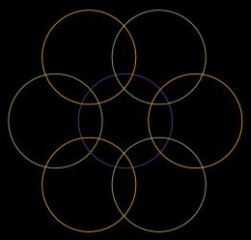

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