Leicestershire Partnership NHS Trust

Quality Assurance Committee – December 2022

Quality & Safety Review

Purpose of the report

In response to a letter received from the National Director for Mental Health on 30 September 2022, NHS Trusts are asked to undertake an immediate quality and safety review of inpatient mental health, learning disability and autism services. Trusts are asked to consider the following as part of the review:

1. **Boards to review the safeguarding of care in the organisation and identify any immediate issues requiring action now; including but not limited to:**

- Freedom to speak up arrangements,
- Advocacy provision,
- Complaints,
- CETRs and ICETRs,
- Other feedback on services.
- Could this happen here?
- How would we know?
- How robust is the assessment of services and the culture of services?
- Are we visible enough and do we hear enough from patients, their families? and all staff on a ward e.g., the porter, cleaner, HCAs?

2. **In your own organisations you must ask:**

- How you are not only hearing the patient voice, but how you are acting on it?
- When people and families tell us things are not right as leaders, we must act. We should therefore consider independent peer-led support to people being cared for in your most restrictive settings and peer-led feedback mechanisms.

3. **Review why people in our services are in Seclusion and Long-Term Segregation, how long for, what is the plan to support them out of these restrictive settings?**

The Group Director of Patient Safety has led the review of LPT services and focussed on a one-year period between October 2021 – September 2022. Terms of reference for the review are included in Appendix 1.

Analysis of the issue

A key component of the quality & safety review is the learning that can be achieved with regards to how we recognise early signs of closed cultures within LPT services. CQC define a closed culture as 'a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm. Although the focus is primarily on inpatient mental health and learning disability services, it is important to reflect that any service that delivers care can have a closed culture.

The indicators of a closed culture include.

- people in a service are highly dependent on staff for their basic needs
- People in a service are less able to speak up for themselves without good support, for example, in learning disability or children's services or care homes for people with dementia
- Restrictive practices are used in a service
- People remain in a service such as a mental health unit for months or years.
- Staff not understanding or speaking warmly about the people they are caring for.
- Staff belittling, excluding, or taunting people.
- Care plans not being individualised or reflecting the person's voice.
- A lack of reasonable adjustments for disabled people.
- Poor or absent communication plans for people who have communication needs and or communication plans not being followed.
- Potentially punitive approach to care.
- Restrictions, including restraint, long-term segregation, and prolonged seclusion, being imposed on people without an assessment of need, legal authority/legitimate aim or that have been imposed legitimately but are not subject to review and or do not ease over time.
- Blanket restrictions are in place and are not necessarily the least restrictive option.
- People being asked to go to their rooms or another area and prevented from leaving.
- The way premises are being used leads to increased restriction or lack of choice for people. For example, in mental health services, seclusion facilities are being used for long-term segregation without any adaptations to meet the needs of the person.
- Poor application or understanding of the Mental Capacity Act (MCA) and Mental Health Act (MHA), including not following the MCA, DoLS and MHA Codes of Practice.
- Concerns about medicine management including inappropriate use of medicines to restrain or control behaviour.
- People are not safeguarded against discrimination, harm, and abuse. For example, specific concerns raised in relation to this or a high or increasing number of safeguarding incidents, complaints, poor feedback through surveys, NHS choices or other notifications.
- In inpatient mental health units, no or poor information about rights provided to people and their families when they first arrive in hospital as well as at regular interval during their stay in hospital.

Potential causes of a closed culture include weak leadership and management; Poor skills, training and supervision of staff providing care; Lack of external oversight.

The Quality & Safety review has focussed on the following LPT services:

- MH Adult acute wards
- OPMH Wards
- Adult PICU
- Long stay rehabilitation ward
- Forensic wards

- CAMHS Wards
- Learning disability wards

Complaints & concerns data

Between October 2021 – September 2022, there were 3 complaints received regarding the services the review has focussed on and that align with the indicators of closed cultures:

- Of the 3 complaints received during this period, all were related to mental health wards (Aston, Wakerley & Welford wards)
- 2 were categorised as failure to provide adequate care and 1 failure to act in a professional manner.

Between October 2021 – September 2022, there were 17 concerns received regarding the services the review has focussed on and that align with the indicators of closed cultures:

Directorate of Mental Health:

- Ashby ward: 3 of the concerns related to Ashby ward with all being due to failure to provide adequate care and 1 due to referral/delay.
- Aston Ward: 2 of the concerns related to Aston ward, 1 being due to failure to provide adequate care and 1 due to care needs not being adequately met.
- Beaumont Ward: 2 of the concerns related to Beaumont ward, both were due to a failure to provide adequate care.
- Bosworth Ward: 1 of the concerns related to Bosworth ward and was due to Mental Health Act detention.
- Thornton Ward: 1 of the concerns related to Thornton ward and was due to discharge arrangements.
- Watermead Ward: 1 of the concerns related to Watermead ward and was due to Mental Health Act: Disagreement with Section.
- Kirby Ward: 1 of the concerns related to Kirby ward and was due to Failure to provide adequate care
- Welford ward: 2 of the concerns related to Welford ward, 1 due to delay or failure in treatment or procedure and 1 due to inadequate support provided
- Wakerley Ward: 1 of the concerns related to Wakerley ward and was due to incorrect/no information given.
- Skye wing: 1 of the concerns related to Skye wing and was due to privacy and dignity.
- Veteran's service: 1 of the concerns related to the Veterans service and was due to privacy and dignity

Families, Young People, Children & LD:

- Beacon ward: 1 concern was received relating to Beacon ward, this was due to failure to provide adequate care.

Key points from complaints and concerns:

- The number of complaints received regarding mental health wards suggests that those people who use the services know how to and are given information on how to provide feedback. Those providing formal feedback, such as complaints, are supported to do so.
- Most complaints and concerns relate to failure to provide adequate care
- There were no recorded withdrawn complaints during this period.

Friends & Family Test

The Friends & Family Test care data for the Trust is captured for the period October 2021 – September 2022:

Acute MH wards	Eligible patients	Total responses
Ashby	56	3
Aston	11	1
Beaumont	210	6
Belvoir Unit	44	1
Bosworth	84	5
Griffin	0	0
Heather	117	15
Phoenix	9	9
Thornton	36	4
Watermead	103	5

Long-stay rehabilitation MH wards	Eligible patients	Total responses
Mill Lodge	24	16
Stewart House	17	1

LD wards	Eligible patients	Total responses
Agnes Unit	9	9

CAMHS Wards	Eligible patients	Total responses
Beacon	17	10

Older People' MH wards	Eligible patients	Total responses
Coleman	5	5

Key points for Friends & Family Test:

- Aside from Mill Lodge, Beacon and the Agnes unit, response rates are low across the inpatient areas
- We do have access to demographic data however, it is difficult to extract this. We have requested Health comms, who oversee the Envoy system, review this and develop the system so that we can extract the data in one report.
- In terms of working and supporting services to increase responses rates – the patient experience team send out a quarterly FFT newsletter which has incentives for each quarter. The team also audit response rates monthly and link in with the service leads to look at ways of improving low response rates. We are planning to reintroduce patient experience champions in each service to support services with patient feedback.

- We are also asking services to inform people of improvements made because of patient feedback by uploading a 'feedback into action' learning board on our public website, and the 'You said we did' posters that can be displayed in wards and outpatient clinics.

Patient Safety

The patient safety team provide advice, support, guidance, and training to clinical and non-clinical services. The team also interface with commissioners, Local Authority, Police and coroners and report incident data into national portals.

Between Oct 21-Sept 22, there were 5446 patient incidents reported on Ulysses, averaging 453 incidents per month. In this period, there were 1026 reported incidents (reported by MH/LD/CAMHS inpatients) that were searched on Ulysses as potentially meeting the indicators of a closed culture. On examination of the incidents:

Of the 1026 that potentially meet some of the indicators of a closed culture:

- 439 of the incidents reported were related to Langley ward
- 188 of the incidents reported were related to Beacon Unit
- 67 of the incidents reported were related to Beaumont ward
- 51 of the incidents reported were related to Heather ward
- 41 of the incidents reported were related to Watermead ward
- 41 of the incidents reported were related to Belvoir ward
- 27 of the incidents reported were related to Ashby Ward
- 20 of the incidents reported were related to Griffin ward (PICU)
- 19 of the incidents reported were related to The Willows
- 17 of the incidents reported were related to The Agnes Unit
- 17 of the incidents reported were related to Kirby ward
- 14 of the incidents reported were related to Thornton ward
- 12 of the incidents reported were related to Bosworth ward
- 12 of the incidents reported were related to Skye Wing
- 12 of the incidents reported were related to Welford ward
- 10 of the incidents reported were related to Wakerley ward
- 9 of the incidents reported were related to Coleman ward
- 9 of the incidents reported were related to Phoenix ward (Herschel Prins centre)
- 8 of the incidents reported were related to Aston ward
- 6 of the incidents reported were related to Mill lodge
- 4 of the incidents reported were related to The Grange
- 2 of the incidents reported were related to Gwendolen ward
- 1 of the incidents reported were related to The Gillivers

Cause:

- 65% were related to Mental Health Act
- 10% were related to case notes/records
- 7% were related to Access/discharge
- 5% were related to environment
- 4% were related to communication

- 3% were related to confidentiality
- 1% were related to hate/prevent
- 3% were related to nutrition/hydration
- 2% were related to safeguarding and consent

Severity:

- 93.7% were categorised as no harm
- 6% were categorised as low harm
- 0.3% were categorised as moderate harm

Key points for patient safety

- The data suggests that the Trust has a high reporting culture.
- Reporting predominantly relates to the MHA (94% relate to treatment against consent). The data suggests that a high proportion relate to NG tube feeding using MAPA holds under Section 62 of the MHA due to patient resistance. Section 62 allows for urgent treatment to be given to detained patients in advance of the Section 58 safeguards. A Second Opinion Appointed Doctor should normally have been requested before Section 62 is used. To be lawful under Section 62 medication/treatment must be immediately necessary to; Save the patient's life; or (Not being irreversible) prevent a serious deterioration in their condition; or alleviate serious suffering; or represent the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or others.
- Most incidents reported that include indicators of a closed culture were categorised as no harm.
- Langley ward and The Beacon Unit are the outliers making up 61% of those reported although in the case of the Beacon Unit, several of these relate to treatment against consent and the fact these are being reported demonstrates transparency and openness.
- Currently, it is challenging to determine from incidents reported on Ulysses as to whether staff are raising concerns that amount to a closed culture.

Incidents that are categorised as moderate or above in severity are discussed at the weekly Incident Review Meeting which is MDT in approach and chaired by the Head of Patient Safety or Deputy Director of Nursing.

Mandatory Training

FYPC&LD

Certification	Conflict Resolution		Equality, Diversity & Human Rights		Fire Safety Awareness		Health, Safety & Welfare		Infection Prevention & Control Level 1	
Team	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total
313 1810 Langley Ward ED Inpatient Service	96.60%	(28/29)	96.60%	(28/29)	89.70%	(26/29)	100.00%	(29/29)	100.00%	(29/29)
313 4900 CAMHS Inpatient Services - Ward 3	94.40%	(34/36)	97.20%	(35/36)	77.80%	(28/36)	97.20%	(35/36)	94.40%	(34/36)
313 5980 Agnes Unit Management	100.00%	(52/52)	100.00%	(52/52)	92.30%	(48/52)	98.10%	(51/52)	100.00%	(52/52)

Certification	Data Security Awareness (IG)		Moving & Handling Level 1		Safeguarding Adults Level 1		Safeguarding Children Level 1		Prevent Basic Awareness		PPE Donning & Doffing	
Team	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total
313 1810 Langley Ward ED Inpatient Service	93.10%	(27/29)	93.10%	(27/29)	86.20%	(25/29)	86.20%	(25/29)	100.00%	(29/29)	100.00%	(29/29)
313 4900 CAMHS Inpatient Services - Ward 3	86.10%	(31/36)	91.70%	(33/36)	83.30%	(30/36)	86.10%	(31/36)	88.90%	(32/36)	100.00%	(36/36)
313 5980 Agnes Unit Management	94.20%	(49/52)	100.00%	(52/52)	98.10%	(51/52)	98.10%	(51/52)	96.20%	(50/52)	100.00%	(52/52)

Mental Health:

Certification	Conflict Resolution		Equality, Diversity & Human Rights		Fire Safety Awareness		Health, Safety & Welfare		Infection Prevention & Control Level 1	
Team	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total
313 0021 Inpatient Management	88.90%	(8/9)	100.00%	(9/9)	77.80%	(7/9)	100.00%	(9/9)	100.00%	(9/9)
313 0024 Rehab & HD Management	100.00%	(2/2)	100.00%	(2/2)	100.00%	(2/2)	100.00%	(2/2)	100.00%	(2/2)
313 0025 Adult & LD Management	100.00%	(4/4)	100.00%	(4/4)	100.00%	(4/4)	100.00%	(4/4)	100.00%	(4/4)
313 0026 Psychology & Psychological Therapies Mgt	100.00%	(7/7)	100.00%	(7/7)	85.70%	(6/7)	100.00%	(7/7)	100.00%	(7/7)
313 0340 Bosworth Ward	91.30%	(21/23)	91.30%	(21/23)	87.00%	(20/23)	91.30%	(21/23)	78.30%	(18/23)
313 0570 Willows Unit	100.00%	(2/2)	50.00%	(1/2)	50.00%	(1/2)	100.00%	(2/2)	100.00%	(2/2)
313 0574 Cedar (Willows)	100.00%	(16/16)	100.00%	(16/16)	100.00%	(16/16)	100.00%	(16/16)	100.00%	(16/16)
313 0576 Sycamore (Willows)	100.00%	(12/12)	100.00%	(12/12)	75.00%	(9/12)	100.00%	(12/12)	91.70%	(11/12)
313 0578 Maple Ward (Willows)	100.00%	(13/13)	100.00%	(13/13)	92.30%	(12/13)	100.00%	(13/13)	100.00%	(13/13)
313 0590 Stewart House	100.00%	(33/33)	100.00%	(33/33)	84.80%	(28/33)	100.00%	(33/33)	100.00%	(33/33)
313 0600 Veterans Team	0.00%	(0/1)	100.00%	(1/1)	0.00%	(0/1)	100.00%	(1/1)	100.00%	(1/1)
313 0920 Bradgate Wards Other	100.00%	(6/6)	100.00%	(6/6)	83.30%	(5/6)	100.00%	(6/6)	100.00%	(6/6)
313 0940 Thornton Ward - Bradgate Unit	95.80%	(23/24)	91.70%	(22/24)	95.80%	(23/24)	91.70%	(22/24)	91.70%	(22/24)
313 0950 Watermead Ward (Bradgate Unit)	100.00%	(20/20)	100.00%	(20/20)	85.00%	(17/20)	100.00%	(20/20)	100.00%	(20/20)
313 0955 AMH Inpatient Psychology	84.60%	(11/13)	92.30%	(12/13)	84.60%	(11/13)	92.30%	(12/13)	84.60%	(11/13)
313 1850 Beaumont Ward - Bradgate Unit	90.90%	(20/22)	86.40%	(19/22)	81.80%	(18/22)	90.90%	(20/22)	95.50%	(21/22)
313 1860 Belvoir Psychiatric Intensive Care Unit	96.80%	(30/31)	100.00%	(31/31)	80.60%	(25/31)	96.80%	(30/31)	100.00%	(31/31)
313 2012 Griffin Ward (HPC)	100.00%	(17/17)	100.00%	(17/17)	82.40%	(14/17)	100.00%	(17/17)	100.00%	(17/17)
313 2014 Phoenix Ward (HPC)	100.00%	(20/20)	95.00%	(19/20)	95.00%	(19/20)	100.00%	(20/20)	100.00%	(20/20)
313 2015 Bradgate Admin	100.00%	(7/7)	100.00%	(7/7)	100.00%	(7/7)	100.00%	(7/7)	100.00%	(7/7)
313 2365 Heather Ward	100.00%	(19/19)	100.00%	(19/19)	84.20%	(16/19)	100.00%	(19/19)	94.70%	(18/19)
313 2410 Ashby Ward (Bradgate Unit)	95.70%	(22/23)	91.30%	(21/23)	69.60%	(16/23)	95.70%	(22/23)	91.30%	(21/23)
313 3410 MHSOP Inpatient Therapy - Evington	90.90%	(10/11)	90.90%	(10/11)	72.70%	(8/11)	90.90%	(10/11)	90.90%	(10/11)
313 3415 MHSOP Inpatient Therapy - Bennion	100.00%	(15/15)	100.00%	(15/15)	100.00%	(15/15)	100.00%	(15/15)	100.00%	(15/15)
313 3610 Gwendolen Ward	94.40%	(34/36)	97.20%	(35/36)	100.00%	(36/36)	94.40%	(34/36)	100.00%	(36/36)
313 3620 Kirby Ward	100.00%	(26/26)	100.00%	(26/26)	96.20%	(25/26)	100.00%	(26/26)	92.30%	(24/26)
313 3710 Wakerley Ward	50.00%	(1/2)	50.00%	(1/2)	50.00%	(1/2)	50.00%	(1/2)	100.00%	(2/2)
313 3910 Coleman Ward	93.10%	(27/29)	96.60%	(28/29)	82.80%	(24/29)	93.10%	(27/29)	96.60%	(28/29)
313 3920 Welford Ward	92.90%	(26/28)	96.40%	(27/28)	75.00%	(21/28)	89.30%	(25/28)	96.40%	(27/28)

Certification	Data Security Awareness (IG)		Moving & Handling Level 1		Safeguarding Adults Level 1		Safeguarding Children Level 1		Prevent Basic Awareness		PPE Donning & Doffing	
Team	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total
313 0021 Inpatient Management	100.00%	(9/9)	100.00%	(9/9)	100.00%	(9/9)	100.00%	(9/9)	100.00%	(9/9)	100.00%	(9/9)
313 0024 Rehab & HD Management	100.00%	(2/2)	100.00%	(2/2)	100.00%	(2/2)	100.00%	(2/2)	100.00%	(2/2)	100.00%	(2/2)
313 0025 Adult & LD Management	100.00%	(4/4)	75.00%	(3/4)	75.00%	(3/4)	50.00%	(2/4)	75.00%	(3/4)	75.00%	(3/4)
313 0026 Psychology & Psychological Therapies Mgt	100.00%	(7/7)	100.00%	(7/7)	100.00%	(7/7)	100.00%	(7/7)	100.00%	(7/7)	100.00%	(7/7)
313 0340 Bosworth Ward	91.30%	(21/23)	95.70%	(22/23)	87.00%	(20/23)	82.60%	(19/23)	78.30%	(18/23)	95.70%	(22/23)
313 0570 Willows Unit	50.00%	(1/2)	100.00%	(2/2)	50.00%	(1/2)	50.00%	(1/2)	100.00%	(2/2)	100.00%	(2/2)
313 0574 Cedar (Willows)	100.00%	(16/16)	100.00%	(16/16)	100.00%	(16/16)	100.00%	(16/16)	100.00%	(16/16)	100.00%	(16/16)
313 0576 Sycamore (Willows)	91.70%	(11/12)	100.00%	(12/12)	100.00%	(12/12)	100.00%	(12/12)	100.00%	(12/12)	100.00%	(12/12)
313 0578 Maple Ward (Willows)	92.30%	(12/13)	100.00%	(13/13)	92.30%	(12/13)	100.00%	(13/13)	100.00%	(13/13)	100.00%	(13/13)
313 0590 Stewart House	97.00%	(32/33)	97.00%	(32/33)	93.90%	(31/33)	93.90%	(31/33)	93.90%	(31/33)	100.00%	(33/33)
313 0600 Veterans Team	0.00%	(0/1)	100.00%	(1/1)	100.00%	(1/1)	100.00%	(1/1)	100.00%	(1/1)	0.00%	(0/1)
313 0920 Bradgate Wards Other	83.30%	(5/6)	100.00%	(6/6)	83.30%	(5/6)	83.30%	(5/6)	100.00%	(6/6)	100.00%	(6/6)
313 0940 Thornton Ward - Bradgate Unit	91.70%	(22/24)	83.30%	(20/24)	91.70%	(22/24)	87.50%	(21/24)	91.70%	(22/24)	100.00%	(24/24)
313 0950 Watermead Ward (Bradgate Unit)	95.00%	(19/20)	100.00%	(20/20)	95.00%	(19/20)	100.00%	(20/20)	95.00%	(19/20)	95.00%	(19/20)
313 0955 AMH Inpatient Psychology	84.60%	(11/13)	84.60%	(11/13)	92.30%	(12/13)	92.30%	(12/13)	92.30%	(12/13)	100.00%	(13/13)
313 1850 Beaumont Ward - Bradgate Unit	77.30%	(17/22)	90.90%	(20/22)	95.50%	(21/22)	90.90%	(20/22)	90.90%	(20/22)	100.00%	(22/22)
313 1860 Belvoir Psychiatric Intensive Care Unit	93.50%	(29/31)	100.00%	(31/31)	96.80%	(30/31)	96.80%	(30/31)	96.80%	(30/31)	100.00%	(31/31)
313 2012 Griffin Ward (HPC)	88.20%	(15/17)	94.10%	(16/17)	100.00%	(17/17)	100.00%	(17/17)	94.10%	(16/17)	100.00%	(17/17)
313 2014 Phoenix Ward (HPC)	90.00%	(18/20)	95.00%	(19/20)	95.00%	(19/20)	100.00%	(20/20)	100.00%	(20/20)	100.00%	(20/20)
313 2015 Bradgate Admin	100.00%	(7/7)	100.00%	(7/7)	100.00%	(7/7)	100.00%	(7/7)	100.00%	(7/7)	100.00%	(7/7)
313 2365 Heather Ward	84.20%	(16/19)	100.00%	(19/19)	100.00%	(19/19)	100.00%	(19/19)	100.00%	(19/19)	100.00%	(19/19)
313 2410 Ashby Ward (Bradgate Unit)	87.00%	(20/23)	95.70%	(22/23)	91.30%	(21/23)	91.30%	(21/23)	91.30%	(21/23)	95.70%	(22/23)
313 3410 MHSOP Inpatient Therapy - Evington	90.90%	(10/11)	90.90%	(10/11)	81.80%	(9/11)	81.80%	(9/11)	90.90%	(10/11)	100.00%	(11/11)
313 3415 MHSOP Inpatient Therapy - Bennion	100.00%	(15/15)	86.70%	(13/15)	100.00%	(15/15)	100.00%	(15/15)	100.00%	(15/15)	100.00%	(15/15)
313 3610 Gwendolen Ward	100.00%	(36/36)	94.40%	(34/36)	100.00%	(36/36)	100.00%	(36/36)	97.20%	(35/36)	100.00%	(36/36)
313 3620 Kirby Ward	96.20%	(25/26)	100.00%	(26/26)	92.30%	(24/26)	92.30%	(24/26)	96.20%	(25/26)	100.00%	(26/26)
313 3710 Wakerley Ward	50.00%	(1/2)	50.00%	(1/2)	50.00%	(1/2)	50.00%	(1/2)	50.00%	(1/2)	50.00%	(1/2)
313 3910 Coleman Ward	89.70%	(26/29)	89.70%	(26/29)	89.70%	(26/29)	86.20%	(25/29)	89.70%	(26/29)	96.60%	(28/29)
313 3920 Welford Ward	82.10%	(23/28)	96.40%	(27/28)	92.90%	(26/28)	92.90%	(26/28)	92.90%	(26/28)	100.00%	(28/28)

Key points from mandatory training:

- The overall data shows compliance is above or approaching Trust target for FYPC&LD
- Data for MH wards is predominantly above or approaching Trust target. There are outliers which are significantly below target with regards to Wakerley Ward & Willows Unit.

<u>Appraisal & Supervision</u>

FYPC&LD:

Topic Group	Appraisal/Supervision							
Certification	Appraisal		Clinical Supervision		Managerial Supervision		Safeguarding Supervision	
Team	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total
313 1810 Langley Ward ED Inpatient Service	82.10%	(23/28)	85.20%	(23/27)	75.00%	(21/28)		(0/0)
313 4900 CAMHS Inpatient Services - Ward 3	75.00%	(24/32)	80.60%	(25/31)	78.10%	(25/32)	45.80%	(11/24)
313 5980 Agnes Unit Management	82.00%	(41/50)	83.30%	(40/48)	78.00%	(39/50)		(0/0)

Mental Health:

Topic Group	Appraisal/Supervision					
Certification	Appraisal		Clinical Supervision		Managerial Supervision	
Team	% Indate	Indate / Total	% Indate	Indate / Total	% Indate	Indate / Total
313 0021 Inpatient Management	100.00%	(9/9)	50.00%	(1/2)	77.80%	(7/9)
313 0024 Rehab & HD Management	50.00%	(1/2)		(0/0)	50.00%	(1/2)
313 0025 Adult & LD Management	50.00%	(2/4)	100.00%	(1/1)	100.00%	(4/4)
313 0026 Psychology & Psychological Therapies Mgt	100.00%	(7/7)	57.10%	(4/7)	85.70%	(6/7)
313 0340 Bosworth Ward	78.30%	(18/23)	68.20%	(15/22)	69.60%	(16/23)
313 0570 Willows Unit	50.00%	(1/2)	50.00%	(1/2)	50.00%	(1/2)
313 0574 Cedar (Willows)	93.80%	(15/16)	100.00%	(16/16)	100.00%	(16/16)
313 0576 Sycamore (Willows)	100.00%	(12/12)	91.70%	(11/12)	91.70%	(11/12)
313 0578 Maple Ward (Willows)	84.60%	(11/13)	84.60%	(11/13)	84.60%	(11/13)
313 0590 Stewart House	84.80%	(28/33)	90.90%	(30/33)	90.90%	(30/33)
313 0600 Veterans Team	100.00%	(1/1)		(0/0)	0.00%	(0/1)
313 0920 Bradgate Wards Other	50.00%	(3/6)	75.00%	(3/4)	66.70%	(4/6)
313 0940 Thornton Ward - Bradgate Unit	83.30%	(20/24)	79.20%	(19/24)	79.20%	(19/24)
313 0950 Watermead Ward (Bradgate Unit)	80.00%	(16/20)	94.10%	(16/17)	89.50%	(17/19)
313 0955 AMH Inpatient Psychology	30.80%	(4/13)	69.20%	(9/13)	53.80%	(7/13)
313 1850 Beaumont Ward - Bradgate Unit	86.40%	(19/22)	80.00%	(16/20)	81.00%	(17/21)
313 1860 Belvoir Psychiatric Intensive Care Unit	83.90%	(26/31)	72.40%	(21/29)	73.30%	(22/30)
313 2012 Griffin Ward (HPC)	88.20%	(15/17)	47.10%	(8/17)	41.20%	(7/17)
313 2014 Phoenix Ward (HPC)	65.00%	(13/20)	80.00%	(16/20)	80.00%	(16/20)
313 2015 Bradgate Admin	71.40%	(5/7)		(0/0)	14.30%	(1/7)
313 2365 Heather Ward	89.50%	(17/19)	70.60%	(12/17)	72.20%	(13/18)
313 2410 Ashby Ward (Bradgate Unit)	65.20%	(15/23)	47.60%	(10/21)	36.40%	(8/22)
313 3410 MHSOP Inpatient Therapy - Evington	63.60%	(7/11)	72.70%	(8/11)	72.70%	(8/11)
313 3415 MHSOP Inpatient Therapy - Bennion	80.00%	(12/15)	86.70%	(13/15)	93.30%	(14/15)
313 3610 Gwendolen Ward	97.20%	(35/36)	88.60%	(31/35)	88.90%	(32/36)
313 3620 Kirby Ward	92.00%	(23/25)	95.80%	(23/24)	96.00%	(24/25)
313 3710 Wakerley Ward	0.00%	(0/2)	50.00%	(1/2)	50.00%	(1/2)
313 3910 Coleman Ward	93.10%	(27/29)	39.30%	(11/28)	37.90%	(11/29)
313 3920 Welford Ward	85.70%	(24/28)	80.80%	(21/26)	77.80%	(21/27)

Key points from appraisal & supervision:

- The overall data shows compliance is above or approaching Trust target for FYPC&LD
- Data for MH wards is predominantly below Trust target. Triangulation with mandatory training shows that Wakerley Ward & Willows Unit are again outliers. However, it has been confirmed that the Wakerley data is inaccurate due to staff who no longer work in the service remaining on the workforce data.

NHS Staff Survey

The high-level analysis of the 2021 National Staff Survey results (shown below) indicate that Leicestershire Partnership NHS Trust is higher than the average across all questions under the People Promise element – '*We each have a voice that counts'* and demonstrates a continued improving trajectory on the 2020 survey. This is very positive and suggests an embedding of a culture where staff feel safe and able to speak up.

Question 17a - I would feel secure raising concerns about unsafe clinical practice

	2020	2021
Best	81.7%	86.1%
LPT	**75.5%**	**81.5%**
Average	75.6%	79.6%

Question 17b - I am confident that my organisation would address my concern

	2020	2021
Best	76.5%	74.4%
LPT	**62.0%**	**65.1%**
Average	63.1%	64.2%

Question 21e - I feel safe to speak up about anything that concerns me in this organisation

	2020	2021
Best	78.3%	78.7%
LPT	**68.0%**	**69.1%**
Average	68.3%	66.8%

Question 21f - If I spoke up about something that concerned me, I am confident my organisation would address my concern – *no trend data are shown as this is a new question*

	2021
Best	71.3%
LPT	**56.8%**
Average	55.1%
Worst	34.3%

The FTSUG is working collaboratively with the People Promise Manager, Health and Wellbeing Lead, Organisational Development Lead and Staff Engagement Lead to underpin and embed the key FTSU messages within these work domains. The Model Health System supported by NHS England provides data sets and will be used to provide benchmarking data across the wider NHS peer group.

Workforce analytics

High levels of staff sickness and turnover can be an indicator of a closed culture due to poor leadership and management and Poor skills, training and supervision of staff providing care. The below graphs show the data for LPT services:

Turnover Rate - October 2021 to September 2022

Team	Average Headcount	Starters Headcount	Leavers Headcount	Turnover Rate
313 0340 Bosworth Ward	11.00	2	1	9.09%
313 0540 Mill Lodge	32.00	13	3	9.38%
313 0570 Willows Unit	4.00	0	0	0.00%
313 0574 Cedar (Willows)	11.00	0	0	0.00%
313 0576 Sycamore (Willows)	4.50	0	0	0.00%
313 0578 Maple Ward (Willows)	21.00	0	2	9.52%
313 0590 Stewart House	33.50	6	2	5.97%
313 0920 Bradgate Wards Other	5.00	2	0	0.00%
313 0940 Thornton Ward - Bradgate Unit	23.50	2	1	4.26%
313 0950 Watermead Ward (Bradgate Unit)	23.50	1	2	8.51%
313 0955 AMH Inpatient Psychology	5.00	2	2	40.00%
313 1850 Beaumont Ward - Bradgate Unit	27.00	0	3	11.11%
313 1860 Belvoir Psychiatric Intensive Care Unit	29.50	0	1	3.39%
313 2012 Griffin Ward (HPC)	21.50	0	1	4.65%
313 2014 Phoenix Ward (HPC)	21.00	1	4	19.05%
313 2365 Heather Ward	22.00	1	4	18.18%
313 2410 Ashby Ward (Bradgate Unit)	24.00	1	2	8.33%
313 2424 Mental Health Physical Nurse Team	5.00	1	1	20.00%
313 3610 Gwendolen Ward	18.00	1	0	0.00%
313 3620 Kirby Ward	25.50	1	2	7.84%
313 3710 Wakerley Ward	21.00	2	4	19.05%
313 3910 Coleman Ward	29.50	2	2	6.78%
313 3920 Welford Ward	29.50	0	4	13.56%
313 1810 Langley Ward ED Inpatient Service	28.00	4	4	14.29%
313 4900 CAMHS Inpatient Services - Ward 3	34.50	13	10	28.99%
313 5980 Agnes Unit Management	54.00	6	3	5.56%

Sickness Absence Rate by Team

Team	Oct 21-Sept 22 (YTD)
313 0340 Bosworth Ward	2.97%
313 0540 Mill Lodge	13.23%
313 0570 Willows Unit	2.48%
313 0574 Cedar (Willows)	16.52%
313 0576 Sycamore (Willows)	8.06%
313 0578 Maple Ward (Willows)	10.67%
313 0590 Stewart House	9.02%
313 0920 Bradgate Wards Other	0.69%
313 0940 Thornton Ward - Bradgate Unit	6.67%
313 0950 Watermead Ward (Bradgate Unit)	2.52%
313 0955 AMH Inpatient Psychology	0.37%
313 1850 Beaumont Ward - Bradgate Unit	4.67%
313 1860 Belvoir Psychiatric Intensive Care Unit	11.62%

313 2012 Griffin Ward (HPC)	13.22%
313 2014 Phoenix Ward (HPC)	4.10%
313 2365 Heather Ward	9.25%
313 2410 Ashby Ward (Bradgate Unit)	6.28%
313 2424 Mental Health Physical Nurse Team	1.94%
313 3610 Gwendolen Ward	4.17%
313 3620 Kirby Ward	10.73%
313 3710 Wakerley Ward	6.96%
313 3910 Coleman Ward	9.59%
313 3920 Welford Ward	7.15%
313 1810 Langley Ward ED Inpatient Service	5.40%
313 4900 CAMHS Inpatient Services - Ward 3	11.24%
313 5980 Agnes Unit Management	10.20%

Definitions

- *Turnover - Number of staff leaving (headcount) within the month (data extracted on the last day of the rolling 12 months period) / Average Staff in Post (Headcount) * 100*
- *Sickness - Sickness FTE / Total Available FTE * 100 = Sickness % Covers the reporting month only.*

Key points from workforce analytical data:

Several wards are outliers with regards to higher sickness levels:

- Beacon: There is a variety of long- and short-term sickness on the unit that is attributed to staff mental well being and injuries sustained during restraints. The team are being supported by HR.
- Mill Lodge: The high rate of sickness is split between long- and short-term absences. Several staff on mill lodge have a underlying condition combined with the nature of the ward has resulted in some short-term stress. As above, the service is being supported by HR.
- Agnes Unit: There is a variety of long- and short-term sickness on the unit that is attributed to staff mental well-being, injuries sustained during restraints and musculoskeletal injuries. The team are being supported by HR and Occupational Health.
- Wakerley ward: Errors on the workforce return with staff still showing who have now moved from the team so the % appears higher than it should.

Freedom to Speak up

All NHS trusts are required to have a named freedom to speak up guardian within the Trust. The guardian role works alongside the trust leadership teams to support the organisation to become a more open and transparent place to work where all staff are actively encouraged and enabled to speak up safely. The guardian role is there to support staff to speak up but also to proactively improve the culture of the Trust to focus on learning and improvement. Whether it is the potential for things to go wrong or in response to an incident, it is important that we all feel able to speak up so that potential harm is prevented. Even when things are good, but could be even better, we should feel able to say something and should expect that our suggestion is listened to and used as an opportunity for improvement. Speaking up is about all these things.

To maintaining confidentiality of those who have spoken up, this review will only report on themes and will not identify individual wards/teams.

A 6 monthly report is presented to Trust Board, the following was included at the April 2022 Board.

Generally, colleagues request that their issue be dealt with confidentially however with support and reassurance many have felt confident to be identified and further-more discuss issues openly with their senior leaders or managers through an informal 'listening meetings'. These meetings create opportunities for staff to be listened to and to understand any future actions in response and/or achieve resolution. Feedback on this process has been positive and builds on the development of an open and transparent culture.

Comparative Summary of speaking up cases 2021 -2022

Service Area	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23
DMH	7	12	17	14
CHS	5	5	4	1
Enabling	0	2	2	3
FYPC/LD	12	4	4	4
Hosted	0	0	1	0
TOTAL	**24**	**23**	**28**	**22**

	No. of Contacts	Internal	External	Anonymous
Q4 21/22	28	25	3	3
Q1 22/23	21	21	0	0

Themes *	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23	Overall %
Patient Safety/quality	12	8	9	7	9.5%
Staff Safety	12	12	21	9	14.3%
Attitudes & Behaviours	9	18	15	8	13.2%
Bullying/Harassment	3	5	5	5	4.8%
System/Process	14	9	18	10	13.5%
Infrastructure/Environment	5	2	2	1	2.6%
Cultural	5	16	14	4	10.3%
Leadership	15	18	21	10	16.9%
Senior Management Issue	1	3	3	7	3.7%
Middle Management Issue	11	10	14	7	11.1%

Speak Up cases often contain multiple themes; therefore, data sets do not always equate together.

Contacts by Professional Groups

There is a wide cross-section of the Trust workforce, that have contacted the FTSU guardian, from a variety of professional groups and levels of seniority.

The nature of the role of the FTSU Guardian tends to lead to individual members of staff speaking up in relation to specific individual cases and therefore it is often difficult to see generalised themes within teams, departments, directorates or indeed across the Trust.

Discussion of Themes

Staff Safety, Attitudes & Behaviours, Systems & Processes, and leadership behaviours often relating to professional relationships and management issues were the highest categories of concern during Q4 21/22 and Q1 22/23. Issues relating to attitudes and behaviours, and more recently leadership behaviours have been consistently reported within each quarter and work is being undertaken to embed compassion and civility into the culture. In these cases, sign posting regularly includes recommendation to undertake Leadership Behaviours and Giving and Receiving Feedback training to support the development of an open, just and learning culture. In addition, staff are supported through coaching style conversations to manage expectations, explore options, and agree future actions. Actions may include facilitated conversations, mediation or listening meetings. Where concerns relating to staff safety have been highlighted these have reflected how a member of staff is feeling within the team dynamic and does not directly relate to a specific risk. In these cases, feedback is provided to the individuals and learning shared within service areas when appropriate.

Issues identified as systems and processes mainly relate to interpretation and actions under policy and guidance procedures. Colleagues have been supported to explore these issues through the appropriate responsible team or department and where appropriate learning has been shared.

<u>Freedom to Speak Up Champions</u>
The Trust now has over 20 volunteer Freedom to Speak Up Champions who play an important role in positively promoting the key messages about speaking up and widening the reach of the FTSU agenda. They can offer support and signpost colleagues to appropriate services as required.
Given the national acknowledgment of additional barriers for speaking up on certain groups of staff, great care has been taken to ensure the Champions network is representative of the workforce in terms of equality, diversity and inclusion and professional groups. The Trust Champions network has representatives from all staff support networks and from a variety of services and disciplines including physical health and mental health teams (nurses and Health Care Support Workers), Allied Health Professionals and administrative roles across the breadth of the workforce.

Key points from Freedom to speak up:

- The Directorate of Mental Health has consistently, the highest levels of staff raising concerns to the FTSU guardian

- Trust wide, concerns regarding leadership is the highest reported concern overall with 16.9% of those raised
- The concerns raised to the FTSU Guardian were escalated and manage appropriately.

Reducing Restrictive practice

The Reducing restrictive practice lead undertakes monthly audits of restraints and seclusion on our inpatient areas and produces highlight reports. The audits for 2022 to date are as follows:

Seclusions

Month	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Total
Seclusions	26	19	20	33	19	14	5	11	8	16	28	**199**
Seclusions over 2 hours	23	13	12	26	19	11	5	9	6	13	14	**151**
Prone restraint supported	3	2	3	2	0	0	0	2	0	2	1	**15**
Prone restraint unsupported	0	0	1	0	0	0	0	0	0	0	0	**1**
Restraints over 10 minutes	80	86	102	96	88	49	54	27	18	7	20	**627**
Rapid Tranquilisations	22	29	33	20	27	5	4	13	12	13	26	**204**
Total restrictive practices	298	322	405	378	355	230	198	191	142	141	216	**2876**

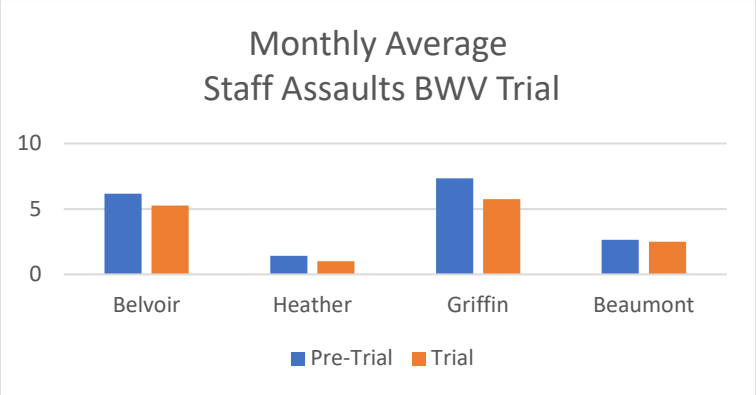
LPT has a restrictive practice policy that covers principles that underpin the use of restrictive practices and the aim to reduce the use of restrictive practices within the Trust. These principles follow safe and therapeutic responses to disturbed behaviour (Code of Practice, 1983) current best practice guidance, with a revised focus following the Mental Health Units (Use of Force) Act 2018. The Trust also has a blanket restrictions policy.

The Trust are also piloting the use of body worn cameras on 4 of our mental health wards; Belvoir; Heather; Griffin & Beaumont. Body worn cameras (BWC) have been used on 3 of the adult wards since March 2022 and in May 2022 another ward was added to the pilot project giving a pilot group of 4 wards. The pilot has now entered the evaluation and recommendation stage and the following options are being considered:

- Purchasing the cameras and supporting equipment on the 4 wards and continuing the use the body worn cameras on those wards.
- Considering initial feedback rolling out the body worm cameras across other adult acute wards – agreement by Trust Group and Executive Team required.
- Ending the pilot and not taking the project forward.

Early findings from the pilot have demonstrated a reduction in assaults on the wards:

	Pre-Trial	Trial	Trend
Belvoir	6.166667	5.25	Down
Heather	1.416667	1	Down
Griffin	7.333333	5.75	Down
Beaumont	2.642857	2.5	Down



The recommendations from the Trust Reducing Restrictive Practice Group are to purchase the BWC on the 4 pilot wards, along with 6 extra cameras to bring 3 of the trial wards up to 6 cameras per ward and a dedicated PC with the correct specifications to replace the laptop currently being used on one of the trial wards. The group has also recommended the roll out of the BWC to the remaining adult acute wards – a supported approval would go to the Trust Group and Executive Team for Trust agreement.

Key points from Reducing restrictive interventions processes:

- The Trust have an open and transparent reporting process with regards restrictive practice
- The levels of seclusion are appropriate and comparable when benchmarked with other Trusts (NHFT)
- The trend shows that, overall, levels of restrictive practice are decreasing over the 12-month period. Where higher levels or spikes in restraints are detected, this is due to 1-2 individual patients.
- The use of body worn cameras is a step in the right direction with regards reducing restrictive practice and growing the safety and learning culture within the organisation.

Mental Health Act

The Mental Health Legislation Team offers a comprehensive Trust wide service to all in-patient and community services within LPT providing expertise in all aspects of the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), including associated Court of Protection (CoP) work. The team strives to deliver a consistently high standard of support to all LPT staff offering advice, guidance, and training in relation to the above legislations to ensure the Trust is lawfully compliant, maintain the Trust's reputation and protect from unlawful practice and litigation claims.

The Mental Health Act annual activity summary 2021-22 shows the following:

- An overall decrease in activity from 2020-21
- Decrease year-on-year of 64 from 868 to 804 for admissions under detention
- Decrease year-on-year of 83 from 669 to 586 for admissions under section 2 (28-day assessment order)
- The use of emergency holding powers under section 5 showed section 5(4) (nurses' emergency holding power) – decrease of 17 year-on-year from 34 to 17 and section 5(2) (doctors' holding power - decrease of 19 year-on-year from 95 to 76
- An overall decrease year-on-year of 164 from 1514 to 1350 changes to the status of a patient
- The number of Tribunals that were held decreased by 24 over the year from 268 to 244

- The number of Managers Panel Hearings held increased year-on-year, 178 were held in 2021-22, an increase of 26 from the previous year (152)

The MHA Census monitors several different aspects of compliance at the point of care, namely:

- Uploaded statutory paperwork and scrutiny forms
- Section 132
- Section 17
- Consent to Treatment
- The census is compiled by the MHA Office and validates the information maintained across different systems, i.e., excel and SystmOne. Wards receive individual monthly reports. 100% compliance is expected across all reporting data items

The census showed:

- Completion of Medical Capacity Form on SystmOne across LPT (mental health wards) rose from 50% in October 21 to 63% on March 22
- Compliance with Section 132 – Duty to provide information (rights) across LPT (mental health wards) rose from 76% in October 21 to 83% on March 22
- Completion of Part B (patient information) of Section 17 leave of Absence Form on SystmOne across LPT (mental health wards) dropped from 38% in October 21 to 33% on March 22

Tribunal Service Mental Health:

The Trust continues to support patients in their right of access to the Tribunal Service and to legal representation:

- 514 hearings were initiated with a total of 244 being held
- 191 of the 514 initiated were done so under section 2, 96 of which were subsequently held
- The tribunal exercised their right to discharge a total of 23 patients across the year
- The MHA Office is currently working with the Tribunal Service supporting their implementation (nationally) of a new platform underpinning improvement to the remote hearing experience.

MHA compliance reports are also completed bi-monthly, and the team undertake a monthly MHA audit that looks at operational compliance and triangulates information, this is shared with the wards, senior managers and reported to the MHA GDG.

Mental Capacity Act & Deprivation of Liberty Safeguards

The MCA / DoLS / LPS (Mental Capacity Act, Deprivation of Liberty Safeguards and Liberty Protection Safeguards) sit directly as a part of the LPT Safeguarding Team. The work is overseen by the Safeguarding Committee – early in 2022, the agenda was overseen by the Legislative Committee (with the Mental Health Act). It was recognised that the MCA agenda was not getting the airtime or scrutiny it should because of how vast the MHA agenda was. It was then moved back under the remit of the safeguarding committee (Autumn 2022).

- There is training data available regarding MCA (which is undertaken via E-Learning)
- There is a NICE audit which was undertaken which for the first time made the trust compliant with the systems and structures we should have set up and in place for our organisation
- The trust has a policy in place for MCA and a policy in place for DOLS

- There is a mental capacity support group however it has not met for a few months since the adult safeguarding lead who also has responsibility for MCA/DoLS/LPS left the trust. We currently have an advert out in NHS Jobs with a view to recruiting early in 2023.

Despite all these things which we have in place, we have two significant issues.

- Frontline service does not necessarily send the DoLS request forms to the safeguarding admin team (as per protocol), as we are aware that some wards and departments are sending them directly to the local authority. Therefore, we are unable to give an accurate picture on the number of DoLS detentions as an organisation
- We request that the local authority provide the feedback from the DoLS application (whether that is authorised or not), and they do not necessarily do this with consistency (if a notification is replied to at all).

Mental Health Compliance:

Certification	**Mental Capacity Act**	
Team	% In date	In date / Total
313 0340 Bosworth Ward	72.70%	(16/22)
313 0540 Mill Lodge	75.60%	(31/41)
313 0574 Cedar (Willows)	93.80%	(15/16)
313 0576 Sycamore (Willows)	83.30%	(10/12)
313 0578 Maple Ward (Willows)	92.30%	(12/13)
313 0920 Bradgate Wards Other	50.00%	(2/4)
313 0940 Thornton Ward - Bradgate Unit	87.50%	(21/24)
313 0950 Watermead Ward (Bradgate Unit)	77.80%	(14/18)
313 1850 Beaumont Ward - Bradgate Unit	81.00%	(17/21)
313 1860 Belvoir Psychiatric Intensive Care Unit	86.70%	(26/30)
313 2012 Griffin Ward (HPC)	76.50%	(13/17)
313 2014 Phoenix Ward (HPC)	90.00%	(18/20)
313 2365 Heather Ward	94.40%	(17/18)
313 2410 Ashby Ward (Bradgate Unit)	77.30%	(17/22)
313 3610 Gwendolen Ward	91.40%	(32/35)
313 3620 Kirby Ward	80.00%	(20/25)
313 3710 Wakerley Ward	50.00%	(1/2)
313 3910 Coleman Ward	89.30%	(25/28)
313 3920 Welford Ward	85.20%	(23/27)

<u>FYPCLD compliance:</u>

Certification	**Mental Capacity Act**	
Team	% In date	In date / Total
313 1810 Langley Ward ED Inpatient Service	82.10%	(23/28)

313 4900 CAMHS Inpatient Services - Ward 3	80.00%	(28/35)
313 5980 Agnes Unit Management	90.00%	(45/50)
313 6550 The Grange	92.90%	(13/14)
313 7620 Gillivers	94.70%	(18/19)

Key points for MCA & DOLS

- There are two risks on the risk register that relate to MCA & DOLS; (4546) – MCA and DoLS application; (5173) – MCA Training
- The current processes in place to provide assurance, record keeping and application of the MCA and DOLS require review

Safeguarding

The safeguarding team include mental health nurses, adult nurses, children's nurses, midwives, social workers and a speech and language therapist. The dialogue therefore across the team looks more holistically at a case, thus improving the quality of the advice and support given and improves the outcomes for practitioners asking the advice – but more importantly the patients and their families who reap the benefit of the advice.

In 2019 there was a review of safeguarding across the whole trust (including the safeguarding team). This identified many gaps in safeguarding practice and awareness as well as deficits in the core offer from the LPT Safeguarding Team. The trust safeguarding team is currently engaged on a full Quality Improvement pathway regarding safeguarding in the organisation. Some of the changes have been embedded already – there are many more still to do. There is an estimated target date for completion of end March 2024. The QI Workplan (1.5, DEC22), review and its findings are overseen by the safeguarding committee, the ICB through the SCAT (Safeguarding Collaborative Assurance Template), QAC and the trust board.

The core work in the LPT Safeguarding team is built around:

- Safeguarding support and advice
- Incident Support
- Training
- Supervision
- Writing reports and providing analysis for several safeguarding enquiries and reviews including s42 enquiries, SI investigations, Multi-Agency Reviews (SAR, DHR, LSCPR).

Safeguarding Support and Advice

The safeguarding team run an advice line Monday to Friday (9-5). There are several ways the team are accessible including email, tasking on SystmOne, phone, visibility. The data for the safeguarding advice line is closely monitored, and we have more than trebled the number of contacts from before covid to now. There are a few possible reasons for this including complex safeguarding and abuse is going up and people need more support, the gap in training regarding adult safeguarding, the quality of the support is being shared word of mouth across the trust generating more contacts. The advice line receives all DASH assessments for high-risk domestic abuse which are screened, and quality assured before being uploaded onto the police data base, additionally the team respond to external

enquiries from the local authority, screen allegations against professionals, and provide support to all practitioners in need of safeguarding advice.

Incident Support

This is demonstrating the responsiveness and commitment of the safeguarding team in picking up projects and work through other services QI projects. There have been 3 in-patient wards that have each had significant safeguarding issues and needs. As such, the safeguarding team were a central part of the action plans from providing team supervision, sending a member of staff to work on and with the ward for a while, to chairing meetings when discussing cases and establishing whether there were safeguarding needs or not. Each of the services have improved as a part of the QI plan – and this has not been in any small part because of the interventions from the safeguarding team. It is important to note that the safeguarding team are responsive to unfolding service 'situations' and provide a detailed assessment, analysis, recommendations, and interventions to support the Quality Improvement plans and journeys.

Writing Reports

Each of these tasks both individually, and cumulatively are reinforcing the high standards and quality of preventing abuses taking place, or in providing detailed learning and analysis following a safeguarding incident having taken place. With reference to the reports written, there are high standards throughout the process from the checks and balances which are taken from the report being written, to the check and sign off by a LPT Safeguarding Team Manager, and the sign off by the Executive Leads for safeguarding followed by the multi-agency scrutiny of the report, its analysis and learning. LPT are frequently complimented by the safeguarding boards for the quality and transparency we demonstrate in all the reviews. We are currently involved in 49 reviews all at various stages of completion.

Collaborative Working with the ICB

This has been a positive relationship working with the Designated Nurse for Safeguarding. We have worked well together in driving through improvements, joining up the work across the whole health community, which has included the work on the SCAT piloted by LPT and the ICB. The Designated Nurse attends the trust safeguarding committee where assurance is gathered regarding the progress on the agenda and workplan for the committee. The SCAT is completed by LPT, and discussed then with the Designated Nurse who, because she has attended the safeguarding committee is assured and signs off the report swiftly for the Quality Accounts meeting with the trust and the ICB. Safeguarding has never proven to be a significant issue or concern as there is often swift identification within LPT, and a robust response which provides the necessary assurances regarding the quality of safeguarding practice, interventions, and processes.

Key points for Safeguarding:

- The current demand has left an approximate 3 week wait for the less urgent contacts to the safeguarding team (5306 is the risk number on the risk register regarding this challenge). Initiatives to mitigate the difficulties include pressure ulcer work being handed back to frontline services. Some of this challenge is also because of the increase in contacts with the safeguarding advice line by LPT staff.

- We need to strengthen our systems and processes to robustly monitor, sign off and evidence the learning across the trust to report back to the safeguarding boards. We are currently in the process of creating one system to work across the 3 directorates governance teams, which the action plans will be evidenced, overseen, and signed off by the Safeguarding Governance Facilitator – this in turn will lead to a paper being presented at the Safeguarding Committee who will take the ultimate responsibility for oversight. It is estimated this new approach will be fully adopted at the next safeguarding committee in January 2023.

Advocacy

All patients detained under the MHA are automatically referred to IMHA by the MHA office. For patients that lack Mental capacity, wards will refer if appropriate to IMCA.

In addition, the Beacon centre is supported by National Youth Advocacy Service (NYAS) for both informal and detained patients. NYAS produce quarterly activity reports that are reviewed by the inpatient team.

The Trust had a trial of NYAS supporting the Agnes unit, however, feedback from both advocate and staff were as IMHA visit on a fortnightly basis, they didn't feel that NYAS would add further value. Currently all patients at Agnes unit are detained. We do however have a spot purchase option from NYAS if required e.g., if Agnes unit admitted an informal patient.

Key points from Advocacy services:

- The Trust has appropriate and supportive advocacy processes in place

Co-production & peer support

<u>Peer Support Workers</u>
This new role is just one of the improvements LPT is introducing as part of its current transformation of its mental health services. The peer support workers will use their personal experiences of mental health issues and services to bring hope to current service users and empower them to feel confident to take actions towards recovery and live independently where possible.
Peer support work will take place in each community mental health team and in assertive outreach, as well as further roles recruited to work in LPT's child and adolescent mental health services (CAMHS). Our ambition is to have 75 peer support workers recruited by the end of 2024. Training is delivered through the Trust's Recover College and in partnership with IMROC.
<u>Lived Experience Leadership Framework for Involvement</u>
As part of the 'P' in our Step up to Great strategy, the Trust is currently developing the Lived Experience Leadership Framework for Involvement. The framework includes:

- Collaborative care planning and shared decision making
- Involvement in focus groups, recovery cafes and service improvement
- Patient and care leadership as part of members of committees/groups, interview panels, QI partners with services
- Collaborative working with experts by lived experience, co-leading projects, and chairing committees
- Peer support worker roles, working within and alongside services
- Patient leadership triangle
- Proposal for a lived Experience Lead Professional

The People's Council

Since its establishment in September 2020 the work of the People's Council, made up of patient and carer leaders and Voluntary and Community Sector representatives continued throughout the past year. The Council worked with an external facilitator and the communications team to help them establish their core purpose, which is to provide an independent voice to make LPT services great for all. They worked with the external facilitator to create the objectives of:

- Represent and be an independent voice of patients, carers, and their families, especially for people more likely to experience inequity.
- Contribute to the development of Leicestershire Partnership NHS Trust services and policies for example, Step Up to Great for Mental Health, and operate as a constructive check and balance to the LPT Executive Team and the Board of LPT.
- Work to ensure that people with mental and physical health needs can access services and that access is continually improving.
- Ensure that we are equal partners with the Executive Team and Board using our regular joint development sessions to ensure that there is an element of co-production on key strategic matters.
- Ensure that Patient and Carer Leaders and Voluntary and Community Sector representatives are equally valued.
- Developing patients, carers, and their family's knowledge of how to work with professionals in the management of their health.
- Work towards helping equity in access, experience, and outcomes of services for those more likely to experience inequity.

In addition to this a set of principles on how the Council will work with the trust Board were agreed and twice-yearly joint development sessions established. The Council agreed to focus on several priorities, which were Step Up to Great for Mental Health, the personalisation of care and equality, diversity, and inclusion. They provided comprehensive feedback on the Step Up to Great Mental Health consultation carried out by the combined Clinical Commissioning Group for Leicester, Leicestershire and Rutland and inputted into the refresh of the Trust's Step Up To Great Strategy.

The Council's leadership team held bi-weekly meetings to co-ordinate the work of the group and to be a conduit between Trust Board and the Council. As the Council approached its first-year anniversary an independent review has been undertaken looking at the activity of the Council over the last year and included interviews with members of the Council and a review of the Terms of Reference. The review recommended that:

• Expanding the membership of The People's Council to provide a wider viewpoint of LPT services
• Consider moving to face to face meetings to ensure better interaction with members
• Improve the impact of the Council

Reform the Council to:

• Speed up decision making
• Provide more welfare support to members of the Council

Community Education Treatment Reviews

CTRs are part of a national programme led by NHS England called Transforming Care. The aim of Transforming Care is to reduce the number of people with a learning disability or autism living in an inpatient hospital unnecessarily. Any inpatient admission should be based on very clear reasons why certain needs can only be met in hospital. The slogan "Hospitals are not homes" is often used as inpatient services should not be used due to a lack of local services and support. The aim of a CTR is to avoid admission wherever possible, or to plan discharge.

The review will look at 4 areas:

- Is the person safe?
- Are they getting good care now?
- What are their care plans?
- Can care and treatment be provided in the community?

A C(E)TR will be chaired by LLR ICB and should include the person, their family, the multi-disciplinary team (MDT) involved in their care, and two independent experts – one expert-by-experience (a family carer or a person with a learning disability), and one clinical expert.

The community C(E)TR process is designed to support people with learning disabilities and/or autism, who are at risk of admission to specialist hospital for LDA/MH. The objective is to find alternative outcomes to continue their support in the community or at least if admitted, to ensure they have adequate oversight, care planning, are discharge tracked straight away, receive best possible care with reasonable adjustments, for as short a time as possible, as close to home as possible.

The inpatient C(E)TR process is to ensure the above & continued monitoring of their inpatient journey, discharge planning, best possible care is provided.

The below tables describe the data related to inpatient C(E)TR reviews coordinated by the LLR ICB team:

Total LLR Inpatient C(E)TRs (Sept 21-Oct 22)	45
Outcome C(E)TRs 'Ready for discharge'	27
Outcome C(E)TRs 'Not ready for discharge'	18

Total LLR Inpatient C(E)TRs in LPT based specialist hospitals (Sept 21-Oct 22)	20
Outcome C(E)TRs 'Ready for discharge'	10
Outcome C(E)TRs 'Not ready for discharge'	10

Total LLR Inpatient C(E)TRs in out of area specialist hospitals (Sept 21-Oct 22)	25
Outcome C(E)TRs 'Ready for discharge'	17
Outcome C(E)TRs 'Not ready for discharge'	8

Key points for Community Education Treatment Reviews:

- The process in place by both inpatient and community based LLR services follows NHS England guidance and ensures that people are not spending unnecessary or disproportionate periods of time in hospital

Quality assurance, Self-assessment, and accreditation

There is a robust Quality governance framework developing within the Trust that aligns quality assurance, self-assessment, and accreditation.

Quality Assurance

Quality assurance within the directorates is provided via the governance framework (appendix 2). For DMH, monthly, the various groups are required to formally report into the DMH Q&S meeting via their respective highlight reports/verbal updates. Decisions/Outputs from the monthly DMH Q&S meeting are fed back to services via their service line reps. Escalations etc from the DMH Q&S meeting are fed upwards to the DMT Q&S monthly meeting via a highlight report.

Feedback from LPT Level 1,2,3 Governance forums is captured by DMH reps who attend those meetings and should come to the DMH Q&S meeting each month via a feedback report template that is used for this purpose.

Within FYPC LD, there is a governance arrangement in place for the Agnes Unit and the CAMHS Beacon Unit which has oversight of the quality of service provided. At a ward level, operational and clinical matters related to quality and safety are regularly discussed and reviewed during shift handover, MDT meetings as well as in team/staff meetings, nurses' meetings, and ward management/governance meetings – this includes incident management, investigations and any learning, staffing, patient/carers and staff concerns, training and supervision compliance, audits, H&S, and risk.

The Directorate Inpatient Assurance Group takes place weekly and covers operational and clinical matters of both services – with the support of the allocated Deputy and Head of Nursing. The Group has oversight of incidents management and any immediate learning, training, and supervision compliance, CQC must dos, oversight of audits, H&S actions, and oversight of specific areas of risk or improvement.

Alongside the above, incidents are reviewed daily within working hours by the Senior Nursing Team and Governance Team with support and oversight of follow up/immediate actions if required. There is a daily acuity meeting covering CAMHS Services (including CAMHS Beacon) where senior leadership are often in attendance.

The Deputy Head of Nursing and Service Group Manager regularly work from both sites which supports the option of arranging escalation meetings if required. Q&S DMT has overall oversight of both services via the Q&S Report and the Inpatient Assurance Group Highlight Report.

If items require escalation from ward, these goes via the Inpatient Assurance Group as well as the relevant Service Leadership Group and Clinical Leadership Forum. Escalation from these 3 groups all feed into DMT Ops on a weekly basis if needed or Q&S DMT monthly and Trust level QST weekly meetings, Quality Forum and QAC Level 1 committee.

Self-assessment

Self-assessment is a powerful way to better understand your own leadership behaviours, highlighting area that you or the team may need to focus on as you grow as a team and provide a natural pause to reflect on all the positives you have achieved together. The SUTG strategy sets the standards that we are working towards within LPT, and the valuing high standards accreditation programme (VHSA) will underpin teams time to shine and be the platform for championing team development.

Our self-assessment tool challenges you, your team, department, directorate to gather and consider a wide range of evidence to determine compliance against how great you are meeting the accreditation challenge as a team aligned to the SUTG standards and evidenced through compliance with:

- CQC domains of: Safe, Caring, Effective, Responsive, Well Led.
- CQC "We Quality" statements matrix (appendix 1).
- Awards or celebrations of good practice.
- LPT Policy and guidance.
- Acts of parliament.
- National and local standards.
- Medication and treatment regulations.
- Professional governing organisations & bodies.
- Feedback from people using services.
- Feedback from staff.
- Partnership feedback.
- Governance compliance.
- Research based practice.
- External accreditation.
- Serious incident investigation, safeguards, complaints & their responses, and actions.

Aims of Accreditation

- Recognise, celebrate, and incentivise high standards.
- Provide assurance that LPT core standards and wider regulatory requirements are being met.
- Standardise service user and staff experience at team and departmental level.
- Identify where improvements are necessary and be part of the solution.

Through accreditation teams can really self-assess against the standards that are most important to our service users and colleagues. Our SUTG standards cover a range of service provision, also seen in clinical audit as well as CQC and other regulatory standards. Through cross matching and understanding 'how we are doing' in relation to these standards is fundamental to our growth as an NHS trust. Identifying evidence to support high standards of service and excellence as a team will also reflect the great work being undertaken in our teams, regardless of grade or profession. Therefore, by taking part in the programme, teams can complement to their overall quality assurance and transformation activities.

The self-assessment accreditation will be led at team level by Quality Champions, who will support accreditation assessments in their area as part of their leadership role. It is expected that this role will be mostly undertaken by the team manager or lead. Quality champions are encouraged to identify with their team a wide and varied portfolio of evidence that demonstrates their team's adherence to SUTG and high standards and must consider the compliance list above as the golden threads that will guide teams to self-score their evidence.

Self-Assessment Score

All evidence for each self-assessment needs to be reviewed, discussed, and then given an overall graded to give the score for the standard. The evidence collected by the team should be from the last 6 months prior to self-assessment and graded using the self-assessment score:

- Great Evidence = 3
- Good Evidence = 2
- Partially met = 1
- Not met = 0

MUST MEET STANDARD – indicates that the team must meet this standard to be considered for accreditation award.

Foundation Award

Following completion and return of the scored team self-assessment accreditation paperwork and confirmation that supporting evidence has been stored appropriately and is available to facilitate formal accreditation, the team will receive a Valuing High Standards Accreditation Self-Assessment Foundation Award. There will be a pause between foundation and a formal accreditation award, and this is a time for the team to review its processes and practices against the standards and, where necessary, to make the improvements required to achieve the best final award possible.

Pre- Formal Accreditation Assessment

To promote openness and transparency between managers, staff, people using the service and external professionals and organisations before the formal assessment Heads of Service, Senior leaders or their delegated deputies must review the evidence that is to be submitted with the team for risks relating to closed cultures. This includes assessing if the current model of care is consistent with relevant guidance, such as Right Support, Right Care, Right Culture.

Right support:

- Model of care and setting maximises people's choice, control, and independence

Right care:

- Care is person-centred and promotes people's dignity, privacy, and human rights

Right culture:

- Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive, and empowered lives

For consideration during open conversations and evidence review:

- protects people from abuse and uphold their human rights, including involving people in their care, and providing them with dignity, equality, safeguarding and procedural safeguards on human rights. This includes, for example, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards 2009 (DoLS)
- promotes an open culture, where people who use services, staff and people visiting the service (relatives, friends, professionals) are involved in developing the service, feel safe to speak up about concerns, and meet the duties relating to the Duty of Candour
- have a positive record of compliance in this and or other locations
- manage change effectively, including ensuring the service has the right leadership in place
- have a workforce with the right skills and training, including specialist training
- can respond to the changing needs of people who use services; for example, increasing staffing levels if people's support needs change
- comply with or have made a declaration relating to non-compliance with the regulations. If non-compliant, does the declaration relate to inherent risk or warning sign, for example management or staffing

- can provide evidence of internal governance systems and external, independent oversight of the service.

Formal Accreditation Assessment

A formal assessment day will be agreed with the team and a full schedule and agenda for the assessment shared. The assessors wish to have a real sense of the team, the environment and their interactions with colleagues and people who use their services and do not want to base their decision on data alone. Whilst, reviewing evidence the assessors will expect that the team will ensure that staff, and users of their services have an opportunity to meet in person or virtually with the assessors and engage in the accreditation process. The Quality Champion will be responsible for organising and share meeting information (either face to face or virtual) needed to promote engagement in the accreditation day from people who use the service and team member.
People using our services may be able to claim expenses for their input into the accreditation assessment and it is the team responsibility to ensure that this is followed up and processes for the identified people.

Any verbal feedback or comments given by staff, service users and carers will be treated as confidential. All information will solely be used for the purpose of the formal accreditation assessment visit. When conducting the assessment, the assessors will explain and make clear they will protect the origin of an individual's comments, if using them for the final report or suggestions. Assessors must, however, be clear that they have a duty to pass on disclosures that either raise safeguarding issues, and/or in circumstances where serious misconduct is involved.
Formal assessment will be completed by at least two members of the compliance team led by the accreditation lead. In terms of achieving accreditation status, teams will have completed a substantial portfolio of evidence to submit for accreditation. This evidence is the qualitative and quantitative data that supports the final accreditation award. Formal scoring will be based on the cross referencing of evidence between the SUTG strategy standards and the golden threads of best practice and regulation.

Steps of the report submission

- The accreditation will prepare the first draft after the assessment and send it to the compliance team for review.
- The compliance team will review the report and consult with the accreditation lead and the assessing team.
- The compliance team will send the agreed draft report to the assessed team Quality Champion for comment.
- The Quality Champion will have up to 2 weeks to respond to the report.
- Any challenges to the report or its outcomes will be carefully considered, and changes made to the report as necessary by the accreditation lead with oversight from the compliance team.
- The Accreditation committee will meet quarterly and review all recent reports nominated for gold awards.
- Final report will be sent to the clinical team and copied to the Quality Champion, Head of Service, and the Service Director.
- Compliance team will issue the appropriate certificate to the Head of Service.
- Service Head and Director are responsible for ensuring that teams receive their certificate, and their achievements are acknowledged and celebrated.

Accreditation Awards

On completion of the formal accreditation assessment the team will be awarded either:

- White – Evidence not met, and to remain at Foundation– re-assess within 1 month.
- Bronze = score between 76-85 points (*All must meet - achieved)
- Silver = score between 86-96 points (*All must meet - achieved)

White Award

Teams, who will require further support or time to meet the accreditation criteria for bronze or above will be informed by the accreditation lead and will remain at foundation status. The Quality Champion will receive the draft and final accreditation report for comment and the team and service representatives will be offered a meeting to review the final report recommendations. The team will have an agreed timeline to address and implement recommendations ready for formal assessment to revisited.

Gold Award

Teams being eligible for gold will have provided evidence scored within the gold range of 97 108 points (*All must meet - achieved). The results of the self-assessment and assessors visit for a gold nomination will be appraised by an accreditation panel. The accreditation panel's role is to assure governance and consistency of measuring the quality of the services that are nominated for gold accreditation awards. The panel members will include representation from people with lived experience of LPT services, a change champion, and representatives from the senior leadership team. The panel will make the final recommendation to either gold or another other accreditation award.

Preparing for Future Self-Assessment

Regardless of the award received after the full process, teams benefit from building on the level of accreditation received, demonstrating a commitment to continuous improvement and excellence, and where relevant work towards the next level of accreditation. A report summarising results from the formal assessment and accreditation assessors visit will be presented to the team, outlining their level of adherence to the accreditation standards, highlighting areas of strength and for improvement. Each team will as necessary, develop an improvement plan led by the quality champion that will have regular oversight and challenge provided by the directorate leadership, monitored through local governance structures. The directorate will develop a single forum that will draw together all their team's accreditation action plans. This agenda from this forum will be the vehicle to deliver the aims and ambitions of the directorate for future self-accreditation. Each division will need to ensure that they support their Quality Champions to lead on delivering their local accreditation improvement plans whilst, ensuring that accreditation focuses on a whole team approach.

Safeguarding

To support high standard throughout the accreditation year the directorate leadership, governance and quality compliance team will continue to triangulate team data. In the event the compliance team is notified that the service has, in relation to the standards, received a significant serious complaint, serious incident or is believed to have consistently fallen short of minimum standards of care in some way, the team may suspend the awarded status of accreditation until a tabletop review or resolution is evidenced. Any tabletop reviews or actions arising from them, implemented within the trust or with partners must be acknowledge and included in the evidence for accreditation assessments.

Accreditation cycle

The accreditation award will stand for 12 months, when the next cycle of self-assessment will begin again. To support consistency, team, and service line development the questions for Valuing High Standard Accreditation will be reviewed and relaunched every 2 years. Teams should start

collecting, scoring, and building a portfolio of evidence 6 months before their next self-assessment date.

Ambition of VHSA

Through processes that already champion the involvement of people with lived experience of using LPT services and wider patient experience such as the introduction of Patient and Carer Partners, Experts by Experience, and the Peoples Council, LPT are building a network of people who may have many transferable skills to support future accreditation.

It is our ambition to grow opportunities for those with lived experience of our services to work with us in partnership to improve the quality of our services, this includes our high standards accreditation programme, we have already started to recruit 15 Steps Challenge and PLACE reviewers and we are now looking at out Gold Accreditation Panel membership. Through each cycle of accreditation review, it is anticipated that service users, patients and carers will partner with us, creating more opportunities for collaborative work and towards lived experience leadership of the programme. Colleagues from other areas not part of the directorate being accredited will have the opportunity to shadow and support the assessments to benefit wider learning and development of the tool, enriching the assessments as part of our ongoing commitment to quality improvement (QI).

Key points from processes for monitoring out of area placements:

- The Trust has a robust self-assessment/accreditation process in place.

Information on service visits by Executive team, Non-Executive Directors, and Governors

In keeping with Infection Prevention & Control guidance, service visits by Executives, NED's and Governors are dependent upon any Convid-19 outbreak or activity and are booked in advance with the clinical team. The senior visits are undertaken using the 15-step model, which covers key aspects of identifying closed cultures.

The senior Nursing & AHP leadership team are visible across clinical areas, supporting high standards of care and quality meetings with individual clinicians as part of professional development. For example, Ashton Compassionate Leadership Development Programme for Nurses and AHPs programme. This is an innovative and bespoke clinical and professional leadership programme for band 6/7 clinical leaders. The programme reflects our Trust leadership behaviours for all, values and step up to Great Strategy. It has also been developed in line with national and local resources such as the NHS Improvement Ward Leader handbook and LLR Clinical Professional strategy. The programme is aimed to support to develop professional and clinical leadership skills and grow in confidence as a clinical leader.

The Trust Quality, Compliance and Regulation team maintain a record of visits and shows evidence of visits to most of the services included in the review.

Out of area placements

The Trust have a process for assurance of quality and safety placements for OOA beds, we do this in partnership with colleagues in the ICB Mental Health Team. The ICB team review the CQC reports of all external placement providers for MH acute and PICU, and then keep a central list which is held also by our bed management team.

National next steps

A workshop is being planned for system CNO's/ MD's. This will be an interactive discussion to inform the development of a 'what good looks like' document, providing an opportunity to share best practice and learn from others. The session will also seek to understand how systems and organisations can identify and respond to closed cultures. The aim of the tool is to assist in gaining assurance of the following:

- Leadership: including visibility and accessibility to senior leaders
- Culture: including processes for dealing with poor performance; consistent advocacy
- provision: freedom to speak up arrangements
- Safety culture: including themes from as recurrent complaints; patient safety incidents
- Workforce: including staffing levels; skill mix; agency use; training.
- Staff governance: including supervision, appraisal, and revalidation.
- Educational governance: including complaints and feedback from students and trainees, with transparency of actions following any poor feedback of experience.
- Professional engagement: including referrals to prof bodies from providers or members of the public.
- Clinical Outcomes: including physical as well as mental health care and treatment plans across the pathway.
- Understanding and early intervention of Closed Cultures:
- Knowing the risk factors of a closed culture?
- Identifying the warning signs of closed cultures?
- Understanding the impact on human rights and equality?
- Prompt mobilisation of actions where concerns are identified?

Summary & Conclusion

As a learning organisation, we always strive to improve quality and safety of care and the culture and environment that for patients, families, carers and staff and proposals that capture next steps are included in the below section. The quality & safety review has used a blended methodology of desktop data, information exploration and liaised with staff across several clinical and non-clinical services to provide assurance and to demonstrate our commitment to ensuring that closed cultures do not develop in our Trust.

In conclusion, it is not possible to rule out the prospect that we have some environments where risk factors could result in closed cultures developing within some of our Mental health, Learning Disability or CAMHS Services. Within this report, several of the areas that indicate potential risk factors for closed cultures have highlighted where the Trust has potential weaknesses such as lower levels of patient/family feedback and higher levels of sickness/turnover that are aligned in part to work related mental health issues. Triangulation of the key areas highlights 2 services in particular: Langley ward and Beacon Unit. The Group Director of Patient safety is not concluding that closed cultures currently exist in these services, rather that risk factors are present, and they meet some of the indicators required for continued supportive intervention within the Trust. It is also important to follow the CQC guidance on closed cultures (How CQC identifies and responds to closed cultures - Care Quality Commission

The issues highlighted in relation to both Langley ward & Beacon Unit were known and escalated prior to this review and have been managed over recent months with quality summits chaired by the Executive Director of Nursing, Quality & AHP's that used the CQC 5 key questions as a benchmark and to develop quality improvement plans as part of the on-going work with these services (Appendix 3). High sickness/turnover levels in these services are already being managed via HR/OH

processes. The outputs of the quality summits are also reported to Quality forum and Quality Assurance Committee.

Leadership is the key area raised by staff via the freedom to speak up route, predominantly in DMH and is a key indicator of closed cultures developing. This triangulates with lower mandatory training, appraisal, and supervision compliance in DMH services. During this review, staff have contacted the Group Director of Patient Safety to highlight concerns regarding wards within the directorate. The concerns did not triangulate with the data and information reviewed but does highlight the need to capture ad-hoc staff feedback more effectively, across the trust.

There are key areas across the wider Trust that need to be pro-active improvement to ensure that risk factors do not develop into closed cultures. These include patient and family feedback via the friends and family test; evidence of documentation relating to the MHA; processes relating to mental Capacity Act and Deprivation of Liberty Safeguards and capacity to response to non-urgent safeguarding contacts in a timelier way.

There are however examples of good practice including our processes and governance for quality assurance, self-assessment and accreditation and the system approach to community education and treatment reviews. The wider cultural change, step up to Great Strategy and leadership behaviours work is a vital part of the quality improvement journey that will ensure the Trust is moving forward.

Proposal

The Director of Patient Safety proposes:

Rationale	**Action required**
As part of our BAU processes, the Trust need a mechanism to provide live dashboards, that can bring all insight, and intelligence together to identify early warning of closed cultures.	Executive Director of Nursing, AHP's & Quality & Executive Lead for performance to: • Work with performance colleagues to explore the use of Power BI for early warning score (EWS) triangulation and a live heat map. • The heat map should be used to triangulate early warning information and markers across all services that can be used to identify potential closed cultures at the earliest opportunity (Trust wide, clinical, and non-clinical). • Process that enables a deep dive into service lines that has been identified as a risk from the heat map. • It is advised that a new EWS forum is created that reports to and provides updates to Quality Forum.
Issues highlighted within the report that relate to leadership, mandatory training, appraisal and supervision, documentation relating to MHA in mental health services.	Directors of Mental Health/FYPC/LD to: • Consider and review actions required to improve compliance with mandatory training, appraisal, and supervision

	• Work with MHA team to improve record keeping related to the application of the MHA. • Explore leadership concerns with FTSUG
Issues highlighted in the report that relate to MCA & DOLS	Head of Safeguarding to: • Consider and review actions required to improve systems and processes that assure compliance, communication, record keeping and application of the Mental Capacity Act & Deprivation of Liberty Safeguards
Although we have systems and processes in place to capture feedback from those who use services via routes such as complaints, PALS and FFT, the review has demonstrated that this could be strengthened	Head of Patient Experience to Set up a QI project group: • To improve information for those who use our services on how to provide feedback, particularly those with communication difficulties or do not communicate in English as a first language • To improve responses to FFT with a focus on those from BAME communities and those with communication difficulties
Although we have a culture of co-production and involvement in some areas of the trust, this needs to grow and strengthen further to enhance our patient and family experience to ensure the patient and family voice is heard and acted upon.	Head of Patient Experience to. • Utilise group model with NHFT to link with Mental Health Co-production/Recovery College lead and Head of Patient Experience to explore learning and sharing opportunities.
The Trust needs to strengthen staff understanding and mechanisms to report a risk factor for closed culture via Ulysses.	Head of Patient Safety to: • Work with the Ulysses & patient safety teams to add a specific question on incident reporting forms – Are you reporting concerns/risk factors about a closed culture? If yes, the form would then open to include the definition of a closed culture.
Although the Trust has systems in place to obtain feedback from students, apprentices, and trainees, this doesn't formally link to EWS processes	Deputy Director of Nursing (EW)/Assistant Director of AHP's/Medical Deputy Director/s to enable: • Nursing/AHP/Medical education teams to lead and identify ways to strengthen feedback loops from students, apprentices, trainees for the feedback to be used to inform our EWS processes.
The Trust needs to ensure that we provide education and training on risk factors for closed cultures that aligns with our Trust values and step up to great strategy	Head of Patient Safety to: • Work collaboratively with learning & development team, staff networks and co-production groups to consider how recognition of closed cultures is built

	into staff induction and training, including for bank & agency staff.
Safeguarding – Capacity within the team has meant that non-urgent contacts are not being responded to in a timely way.	Head of Safeguarding to: • Lead a review of current provision within the safeguarding team to explore ways to improve capacity to pick up non-urgent contacts in a timelier way.
Governance mechanisms to capture staff feedback and all staff on a ward e.g., the porter, cleaner, HCAs.	Executive Directors: • All teams (clinical & non-clinical) to create space and build ad-hoc staff feedback into team meetings and wider directorate governance structure and that the feedback is used for continuous improvement. DMT's should be setting the agenda to understand "how it feels to work around here" and build in appropriate and supported feedback mechanisms within all services for example through formal meetings, supervision, training days. DMT's to triangulate this knowledge alongside other feedback mechanism such as staff survey, exit interviews and sickness review meetings.
The quality and safety review should not be a one-off exercise and needs to become part of the Trust business as usual approach to safe and high-quality services.	Director of Nursing, AHP's & Quality and Group Director of Patient safety to: • Work with national team on closed cultures 'what good looks like' tool and embed as a BAU process in LPT • Align the BAU process going forward with NHFT to learn, share and collaborate

Decision required

The Quality Assurance Committee are asked to:

- Take this report as assurance that the trust has undertaken an in-depth piece of work to identify risk factors and assess information on closed cultures in mental health and learning disability inpatient services and is acting via the recommendations to address any areas of concern or systems and processes are in place.
- Provide assurance to January's board of directors in relation to this review.
- Support the publication of the safety review on the trust external website.
- Note and agree the proposals made by the Director of patient safety

Governance table

For Board and Board Committees:	Quality Assurance Committee	
Paper sponsored by:	Anne Scott, Chief Nurse	
Paper authored by:	James Mullins, Director of Patient Safety	
Date submitted:		
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	NA	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	NA	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	One off	
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite?		
False and misleading information (FOMI) considerations:	NA	
Equality considerations:		

Appendix 1

Leicestershire Partnership NHS Trust

Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services

Terms of Reference

Introduction and purpose

In response to a letter received from the National Director for Mental Health on 30 September 2022, NHS Trusts are asked to undertake an immediate quality and safety review of inpatient mental health, learning disability and autism services. Trusts are asked to consider the following as part of the review:

4. **Boards to review the safeguarding of care in the organisation and identify any immediate issues requiring action now; including but not limited to:**

- Freedom to speak up arrangements,
- Advocacy provision,
- Complaints,
- CETRs and ICETRs,
- Other feedback on services.
- Could this happen here?
- How would we know?
- How robust is the assessment of services and the culture of services?
- Are we visible enough and do we hear enough from patients, their families? and all staff on a ward e.g., the porter, cleaner, HCAs?

5. **In your own organisations you must ask:**

- How you are not only hearing the patient voice, but how you are acting on it?
- When people and families tell us things are not right as leaders, we must act. We should therefore consider independent peer-led support to people being cared for in your most restrictive settings and peer-led feedback mechanisms.

6. **Review why people in our services are in Seclusion and Long-Term Segregation, how long for, what is the plan to support them out of these restrictive settings?**

7. **NHSE/I want to ensure that the inpatient quality programme that they are about to launch tackles the root causes of unsafe poor-quality care, looking at the best**

evidence for preventing and uncovering abuse. The work will capture people' views about what support, education, and information, will best help us prevent and fight abusive and poor care. To this end, NHSE/I are fast tracking the roll-out of the programme and will want to shape it with providers, clinical experts, people with lived experience and partners. Therefore, our feedback to the national team through Liz Durrant (L.Durrant1@nhs.net), recently appointed head of programme, will be appreciated.

The Group Director of Patient Safety will lead the review of LPT services and report the findings to LPT Clinical Senate.

Methodology

The Quality & Safety review will focus on the following LPT services:

- MH Adult acute wards
- OPMH Wards
- Marina PICU
- Shearwater PICU
- Wheatfield
- Meadowbank
- CAMHS Wards
- John Greenwood Shipman Centre
- 1 Willow Close
- The Squirrels
- Crisis Houses (The Warren & The Martins)

The review will gather information using the following sources:

- Service visits by the Group Director of Patient Safety, Director of Mental Health & Specialist Services & Director of Community Healthcare.
- Information on mechanisms to provide assurance to Board that we don't have services with an emerging or closed culture.
- Information on how we assure ourselves of the quality/safety of services where we place patients out with LPT.
- Complaints/PALS data October 2021 – September 2022 on complaints received about the above services that focus on any of the indicators of a closed culture. This will also include complaints that have been withdrawn in this period.
- Patient Safety data October 2021 – September 2022 focussing on reported incidents on Datix that flag up any of the indicators of a closed culture in the above services. This will include exploring SI/CI's during this period to see if the actions or findings flagged up any concerns or missed opportunities to act and learn.
- NHS Staff Survey whether there are any concerns for the above services with regards Q17a, Q17b and Q21b.
- Freedom to Speak up arrangements and any data (where appropriate) on concerns raised in the same period on the above services that focus on the indicators of a closed culture?
- Data on seclusion and long-term segregation between October 2021 – September 2022 and information on work being led to reduce restrictive practices and any information on policy/procedural reviews that have been done in the past 12 months or are pending.

- Data on audits between October 2021 – September 2022 of MHA/MCA practice that has flagged up any concerns in the above services and in relation to the indicators of a closed culture.
- Data on DOLS applications between October 2021 – September 2022 in the above services
- Safeguarding – Any reported safeguarding concerns in the above services that relate to the indicators of a closed culture between October 2021 – September 2022.
- Information on the systems and processes for providing advocacy services.
- Information on the Trust approach to co-production and peer support
- Data on Community Education Treatment Reviews between October 2021 – September 2022.
- Self-assessment and quality assurance processes
- Information on external service/peer reviews including accreditation programmes
- Information on service visits by Executive team, Non-Executive Directors, and Governors
- Information on how we measure and assure ourselves of the culture in the above services and Trust wide
- Exploration of assurance mechanisms to ensure we have leadership visibility and do we hear enough from patients, their families, and all staff on a ward e.g., the porter, cleaner, HCAs
- Examples of good practice and proactive work being undertaken across the Trust.
- The review will also utilise the CQC guidance on closed cultures: How CQC identifies and responds to closed cultures - Care Quality Commission

The review will also:

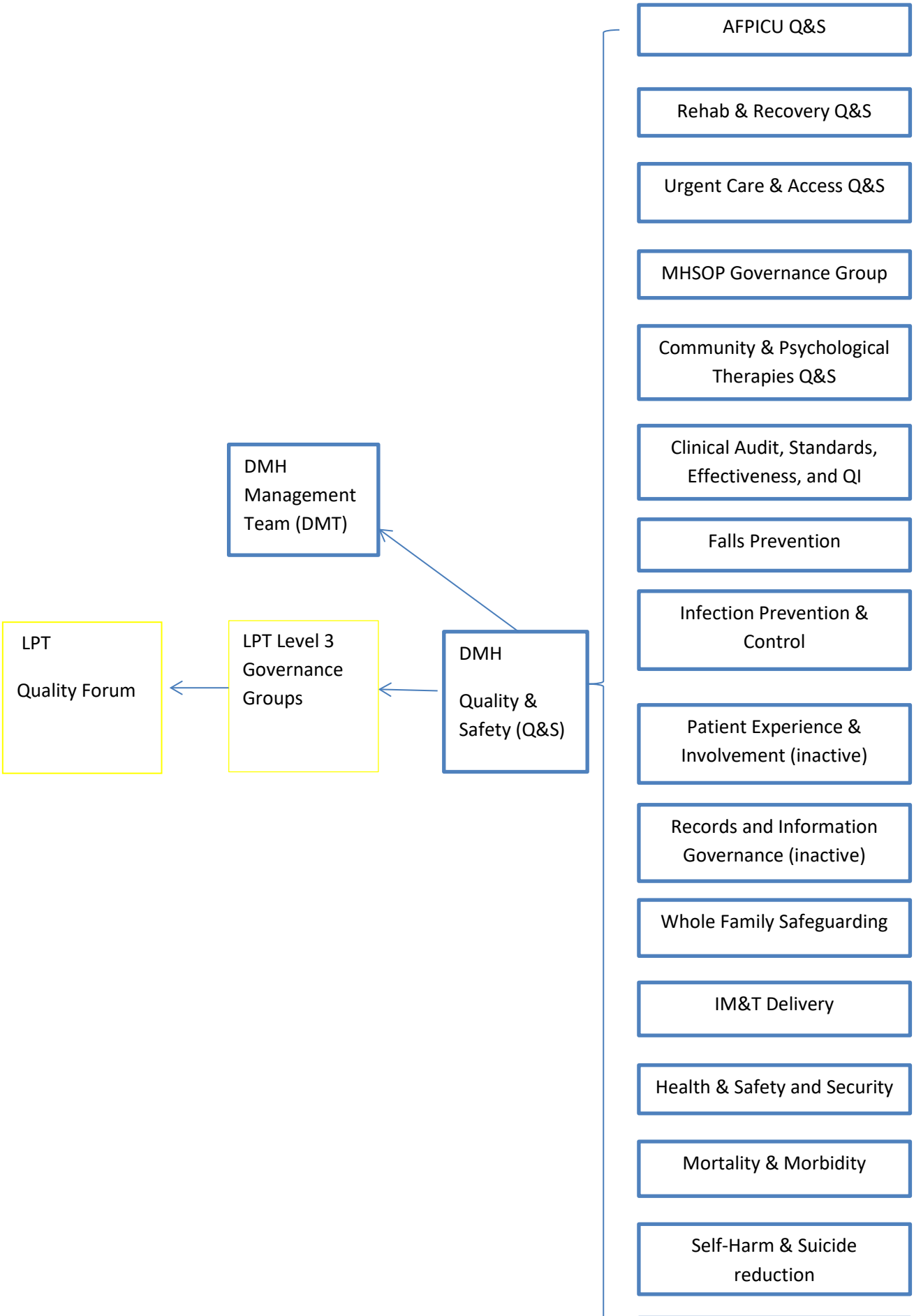
- Recommend, where required, enhancements to service/directorate level governance and the mechanisms required to ensure the Q&S review is not a one-off exercise and becomes part of the Trust' business as usual quality & safety assurance processes.
- Work collaboratively with learning & development team to consider how recognition of closed cultures is built into staff induction and training, including for bank & agency staff.
- Recommend a schedule of senior Nursing & AHP service visits that focus on working alongside staff and teams to provide support and visibility.

Reporting arrangements

A final report will be presented to Quality & Safety Committee in December 2022 and shared as appropriate within the Trust and with external partners.

Appendix 2

DMH Clinical Governance sub-groups & reporting route to LPT Quality Forum



Appendix 3:

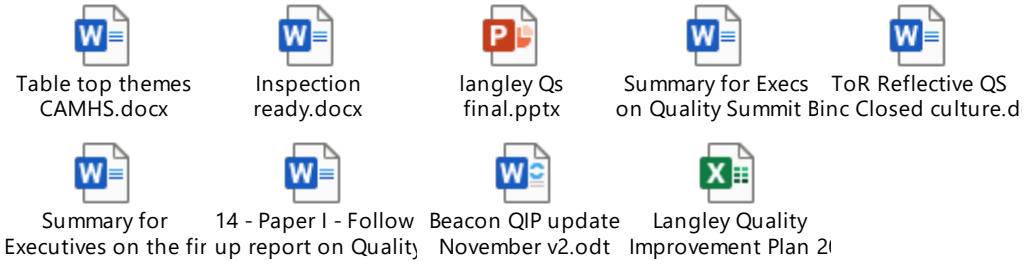


Table top themes CAMHS.docx
Inspection ready.docx
langley Qs final.pptx
Summary for Execs on Quality Summit Binc
ToR Reflective QS Closed culture.d
Summary for Executives on the fir
14 - Paper I - Follow up report on Quality
Beacon QIP update November v2.odt
Langley Quality Improvement Plan 2

Leicestershire Partnership NHS Trust

Quality & Safety Review

Closed Cultures

WeAreLPT
compassion respect
integrity trust

www.leicspart.nhs.uk

Introduction

On 30 September, the Trust (alongside every provider of MH/LD services in England) received notification from the National Director of Mental Health that all organizations are required to undertake a review of the quality & safety services. This followed a BBC documentary that focused on the care being provided by Greater Manchester NHS Foundation Trust within their Medium Secure Service, Edenfield.

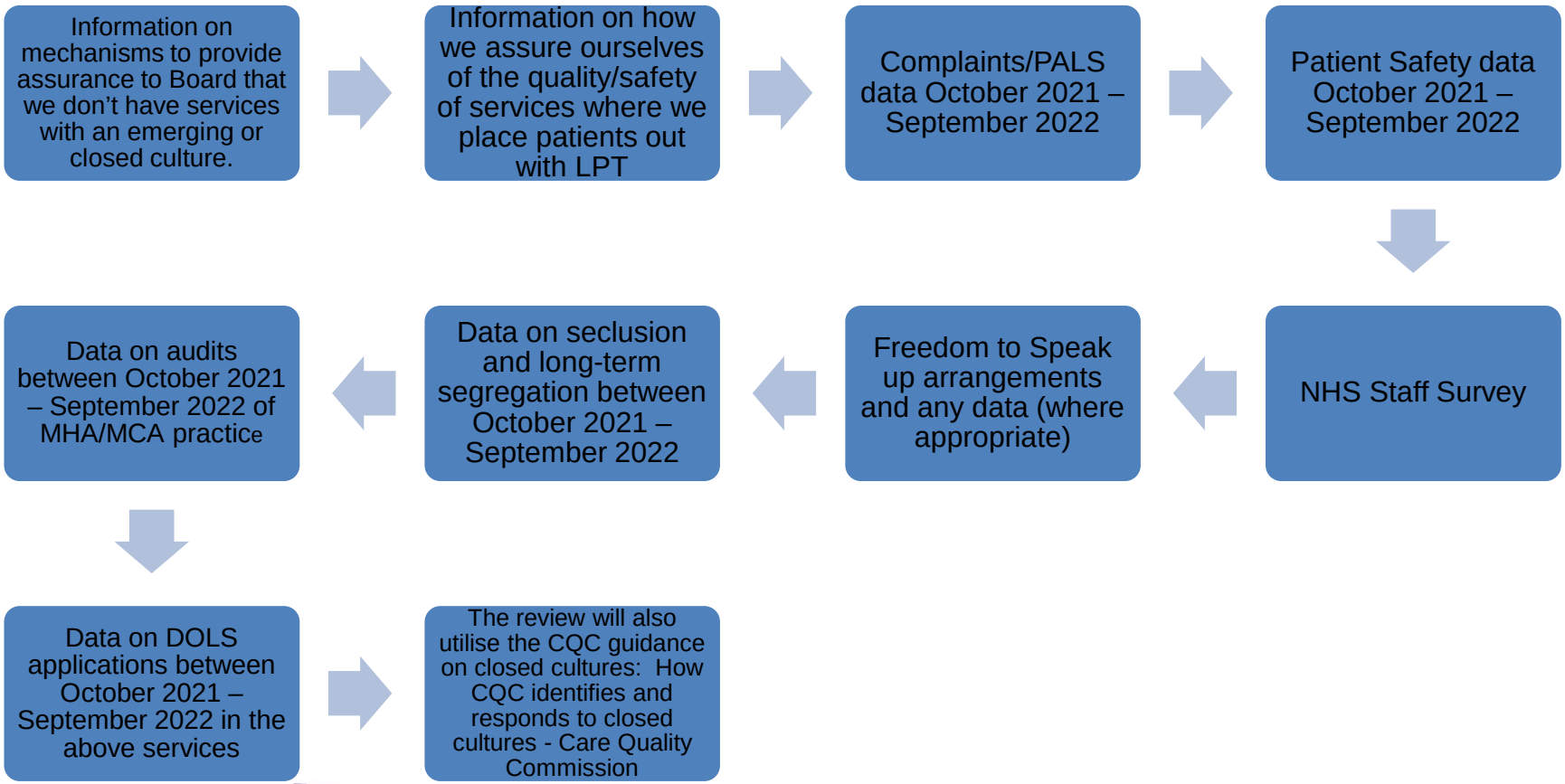
The Group Director of Patient Safety has led the review of LPT services. The Quality & Safety review has focused on the following LPT services:

- MH Adult Inpatients
- CAMHS Wards
- Learning Disability & Autism wards

As a learning organisation, we always strive to improve quality and safety of care and the culture and environment that for patients, families, carers and staff. The quality & safety review has used a blended methodology of service visits and desktop data and information exploration and liaised with staff across several clinical and non-clinical services in order to provide assurance and to demonstrate our commitment to ensuring that closed cultures do not develop in our Trust.

Methodology

The review has gathered information using the following sources:



Methodology

Safeguarding – Any reported safeguarding concerns in the above services that relate to the indicators of a closed culture between October 2021 – September 2022.

Information on the systems and processes for providing advocacy services.

Information on the Trust approach to co-production and peer support

Data on Community Education Treatment Reviews between October 2021 – September 2022.

Self-assessment and quality assurance processes

Information on external service/peer reviews including accreditation programmes

Information on service visits by Executive team, Non-Executive Directors, and Governors

Information on how we measure and assure ourselves of the culture in the above services and Trust wide

Exploration of assurance mechanisms to ensure we have leadership visibility and do we hear enough from patients

Examples of good practice and proactive work being undertaken across the Trust.

Findings

In conclusion, it is not possible to rule out the prospect that we have some environments where risk factors could result in closed cultures developing within some of our Mental health, Learning Disability or CAMHS Services. Within this report, several of the areas that indicate potential risk factors for closed cultures have highlighted where the Trust has potential weaknesses such as lower levels of patient/family feedback and higher levels of sickness/turnover that are aligned in part to work related mental health issues.

There are key areas across the wider Trust that need to be improved to ensure that we do not develop closed cultures. These include patient and family feedback via the friends and family test; evidence of documentation relating to the MHA; processes relating to mental Capacity Act and Deprivation of Liberty Safeguards and capacity to response to non-urgent safeguarding contacts in a timelier way.

There are however examples of good practice including our processes and governance for quality assurance, self-assessment and accreditation and the system approach to community education and treatment reviews. The wider cultural change, Step up to Great Strategy and leadership behaviours work is a vital part of the quality improvement journey that will ensure the Trust is moving forward.