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.

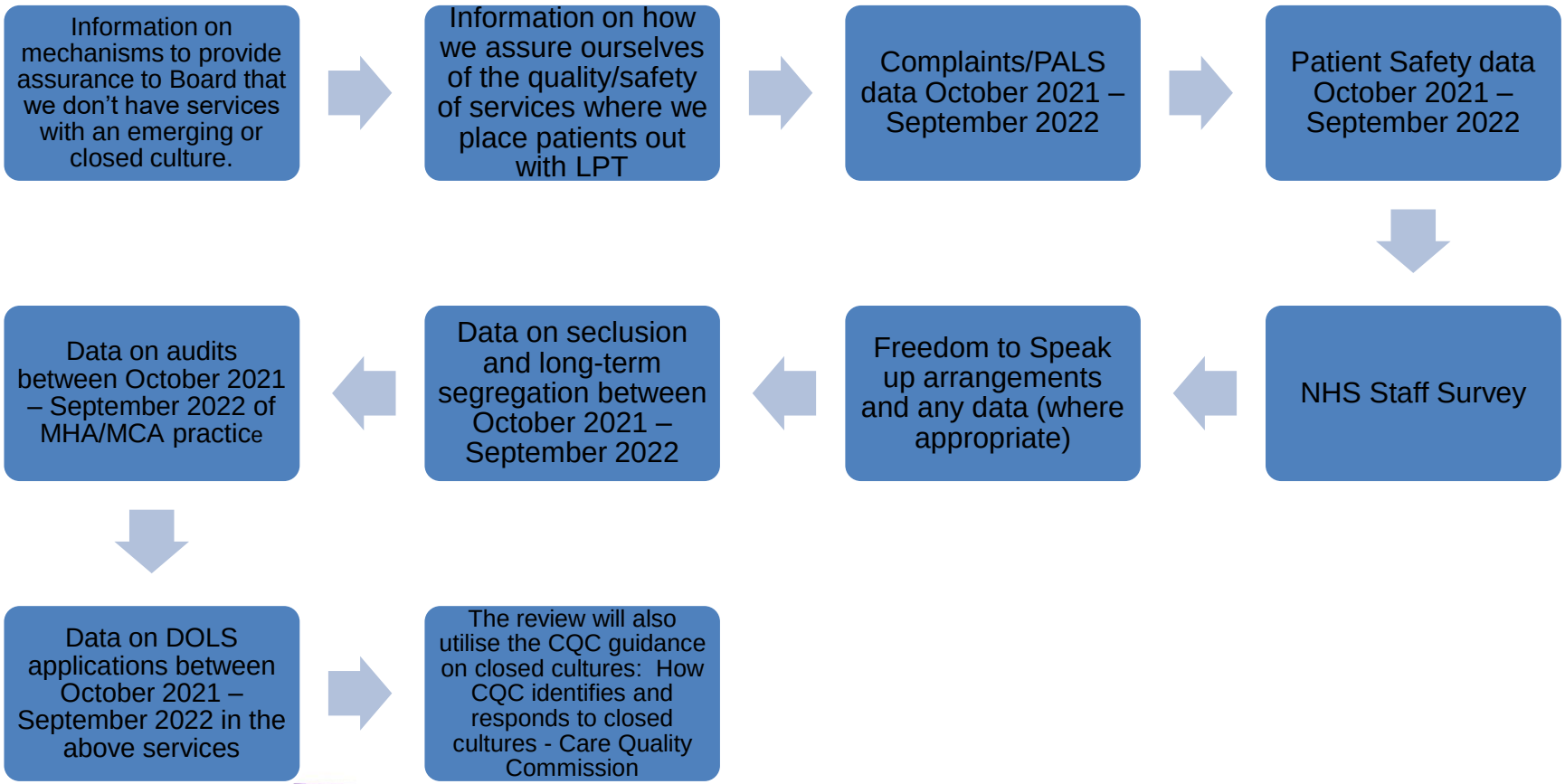
The Group Director of Patient Safety has led the review of LPT services. The Quality & Safety review has focused on the following LPT services:

- 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.