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Leicestershire Partnership NHS Trust

Trust Board – 28th November 2023

LPT Annual Sexual Safety Report 2022 / 2023

1. Introduction/Background

1.1 In 2018 the Care Quality Commission (CQC) worked with NHS Improvement to examine how specialist mental health NHS trusts in England were reporting patient safety incidents of a sexual nature. They analysed nearly 60,000 reports submitted to the National Reporting and Learning System (NRLS) by trusts over a three-month period. More than 900 of these reports related to sexual incidents on mental health wards. A number of these appeared to describe incidents of sexual assault or harassment.

1.2 The CQC published the findings from this work in 'Sexual Safety in Mental Health Wards' in September 2018. In summary their analysis of incidents reported suggests that sexual incidents are commonplace on mental health wards with detrimental effects on patients.

1.3 'When the findings were discussed with people who have used services, they described the distress they experienced when other patients speak to them using sexualised language, or when they observe other patients behave in a sexually disinhibited manner due to their mental ill health. Some patients reported that they had received unwanted sexual advances from other people or that they had engaged in sexual acts when mentally unwell that they have regretted afterwards. This distress and trauma is still very real for people after they leave hospital.

1.4 There was recognition that the work should not have an impact on safe and fulfilling sexual relationships, as they are a part of a person's human rights. 'But as the quality regulator, our priority is to ensure that people using health and care services are kept safe, that due consideration is given to their mental capacity and that their privacy and dignity are maintained' (CQC, p.4).

1.5 The report found that incidents occurred in all ward types but around half of the incidents took place in acute adult wards or psychiatric intensive care units, with almost a quarter reported from forensic units and smaller proportions reported from learning disability units, older people's mental health units, and child and adolescent units. The incident information analysed did not provide enough information to determine if the wards were single sex or mixed sex. The majority of incidents occurred in communal areas or were not able to be classified and a smaller number were reported in private or garden areas.

1.6 The provider response to sexual safety incidents were variable with the majority focusing on interventions around behaviour management, medication, observation, removal to seclusion or other area, less common were contact with the police, victim support, safeguarding discussions, care plan review and actions taken to maintain dignity.

1.7 The learning during the review found that:

- People who use mental health inpatient services do not always feel that staff keep them safe from unwanted sexual behaviour
- Clinical leaders of mental health services do not always know what good practice is in promoting the sexual safety of people using the service and of their staff

- Many staff do not have the skills to promote sexual safety or to respond appropriately to incidents
- The ward environment does not always promote the sexual safety of people using the service
- Staff may under-report incidents and reports may not reflect the true impact on the person who is affected
- Joint working with other agencies such as the police does not always work well in practice

1.8 In July 2019 the Trust was successful in gaining a place on The Sexual Safety Collaborative; this is part of a wider Mental Health Safety Improvement Programme (MHSIP) which was established by NHS Improvement (NHSI) in partnership with the Care Quality Commission (CQC). The aim of the collaborative is to produce a set of standards around sexual safety for mental health and learning disability inpatient pathways (including a strategy to measure and support quality improvement) and produce a library of resources, building on best practice to support the work of mental health trusts to improve sexual safety.

1.9 In 2020 the National Collaborating Centre for Mental Health published 'Sexual Safety Collaborative - Standards and guidance to improve sexual safety on mental health and learning disabilities inpatient pathways. This provided a set of standards around 7 domains to improve sexual safety and is monitored as part of CQC inspection via the 'Brief guide: Sexual safety on mental health wards' (August 2020). Although the National programme stopped in September 2021 the Trust has become part of a Community of Practice for Sexual Safety and regional NHSE sexual safety improvement group.

1.10 Progress has been limited during 2021/22 and 2022/23 due to a pause in the Regional Community of Practice and trusts focusing on the prevention, management and recovery following the Covid-19 pandemic.

1.11 In June 2023 NHS England wrote to all Trusts to ask that they identify leads to ensure the sexual safety of staff and patients in the NHS. This built on the Domestic Abuse and Sexual Violence (DASV) Programme launched in 2022 and paved the way for the NHS Sexual Safety Charter 2023. The Executive Lead for Sexual Safety is the Director of Nursing and Quality and responsibility for delivering the requirements will be held by the Safeguarding Committee and a new subgroup focusing on Sexual Safety commencing in November 2023.

2. Aim

2.1 This Annual Report will provide an update on the Trust actions to address the concerns raised in the finding in the CQC Sexual Safety Report, detail the number and type of sexual safety incidents in the Trust between April 2022 and March 2023 and the plans in place to relaunch the trust group also including the responsibilities for staff sexual safety at work.

3. 2022/2023

3.1 In May 2022, the National Patient Safety Collaborative was asked to focus on one area: Reducing Restrictive Practice and the Sexual Safety was decommissioned. The East Midlands decided to continue a regional Community of Practice (COP) and this was relaunched, LPT are members of the collaborative.

3.2 Plans to commence a new quality improvement project in September 2022 focussed on identified priorities in the 'Sexual Safety Collaborative - Standards and guidance to improve sexual safety on mental health and learning disabilities inpatient pathways were delayed and will commence in quarter 3 2023/24.

3.3 Adverse Childhood Events (ACE) training has commenced led by psychology colleagues for staff within DMH that is being run alongside Decider Skills training for all staff.

4. Incidents Data

4.1 The table below shows the number of incidents over the last 5 years, although the total number of incidents in 2018/19 were considerably lower than the following 4 years; there had been an increase in staff awareness of sexual safety and guidance from the trust safeguarding team regarding the reporting and further actions required when incidents take place. There were 50 sexual safety incidents reported during 2021/22 which was less than the previous 2 years, it is difficult to establish if this was related to the impact of Covid 19, or preventative approaches in inpatient wards.

Year	2018/19	2019/20	2020/21	2021/22	2022/23
Total incidents	39	60	70	50	92 (83 confirmed as corectly coded)

4.2 In 2022/23 there has been a significant increase in the number of sexual safety incidents reported.

The majority of incidents in inpatient wards occurred in the male PICU or mixed sex acute mental health wards and this was a similar picture to previous years.

Inpatient wards:

Acute/PICU MH Wards	Number of incidents	CAMHs Ward	Number of incidents
Sexually disruptive behaviour	22	Sexually disruptive behaviour	2
Sexual assault	11	Adult Eating Disorders Ward	
Rehabilitation MH Wards		Sexual assault	1
Sexually disruptive behaviour	4	Learning Disability Acute Ward	
Mental Health Services for Older People Wards		Sexually disruptive behaviour	1
Sexually disruptive behaviour	1	Community Hospital Wards	
Sexual assault	2	Sexual assault	3
Low Secure MH Ward		Other:	
Sexually disruptive behaviour	3	UHL Ward - Sexually disruptive behaviour	1
Sexual assault	1	Total incidents:	52

The inpatient incidents can be split by type as:

Sexual assaults – 18 incidents
4 incidents involving patient on patient
8 incidents involving patients on staff
5 incidents involving staff on patients
1 incident of staff on staff

The sexual assault incidents were all addressed appropriately and 34 incidents involving sexually disruptive behaviour

Of the 34 sexually disruptive behaviour incidents there were over half related to patients exposing themselves to staff or others and this will be considered in work around ward sexual safety charters.

Community incidents

MH Community Teams	Number of incidents	LD Community Teams	Number of incidents
Sexually disruptive behaviour	19	Sexually disruptive behaviour	5
CHS Community Teams		Sexual assaults	3
Sexually disruptive behaviour	3		
Sexual assaults	1		

The reported incidents in the community are mainly disclosures of historical sexual abuse or assault towards patients by members of non LPT staff or members of the public. These were followed up appropriately with safeguarding in the Local Authority. Further analysis of reporting is being discussed by the Safeguarding Team with the Local Authority.

5. Monitoring and Assuring

5.1 The Ulysses safeguard system captures sexual safety related incidents under the following relevant categories:
- Violence and abuse
- Patient on patient
- Patient on staff
- Staff on patient
- Staff on staff
- Disruptive behaviour

5.2 All incidents are discussed in the service line incident review meetings and directorate safeguarding groups.

5.3 The Safeguarding Team previously maintained an overview of all incidents; however, this has changed to encouraging all staff to seek advice from the team as soon as an incident occurs and then take the appropriate actions.

5.4 The Complaints Team review all complaints and the Safeguard system has a distinct category for sexual safety complaints to ensure these are flagged.

5.5 The Friends and Family Test data is collated on the Envoy system. Key words have been set up with an alert so that sexual safety related feedback is flagged and reviewed by the relevant Head of Nursing.

5.6 The weekly safeguarding/ allegations meeting have continued in the mental health directorate and enable operational and clinical leaders to meet with the safeguarding team and Human Resources. Some sexual safety incidents are discussed and actions agreed through this group.

5.7 A key issue for the Trust is managing sexual safety due to mental health related sexual disinhibition. The Trust has put in place some mitigation to respond to this:
- The organic mental health older person's wards do not support a mixed sex patient group due to the inability to manage the risk in this environment.
- Patients can be internally transferred to other wards if sexual safety incidents occur, or risk assessments suggest this is required.
- The use of shared room risk assessments in dormitories to prevent incidents and risks to patients.
- The Trust is in the final stage to remove dormitory accommodation, following a 3-year programme to eliminate the current dormitory accommodation for mental health wards. All of the Acute wards have been completed and work on MHSOP wards are on target for completion in 2023/4.

5.8 The Trust has a process for addressing any concerns regarding sexual behaviours within risk assessments, care plans and delivery of care, this includes completion of personal care and chaperoning physical examinations. Concerns can be discussed with the Safeguarding Team which provides advice and support to staff and the team have developed resources for staff to support processes.

6. Conclusion

6.1 There are processes in place to ensure that sexual abuse or disruptive behaviour is reported, risk assessed and minimised on the wards. Any sexual safety incidents or complaints are flagged, reviewed and investigated appropriately. The Trust takes proactive measures to secure the sexual safety of patients, particularly for those admitted to mixed sex accommodation and are actively working on co-produced approaches to ensure patients and staff feel safe.

6.2 The Trust will ensure the Domestic Abuse and Sexual Violence (DASV) Programme will be taken forward as part of the Sexual Safety Group, to build on our robust safeguarding processes for protecting patients, improve victim support, and focus on early intervention and prevention.

7. Recommendations

7.1 Continue with a Trust wide Sexual Safety Group to progress the work areas identified below regarding patient sexual safety and now will include meeting the requirements of NHS guidance on maintaining staff sexual safety :

- Continue to be part of the Sexual Safety Community of Practice
- Review of the incidents to continue to establish local learning, themes, and any training requirements
- Continue with the trauma informed care training in a planned approach to increase opportunity for attendance.
- Guidance for staff on managing sexual safety incidents and support for patients and staff with partners from the police and safeguarding team.
- Increase the opportunity for co-production of resources, training, and guidance.
- To expand the ward sexual safety charter to all wards and ensure leaflets are available.
- Develop a plan to meet the requirements of the NHS guidance for staff sexual safety in healthcare and deliver the principles in the NHS Sexual Safety Charter.
- To explore a specific Sexual Safety Policy for LPT with Safeguarding Team.

7.2 Ask that the Trust signs up to the new Sexual Safety in Healthcare – organisational charter published in September 2023.

Governance Table

For Board and Board Committees:	Trust Board 28th November 2023	
Paper sponsored by:	Anne Scott Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Michelle Churchard-Smith, Deputy Director of Nursing, AHPs and Quality	
Date submitted:	14.11.23	
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):	Safeguarding Committee 29th September 2023. Quality and Safety Committee 31st October 2023.	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	Assured Assured	
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	Annual report	
STEP up to GREAT strategic alignment*:	High Standards	√
	Transformation	
	Environments	
	Patient Involvement	
	Well Governed	√
	Reaching out	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:		