

3As Highlight Report

Meeting Name: Quality and Safety Committee

Meeting Chair & Report Author: Josie Spencer Non-Executive Director

 Meeting Date: 18th February 2025

Quorate: Yes

Agenda Item Title:	Minute Reference	Lead:	Description:	BAF Ref:	CRR Ref:	Directorate Risk Ref:
ALERT: Alert to matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the Trust's strategy						
None						
ADVISE: Advise the Board of areas subject to on-going monitoring or development or where there is negative assurance						
Safeguarding Committee	Item 13	James Mullins	The Committee were advised that although there has been some progress, several children and adults domestic homicide case review actions remain open for LPT. The Committee is monitoring this with a view to closing these down by March 2025. The risk in relation to the Safeguarding Workforce disruption has been updated and the score has reduced, due to the mitigations in place to manage.	06 11		
Safeguarding report Q3 2024-25	Item 14	James Mullins	The Committee was advised of an emerging issue which stems from a backlog of local authority case reviews. The situation has been resolved however this has resulted in 60 case reviews being sent to LPT in one go and there are now challenges around capacity to input these onto the system. Additional staff from the Enabling directorate and bank staff will be utilised to address this backlog. A revised improvement plan has been developed with the involvement of external partners and was approved at the January 2025 Safeguarding committee. The Committee will receive an update on progress through the quarterly safeguarding reports.	11		
Director of Nursing, AHPs & Quality Escalation report	Item 19	James Mullins	An update was received on the Care Quality Commission (CQC) Nottingham healthcare review. NHS England has recently published its Independent Mental Health Homicide Investigation report and LPT is currently reviewing action plans to ensure these align to the recommendations in the report. The outcome of this work will be presented to Executive Management Board and Strategic Executive Board in March 2025, Quality and Safety Committee in April	06 11		

			<p>2025 and Trust Board in May 2025, to ensure the national requirement for Board oversight by June 2025 is achieved. Work is ongoing to prepare our Community Mental Health Teams for potential inspection activity (following the CQC Nottingham healthcare review). Teams in Mental Health, Learning Disabilities and Child and Adolescent Mental Health services have undertaken a series of mock inspections, which have been effective. Daily 'Scrum and Sprint' sessions have been implemented to add further scrutiny and challenge. Good progress was reported on the implementation of the Patient Safety Improvement Plan. Each workstream has developed a plan on a page to provide clear structure, aims and actions. A deep dive on the Patient Safety Improvement Plan will be received by the Committee in June 2025.</p>			
Learning from Deaths Q3 2024-25	Item 24	Bhanu Chadalavada	<p>The first draft of the Learning from Deaths Policy has recently been circulated for comment. It was noted that there has been a delay in disseminating the Policy for consultation, due to the work that was needed to take place on changes to the Medical Examiner system.</p> <p>The corporate patient safety team is working with the Medical Examiner office to establish a process for requesting, obtaining and recording the Cause of Death for Community and In-Patient In-Scope deaths, to enable investigations to be completed in a timely way. FYPCLDA has a high backlog of patient deaths for review. A screening tool is being developed and extra capacity to support this will be required. A section has been included in the report relating to Learning from lives and deaths—People with a learning disability and autistic people (LeDeR) data for Quarter 3 2024-25. In October 2024, when the Quarter 2 2024-25 Learning from Deaths report was submitted, the Quality and Safety Committee had requested assurance around LeDer in the next iteration. There were 32 new notifications of deaths of people living with learning disability and/or autism received to the LeDeR platform for LLR during Quarter 3 2024-25. Learning identified for our LDA services includes cancer including, advanced care planning and Mental Capacity Act.</p> <p>It was noted the content of the report is maturing and evolving and is assured by the improvements documented, due to increased availability of data.</p>	11		
ASSURE: Inform the Board where positive assurance has been received						
Policies approved/ extensions granted:			Nil			

Community Nursing	Item 5	Sam Leak	In October 2024 the Committee received a paper outlining the outcomes and recommendations from a deep dive which had been commissioned by the Executive Management Board in response to concerns around ongoing sustained pressure in the Community Nursing service. This paper gave initial assurance on progress against the Community Nursing transformation workstream. However, given the ongoing work required the Committee will receive an update in six months (August 2025). This will include a focus on outcomes and include feedback from the Executive Team service visits to the hubs to provide frontline staff perspective and narrative.	01 06 08		
Seclusion Deep Dive	Item 7	James Mullins	The Committee received a report providing a detailed review of seclusion and segregation in LPT, including Statistical Process Charts for the period January 2022 to December 2024. The information presented evidenced the gradual overall decline in use of seclusion and segregation in LPT. Seclusion data, analysis of variations, audit action progress and risk relating to seclusion is overseen by the DMH Directorate management team and the Trust Least Restrictive Practice group. The Committee received good assurance from the seclusion deep dive and agreed that going forward the Quality dashboard will report seclusion data.	11		
Freedom to Speak Up (Quarters 3 2024-25)	Item 8	Pauline Lewitt	The Freedom to Speak Up Guardian joined the meeting to present the quarterly update report. The Committee was assured by the content of the report. Going forward it has been agreed that Freedom to Speak Up will be moved to the overall oversight of the People and Culture Committee. This is in line with the indicators outlined in the insightful board guidance. The Quality and Safety Committee will continue to receive any relevant quality and safety issues from the Freedom to Speak Up analysis via the Safety Forum, this will be a pinned item for the Safety Forum AAA report so that an update is provided at each committee meeting. The Forum will triangulate any themes and issues with the wider safety portfolio and feed these into the QSC. The Committee can also receive themes and updates via the environmental scan item.	06		
Sexual Safety subgroup update	Item 15	James Mullins	The Trust Sexual Misconduct Policy and supporting materials will be launched mid-February 2025 and will go to the February 2025 Senior Leadership Forum. Upon the receipt of NHS England guidance, which is awaited, the Trust will devise and establish advanced training. There are plans to improve triangulation of data relating to incidents, staff survey feedback and freedom to speak up cases. There are plans to launch			

			patient sexual safety resources on the acute wards, implement the updated Sexual Abuse training for direct care staff and review the Sexual Safety Charter implementation.			
Safe Staffing – Six monthly report	Item 23	James Mullins	The Committee noted that there were zero off-framework requests across the Trust between July and December 2024. It was confirmed that a triangulation of complaints and nurse sensitive indicators (NSIs) with planned versus actual staffing has not identified any direct correlation between staffing levels and the impact on quality and safety of patient care and the Trust continues to monitor this. It was reported that the full establishment staffing reviews commenced in October 2024 across all inpatient areas and this, together with the light establishment review is an ongoing process throughout the year.			
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding						
Quality Forum highlight reports - December 2024 & January 2025	Item 12	James Mullins	The Committee were delighted to note that Mental Health Services for Older People Charnwood Community Mental Health team has been awarded Gold accreditation for Valuing High Standards and they are the first community team in LPT to achieve this.			