University Hospitals of Leicester NHS
NHS Trust

Trust Board public paper F3

Meeting title:	Trust Board
Date of the meeting:	14 August 2025
Title:	**Escalation Report from the Quality Committee (QC): 26 June 2025**
Report presented by:	Dr Andy Haynes, Quality Committee Non-Executive Director Chair
Report written by:	Alison Moss, Corporate and Committee Services Officer

Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	Not applicable					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which

Yes. BAF risk within the remit of QC is listed below:
Quality Risks (BAF reference: 01-Quality)
1) There is a risk that a positive safety culture is not consistently embedded across services, due to underreporting and variable staff confidence in raising concerns and learning from incidents, leading to patient harm, low morale, reputational damage, and non-compliance with safety standards
2) There is a risk that hospital-acquired infections and harm do not reduce as planned, due to inconsistent delivery of fundamentals of care, overcrowding and variable protocol compliance, leading to avoidable harm, longer stays, cost pressures, and reduced confidence in care
3) There is a risk that patients, families, and carers are not fully engaged in service development and feedback, due to limited access to and responsiveness of engagement mechanisms, leading to unmet needs, dissatisfaction, and increased complaints
4) There is a risk that care for patients with mental health needs, learning disabilities, autism, dementia, or at end of life remains inconsistent, due to variable screening, staff training, and service capability, leading to poorer outcomes, readmissions, and non-compliance with national standards– current rating = 15
5) There is a risk that patients from underserved groups continue to experience poorer access, communication, and outcomes, due to insufficient data insights, inconsistent reasonable adjustments, and language/cultural barriers, leading to continued health inequalities and dissatisfaction among diverse patient groups, missed appointments, and reputational damage – current rating = 15

Impact assessment

N/A

Acronyms used:
CMG – Clinical Management Group
CQC – Care Quality Commission
PALS – Patient Advice and Liaison Service
QC – Quality Committee
VTE - Venous Thromboembolism

1. Purpose of the Report

To provide assurance to the Trust Board on the work of the Trust's Quality Committee, and escalate any issues as required.

2. Summary

The Quality Committee met on 26 June 2025 and was quorate. It considered the following items, and the discussion is summarised below:

3. Public items recommended to the Trust Board

4. Learning Disability, Autistic People and Mental Health – Annual Report

The Committee received the Annual report for Learning Disability, Autistic people and Mental Health, noting the improvements seen, specifically on systems and process within the Trust and challenges for the next year. The

Committee noted the need to reflect on the support to adults with Learning Disabilities and Autism and consider intersectionality.

The Annual Report 2024/25 be endorsed and recommended for Trust Board approval. The report is appended to this escalation report accordingly.

5. Discussion items

5.1 Board Assurance Framework (BAF)

The Committee received the BAF noting the updates including the temporary closure of St Mary's Birth Centre, the roll out of the fundamentals of care programme and the concerns raised by the CQC inspection. The risk scores remained unchanged. The Committee note that there was more work to do to identify and tack gaps.

5.2 Mortuary Services Report / Human Tissue Authority Designated Individual Report

The Committee was updated on the operational situation of the UHL mortuary service. Refurbishment of the mortuary at Glenfield was supported by the Patient Safety Committee. The Trust is expecting an inspection from the Human Tissue Authority. Staffing had improved as a number of roles had been recruited to and their training was nearing completion. There are challenges for paediatric pathology and cases being sent to mortuaries located at some distance from Leicester. NHSE is working towards stablishing this service on a firmer footing for next year. The intention is for trusts to form collaborative alliances.

Given the new CMG reporting mechanism for fragile clinical services, the Committee thought it was timely to review reporting mechanisms to QC including non-clinical services with issues which impact on clinical services, safety and quality.

This update is highlighted to the Trust Board, for information.

5.3 Quality and Safety Performance Report – April 2025

The Committee noted improved performance for falls, hospital-acquired pressure ulcers, and VTE risk assessment compliance. Mortality rates are within the expected range. Friends and Family Test scores are above the national target (except for maternity). There is a decline in complaints performance and an increase in PALS concerns. Mandatory training compliance has dropped (93%). There is a significant increase in staff-related incidents and violence and aggression reports. There is improved visibility of these incidents and work to support staff and ensure a zero-tolerance approach. There is work with NerveCentre to increase number of patients over 65 years of age having cognitive screening assessments.

The Committee queried whether workforce reductions were being mapped to variances in quality and safety indicators. It was suggested there could be an impact at a later date and this should be monitored. How this will be reported would be the subject of further consideration.

Committee members asked questions around cognitive screening assessments, C-diff rates, the management of open incidents, overdue complaints, and the use of temporary escalation spaces.

5.4 Audit Review report re. CQC Safe Domain

The Committee received the Internal Audit Report of the actions being taken with respect to the Requires Improvement to Good Steering Group. Internal Audit was asked to review how the evidence was captured which they did not comment on. It provided feedback on the governance which was helpful. It was reported that the actions identified by Internal Audit would be completed by September 2025.

5.5 Changes to CQC Statement of Purpose

The changes of the CQC Statement of Purpose were noted as: addition of Preston Lodge; removal of Ashton Lodge; addition of Chandra Mistry Renal Unit at Peterborough as a satellite location (to support the reduction in patient numbers at the Peterborough Dialysis unit due to fire safety concerns); and updates for the Hinckley Community Diagnostic Centre. It is hoped that discussions with the relevant Fire Services would resolve the issues shortly.
This change to the CQC Statement of Purpose is highlighted for the Trust Board's attention.

5.6 Update on Fundamentals of Care and Patient Story Actions

The Committee noted progress on the Fundamentals of Care Programme launched earlier in the year in response to a patient's story heard by the Trust Board. The Programme sets out what good care looks like, considering culture and the way colleagues work together to provide seamless patient care. The Committee commended the work on noise reduction at night to promote sleep. There will be further consideration of the equality, diversity and inclusion aspects of the programme.

5.7 Action Plan for Complaints Handling in UHL

The Committee received the Internal Audit Report on the audit of complaints handling in the Trust. The Audit provided significant assurance. There is still work to do specifically with respect to acknowledging complaints and contact with complainants when deadlines are extended. A sample of complaints were sent to Executive Directors to review; it was agreed to extend this to Non-Executive Directors.

5.8 Safeguarding Assurance Committee Report

The Committee received the quarterly report of the Trust's Safeguarding Assurance Committee. It noted how learning from recent multi-agency incidents was shared and joint work with University of Northampton Hospitals on referrals and consistent practices. Committee members asked about the increase in number of babies being taken into care.

5.9 Perinatal Assurance Committee Update

The Committee received a report on the work of the Perinatal Assurance Committee. There is a risk in relation to the transition of the Maternity Voices Partnership, as the existing arrangement delivered tangible benefits and outcomes. Foetal medicine remains a concern, and an action plan was being drawn up. The peer review arrangement with Leeds NHS Trust would cease and UHL is seeking another peer trust which provides tertiary services. There will be an update in the next report on outcomes in light of deprivation and ethnicity data.
This update is highlighted to the Trust Board, for information.

5.10 Patient Safety Committee Update

The Committee was briefed on the operation of bleeps, noting the issues with reception and the mitigations in place. An options appraisal is being drawn up for a longer-term solution. The recruitment of the Maxillofacial Head and Neck consultant was welcomed. Noting the capacity constraints for Ophthalmology, the Committee was advised of the potential for new technologies to bring about transformation, however, this is difficult to address when the service was facing immediate pressures.

Committee members asked about the recurrent failures with lifts, and it noted that a report would be presented to Risk Committee. The risks around the aging estate are reflected in The BAF but need to be kept under review.

5.11 Feedback from and escalation to LLR System Quality Board

The LLR System Quality Board had considered the audit of discharge letters the CQC inspections and visit from the Royal College of Surgeons. There had been a Quality Impact Assessment on prehabilitation following the reduction in finding which would be submitted to the Integrated Care Board.

5.12 Items for Noting

Integrated Performance Report 2025/26 – Month 2
Perinatal Surveillance Scorecard

University Hospitals of Leicester NHS

NHS Trust

Caring at its best

ANNUAL REPORT

Learning Disability, Mental Health and Autistic People

April 2024 – April 2025

1. INTRODUCTION

Welcome to the second combined Mental Health, Learning Disability and Autistic People annual report, which describes the work undertaken across the Trust to support people with mental health, learning disability and autism.

The report includes contributions from the Trusts subject matter experts who describe in detail the achievements and priorities for the year ahead

The report ~~will~~ provides an update of the work undertaken throughout the year; provides assurance about how we satisfy ourselves that our service meets and exceeds statutory requirements and ~~to~~ outlines our work priorities for the year ahead.

2. OUR COMMITTMENT

In the past year, UHL has continued to work alongside our partners to strengthen the contribution that the organisation makes to support people with their mental health, those who are autistic or those with a learning disability.

Leicestershire Partnership Trust is the local provider, of specialist Mental Health, Learning Disability and Autism services.

The Integrated Care Board for Leicester, Leicestershire and Rutland have been instrumental in supporting work to improve service provision through the LLR Mental Health Collaborative and Learning Disability/ Autistic People Collaborative

The Chief Allied Health Professional chairs the Trusts Mental Health, Learning Disability and Autistic People Steering Group. Now in its second year the group, with representation from CMGs and external partners, has the oversight and influence to support change. This report reflects the steering groups work.

3, KEY ACHIEVEMENTS

Notable achievements within the past year include:

- Launched the Oliver McGowan Mandatory Training Part 2(OMMT), leading to increased numbers of staff completing training.
- The LLR OMMT team were highly commended in the workforce development category and won the co-production award at the regional finals of the Great British Care Awards.
- Completion of work to implement Right Care / Right Person within UHL
- The appointment of a Children's Mental Health Matron and Children's Learning Disability & Neurodiversity Specialist Nurse, to improve service provision for children attending UHL.

- Through the work of the Children's Clinical Mental Health Lead, there has been a significant sustained decrease in the length of stay and admissions of young people with mental health illness coming to UHL
- The introduction of a learning disability and autism shared decision council in the Children's Hospital
- Completion of an independent Enter and View review of facilities for adults with a learning disability by Healthwatch Leicestershire
- Work has begun to embed LLRJOY and NHS 111 # 2 across clinical areas, to ensure adults in mental health crisis can access support in a timely way
- The Trust joined the Leicester, Leicestershire and Rutland Learning Disability and Autism Collaborative and the Mental Health Collaborative
- Through collaboration with Leicestershire Partnership Trust we started to collect data on activity to help inform service planning

3. PARTNERSHIP AND COLLABORATION

The best way in which services can develop is through co ownership and collaboration. Across Leicester, Leicestershire and Rutland there is a Mental Health Collaborative and Learning Disability and Autism Collaborative. Both have representation from health, social care and voluntary organisations who work together to develop services and joint working initiatives.

These partnerships are invaluable for the Trust being able to access specialist resources and to understand issues and priorities for the local communities. It has presented opportunities for closer working with partner agencies, and to link into wider initiatives aimed at improving access to services in the community.

The JOY app is a social prescribing resource which provides detail of services available in local communities for people seeking early mental health support. It is a single access point that provides details of how to access locality based services. Work began to embed JOY in the McMillan Cancer services and hospital discharge services by linking IT systems together to improve referral process.

Right Care / Right Person is a Home Office initiative to reduce the amount of police time spent responding to people in mental health crisis when they are not the most appropriate service to respond. In collaboration with social care, police and partner health organisations, work was undertaken to conform with the new guidance. In view of this new initiative the Trust reviewed its policy, procedure and guidance for staff. This has resulted in a reduction in police calls. This is a new process and is being carefully monitored through partnership arrangements

During 2024 in collaboration with Leicestershire Partnership Trust, work was promoted which provided community based alternatives for people in mental health crisis. In particular the use of crisis support, including the use of NHS 111 # 2. This work has seen benefits in particular for children's services. In adults the improved accessibility to support services has seen an increase in demand and work continues to manage this

4. SERVICE SPOTLIGHTS

CHILDREN & YOUNG PEOPLE - MENTAL HEALTH

There is a Clinical Children's Mental Health Lead and Children's Mental Health Matron who have dedicated time to support the Children's and Young Peoples Mental Health agenda. The team have provided the following update

CYP presenting with MH concerns have decreased a recent study in the Lancet showed UHL continues to admit the lowest number (across England), of CYP with MH concerns to acute wards.

Time spent in the CED (Length of Stay: LOS) for CYP attending with MH concerns has also decreased

Prolonged stays in CED have also significantly reduced from last year, by 59% for lengths of stay >12 hrs and by 50% for stays > 24 hrs

Children's Hospital Eating Disorders Service

Admissions for CYP with eating disorders have increased

CYP with MH concerns presenting to UHL Children's Emergency Department/Single Front Door Service

Attendance rates for CYP with MH concerns attending CED have decreased by 16% compared with last year, (although levels still remain higher than in 2022) and also have dropped as an overall percentage of CED attendances by22% (In 2023, MH attendances were on average 1.56% of CED attendances but in 2024 represent 1.34%). Discharge rates continue to rise, with current discharge rates of 98.2%

Prolonged length of stay in CED and Abandoned Children

For the more complex individuals, prolonged length of stays have also improved with a decrease of 59% for stays>12 hrs and by 50% for stays >24 hrs. This is despite the number of "abandoned CYPs" remaining similar to 2023 (approx. 1 per every 2 months), and would suggest the escalation process for Abandoned CYP is working well.

Admission rates

Admissions for CYP with MH concerns attending UHL is 1.8% of all CYP attending with MH concerns. In Feb 2025, the Lancet (Child and Adolescent Health) published a cohort study of admissions to acute medical wards for mental health concerns over 10 years (2012-2022), Admission to acute medical wards for mental health concerns among children and young people in England from 2012 to 2022: a cohort study - The Lancet Child & Adolescent Health. UHL continue to admit the least patients across England. The majority of MH admissions to UHL are for medical management of the consequences of either Eating Disorders or of overdoses, although the majority of this latter group are now successfully managed within the Emergency Floor (CSSU/EDU) with medical management and subsequent mental health review occurring prior to discharge, without necessitating an in-patient admission.

Children's Hospital and CYP with Mental Health Concerns

Admission rates have increased from last year (25 patients in 2023 and 40 patients in 2024, with 6 of the 40 requiring two admissions)

60% of the admitted patients were confirmed neurodivergent although the likelihood is that this is probably an underestimate of true prevalence as several CYP were suspected of being neurdivergent and are awaiting formal assessment.

Length of stay for this group of patients continues to fall and is currently an average of 21.8 days (in keeping with MEED guidance "For CYP requiring hospitalisation, 3 weeks has been suggested for a structured admission to a paediatric setting, although in practice the duration will depend on the severity of the presentation and an assessment of community support and parent/carers needs" which is a reduction of 32% on length of stay for this group of patients in 2023, and a reduction of 52% in length of stay before the Eating disorder team was officially started .

CYP with general psychosocial concerns

The General Paediatric CAMHS Liaison team has continued to grow in 2024 and now comprises of a CAMHS liaison psychiatrist, CAMHS CYP psychologist, CAMHS CYP MH nurse, CAMHS Family Therapist and CAMHS CYP Occupational therapist.

The UHL – Liaison Psychiatry team meet fortnightly with an open invitation for the UHL MDT to bring cases where CYP with a psychosocial element to their presentation are under the care of a UHL consultant. This has included, but is not limited to CYP with a functional disorder diagnosis, or non-epileptiform seizure activity, difficulties emerging from underlying physical illness diagnosis or difficulties with treatment. All CYP discussed have subsequently been accepted for assessment by the general psychology team or the liaison psychology team, and the impact is reduction in length of stay, reduction in both number of or severity of symptoms, and reduction in attendance at CED /Single Front Door service. The work of this joint service is being presented nationally at the RCPCH Spring Conference Mar 2025.

CYP Mental Health Education & Training

Education has been provided to and continues to be delivered to junior and senior doctors via local, regional and national education events for both paediatricians and emergency medicine trainees.

There has been specialist training provided by the Eating Disorder team to ward based staff within the Children's Hospital

The weekly Eating Disorder Psychosocial Meeting and the fortnightly General Paediatric Psychosocial Meeting occur, both of which are for the MDT and attended by both UHL and CAMHS colleagues.

Newly appointed CYP MH Matron is working with the Education Teams in ED, Children's ED and Children's Hospital to enhance and further develop education around CYP with Mental Health concerns.

. To work with CYP MH Matron to deliver further clinical guidelines and SOP for the management of dysregulated CYP presenting to/admitted to CH and those with MH concerns

. To work with CAMHS colleagues and wider stakeholders to develop alternative pathways of care for CYP with MH concerns (inc. eating disorders) currently presenting to UHL

. To ensure environments within UHL continue to be in line with national recommendations (HSSIB: Keeping Children and Young People with Mental Health Needs Safe: the design of the paediatric ward https://www.hssib.org.uk/patient-safety-investigations/keeping-children-and-young-people-with-mental-health-needs-safe-the-design-of-the-paediatric-ward

CHILDREN WITH LEARNING DISABILITY AND/OR NEURODIVERSITY

In 2024 the Children's Hospital appointed a dedicated Children's Learning disability and neurodiversity nurse. The following is a summary of the work they have completed to date

Children's Outpatients Department letters were to encourage parents to get in contact to discuss reasonable adjustments

Developed a LD and Autism Shared Decision Making Council - current projects include patient information boards, magnets to identify CYP with LD/ND and improving access to sensory items on the wards

Embedded an electronic Learning Disability assessment on Nerve Centre to enable early identification of CYP admitted to the Children's Hospital, consideration of reasonable adjustments, direct support from the Clinical Lead Nurse for children with LD to improve their inpatient experience and enhance multi-disciplinary working

Launched an adapted pain assessment for CYP with LD/ND who are non-verbal or have difficulty using traditional pain tools

Introduced a nurse-led LD epilepsy clinic at Ash Field Academy in line with Core20PLUS5 priorities, enabling improved multi-disciplinary working and signposting e.g. to Annual Health Checks, charitable organisations/ support services, information about transition

Future planned work includes

- Adaptations to the Children's Outpatients Department - hoping to introduce a pager system to improve wait time experience, as well as access to quiet spaces/ a sensory room
- Electronic storage of hospital passports - currently awaiting an update from change request sent to IT
- To review transition of young people with LD into adult services

ADULT MENTAL HEALTH

There is a dedicated clinical lead and ED Matron for adult mental health, who works closely with the Adult Mental Health Liaison Team employed by Leicestershire Partnership Trust.
During the past year they have

- facilitated access to Nervecentre for the LPT Mental Health Liaison Service,
- introduced referrals
- reviewed the mental health pathways for patients attending the Emergency Department
- supported the implementation of the revised Missing Patient Policy

For the year ahead the service is planning to review the service level agreements for response times and strengthen links between the liaison psychiatrists to reduce waiting times following referrals.

ADULT LEARNING DISABILITY

The Trust has a small team of adult learning disability liaison nurses. Who provide support for adult learning disability patients across the Trust. Below provides detail of their activity

In total there were 1452 enquiries/referrals made into the UHL Specialist LD Acute Liaison team in 2024 compared with 1028 in 2023 and 724 in 2022. Showing an increase of 100% in 2 years.

By far the largest proportion was for emergency inpatient support and then involvement in planned admissions.

Referrals for LD team support with planned admissions may be identified through the monthly TCI lists or directly from families, community LD service providers, community LD teams or increasingly from Consultants and Service Managers within UHL. Whilst this is positive in respect of greater team recognition and confidence in the team's expertise, it also has a huge impact on the capacity of the team, particularly in complex cases which can demand many hours of negotiating with various departments to ensure a seamless admission and the best experience for the patient. The team have successfully supported a number of extremely complex admissions in 2024.

Due to increased referrals and demand a prioritisation strategy was developed in 2024, outlining the work of the team and prioritising the workload. Direct inpatient support remains the top priority with the aim to visit all patients on the ward within 2 working days of admission with a follow up visit following a ward move and then a minimum of a weekly visit if the stay is extended.

The team have also been supporting the discharge specialist teams to promote timely discharges and prevent patients from staying in hospital too long.

Despite the high volume of referrals, members of the team have continued to be involved in various different projects including the review of an accessible maternity passport, cancer pathways, joint work with LPT on the development of an aspiration pneumonia risk assessment and individual care plan, Involvement in SJR's and the LeDeR process, the development of easy read resources and on-going support for the roll out of the Oliver McGowan Mandatory training. The OMMT teams have been recognised in the Great British Care Awards with regard to the involvement of people with lived experience, winning the Regional Award and therefore going through to the finals of the National Awards which will be held in Birmingham on 14th March.

Healthwatch Leicestershire conducted an 'Enter & View' visit in September 2024, visiting patients & carers on a number of different wards in LRI to observe their care and ask them about their experience. The results were on the whole favourable with a few recommendations which are contained within a separate report.

For 2025 – We have secured the booking of the big hall in the School of Nursing at Glenfield for a day in July where we plan to hold a 'Big Health Day', inviting people with LD & their carers to come and talk to staff from various departments/areas, learn more about how to look after their health, hopefully perform some basic health checks such as weight, height and BP, and also have some tables where people with lived experience can share their views on what works well at UHL and what can be improved. We will be contacting various teams across the Trust soon to ask if they can help us with the event. The team are hoping to engage some of our champions to help facilitate the day and would love to hear from anyone who would like to be involved.

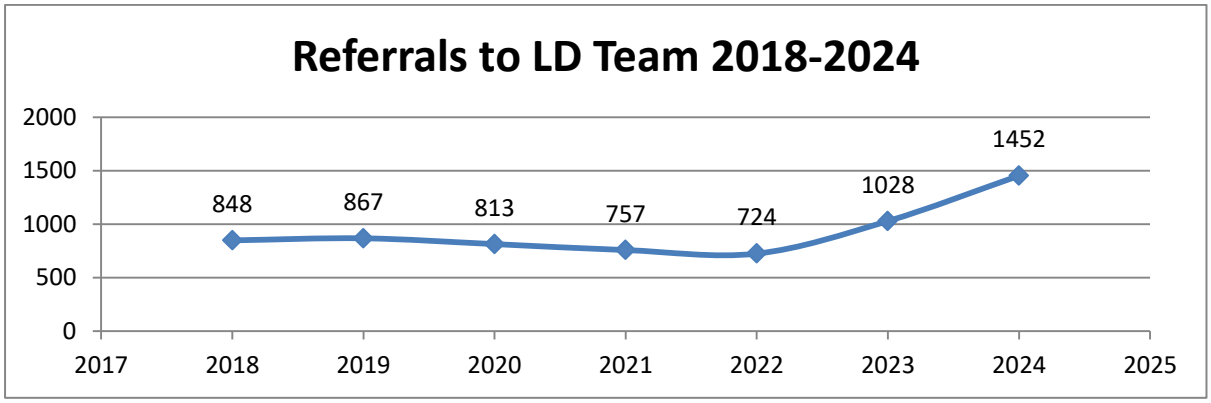
5. PERFORMANCE

The Trust's MH, LD and AP steering group oversees performance and activity across the Trust. As a newly developed group, work is still in progress to develop a dataset of performance measures the data presented below shows the current data available to the group

Adult Learning Disability Referral Data

The table below shows the number of referrals received by the Trusts Adult Learning Disability Team over the past seven years.

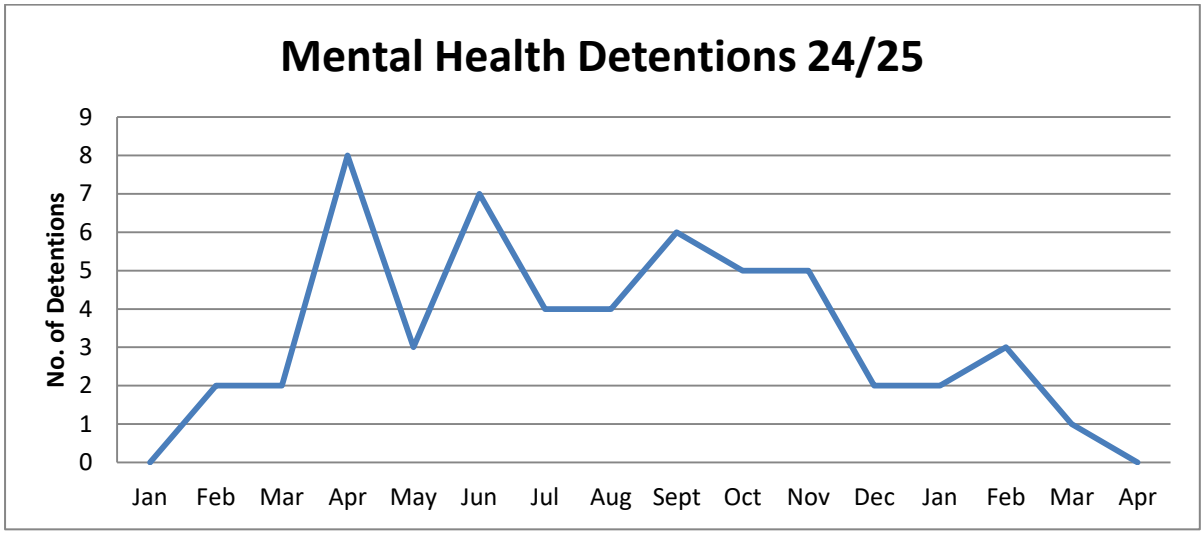
Since the launch of the Oliver McGowan training in 2023 the team's activity has significantly increased. The demand for the specialist service



Applications for Mental Health Act Detentions

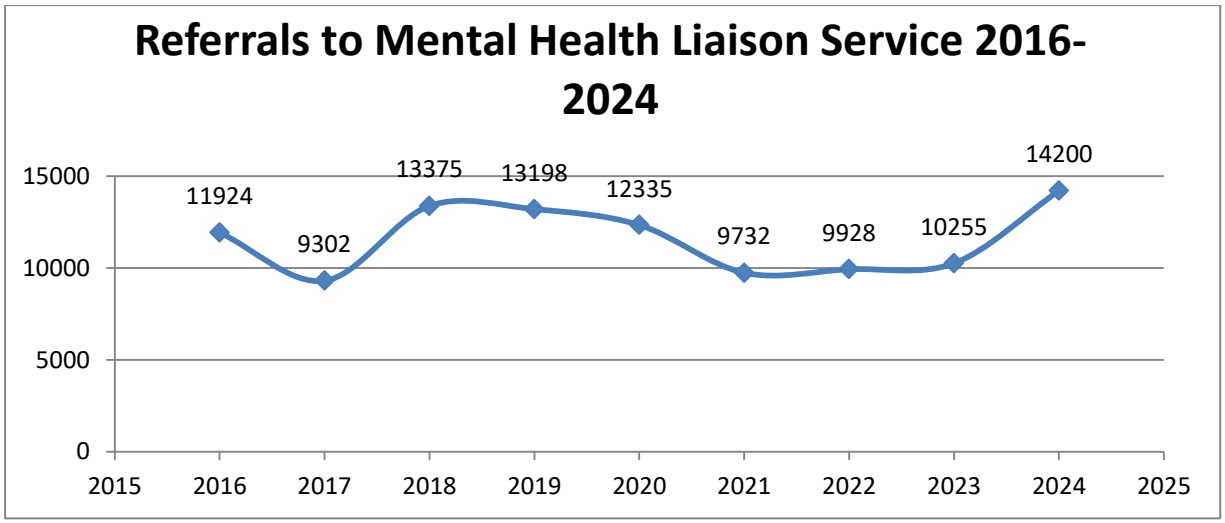
The Trust has a service level agreement with Leicestershire Partnership Trust, to administer Mental Health Act detentions. Patients may be detained under the Mental Health Act, to receive psychiatric treatment and assessment whilst in the Trust.

The chart below shows the number of approved detentions over the past 3 years. In 2024 there was a significant increase in the number of mental health act detentions, which is associated with increased service demand in adult services and temporary refurbishment to inpatient mental health beds across LLR. This has now been completed.



Referrals to the Mental Health Liaison service

The Trust benefits from an onsite mental health liaison service provided by Leicestershire Partnership Trust. They provide a single access point for referrals and advice. The charts below show the current activity, which shows a significant increase in the past year.



6. GOVERNANCE AND ASSURANCE

The arrangements for governance and assurance of mental health, learning disability and autism provision are overseen by steering group through to the Trust's Safeguarding Assurance Committee, with updates of work being provided to the Trust's Quality Committee on a quarterly basis.

During 2024 a work plan and audit schedule programme was followed

The Trusts Mental Health strategy was reviewed and updated in 2024, which sets out the priorities for the year ahead. The steering group also ensures that learning from the deaths of people with learning disabilities is embedded into clinical practice.

The Trust participates in the NHS England annual Learning Disability benchmarking exercise, and the submission date changed to March 2025

Through the work undertaken, the steering group is beginning to understand the risks and service pressures. The following risks have been considered as priorities for further work.

Specialist workforce capacity to care and support patients with learning disability, autism and mental health. Due to the lack of any commissioned service and increased activity

Increased demand in mental health services, due to the reduction of beds at the Bradgate Unit

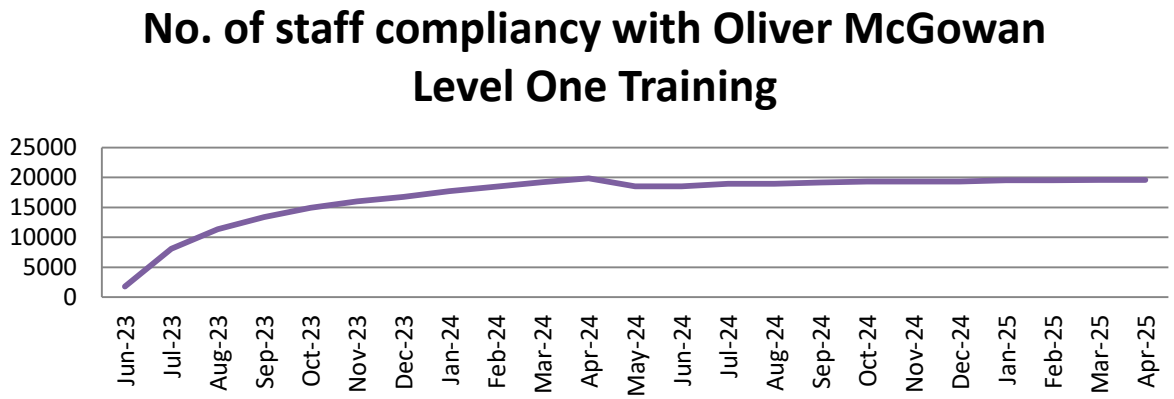
Lack of service provision for people with autism

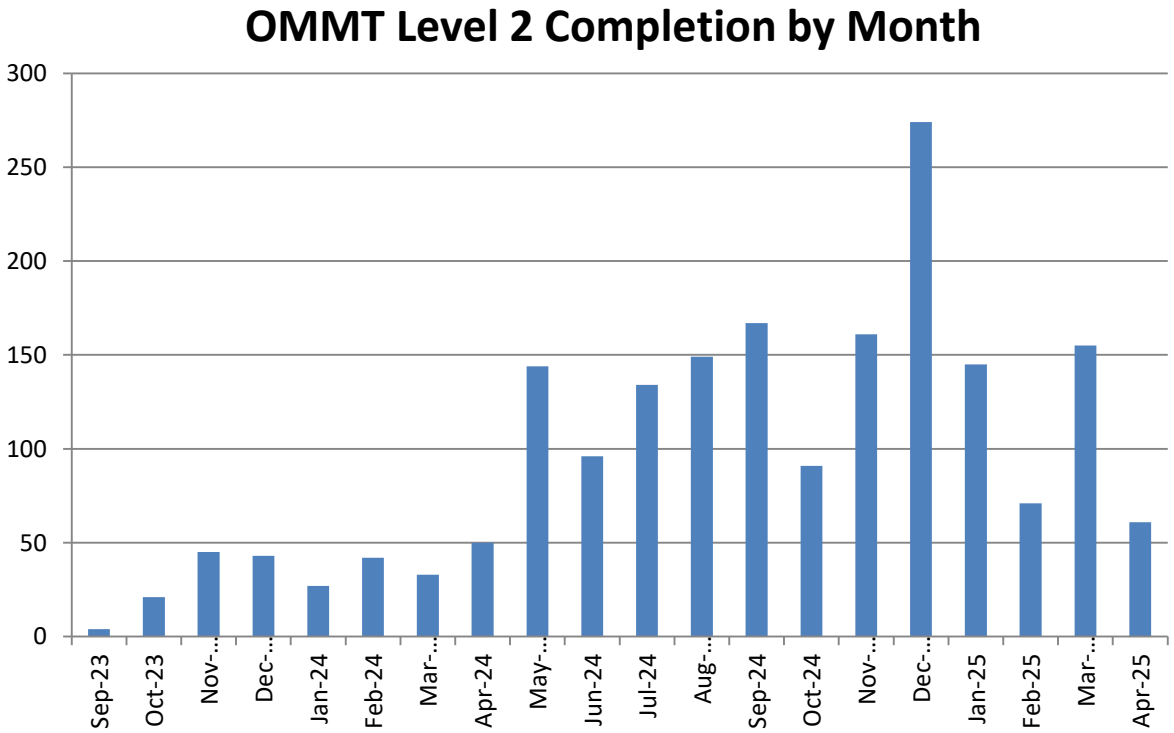
Management of ligature risks, and requirement to audit compliance of the clinical environment in paediatric areas against new guidance

7. TRAINING AND DEVELOPMENT

In early 2023, NHS England launched the Oliver McGowan training in learning disability & autism, which is mandatory training for all Health and Social Care staff. The Training is in two parts, Part 1 is online awareness training that all staff should complete. Part 2 is either an online live interactive training session or full day face to face training depending on job role.

The Trust launched Part 1 training in June 2023 and the chart below illustrates compliance until 31st March 2025. Part 2 training has been introduced across the Trust, but is reliant on training places being made available via NHS England and there are insufficient places to offer this training.





Mental Health awareness training was added onto the Trusts learning system in December 2023, which is optional for staff at the current time. Feedback from staff was poor and following feedback it was agreed through the steering group to commission a bespoke e learning package which at the time of writing is going through a procurement process

8. LEARNING FROM SERIOUS INCIDENTS, AUDIT AND CASE REVIEWS

There is a statutory duty for the Trust to participate in multi-agency reviews when someone has died who has a learning disability or autism, through the national Learning from Deaths programme. Learning from cases is shared with the steering group quarterly along with changes in practice.

In 2024, learning from incidents was extended to include sharing learning from investigations following the deaths of people with mental health illness accessing health services. Whilst this work is in its infancy, it is beginning to generate discussion and reflection about how services can be improved.

As a result of this work changes have been made to practice which include –

A review of the referral process used in the Emergency Department to request mental health assessments, using NERVECENTRE

The introduction of a new ligature risk assessment process

Providing access to the LPT All Age Mental Health team to NERVECENTRE to improve record keeping

Establishing links with the UHL Enhanced patient observation team and Mental Health teams to develop patient observation plans

A review of the abandoned child process, to ensure timely actions and response

KEY PRIORITIES AND RISKS FOR 2025

During 2025 work will progress to strengthen and make improvements to care.
Through this work the steering group has identified future work priorities and areas of potential risk, and are reflected in the Trusts revised work plan, in particular
Working with the LLR Learning Disability and Autism Collaborative. To find solutions to manage the increased referral activity of the adult learning disability service.

To complete a review of the children's hospital environment where mental health patients are cared for against newly introduced NHS standards

Raise awareness and monitor the use of the reasonable adjustment flag which will be launched in the summer of 2025

Continue to promote the use of LLR JOY and raise awareness of NHS 111 #2

CONCLUSION

The aim of this report is to outline the work undertaken during 2024 - 2025 to promote the welfare of people with Mental Health, Learning Disability and Autism. As stated within the report, there have been significant developments, with work focussed on creating robust governance and reporting structures.

Moving into 2025 the Trust will continue to make improvements as part of a continuous journey to provide excellent care. As outlined in this report

Michael Clayton
Head of Safeguarding with contributions from the UHL clinical leads for Learning Disability, Autism and Mental Health
April 2025