East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
23 September 2021

Title	Quality Assurance Committee held on 26 July 2021 and 6 September 2021 Committee Chair's Report
Committee Chair	Deborah Wheeler, Non-Executive Director and chair of the committee meeting held on 28 June 2021
Author	Cathy Lilley, Director of Corporate Governance

Purpose of the report

To bring to the Board's attention key issues and assurances discussed at the Quality Assurance Committee (QAC) meeting held on 26 July 2021 and 6 September 2021.

Key messages

Meeting held on 6 September 2021: The Committee considered a range of items which focused on quality and safety at the Trust including:

- Quality and safety reports: CAMHS and SCYPS
- Quality and safety cross cutting themes deep dives: access/waiting times and pressure ulcers
- Quality and safety focus: vaccination and winter planning
- Board Assurance Framework: clinical risk 4
- Patient safety report Q1
- Patient safety going forward
- Learning from deaths Q1
- Learning from inpatient deaths
- Seclusion SI update
- Guardian of Safe Working Q4 and Q1
- Internal audit update
- CQC update
- Data Security and Protection Toolkit Annual Compliance Update 2020-2021: noting compliance and the submission of a 'standards met' rating
- Infection, Prevention and Control Annual Report 2020-2021: noting the positive work on infection prevention and control during the pandemic

A summary of the discussions and assurances provided at the meeting are included in Appendix 1.

Meeting held on 26 July 2021: The Committee held an additional meeting to receive and approve the following annual reports for 2020-2021 (copies of the reports are attached):

- Complaints Annual Report
- Emergency, Preparedness, Resilience and Response Annual Report
- Freedom to Speak Up Annual Report
- Guardian of Safe Working Annual Report
- Health, Safety and Security Annual Report
- Learning from Deaths Annual Report
- Legal Claims Annual Report
- Mental Health Law Annual Report
- Safeguarding Annual Report
- Serious Incident Annual Report
- SIRO Annual Report

Previous Minutes

The approved minutes of the meetings held on 28 June and 26 July 2021 are available on request by Board Directors from the Director of Corporate Governance.

Appendix 1: Quality Assurance Committee Meeting - 6 September 2021

The Committee considered a wide range of items that focused on quality and safety at the Trust at its meeting on 6 September 2021 and wished to draw the Board's attention particularly to its discussions on:

- **Quality and Safety Report: CAMHS (Children and Adolescent Mental Health Services)**
  - The range of **achievements** during a challenging period include: the expansion of crisis services; established closer working relationships across the systems enabling a more integrated, flexible and mixed provision offer; expansion of the single point of referral system across London; active service user group involved in both local services and CAMHS provider collaborative; funding secured to establish an inpatient unit in Bedfordshire and Luton; establishment of mental health school teams in all boroughs providing a more integrated offer within schools
  - Work is under way to promote equality and diversity including active involvement by service user groups and the appointment of a CAMHS equality lead
  - **Challenges** include the national surge in children's crisis and eating disorder presentations; complex and late cases; increased demand for CAMHS inpatient beds; disruption to patient flow with difficult discharge pathways; increased acuity in some units and staffing pressures (recruitment and retention)
  - Assurance received on the **mitigations** and the wide range of actions being taken include: promotion of collaborative system working; identifying ways of strengthening clinical leadership; ensuring there are effective single points of entry across all systems; ongoing workforce development and staff wellbeing; establishing a digital group to develop digital offers and solutions; service user involvement on QI projects; coproduction with service users on system development and direction.

- **Quality and Safety Report: SCYPS (Specialist and Young People's Services)**
  - The range of **achievements** include: improved partnership working in Newham including leading on autism, learning disabilities and SEND (special education needs or disability) learning; development of a funded plan for clearing the backlog of children waiting autism assessments; strengthened clinical leadership; completion of recruitment of substantive consultant paediatricians; agreement for the development of a more effective speech and language therapy service
  - **Challenges** include a lack of dietetics capacity for children; outstanding SEND healthcare plan assessments; gaps in capacity in therapies and specialist nursing; and building more integrated working with LBN health visiting and school nursing
  - Work is under way to increase a multi-disciplinary way of working across clinical services and improving data and reporting
  - Assurance received on the **mitigations** and the wide range of actions being taken include**:** taking forward integrated working; more parent and carer engagement; increased transparency and opportunities for improvement; strengthening clinical pathways; joint working with CAMHS particularly on overlaps.

- **Cross Cutting Theme Deep Dive: Access/Waiting Times**
  - Clear principles have been established for the management of people's safety during waiting times and these have been disseminated across the Trust
  - Ongoing work with all services on recovery plans and how they can work differently to manage backlogs
  - Recruitment challenges for physiotherapists is currently contributing to the escalating problem around MSK
  - QI team are working on the provision of more transparent data and standardising definitions with partners within the ICSs
  - The Committee welcomed the collaborative approach taking a population health perspective

- **Cross Cutting Theme Deep Dive: Pressure Ulcers:**
  - Tissue viability services are working with services across the Trust with a prevention and management plan in place which Includes early and ongoing assessment and training, and ensuring accurate reporting leading to root cause analysis and a sharing of lessons learned
  - Historically was considered a nurse's responsibility but now a more multi-disciplinary approach is taken
  - A steep rise in all categories of pressure ulcers was experienced during the pandemic due to some patients declining home visits, staff shortages across all areas, a decline in mobility due to room confinement in residential care settings and patients with Covid skin changes which were presenting as ulcers
  - Wider system working: re-starting a QI project with Bart's Health with recruitment of service users and a Peer Support Worker into the project; and collaborating with NELFT on sharing good practice and lessons learnt
  - Assurance received on the **mitigations** and the wide range of actions being taken include: use of DHSC safeguarding tool to determine reporting requirements; working with service users on the development of a pressure ulcer passport; strengthening shared care with agencies and family carers; exploring a wound assessment app; improving value via a dressings optimisation scheme.

- **Board Assurance Framework – Clinical Risk 4**
  - The Committee acknowledged the improvement in the revised BAF format which has made the information clearer and easier to read
  - The Committee agreed no changes to the risk wording or risk scores, and received assurance that appropriate controls are in place and operating effectively.

- **Patient Safety Report Q1:**
  - There were 28 new SIs, 16 related to deaths of service users, seven suspected suicides and one homicide.

- **Patient Safety Going Forward**
  - The Committee supported the proposals and actions being taken to improve the patient safety culture and system within the Trust that are based on engaging with existing assets including service user involvement, staff engagement, QI and clinical leadership; and how learning from patient safety incidents can help towards improving the quality of service provided
  - This paper is also being presented as an agenda item at the Trust Board in public on 25 September 2021.

- **Learning from Deaths Report Q1**
  - There were 523 deaths of service users; 471 were expected and 52 unexpected of which 18 required 48 hour reports; six of these were closed, 11 required SIs and one a concise report
  - Eight deaths were recorded as relating to COVID – all due to underlying conditions and on end of life pathways
  - All patients on the gold standard framework for end of life care died in their preferred place of care
  - Cancer was the most common cause of death across both male and female patients
  - There were also eight learning disability deaths subject to LeDeR reviews.

- **Learning from Inpatient Deaths**
  - A review has been undertaken of unexpected deaths linked to serious incident reviews among adult mental health inpatient over the last five years with themes being identified and taken forward to improve patient safety within the Trust's mental health inpatient services

- Assurance received that action is being taken to improve quality and outcomes where areas of improvement have been identified, and that the aim is to facilitate shared learning across the Trust and with partners
- Actions being taken forward include a QI project on physical health as a multi-disciplinary responsibility; and the building of an early warning system using predictive analysis to identify early indicators of a likely SI which will be a first in the country
- The report took a broader population health approach and is being presented as an agenda item at the Trust Board in Public on 25 September 2021.

- **Guardian of Safe Working Q4 & Q1**
  - The Committee received assurance on compliance with the junior doctors contracts and no signification issues had been raised during the period January to June 2021
  - Work schedules and rotas for junior doctors remain compliant with their contracts
  - There were 41 reports and six breach fines in Q4; and 28 reports and ten breach fines in Q1
  - Use of external agencies to cover vacancies remains low
  - Encouragingly in Q1 the number of vacant shifts returned to 2019 levels.