East London NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
24 September 2020

Title	Quality Assurance Committee held on 15 and 17 September 2020: Committee Chair's Report
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Purpose of the report

To bring to the Board's attention key issues and assurances discussed at the Quality Assurance Committee (QAC) meetings held on 15 and 17 September 2020.

Issues to be brought to Board's attention

Meeting Held on 15 September 2020

The Committee considered a range of items which focused on quality and safety at the Trust primarily since COVID-19 pandemic including updates on:

- Infection control
- Planning for phase 2 and workstreams
- Bedford and Luton Adult Mental Health Services
- Service user led accreditation
- Learning from deaths for Q1
- Patient safety for Q2
- Guardian of safe working reports for Q4 2019/20 and Q1 2020/21
- Board Assurance Framework - clinical risk
- Quality report and accounts preparation for 2019/20
- CQC
- The work of the Quality Committee
- Internal audit.

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

Meeting held on 17 September 2020

The Committee held an additional meeting to receive the following annual reports:

- Quality Plan 2019/20 and Clinical Audit Work Plan for 2020/21
- Learning from Deaths 2019/20
- Information Governance 2019/20
- SIRO 2019/20
- Emergency, Preparedness, Resilience and Response 2019/20
- Health, Safety and Security 2019/20
- Guardian of Safe Working 2019/20
- Mental Health Law 2019/20
- Safeguarding (Adults and Children) 2019/20.

A summary of the discussions and assurances provided at the meeting are included in Appendix 2 including copies of all the annual reports.

Previous Minutes

The approved minutes of the meeting held on 15 and 17 September 2020 are available on request by Board Directors from the Director of Corporate Governance.

Glossary

QAC	Quality Assurance Committee	RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
LD	Learning Disabilities		
SI(s)	Serious Incident(s)	EPRR	Emergency Preparedness and Resilience
NHSE/I	NHS England and NHS Improvement		
MHLMG	Mental Health Law Monitoring Group	CCG(s)	Clinical Commissioning Group(s)
MHA	Mental Health Act	CQC	Care Quality Commission

Appendix 1: Quality Assurance Committee Meeting – 15 September 2020

The Committee wished to draw the Board's attention particularly to its discussions on:

Quality and Safety COVID-19 Update

- As at 14 September 2020 there were no active COVID cases in the Trust; 60 swabs awaiting results; 136 deaths of service users of which 22 were inpatients; 50 staff absent due to COVID-related illness (as opposed to 1000 at the peak of the pandemic)
- Gold command meetings continued to be held although twice-weekly as opposed to twice a day
- Workstream reviewing track and trace and outbreak management including possible reconfiguration of services and the identification of vulnerable people (including older adults in care homes, people with learning disabilities) and how the Trust can support them
- Concern expressed about the lack of control on testing arrangements
- Continued focus on infection control and management of onward transmission through handwashing, use of PPE and social distancing
- System wide collaboration is essential.

Infection Control Update

- The Infection Control BAF (presented to the QAC in July) has since been shared with the CQC who were satisfied with the Trust's approach to infection control
- The CQC report is not rated and will not be published; however, the Trust has used the feedback in its infection control action plan
- The intention is that the themes and trends will be shared amongst Trusts
- There is a focus on managing information and communications fatigue, and to 'normalise' the language, e.g. considering introducing a more localised approach led by the practitioner infection control nurses
- Assurance provided that flu planning is included in the overarching infection control action plans.

Bedford and Luton Adult Mental Health Services Quality and Safety Report

- An overview of the services with a quality and safety lens was provided which highlighted successes and achievements, areas for celebration, variations and challenges
- Key areas the Committee wished to highlight include:
    - The excellent work being undertaken in the locality including the reconfiguration of wards and emergency hub mobilisation in response to COVID-19, increased integrated working and innovation in restarting memory assessment service
    - The five year approach to reducing agency usage, particularly in respect of consultants and in CMHTs is showing positive results
    - The potential financial consequences if there is a decrease in funding
    - The importance of identifying solutions to provide adequate estate provision in East Bedfordshire .

Board Assurance Framework - Clinical Risk

- The Committee agreed the proposal that the current risk score for Risk 4 - *If essential standards of quality and safety are not maintained, this will/may result in the provision of sub-optimal care and increases the risk of harm* – should remain at Significant 20 acknowledging that the Trust continues to operate in an unprecedented time and although the biggest impact on delivery of services was during the lockdown and although the lockdown restrictions have eased, new ways of working continues to have an impact on quality and safety
- The Committee, however, acknowledged the significant activity being undertaken to maintain the quality and safety of services during the pandemic.

Learning From Deaths Q1

- A total of 780 deaths reported in Q1 of which 749 were expected
- 517 expected deaths were subject to a Structured Judgement Review (SJR) mainly relating to elderly patients. It is not known if these were 'premature' deaths
- Overall mortalities among males was higher than for females, cancer was the most common cause of death in both males and females, and COVID-19 positive patients had the second highest rate of death
- All patients on a Gold Standard Framework end of life pathway were cared for and died in their preferred place of care
- A total of 8 suspected suicides (to be confirmed following completion of a Coroner's inquest into these deaths)
- Three main areas identified from completed SIs into unexpected deaths for learning are: unsuccessful attempts by service user to make contact with the service and care co-ordinator, there were no GP reports recorded which indicated mental health input from 2015 (service migrated to Rio in third quarter of 2015) and Court informed that inquest was adjourned from 12/12 as awaiting details of Safeguarding Review
- Triangulating the learning and themes will be conducted to ensure learning is shared across the Trust to support of increasing compliance with follow up protocols and improved communications within in and out with the organisation
- A spike of suicides was seen during the pandemic in Hackney; the Trust will undertake a table top review on all Sis to identify any trends, and will be working with Public Health in Hackney to understand if the different demographics and social lifestyle were contributing factors; Hackney has the highest number of single occupancy households compared to other London boroughs which often results in increased isolation and loneliness. Assurance was provided that the Trust providing a range of support including befriending work, virtual crisis cafes, for example the Lighthouse in Leighton Buzzard.

Patient Safety Report 1 June – 31 July 2020

- There were no independent reviews published during this timeframe and no panel led comprehensive SI investigation reviews falling within this period
- 25 new Sis were identified of which 15 involved deaths of an adult service user where, against information received to date, it appears that eight are likely to be suicides (subject to inquest). Of these eight cases, four involved service users from Bedfordshire, two from City and Hackney, and one from Luton and one from Newham
- Although a larger proportion of unexpected deaths occurred in Bedfordshire, it is acknowledged that Bedfordshire has an estimated population that is much greater than other areas where the Trust provides services and subsequently has a higher number of its population in contact with ELFT services
- As previously advised there has been an overall increase of incidents reported since January 2018 with a spike in incidents in May 2019 (2,102 incidents) and in January 2020 (2,087 incidents)
- There has been a decline in the completion within the 60-day investigation timeframe predominantly due to the change in working practices across the Trust due to the pandemic. Assurance was provided that there is sufficient resource to catch up on the outstanding or overdue investigations
- A wider approach to lessons learnt is being undertaken.

Guardian of Safe Working Q4 and Q1

- Work schedules are compliant with the junior doctor contract
- Seven fines have been issued due to breaches of working hours safeguards
- Total vacancies remain high at 9% with absences from rotas contributing to increased workload which was compounded by the start of the COVID-19 pandemic during the reporting period
- Exceptions to work schedules are under-reported and payment errors have had an affect on morale of those affected

- The majority of vacant on call shifts have been covered without the use of agency staff
- Governance structure has been strengthened to improve communications, engagement and interface between clinical directors and junior doctors
- There is an intrinsic link between the work of the Guardian of Safe Working and Freedom to Speak Up Guardian who will be working together to triangulate themes and identify required actions.

Service User Led Accreditation Programme

- The programme aims to recognise and celebrate excellence as defined and measured by service users, support improvement and reduce inequality in service user experience, enable people participation and collaboration between service users and clinical services, and improve population health
- An overview of the implementation of, and the learning from, the first year of this programme was shared:
  - 72 clinical teams have registered of which 52 have completed their assessment and 17 have dropped out of the process before its conclusion
  - One service who participated in the first test cycle and who were not accredited, impressively were asked to be reassessed six months later and achieved a Gold award
  - Feedback is routinely collected to help understand the impact of the programme which to date as been extremely positive from both service users and services perspective
- The assessment process will be delivered virtually in the light of COVID-19 and the need for social distancing; support is being provided to staff and service users to enable this change
- The programme has been shortlisted for two awards at the Patient Experience Network National Awards (PENNA).

Appendix 2: Quality Assurance Committee (QAC) Meeting – 17 September 2020

An additional meeting was held to receive the quality and safety related annual reports so that these reports would be reviewed and discussed in a timely fashion. The Committee commended the new approach as it provided the opportunity for the Committee to have a strategic overview, receive assurance, review learning and understand the opportunities for future improvement. The Committee agreed to follow this approach for 2020/21. A meeting would be planned as close to year end as possible and further consideration will be given to the value of standardising reports and/or providing a template for key reporting requirements.

Annual Report 2019/2020	Key Points	Challenge/Assurance	Action
Quality Plan and Clinical Audit Work Plan	• Incorporates the two domains of assurance and improvement • Quality control is now reported within the integrated performance report, which includes quality measurement at organisational level	• Thematic learning from complaints are triangulated as part of assurance to Board through the Quality Report • QAC receives updates on complaints bi-annually (part of new complaints process) • Audit includes a blend of digital and manual data collection – this does not provide any restrictions • Eprescribing has had a positive impact on audit • Requirements for junior doctors to undertake an audit project have changed – junior doctors at the Trust are encouraged to conduct an improvement activity	
Learning from Deaths Annual Report	• Reporting includes March 2020 – early part of the COVID-19 pandemic • Anticipated that numbers will be affected by the pandemic – full data awaited • There has been an increase in expected deaths and were particularly higher in community health services (morbidity rate of patients and those in receipt of palliative care is highest) • 12 deaths of patients with a learning disability; of the four subject to SI process, conclusion was that although the deaths were predictable were not preventable • Spike in unexpected deaths in December attributable to the change to Datix incident reporting criteria • Trust received one prevention of future deaths report (low number compared to nationally) • Continued focus on suicide prevention	• There is no current requirement for the Trust to have a named Medical Examiner (current focus in on acute sector) – the intention is that by 2022 there will be a Medical Examiner for the area providing a joined up approach with other agencies to understand cause of death • In addition to treating patients(including service users with learning disabilities), the Trust also has an advocacy role, e.g. to ensure physical health checks are undertaken, appropriate access to services and actions being followed through • Access to health care is being taken through the Inequalities Workstream which is focusing on health care inequalities	• Review terminology used in the report, i.e. preventable and predictable • Report to reflect the Trust's advocacy role

Annual Report 2019/2020	Key Points	Challenge/Assurance	Action
Serious Incidents (SI) Annual Report	• Service developments and improvements include introduction of support networks and psychological supervision for corporate review team, introduction of patient safety learning event; and COVID-19 fostered changes to incidents management in conjunction with CCGs and NHSE/I including introduction of table top focused SI reviews • Total incidents for 2019/20 was 23,708 of which 0.6% were escalated to SIs • Three main themes: delays in treatment, discharge issues and record keeping	• Steps taken to embed a 'just culture' embracing learning both within the Trust and across the system • Focus has been on ensuring report tone is appropriate and greater emphasis on involving families to help shift of thinking • Commissioned external patient safety report will help to develop an advanced learning system in the Trust	
Information Governance Annual Report	• Due to COVID-19 submission date was extended to 30 September 2020 giving organisations another six months for completion • Standards 'met' rating achieved	• Internal audit confirmed compliance requirements met • Given COVID-19 priorities, some areas where further work is required to retain compliance for 2020/21 – particularly challenging given six months to complete and also room for further investment • More inclusive and joined up approach to information governance being taken	
SIRO Annual Report	• Significant improvements in data and cyber security compliance particularly during the last six months • Biggest remaining risks to the Trust are asset and data flows mapping and information governance annual training compliance • Cyber security is an area of intense and continued focus: Trust is working with NHS Digital and third party providers to address ongoing risks and achieve CyberEssentials+ accreditation	• No conflicts of interest – Dr Amar Shah is now SIRO and Dr Paul Gilluley is the Caldicott Guardian • The Trust views data and cyber security as risks to clinical quality, and therefore monitoring and review is by the QAC. Oversight and assurance to the Audit Committee is provided by the Chair of QAC who is a member of Audit Committee. In addition there is internal audit representation on both committees	
Emergency, Preparedness, Resilience and Response (EPRR) Annual Report	• EPRR and business continuity continued to be strengthened during 2019/20 through a framework of plans addressing the highest risks and exercises carried out to test plans • Full compliance score achieved • The Trust's Incident Response Plan was identified as being of a very high standard and is included on a national EPRR database of good practice • Following the declaration of the level 4 major incident	• Debrief of emergency response undertaken and number of actions being taken forward in preparation for potential wave 2; this included understanding the vulnerability of moving services between buildings and the impact on those buildings which the Trust does not own • Since the pandemic there has been a greater reliance on digital technology which is built into business continuity plans; review of resilience and investment	

Annual Report 2019/2020	Key Points	Challenge/Assurance	Action
	by NHSE/I the Trust fully implemented its Incident Response Strategy led by the Accountable Emergency Officer • In March 2020 the Trust's Response Team (Gold Command) was mobilised meeting regularly and timescales adapted according to need • Extensive workplan for 2020/21 includes preparation for flu and Brexit as well as COVID-19	levels being undertaken • Digital has been helpful in response to COVID-19, e.g. Director on call pack is fully digital	
Health, Safety and Security Annual Report	• 77 RIDDORs (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reported of which 66% account for physical assaults (reduction of 37 from previous year) • Dedicated mental health liaison officers appointed in the London boroughs who attend monthly crime management meetings with senior staff • Mental health investigations officer appointed by Bedfordshire police to deal with incidents which occur on the wards in Bedfordshire and Luton. This has resulted in a 45% increase in reports of offences to the police and 37 charges of assault compared to the one charge for last year • As Skyguard compliance was low, the Trust has adopted the Skyguard Smartphone app. A full implementation and training programme is in place	• Process is in place for identification of RIDDOR in relation to COVID-19 • Good relationships with and involvement from staffside who are members of the Trust's Health, Safety and Security Committee	
Guardian of Safe Working Annual Report	• The overall vacancy rate for doctors in training is between 9 – 11 % • In 2019/20, 183 exception reports were submitted (66% increase on 2018/2019) • Most of these relate to hours worked over the rostered hours, or covering for absent colleague on call. • There were 11 breaches of working hours contract rules leading to Guardian fines of £6,709 • Although the available workforce was reduced during the pandemic at the end of this period, on call rotas remained filled • Rotas in the Trust are compliant with the contract	• Vacancies on shifts are in relation to sickness, maternity cover, etc and are expected to increase over the COVID-19 period; however, there are no issues with filling the vacancies and more than 90% are covered internally by Trust doctors • Support is provided to junior doctor trainees to apply for consultant vacancies at the Trust	• Obtain data re junior doctor conversion rate to consultant posts • To support leadership skills, consider recommendation of inviting junior doctor trainees to talk to the Board about their

Annual Report 2019/2020	Key Points	Challenge/Assurance	Action
	• Junior doctor forum is active and engaged • A focus remains on a supportive reporting culture and a supportive training environment for junior doctors remains a goal		experiences of working with the Trust
Mental Health Law Annual Report	• Mental Health Law Monitoring Group (MHLMG) established in year that has oversight on Mental Health Law and takes forward actions as required • People admitted to hospital under detention of Mental Health Act (MHA) continues to increase at same rate year on year • Place of safety hub in City and Hackney? • MHLMG working with Informatics and QI to improve data reporting • Delays in legislation including the MHA and the Mental Capacity Amendment Act (latter now expected to be implemented in April 2020 with Deprivation of Liberty replaced by limited protection safeguards) • Coronavirus Act: provisions for amendments to the MHA did not come into force	• MHLMG provides assurance through the oversight at senior director and operational level • Appropriate checks and balances are in place to ensure the Trust exercises its powers under the MHA wisely • Disproportionate use of MHA on certain demographics, particularly black men, is a national issue and a concern to the Trust. • The Trust has a programme of work to look at this including: - Initial conversations have been held with Barnet, Enfield and Haringey NHS Trust on this particular area - Being asked to participate in a pilot project with NHSE/I on patient carer race equality standards - Signing up to 'Synergy' through Hackney CCG which is a community which will look at the experiences of black people.	
Safeguarding Annual Report (Adults and Children)	• Joint adult and children approach adopted in line with the Trust's shared safeguarding agendas, shared principles, duty of care and 'Think Family' approach • Positive aspects during 2019/20 include good partnership working with the Local Authority safeguarding boards, internal governance of safeguarding, staff knowledge and training, and an experienced and credible safeguarding team (which is now fully staffed) • Domestic abuse agenda continues to be a significant priority area • During the pandemic the safeguarding team encountered some barriers to effective practice such as reduced amount of referrals, reduced contacts by	• Safeguarding is a positive approach which links to the Trust's population health approach, and how to improve the quality of people's lives • Focus is not just on referrals but also about proactively taking ownership in an advocacy role • Gill Williams has been appointed to a newly created role of Director of Social Care which is a pivotal role to support the safeguarding agenda • COVID-19 has highlighted the vulnerability of service users with Learning Disabilities and the Trust has taken action to learn from the deaths including increased working with primary care to establish multi-disciplinary teams across CQC registered homes for people with LD, revised plans to support annual health	

Annual Report 2019/2020	Key Points	Challenge/Assurance	Action
	network and agencies, limited opportunities for face to face contact with service users. The volume and complexity of new information and the shortage of staff all impacted on the working arrangements of the team • Staff have changed ways of working including working from home and undertaking training via online platforms to ensure that all safeguarding remained a core function despite restrictions caused by the pandemic • Positive feedback from Luton Adult Safeguarding Board and Central Bedfordshire safeguarding team for the positive contribution made by the safeguarding and LD team to improve the safety of the service users and communication with partners	checks, and working with Public Health England to review shielding lists, discuss with 111 services about recognising LD as a specific vulnerability, and agreeing testing regimes across provider services • A strategic lead for Learning Disabilities has also been appointed providing an opportunity to focus and work collaboratively on population health •	