East London NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
3 DECEMBER 2020

Title	Quality Assurance Committee held on 2 November 2020: Committee Chair's Report
Committee Chair	Jenny Kay, Committee Chair
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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) meeting held on 2 November 2020.

Issues to be brought to Board's attention

Meeting Held on 2 November 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:

- Winter planning
- Forensic Services quality and safety report
- Cross cutting theme deep dive: observations and inpatient safety
- Learning from deaths for Q2
- Patient safety for Q2
- Board Assurance Framework - clinical risk
- Quality report and accounts for 2019/20
- CQC
- Legal claims annual report 2019/20
- Freedom to speak up annual report 2019/20
- Internal audit.
- Infection control
- Revalidation report
- NICE guidance progress update
- Quality committee assurance report

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

- **Forensic services quality and safety report**
  - Positive assurance was provided with regards to the excellent progress with discharge rates from secure services and that service users are offered intensive support post discharge
  - There has been continued work to improve carers' experience and engagement by finding alternative ways for carers to see their loved ones (the service has been nominated by Meg Hillier MP for Hackney South and Shoreditch for a Parliamentary Award)
  - Trust's forensic services is now involved in the new models of care provider collaborative – a consortium with four mental health trusts in north London. Although there are some challenges with regards to different ways of working, there has been some excellent innovation and progress particularly in respect of providing support with difficult and complex cases
  - Challenges include high incident rates with regards to violence and aggression towards staff, and there are high levels of long term segregation during the year, albeit affecting a small number of people.

- **Cross cutting theme deep dive: observations and inpatient safety**
  - Inpatient safety is a key area of focus across London mental health trusts and a strategy to address this has been developed
  - The deep dive described the learning from serious incidents where observation prescription and practice have been a contributing factor in inpatient deaths

- The purpose and frequency of observations have led to a diminished rigour in their completion to the required standard and a reliance on a process that has systemic flaws
- Using a Quality Improvement approach, teams have developed ideas to test and to simultaneously reduce the volume of observations and increase engagement, including the use of electronic observations to reduce reliance on paper systems that sit outside the electronic patient record, and subsequently a major revision of policy and practice on observations.

- **Learning from deaths for Q2**
  - Assurance was provided that all patients who wanted to die at home did so which was an excellent example of integrated care
  - Although Bedfordshire and Luton unexpected deaths appear high, this can be attributed to the different demographics and multiple factors at play so the data is not strictly comparable.

- **Board Assurance Framework - clinical risk**
  - Assurance was provided there is a range of actions being undertaken to mitigate the risk but agreed that the current score should remain at 20
  - Requested that primary care, community and care at homes, and the use of agency and workforce feature more strongly in the BAF, particularly in controls and assurance.

- **Quality report and accounts for 2019/20**
  - Received and approved the quality report and accounts for 2019/20 subject to final feedback/opinion from commissioners and highlighted the report provides a good overview of all the Trust has achieved
  - Commissioners had requested more granularity this year in respect of differences in services and geographical areas
  - Due to the pandemic and the relaxing from the centre of certain previous regulatory requirements, there was no requirement this year to have include an external audit opinion.

- **Legal claims annual report 2019/20 (report is attached at appendix 1):** The Committee:
  - Highlighted the importance of ensuring that in addition to any financial compensation, there is appropriate care and support for staff with regards to claims from staff who suffer violence at work
  - Noted the main areas for liability to third parties are violence and aggression, and slips, tips and falls. There are very few cases which go to trial – there was one last year which was the first in nearly 20 years. The usual approach is to try to settle outside of court.

- **Freedom to speak up annual report 2019/20**
  - The Committee was pleased to note the work with the Guardian of Safe Working Hours for junior doctors to triangulate findings and data; to date no similarities have been identified
  - *A detailed report is included on the Trust Board in public agenda – item 12*

- **Infection prevention and control annual report 2019/20 (report is attached at appendix 2)**
  - The report demonstrates compliance with the Health & Social Care Act 2015 by providing assurance that there are systems and processes in place from ward to Board
  - The impact of Covid changed the direction of work within the infection prevention and control team as there was a need to expand the services to work seven days a week due to an increase in demand
  - Environmental audits halted due to Covid but have now been reinstated
  - A review has been undertaken on the service model for the coming year
  - The Committee commended the team on its responsiveness and constructive and supportive approach particularly during the first phase of the pandemic.

- **Revalidation report 2019/20 (report is attached at appendix 3)**
  - As a result of the pandemic all appraisals were suspended in March 2020 and postponed for one year; in accordance with GMC advice they resumed in October on a flexible basis

- Assurance was provided that doctors are being appropriately appraised and revalidated
- No issues were identified in Trust practice which required remedial action following the completion of its last Annual Organisational Audit (AOA) in June 2019; the audit for 2020 has been suspended
- The Committee approved the statement of compliance confirming that the Trust is in compliance with the Responsible Officer's Regulations.

- **NICE guidance progress update:** The Committee noted:
  - Assurance was provided with regards to the implementation of the approved process for disseminating, reviewing and implementing NICE guidance, and actions to address any gaps in implementation
  - NICE process is broadly functioning well but with some variation across the various directorates; the Quality Assurance Team will be working with directorates to ensure consistent implementation across the Trust
  - All relevant guidance has been reviewed with one exception; completion of this will be monitored and reported on to the Quality Committee by the QA team
  - The QA team will be prioritising supporting the new Primary Care Directorate to set up its structures to support implementation of the process
  - There is limited mental health guidance being published; however, the Trust has developed its own standards internally to address the gaps and have effective internal assurance systems, e.g. the service user led accreditation programme.

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.