NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
26 May 2022

Title	Quality Assurance Committee: 9 May 2022 – Committee Chair's Report
Committee Chair	Prof Dame Donna Kinnair, Non-Executive Director and Chair of QAC
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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) on 9 May 2022.

Key messages

Covid-19 Update

- Currently whole of NHS remains at level 4 incident management; however, the government is currently reviewing whether this should be lowered. Full infection control measures are in place both in our clinical and corporate services
- Although continuing to see a reduction in the number of our service users and staff testing positive for Covid, many staff members are experiencing mental health challenges
- There continues to be a high demand on all our services with a high level of activity and occupancy levels around 95%
- As part of system working are currently working on winter planning for 2022-2023, taking forward the learning from the last two years.

Prevention of Future Deaths

- Assurance was provided that following the two incidents, SI investigations were immediately undertaken and actions put in place to address the areas identified as requiring improvement. These action plans are reviewed and updated following the issue of the Coroner's report
- Assurance was also provided that the Trust will provide feedback to the Coroner on his/her assertions where appropriate
- *An update on the PFDs included as an agenda item at May Trust Board meeting in public*

Learning from Deaths Q4

- There were 595 deaths of which 496 were unexpected and 99 unexpected deaths
- Of the 99 unexpected deaths, 18 resulted in SI investigations
- Eight of the 31 inquests opened in the quarter were concluded; with two Coroner's verdicts of suicide
- Main areas identified for learning from the SIs and inquests included disruption of service delivery may have been caused by change of care coordinators in a short space of time; failure to complete observations and four week medication review on discharge from the ward; no follow up appointment and no place in place for support
- There were 14 learning disability deaths, all notified to the Learning Disability Mortality Review (LeDeR)
- There were 19 reported Covid-19 related deaths; all the deceased had underlying health conditions and were receiving palliative or end of life care
- 177 Structured Judgement Reviews were completed for 177 of the expected deaths. Overall cancer was the most common cause of death in both males and females, and deaths were higher in males
- Assurance was provided that the themes will be triangulated across the Trust to ensure increased compliance with follow up protocols as well as improved communications.

Patient Safety

- Report provides assurance that following reviews, issues and learning are being taken forward and monitored through action plans

- Challenges with completion of reports primarily due the high level of staff absences. The position is monitored at weekly grading meetings and a recovery plan is in place
- Consideration to be given to providing an overarching quarterly patient safety report that will combine both the Learning from Deaths and Patient Safety reports; this will be taken forward by the Director of Patient Safety as part of the Trust's patient safety strategy.

Quality and Safety Ockenden Report

- The Ockenden review into the Shrewsbury and Telford Hospital NHS Trust maternity services outlined 15 immediate and essential actions to improve maternity care across England for Trusts with maternity services requiring Board oversight; the actions focus on maternity services but there are clear links to perinatal mental health services
- ELFT perinatal services comprise of an inpatient perinatal service and community perinatal services; in addition the Trust is piloting Ocean, the new maternal mental health services
- A key recommendation that the Trust will be focusing on is sharing and embedding learning across the networks and systems
- Although not covered in the Ockenden report, will be focusing on health inequalities in maternity and perinatal services linking into the Trust's work on the Core20PLUS5 approach to reducing health inequalities.

Adult Mental Health Services
City & Hackney

- Achievements
  - Despite continuing bed pressures and length of stay challenges, received positive feedback from service users and carers on maintaining high quality safe inpatient care
  - A number of national accreditations achieved against the backdrop of another challenging year
  - Eight neighbourhood teams established working with primary care networks and local place communities to delivery community based care
  - Complex needs transformation work
- Key issues and variations:
  - Clinically led improve patient flow group established to understand reasons for variations in patient flow (time from referral to appointments which has seen a significant increase since the pandemic) and ADHD demand and capacity, to oversee further improvements and ensure clinical ownerships
  - Significant increase in crisis line calls partly due to increase social isolation exacerbated by the pandemic
  - Embedding neighbourhood approach and working with partners, stakeholders and service users to understand the effectiveness of this approach
  - Challenges with recruitment across the service
  - Staff burnout and exhaustion with the service taking a renewed focus on staff wellbeing.

Newham

- Achievements
  - Working in collaboration on transformation; have operationalised six CIMHS teams and working with London Borough of Newham to improve adult and older adult discharge
  - New service developments including MBTD service now in operation and ASD offer in development
  - Innovation in recruitment with a QI project with Our Newham
  - Improved waiting lists and returning to face to face as the first option for all community appointments
- Key issues and variations:
  - Health inequalities across mental health services, e.g. investment and commissioning gaps (to manage ADHD demand and capacity
  - Workload pressures, limited resources and multiple priorities can lead to variable responses in quality of care
  - Recruitment difficulties and vacancies create a variation to the staff models – taking a more creative risk approach

- Waits are outside the desired levels for memory clinic and SPS
- Reviewing to ensure estates are fit for purpose
- Staff wellbeing with the service taking a renewed focus on staff wellbeing

Tower Hamlets

- Achievements
  - Service accreditations
  - Positive feedback following CQC visit in older adult services
  - Community transformation continues at pace with closer working with PCNs
  - Developing relationships with local communities and the voluntary sector
  - Bed management (not using private sector)
- Key issues and variations:
  - Have a working project in inpatient services to Improve care planning and embedding Diaolg+ consistently across community and inpatient services
  - Teams are working with communities to provide equality in access for different services
  - High bed occupancy
  - Staff fatigue due to pandemic response, and difficulties in staff recruitment to some services.

Board Assurance Framework: Improved Experience of Care – Risk 4

- **Risk 4:** *If essential standards of quality and safety are not maintained, this may result in the provision of sub-optimal care and increases the risk of harm*
- Although Covid-related pressures and disruption are declining, demand for services remains high in crisis services and bed occupancy consistently high above 90%; therefore no changes to the risk score.

Previous Minutes

The approved minutes of the previous meeting are available on request by Board Directors from the Director of Corporate Governance.