NHS
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NHS Foundation Trust

Board of Directors Meeting

To be held in public

Thursday 28 July 2022 from 13:00-16:00
Venue 360, 20 Gipsy Lane, Riverside Oak Room, Luton, LU1 3JH and by Zoom

AGENDA: meeting held in public

Opening Matters

1	Welcome and Apologies for Absence*	Note	Eileen Taylor	13:00
2	Patient Story: “Trials and Hope, My Story”	Note		
3	Declarations of Interests	Assurance	ALL	13:20
4	Minutes of the Previous Meeting held in Public on 26 May 2022	Approve	Eileen Taylor	
5	Action Log and Matters Arising from the Minutes	Review	ALL	
6	Chair’s Report	Assurance	Eileen Taylor	13:25
7	Chief Executive’s Report	Assurance	Paul Calaminus	13:35

Quality and Performance

8	Quality Assurance Committee Assurance Report *inc Annual Reports 2021-2022*	Assurance	Prof Dame Donna Kinnair	13:55
9	Quality Report	Assurance	Dr Amar Shah	14:15
10	Performance Report	Assurance	Dr Amar Shah Edwin Ndlovu	14:25
11	Prevention of Future Deaths Notice	Assurance	Dr David Bridle	14:35

People

12	People Plan Report	Assurance	Tanya Carter	14:45
13	Safer Staffing Report	Assurance	Lorraine Sunduza	14:55

Finance

14	Finance, Business & Investment Committee Assurance Report	Assurance	Aamir Ahmad	15:05
15	Finance Report	Assurance	Samanthi Gibbens	15:10

Governance

16	Trust Board Committees: • Audit Committee - NHS Self Certification 2022 - Modern Day Slavery 2022 - FPPR 2022 • Charity Committee • People Participation Committee	Assurance	 Anit Chandarana Aamir Ahmad Aamir Ahmad	15:20
17	Board of Directors Forward Plan	Note	Eileen Taylor	15:45
18	Any Other Urgent Business*: *previously notified to the Chair*	Note	Eileen Taylor	
19	Questions from the Public*		Eileen Taylor	
20	Dates of Next Meeting* • Thursday 29 September 2022 • Thursday 24 November 2022 • Thursday 26 January 2023 • Thursday 30 March 2023			

*verbal update

Eileen Taylor
Acting Chair of the Trust

12:00 – 13:00	Lunch
15:50 – 16:20	A teatime presentation focusing on the work with Rainbow Bedfordshire Presenters: • Mack McLean

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Board of Directors Register of Interests: 15 July 2022

East London NHS Foundation Trust is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish this Register of Interests which draws together Declarations of Interest made by members of the Board of Directors. In addition, at the commencement of each Board meeting, members of the Board are required to declare any interests on items on the agenda.

Name	Job Title	Interests Declared
Aamir Ahmad	Non-Executive Director	• Director and Trustee Place2BeCrisis • Volunteer, Shout (crisis support text line charity) • Psychotherapy Student, Regents University
Ken Batty	Senior Independent Director	• Chair of Trustees, Mosaic LGBT+ Young Persons Trust (receives funding from Lambeth CCG) • Chair of Nominations Committee, Royal College of Emergency Medicine • Director, 97 Langney Road Ltd • Director, Effingbat Properties Ltd • Director, Ken Batty in London Ltd • Fellow Royal Society of Arts (FRSA) • Vice Chair, Inner Circle Educational Trust • Trustee of Dr Frost Learning • Member, Queen Mary University of London (QMUL) Council
David Bridle	Interim Chief Medical Officer	• Member, British Medical Association • Member, Medical Protection Society • Member, Royal College of Psychiatrists • Member, General Medical Council
Paul Calaminus	Chief Executive	• Member of North East London Integrated Care Board • Member of City and Hackney Integrated Commissioning Board • Wife is a Civil Servant in Department of Health • Named Shareholder for Health E1 • Named Shareholder for Tower Hamlets GP Care Group • Named Shareholder for City & Hackney GP Federation • Named Shareholder for Newham GP Federation

Name	Job Title	Interests Declared
Richard Carr	Non-Executive Director	• Director and part owner, Richard Carr Consulting Ltd • Managing Director of East Midlands Development Corporation • Interim Director of Corporate Services, Edinburgh City Council (part-time)
Tanya Carter	Chief People Officer	• Board Member of the Healthcare People Management Association (HPMA) • Chair of the Healthcare People Management Association Talent Board (HPMA) • Co - Chair of the London HR Directors Network • Member Chartered Institute of Personnel Development (CIPD)
Anit Chandarana	Non-Executive Director	• Lead Director, Network Rail Infrastructure Limited
Steven Course	Chief Finance Officer / Deputy Chief Executive – Luton & Bedfordshire	• Director, Health & Care Space Newham Ltd • Wife is a physiotherapist working at March Physiotherapy Clinic (private practice)

Professor Sir Sam Everington KBE	Non-Executive Director	• GP Partner in Tower Hamlets since 1989 in Bromley By Bow Health. • General Practice, based on the same site as the The Bromley by Bow Centre (Charity). • Chair of Tower Hamlet's CCG (Now part of North-East London CCG) 2013- • Vice Chair North-East London CCG 2021- • Deputy chair Tower Hamlets health and wellbeing board 2016- • Associate director NHS Resolution 2018- • Non-executive director of ELFT 2020- • Director Bromley by Bow Health Limited - joint venture with Greenlight Pharmacy around training of pharmacists in primary Care Sept 2020- • BMA Council member, 1989- • Vice President of the BMA, 2015- • Fellow and Honorary Professor of Queen Mary University of London 2015- • As a GP partners member of the MDDUS - insurance for the GP partnership. • Vice President Queen's Nursing Institute 2016- • Vice President and Council member the College of Medicine 2019- • Board member NHS Strategic Infrastructure Board 2020- • Nesta Advisory Board 2018- • Member of the Royal College of GPs 1989- • HEE Chair medical apprenticeship committee 2020- • HEE member of GP pilot committee 2019- • Wife Linda Aldous is a Partner in Bromley by Bow Health and a clinical lead for North-East London CCG and Director Bromley by Bow Health Limited - joint venture with Greenlight Pharmacy around training of pharmacists in primary Care Sept 2020- • (GP Business Partners, Dr Khyati Bakhai, Dr Selvaseelan Selvarajah, are Directors of Greenlight GP Connect Ltd Sept 2020-) • Director and Chair of MEEBBB Health CIC (A Primary Care Network, Tower Hamlets) • Stepson Jordan Aldous-Wilson is employed by Bromley By Bow Health as a receptionist. Business Partners: • Rob Trimble, Chief Executive of The Bromley by Bow Centre is a non-paid partner of Bromley by Bow Health • Dr Julia Davis, GP business partner is paid by the GP Partnership to act as deputy CEO of the Bromley By Bow Centre (Charity) • Dr Savitha Pushparajah, GP Business Partner is a non-paid director of the Bromley By Bow Centre (Charity)

Name	Job Title	Interests Declared
		• GP Business Partners, Dr Khyati Bakhai, Dr Selvaseelan Selvarajah, are Directors of Greenlight GP Connect Ltd Sept 2020- • GP Business Partner, Dr Joe Hall, Board Member of GP Care Group cic, Confederation of all general practices in Tower Hamlets.
Richard Fradgley	Executive Director of Integrated Care	• Social Worker registered with Social Work England
Samanthi Gibbens	Interim Chief Finance Officer	• Director, Health & Care Space Newham • Husband works for Hatmill as a consultant in Supply Chain, currently working with senior NHSIE staff on the Covid Vaccination Programme (Skipton House, London). • Brother is Senior Public Health Commissioning and Contract Manager at NHSEI, East of England
Dr Paul Gilluley	Chief Medical Officer	• Board of LGBT Foundation • Member, British Medical Association • Member, General Medical Council • Member, Medical Defence Union • Member, Royal College of Psychiatrist • Member, Stonewall
Philippa Graves	Chief Digital Officer	• None
Professor Dame Donna Kinnair DBE	Non-Executive Director	• Board Member, NHS Race and Health Observatory • Chair, SH24 (until May 2022) • Honorary Fellow, Faculty of Nursing and Midwifery RCSI • Leadership Fellow, Windsor Castle, Society of Leadership Fellows • Member, College of Medicine • Patron, Trinity College Medical Society • Trustee, Burdett Trust for Nursing
Mark Lam	Trust Chair	• Group Chair, Royal Free London NHS Foundation Trust • Chair, East London NHS Foundation Trust • Chair, North Middlesex University Hospitals NHS Trust (appointed from 30 October 2021) • Vice-Chair, UCL Health Alliance • Vice-Chair and Shareholder of Broadway Partners, a broadband telecommunications business. Broadway Partners is backed by the private equity firm Downing LLP (1 February 2022) • Non-Executive Director, Social Work England • Private business consultant • Hastings International Piano Trustee

Name	Job Title	Interests Declared
Edwin Ndlovu	Chief Operating Officer	• None
Dr Amar Shah	Chief Quality Officer	• Director, AS Healthcare Improvement Ltd • National Improvement Lead for Mental Health and Chair of QI faculty, Royal College of Psychiatrists • Faculty Member with Institute for Healthcare Improvement, US • Honorary Visiting Professor, University of Leicester • Honorary Visiting Professor, City University London • Member, General Medical Council • Member, Royal College of Psychiatrists • Associate, Faculty of Clinical Informatics Practitioner • Practitioner, The Chartered Quality Institute • Member, American Society of Quality • Wife is a GP on the bank at ELFT • Private teaching and consulting related to healthcare improvement
Lorraine Sunduza	Chief Nurse / Deputy Chief Executive - London	• Member of Unison
Eileen Taylor	Vice-Chair/Non-Executive Director (Acting Chair w/e 4 April 2022)	• Non-Executive Director of MUFG Securities EMEA Ltd
Dr Mohit Venkataram	Executive Director of Commercial Development	• CEO and Director, Compass Wellbeing CIC • Director, Health & Care Space Newham • Director, Stratford PCN Ltd • Partner, Leighton Road Surgery • Director, ELFT Charity • Director, East Bedford PCN (from 20/07/2022) • Member of Apna NHS • Wife works as a partnership tax manager at Towers and Hamlin

Name	Job Title	Interests Declared
Deborah Wheeler	Non-Executive Director	• Board Trustee, Epilepsy Society (member of Audit Committee and Appointments and Remuneration Committee) • Board Trustee and Lead Trustee for Safeguarding, Revitalise Respite Holidays (member of Quality & People Committee • Registrant, Nursing and Midwifery Council • Member, Royal College of Nursing • Member of NMC Assurance Advisory Committee for Test Competence • Member of Benevolent Committee of the Barts League of Nurses (a charity) • Son is an employee of ELFT

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DRAFT Board of Directors

Minutes of the Board of Directors meeting held in public on Thursday, 26 May 2022 from 1.00pm at Events@No 6, Terrace Room, 6 Alie Street, London E1 8QT and by Zoom.

Present:	Eileen Taylor	Acting Trust Chair
	Paul Calaminus	Chief Executive
	Aamir Ahmad	Non-Executive Director
	Ken Batty	Non-Executive Director
	Tanya Carter	Chief People Officer
	Anit Chandarana	Non-Executive Director
	Steven Course	Chief Finance Officer and Deputy CEO
	Professor Sir Sam Everington	Non-Executive Director
	Richard Fradgley	Executive Director of Integrated Care
	Paul Gilluley	Chief Medical Officer
	Philippa Graves	Chief Digital Officer
	Prof Dame Donna Kinnair	Non-Executive Director
	Edwin Ndlovu	Chief Operating Officer
	Dr Amar Shah	Chief Quality Officer
	Lorraine Sunduza	Chief Nurse and Deputy CEO
	Dr Mohit Venkataram	Executive Director of Commercial Development
	Deborah Wheeler	Non-Executive Director
In attendance:	Diana Adu	
	Victoria Aidoo-Annan	Governor
	Roshan Ansari	Governor
	Fatima Begum	Governor
	Gren Bingham	Governor
	David Bridle	Medical Director, London Mental Health Services, Interim Chief Medical Officer designate
	Patience Chabvuta	Nurse Manager
	Derek Feeley	Board Adviser
	Samanthi Gibbens	Deputy Chief Finance Officer, Interim Chief Finance Office designate
	Rofikul Islam	Governor
	Smira Javed	Health Improvement Practitioner
	Rajiv Jaitly	Non-Executive Director for Audit on ICB
	Norbert Lieckfeldt	Corporate Governance Manager
	Cathy Lilley	Director of Corporate Governance
	Khtija Malik	Governor
	Nicki McCoy	Corporate Secretariat Manager
	Upma Monga	Lived Experience Learning Academy Lead
	Joanna Moonesinghe	Service User
	Caroline Ogunsola	Lead Governor
	Jamu Patel	Deputy Lead Governor
	Steph Quitaleg	Senior Executive Assistant
	Betsy Scott	Governor
	Belinda Sherlock	Dramatherapist
	Gill Skrzypczak	Corporate Services Minute Taker

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	Suzana Stefanic	Governor
	John Sterling	Psychiatrist
	Felicity Stocker	Governor
	Hazel Thomas	Governor
Apologies:	Mark Lam	Trust Chair
	Richard Carr	Non-Executive Director

The minutes are produced in the order of the agenda

1 Welcome and Apologies for Absence

1.1 Eileen Taylor welcomed all to the meeting, acknowledging some people were joining online, and gave assurance that appropriate infection control and Covid safety checks have been undertaken in the interests of protecting staff and attendees; attendees were requested to wear masks unless speaking during the meeting.

She introduced Samanthi Gibbens who will be the Interim Chief Finance Officer and David Bridle who will be the interim Chief Medical Officer, following the departures of Steven Course and Paul Gilluley respectively on 30 June 2022.

1.2 Apologies were received from Mark Lam who is on sabbatical and Richard Carr.

2. Patient Story: Academy of Lived Experience

2.1 Upma Monga, the Academy of Lived Experience Lead, introduced Joanna Moonesinghe, a service user and member of the Academy:

- Joanna is a carer for her husband who has Alzheimer's which has led to speech and mobility issues, and their home having to undergo major changes with the installation of medical aids to assist in his care.
- The onset of the disease, plus a stroke, set Joanna on a steep learning curve and she recounted both the emotional and physical challenges they had to overcome, and the feelings of complete isolation.
- Six months into her husband's diagnosis Joanna became involved in the people participation group which gave her the opportunity to share her in depth experience of being a carer with a wide range of people, including doctors, answer questions and take part in simulation programmes aimed at improving the treatment of patients with dementia.
- Being a part of the Academy of Lived Experience has given Joanna an opportunity to improve recognition of the carer's role, and the confidence to take an active part in interview panels and giving presentations, such as today. She firmly believes that giving a platform to people with lived experience is the best way forward, engaging as wide an audience as possible.
- The Academy is now actively involved in supporting training for doctors, psychiatrist, social workers and other healthcare professionals, contributing to training packages for use Trust wide and for system partners in North East London and Bedfordshire, with other Trusts also becoming engaged with this initiative.

2.2 In discussion, the Board:

- Thanked Joanna and Upma for their presentation and the hugely positive input the Academy makes to the Trust.
- Acknowledged the experience and opinion of carers on interview panels helps to broaden the approach to recruitment of people to the Trust.

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- Noted the increased importance of embedding the voice of carers into the work of the Trust, and the imminent rollout of the carer's strategy.
- Noted the importance of the role of carers in admission avoidance and widening the clinician's lens around the impact on an individual of both the illness and their domestic circumstances.
- Acknowledged the challenge to the organisation in ensuring a robust method for feedback from the Academy, enabling this to directly influence the quality of care provided by the Trust.
- Noted the utilisation of digital systems would ensure the full involvement of carers in the patient's clinical pathway.
- Requested the continued challenge from carers in asking the difficult questions, and ensuring any negative undertones are heard in order to better improve the quality of service for the future.

3. Declarations of Interests

3.1 There were no interests relevant to the meeting other than those in the published register.

The Register of Interests for the two new Board members to be updated to include:

- David Bridle: Memberships of British Medical Association, Medical Protection Society, Royal College of Psychiatrists and the General Medical Council.
- Samanthi Gibbens: Husband works for Hatmill as a consultant in Supply Chain, currently working with senior NHSIE staff on the Covid Vaccination Programme (Skipton House, London). Her brother is Senior Public Health Commissioning and Contract Manager at NHSEI – East of England.

4. Minutes of the Previous Meeting Held on 24 March 2022

4.1 The minutes of the meeting held in public on 24 March 2022 were **APPROVED** as a correct record subject to two minor grammatical corrections already notified (11.2 and 14.2).

5. Action Log and Matters Arising from the Minutes

5.1 **Action Log**
Actions were noted as either closed, in progress or not due; there were no matters arising.

6 Chair's Report

6.1 Eileen Taylor congratulated Paul Calaminus on his inclusion as the sixth most influential provider Trust CEO in the country, in a Top 50 published by the Health Service Journal.

She invited Deborah Wheeler and Aamir Ahmad to feedback on recent NED visits.

6.2 Deborah Wheeler reported on a recent in person visit to the East Ham Care Centre, highlighting:

- The positive, warm and caring atmosphere in the unit which is well equipped to care for their service users, particularly those with dementia. A core member of the team is the housekeeper who identifies various issues including nutrition for patients, actively taking the care of people beyond just their clinical condition. The unit also undertakes work with local care homes on food preparation and eating.
- There was strong evidence of good relationships with patients, their carers and families; the unit runs a carer support group to ensure carers are in a good position to support individuals at home following discharge. One of their particular innovations

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to help orientate patients is to place photographs of their home front doors on their bedroom doors.

- Issues include some of the floors not being dementia friendly, challenges around double occupancy rooms on some wards, the capacity for local GPs to maintain a connection with inpatients and the new Learning Management System not yet being able to provide evidence of compliance for their staff around mandatory training. There is work ongoing to resolve this issue but better communications to staff on both the problem and the fix is encouraged.
- The positive aspect of having so many facilities in one place; a multi-disciplinary site which includes GPs and community health services.

6.3 Aamir Ahmad updated on a recent visit to Digital Services, highlighting:

- There have been many challenges for the team over the past couple of years including changes to the infrastructure and huge increases in equipment and levels of demand, and they have done an incredible job in the circumstances.
- There is ongoing pressure around the importance of ensuring all teams and clinicians are digitally trained and enabled as this now directly influences safety and quality, with a desire for digital training to becoming part of mandatory training.
- Historically the team has been under understaffed; however, the digital strategy goes a long way to addressing this as, in order to move toward a phase of transformation and future thinking, teams require more mental bandwidth. There have been positives in the new appointments to senior roles and this needs to filter down through the teams to make efficiencies and drive better care and safety.

6.4 In discussion, the Board expressed their gratitude and appreciation to the digital team for their continuing hard work and re-affirmed their support for the strategy.

6.5 The Board **RECEIVED, DISCUSSED** and **NOTED** the updates.

7 Chief Executive's Report

7.1 Paul Calaminus presented the report, highlighting:

- Assurance around the useful guidance relating to Monkeypox issued by the Infection Control Team.
- The publication of the estates strategy expected in the summer, picking up on issues highlighted during Exec walkarounds, NED visits and conversations with teams and service users.
- Work ongoing around the cost of living crisis and themes from the staff survey linking to bullying and harassment, race and dignity at work.
- The appointment of a new Clinical Director for Primary Care, Dr Vaishali Ashar a GP from Newham, and welcomed David Bridle and Samanthi Gibbens as well as acknowledging the departure of Paul Gilluley and Steven Course.
- The level of pressure in all services across the Trust, causing increased waits in emergency departments and Section 136 suites with some increased levels of violence and aggression.
- The ongoing work to build on supporting teams using QI tools, working with service users, collaborative work on flow across the services, where and how to effect most improvement with initiatives to ensure a prompt service.
- An acknowledgment of how our teams have continued to work in a person-centred way, and the importance of providing effective support to enable this.

7.2 In discussion the Board:

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- Expressed concern over the impact the cost of living crisis is having on staff and service users as well as the increased service demands.
- Received assurance around the ongoing work to triangulate data on increasing demand with the results of the staff survey and levels of violence and aggression, and the encouragement for teams to manage resources differently, thinking more preventatively to meet needs without just increasing their workloads.
- Noted the importance of holding true to the Trust's values around coproduction in the current climate, in particular working with system partners to address social circumstances, whilst acknowledging the right solutions for the future will take time.
- Noted feedback on the need for the pathways for staff progression within the Trust to be a smoother process to enable 'growing our own' and tackling staff shortages.

7.3 The Board **RECEIVED**, **DISCUSSED** and **NOTED** the report.

8 Quality Assurance Committee Assurance Report

8.1 Donna Kinnair presented the report, highlighting:

- Received assurance that direct actions as a result of two Serious Incident reports have been undertaken, and some follow up work with the Coroner is underway.
- The concerning number of deaths of people with learning disabilities does correlate with both the particular issues that this group of individuals faced during the pandemic and the exacerbation of existing underlying health conditions.
- The assurance received that themes identified around structured judgement reviews (SJRs) are reviewed Trust wide.
- Encouraging to see that the Trust has acted upon judgements made in the Ockendon Report with respect to our perinatal service.
- An acknowledgment of the challenges faced with rising numbers of people accessing our mental health services but reassured by the work with other community services to widen the ways of access.
- Achievements include the continued learning from services which were very quickly stood up during the pandemic and that teams are beginning to recognise the transformation of services as a positive and helpful step.

9 Quality Report

9.1 Amar Shah presented the update, highlighting:

- How quality improvement is being used to support the Trust's strategic objectives over the next five years, including the Marmot work in Luton, the new pursuing equity programme and optimising flow project, alongside improving the new starter process and supporting work on value.
- Having examined five different forms of feedback from staff and service users over the past nine months, the four key themes with opportunities for improvement are around waits, our estates, the provision of information and the recruitment process.

9.2 Tanya Carter added:

- A QI project around 'time to hire' has improved the time taken between offer of employment and start date to below the Trust target of 43 days, and the new starter project has shown significant improvements in ensuring people have the necessary IT equipment and smart cards as close to their start date as possible.
- A concentrated recruitment episode at the Coborn Unit resulted in the filling of those vacancies.
- Greater utilisation of the system on approvals from finance to HR within TRAC is ongoing.

- There is a focus on workforce planning including recruitment and retention issues.
- Work is ongoing to avoid financial hardship for people with lived experience when being recruited.
- Inter team issues within recruitment are being addressed, with plans in place to address turnover and internal moves.

9.2 In discussion, the Board:

- Noted work ongoing to attract healthcare professionals to the organisation includes utilising enhanced media and cleverer packaging of the benefits of ELFT, along with a continuing focus on work around staff retention.
- Noted that primary care GP numbers nationally are low and Health Education England are developing a new training programme to try and address this. Although recruitment of GPs in Bedfordshire and Luton is challenging, ELFT has no issue attracting GPs to work in London, given our reputation as an outstanding Trust.
- Noted that meetings are taking place with housing associations to explore options for the Trust to support staff in accessing affordable accommodation, and encouraged robust discussions around key workers.
- Acknowledged the Trust's long established links with universities and medical schools and the intention to increase student intakes, whilst ensuring there are enough places to provide a solid learning environment. Also the work to support mature students back into the workplace, and nursing associates to move to registered nurses.
- Acknowledged the need for a system approach to enable sharing of resources and facilitate the release of individuals to further their careers.
- Received assurance that work is underway to increase the amount of newly qualified Band 5 nurses in community health services, whilst recognising the autonomous nature of this work which requires an added level of support.

9.3 The Board **RECEIVED**, **DISCUSSED** and **NOTED** the report.

10 Performance Report

10.1 Eileen Taylor pointed out the important information contained within the report around waiting lists and equity, following the Board's request for the data to be examined through an equality lens. It highlighted awareness of disparities that were previously unknown and identified areas to focus new ideas, resources and attention going forward.

10.2 Amar Shah presented the report, highlighting:

- The meeting of our national 80% goal around suicide prevention, reductions in the rates of violence across the Trust and the IAPT service exceeding national targets in starting treatments and achieving recoveries.
- A number of teams are seeing their creative ideas lead to a reduction in waiting lists however the focus now is around those where waiting lists are continuing to grow, encouraging change ideas to create more capacity.
- The initial work around equity was with data from adult mental health and CAMHS, with some unexpected outcomes including variations within boroughs. Next steps are to take this data to individual teams and encourage them to ask questions and build theories as to why their processes may be leading to some inequities.

10.3 Edwin Ndlovu added:

- Community health services are also experiencing enormous pressures around waiting lists. It is hoped that the optimising flow project will also allow time and space for these teams to think creatively.

- There is an aspiration around the new roles to not only create flow and provide a good experience for service users but also for the enhanced primary care services team at East Ham Care Centre to help create a centre of excellence

10.4 In discussion, the Board:

- Noted the invaluable input of the digital team in helping to manage demand; reducing paperwork, increasing communications between clinicians and the embedding of the wound care system in Tower Hamlets.
- Noted the increase in early intervention and offers of support for people whilst they are on the waiting list including online resources, group work and work with families.

10.5 The Board **RECEIVED, DISCUSSED** and **NOTED** the reports.

11 Prevention of Future Deaths

11.1 David Bridle presented the report, highlighting:

- The sad death of a 37 year old male known to our services, whilst being restrained by security officers at the Excel Centre:
  - Concerns from the Coroner were that he should have been on a CPA; however, nationally there is a move away from a CPA approach and the Trust is keen to base care planning around the embedding of Dialog. It is not thought this is fully appreciated by the Coroner, nor the implementation within our services of the more relevant FACT model, which allows people to be more closely monitored and supported by the community team at a time of deterioration without leading to an admission. This is now well embedded in our Newham services.
  - A concern over the action plan being incomplete following the departure of the responsible staff member has led to an overhaul of how plans are tracked in the future, with improved oversight of the process between the team and the supported accommodation provider.
  - The concerns over factors for clinicians involved to be referred to the NMC have been revisited to ensure there is full assurance that the actions the Trust has taken are appropriate.
- The second case is the death of a 41 year old male in April 2021, whilst in seclusion in Tower Hamlets, relating to the timely identification that he was not breathing and the emergency response that followed:
  - There had been considerable violence displayed during the seclusion, highlighting an extreme risk to staff and necessitating the attendance of the police earlier in the day. In this context the staff awaited the attendance of the full Rapid Response Team before entering the room.
  - Coroner expressed concerns on observation factors around whether someone is breathing or not; the implementation of Oxehealth is underway across all of the Trust's seclusion rooms, as a more robust way to monitor vital signs.
  - There was also concern over the level of emergency response given, prior to the arrival of paramedics, which is for intermediate life support with no expectation or requirement for adrenalin to be given. All staff are trained in CPR, however for further assurance a programme of simulations around emergency responses is being undertaken across the Trust, back by QI to ensure staff feel equipped to deal with this, thankfully, rare occurrence.

11.2 In discussion the Board:

- Noted the unintended consequence within inpatient areas of issues not being identified due to restrictions around visits and inspections by staff outside of services during the pandemic. Was assured that more regular visits by the Chief Nurse and Director of Patient Safety are being reinstated to improve visibility of

areas that may need attention, whilst acknowledging the need for a greater sense of ownership amongst staff, ensuring they know how to raise and address local issues.

- Noted the Trust could provide more training for staff around attendance at Coroner's Courts, to be better prepared and confident in answering questions under the acknowledged pressure of these events.
- Noted the necessary differences between healthcare environments and the general public in the response to post Covid infection control measures, with further guidance around mask wearing under consideration.
- Was assured that the Oxehealth system will not remove the necessity for staff to continue to visually assess for signs of life and ensure an adequate response in an emergency.
- Received assurance that actions on CPR and future plans around pulsometry were thoroughly discussed and reviewed at Quality Assurance Committee

11.3 The Board **RECEIVED, DISCUSSED** and **NOTED** the update.

12 Appointments & Remuneration Committee Assurance Report

12.1 Ken Batty presented the update, highlighting:

- The assurance received that appropriate arrangements are in place to cover the departure of the Chief Medical Officer and the Chief Finance Officer.
- The review and sign off of the Trust's people plan for 2022-2026.
- A detailed examination of the results of the staff survey, receiving assurance that further work is planned where teams scored less than average.
- An update on the work around attraction and retention of staff, and the appointment of a diversity and inclusion officer to drive this work even further forward.
- Agreement to the post of Joint Chair for ELFT and NELFT being paused, and being re-advertised in September/October.

12.2 The Board **RECEIVED** and **NOTED** the update.

13 People Plan Report

13.1 Tanya Carter the update, highlighting:

- Extensive conversations around the cost of living crisis and impact on our staff, including a possible remodelling of mileage allowances.
- A full discussion of the staff survey results.
- The departure of the Deputy People Director and Head of Employee Relations; both posts have been recruited to.

13.2 The Board **RECEIVED** and **NOTED** the report.

14 Finance, Business & Investment Committee Assurance Report

14.1 Aamir Ahmad presented the report, highlighting:

- A strong end to the year, with good financial control achieved during the pandemic.
- Increased uncertainty this year, particularly around the effect of inflation on financial planning and financial viability.
- Constraints to the capital budget will affect our aspirations around digital and estates work, with tough prioritisations having to be made.
- There is an expectation from the centre that Covid related spending will cease in the coming year; however, this is not the experience within the Trust so far.

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- Agency expenditure will be subject to increased scrutiny with constrained usage.

14.2 In discussion the Board was assured that there will be increased vigilance around the oncoming financial pressures with more time being spent on this by the Board.

14.3 The Board **RECEIVED**, **DISCUSSED** and **NOTED** the report.

15 Finance Report

15.1 Samanthi Gibbens and Steven Course presented the report, highlighting:

- Closed the year with a better than expected £1.8m excess and £143m cash balance.
- The externally audited accounts will be presented for sign off in June.
- FV programme ended slightly behind plan with the residual £2.1m to be carried forward into this financial year.
- Covid spend for 2021-2022 totalled £8m, with an expectation for this to decrease considerably in 2022-2023.
- There is a continuing risk to the Trust's CDEL limit around capital, with expected increases in construction costs throughout the year due to inflation

15.2 The Board **RECEIVED** and **NOTED** the report.

16 Trust Board Committees

16.1 **Audit Committee**

Anit Chandarana as chair of the committee presented the report, highlighting:

- Annual accounts for this year are reported as being on track in terms of timescales (sign off June) and no significant issues being identified to date.
- Recognition of the continuing outstanding work of the Counter Fraud Team which has been recognised nationally, and resulted in the Trust being compliant on 12 out of 13 components.
- Outstanding actions highlighted in the Internal Audit report continue to be monitored, with several now closed.

16.2 **Charity Committee**

Aamir Ahmad as chair of the committee presented the report, highlighting:

- Took some time for awareness of the charity to permeate throughout the Trust.
- There are several creative ideas around population health and reducing isolation, making connections and physical health initiatives are beginning to flow through, with several exciting projects in the pipeline.

16.3 **Integrated Care and Commissioning Committee**

Richard Carr as chair of the committee presented the report, highlighting the Committee fully supported the progress with the development of the BCA governance including the terms of reference, and work plans.

16.4 **People Participation Committee**

Aamir Ahmad as chair of the committee presented the report, highligting:

- Continuing discussions around peer support and the Befriending services.
- Approval of the carers strategy; a good partnership to the strong service user voice within the Trust.
- How the equalities plan forms part of Trustwide Working Together Groups' priorities.

16.5 The Board **RECEIVED** and **NOTED** the reports.

DRAFT

17 Board of Directors Forward Plan

17.1 The Board **NOTED** the plan.

18 Any Other Business

18.1 Eileen Taylor acknowledged the departure of Paul Gilluley, the Chief Medical Officer, and Steven Course, the Chief Finance Officer, to larger roles within the NHS system, highlighting again the quality of personnel at ELFT.

She presented them with a small gift from the Board and thanked both of them for their invaluable knowledge, assistance and support to the Board throughout their time in the Trust, in particular for their competent guidance throughout the pandemic.

19 Questions from the Public

18.1 Questions received will be fully responded to offline.

20. Dates of Future Meetings

- Thursday 28 July 2022
- Thursday 29 September 2022
- Thursday 24 November 2022
- Thursday 26 January 2023
- Thursday 30 March 2023

All meetings will commence at 13:00hrs with a tea-time presentation and continue to be held in person with a video conference facility until further notice.

The meeting closed at 3.10pm

DRAFT

ELFT
Action Log Trust Board (Part 1)

Ref	Meeting Date	Agenda item	Action Point	Executive Lead	Due Date	Status	Comments
361	25-Nov-21	People Plan Update	Future Board seminar to revisit the changing cultures around staff expectations in the future, changing clinical requirements and transformation of people agenda in general	Tanya Carter	29-Sep-22	In progress	Date deferred due to changes to timing of June BDS
362	27-Jan-22	People Plan Update	To undertake a special cause variation study around increase in the likelihood of BAME staff entering the disciplinary process during Covid	Tanya Carter	29-Sep-22	Closed	Update to be provided to next Appointments and Remuneration Committee as part of the People Update report - included on RemCo forward plan
364							

NHS
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REPORT TO THE TRUST BOARD IN PUBLIC
28 July 2022

Title	Chair's Report
Author	Eileen Taylor, Acting Trust Chair

Purpose of the Report

- To provide feedback on Governor discussions so that these inform Board decisions
- To provide updates on the key strategic points arising from Chair and Non-Executive Director activity as part of the Board's commitment to public accountability

Committees / Meetings where this item has been considered:

14 July 2022	Council of Governors Meeting

Key Messages

This report informs the Board of key points arising from the Council of Governors and members discussions and the Chair's and Non-Executive Directors' most significant activities.

Strategic priorities this paper supports

Improved experience of care	☒	Council of Governor identifies annually its strategic priorities which will assist the Trust to improve experience of care at critical points in the patient journey
Improved population health outcomes	☒	Board discussions on how we can best achieve our population health ambition within a changing context will enable the organisation to be better prepared. Governor's focus on member priorities emphasises improving population health outcomes
Improved staff experience	☒	Governors and NEDs have highlighted staff experience as a key priority for the Trust and provided areas of focus
Improved value	☒	Working collaboratively with our health and care partners will secure better integrated and more accessible care, thereby increasing value

Implications

Equality Analysis	Positive impact on reducing health inequalities through system partnerships
Risk and Assurance	Ensuring that we respond effectively to member feedback will provide additional assurance, minimise risk and improve accountability
Service User / Carer / Staff	Focusing on the Council's strategic priorities will support improving service user and carer experience and staff engagement
Financial	Increasing the potential for creating value by involving and working with others to maximising benefits of investments.
Quality	Improving in response to the experiences of Members will help drive quality improvements further.

1. Background/Introduction

1.1. This report updates the Board on the Council of Governors discussions so that these views inform Board decisions. It also provides information on the Chair's main activities and strategic outcomes of Non-Executive Director (NED) visits and Board discussions as part of the Board's commitment to public accountability.

2. Council of Governors Update

2.1. At its recent meeting on 14 July 2022, the Council:

- Received assurance through an update by Chief People Officer Tanya Carter on how the Trust is reviewing ways in which they can support staff with the current cost of living crisis and pressures. Governors welcomed the work undertaken and the range of initiatives being considered, and noted there is some complexity particularly around potential impact on individual's taxation which the Trust is trying to resolve. I was really pleased to see Governors actively contributing to ideas and sharing ideas of activities and support available in their local community such as credit unions or third sector organisations.
- Received a presentation from Sarah Wilson (Director of Specialist Services) about the Trust's work to Give Every Child the Best Start in Life, one of the Council's four chosen priorities for the current year. Richard Fradgley and Angela Bartley set the scene in terms of the policy context around ELFT's population health and Marmot Trust ambitions. I was really pleased to once again notice how much the Governors' own priorities dovetail with what the Trust's strategic objectives are.
- Were asked, in breakout rooms, to identify what matters to them in the way the Trust supports children: *What does giving every child the best start in life mean to you as Governors.* Highlights from group feedback included:
    - the crucial importance of partnership working with schools, local authorities, the voluntary sector
    - proactively identify vulnerable families (by working with health visitors and midwives) and provide a coordinated, wrap-around service
    - Support (peer support) for parents, and across generations (include grandparents) but especially mothers, starting during pregnancy and continuing during the early developmental stages of a child's life
    - Opportunities to provide aspiration/inspiration and hope for their future
- Supported my suggestion that a separate briefing session for all Governors around the Marmot principles and how we wish to see them implemented in the way ELFT works would be timely and welcome.
- Agreed that the Board had provided them with sufficient training and development opportunities and support during the last financial year to carry out their roles effectively.
- Discussed and agreed to return to face-to-face Council of Governors meetings from November 2022, subject to future NHS England guidance on infection control and social distancing. The Trust will provide a briefing and Q&A session with the Chief Nurse and ensure that all venues will meet infection control requirements.
- Governors further agreed that one meeting/year should be held in Luton and Bedfordshire but that other meetings such as Committee meetings will continue to be held virtually as an effective and cost-effective way.

2.2. In private session, the Council:

- Mindful of the additional workloads on the Trust Vice-Chair now serving as Acting Chair, appointed Aamir Ahmad and Deborah Wheeler as Acting Vice-Chairs for London, and for Bedfordshire and Luton respectively with effect from 1 July and agreed their terms and conditions. These appointments are until the end of the term of the Acting Chair or 31 December 2022, whichever comes first.

- Received a detailed verbal update by Ken Batty on the Joint Chair recruitment including three days/week as a new minimum time commitment for candidates and the recruitment process to recommence at the end of August. In addition, two Chairs who have experience of either being a Joint Chair to two Trusts or is a Chair in Common have been invited to a meeting to share their experience around the day-to-day working and the governance arrangements that could be put in place to enable a Joint Chair to carry out their role on three days/week.

3. Chair and NED Updates

3.1. In recognition of Mark Lam's sabbatical, my role as Acting Vice-Chair and in discussion with the NEDs, am proposing the following NED membership:

Appointments & Remuneration Committee	Audit Committee	Charity Committee	Finance, Business & Investment Committee	Integrated Care & Commissioning Committee	People Participation Committee	Quality Assurance Committee
Chair	**Chair**	**Chair**	**Chair**		**Chair**	**Chair**
Ken Batty	Anit Chandarana	Aamir Ahmad	Aamir Ahmad	Richard Carr	Aamir Ahmad	Donna Kinnair
NED Members	**NED Members**	**NED Members**	**NED Members**	**NED Members**	**NED Members**	**NED Members**
Aamir Ahmad Eileen Taylor Deborah Wheeler	Richard Carr Deborah Wheeler	Ken Batty	Anit Chandarana Deborah Wheeler	Sam Everington Eileen Taylor Deborah Wheeler	Donna Kinnair Eileen Taylor	Ken Batty Deborah Wheeler

3.2. The Board is requested to approve the NED membership of these committees in line with the Board's standing orders (para 5.1).

3.3. Visits made by the NEDs since the last Board meeting include:

- Quality Improvement
- People & Culture Team*
- Health Based Place of Safety
- Bedfordshire Inpatient Services, Calnwood Court

* indicates a virtual visit

3.4. NEDs met with members of teams delivering critical services including clinicians, support colleagues, and managers. They took the opportunity to thank them for their professionalism, commitment, enthusiasm and meaningful contributions during the toughest health crisis this country has ever experienced.

4. Action Being Requested

4.1. The Board is asked to:

- **RECEIVE** and **NOTE** the report for information
- **APPROVE** the NED membership of the Board's committees.

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REPORT TO THE TRUST BOARD IN PUBLIC
28 July 2022

Title	Chief Executive Officer's Report
Author/Role	Chief Executive Paul Calaminus
Accountable Executive Director	Chief Executive Paul Calaminus

Purpose of the report

The purpose of this report is to provide the Trust Board with the Chief Executive Officer's update on significant developments and key issues over the past two months. The Board is asked to receive and note this report.

Key messages

This report contains details of activity across the Trust, awards and recognition and updates on changes and improvements to services across the Trust. The report also provides a brief update on national/regional issues.

Strategic priorities this paper supports

Improved experience of care	☒	Information presented describes how we are understanding, assuring against and improving aspects related to these four objectives across the Trust and within the local and national systems.
Improved population health outcomes	☒	
Improved staff experience	☒	
Improved value	☒	

Implications

Equality Analysis	This report has no direct impact on equalities.
Risk and Assurance	This report provides an update of significant developments, activities and issues across the Trust.
Service User/ Carer/Staff	This paper provides an update on activities that have taken place across the Trust involving staff, patients and carers.
Financial	There are no direct financial implications attached to this report.
Quality	This report provides an update of significant developments relating to quality

1.0 Purpose

1.1 The purpose of this report is to provide the Trust Board with the Chief Executive Officer's update on significant developments and key issues.

2.0 Operational Update

2.1 As reflected in the performance report in these Board papers, there has continued to be significant demand pressure across the range of services that the Trust provides, as well as services provided by partners in both North East London and Bedfordshire, Luton and Milton Keynes. This has resulted in increased referrals, caseloads, crisis presentations, bed occupancy and waits to access services, including, for the first time in many years, recurring delays of more than 12 hours for mental health patients in Emergency Departments.

2.2 In some areas, this demand pressure is exacerbated by issues with the availability of staff to recruit to new posts that would help to increase capacity. Over the last two months, staff sickness has also increased, not least through the impact of the current wave of COVID-19.

2.3 The Trust has responded with operational, tactical and strategic interventions. These include improvements to interfaces with acute hospitals, provision of increased appointments and capacity to support service users, the implementation of new models of care, an increased focus on approaches to recruitment and retention of staff, use of quality improvement to focus on flow through services, and continued work within ICSs to address challenges as effectively as possible with partners.

2.4 These challenges are also being experienced nationally, and there has been particular national focus on managing clinical risks associated with ambulances queuing at Emergency Departments, and improvements that can be made to discharge processes from hospitals. Within ELFT, we are putting in place a "perfect week" process in which we will focus particularly on discharge processes to try and identify further improvements that can be made. Capital monies have also been made available to support improvements in Urgent and Emergency Care provision for mental health. Within the Trust, this will support improvements to facilities at the Royal London Hospital in the first instance, with the intention of improvements to the Section 136 suite at the Homerton Hospital to be carried out in the 2023-24 financial year.

3.0 Coronavirus Update

3.1 In the period since the last Board meeting in May, there has been a further wave of COVID that has affected people across the UK. This has led to increased numbers of COVID cases on inpatient wards in the Trusts, and an increase in staff sickness as a result.

3.2 New national guidance has been issued that has removed many of the previous COVID restrictions. At ELFT, we have retained a requirement for people to wear masks in clinical settings, and testing for service users in areas where someone has been identified as COVID positive. Staff are still required to self-test for COVID twice a week and report their results to the Trust. Lateral Flow test kits can be obtained for no charge via the Government portal.

3.3 Staff in non-clinical settings or areas where there is no patient/service user contact do not have to wear a mask.

3.4 Arrangements for COVID vaccination boosters have recently been announced by the Joint Committee on Vaccination and Immunisation (JCVI) and the Trust is involved in planning for vaccination centre and outreach vaccination provision for the autumn. This will involve a change of location for the vaccination centre, as current lease arrangements come to an end.

3.5 The lead employer arrangements that have supported the North East London ICS vaccination campaign to date will also continue, albeit with a lower predicted volume of staff required. Given the changes to the scope of the vaccination campaign, the Trust is also continuing to support staff based at the Westfield COVID Vaccination Centre into applying for and obtaining new roles in the health and social care sector.

3.6 The Trust has also received notification that sick pay rules for those who are affected by COVID and Long COVID have been changed. This means that COVID related sickness will now be managed through mainstream sickness absence processes. The Trust is working with those affected and staffside colleagues to implement this change to requirements in a way that best supports our colleagues who have been particularly affected by both COVID and long COVID.

3.7 Nationally, the Terms of Reference for the Public Inquiry into the management of COVID-19 have now been announced. They include specific focus on the impact of COVID on mental health and wellbeing. As with all other NHS bodies, the Trust is putting preparations into effect in case any specific input or information is required.

4.0 System Update

4.1 The North East London and Bedfordshire Luton & Milton Keynes Integrated Care Boards were formally established on 1st July, with the two ICBs taking on the statutory responsibilities of the previous Clinical Commissioning Groups. Papers for the inaugural meeting including the constitution of the North East London ICB can be found here: https://northeastlondon.icb.nhs.uk/events/nel-icb-board-meeting, and for the Bedfordshire, Luton & Milton Keynes ICB here: https://www.blmkccg.nhs.uk/wp-content/uploads/2022/06/2022-7-1-Board-of-the-ICB-in-Public-Meeting-Pack-Final-V1.pdf.

4.2 The NEL ICB has established a Mental Health, Learning Disability & Autism Committee (MHLDA Committee), and a Community Health Services Committee (CHS Committee), as part of its governance structure, with work well underway to develop the operating models through which the two Committees will take on responsibilities for planning to meet the needs of the North East London population. The NEL ICB has also established Committees for the seven places in North-East London, including for City & Hackney, Newham and Tower Hamlets, in which the Trust is fully involved. It is anticipated that all the Committees will meet for the first time in September 2022.

4.3 The BLMK ICB has established a Bedfordshire Care Alliance (BCA) Committee as part of its governance structure, with work underway to develop the operating model through which the BCA Committee will take on responsibility to meet the needs of the population of Bedford, Central Bedfordshire and Luton. Work is also underway to develop and strengthen our mental health collaboration across Bedfordshire, Luton and Milton Keynes with Central North West London NHS Foundation Trust and the Integrated Care Board.

4.4 System planning for 2022/23 is now complete as of the end of June, with substantial new recurrent investment in particular for our CAMHS, IAPT and community and crisis mental health services for adults. We have also secured additional investment to support neuro-developmental waiting list pressures in our childrens services in Newham, and to support Integrated Discharge Hubs. Further work is required to deliver the convergence requirement in North-East London. We are expecting a strategic planning process to be launched in the early Autumn, through which we will be required to prepare two year plans, for 2023/24 and 2024/25.

5.0 Richmond Wellbeing Service

5.1 The Trust has received notice on the Richmond Wellbeing Service, as part of the consolidation of ICS and partnership arrangements in South West London. At present, we are providing the service as a sub-contractor to South West London and St George's Mental Health Trust, and this Trust will now take over the running of the service. Arrangements are being made for staff to TUPE to South West London and St George's Mental Health Trust from November 2022.

5.2 Richmond Wellbeing Service has been part of the Trust services since 2012 and has provided not only a very high quality IAPT service, but also an integrated model of mental health provision in primary care, that will be a strong foundation for the work of localities and neighbourhoods in the new ICS and place-based structures in South West London. Whilst we are sad to see the service leave the Trust, I would want to wish them well working as part of South West London and St George's services, with whom they already have a close working relationship, and am sure that the service will continue to be an important element of service provision within the borough of Richmond.

6.0 Launch of Carers Strategy

6.1 The ELFT Carers Strategy was launched on 21 June. The strategy has been designed and co-produced by carers and staff. The strategy describes what we want to do, how we are going to do it and what carers can expect. It also identifies the ways in which we will measure progress.

6.2 The strategy identifies five key priority areas:

1: Improve Identification and recognition of carers
2: Staff should be aware of carers and trained to engage with carers effectively
3: Clear pathways to access support for carers, and help in a crisis
4: Carer voice and involvement
5: Ensure the right support is in place for young carers

6.3 The implementation of the Carers Strategy will start with individual plans being developed in service areas explaining the tools and processes needed to create strong engagement between staff and carers, and the resources and learning needs of staff to support these relationships.

7.0 Trust Communications Plan

7.1 In support of the Trust strategy, the Trust Executive and the communications team have been taking forward work to revise and update the Trust Communications Plan. The plan represents our ambitions towards improving the lives of our local populations and the important role communicating, engaging, listening, learning and working together plays in that journey.

7.2 The plan sets out to support our Post-Covid pandemic recovery and to help staff and our communities manage the rising cost of living and improve their well-being and physical health. The plan also supports closer collaboration through our Integrated Care Systems (ICSs) and partnership.

8.0 Northern Ireland: Steps to Wellness

8.1 A unique partnership between the Trust and Southern Health and Social Care Trust (SHSCT) in Northern Ireland is reaping rewards. The Steps to Wellness service is based on the Improving Access to Talking Therapies (Talking Therapies) model in England. The ELFT and SHSCT partnership aims to work together to look at new ways to tackle waiting times for people looking for mental health support in Northern Ireland.

8.2 The project, which started in November 2021, aims to make long-term positive changes to the care of people looking for mental health input in this region of Northern Ireland. The Southern Health and Social Care Trust provides health and social care services across the five council areas of Armagh, Banbridge, Craigavon, Dungannon, and Newry and Mourne.

8.3 ELFT have recruited three staff to manage the service and a practitioner to deliver clinical work, and provided training to 10 SHSCT practitioners and team leads to be able to provide IAPT interventions and therapies. SHSCT had a high number of people come forward for support due to the psychological impact of the pandemic, lockdown, illness, and loss, with many reporting low mood, anxiety, feelings of sadness, distress, and other difficult emotions.

8.4 Since the launch, Steps to Wellness has completed over 250 assessments and has been able to accurately identify who would benefit from this approach or has sourced alternative services from the community and voluntary sector where appropriate. In the initial stages of the project, Steps to Wellness has been successful in reducing the waiting time of over 350 service users.

9.0 BLMK CAMHS Unit

9.1 Work is progressing well on the new acute mental health inpatient unit for children and young people in Bedfordshire, Luton and Milton Keynes. This is set to open before the end of 2022.

9.2 The interim unit will be based at the Luton Centre for Mental Health, part of the Luton & Dunstable Hospital site. Its development is being completed in partnership with service users and carers, who have chosen the name 'Evergreen' for the unit.

9.3 Partners are also developing a long-term plan to provide a permanent inpatient unit for children and young people within Bedfordshire, Luton and Milton Keynes, to replace this interim service.

10.0 Visits to the Trust.

10.1 The Deputy Mayor of London for Housing, Tom Copley met members from the East London Rough Sleeping & Mental Health Programme (RAMHP) team at ELFT's Headquarters in Aldgate on 11 May. The Rough Sleepers Adult Mental Health Project was established in 2020 as part of the Mayor's action plan to improve the lives of homeless people in London.

10.2 The RAMHP team were joined by their partners from Hackney, Newham and Tower Hamlets Street Outreach Teams who described the positive impact that RAMHP has on their work. They work together to improve mental health awareness as well as work to overcome mental health or psychological needs of clients so as improve their access to health care.

10.3 RAMHP Service user Alan took part in the presentation, eloquently describing how the team had helped him when he was rough sleeping to access the services he needed which transformed his quality of life.

10.4 The Trust was also delighted to host a visit from Richard Meddings, the new Chair of NHS England, on Monday, July 18. Richard met with colleagues at Alie St

before visiting mental health and community health teams at Newham Centre for Mental Health, Newham CAMHS and the East Ham Care Centre.

11.0 Royal College of Psychiatrists International Conference

11.1 The importance and value of co-production and people participation in medical education at ELFT was highlighted at the Royal College of Psychiatrists International Congress 2022.

11.2 An audience of mental health care professionals from across the world listened to a presentation on the theme from the Trust's head of people participation Millie Smith, service user representatives Adrian Curwen and Megan Hill and Medical Education/ELFT Fellows Sonya Rudra and Abigail Swerdlow.

11.3 Dr Chloe Beale, consultant psychiatrist in City and Hackney and Trust lead for suicide prevention, was another ELFT speaker who attended the congress at the Edinburgh International Conference Centre on June 20-23. She talked about patient safety in one session and gave a masterclass on medical emergencies in eating disorders in another.

12.0 New Director of Patient Safety Appointed

12.1 It is a pleasure to formally welcome Dr Deborah Dover, who has joined the Trust as Director of Patient Safety. This is a new role that will help design and develop an integrated approach to patient safety within the Trust. She will be working with colleagues and community partners to take a positive and whole population approach to safety with an emphasis on patient involvement, improving our systems, spreading good practice, supporting staff and learning from the whole range of care outcomes.

13.0 Awards

13.1 **Queen's Birthday Honours – BEM for Hackney Social Worker**
The Queen's Platinum Jubilee weekend was celebrated across our communities and within the organisation. It came with a special surprise for one of our Hackney social workers, Georgina Osei-Brenyah, who learned she had been awarded a British Empire Medal in the Queen's Birthday Honours for services to the community in Hackney.

13.2 **National NHS Parliamentary Awards 2022**
The Trust's Homeless and Vulnerable Person Outreach Service, based at Hackney's Greenhouse GP Surgery, is the London region winner and National winner of the NHS Parliamentary Awards 2022 for the category Excellence in Primary Care & Community Care. The team were nominated by Dame Meg Hillier MP.

13.3 **National BAME Health & Care Award**

People Participation team member Sam Ogunkoya won a prestigious National BAME Health & Care Award for being the most Inspiring Diversity and Inclusion Lead of the year. Sam has played a key role in ensuring the voice of BAME service users is heard in the Trust and acted on.

13.4 **International Award for ELFT's Quality Department**
The Quality Department were awarded 2022 Quality Team of the Year award at the International Quality Awards which took place on 23 June. The event was attended by international business leaders from all over the world and from a variety of industries including the motor industry, logistics, software, construction, and nuclear power to discuss issues and themes related to quality.

13.5 **CAMHS Psychiatrist Wins President's Medal**
CAMHS Psychiatrist, Dr Helen Bruce, has been awarded a Royal College of Psychiatry President's Medal for her contribution to medical training and the 'Choose Psychiatry' campaign which reversed dwindling recruitment numbers to fill all psych training posts.

13.6 **Informatics Team win Florence Nightingale Award for Excellence in Healthcare Analytics**
The Visual Analytics Team, part of the Trust Informatics Department, were awarded this award by the Royal Statistical Society, supported by the Health Foundation. The have been recognised for their work to develop improvement-focused analytics, bringing together data from different sources in a way that helps our teams understand variation and take action to improve quality.

13.7 **Launch of ELFT Staff Awards**
The 2022 ELFT Staff Awards will take place on 22 October at The Troxy, in Limehouse, Tower Hamlets. Award nominations are welcomed and need to be submitted by 31 July 2022. There are a number of new award categories.

14.0 Action Being Requested

14.1 The Board is asked to **RECEIVE** and **NOTE** the report for information

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REPORT TO THE TRUST BOARD IN PUBLIC
28 July 2022

Title	Quality Assurance Committee: 27 June 2022 and 4 July 2022 Committee Chair's Report
Committee Chair	Prof Dame Donna Kinnair, Non-Executive Director and Chair of QAC
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) meetings on 27 June 2022 and 4 July 2022.

Key messages

Quality Assurance Committee Meeting Held on 4 July 2022

Post Covid and Winter Planning

- The resurgence of Covid is causing significant operational disruption and the challenges on bed pressures has been exacerbated by Covid-related absences
- Additional challenges being experienced in primary care due to the huge increase in demand alongside the catch up processes which were already under way
- Focus on ensuring sufficient resources available for the winter period
- Aiming to commence earlier and more nuanced communications to our wider patient groups on the alternatives to A&E
- Staff welfare remains a priority with staff being encouraged to test more regularly particularly if they have been in places where there are large gatherings

Prevention of Future Deaths

- A PFD has been received relating to a falls risks assessment following the death of a service user in Newham following a fall; assurance was provided that the falls assessment process had been identified in the SI review which took place within 48 hours of the incident and a range of actions have been put in place to mitigate possible future incidents
- A thematic report on the issues raised through PFDs and learning identified to be presented to Trust Board.

Patient Safety

- Although there has been an increase in the total number of incidents raised on Datix over the past two years compared to the period before Covid, this has not translated into changes in the total number of SIs over time
- Two panel-led comprehensive SI reviews have been completed since May 2022 both highlighting good practice as well as areas for improvement
- Two SI reviewers appointed which will support with reducing the SI reviews backlog
- Assurance was provided that there is good access to interpreting services for staff, which are widely used. Bi-lingual word for word interpretation is also available for specific cases.

Quality and Safety: IAPT Services

- There are four community IAPT services covering Tower Hamlets, Newham, Richmond and Bedfordshire providing interventions for people with common mental health problems
- Achievements
  - Supporting the Southern Health and Social Care 'Steps to Wellness' project in Northern Ireland to develop their service model of care
  - Digital IAPT service: progress with automation and digital advances including increasing the use of remote workers to improve capacity and reduce waiting times, and an automation project to improve the efficiency of administration services
  - Patient experience questionnaires show consistent service user satisfaction above 90%

- Range of QI projects: group work, increasing access, staff wellbeing
- Improving access to services for BAME service users
- Maintaining an equality improvement lens in the service and holding regular Working Together Groups with people participation leads and service users.

- Key issues and variations:
  - A reduction in the recovery rate, although ELFT is maintaining an above average figure of slightly over 50%
  - Waiting times for assessment are fairly low for triage; however, secondary waits are higher than usual
  - Recruitment and swift onboarding challenges
  - IT issues around telephony system in Newham.

Quality and Safety: Addictions Services

- This specialist addiction service has one drug and alcohol recovery pathway, run from two hubs based in Bedford and Dunstable. There are approx. 1200 service users at any one time, with an average of 2000 per year, ranging from individuals with small addiction habits to those with 30+ year hard drug and alcohol use. Also run rough sleeper and criminal justice services
- Achievements:
  - Recent retention of the contract for a further nine years
  - Work around dual diagnosis with adult MH services, resulting in a 40% drop in dual diagnosis service users in treatment and removing areas of duplication for service users
  - Successful recruitment of 20 new staff over the past year, bridging the acknowledged gap in in drug and alcohol expertise by offering programmes of secondment and training for Band 3 & 4 Healthcare Assistants to become Band 5 Recovery Workers
  - Devolved responsibility from the local authority for safeguarding, receiving praise for the thoroughness of the work carried out on this
  - The delivery of a high quality service, centralising themselves across Bedfordshire to occupy a leading position with local authority services and their partners
  - A lower than the national average death rate amongst service users that can be attributed to the focus during the pandemic on keeping people safe by continuing to see service users face to face, keeping their physical healthcare service open and the embedding of a service in the hotel that housed rough sleepers in Bedford; as well as work to upskill third sector housing organisations and helping to build safety plans around health
- Key issues and variations:
  - An increase in service users re-presenting within six months
  - A fall in successful completions during the pandemic; however, a plan is in place to work with GPs around people on high painkiller doses and an increase in targeted work with low users
  - The rise in presentations creating caseload pressures but with newly trained staff ready to take on bigger caseloads it is hoped this will ease.

Cross Cutting Theme Deep Dives: Inpatient Occupancy

- Significant pressures include post pandemic bed occupancy running at over 95% which is unprecedented for the Trust; crisis lines are working at full capacity; 12 hour breaches have increased although remain the lowest in London; admissions have increased for both sections, informal and CAMHS T4
- Added complexity in presentations with a new cohort of people coming into our services
- Range of initiatives being undertaken both by the Trust, with NELFT and within the system including the optimising flow project; focus on urgent and emergency care at ICS system level; partnership working on social care solutions rather than medical especially in CAMHS; provision of response cars for street triaging with the aim of reducing Section 136 cases; working with the voluntary sector to increase beds in the Crisis House in Tower Hamlets to divert people from acute inpatient care

- System working has reduced out of area placements and enabled the commissioning of three new eating disorder community teams for two years
- Initiatives to reduce the pressures in primary care include commissioning specialist training on care navigation; increasing the number of pharmacists; appointing community matrons; however, the GP vacancy rate in Bedfordshire and Luton is one of the highest in the country
- Important to keep the patient voice central amidst the rise in demand on wards, recognising that patient safety must be monitored to keep people feeling safe. We are able to manage our beds across a wider system in Beds & Luton to provide consistent levels of care.
- The Committee acknowledged the huge system pressure on bed capacity and the impact this has on staff, service users and families.

Patient and Carer Race Equality Framework (PCREF)

- The Trust is one of four pilot Trusts in the UK to look at the experience of ethnic minorities with mental health services with the aim of improving BAME access to mental health care, having culturally competent care, rejecting the 'one size fits all' approach and encouraging people to speak up about the inequalities they experience
- This work is being coproduced with service users at local place based groups
- Feedback includes the challenges in respect of digital poverty, lack of trust in the NHS as an institution, and lack of trust in coproduction and translation delays
- Feedback also included the importance of cultural awareness and the need for increased appreciation and understanding of cultural assets.

CQC Update

- Action plan is progressing well
- Working with primary care on their readiness for CQC inspections.

Internal Audit

- Two final reports issued: recruitment and retention, and equality and diversity with good practice highlighted in both reports
- Assurance received that work is ongoing to ensure current resources in people and culture are being deployed in the most effective way in the light of the comments around teams being under-resourced.

Board Assurance Framework: Improved Experience of Care – 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

- BAF reflects work on incident response, PFDs and increase in service demands
- Intention to set up a collaborative on observations and observation practice
- Commencing quality and safety reviews of practice for AHP colleagues initially in community and primary care, to be followed by crisis and mental health services
- Director of Patient Safety has now joined the Trust
- The Committee agreed there were no change to the risk score and that appropriate controls are in place and operating effectively.

Quality Assurance Committee Meeting Held on 27 June 2022

The meeting focused on receiving and approving the quality and safety related annual reports so that they could be reviewed and discussed in a timely fashion and to provide the opportunity for the Committee to have a strategic overview, receive assurance, review learning and understand the opportunities for future improvement. A summary of discussions are attached at appendix 1.

Previous Minutes

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

Appendix 1: Meeting held on 27 June 2022 to receive quality and safety related annual reports

Annual Report 2021-2022	Matters of Concern/ Improvements	Key Points	Positive Assurance
Learning From Deaths Annual Report	• No concerns raised	• The report triangulates the themes from PFD reports, SI reviews, complaints and Patent Safety Forum to ensure learning and action plans are aligned and robust • Reported deaths are 25% lower than the previous year which was higher due to Covid; the majority of which were expected deaths, i.e. people on end of life care – most of whom had an end of life care plan in place • The Trust received five PFD notices; the SI reviews undertaken within 48 hours of an incident identified the issues included in the PFDs and so actions were already being put in place before the notices were received • Due to a number of homeless service users and rough sleepers dying during the year, the Trust is working more closely with a homeless charity and the rough sleepers mental health project	• The Committee approved the annual report
Serious Incidents Annual Report	• No concerns raised	• SI levels are approx the same as the previous year but the number of overall incidents is high compared to pre-pandemic • Some issues with the timely completion of 48 hour reports although the SI framework is for 72 hour completion; this is being addressed through refresher training for relevant staff and plans for a QI project • Although the 60 day threshold for completing SI reviews is indefinitely suspended, the Trust has not met this target due to impact of the pandemic as well as gaps in staffing. However, mitigations have been put in place to ensure patient safety if there has been a delay and there is a commitment to meeting the timeframe to improve timely learning	• The Committee approved the annual report

Annual Report 2021-2022	Matters of Concern/ Improvements	Key Points	Positive Assurance
		• The new Patient Safety Incident Response Framework will replace the SI framework as part of the National Patient Safety Strategy with the aim of looking at incidents across the system and identifying themes; the Trust will be working with partners in our ICS to prepare and implement the new framework requirements	
Safeguarding Annual Report (for Adults and Children)	• No concerns raised	• The 'Think Family' approach is being successfully embedded Trust-wide; its aim is to protect all those at risk of harm, abuse or neglect, and recognises that safeguarding is only effective when working collaboratively and restoratively with partner agencies • Training compliance has significantly improved and safeguarding supervision is offered to all teams • Datix system is now able to track actions which helps with audits, identification of themes and training; however, due to the number of systems at the Trust there can be duplication of reporting • Training is being provided to support with the increasing complexity of cases and the understanding of legal literacy • Working with operational services on transitional safeguarding arrangements	• The Committee approved the annual report
Guardian of Safe Working Annual Report	• No concerns raised	• Junior doctor work schedules are compliant with the junior doctor contract • There has been an increase in exception reports compared to the previous year which is viewed as being positive as people are encouraged to report; most exception reports are for working one or two hours over the rostered hours • Where there have been breaches, the issues have been addressed	• The Committee noted the annual report

Annual Report 2021-2022	Matters of Concern/ Improvements	Key Points	Positive Assurance
		• Reporting on CAMHS rota will be included in future reports following the recruitment of a rota coordinator	
Freedom to Speak Up Annual Report	• No concerns raised	• Although FTSU was set up for patient safety concerns, staff issues are also consistently raised • Reduction in the number of concerns raised compared to the previous year; work is ongoing to increase awareness of how to raise concerns • Themes of concerns raised include patient safety, quality of care, bullying and harassment, and worker safety, with the highest percent of concerns relating to processes and organisational structure • Assurance was provided that there have been no examples of cases which have been resolved and are raised again	• The Committee noted the annual report
SIRO Annual Report	• No concerns raised	• The report provided assurance about the progress and practice on information risk management and the security arrangements for information sharing; and encompassed both information governance and digital • The number of FOI and SAR requests have increased over the last two years • The pandemic saw a spike in breaches of information by email; following focused work on safeguards this number has reduced • The number of overall breaches has increased in reflecting national trends; there have been no issues raised by the ICO • Positive changes include moving to digital archiving, working in a more agile way, and ensuring staff can work safely remotely	• The Committee approved the annual report
Infection, Prevention and Control Annual Report	• No concerns raised	• Work during the year had remained impacted by Covid as well as dealing with other issues including non-Covid infections, cleanliness, staff safety and water safety	• The Committee approved the annual report

Annual Report 2021-2022	Matters of Concern/ Improvements	Key Points	Positive Assurance
		• A significant amount of work was undertaken during the year to ensure that high standards of infection prevention and control are maintained which at times required responsive actions due to the face paced environment and regular guidance changes • Root cause analyses are carried out when there are infections and lessons learnt are disseminated within the Trust in a timely fashion • Range of quality improvements implemented • Good communications within the local system continued to reap benefits through timely sharing of information • Environmental audits completed and action plans in place • Working with new soft FM contractor to ensure minimum standards are rolled out	
Emergency, Preparedness, Resilience and Response Annual Report	• No concerns raised	• Report summarises how the Trust has responded to the major events of 2021-2022 • Throughout the pandemic the Trust fully maintained its incident response strategy • Digital resilience capability will be a major feature in future reports • The Trust is standing up a response to the Covid public enquiry • Training is being increased covering loggist training and business continuity planning workshops • Induction pack for directors on call been designed for inclusion on the learning academy • Key learning is to undertake more regular and increased number of exercises	• For the third consecutive year, the Trust is fully compliant with NHSE requirements on emergency plans and resilience and have received positive feedback from NHSE who highlighted the high quality plans, schedule of training and exercising, a robust emergency preparedness and business continuity arrangement, and the work undertaken to achieve additional standards whilst in the pandemic • Trust-wide exercise conducted recently attended by 45 people including NHSE who provided positive feedback and will be using the exercise for a national programme • The Committee approved the annual report
Health, Safety and Security Annual Report	• No concerns raised	• Significant reduction in RIDDORS (reports of injuries to staff) and in physical violence against staff compared to previous year; the latter attributable to the violence and aggression QI	• The Trust was awarded the Violence Reduction Initiative Award from the national Association for Healthcare Security for both 2020 and 2021 (for the police work)

Annual Report 2021-2022	Matters of Concern/ Improvements	Key Points	Positive Assurance
		project and the introduction of senior management group RAG rating that identifies higher risk areas for focus • Police liaison continues to be an area ELFT can be proud of • Increasing numbers of staff accessing the people safe lone working app through changing culture • Reviewing opportunities to digital solutions to improve governance arrangements	• The Committee approved the annual report
Mental Health Law Annual Report	• No concerns raised	• MHA activity has been broadly similar to 2020-2021; however, there is an emerging challenge with S136 activity resulting in some patients being detained in health based places of safety beyond statutory time limits; this issue is being monitored and addressed through the MHL Monitoring Goup • The Trust is implementing an end to end digital MHA solution which will free up staff time in our services by reducing administrative tasks – ensuring safer and more efficient MHA administration • Work is taking place to implement the Mental Health Units (Use of Force) Act 2018 • Future plans include the implementation of the new Liberty Protection Safeguards (replacing DoLS) • There are changes to the MHL team leadership as both the Associate Director of Mental Health Law and the Deputy are retiring	• Assurance was provided that appropriate training has been provided to all Associate Hospital Managers and regular reviews are undertaken • The Committee approved the annual report
Annual Quality Report	• No concerns raised	• Quality Accounts now complete and reflects the feedback from the Committee, with the exception of the statement from commissioners in North East London	• Quality Accounts will be finalised and ready for publication on the Trust's website by 30 June 2022 deadline • The Committee approved the annual report
Complaints, PALS and Compliments Annual Report	• No concerns raised • Future reports to include information on Ombudsman investigations including	• There has been an increase of 21% in complaints during 2021-2022 • The number of complaints closed has also increased by 10% compared to the previous year	• The Committee approved the annual report

Annual Report 2021-2022	Matters of Concern/ Improvements	Key Points	Positive Assurance
	conclusions/findings, and the Trust's response	• Good progress using the stage 1 local resolution process with 86% of all complaints resolved using this approach • Backlog of complaints has been cleared, which has also resulted in improved processes • Triangulation of themes and lessons learnt from complaints, SIs and Learning from Deaths will inform a lessons learned programme and schedule of work • Impact from learning to be included in future reports	
Research and Innovation Annual Report	• No concerns raised	• There is a positive correlation between research and outcomes and quality; the aim is to maximise numbers of staff to become involved in research • The vision is to support all services to embrace innovation as business as usual • The Trust has a service user and carer research group which is unique in the NHS • The aim is to operate research as a corporate function rather than as an add on to clinical services	• The Trust has delivered some novel and sometimes complex interventions during the pandemic, overall providing good value for money as measured by the local Clinical Research Network • The Committee noted the annual report
Legal Claims Annual Report	• No concerns raised	• Number of claims have remained stable in comparison to previous year • There was an anticipated decrease in the number of incidents reported during the year following the extension to the limitation period for all claim types due to the pandemic; this extension may be masking an increase in incidents resulting in claims • Themes from Clinical Negligence claims are similar to those in previous years and include death by suicide, physical attacks and diagnosis issues • Themes from Liability to Third Party have changed with the top category being information governance breaches • Future focus on working with the new Director of Patient Safety to look at learning from PFDs, SIs and through non-PFD incidents	• The Committee noted the annual report

Annual Report 2021-2022	Matters of Concern/ Improvements	Key Points	Positive Assurance
Supporting the Armed Forces Community Annual Report	• No concerns raised	• Good progress has been made on external standards, working in coproduction with the Armed Forces community where their voice has been central to the work • The Trust has achieved both the Bronze and Silver Standards status with the Defence Employer Recognition Scheme – only the second Trust to achieve this • A business case and proposal has been submitted to the ICS to establish an Armed Forces Lead from the veteran's community to ensure the implementation plans across the Trust and more widely in the ICS are coproduced in a meaningfully manner	• The Trust continues to meet both its moral and legal obligations to the UK Armed Forces community • The Committee noted the annual report
Medical Education Annual Report	• No concerns raised	• The medical education department was set up to support medical students and doctors in training to meet their curriculum requirements and to become our future workforce • Supporting general wellbeing has also become important as a result of the pandemic • Good progress has been made against the department's objectives • Attention is being given to the areas for improvement recommendations from HEE's learner reviews following the 2021 GMS survey results • Strong focus on service user involvement being embedded in medical education • The opening of the Experiential Learning Centre has provided capacity for more innovative and multi-professional learning	• The report demonstrates there is a growing cohort of well supported, well trained psychiatrists with the values that matter to the Trust for working in our services • The Committee noted the annual report

NHS
East London
NHS Foundation Trust

QUALITY ASSURANCE REPORT
27 June 2022

Title	**Learning From Deaths Annual Report**
Reporting period	**1st April 2021 31st March 2022**
Author(s)	Kim MacGillivray, Mortality Reviewer Abiola Ajayi-Obe, Associate Director Risk and Governance
Accountable Executive Director	Dr David Bridle, Interim Chief Medical Officer

Purpose of the Report:

- To inform the Board of themes and trends from all reported deaths during the reporting period.
- To inform the Board of all LeDeR deaths
- To inform the Board of all COVID 19 deaths Trust Wide
- To inform the Board of deaths reviewed at Coroner's Inquests
- To inform the Board of any trends or concerns from reported deaths within this period.
- To update the Board on the Learning from Deaths Panel's planned focus for 2022/2023

Summary of Key Issues:

- A total of 2184 deaths were reported by the Trust during the 2021/22 year, which is almost 25% less than the 2020/21 year. The 2020/21 year included two significant Covid-related death peaks which were not replicated in 2021/22.
- Most of the deaths reported (1866) were expected deaths. Structured Judgement Reviews were conducted on a large sample of this cohort and this found that the standards of care expected at End of Life were almost always met and that Gold Standard Frameworks were in place as expected. Some End of Life Plans were not in place in understandable circumstances (e.g. referred to ELFT and died before being seen).
- Many of the 318 unexpected deaths during this period did not meet the threshold for being considered as Serious Incidents, e.g. under palliative care but did not die in expected time frame. However, 65 of the deaths were investigated as Serious Incidents (SI) with the largest category within this group being suicide as cause of death. The SI reviews identified a range of themes for learning and improving, including general and/or physical health observation policy not being followed for inpatients, issues with the quality of resuscitation, issues with communication amongst services and professionals and issues with follow up following discharge from inpatient units. Specific action plans have been put in place for the identified care or service delivery problem in each SI review, with programmes of work for Trust wide changes and learning for relevant, important and recurring issues, e.g. observations.
- The Coroner's inquests and verdicts for 2021/22 did not necessarily relate to people who died in this year. Nonetheless there was some overlap in the dominance of suicide verdicts as the highest cause of death (followed by drug related deaths) and in some of the themes arising in the 5 Prevention of Future Deaths (PFD) Reports received in the

year. The original SI investigations had identified many of the themes in the PFDs and initiated actions to address them (e.g. improved transition arrangements at the age of 18; actions to improve the functioning of crisis lines). The PFD reports and actions to address the important themes they highlight, as well as significant themes from SI reviews that have not led to PFDs, are now considered and monitored in the Patient Safety Forum which was established during this year.

- The LeDeR (Learning Disability Mortality Review) process was adhered to for all 33 deaths of patients with Learning Disabilities during 2021/22. None of these deaths required an SI review in ELFT.
- The plans for the year ahead include building greater partnerships for investigating and learning together with other healthcare providers (systemically) following a death, a specific focus on reviewing/learning from the deaths of homeless people, and enhancing the support to staff members affected by deaths of service users.

Strategic priorities this paper supports (Please check box including brief statement)

Improved patient experience	☒	The purpose of this report is to update the Board on the themes and trends identified as a result of learning from deaths reviews
Improved health of the communities we serve	☒	Summarises themes where the aim is to learn lessons to improve the health of the communities we serve and deliver requested end of life care pathways
Improved staff experience	☐	The purpose of this report is to update the Board on learning from deaths investigations and lessons learnt by staff to improve their working experience.
Improved value for money	☐	There are no financial implications

Committees / Meetings where this item has been considered:

Date	Committee/Meeting
	Quality Assurance Committee Meetings from 01/04/2021 to 31/03/2022
	Learning from Deaths Panel Meetings from 01/04/2021 to 31/03/2022

Implications:

Equality Analysis	This report will have no impact on equalities
Risk and Assurance	This report outlines actions taken following investigations to improve the safety of patients and quality of care we provide.
Service User / Carer / Staff	This paper has implications for staff service users and carers.
Financial	Any financial implications of recommendations from the investigations are highlighted but discussed in other forums.
Quality	This report outlines actions taken following investigations to improve the safety of patients and quality of care we provide.

Supporting Documents and Research material

a) National Quality Board Guidance on Learning from Deaths 2017
b) Learning Disability Mortality review (LeDeR) 2017
c) ELFT Serious Incidents Policy
d) NHSE SI framework 2015

Glossary

Abbreviation	In Full
DNACPR	Do not attempt cardiopulmonary resuscitation
CHS	Community Health Services
Corporate Reviews	Serious Incident investigations led by a corporate SI reviewer together with a co-reviewer from the locality.
CPNS	COVID 19 Patient Notification system
CQC	Care Quality Commission
ELP	End of Life Pathway
GSF	Gold Standard Framework–standards and framework with the seven domains of end of life care
LeDeR	Learning Disability Mortality Review - reviews of all deaths of people who have a learning disability over the age of 4
MR	Mortality Reviewer
PFD	Prevention of Future Death
PLI	Panel Led Investigations - investigations into the most serious of incidents (e.g. homicide) which are led by an independent reviewer together with an independent clinician and a lead nurse.
PPC	Preferred Place of Care
PPD	Preferred Place of Death
RAMPH	Rough Sleepers Mental Health Project
RCA	Root Cause Analysis
SIR	Serious Incident Review
SJR	Structured Judgement Review

1.0 Introduction

1.1 In March 2017 the NHS Quality Board issued national guidance on Learning from Deaths. This required Trusts to put in place a policy setting out their approach to mortality review and to publish data relating to deaths.

1.2 The Trust has one full time Mortality Reviewer (MR) and a Mortality Administrator Apprentice. The Mortality Reviewer undertakes structured judgment reviews (SJR's) for all East London Foundation Trust (ELFT) managed expected deaths and 25% of hospital and care home deaths. The Trust Mortality Administrator is responsible for the collection, analysis and reporting of data. The roles sit within the Governance & Risk Department working closely with incident review colleagues and are overseen by the Trust's Learning from Deaths Review Panel

1.3 The Learning from Deaths Review Panel consists of the following:

Dr David Bridle (Consultant Psychiatrist and Medical Director/Chair)
Dr Paul Gilluley (Chief Medical Officer)
Lorraine Sunduza (Chief Nurse and Deputy Chief Executive)
Sasha Singh (Director of Nursing)

Abiola Ajayi-Obe (Associate Director of Governance & Risk)
Kim MacGillivray (Serious Incident and Mortality Reviewer)
Dr Ben Braithwaite (Clinical Director)
Ruth Bradley (Director of Nursing- Integrated Care)
Ruth Cooper (Operational and Strategic Lead for Learning Disability)
Sanjay Nelson (Consultant Psychiatrist and Clinical Director for Learning Disability)
Judith Dimmock (Macmillan Lead Nurse for Palliative Care)
Day Njovana (Head of Nursing and Associate Clinical Director of Safety)
Dr Chloe Beale (Consultant Liaison Psychiatrist & Suicide Prevention Lead)
Elizabeth Furber (Senior Practitioner for Rough Sleepers Mental Health Project)

2.0 Background

2.1 In December 2015, the secretaries of State for Health commissioned the Care Quality Commission (CQC) to carry out a review of how acute, community and mental health Trusts across the country investigate incidents and learn from deaths. This was to find out whether opportunities for preventing deaths have been missed, and identify any improvements needed.

2.2 The NHS Quality Board national guidance was followed in July 2018 with specific guidance for NHS Trusts on working with families and carers. This was co-produced with families and carers to provide Trusts with advice on how they should support, communicate and engage with families following the death of someone in their care.

2.3 Whilst the guidance from the National Quality Board makes it clear that Trusts should report on inpatient deaths and those inpatients that have died within 30 days of leaving hospital. Locally Trusts are able to determine their own individual approaches to undertaking mortality reviews including definitions of deaths and scope for review.

Consequently, Mortality data is therefore not comparable between Trusts. As such the Trust will continue to evolve its processes and refine reporting over time in accordance with local and national learning. This is in addition to the detailed reporting and investigation of deaths meeting the national criteria for serious incident review.

3.0 Learning from Deaths Review Process

3.1 Prior to the COVID 19 pandemic, ELFT reviewed 100% of all expected deaths of Community Health and Mental Health patients in contact with ELFT services at the time of their death. These are Structured Judgement Reviews (SJR), a process to effectively review the care received by patients who have died. It also aims to improve learning and understanding about problems and processes in healthcare that are associated with mortality with a view to sharing best practice.

Since March 2021 the number of Community Health and Community Mental Health expected deaths subject to an SJR was reduced to 50% and has remained at this percentage. Deaths that occurred in acute hospitals, care homes or hospices were not reviewed between January 2020 and March 2021. Since April 2021, 25% of these deaths are reviewed. These changes were made in agreement with the Learning from Deaths Panel due to the increased numbers of expected deaths since the Coronavirus outbreak.

COVID 19 deaths were reviewed within the required percentage of SJRs and continue to be reported to the COVID 19 Patient Notification System (CPNS).

3.2 Trends and themes are reported to the Learning from Deaths Panel. Any SJR that reveals any concerns around care provision, service provision, or identifies issues which may have contributed to the death of a service user or patient are presented to the Learning from Deaths Panel and, where appropriate, are reviewed via a serious incident Root Cause Analysis (RCA) investigation.

3.3 Unexpected patient safety related deaths are directed to the Serious Incident Review (SI) team and are subject to either a panel led or corporate led investigation as appropriate.

3.4 All Learning Disability Deaths in ELFT are allocated to the mortality reviewer who is also RCA trained. These deaths are reported to the Learning Disability Mortality Review (LeDeR). They are reviewed by LeDeR and findings are reported to NHS England.

4.0 Learning from Deaths Review Statistics

4.1 Total deaths

A total of 2184 deaths were reported by the Trust between 1 April 2021 and 31 March 2022, this is a 24.42% decrease from the number of deaths (2890) reported tween April 2020 and March 2021. Numbers were higher between April 2020 and March 2021 due to the two Coronavirus pandemic peaks of April 2020 and January/February 2021.

There were 1866 expected deaths and 318 unexpected deaths reported between April 2021 and March 2022. Of the 318 unexpected deaths 65 were subject to the SI process.

5.0 Expected Deaths

5.1 Structured Judgement Review Process

The application of a Structured Judgement Review (SJR) is to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened. At ELFT, SJRs are carried out by the Mortality

Reviewer who examines the last 3 months of care provision provided to patients/Service Users (SU) prior to their death.

Any death that has been clinically assessed using a SJR of case records and is more likely than not to have resulted from problems in care provision, will be raised at the bi-weekly Grading Panel meeting.

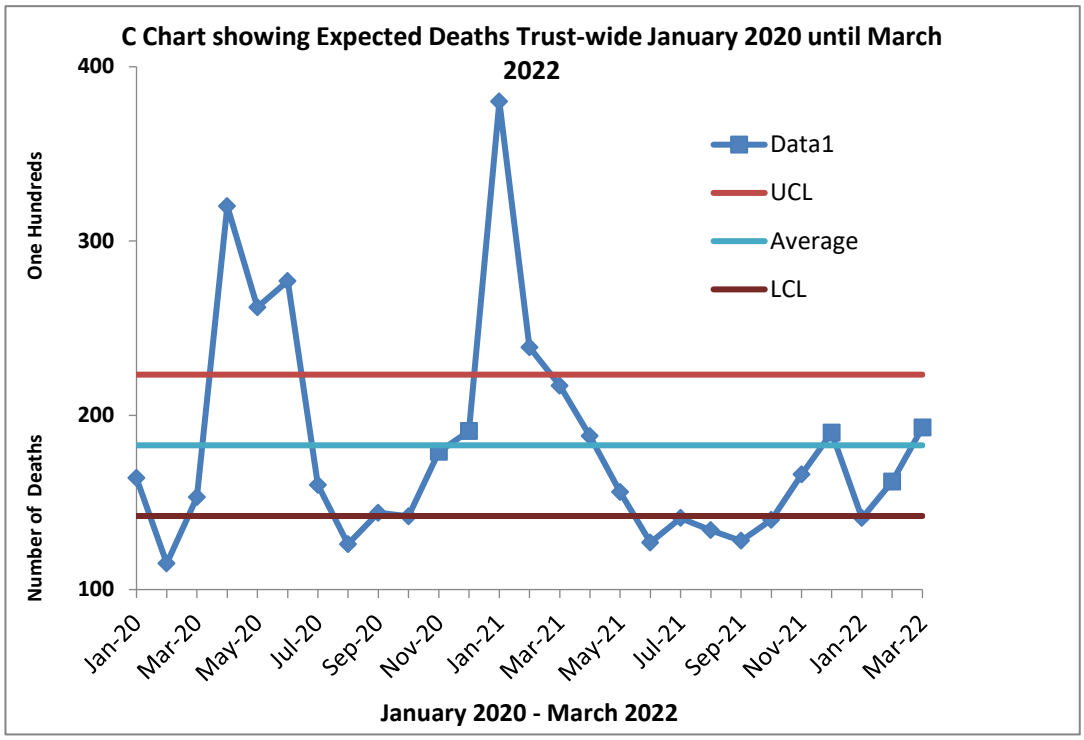
5.2 Identified concerns from SJR of a death due to a problem in care

Where there are any concerns identified as a result of a SJR review into a death the panel will request a 48-hour report from the directorate/service to provide additional background information into the care and treatment of a patient /service user whilst under ELFT services.

Any case which requires further investigation will be subject to a Serious Incident (SI) Review and will be investigated by the ELFT SI Team.

Chart 1 below is a C chart showing the data on expected deaths Trust-wide from mortality data collection in January 2020. A total of 1866 patients died expectedly between April 2021 and March 2022, the reporting period.

Chart 1 - C Chart showing Expected Deaths Trust-wide January 2020 until March 2022



Jan 20	164
Feb 20	115
Mar 20	153
Apr 20	320
May 20	262
Jun 20	277
Jul 20	160
Aug 20	126
Sep 20	144
Oct 20	142
Nov 20	179
Dec 20	191
Jan 21	380
Feb 21	239
Mar 21	217
Apr 21	188
May 21	156
Jun 21	127
Jul 21	141
Aug 21	134
Sep 21	128
Oct 21	140
Nov 21	166
Dec 21	190
Jan 22	141
Feb 22	162
Mar 22	193

C Chart

Table 1 below shows a breakdown of expected deaths Trust Wide by Directorate between April 2021 and March 2022. The average for this period was 182.78. April 2020 (320) and February 2021 (380) show the increase in deaths that occurred during the two peaks of the Coronavirus pandemic.

Table 1. Breakdown of Expected Deaths by Directorate from April 2021 until March 2022

Breakdown of Expected Deaths by Directorate	Total
Mental Health Services	
Bedfordshire Mental Health Services	71
City and Hackney Mental Health Services	56
Forensic Services	1
Luton Mental Health Services	36
Newham Mental Health Services	39
Tower Hamlets Mental Health Services	60
Community Health Services	
Tower Hamlets Community Health Services	417
Newham Community Health Services	476
Bedfordshire Community Health Services	693
Specialist Services	
Specialist Services and CHN Children's Services	11
Primary Care Services	6
Total :	**1866**

Mental Health Services reported a total of 263 expected deaths, 14.094% of the total 1866 reported between 1 April 2021 and 31 March 2022. This was 66.36% less than the 782 deaths reported between 1 April 2020 and 31 March 2021. Higher numbers between April 2020 and March 2021 can be attributed to the Coronavirus Pandemic and higher numbers of excess deaths in the Older Persons mental Health Services such as Memory Clinics and Dementia Services.

3 deaths reported by Primary Care Services were homeless service users.

Bedfordshire deaths were higher, than for other Trust localities, and this can be explained by the larger population size; population age and physical health related deaths in people accessing services such as Memory Clinics and Older Persons Occupational Therapy.

There were 11 expected deaths in Specialist Services, Children’s Services and different therapies. Forensic Services reported 1 expected death in the reporting period, a 38 year old woman with respiratory failure who had been discharged from an acute hospital to receive physical health care and palliative care on a medium secure ward.

The 6 reported expected deaths in primary care services included rough sleepers and homeless service users. Learning from these deaths has included working with St Mungo’s homeless charity and the Trust’s Rough Sleepers Mental Health Project (RAMHP).

The Trust held a number of events during the Dying Matters Week in May 2021. Sessions included advanced care planning; supporting people in the final stages; the importance of talking about someone’s final wishes. Bedford and London have dedicated palliative care

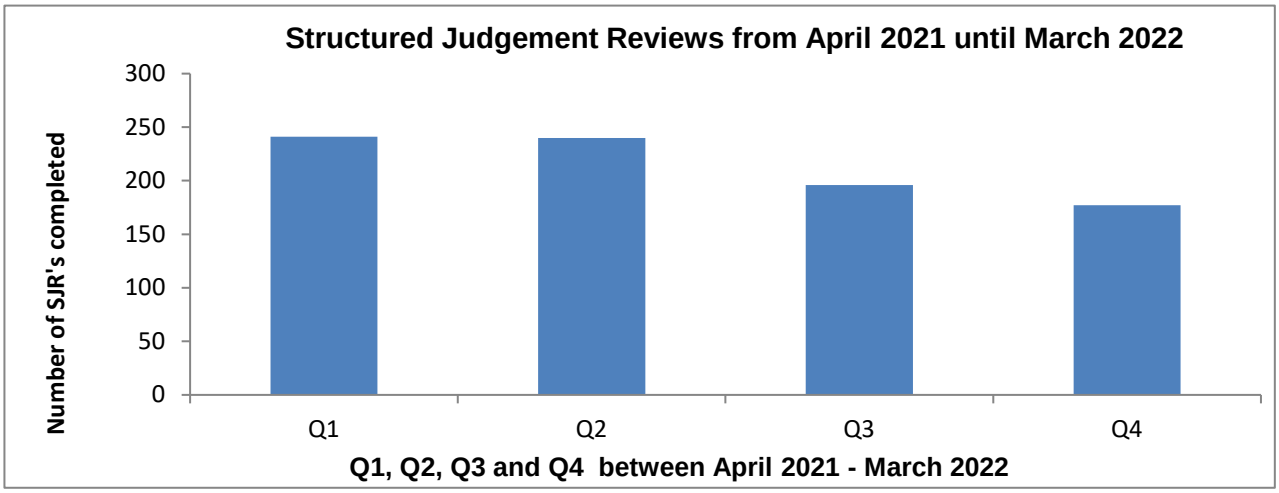
leads who work closely with the district nurses and oversee the advanced care planning teams and primary care services which includes the Trust's homeless services.

5.3 Deaths reviewed under the SJR Process

A total of 854 SJR's were carried out between 01 April 2021 and 31 March 2022. This was a decrease of 48.648% from the previous year between April 2020 and March 2021 when 1403 SJR's were completed. During 2020 and 2021 the number of excess deaths had increased due to the pandemic, reviews were reduced from 100% to 50%. Excess deaths had decreased between January 2021 and March 2022 although not to pre-pandemic numbers and reviews continued to remain at 50%of reported figures.

Of the 854 deaths reviewed, 430 were male and 424 were females. The highest number of deaths was amongst the 76-100 year old group.

Chart 2. Column Chart Structure Judgement Reviews from April 2021 until March 2022



Column chart

Patients whose deaths were reviewed as an SJR tended to be older and had been accessing Community Health Services such as district nursing; continence; podiatry and diabetic services. Those accessing Mental Health Services were under memory clinics; dementia services and therapies such as Occupational Therapy (OT) and Physiotherapy (PT). This group of patients also tended to be receiving palliative care and their deaths had been expected

Overall deaths were higher in Community Health Services as they included more patients' over 65 who were terminally ill. Within this cohort of patients, the highest number of deaths arose in patients with cancer and organ failure. Cancer related deaths were higher in all age ranges followed by deaths from organ failure. Older patients also died from causes related to end stage dementia.

6.0 COVID 19

Trust-wide a total of 49 patients died, during the reporting period. These patient had tested positive for COVID 19 in the 28 days prior to death.

There was one inpatient death, an 89 year old woman who had been admitted to a community bed from her own home as she was at risk of developing sepsis due to self-neglect. She had hypertension, Type 2 diabetes mellitus (T2DM), chronic kidney disease (CKD) and multiple pressure ulcers (PU's). She had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place and was not for ventilation so was not admitted to an acute hospital.

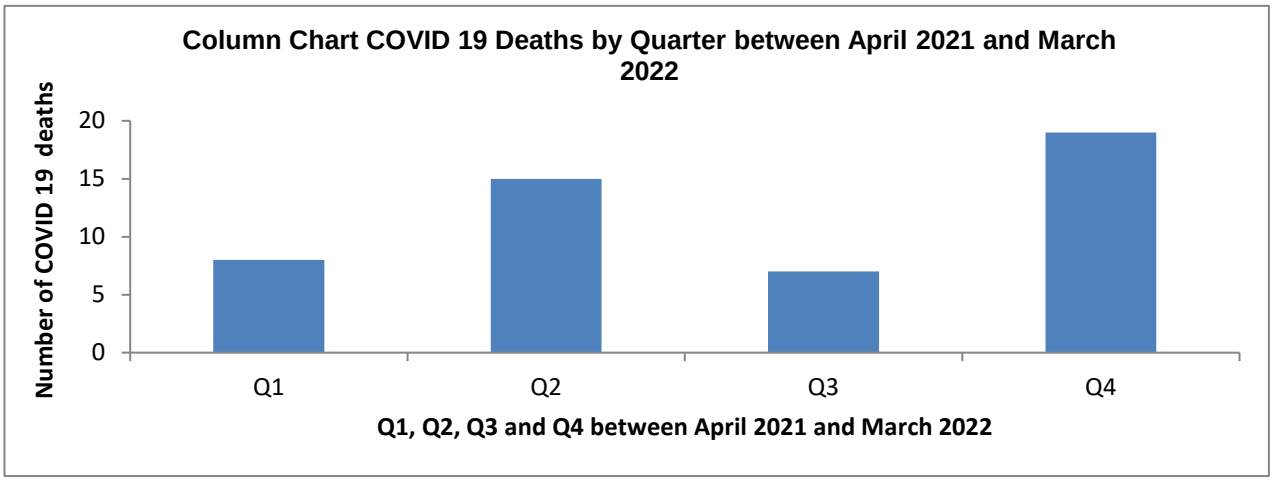
The remaining 48 deaths were in the community and death occurred either in a care home; an acute hospital; or in the patient's own home.

The youngest patient to die who tested positive for COVID 19 was a 23 year old man, he died in an acute hospital.

He had a diagnosis of DiGeorge Syndrome with polycystic kidneys. He contracted COVID 19 at home and was admitted to hospital requiring ventilation and died as a result.

The column chart below shows the total number of COVID 19 related deaths for each quarter during the period between April 2021 and March 2022. There were no deaths where COVID 19 was the primary cause of death and where 1a COVID 19 was recorded on the patient's death certificate.

Chart 3. Column Chart COVID 19 Deaths by Quarter April 2021 and March 2022



Colum chart

Table 2 below shows the number of patient deaths Trust-wide by Directorate where the patient had tested positive for COVID 19 within 28 days of dying.

Table 2. COVID 19 Deaths Trust Wide by Directorate

Directorates	
Tower Hamlets Mental Health	5
Newham Mental Health	3
Luton Mental Health	4
Bedford Mental Health	4
City & Hackney Mental Health	3
Tower Hamlets Community Health (included 1 inpatient death)	7
Newham Community Health	9
Bedford Community Health	14
Total	**49**

COVID 19 deaths were reviewed within the samples of SJR's**.** All of these deaths were 'of patients who were receiving palliative care or were on an End of Life Pathway prior to contracting COVID 19. They were not for resuscitation or for ventilation. All had authorised Do Not Attempt Resuscitation (DNAR) in place.

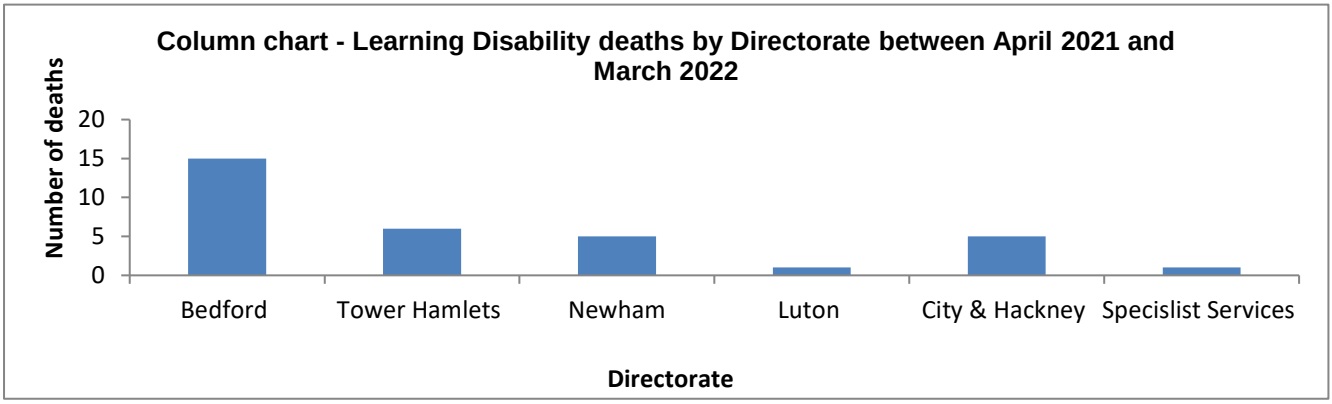
In all inpatient settings testing for COVID 19 continues and swabs are routinely taken across the Trust.

Deaths continue to be reported, as appropriate, to COVID 19 Patient Notification system (CPNS); the Trusts' Infection Control Team and are uploaded onto the Trusts COVID 19 Dashboard. These numbers can be found on the Governance & Risk department Intranet Page.

7.0 Deaths reported to the Learning Disability Mortality Review (LeDeR)

33 deaths were reported where the patient had a learning disability between April 2021 and March 2022. The youngest patient to die was an 18 year old man who had a degenerative condition and was under the care of the Specialist Diana Team. Chart 4 below shows the total of learning disability deaths by Directorate.

Chart 4. Column chart showing Learning Disability deaths by Directorate between April 2021 and March 2022



The higher number of deaths in Bedfordshire reflects the larger number of people with a learning disability that live in either residential or supported living accommodation in the locality.

8.0 Unexpected Deaths

A total of 318 unexpected deaths were reported Trust Wide between April 2021 and March 2022. Notably, not all unexpected deaths meet the threshold to be investigated as a Serious Incident Review. Of the 318 reported on DATIX, the Incident Reporting database used by ELFT 238 met the threshold for review via the SI process. A total of 152 were reviewed as a 48 Hour report with no further escalation, 21 concise reviews were concluded and 65 were investigated as a Serious Incident Review (SIR). The remaining 80 were reported as unexpected deaths and were either ; unexpected where the cause of death was known, unexpected and under pallitive care but did not die within the expected timeframe or unexpected but not patient safety related.

8.1 Serious Incident Review Process (SI)

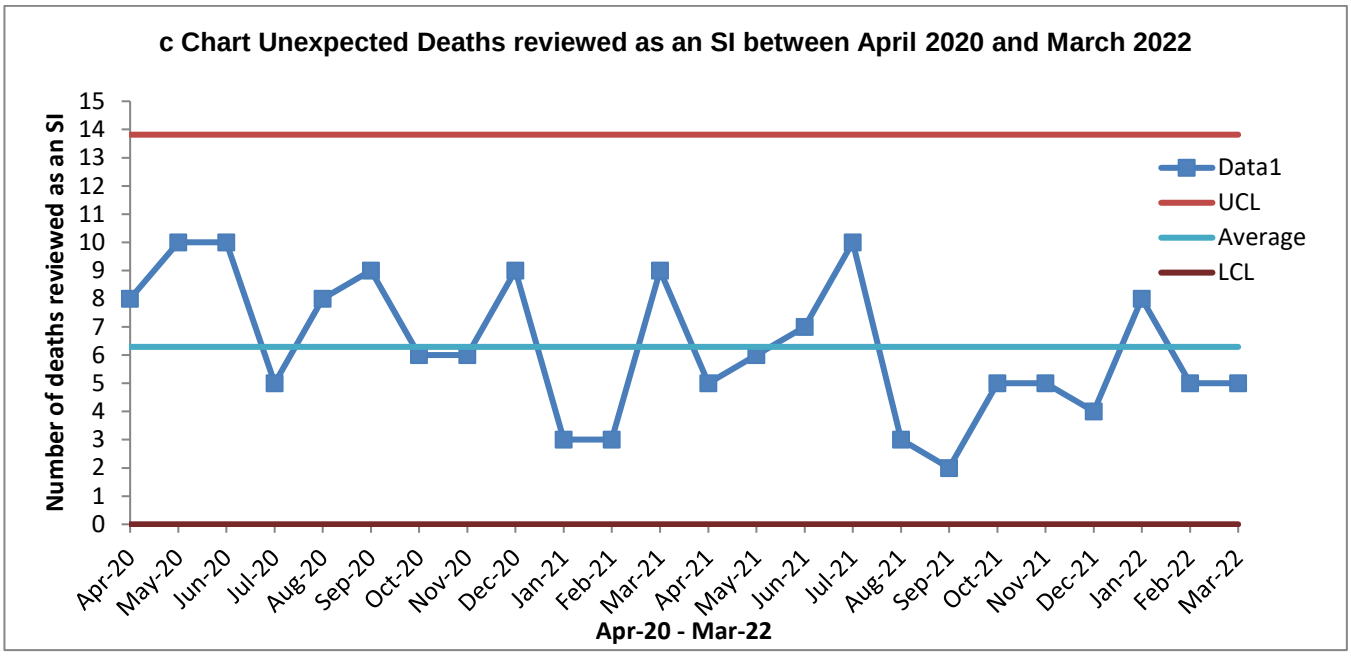
An SI review is a systematic analysis of an iatrogenic or naturally occurring incident, including unexpected deaths, to identify what happened, how it happened and why.

This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to, where possible, reduce the risk of future occurrence of similar events.

8.2 Unexpected Deaths subject to investigation

There were 65 deaths that were escalated and concluded as an SI between April 2021 and March 2022. Chart 6 below shows the number of unexpected deaths that were subject to an SI between April 2019 and March 2022. The average is 6.29 deaths per month over the period.

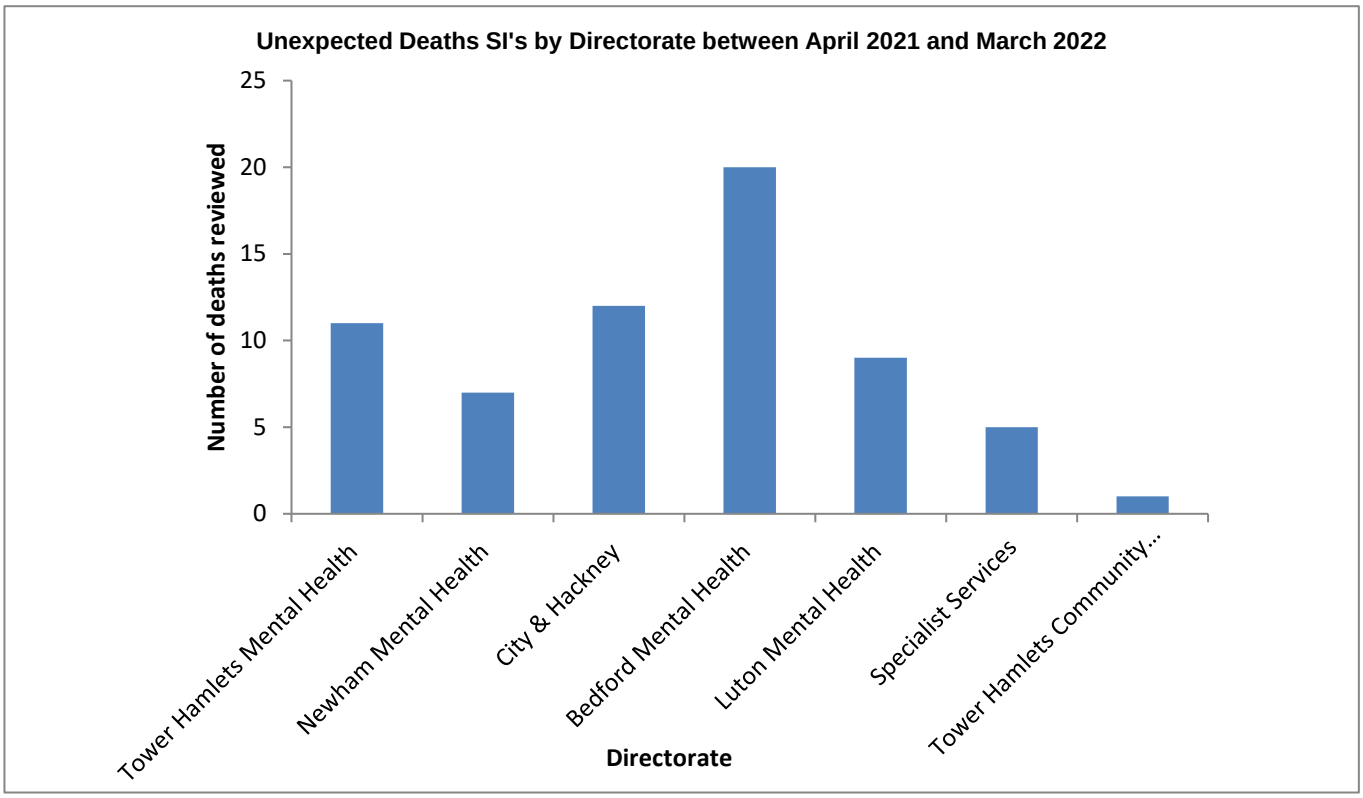
Chart 5. C Chart - Unexpected Deaths reviewed as an SI between April 2020 and March 2022



C chart

Chart 6 below shows the number of unexpected deaths reviewed as an SI by Directorate. Bedford Mental Health had the highest number of patient safety related deaths due to the higher number of patients in touch with ELFT services within this locality. The highest number of deaths reported by Mental Health Services was suspected suicides.

Chart 6. Column Chart - Unexpected Deaths SI's by Directorate between April 2021 and March 2022



Column chart

9.0 Learning from Inquests

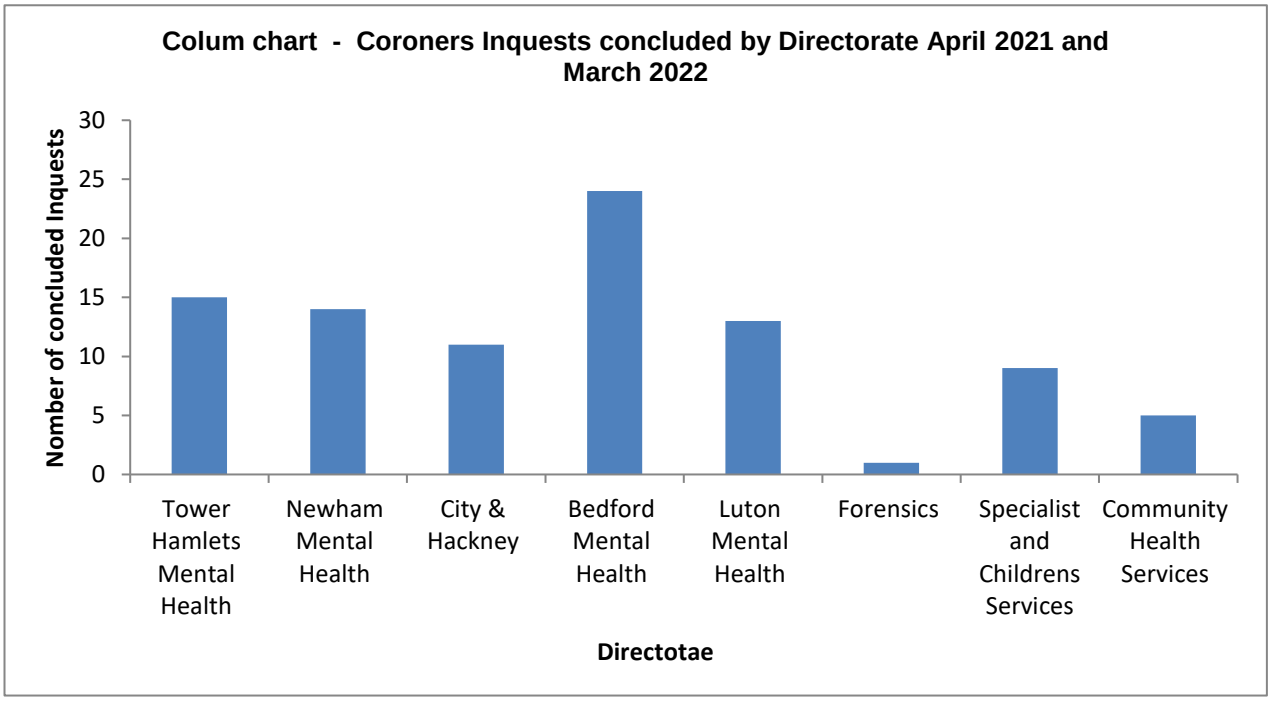
A death is reported to a Coroner in the following situations:

- a doctor did not treat the person during their last illness
- a doctor did not see or treat the person for the condition from which they died within 28 days of death
- the cause of death was sudden, violent or unnatural such as an accident, or suicide
- the cause of death was murder
- the cause of death was an industrial disease of the lungs such as asbestosis
- the death occurred in any other circumstances that may require investigation

A death in hospital should be reported if:

- There is a question of negligence or misadventure about the treatment of the person who died
- they died before a provisional diagnosis was made and the general practitioner is not willing to certify the cause
- the patient died as the result of the administration of an anaesthetic
- death should be reported to a Coroner by the police, when a dead body is found death is unexpected or unexplained, or when a death occurs in suspicious circumstances

Chart 7. Column chart - Coroners Inquests concluded by Directorate April 2021 and March 2022



Column Chart

9.1 <u>Number of deaths subject to Coroner's Inquest and Verdicts between April 2021 and March 2022</u>

Notably, not all the deaths heard at Coroners Court between April 2021 and March 2022 occurred during the time period being considered. And not all of the Coroners Inquests that have been opened during the reporting time period have been closed.

A total of 91 inquests into deaths of ELFT patients' / service users were concluded at Coroners Court during the reporting period.

There were 5 Community Health Service related deaths heard at inquest. The highest number of deaths heard at inquest were from Bedford Mental Health services with a total of 24. The highest number of ELFT deaths which resulted in a Coroner's Inquest relate to death suicide.

Nationally deaths as a result of suicide are, sadly, one of the most frequent causes of death to people who have accessed mental health services. The Trust together with NHS England are actively working to reduce the number of deaths by suicide with a number of initiatives including; adopting the 10 Key Elements of the National Confidential Inquiry into Suicide and Safety.

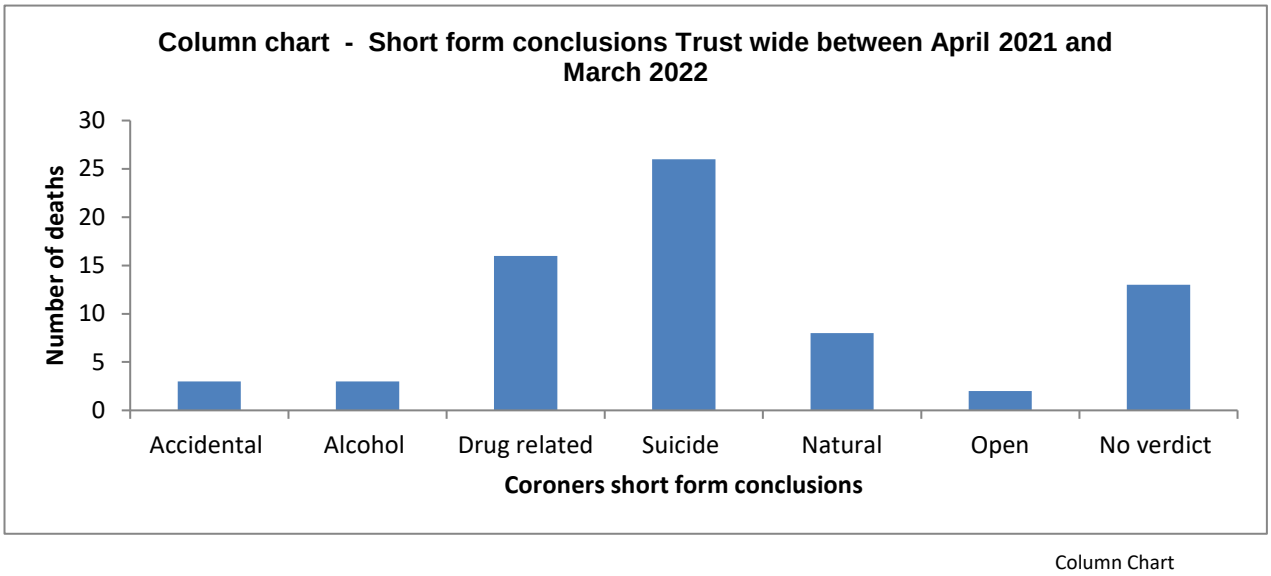
Following the success of a Trust-wide workshop on Suicide Prevention in 2020 it was recognised that further regular sessions and workshops would share good practice and identify interventions that are taking place. Weekly sessions on Suicide Prevention were introduced and continue to be facilitated along with Suicide First Aid Training - Understanding Suicide Intervention (full day or 2 half days)

A number of initiatives took place during 2021 and 2022 involving ELFT and health provision partners. Network Rail have funded a Nurse Lead secondment to The Pioneering ELFT & Network Rail's Suicide Programme.

The Trust has a legal team who provide support and advice to all staff who are summonsed to inquests as witnesses.

9.2 Coroners Short Form Conclusions

Chart 8. Coroners Short Form Conclusions between April 2021 and March 2022



There was a total of 26 suicide verdicts Trust-wide. Suicide was the highest cause of death Trust wide with death related to drug use being the second highest.

9.3 Coroners Narrative Conclusions

There were 20 narrative conclusions made between 01 April 2021 and 31 March 2022

Coroners Narrative Verdicts
Service user was found hanged at her home in November 2020. She was known to Perinatal Mental Health since January 2020 and was discharged in June 2020. The deceased was also known to Home Treatment Team and was discharged in September 2020. COD: 1a Suspension
The young person was under CAMHS for a couple of months and was allocated a keyworker. She had taken an overdose of 20 metformin during her attendance at college. The actual strength of the metformin was unknown and it was unclear where she obtained the medication. She was found and taken to A&E and admitted to ITU where she subsequently died. COD: 1a Bilateral bronchopneumonia 1b Metformin overdose

Service user was known to community mental health services. She had a diagnosis of breast cancer and it was initially suspected that this had been the cause of death. Her family had raised concerns that her psychiatric medication had also contributed to her death. COD: 1a Acute cardiac arrhythmia 1b Left ventricular hypertrophy, psychosis treated with olanzapine and carcinoma of the breast treated with chemotherapy
Service user last seen in October-November 2019 when he attended A&E and was referred to the Home treatment team (HTT). The HTT attempted to contact him on 3 separate occasions and discharged him from the service due to being unsuccessful. He did not have any contact with services for approximately 11 months prior to the incident. His last contact was an assessment in November 2019, he died in October 2020. COD: 1a Cardiac Tamponade 1b Incised wound to chest penetrating right ventricle
Service user passed away in Royal London Hospital after being found unresponsive and then suffered cardiac arrest. He was known to CMHT and Clozapine Clinic. COD: 1a bronchopneumonia 1b hypoxic ischaemic encephalopathy following cardiac arrest 1c cocaine toxicity
The police were called to reports of the deceased throwing items out of her window. When the police arrived at her accommodation she appeared to have fallen from a height and was found to be deceased. At the time of her death she was known to the ELFT Liaison and Diversion Team - who were supporting her on a weekly basis, making contact and assisting her with job and housing issues. COD: 1a Multiple Traumatic Injuries
The deceased was referred to the Psychiatric Liaison Service by the A&E department after an intended overdose. He agreed for an informal admission to a Trust Ward. While he was on leave, he took another overdose with 2 bottles of wine and wrote a suicide note. He returned to the ward that evening. He was then discharged from the ward and he had hoped to be taken on by the CRHT as he had previously been supported by the service. The deceased's wife informed the CRHT that the patient had taken his own life. CoD: 1a Asphyxia 1b Hanging
The community nursing team received referral to administer EOL medication to the patient. The day before death the patient's daughter called to report that patient was struggling with breathing. She was visited by District Nurse Team Leader. Medication was administered. Again, early evening the daughter called requesting a further review. The DN administered medication and no concerns identified and patient was left comfortable and the daughter was advised to call an ambulance if she had any further concerns. She was concerned about the patient's deterioration the following day and had called an ambulance, the patient died while being transported to hospital. COD: 1a Bronchopneumonia 2 Previous Cerebrovascular Accident
The deceased was a 58 year old inpatient. He was observed coming out of his room on the ward struggling to breathe and coughing out a dark brownish substance. Patient collapsed to floor and paramedics were unable to resuscitate him. COD: 1a Laryngeal obstruction by foreign material and aspiration of gastric contents.

Service user was known to mental health services between July 2018 and August 2020. Last contact was August 2020 with the Specialist Psychotherapy Service when she was placed on their waiting list for 1:1 therapy. In March 2021, she was found hanging in her home. COD: 1a suspension by ligature
The service user was not open to any services at the time of the incident. He was assessed by the CRHT after attending A&E following an overdose two months prior to his death. He was discharged by the Psychiatric Liaison Service (PLS). He was not thought to have been mentally impaired or experiencing a mental disorder. He was referred to the Community Mental Health Team (CMHT), wellbeing services and continued to receive support from his GP. On the day of the incident patient had argued with his wife over financial issues and had used an air rifle on his father in law. He was arrested and had suffered a number of seizures in police custody. It is unclear as to whether patient had a toxic ingestion of an unknown substance. He became bradycardic when he was with the ambulance crew just prior to arrival at hospital. He received prolonged resuscitation in A&E and a decision was made to stop CPR in conjunction with ITU team. COD: 1a Cocaine intoxication
Last known to older persons CMHT. Not known to ELFT services for over one year. Coroner requested an overview report of last episode of care. COD: 1a. Malnutrition 1b. Ischaemic heart disease, alcohol related liver disease, alcohol dependency
History of depression, alcohol dependence, hematemesis, overdoses, organic personality change. This patient was admitted to ward and discharged in January. She was then referred to the Recovery Team, the referral was declined and was found deceased 5 days later. CoD: TBC
Due to safeguarding concerns, the service user was being seen by the CRHT every evening and CMHT to make contact every day. 5 days before his death he had been found unconscious in a public place with spice in his system. He was informally admitted as an inpatient and discharged 2 days before he died. The CRHT attempted to make contact and found him deceased in his flat. COD: 1a Acute Cardiorespiratory Failure 1b Cocaine and Heroin Use 2 Confluent Bronchopneumonia
The deceased was last seen by mental health services in A&E two weeks before his death. No follow up was required. COD: 1a Hospital acquired pneumonia, 1b Heart failure, II) Neck of Femur Fracture (operated in 29/05/2021), Prostate Cancer, Congestive Cardiac Failure, Frailty
The deceased had been under the CMHT between January 2020 and March 2021. There had been concerns for mental health; alcohol use and domestic violence. Recent assessments had shown no acute mental illness and rather social stressors at home and was signposted to P2R to be followed up for management of drug and alcohol use. COD: 1a. Multiple Traumatic Injuries 2. Alcohol and Cocaine Misuse
The deceased had been moved out of borough due to risks from gangs. He had taken an overdose and was detained under section 2 MHA a month before his death; discharged from

hospital approximately 10 days later to an accommodation out of borough. The crisis team discharged him 3 days before death. He was found hanging in his property. COD: 1a Compression of the neck by ligature
The deceased was known to mental health services. He was admitted under section 2 of MHA at the end of July. He was an inpatient for 3 weeks and had been discharged into the care of the Community Recovery Team (CRT) and had been seen by a Consultant. He was found hanged at an address COD: 1a Suspension
The deceased was found hanging from a ligature tied to a tree in a park. Paramedics attended but death was confirmed on arrival. The deceased had been known to mental health services for many years. Following a deterioration in his mental health and his own thoughts of suicide he was admitted for 1 week in December 2020. He was diagnosed with an adjustment disorder and anxiety/depression. His medication was increased. He was discharged for a 72 hr follow up by the CRHT and back to the CMHT. He was assessed by a consultant psychiatrist by telephone (due to COVID19) in January 2021 and due to an oversight his next appointment was not arranged until May 2021. Apart from a welfare call to his wife in March 2021 there were no follow up appointments and no plan in place for support. COD: Asphyxiation , Hanging
Police were called after a carer found the deceased with a bag over her head. The deceased did not arrive for a scheduled coffee morning and this had raised concern from other residents. The residents attempted to cut the bag from the deceased's head and called the emergency services. The London Ambulance Service and the Police attended. COD: 1a Acute Hypoxic Ischaemic Encephalopathy and Drug Toxicity 2 Chronic Hydrocephalus due to partial Aqueduct Stenosis, Meningeal Fibrosis suggestive of prior Neurological Disease, COVID 19 infection

9.4 <u>Themes for Unexpected Deaths</u>

- Poor or no follow up after discharge from a ward and lack of appropriate referral
- Failure to document information on the patient electronic recording systems
- Poor or no communication between multi services, Drug and Alcohol; Psychiatric Liaison and Community Mental Health Services
- Failure to follow intermittent/general observation policy
- Nursing observations possibly not constant or effective
- Doctor not familiar with emergency grab bag
- Uncertainty on how to administer adrenaline
- Chest compressions being administered in incorrect body area
- Failure to monitor physical health observations and follow policy
- Poor record keeping
- Poor communication between professionals
- Poor assessments

9.5 Suicides and Homicide

There were a total of 26 suicides determined by concluded Coroner's inquests during the reporting period.

9.6 Themes from Prevention of Future Deaths Reports

The Trust received 5 Prevention of Future Deaths (PFD) between April 2021 and March 2022

1) A 32 year old woman jumped from her top floor home. Her father had called the crisis line in desperation the day before. It is unclear whether any alternative action by the crisis team would have changed the outcome.
    - The fathers call was not treated with the seriousness it deserved and the clinician then made no note of the call in the medical records, even retrospectively.

2) A 37 year old man had been reviewed by the CRT, his mental state had been found to be stable and he left the meeting. Over the course of the next 35 minutes a total of 13 calls had been made to the police concerning his assault of members of the public and walking into traffic. He proceeded to a venue where he was restrained by security guards. Police attended and found the man being restrained in prone position by security officers, he was unresponsive. The London Ambulance Service (LAS) attended and commenced advanced life support, he was taken to hospital where continued resuscitation was futile resulting in his death.
    - Failure to effectively monitor whether he was on a care programme approach (CPA).
    - Staff did not effectively review medical records prior to assessing him.
    - Failure to communicate important information between service and external stakeholders
    - Failure to document important information arising from an assessment
    - Incomplete action plan due to errors from the Trusts Governance Team
    - No evidence that the Trust had considered the necessity to make a referal to a regulator regarding the failings of staff within the CRT

3) The deceased was an 18 year old man who had a diagnosis of Autism and ADHD. He had been in the care of social services and living in supported accommodation from the age of 15. When he turned 18 he was moved to an independent living accommodation. He was the victim of cuckooing and alcohol and drug misuse. In May 2020 he was admitted to an adult ward after a spice overdose. He was discharged back to his own accommodation where he had been a victim of cuckooing and had made contact with a known drug user. He was found deceased in his flat 2 days later.

- Transition arrangements for individuals with high functioning autism were inadequate when he turned 18 and, as a result, he was not transferred to the appropriate adult mental health team for continued treatment and to enable provision of an appropriate adult social care package, including suitable accommodation for him.

4) The deceased was a 41 year old male inpatient who died alone in a seclusion room. He had been on continuous observation and was found in cardiac arrest with hypostasis.

- Nursing observations possibly not constant or effective
- Entrance to the seclusion room was not immediate as it was felt it would not be safe to do so
- Visibility was poor through the Perspex viewing panel , this had never been reported
- The rapid response team was not called immediately,
- Delay in entering the seclusion room
- Doctor not familiar with emergency grab bag and unsure how to administer adrenaline
- Chest compressions being given by a nurse on the abdomen

5) A 32 year old man was found unresponsive by nursing staff during hand over. Attempts by staff and paramedics to resuscitate him were unsuccessful.

- Failure to complete adequate search, the deceased was subject to a property search, yet he retained controlled drugs and a bracelet consisting of a ligature and a blade which had previously been seized by police.
- 15 minute intermittent observations were unreliable and falsified.
- Staff failed to both follow the Trust's Rapid Tranquilisation (RT) and Monitoring Policy and complete the documentation that is required to ensure patient safety post RT. The jury determined that this failure contributed to his death.

9.7 <u>Themes from Inquest Verdicts</u>

A review of all deaths heard at inquest has been undertaken and the following themes identified from the 91 concluded inquests conducted into unexpected deaths held during the reporting period as follows:

Themes:

- Poor or lack of communication
- Inadequate telephone response
- Inadequate assessments

- Failure to carry out observations according to policy
- Failure to record information
- Failure to complete an adequate search
- Failure to understand and provide emergency medical support

All of the above issues were identified in SI reviews, conducted into these deaths heard at Inquest. Associated recommendations and action plans have been developed to address these findings.

During the reporting period a total of 91 Coroner's Inquest were held and concluded.

10.00 Themes from Expected Deaths

10.11 Themes & Trends

The review looked at themes and trends from both expected and unexpected deaths across the Trust. The highest number of overall mortalities related to patients under Community Health Services.

There were more expected deaths than unexpected deaths. Unexpected deaths were higher in the Inpatient and Community Mental Health Services, where suicide was the highest figure. Outside of the higher numbers of overall reported deaths these findings are not unusual when compared to previous years' figures.

End of Life Pathway (ELP) and Preferred Plan of Care (PPC)

Over the period 1 April 2021 and 31 March 2022 there has continued to be a steady increase in the number of patients with an End of Life Plan (ELP) in place. Patients that did not have an ELP in place and available for review had either; deteriorated unexpectedly requiring an emergent hospital or hospice admission or the patient was referred to ELFT and died before being seen or they were patients who had contracted and died from COVID 19. Patients without an ELP were not specific to a single directorate or geographical area.

Age

The highest mortality rate was observed in the 76 – 100-year-old age group. Unsurprisingly, the highest number of deaths occurred with patients under Community Health Services. Deaths that occurred in patients' under the age of 18 were all under Specialist Children's Services and all had life limiting conditions.

Gender

Differences in the numbers of deaths in males and females were noted monthly throughout the reporting period. Variations in gender were minimal and when observed as a collective showed that overall only 6 more deaths were recorded in males than in females.

Standard of care

Care of the dying person was reviewed using the East London Foundation Trust (ELFT) Dignity in Care at the End of Life Practice Guidance and the Gold Standard Framework (GSF) Guidance.

Dignity in Care at the End of Life Practice Guidelines enables teams to develop a person centred holistic plan of care enabling patients to make their own choices on where they wished to be cared for and their preferred place to die.

The Risk and Governance team also review the quality of information being reported on the daily DATIX incident report including: missing information, missing patient details and any other required information.

The GSF sets out 7 domains of guidance including; communication; co-ordination; control of symptoms; continuity of care; continued learning; care support and care in the dying phase. These domains are reviewed under the SJR process.

Between April 2021 and March 2022 the case notes reviewed under the SJR process showed that in general the care delivered across the Trust met the requirements expected when caring for a dying person and that had a GSF in place.

Diagnosis and Cause of Death

The highest number of deaths was amongst cancer patients.

10.0 Conclusion

Altogether, the highest proportion of deaths at ELFT occur within Community Health Services. There is direct correlation in patient deaths where the morbidity rate of patients is highest and where the number of patients in receipt of palliative care is greatest.

During the reporting period there, sadly, have been a total of 26 deaths which were concluded at Inquest as being due to suicide. These incidents of death by suicide are a matter that the Trust is resolved to work toward preventing and reducing. The use of the National Confidential Enquiry into Deaths Toolkit is one of several mechanisms the Trust has adopted to support initiatives in this area.

During the course of the year the Learning from Deaths Group identified repetitions in themes arising following mortality reviews and moved to focus in greater depth on learning and driving improvements to end of life care planning and the revision of services where necessary.

The Trust participated in Dying matters Awareness Week including 4 Roadshows, Podcasts promoting End of Life Conversations. Online events including webinars and workshops.

The Learning from Deaths Group 2022- 2023 plan is to focus on;

I. Reviewing and evaluating End of Life Pathways to determine whether patients' preferences, including their wishes related to where they wish to die, have been met or not.

II. Engaging in partnership Learning from Deaths together healthcare providers including; GP's, hospitals and hospices.

III. Engagement with Homeless Services, Rough Sleepers Mental Health Project (RAMHP) and St Mungo's Homeless Charity to identify themes and issues in accessing palliative care and support at the end of life.

IV. Reviewing, with the aid of the Structured Review of Deaths Toolkit;

- Deaths on the national personal demographics spine against those reported on the Trust's incident reporting database (Datix)
- Individual case reviews
- Themes and trends identified from the process of care

V. Conducting High Level Strategic Reviews of all deaths to inform systems and planning processes.

VI. Embracing learning from PFD reports issued to other organisations where the patient safety of ELFT patients can be further enhanced.

VII. Consider ways of providing enhanced support to ELFT staff emotionally affected by the death of long term patients'/service users. The Trusts team of Serious Incident Reviewers will receive training in bereavement awareness to improve the support offered to families.

11.0 Recommendations

11.1 It is recommended that the Board receive and approve this report.

12.0 Action being requested

12.1 For noting and discussion

NHS
East London
NHS Foundation Trust

REPORT TO QUALITY ASSURANCE COMMITTEE
27 June 2022

Title	Serious Incidents Annual Report 2021/22
Period covered	01 April 2021 - 31 March 2022
Author	Charlotte Walton, Joint Interim Incidents & Complaints Manager, Abiola Ajayi-Obe, Associate Director Risk and Governance.
Accountable Executive Director	Dr David Bridle, Interim Chief Medical Officer

Purpose of the Report

To provide the Trust Board with an overview of the Trust's management of incidents and Serious Incidents over the past financial year.

Committees/meetings where this item has been considered

Date	Committee/Meeting

Key messages

- Incident reporting in the Trust has remained roughly unchanged in 2021/22 compared to the previous year, and only a small minority of those met the criteria to be escalated to SI reviews.
- The Risk and Governance team has identified key issues for learning from the SI reviews undertaken (and from the other reported incidents) which have led to specific action plans that are owned and monitored. The specific learning and themes have been shared to spread learning across the Trust through changes to processes/systems and Learning Lessons seminars, e.g. topics on observations on inpatient wards, discharge from inpatient units, medication errors, etc. There has also been a focus on learning from near misses.
- A large thematic review was undertaken together with the Coburn Centre in 2021/22 due to the pattern of datix incidents relating to violence there, and this led to helpful focus and learning that has been applied.
- A thematic review was also undertaken into Mental Health Inpatient deaths in 2021/22 which focused learning (and associated changes) on specific areas including physical health monitoring on the mental health wards and the need for a different solution to observations (e-observations and related training).
- There are delays in the completion of some 48 hour reports (73% completed within the NHSE threshold of 72 hours) which is now being addressed through refresher training for relevant staff and plans for incorporation in a QI project.
- The Risk and Governance team's capacity to conduct SI's within 60 days has been significantly impacted during 2021/22 by Covid-related factors and gaps in staffing in the team. Of the current SI reviews in progress, half are already over the 60 day threshold and there are further SI reviews to be allocated. Although the previous national threshold of 60 days for completion of SI reviews remains indefinitely suspended by NHS-E and CCGs, the importance of timely investigations is clearly recognised and the team is committed to re-establishing completion of SI reviews within 60 days during this year. This aim is feasible following the recent recruitment of 2 substantive reviewers alongside the use of trained bank reviewers. Mitigations have also been in place to ensure patient safety while there have been delays in completion of reviews – this has included ensuring that robust immediate learning and actions are implemented through the 48 hour reviews, a process of prioritisation of reviews and still ensuring early contact is made to

support and inform patients/family affected by any SI.

- We are expecting the publication of the new Patient Safety Incident Response Framework (PSIRF) soon, possibly by the end of June 2022. PSIRF will replace the SI framework and this change is part of the National Patient Safety Strategy. It is expected to take around a year to prepare and implement before the organisation switches over to it. A significant program of work will be set up to ensure the successful introduction of PSIRF in the Trust over the year ahead. We will be undertaking this in collaboration with other partners in our ICS (with the intention that all ICS partners switchover simultaneously) and in line with the national guidance.

Strategic priorities this paper supports

Improved population health outcomes	☒	Identifying patient safety risks and implementing systemic learning across the Trust to reduce risks and prevent reoccurrence.
Improved experience of care	☒	Ensuring the Trust meets Serious Incident Framework responsibilities and actions for dealing with Serious Incidents; that Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again and other statutory regulations e.g. Duty of Candour.
Improved staff experience	☒	Empowering and supporting staff in providing them with the correct tools, policies, procedures, documentation and training to improve patient safety.
Improved value	☒	Ensuring the Trust meets Statutory regulations and CQC guidelines. Monitoring accidents and incidents. Reducing potential risk where possible by providing robust control measures and in house training.

Implications

Equality Analysis	This report has no direct impact on equalities.
Risk and Assurance	This report provides assurance that incidents are appropriately reported and investigated, robust actions taken where necessary and learning is gained from investigations.
Service User/Carer/Staff	The recommendations and action plans pertaining to the incidents investigated as serious incidents have implications for service users, carers, staff and services across the organization.
Financial	There are financial implications regarding resource management & potential for litigation.
Quality	There are no implications for Quality Improvement raised in this report.

Glossary

Abbreviation	**In full**
A&E	Accident and Emergency
AEDs	Automated External Defibrillators
CHS	Community Health Services
Datix	Trust incidents and complaints reporting and management system
DoC	Duty of Candour
ELFT/ The Trust	East London NHS Foundation Trust
IG	Information Governance
IM&T	Information Management and Technology
MHS	Mental Health Services
NHSE/I	NHS England/Improvement
QI	Quality Improvement

PFD	Prevention of Future Deaths
SI	Serious Incident
SIR	Serious Incident Review
StEIS	Strategic Electronic Incident System (National SI reporting system)
STP	Strategic Transformation Partnership
TABI	Treatment and Brief Intervention

1.0 Background/Introduction

1.1 East London NHS Foundation Trust (ELFT) has contractual and statutory obligations to report on and appropriately manage all incidents reported to the Trust. This report provides Trust wide data on incidents and for the defined reporting period as well as over previous reporting time lines.

1.2 The Trust is committed to improving the services and care that we provide; learning from incidents and listening to feedback we receive from patients, their families and carers during serious incident reviews, helps us to identify areas where patient safety can be improved and ensure that actions are taken to prevent the same things happening again.

All incidents are overseen and supported by a dedicated, corporate team to ensure that processes and investigations are impartial, open, candid, facilitate learning and do not apportion blame. The Trust works closely with its commissioners to ensure adherence to the NHSE Serious Incident Reporting Framework 2015.

The Trust's Chief Medical Officer oversees incident management processes and the approval of all reviews.

1.3 This report covers the period from 1 April 2021 to 31 March 2022.

2.0 Learning from incidents

2.1 Incident themes

The main categories of incidents reported in this reporting period were:

1. Pressure Ulcer / Moisture Associated Skin Damage (4,282)
2. Treatment/Procedure (3,594)
3. Actual Physical Attack (2,356)
4. Death of an Adult Service User (2,276)
5. Threatening Behaviour (1,649)
6. Self-Harm (1,330)
7. Attempted Physical Attack (1,101)
8. Medication Incident (917)
9. Breach of Security (835)
10. Access or Transition Problem (765)

2.2 Serious incidents by type

SIs by Type

1. Death
2. Care & Treatment
3. Violence & Aggression
4. Slip, Trip or Fall
5. Children at Risk
6. Adult at Risk of abuse, neglect or exploitation

2.3 Serious Incident by Sub-Category

SIs by Sub-Category (Top 10)

1. Unexpected Death – Cause Unknown
2. Suspected Suicide – Strangulation
3. Unexpected Death – Cause Known
4. Pressure Ulcer
5. Suspected Suicide – Method Unknown
6. Suspected Suicide – Jumping from Height
7. Suspected Suicide - Medication Overdose
8. Suspected Suicide – Tube/Railway
9. Suspected Suicide – Drowning
10. Alleged Homicide by Service User

2.4 Serious incident review learning themes

Top Ten SI Review Learning Themes

1. Admin/process tasks
2. Issues relating to clinical care/failure to follow up
3. Issues with training, induction & supervision
4. Poor record keeping/ IT connection
5. Poor transition between services
6. Lack of engagement/involvement of carers / families
7. Discharge issues/ joined up working with external agencies
8. Safeguarding
9. Lack of engagement/communication with patients
10. Staff performance and capability (new)

2.5 Overview of Learning Themes

- Trustwide Learning Lessons Seminars are scheduled monthly throughout 2022/23. These address the various themes identified from SIRs in 2021/22 as follows:

  - Inpatient Management (incl. Observations)
  - Physical Health Management
  - Medication
  - Referral Criteria

- Service Adaptability
- Out of Area Inpatient Placement
- Discharge
- Safeguarding
- Clinical Risk Assessment
- Online Medication Purchase
- Autism
- Never Events and Near Misses

- A number of initial Datix incidents in 2021/22 gave rise to concerns about the number of incidents taking place within The Coborn Centre for Adolescent Mental Health relating to both Service User (SU) attacks on staff and Staff alleged attacks on SUs. In August 2021 a thematic review into The Coborn Centre was produced.

- In September 2021, a thematic review of Mental Health Inpatient Deaths identified four sets of action to ensure lessons are learnt from the findings (including those around care planning and co-production of safety plans, physical health monitoring of mental health patients, e-observations platform to replace a paper-based system and nurse training).

- In response to a PFD notice, the Patient Safety Forum directed the Trust on rapid improvement of Observations: Reinforcement the Existing Observation Policy; Frequent, local monitoring and reporting of observation practice; Observations audits; Nurse Observation Training Modules; Medical Records Training; and E-observations platform.

- A thematic review of the Treatment And Brief Intervention (TABI) Service is due to take place in 2022/23 in response to a number of incident investigations (Concise and SIRs) in 2021/22.

3.0 Service developments

3.1 Team and process developments

The Risk and Governance team's capacity to conduct SI's within 60 days has been significantly impacted during 2021/22 by Covid-related factors and gaps in staffing in the team. Of the current SI reviews in progress, half are already over the 60 day threshold and there are further SI reviews to be allocated. Although the previous national threshold of 60 days for completion of SI reviews remains indefinitely suspended by NHS-E and CCGs, the importance of timely investigations is clearly recognised and the team is committed to re-establishing completion of SI reviews within 60 days during this year.

Nonetheless, throughout the year we have continued to produce robust reports to tight deadlines; some investigations have been completed in as little as four weeks to meet inquest dates scheduled at relatively short notice whilst Coroner's strive to clear their Covid related backlog. We - have continued to strengthen processes in place to coordinate learning from incidents including:

- Staff support programmes have continued throughout the year including; psychological clinical supervision, group supervision and peer support.
- Two joint managers from within the team were appointed on an interim basis in January 2021 into the Head of Incident Management role, currently being substantively recruited into.
- In the event of an unexpected inpatient death, The Associate Director of Risk and Governance routinely meets with ward staff, to gain a better understanding of the impact on staff and provide reassurance and support around the serious incident review process.
- Undertaking Specialist reviews from trends identified through incident reporting. A specialist review of the Coborn Unit was completed in September 2021.

- Monthly SI meetings take place to share knowledge and learning from completed reviews.
- An Annual Trustwide Learning Lessons event was held in October 2021 in addition to adhoc Learning Lessons events held across several Mental Health directorates.
- Staff resumed face to face attendance at most inquests and at, family meetings, and feedback meetings in person.
- An annual programme of monthly Trustwide Learning Lessons has been scheduled commencing May 2022. Held on the last Wednesday of the month these sessions address various themes arising from SIRs.
- Five Bank reviewers were appointed in January 2022, three of which were formerly senior manager's within ELFT and NELFT. One was previously employed in ELFT's Legal Affairs Team. They altogether bring with them a wealth of valuable knowledge and experience.
- An out of programme experience, Trainee Psychiatrist is embedded within the Incident Team 4 days per week to obtain practical operational patient safety experience whilst assisting with Concise and Serious Incident Reviews and providing clinical expertise support to the team
- Interviews for two substantive Serious Incident Reviewers and a Head of Incidents Management will be completed by July 2022.
- Two new Band 4 Risk and Governance Assistant positions have been filled, providing much needed support to the Incident process and Datix Final Approvals for NRLS uploading.

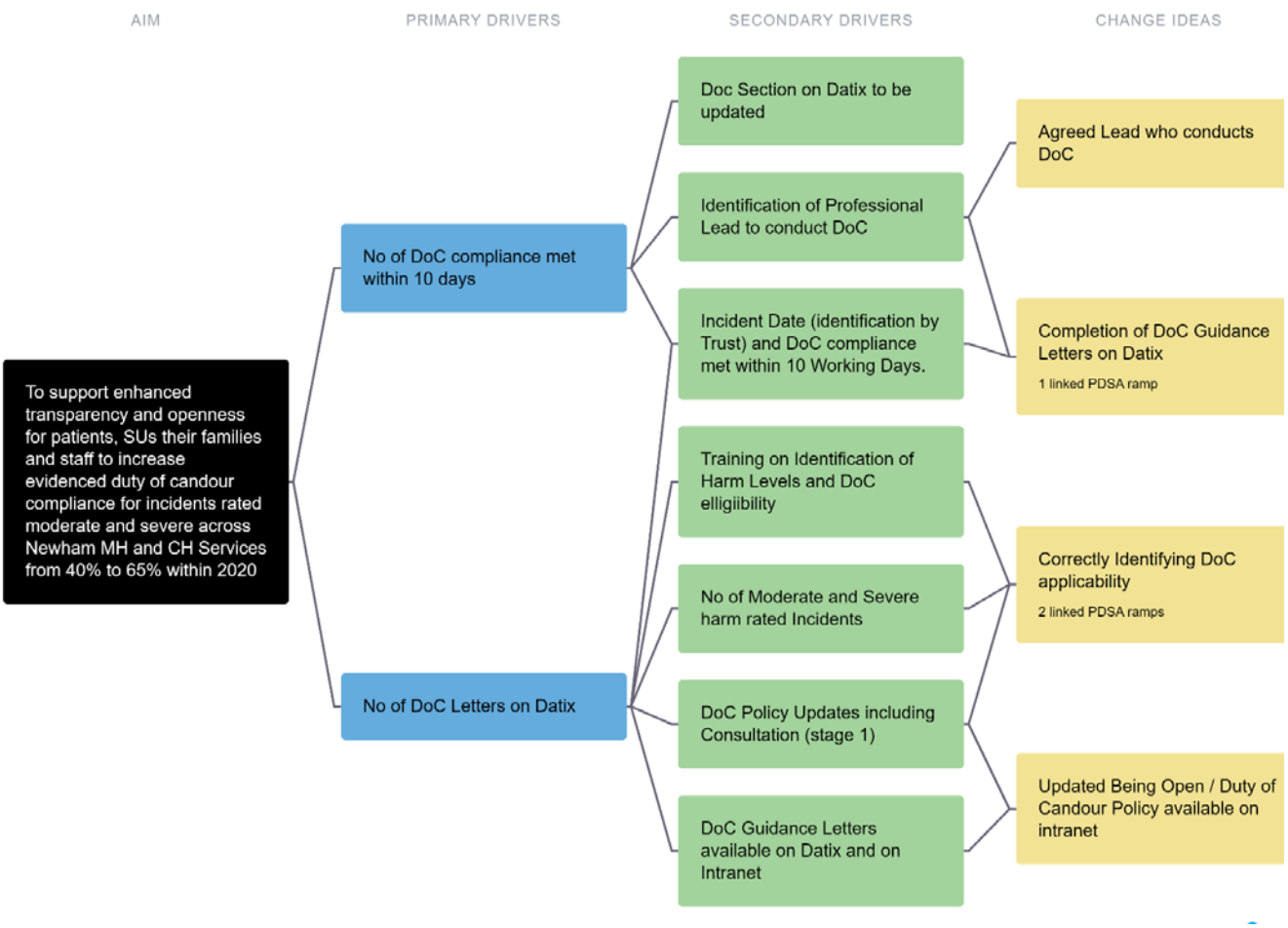
Forthcoming Initiatives

- The Patient Safety Incident Response Framework (PSIRF) will be introduced by end of June 2022. Currently the Trust is working alongside systems colleagues including; Clinical Commissioning Groups, North East London Foundation Trust (NELFT) Barts Health NHS Trust, Homerton Healthcare NHS Foundation Trust, Primary Care, Voluntary Sector and Local Authorities to set in place systems working arrangements between ourselves to support PSIRF working. Training for Trust staff will commence once NHSE formal guidance has been issued.

3.2 Family engagement liaison, namely in cases of unexpected deaths, continues to be well received. Where possible, the family/next of kin contact is identified and an introductory letter is sent explaining that an SI Review will take place. This has ensured timely notification of the SI Review process and ensured involvement of patients, families and carers in the reviews.

3.3 The Datix action module has been in use since June 2020 and will be utilized to analyse trends and further scrutinize the efficacy of actions included in incident reviews.

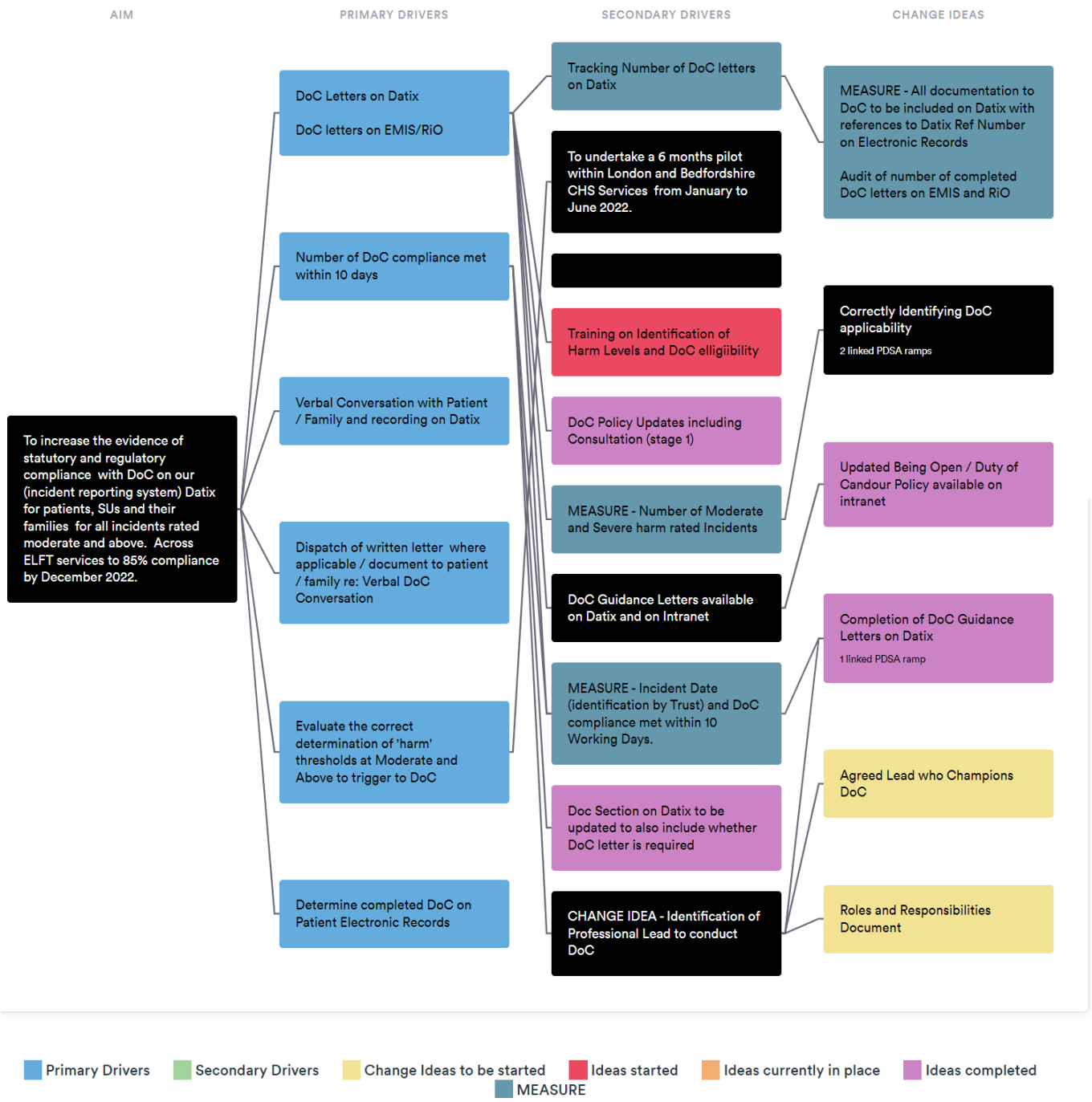
3.4 <u>Duty of Candour Quality Improvement Project</u>



The Trust has successfully implemented a Quality Improvement Project on Duty of Candour with the aim of supporting enhanced transparency and openness for patients, service users and their families by staff increasing ‘evidenced’ duty of candour compliance.

Due to the Trustwide applicability of the DoC Project initiatives it is actually a Qi Programme rather than a project. To accommodate Trust wide requirements, the Qi project has been extended to include Trustwide staff and user representation with the change ideas extended as the following updated driver diagram indicates.

Updated Driver Diagram with Change Ideas and Measurement Parameters :



The rationale for the Duty of Candour Quality Improvement Project is to ensure that the Trust Meets the regulatory requirements, for both stage 1 and 2 of duty of candour compliance. Although, the QI project is being tested in Newham Mental Health and Community Services the change ideas are being delivered Trustwide.

This QI Project's Change Ideas include;

<u>Identification of Agreed Leads for DoC across Trust Services</u> –

Update: DoC Champions have been identified across all Mental Health, Community Health Services and Corporate Directorates. *Local service DoC Champions are currently being trained.*

<u>Completion of DoC Guidance Letters on Datix</u> –
<u>Update</u>*:* This is now 100% complete*.*

<u>Training to Correctly Identify DoC Applicability</u> - *Duty of Candour Training Webinars, inclusive of*

'good' and 'poor' examples of how to conduct Duty of Candour conversations to meet the stage 1 requirements of Duty of Candour has been developed. The Webinar also includes resources for Trust staff to use to ensure correct compliance with the regulatory requirements.

Update*:* Training Webinars have been delivered Trustwide across Mental Health and Community Health Services. A total of 113 staff members attended Duty of Candour Train the Trainer sessions to enable them to facilitate and deliver DoC training to their teams. At the time of reporting, 95 staff within the directorates, have received Delivering DoC training.

Updated Being Open / DoC Policy

Update: The Policy has been updated and is available on the intranet.

Two, newly identified, Change Ideas are yet to be completed including; Agreement on the DoC Directorate Champions and the finalizing of the DoC Roles and Responsibilities document.

3.5 Covid-19 response

In response to the challenges of both waves of Covid-19, and the pressures on clinical staff to deliver safe care, the Trust temporarily revised the investigation thresholds for incident management and SI review processes, with the agreement of Trust Commissioners, to enable staff to focus on the provision of front line patient care. The revised thresholds and investigation parameters included a focus on conducting reviews into all cases of unexpected deaths through table top reviews. The aim of this approach was to ensure a balance between maintaining higher level Patient Safety Review thresholds for investigations and supporting safe operational delivery.

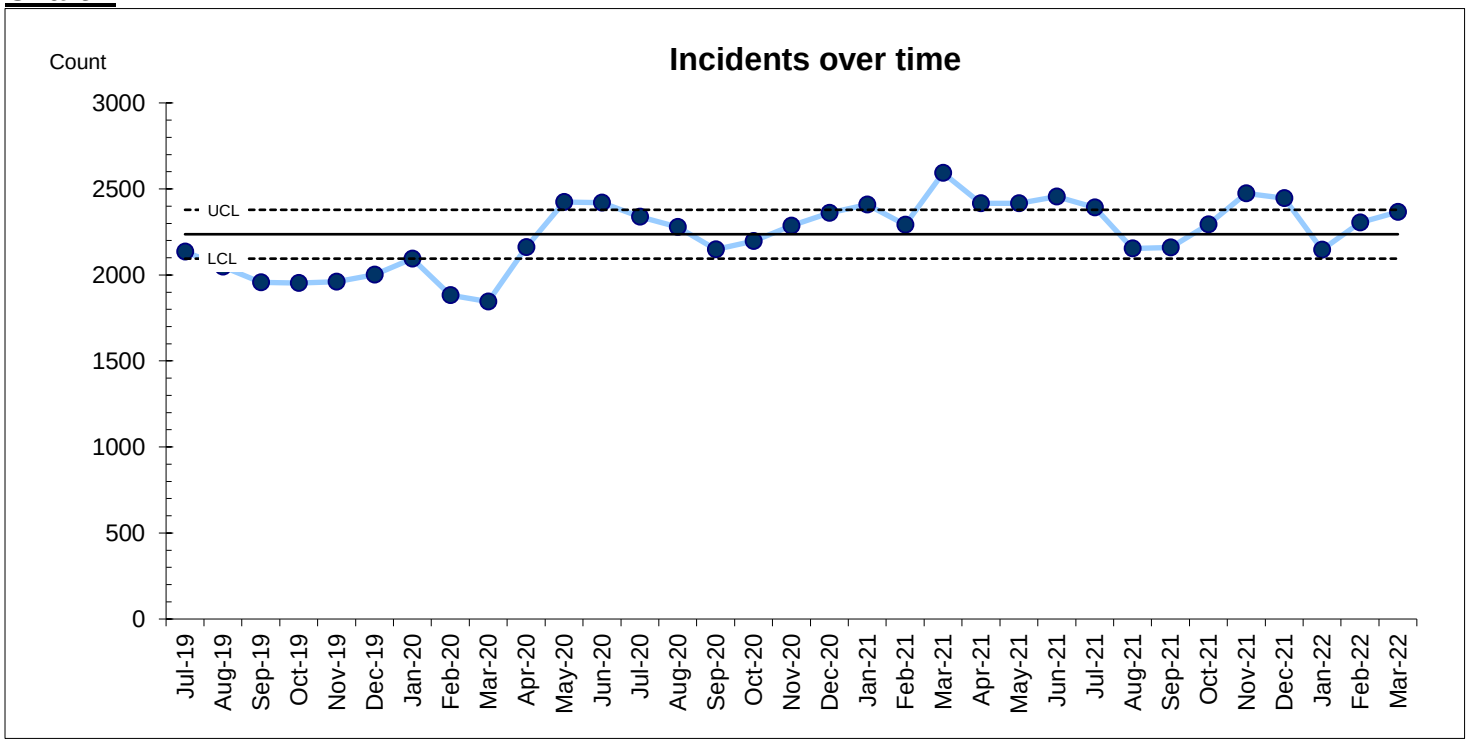
Notably, throughout the pandemic, the Trust continued to triage all issues of patient safety, practitioner performance and safeguarding matters, on a daily basis with clear lines of escalation through to Trust Patient Safety Executives (Chief Medical Officer and Chief Nurse) to ensure that the most serious of incidents were appropriately managed and safe patient care maintained.

This revision to the usual reporting threshold ended on the 31st March 2021 and we are now in the process of reverting back to normal timescales.

4.0 Incidents Data

4.1 Incidents reported monthly over time

Chart 2



28,112

new incidents were reported across the Trust between April 2021 and March 2022. An **increase** of **206** on the previous year.

Table 2- Total incidents reported by Trust Directorate (historical data included)

Directorate	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Bedfordshire MHS	166	140	169	163	142	223	172	153	140	173	134	151	162	144	157	136	181	157
City & Hackney MHS	219	202	224	231	232	269	242	306	278	280	276	322	371	331	352	191	278	310

CHS Combined	867	903	867	1000	889	941	873	824	872	827	758	706	797	809	888	819	781	851
Corporate	7	3	3	3	7	3	1	4	7	3	3	3	3	4	5	2	3	3
Forensic Services	265	232	265	254	227	311	297	256	269	218	223	216	224	282	281	239	208	185
Luton MHS	182	181	173	166	183	187	182	186	163	160	154	122	114	176	125	177	137	165
Newham MHS	155	189	229	206	184	182	199	195	247	271	180	195	218	236	257	169	219	210
Specialist & CHN Children's Services	178	227	238	199	212	218	191	265	220	188	195	167	149	166	109	144	149	171
Tower Hamlets MHS	153	195	186	177	208	229	189	215	233	259	220	257	241	290	257	254	325	298
Primary Care	5	15	6	10	7	29	71	13	26	14	11	21	14	36	16	15	24	17
Total	**2197**	**2287**	**2360**	**2409**	**2291**	**2593**	**2417**	**2417**	**2455**	**2393**	**2154**	**2160**	**2293**	**2474**	**2447**	**2146**	**2305**	**2367**

Table 3- Incidents to population ratio (incidents:100,000)

Period	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Population (approx.)	1,659,900																	
Total Incidents	2197	2287	2360	2409	2291	2593	2417	2417	2455	2393	2154	2160	2293	2474	2447	2146	2305	2367
Ratio:100,000	132	138	142	145	138	156	145	145	147	144	129	130	138	149	147	129	138	142

4.2 Incident approval process and timescales

All incident reports require approval by the manager of the service submitting the form. This approval should take place within 48 hours of the incident being reported on Datix to ensure the quality, accuracy and completeness of incident reports. The incident approval process is an important part of the learning lessons process to allow managers to take action on any issues and identify areas of risk or weaknesses during the approval process.

Of the 28,112 incidents reported on Datix in this reporting period, 76% were approved by the manager within 48 hours.

Table 4- Overdue incident approvals

Directorate	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Bedfordshire MHS	52	68	42	38	27	38	40	20	25	27	41	29	37	32	42	44	42	38
City & Hackney MHS	82	92	118	120	189	201	126	46	65	45	82	80	79	120	113	64	98	100
CHS Combined	120	111	129	114	168	172	156	146	147	136	131	183	128	167	173	166	160	140
Corporate	20	8	8	10	13	10	9	2	7	9	11	14	14	12	12	13	13	14
Forensic Services	37	65	38	29	32	33	30	37	55	28	52	43	67	79	64	55	78	27
Luton MHS	29	41	31	51	13	25	23	20	21	21	31	16	12	25	17	20	38	34
Newham MHS	28	36	61	43	28	30	12	20	24	21	39	39	30	47	65	63	29	24
Primary Care Services	21	6	5	13	1	10	33	9	26	17	5	2	4	33	14	11	8	9
Specialist & CHN Children's Services	43	120	226	162	148	137	227	230	172	26	112	44	46	69	133	60	113	143
Tower Hamlets MHS	49	37	38	33	84	108	87	72	23	24	48	47	55	81	52	34	37	61
Total	**480**	**584**	**696**	**613**	**703**	**764**	**743**	**602**	**565**	**354**	**552**	**497**	**472**	**665**	**685**	**530**	**616**	**590**

4.3 48hr reports

When an incident potentially meets the serious incident threshold or further information is required to ascertain the extent and harm caused by an incident, the Chief Medical Officer, Chief Nurse or nominated deputies will request a 48 hour report. The fundamental purpose of the 48hr report is to obtain further information about the nature of an incident, the seriousness of the consequences, the remedial action taken, the learning that has taken place and identify any need for further investigation.

Table 5- 48hr reports status

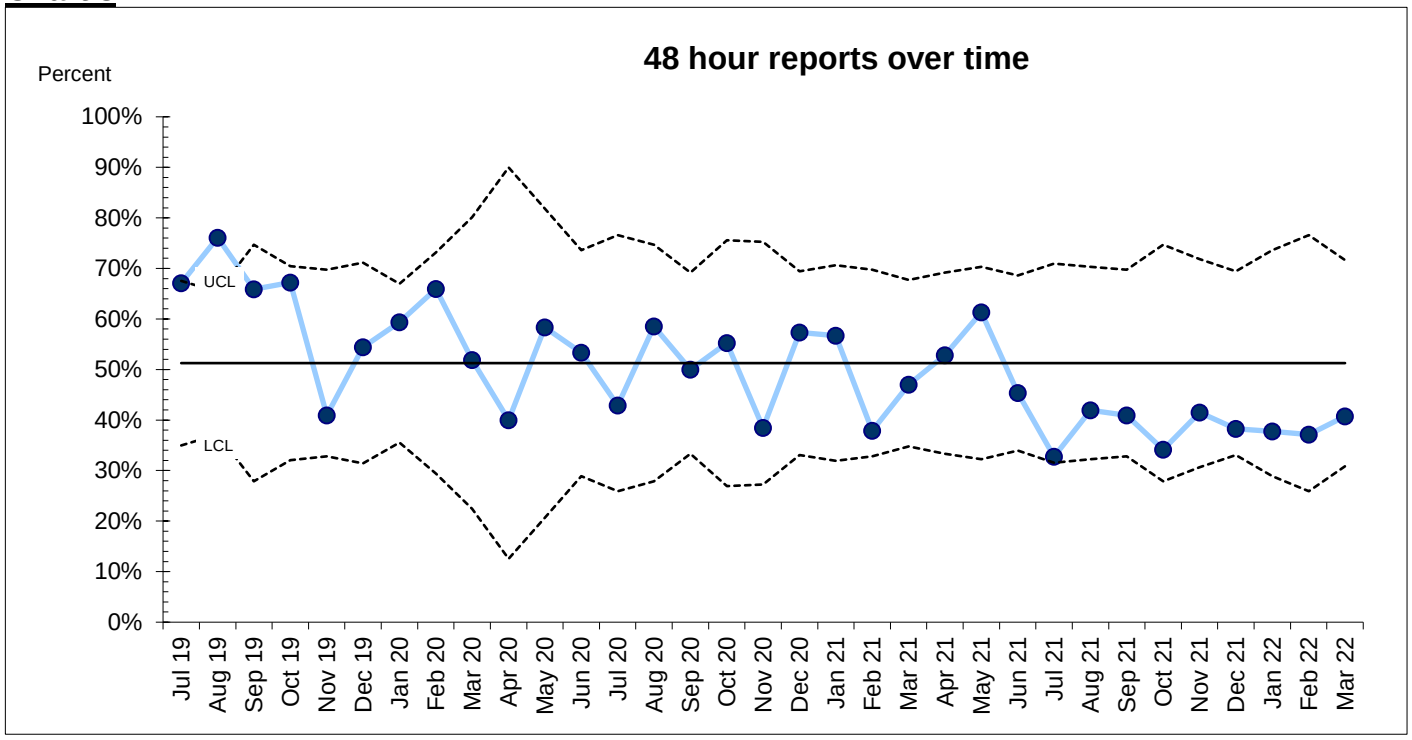
48hr reports	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Total requested	38	39	68	60	66	83	70	62	75	58	62	66	41	53	68	45	35	54

Received on time	21	15	39	34	25	39	37	38	34	19	26	27	14	22	26	17	13	22
Received overdue	17	24	29	26	41	44	33	24	41	39	36	39	27	31	42	27	22	32

Table 6- Overdue 48 hour reports by Directorate

Directorate	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Bedfordshire MHS	8	3	3	4	2	8	7	2	5	2	7	7	2	2	7	4	4	4
City & Hackney MHS	1	1	5	2	5	9	5	3	5	6	5	9	3	8	2	3	6	2
CHS Combined	0	0	5	5	1	2	3	2	4	4	4	4	3	3	5	2	0	1
Corporate	1	1	0	0	2	0	0	0	0	2	0	0	0	0	1	0	0	0
Forensic Services	1	2	6	3	1	6	6	3	5	5	1	3	1	3	8	5	1	4
Luton MHS	1	3	3	3	8	5	4	4	3	5	2	8	5	4	4	2	0	10
Newham MHS	1	5	5	3	5	3	3	3	7	5	4	3	4	2	3	3	6	3
Specialist & CHN Children's Services	1	3	1	2	4	4	1	2	4	3	5	1	2	3	3	4	1	3
Tower Hamlets MHS	3	6	1	4	10	6	3	5	7	5	8	4	7	6	8	4	4	5
Primary Care Services	0	0	0	0	1	1	1	0	1	0	0	0	0	0	0	0	0	0
Total	**17**	**24**	**29**	**26**	**41**	**44**	**33**	**24**	**41**	**39**	**36**	**39**	**27**	**31**	**42**	**27**	**22**	**32**

Chart 3



Of the 28,112 incidents reported in this reporting period only

2.4%

(689) were escalated to 48 hour reports of which 295 were received on time.

This was a **16% increase** on the number requested in the previous year (578).

During Wave 1 and 2 of the Covid 19 pandemic the threshold for requesting a 48 hour reports increased to only those where moderate or severe harm had been caused.
Currently 73% of 48 hour reports are being produced within 72 hours. i.e. The NHSE threshold requirement for the completion of After Action Reviews. In line with the SI 2015 Framework. A meeting with Clinical Directors has identified the need for refresher training on the rationale and process for completing 48 hour reports. And update training on the robust completion of Datix Incident forms which will negate the need for specific 48 hour report requests, as correctly completed Datix Forms will provide the required information on early learning and immediate actions following an incident occurring. A Qi Project has been identified for SI Process Management including the appointment of SI Sponsors which will further support the timely completion of 48 hour reports.

4.4 Concise reviews & reports

Concise reviews are an opportunity for the Trust to investigate incidents that may not meet the NHSE SI framework criteria for a reportable serious incident but provide learning opportunities for the Trust. These are conducted by the directorates and consist of a review of the incident and preceding circumstances (patient details, care provided, who and what was involved etc.), an investigation report and a supporting action plan.

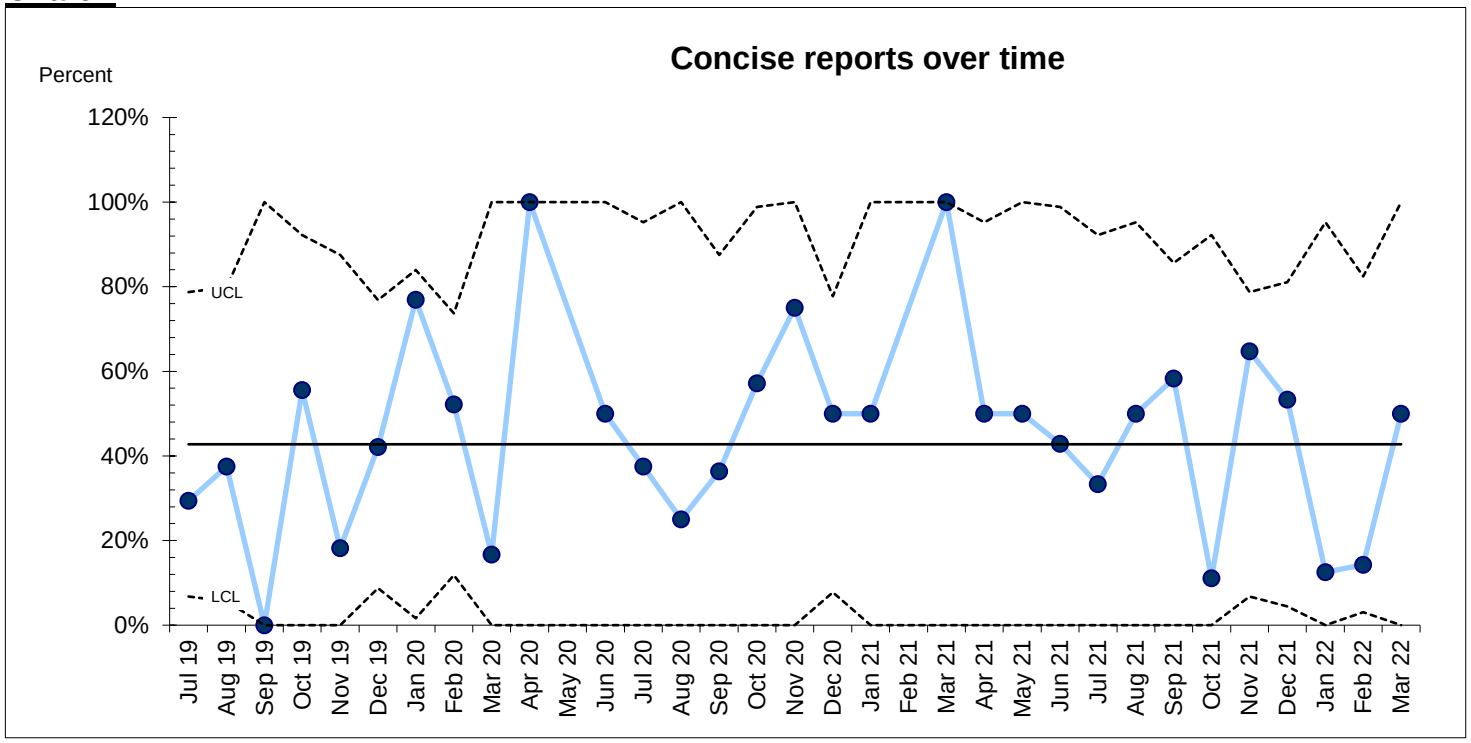
Table 7- Total Concise reviews/reports requested by Directorate

Concise reports	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Total requested	7	4	18	2	0	1	8	4	7	9	8	12	9	17	15	8	14	6
Received on time	4	3	9	1	N/A	1	4	2	3	3	4	7	1	11	8	1	2	3
Received overdue	3	1	8	1	N/A	0	4	2	4	6	4	5	8	6	7	7	12	3

Table 8- Overdue Concise reviews/reports by Directorate

Directorate	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Bedfordshire MHS	0	0	2	0	N/A	0	3	2	0	0	0	1	4	0	1	1	3	0
City & Hackney MHS	1	0	1	0	N/A	0	1	0	1	2	1	0	0	0	3	0	3	1
CHS Combined	0	0	1	0	N/A	0	0	0	1	1	0	1	2	0	0	0	0	0
Corporate	0	0	0	0	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services	0	0	0	0	N/A	0	0	0	1	0	1	0	0	0	1	1	2	0
Luton MHS	1	0	1	0	N/A	0	0	0	0	0	2	0	0	3	0	1	2	1
Newham MHS	0	0	1	1	N/A	0	0	0	1	1	0	1	1	0	1	1	1	0
Specialist & CHN Children's Services	0	0	0	0	N/A	1	0	0	0	0	0	2	1	2	0	0	1	0
Tower Hamlets MHS	1	0	2	0	N/A	0	0	0	0	2	0	0	0	1	1	2	0	1
Primary Care Services	0	1	0	0	N/A	0	0	0	0	0	0	0	0	0	0	1	0	0
Total	**3**	**1**	**8**	**2**	**N/A**	**1**	**4**	**2**	**4**	**6**	**4**	**5**	**8**	**6**	**7**	**7**	**12**	**3**

Chart 4



117

Concise reviews were requested in the reporting period (0.4% of the total incidents reported), of which 49 (41%) were completed to timescale.

The number of reports requested has increased by 95% on the previous year (60).

Serious incidents reported monthly

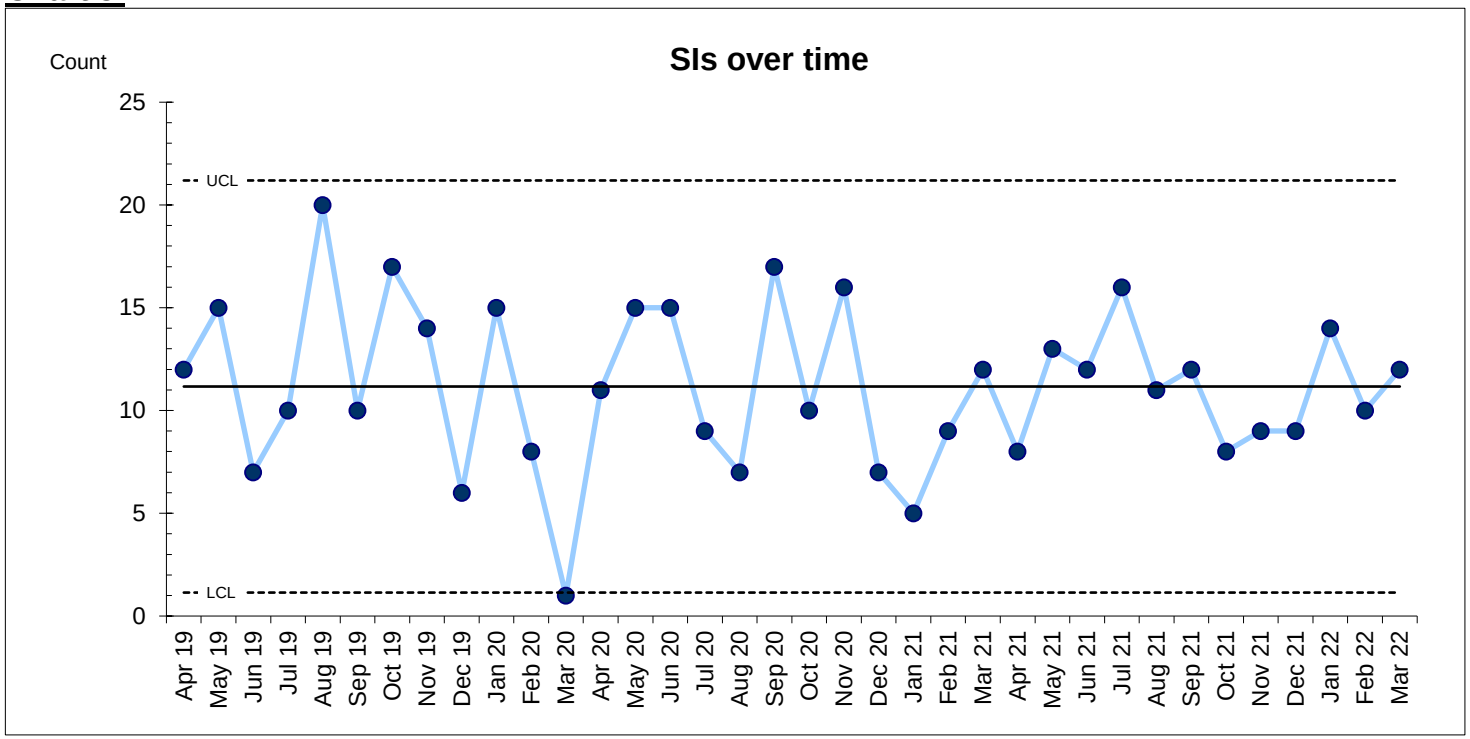
Table 9- SIs reported monthly by directorate (over time)

Directorate	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Bedfordshire MHS	4	2	1	1	0	1	1	2	5	5	3	2	3	4	1	3	2	2
City & Hackney MHS	0	2	0	3	1	2	0	3	2	4	1	4	1	2	2	1	4	2
CHS Combined	0	2	1	0	3	2	2	2	1	1	3	1	0	0	1	1	1	0
Corporate	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services	0	1	2	0	0	0	0	0	0	3	0	0	0	0	0	1	0	1
Luton MHS	2	1	1	0	1	2	2	1	2	0	2	2	1	1	1	4	0	2
Newham MHS	2	4	1	0	0	2	0	2	0	1	2	0	1	1	1	0	2	2
Specialist & CHN Children's Services		2	1	0	2	1	1	1	1	0	0	1	1	1	0	1	0	1
Tower Hamlets MHS	1	2	0	1	2	1	2	1	1	2	0	2	1	0	3	3	1	2
Primary Care Services	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Total	**10**	**16**	**7**	**5**	**9**	**12**	**8**	**13**	**12**	**16**	**11**	**12**	**8**	**9**	**9**	**14**	**10**	**12**

Table 10- Serious Incidents (SI) to population ratio (SI:100,000)

Period	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Population (approx.)	1,659,900																	
Total SI	10	16	7	4	9	12	8	13	12	16	11	12	8	9	9	14	10	12
Ratio:100,000	0.6	1.0	0.4	0.2	0.5	0.7	0.4	0.7	0.7	1.0	0.6	0.7	0.4	0.5	0.5	0.8	0.6	0.7

Chart 5



134

Incidents (0.5% of total incidents reported) were raised to serious incidents.

During Wave 1 and 2 of the Covid 19 pandemic corporate SIs were only requested where there was evidence that severe harm had been caused. Usually this would be due to an unexpected death or a homicide. Other requests for SIs were reviewed by the Chief Medical Officer /Chief Nurse on an individual basis.

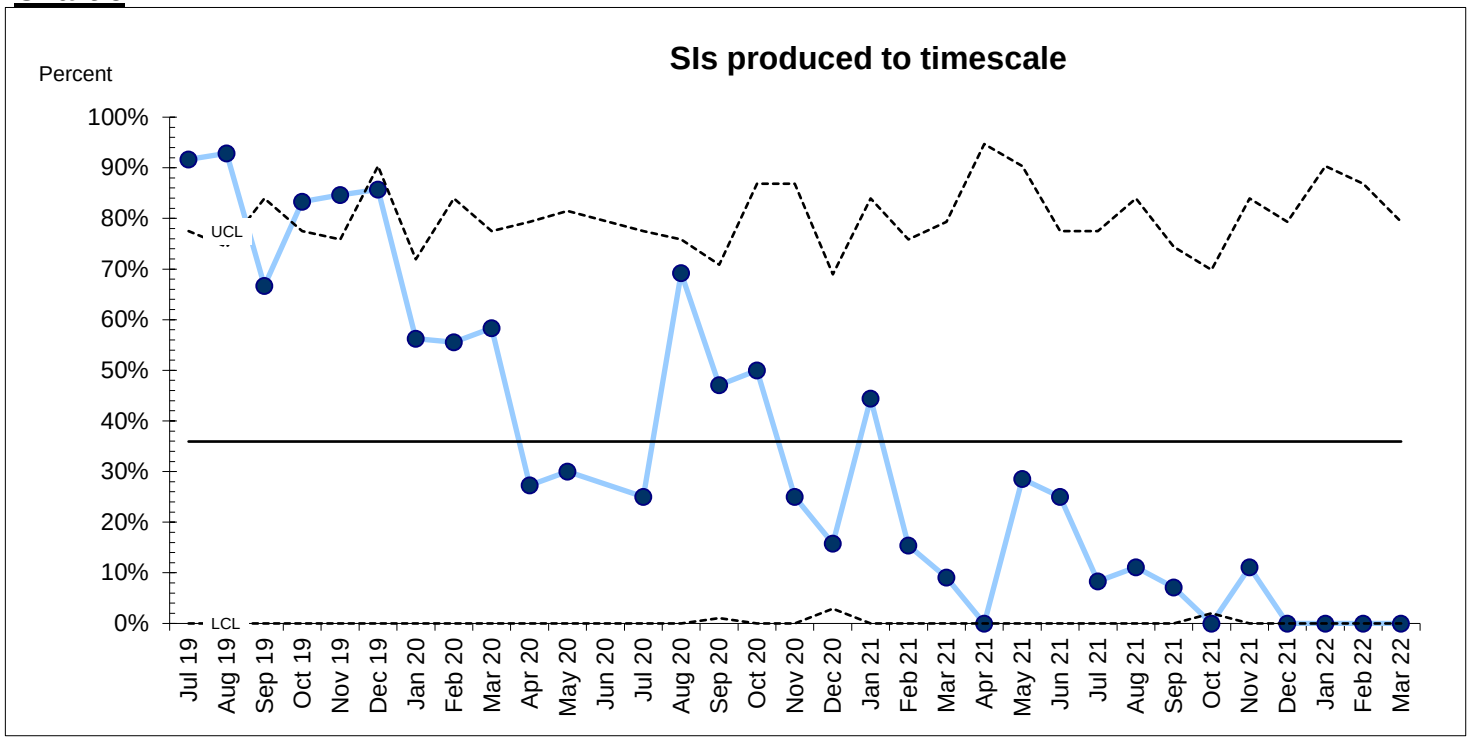
4.6 Adherence to SI review process and timescales

The time frame for completing a serious incident investigation is set by NHS Improvement at 60 working days as prescribed in the NHSE SIF. The Trust's Commissioners monitor compliance via the Strategic Executive Information System (StEIS). During Wave 1 and Wave 2 CCG's agreed to blanket extensions owing to the pressures on clinical staff.

Table 11- SI reports- adherence to timescales

	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Total SI due in month	9	8	19	9	13	11	6	7	12	12	9	14	18	9	11	7	8	11
Produced to timescale	3	2	3	4	2	1	0	2	3	1	1	1	0	1	0	0	0	0
Overdue	6	6	16	5	11	10	6	5	9	11	10	13	18	8	11	7	7	11

Chart 6



During the Wave 1 and 2 COVID 19 pandemic staff ability to do extra duties i.e. act as investigators; give witness statements, conduct in patient safety investigations was severely limited and therefore achieving the 60-day investigation timeline was not always feasible. NHSE and CCGs continue to support SIRs being produced outside of the 60 day thresholds in recognition of pressures all Trusts are under to produce reports to this threshold. The Governance and Risk Team are prioritising for investigations, SIRs related to unexpected deaths and due to be heard at Coroners Court. This has resulted in some cases, of SIRs being produced within as little as 3 weeks, creating huge additional pressures to the SI Lead Reviewer Authors, due to Inquest timetables and short notification of inquest dates from Coroners Courts. This has had a knock on effect with those SIRs not related to deaths. With respect to SIRs not going to Inquest - immediate learning and action plans are identified in the 48 hour reports received from services. 73% of which are received within 72 hours. The Trust has recently appointed 2 substantive SI Lead Reviewers taking the substantive SI Lead Reviewer team up to its full establishment of 5, the first time full establishment has been reached since May 2020. Both new appointments will be in post by end of September 2022. It will take a while for the new SI Lead Reviewers to understand Trust investigation processes until they can comfortably hold a case load of 9 SIRs to investigate and thereby reducing the current SIR backlog of 27 cases which are yet to be allocated at the time of writing.

4.7

National Reporting and Learning System (NRLS)

The Trust has continued to submit patient safety incidents to the NRLS in line with national reporting requirements during the period 01 April 2021 to 31 March 2022.

Table 12 details the number of incidents exported from the Datix Risk Management system to the NRLS portal for each month, meeting the twice yearly NRLS May and November deadlines.

Table 12 - Incidents submitted to the NRLS by month.

Period	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
NRLS Incident Uploads	807	2460	784	707	651	958	1119	2072	1139	707	591	810	1509	784	1144	900	936	843

The graph at Chart 7 details the numbers of incidents by severity reported to the NRLS over a 3-year period from 2018 to 2021.

The number of incidents uploaded to the NRLS has fluctuated from 8496 in 2018, 12198 in 2019 and 10515 2020 (for each financial year)

Chart 7 - Incidents exported to the NRLS for the period of 01 April 2019 to 31 March 2022 by Severity

(To note moderate harms exported to the NRLS include pressure ulcers acquired outside of the Trust)

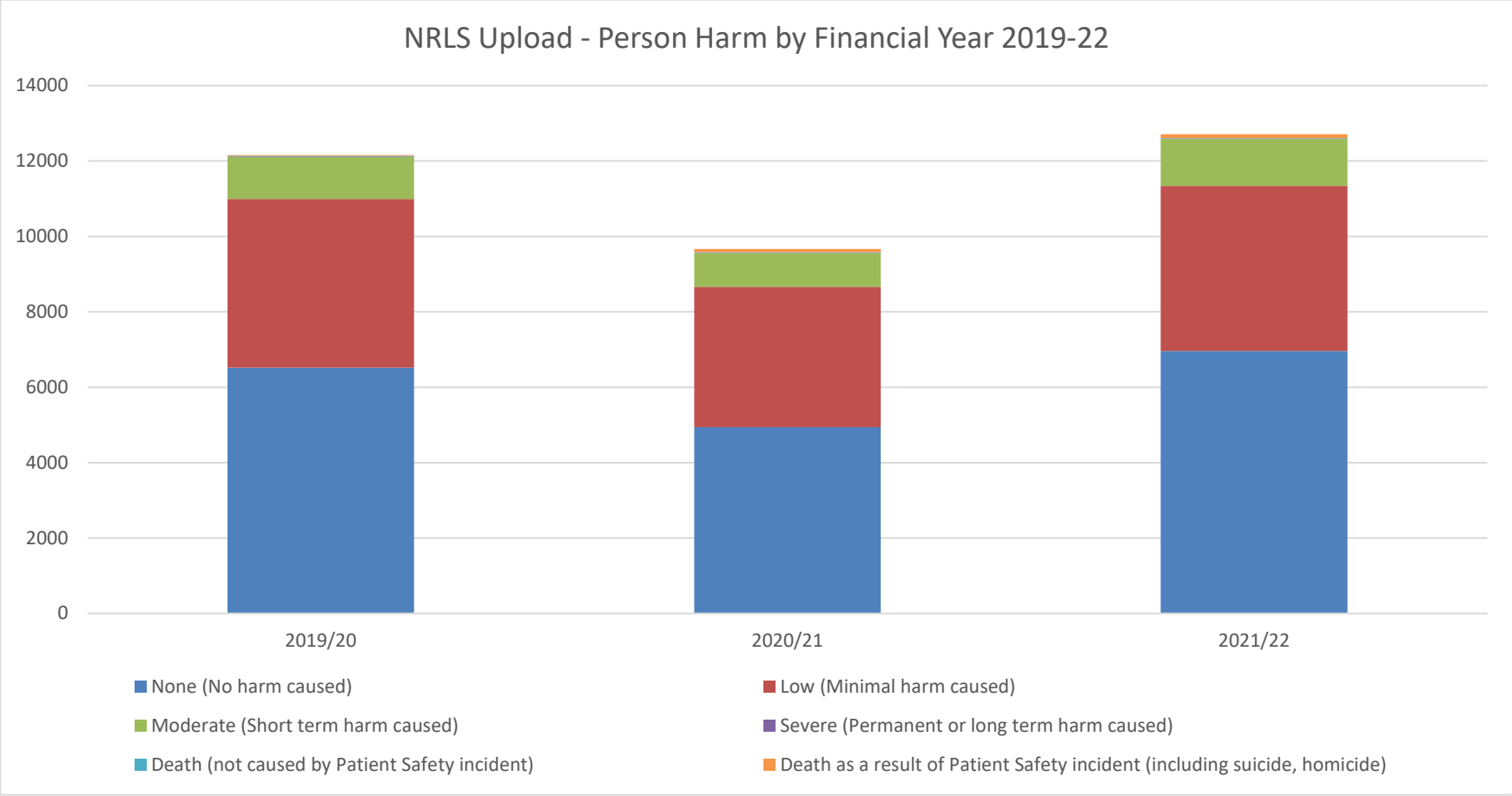
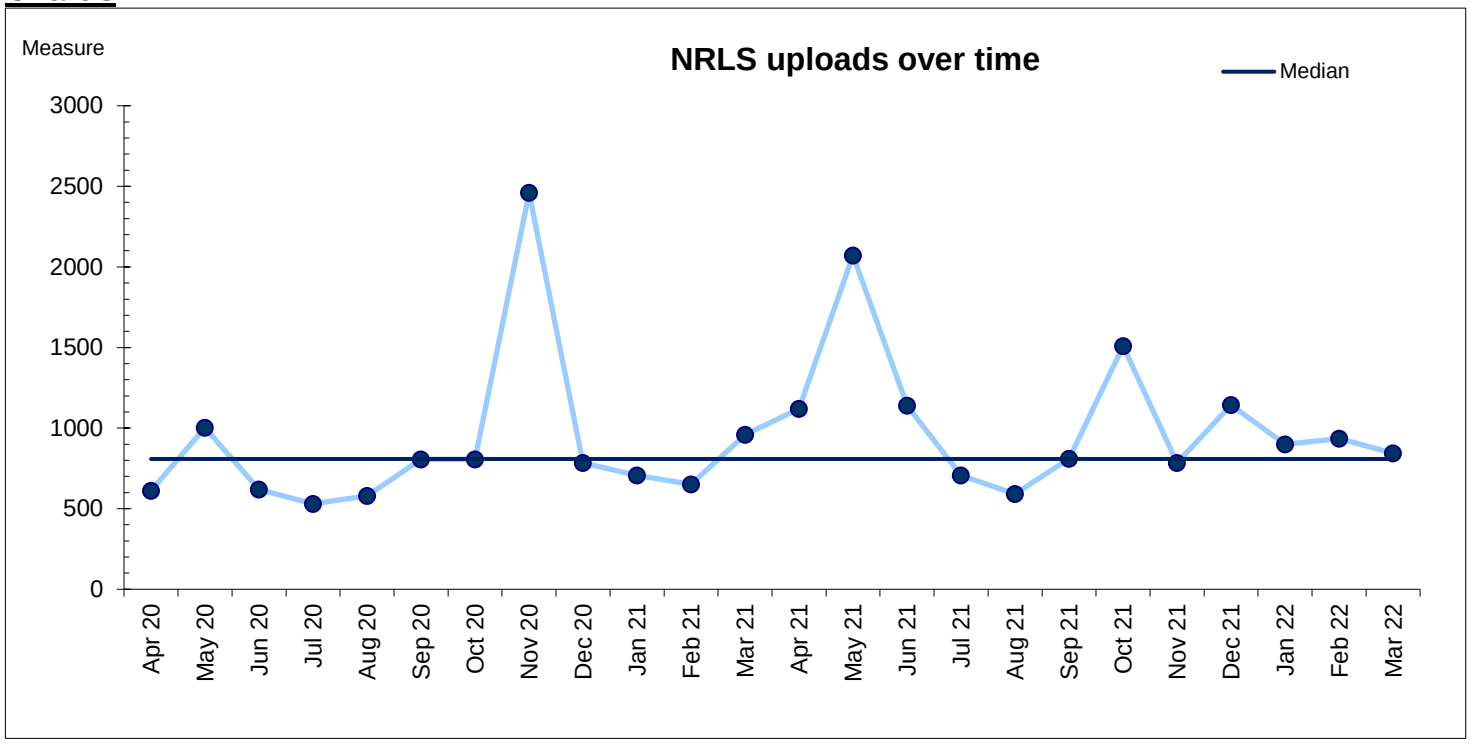


Chart 8



Of the 28,112 reported incidents, the Trust uploaded

12,554 (44%)

eligible patient safety incidents to the NRLS during the reporting period.

5.0 Recommendations

5.1 None.

6.0 Action being requested

6.1 The Board/Committee is asked to:

a. The Board is asked to receive and approve this report.

b. Note the assurance provided and consider if further sources of assurance are required.

NHS
East London
NHS Foundation Trust

ANNUAL REPORT TO THE QUALITY COMMITTEE

27 June 2022

Title	Safeguarding Annual Report 2022-23
Authors	Claire McKenna – Director of Nursing Dinh Padicala- Associate Director for Safeguarding Adults and Lead for Domestic Abuse and Prevent. Tim Bull – Associate Director for Safeguarding Children
Accountable Executive Director	Lorraine Sunduza, Chief Nurse/Deputy CEO

Purpose of the Report:

This is the fourth combined adult and children Safeguarding Annual Report that has been adopted in line with the Trust's shared safeguarding strategy. Its purpose is to inform Trust Board members of the progress with regard to its responsibilities for safeguarding adults and children's activity as part of its regulated and statutory responsibilities, and to ensure that patients, service users and carers know that safeguarding of children and adults is a Trust priority. This includes the achievements, main areas of development and challenges for safeguarding during 2021-2022.

Summary of Key Issues:

The Corporate Safeguarding team is seeing an increase in the complexity of concerns being bought to their attention requiring complex mental capacity assessments and legal support. A number of cases required intensive support from the team to ensure the risk to the service user is appropriately managed and the person's views and wishes are adhered to. The team has achieved positive outcomes for service users by working in partnership with key agencies.

Despite the impact and challenges faced over the last twelve months by Covid-19 we are assured that there has been no disruption to safeguarding provision and service provision across the Trust. We continue to make good progress in relation to our ambitions as set out in our 20/21 Annual Report.

Safeguarding children, young people and adults cannot be done in isolation; it is only truly effective when we work collaboratively and restoratively with our partner agencies to 'Think Family' and protect all those at risk of harm, abuse or neglect. This Trust wide approach is being embedded across all of our services, whilst focusing on developing evidence informed approaches to safeguarding practice that balances the rights and choices of an individual, with the Trust duties to act in their best interest to protect the patient, the public and the organisation from harm.

Safeguarding is a complex area of practice and the team is made up of a diverse and multi-professional team, who provide specialist and expert safeguarding training, advice, support and supervision to all Trust employees to fulfil their safeguarding responsibilities and duties on a wide range of safeguarding issues affecting the unborn, children, young people transitioning, the working age and the older people across the trust. The Corporate Safeguarding Team strive to ensure all safeguarding processes are robust and effective;

we are responsive to the emerging local and national needs. This report illustrates how the Trust has met it's safeguarding responsibilities

Strategic priorities this paper supports

Improved patient experience	☒	Work around Making Safeguarding Personal (MSP) and Think family agenda is likely to improve experience
Improved health of the communities we serve	☒	Promotion of early identification of safeguarding risks and embedding learning from safeguarding incidents
Improved staff experience	☒	Improved confidence in safeguarding processes to support service users
Improved value for money	☒	Providing combined adults and children's training and supervision to enable staff to 'Think Family'

Committees / Meetings where this item has been considered:

Date	Committee / Meeting
27/06/2022	Quality Committee

Implications:

Equality Analysis	This report provides an overview of actions the safeguarding team have taken to identify inequalities that can contribute to vulnerabilities of service users and strategies to address these.
Risk and Assurance	The report provides assurance of the monitoring and understanding the occurrence of safeguarding practices and incidents with learning lessons.
Service User / Carer / Staff	Positive service user impact
Financial	Review of team from external review resulting in increase of resources.
Quality	Increase in quality displayed through audit.

Supporting Documents and Research material

INTERCOLLEGIATE DOCUMENT- Adult Safeguarding: Roles and Competencies for Health Care Staff (2018)
INTERCOLLEGIATE DOCUMENT - Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Forth Edition (2019)
Care Act 2014 and support statutory guidance 2016 and 2020
Children act (1989, 2004)
Working Together to Safeguard Children (2018)
Children and Social Work Act (2017)
CQC registration standards, Health and Social Care 2008 (Regulated activities) Regulations 2014:Regulation 13
CQC national standards of quality and safety-Outcomes 7-11: Essential standards of quality and safety.

Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (2019)
Safeguarding Allegations Policy - Management of Safeguarding Children and Adults Allegations against Staff and Volunteers
Serious Crime Act (2015)
Modern Slavery Act (2015)
Counter-terrorism and Security act (2015)

Glossary

Abbreviation	In full
ELFT	East London Foundation Trust (the Trust)
LSCP	Local Safeguarding Children Partnership
LSAB	Local Safeguarding Adults Board
CAMHS	Child and Adolescent Mental Health Services
CMHT	Community Mental Health Team
LeDeR	Learning Disabilities Mortality Review programme
WRAP	Workshop to Raise Awareness of Prevent
BPA	Basic Prevent Awareness
SPR	Safeguarding Practice Reviews
SAR	Safeguarding Adult Reviews
DHR	Domestic Homicide Reviews
MSP	Making Safeguarding Personal
LAC	Looked After Children
CSPR	Child Safeguarding Practice Review

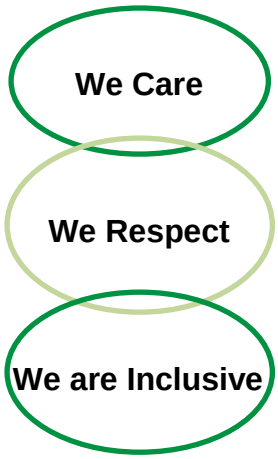
2021-22 Safeguarding Adults and Children Annual Report

1.0 Background / Introduction

1.1 The annual report summarises safeguarding work undertaken across the Trust and demonstrates to the Trust Board and external agencies how ELFT discharges its statutory duties and responsibilities in relation to Section 11 of the Children Act 2004, Working Together to Safeguard Children (2018), the Mental Capacity Act 2005 and the Care Act 2014.

The report outlines safeguarding activity across the Trust and highlights the achievements, challenges and priorities during the year. This is in accordance with the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (NHSEI, 2019). The framework provides an assurance that service users and their families are effectively protected.

All safeguarding work across the Trust is underpinned by our Trust values:



Everyone is entitled to the highest quality care.

Everyone should be treated with kindness and respect.

Everyone should have access to our services when they need them, and we actively seek suggestions from all on how we can improve.

Staff are supported to work in partnership, and to respond proportionately and appropriately to safeguarding concerns for children, young people and adults at risk who access services across ELFT in accordance with their statutory responsibilities:

1.2 The Trust operates from the following Boroughs:

- Tower Hamlets
- City of London
- Hackney
- Newham
- Richmond
- Luton
- Bedford Borough
- Central Bedfordshire

1.3 The Trust employs 6715 permanent staff. The mixed demographic profile of the trust results in a range of adult and children safeguarding issues that require an individual response based on local partnership arrangements.

2.0 Quality Assurance

2.1 All health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these are working (Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework. NHSEI, 2019).

This includes:

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable children as appropriate.
- A suite of safeguarding policies and procedures that support local multi-agency safeguarding procedures.

- Effective training of all staff commensurate with their role and in accordance with the intercollegiate competences for Safeguarding children and adults.
- Effective supervision arrangements for staff working with children / families or adults at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies.
- Developing and promoting a learning culture to ensure continuous improvement.
- Identification of named safeguarding professionals.
- Developing an organisational culture where all staff are aware of their personal responsibilities for safeguarding and information sharing.

3.0 Governance and Accountability arrangements

3.1 ELFT Safeguarding governance

3.2 ELFT is accountable for ensuring that its own safeguarding structure and processes meet the required statutory requirements of the Care Act 2014, Children Act 2004 and other statutory and national guidance. The safeguarding roles, duties, and responsibilities of all organisations in the NHS are laid out in the NHS England Accountability and Assurance Framework which was published in 2015 and updated in 2019.

3.3 The Trust is statutorily required to maintain certain posts and roles within the organization in relation to safeguarding. See appendix 1 for organization chart.

3.4 The Chief Nurse / Deputy Chief Executive is the Executive Director for safeguarding who provides leadership in overseeing and steering safeguarding arrangements.

3.5 The Chief Nurse and Director of Nursing have delegated responsibilities for safeguarding leadership, ensuring that the Trust safeguarding strategy is aligned to local safeguarding children partnership and safeguarding adult board priorities.

3.6 The Director of Nursing taken up the strategic responsibility for the safeguarding children and adult functions supported by the Associate Directors for Safeguarding Adults and Children.

3.7 The Associate Directors of Safeguarding and Domestic Abuse (Adults and Children) have provided operational leadership and co-ordination for the corporate safeguarding teams.

3.8 Named professionals provide the Trust with operational advice, support and training. The professionals are committed to supporting embedding it into ‘everyday business’ and improving outcomes for service users. They are

allocated to each borough, though provide corporate cover across the service (Appendix 1 and 2).

3.9 The Corporate Safeguarding team is committed to providing a 'Think Family' approach throughout its organisational structure. The Safeguarding Committee has a combined Terms of Reference and work plans to achieve this objective.

3.10 Each directorate has a lead manager representative at the safeguarding committee and local safeguarding boards to ensure that safeguarding priorities are embedded at an operational level and feeds back to their local quality assurance group. Each service directorate considers safeguarding children and adults regularly at their Directorate Management Team meetings.

3.11 The Safeguarding Committee meets bi-monthly and provides challenge and assurance with regards to the safeguarding arrangements within the Trust and monitors compliance and benchmarking with external standards and report, advise and act on findings to address any gaps in service.

3.12 Bi-monthly Safeguarding Committee minutes and exception reports are shared with the Quality Committee and assurance group which informs the Trust Board. These assurance reports are also provided to the CCG in line with the reporting arrangements.

3.13 The Adult and Children Named Professionals and local operational teams contribute to the Local Safeguarding Board and Partnership reports.

3.14 To support the analysis and highlight patterns of concern and to monitor the safeguarding team's activity, the team developed a number of dashboards and datasets to capture and understand the themes, trends and risks present in safeguarding across the trust.

3.15 The dashboard captures information about training, safeguarding concerns, safeguarding enquiries, safeguarding reviews, domestic homicide reviews, Prevent and staff allegation issues. They ensure transparency and provide assurance to our partners and stakeholders of the statutory safeguarding activity the Trust is delivering across its services.

4.0 External Safeguarding Governance and working with Partners

4.1 The Trust is committed to working in collaboration with all partners seeking to protect adults and children at risk from harm caused by abuse or neglect, regardless of their circumstances. As part of these arrangements the Trust is represented at 7 Safeguarding Adult Boards and Safeguarding Children Partnerships covering the local authority areas where ELFT has a presence.

The local safeguarding partnerships look at areas of concern for their local populations. Our services work in partnership to address these identified areas. These partnerships also have an assurance function that ELFT reports into.

4.2 Operational Directors or their representatives supported by the Associate Directors for Safeguarding attend the local Adult / Children Safeguarding Partnership meetings and contribute to the strategic development and objective setting with regard to local accountability and assurance. Any actions and deliverables are reported at the Trust's Safeguarding Committee.

4.3 The Operational teams, Associate Directors and Safeguarding Named Professionals are proactive on the local Safeguarding Partnership subgroups ensuring the Trust is linked in at all levels to multiagency developments and assurance. Named Professionals contribute to multi-agency and single agency audits in their local boroughs of operation.

4.4 There have been safeguarding adult reviews, child safeguarding practice reviews, domestic homicide reviews, learning disabilities mortality reviews, channel panel, PREVENT/CONTEST boards and serious incidents which ELFT has been representing in the reporting year.

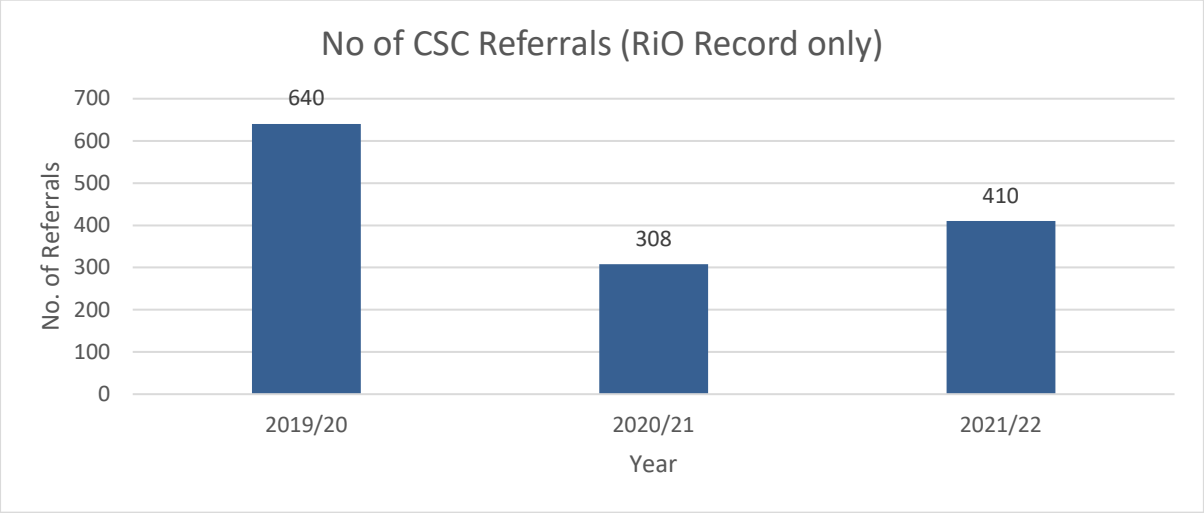
4.5 Alongside an internal audit cycle, the team have collaborated with partners to ensure ELFT participation in a number of multi-agency audits and multi-agency training with the LASB and LSCPs.

4.6 In 2021-22 approximately 2100 safeguarding concerns were raised for ELFT service users by staff, public, police and partner agencies across the trust. There is no comparable data for previous years as the datasets were not developed at that time

4.7 The Trust was involved in about a 570 section 42 enquiries which remains consistent with the previous year. The average conversion rate of section 42 enquiries across the Trust is at 25% to 27% which is consistent with the national average The volume of section 42 enquiries complete by the trust reflects the national picture and shows self-neglect, neglect and acts of omission and domestic abuse as major concerns which remains consistent with the previous year's reporting.

4.8 During the reporting period ELFT systems have recorded 410 referrals to children social care. This is an increase on last years but remains lower than previous years as per graph below. It is likely that the actual number of referrals to children social care is actually far higher than this. As part of a quality improvement project into how the trust records social care referrals, it was noted that Newham social care alone received 714 referrals from ELFT

between April 2021 and January 2022, of which only 60 (8%) were recorded on ELFT systems.



4.9 The top three recorded reasons for referral are emotional harm, domestic abuse and sexual harm. A QI project is underway to improve reporting compliance to more clearly reflect the actual number of referrals being made, and bringing standardised referral categories used to capture this information in line with the 4 categories of abuse set out in statutory guidance.

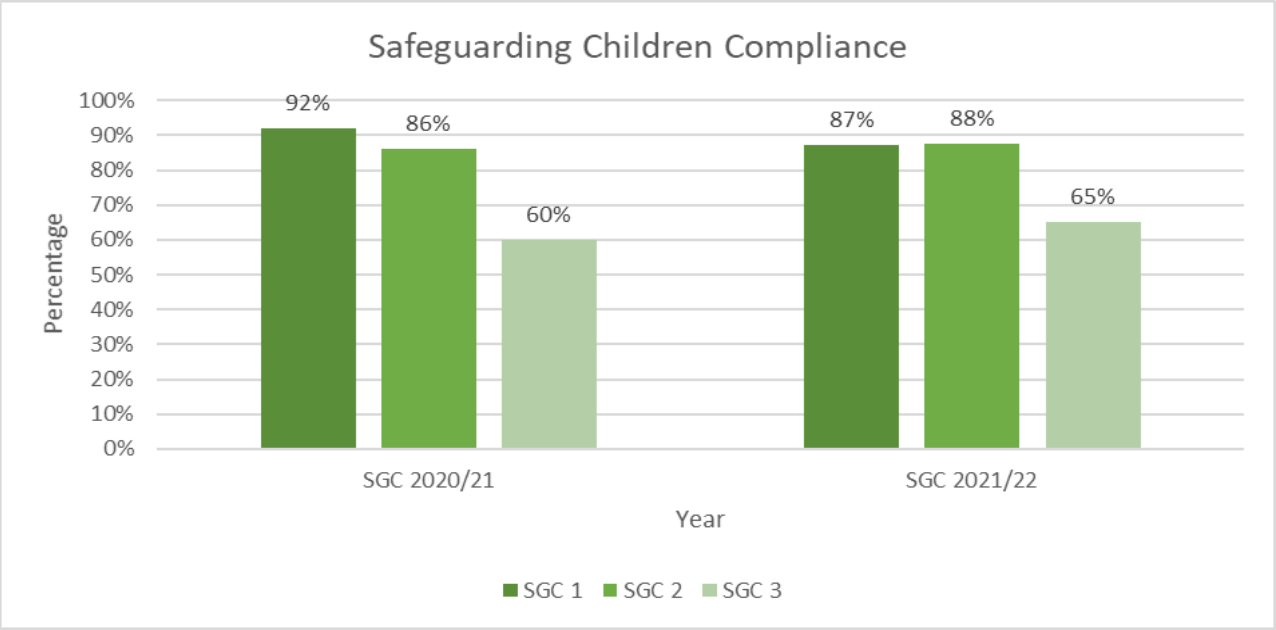
4.10 Other examples of partnership working include:

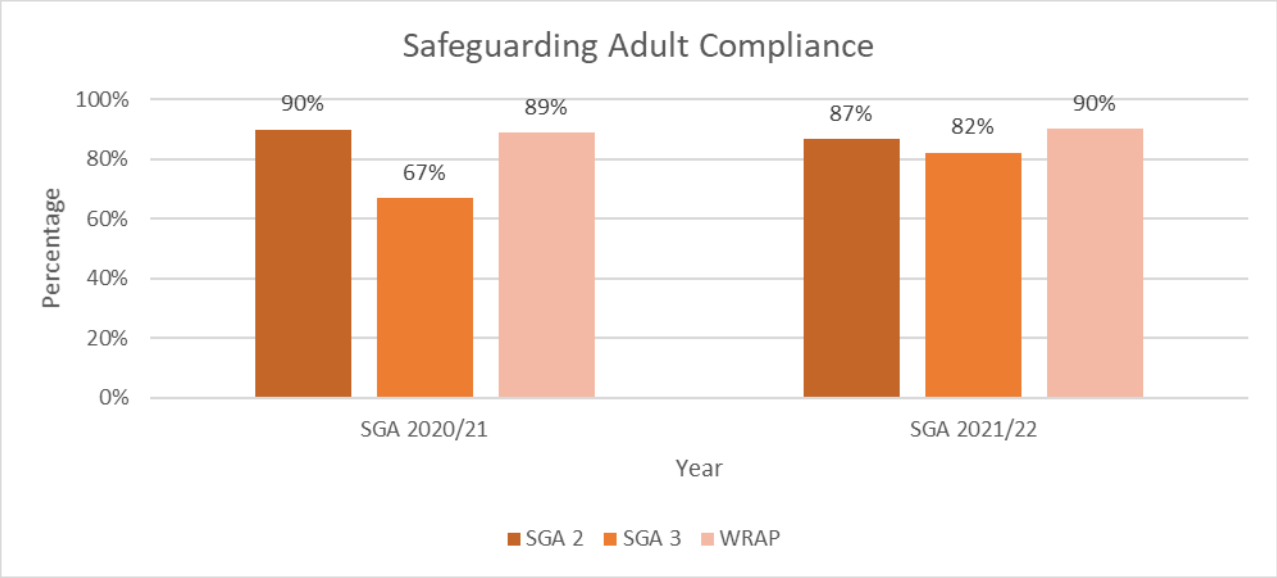
- Attendance at Counter Terrorism Local Profile (CTLP) briefings across the trust.
- Attendance at a range of partnership sub-groups including safeguarding practice review groups, performance, quality and assurance groups, training, learning and development sub-groups, and violence against women and girls sub-groups as well as the LSCP and LSAB executive meetings.
- Working alongside child death review partners and participation in the child death overview panel (CDOP)
- Attendance and dissemination of information at the Multi-Agency risk Assessment conference (MARAC), multi-agency gang panel (MAGPAN), multi-agency child-exploitation meetings (MACE) and Multi-Agency Public Protection Arrangements (MAPPA) when appropriate.
- Commitment to support Prevent arrangements and attendance at Channel Panel.
- Annual meeting with CN and DON

5.0 Safeguarding Training Compliance

5.1 The Trust has a Safeguarding Training Strategy and Training Needs Analysis in place which is based on the Intercollegiate Document, Safeguarding Children and Young People: Roles and Competencies for Health Care Staff. Fourth edition (2019) and Adult Safeguarding: Roles and Competencies for Health care Staff. First edition: August 2018. The strategy outlines the levels of training staff require to be compliant and frequency of training.

5.2 The training plan incorporates safeguarding children, adults, domestic abuse and PREVENTS training. The aim of high quality training is to improve practice and service provision.





5.3 Level 1 and level 2 safeguarding children and adult training is completed via an online package. The Level 2 Adult safeguarding training was at 88.50% at the end of quarter 3 as we don't have data from the quarter 4 figures due to the Learning department adopting a new platform.

5.4 The level 3 safeguarding training has been redesigned based on QI methodology to be delivered via a virtual platform, facilitated by the named professionals for safeguarding. This has led to improved access from staff and positive feedback attained on evaluation. Features of the new training package include annually updated themes gained from across all case reviews ELFT have partaken in, and the grouped learning from these as well as themes that the safeguarding team are most frequently contacted about.

5.5 The compliance for level 3 safeguarding children has increased from 60% to 65% from the previous reporting period. The remapping of 1125 extra members of staff to receive level 3 training coincided with the start of the pandemic and a halt of all face to face training. The double effect of this significantly affected the ability for the Trust to meet the trajectory that had been planned for. In order to mitigate this the new training package is able to reach more staff per training session, is being offered more frequently and staff attrition rates have improved. 485 staff members were trained in the Q4 reporting period, which is a 114% increase on the same period from 2020-21.

5.6 Adult Safeguarding training compliance has significantly improved since the last reporting period from 67% to 86.33%.

5.7 The Trust compliance with WRAP (Workshop to Raise Awareness of Prevent) training is at 87%. This data is based on the quarter three figures and it's likely that the actual figure is likely to be higher.

5.8 The safeguarding team have delivered bespoke training to the trust staff where they identified deficits in practice which was either picked up in the monthly audits or supervision.

5.9 The safeguarding adult's boards and safeguarding children partnerships also provide multi-agency training and ELFT staff are encouraged to access this training. There was a pause in delivery from some partnerships due to the pandemic, but most are now delivering a program of virtual training.

5.10 The Corporate Safeguarding team is offering quarterly "Think Family" seminars covering various subjects based on the board priorities, audit outcomes and supervision discussions.

5.11 The feedback from the training delivered has been highly positive. This has included:

'Best training ever in ELFT. This was one of the most organised and slick virtual sessions I have attended. Thank you.'

"The pace of the day was great, facilitators were hugely knowledgeable and kept me engaged in a challenging & emotive subject all day. Liked the videos & vignettes"

"It enhances my knowledge and it will make it a difference in our job dealing this issue"

6.0 Safeguarding Supervision

6.1 Safeguarding supervision for adults and children are provided in line with the respective supervision policy in place. The safeguarding children supervision policy was reviewed and updated in July 2021, and ensures new services acquired by the Trust are considered in the supervision framework.

6.2 Effective supervision should provide opportunities for learning and discussion, provide protected time to think, explain and understand safeguarding concerns, help practitioners cope with the emotional demands of the job and help workers identify unknown issues or offer a new angle on complex issues. The compliance, quality and effectiveness of safeguarding supervision is reviewed via audit and monitored by the Trust Safeguarding Committee, as is representation across the services.

6.3 Safeguarding adult supervision for staff working within adult services was formally launched 10 months back and is gaining momentum. The uptake for supervision is at 60% and a number of services are now requesting for safeguarding supervision. With safeguarding children's team providing supervision for 189 teams across the trust

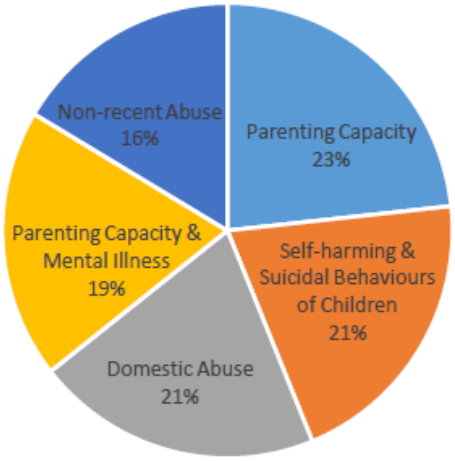
6.4 The safeguarding team facilitates a number joint safeguarding supervision sessions to relevant services wherein the named professional for children and adults will provide joint safeguarding supervision to staff members. This provides staff an objective perspective to help them "think family" and to recognise the impact that parental and family behaviours have on children and young people and vulnerable adults.

6.5 The safeguarding team provides group, one to one and ad-hoc safeguarding supervision including telephone advice to staff across the Trust to ensure effective support and guidance is available to staff appropriate to their roles. Data collection tools have been developed to provide a broader picture of safeguarding themes discussed at supervision.

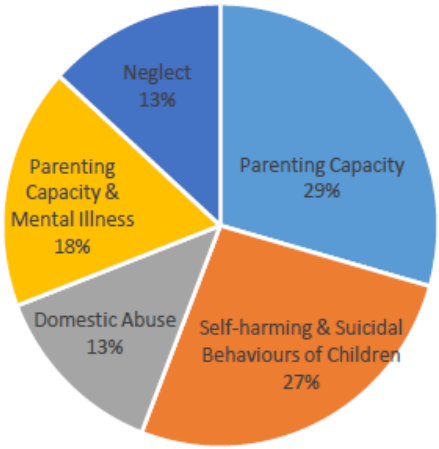
6.6 The safeguarding children team were approached by members of staff for support and advice 1282 times during the 2021-22 reporting period, each relating to concerns they held about the safety and wellbeing of children and their family members. There is no comparable data for previous years as the datasets were not developed at that time. The most common themes gathered from the data regarding these contacts are show in the graphs below.

6.7 As can be seen, parenting capacity, self-harming and suicidal behaviour of children and domestic violence feature heavily. Neglect features as a common theme in planned supervision and non-recent abuse within ad-hoc contacts.

21-22 Presenting Safeguarding Concerns (Ad-hoc)



21-22 Presenting Safeguarding Concerns (Planned)



7.0 The Modern Slavery Act 2015

7.1 Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion or abuse of vulnerability, deception or other means for the purposes of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including criminal or sexual exploitation, forced labour, domestic servitude and organ harvesting.

7.2 ELFT has published a Modern Slavery statement.

7.3 ELFT confirms the identities of all new employees and their right to work in the UK, in line with Safer Recruitment Procedures.

7.4 ELFT safeguarding team supports staff with reporting and sharing information about individuals affected or suspected of being victims of Modern Slavery and trafficking. This includes referral procedures for those requiring the National Referral Mechanism (NRM).

7.5 Modern Slavery and trafficking is included in the Level 2 and 3 training package offered to Trust staff.

7.6 Modern Slavery and trafficking will be included in the quarterly training events to raise awareness as this is a hidden crime and one of the under reported categories of abuse.

8.0 PREVENT Duty

8.1 The Counter terrorism and Security Act 2015, places a specific duty on statutory bodies including the police, local authorities and health organisations to have 'due regard' to help 'prevent' people being drawn into terrorism. It also makes attendance/representation at the Channel process a legal requirement for public bodies. NHS Trust is required to train staff to have knowledge of PREVENT and radicalisation and to spot the vulnerabilities that may lead to a person to becoming radicalised.

8.2 The purpose of PREVENT is for staff to identify and report concerns where they believe children, young people or adults may be vulnerable to radicalisation or exploiting others for the purposes of radicalisation.

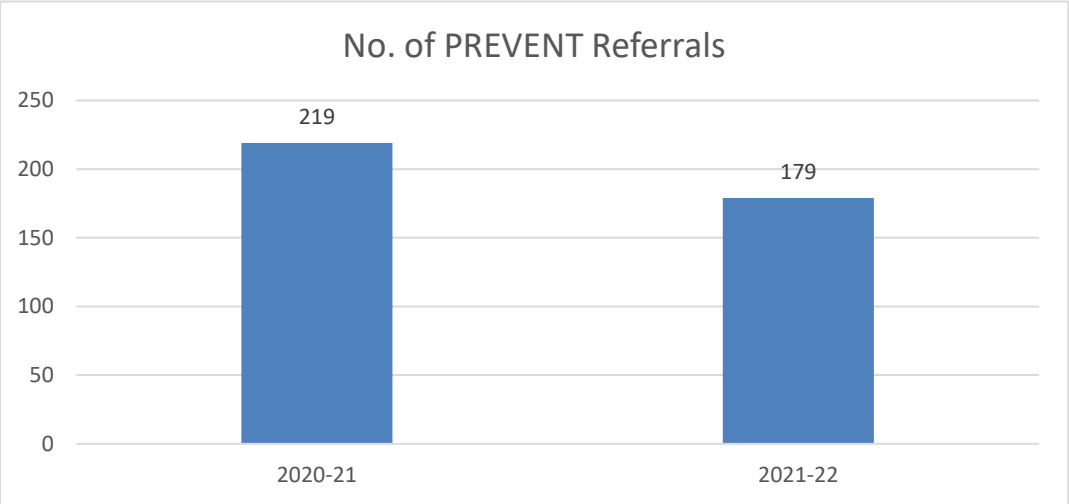
8.3 The trust submits a quarterly return to the Regional Prevent Co-Coordinator and NHS England. The data submitted monitors the key elements of the prevent duties and responsibilities which include:

- Identification of PREVENT Leads- Strategic and Operational
- Delivery of training
- Levels of referrals made via the Channel process
- Representation and engagement with local and regional PREVENT leads.

8.4 All staff are required to complete Basic Prevent Awareness (BPA?) training. Staff mapped at level 3 Safeguarding Adult and Children training are required to complete Workshop to Raise Awareness of Prevent (WRAP) training.

8.5 The staff have achieved 89% compliance with WRAP training and 88% compliance with the Basic Prevent Awareness training against an expected target of 85%.

8.6 In total the trust responded to 179 PREVENT related concerns in 2021-22.This ranges from general enquiries to request by Channel Panel from assessments of people's mental health.



8.7 In 2021-22, the Trust has seen a decrease in reporting of Prevent referrals and this is due to improved screening and training being offered to staff.

8.8 The other major reason is because Mixed, Unclear, Unstable (MUU) Prevent referrals are increasing, however very few present a genuine CT threat or risk, or are escalated to Channel. The main risk gravitates around the vulnerability traits these individuals display.

8.9 The trusts Safeguarding team and operational teams attend Channel Panel meeting every month and contributes to the discussions for the panel to make informed decision on cases.

8.10 The Corporate Safeguarding Team provides advice and support for ELFT staff reporting Prevent cases and liaise with Counter Terrorism team to share information for Channel or high risk cases.

8.11 The Trust continues to attend and participate in Prevent workshops and events in East of England and London and has held workshop to raise to promote awareness not only for our staff but also partner organisations.

8.12 The Associate Director for Adult Safeguarding and Operational Directors attend the PREVENT and CONTEST boards to update them of the work done by the trust and provide inputs to their work plan.

9.0 Domestic Abuse

9.1 The cross-government definition of domestic violence and abuse is:
Any incident or pattern of incidents of controlling, coercive, threatening behavior, violence or abuse between those aged 16 or over who are ,or have been ,intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to, psychological, Physical, Sexual, Financial, and Emotional. This definition includes so called honour-based abuse, female genital mutilation and forced marriage, and is clear that victims are not confined to one gender, religion or ethnic group.

9.2 The Trust's "Think Family" approach ensures there is a shared vision for an integrated safeguarding approach to improve outcomes for adults, children and families at risk.

9.3 There continues to be Trust representation at the local Multi Agency Risk Assessment Conference meetings (MARAC).

9.4 The trust safeguarding team has developed and rolled out a number of Domestic Abuse training sessions for the staff to raise awareness and to ensure early identification of domestic abuse among patients and staff members.

9.5 The trust has a Domestic Abuse and Harmful practices policy and established a domestic abuse steering group. There has been increased communications and awareness in response to increased prevalence of domestic abuse during

the COVID-19 lockdown. The policy was further updated during the Covid-19 pandemic to include staff members who are victims of domestic abuse.

9.6 The trust "Domestic Abuse Steering" group meets bi-monthly to plan and identify areas of work that needs strengthening within the organisation to appropriately respond to concerns of domestic abuse. The meeting is chaired by the Director of Safeguarding and has representatives from various services within the trust and survivors of domestic abuse.

9.7 Domestic abuse training is available to all staff via the joint Think Family quarterly learning events.

10.0 DATIX reported incidents (2021-22)

10.1 The Trust safeguarding team continues to work closely with the Serious Incidents team to ensure that all serious incidents consider safeguarding issues within them and that the trust safeguarding team are engaged in supporting clinical services to develop meaningful and effective plans to improve safeguarding practice and therefore to improve patient's safety.

10.2 All patient safety incidents are reported on the Datix incident reporting system and are monitored, assessed and screened for cases where abuse or neglect or poor care are indicated. This process supports staff in their decision making to consider and identify safeguarding concerns. The information gathered from Datix incident reporting is monitored by the Safeguarding Team and Directorates to ensure appropriate safeguards are in place.

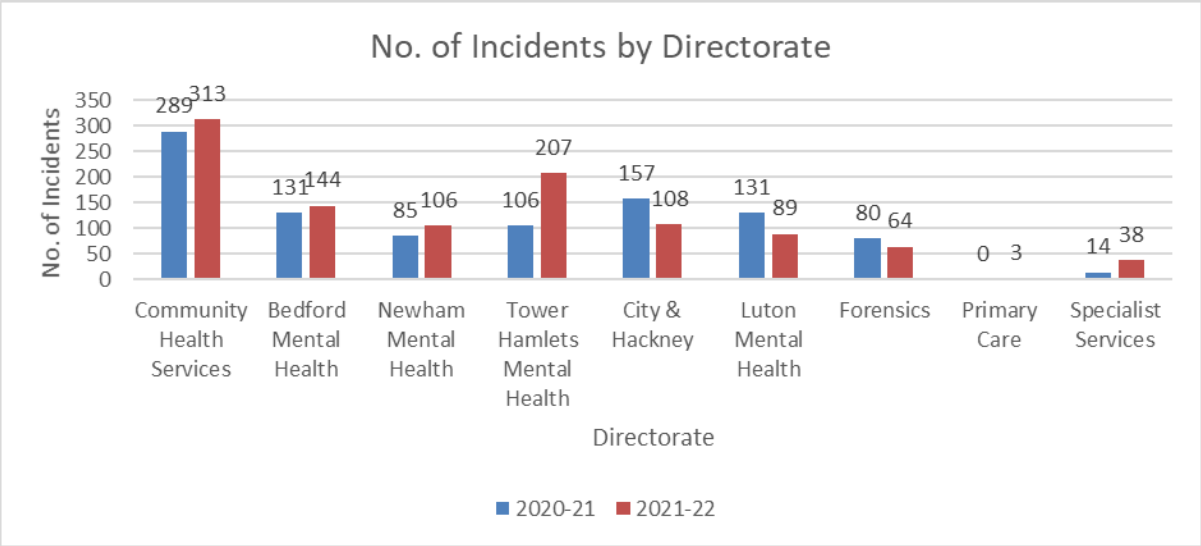
10.3 There were 1072 safeguarding adult incidents raised by the trust staff in 2021-22 compared to 993 incidents raised in 2020 -21 and 843 in 2019-20. In the last three years the trust has seen an increase in the number of incidents being raised by staff and this could be due to increased awareness of Safeguarding issues.

10.4 Tower Hamlets Mental Health and Tower Hamlets Community Health Services raised the highest number of incidents followed by Bedford mental Health and Bedford Community Health Services.

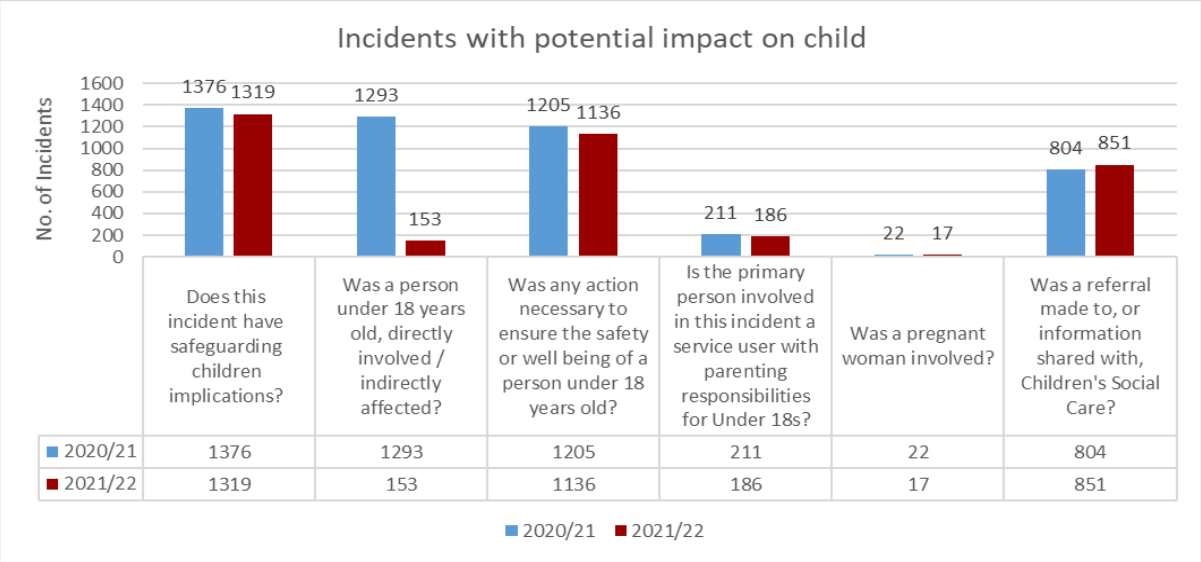
10.5 The highest reported category of abuse was sexual abuse followed by domestic abuse and physical abuse.

10.6 The highest number of sexual abuse and physical abuse was reported by inpatient services while domestic abuse, self- neglect and neglect and acts of omission was reported by Community Mental Health Services and Community health Services.

10.7 The major difference one can see is in the reporting of Domestic Abuse, it's one of the most reported category within MH services and the lowest reported in CHS services.



10.8 During the year a total of 1319 ticked one or more of the safeguarding children fields, a slight decrease on 2020-21.



	Does this incident have safeguarding children implications?	Was a person under 18 years old, directly involved / indirectly affected?	Was any action necessary to ensure the safety or well being of a person under 18 years old?	Is the primary person involved in this incident a service user with parenting responsibilities for Under 18s?	Was a pregnant woman involved?	Was a referral made to, or information shared with, Children's Social Care?
2020/21	1376	1293	1205	211	22	804
2021/22	1319	153	1136	186	17	851

10.9 Self harm, actual physical attack and child / young person at immediate risk of harm are the three most reported concerns.

10.10 The safeguarding team have been working in collaboration with the incident team to change the reporting data to bring it in line with national and local reporting categories of concerns and abuse.

10.11 Of the 1319 incidents which showed that a child could have been affected 208 were made with the primary category of children at risk. This figure is a 16% increase on last year.

10.12 Datix reporting of incidents has significantly improved across the services and the team have also seen a proportionate increase in reporting of safeguarding

concerns.

10.13 An increase in provision and uptake of safeguarding training has directly contributed to the increase in reporting. The other contributory factors include multi-agency working, bespoke training and supervision.

11.0 Safeguarding Practice Reviews

11.1 With the implementation of the Care Act 2014 there is a statutory requirement under section 44 to undertake Safeguarding Adult Review (SAR).
A SAR is about:

- learning lessons for the future
- making sure that Safeguarding Adults Boards get the full picture of what went wrong
- improving the practice of all organisations involved

11.2 A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place.

11.3 The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

11.4 A SAR is commissioned when there is reasonable cause for concern about how SAB members or other agencies providing services, worked together to safeguard an adult if; The adult has died, and SAB knows or suspects that the death resulted from abuse or neglect; Whether or not it knew about or suspected the abuse or neglect before the adult died; The adult is still alive and SAB knows or suspects that the adult has experienced serious abuse or neglect

11.5 A SAR guidance and protocol has been developed for the trust staff to raise awareness about the SAR process.

11.6 During 2021-22 ELFT was involved in 13 SAR's, 1Thematic Review and 2 learning reviews.

11.7 The learnings from SARs have been grouped into three areas of practice summarised below. More detail is provided in appendix 3:

- Quality of direct practice with the individual
- Organisational factors that influence practice
- Interagency or inter professional collaboration

11.8 A child safeguarding practice review takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future. The new arrangements categorise reviews into those at which there is learning to be disseminated at a national level, and learning which is more suitable to a local area.

11.9 During 2021-22 the ELFT Safeguarding Children Team contributed to 31 case reviews involving 42 children/young people. There were two reviews that involved two 18 year olds, both were previously Looked After Children. The case reviews included:

- 16 Rapid Reviews
- 3 Serious Incidents
- 6 Child Safeguarding Practice Reviews
- 1 Safeguarding Adult Review
- 1 Domestic Violence Learning Review
- 2 Domestic Homicide Reviews
- 1 Thematic Review

11.10 Appendix 3 provides an overview of themes derived from all reviews ELFT were actively involved in. As can be seen, sexual abuse and looked after children featured in the majority of the reviews, followed by gangs and concerns of serious youth violence, and suicide of children and young people. There were slightly more males than females subject to reviews and majority in children between 12-17 years of age.

11.11 The most common themes from the learning are summarised below, with more information in appendix 3.

Think Family
Information Sharing
Criminal Exploitation / Gangs / Serious Youth Violence
Safeguarding risks associated with mental health of children and young people

11.12 The Safeguarding Committee receives updates on all safeguarding practice reviews and learning reviews and action plans are monitored at this meeting. The final reports are published by the respective local Safeguarding Children Partnerships or NSPPC and are available on their websites once complete.

11.13 The Named Professionals and the Associate Director are members of the case review sub-groups and contribute to the reviews. The learning from all the reviews are incorporated in the Level 3 training and disseminated to staff through away days, in safeguarding supervision and safeguarding newsletters.

12.0 Allegations against staff

12.1 Despite all efforts to introduce safety mechanisms there will be occasions when allegations are made. All staff have a responsibility for safeguarding and promoting the welfare of adults and children and a duty to report any concerns they may have about service users, members of staff (including bank, agency and honorary, unpaid, volunteers, contractors and those seconded from other services) and visitors.

12.2 The management of allegations against staff policy was revised and updated in October 2021. It outlines the process for referring allegations made against trust staff to the local authority designated officer (LADO) and the local authority lead officer.

12.3 Within the reporting period, 21 referral were made to the LADO. 90% of these referrals were made to the LADO in Newham due to the large volume of allegations arising from the Coborn Centre for Adolescent Mental Health.

12.4 Based on an increase of referrals being made to Newham LADO, a thematic review was undertaken to ascertain what could be driving the high numbers, and the subsequent risk posed to patients and staff. The review highlighted the significant pressure Covid-19 had placed on the unit, and made several recommendations for change.

12.5 The Trust has also held disciplinary processes for 24 staff members, where safeguarding allegations were made against the adult facing staff members. Two of the staff members were dismissed from services and others were disciplined and offered additional training to support them in the area of their practice.

13.0 The Learning Disabilities Mortality Review

13.1 Following the 'Confidential Inquiry into premature deaths of people with Learning disabilities' (CIPOLD), NHS England launched the Learning Disabilities Mortality Review (LeDeR) Programme in conjunction with Bristol University. Subsequent to the publication of the NHS Long Term Plan, the LeDeR programme will continue, with the intention of embedding reviews of deaths of people who have learning disabilities into everyday practice. The programme is now known as Learning from Lives and Deaths of People with a Learning Disability and Autistic People, and the new policy published in 2021 included changes to the platform and review process, with a strengthened level of ownership across the newly formed Integrated Care Systems and Boards.

13.2 Key findings from the fourth annual review paper issued in May 2021 for the year 2020, included the following information related to death in those with a learning disability:

- The median age of deaths has increased by one year between 2018 and 2020
- There is a small but encouraging trend downwards in the number of preventable, treatable and overall avoidable medical causes of death
- The proportion of reviews showing best practice increased
- There is significant evidence of inequality in the care of people with learning disabilities, particularly those from a minority ethnic background, with fewer deaths of those from these backgrounds being reported

13.3 The Trust now has a standard pathway to report any death of a person who has a learning disability, and LeDeR notifications are made through the Assurance Team from a Datix report. The deaths are discussed within the monthly Learning from Deaths meeting. There are also place based Learning from LeDeR groups, and an East London ELFT meeting every two months with colleagues from North East London CCG, to ensure that learning is shared at all levels.

13.4 The Covid 19 crisis has again highlighted the vulnerability of the learning disabled service users as higher death rate was reported among this group of service users and the lack of equity in access to services, although it is notable that the uptake of Annual Health Checks has increased across both London and Bedfordshire/Luton services

13.5 It is of note that from January 2022, the lives and deaths of Autistic people (those without a Learning Disability) will be included in the LeDeR review process and there is a focus in both ICS that ELFT covers to establish clear pathways and processes to support this.

13.6 The learning from the LeDeR review is shared on a quarterly basis with the safeguarding team and this information is incorporated into the safeguarding trainings and supervision.

14.0 Domestic Homicide Review

14.1 A Domestic Homicide Review (DHR) is a locally conducted multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he or she was related, or with whom he or she was or had been in an intimate personal relationship; or,
- a member of the same household as himself or herself.

14.2 During 2021-22 there were 6 DHR’s commissioned by the Community Safety Partnerships in the Local Authority areas that ELFT operates. ELFT

safeguarding team represented the trust in those DHR's and contributed to the reviews (appendix 3).

14.3 The safeguarding team have incorporated the learning from the completed DHR's in the level 3 safeguarding training and Safeguarding Newsletter.

15.0 Complaints

15.1 All complaints are reviewed at entry by the trust complaints team and the safeguarding team is forwarded any complaint where safeguarding concerns are identified.

15.2 The staff screening the complaints has received safeguarding training and understands what constitutes abuse when screening complaints.

15.3 During 2021-22 the trust received 5 complaints related directly to safeguarding team.

15.4 The safeguarding adult's team advised the complaints team to report the concern to the local authority by raising a safeguarding concern.

16.0 Workforce

16.1 Statutory guidance requires the Trust to have robust arrangements for safe recruitment practices including identity and DBS checks for all new and existing every three years. At the end of the financial year the percentage of staff with a valid Disclosure and Barring Scheme (DBS) check was 99.5%. This is a significant increase from 2020-21. The People and Culture team have completed a targeted piece of work to significantly target and manage DBS compliance

17.0 Looked After Children

17.1 The Looked After Children (LAC) health team is responsible for assessing and ensuring that the health needs of all the looked after children and young people from Newham are met, whether they live in the Borough or they have been placed out of area. In addition, the team is also responsible for assessing the health needs of children from other authorities who are placed in Newham when requested to do so.

17.2 A child will cease being "Looked After" when they are adopted, return home or reach the age of 18 years. Social care responsibilities for Care Leavers over the age of 21 has now changed under the recently published Children and Social Work Act (2017), which enables care leavers to request support up to the age of 25, regardless of whether or not they are in education.

17.3 Looked After Children (LAC) often enter the care system with a worse level of health than their peers, in part due to the combined effects of the impact of poverty, poor parenting, abuse and neglect. These young people often enter care from chaotic home situations and/or through the criminal justice system.

17.4 The total number of children looked after by Newham as of March 2022, 432, an increase of 12% (Source: unpublished Azeus reporting LBN). For those living outside of the Borough, care is provided by the host Local Authority and health provider.

17.5 There were 194 children entered into care during 2021-2022.

17.6 64% of Initial health assessments were completed in the 20 working days' time frame. This is a 14% decrease from 2020-2021. The expected national average per annual % of IHAs completed is 88%.

17.7 All breaches of the statutory 20 working day rule and any 'did not attends' are noted and reported to the CCG on a weekly basis.

17.8 The top three reasons for breaches are lack of capacity for UASCs, foster carers citing they cannot make the appointment given and was not bought.

17.9 Under 5yr Review Health Assessments:

17.10 Under 2yrs are reviewed by the Community Paediatricians and age 2-5yr by the Specialist Nurses. For the purpose of this report they are calculated as a whole.

17.11 81% of under 5's Review Health Assessments (RHA) were completed in the set time frame, an increase of 9% from 2020-2021.

17.12 5yr- 18yr Review Health Assessments:

17.13 69% of over 5's were completed in the set time frame. This is a decrease of 11% from 2020-2021. The national average is 88%. The main reason why reviews have not been completed are:

- Foster Family on holiday/declined due to too many appointments/problems with transport/clashed with LAC review/exams
- Young Person refusing

All cases of reviews not being completed are fed back to the child / young person's social worker.

17.14 LAC Governance and reporting arrangements:

- The LAC health team attends Newham Joint Health Sub Group, Newham Corporate Parenting Board and participates in the Corporate Parenting Board Operational Group, the joint LAC and LBN meeting and the quarterly Foster Panel.
- The Named Nurse for LAC attends the Clinical Governance meeting for Specialist Children's and Young Peoples Services (SCYPS), Safeguarding Children Committee and submits KPI data monthly to the CCG.
- The clinical team undertakes quarterly essential audits in record keeping and infection control

18.0 Safeguarding Work Plan

18.1 During 2020-21, the safeguarding team made progress with the safeguarding strategic objectives and work plan underpinned by the Trust's core values.

18.2 The work plan has achieved most of its objectives. Areas such as training, reporting, auditing has improved and embedded in staffs practice and evidenced in this report.

18.3 The achievements of the work plan has been highlighted in appendix 5 of this report.

18.4 A new work plan for the next 3 years has been developed which incorporates some of the ongoing work of the existing work plan and will be reviewed by the Safeguarding Committee on a bi-monthly basis.

18.5 The work plan will ensure the Trust drives forward the safeguarding agenda across the organisation (Appendix-4).

19.0 Action being requested

19.1 The committee is asked to receive the report.

NHS East London NHS Foundation Trust

2021-2022 Safeguarding Annual Plan (based on the Trust Safeguarding Strategy 2019-2022)

No 1	Improved population health outcomes	Action required	Lead	Timescale	Evidence/ progress	Rag rating
1	Provide a comprehensive training programme designed to meet the outcome set out in children and adult intercollegiate documents and to meet Trust training targets.	• Training dates to be delivered to meet the trajectory caused by re-mapping of staff and covid-19 crisis. • Adult and children team to identify areas for joint refresher training focusing on case studies • Use case studies, SCR and SAR and different interactive methods of learning • Capture accurate training data • Ensure infrastructure supports virtual delivery of training • Online form to capture refresher training to be developed	Associate Directors Safeguarding Children and Adults Corporate Safeguarding Team Workforce and Learning Development	Sep 2021	Increase in staff compliance in all levels of safeguarding training to 85% Training audit Training compliance reports	

No 2	Improved experience of care	Action required	Lead	Timescale	Evidence/ progress	Rag rating
2 a	Safeguarding is an everyday business across the organisation evidenced in all areas of the Trust's activities and business.	• Ensure that there is representation at the safeguarding committee from a range of directorates and professions • All areas are compliant with safeguarding training • Themes and trends raised during contact with safeguarding team to be analysed and discussed in Trust SG committee	Chief Nurse and Borough Directors Associate Directors for Safeguarding	Sep 2021	.Audit cycle Safeguarding datasets Safeguarding training remains an action outstanding, otherwise all other actions have been met	
2b	Ensure staff understand that safeguarding is everybody's responsibility	• Details in all Job Descriptions • Review Appraisal documents to see if safeguarding features as a competence • Analyse the number and appropriateness of contacts made to the safeguarding team	Human Resources Directorates HR business partners Associate Directors for safeguarding / Corporate Safeguarding	Sep 2021	Audit cycle Safeguarding datasets	

2c	Ensure patients are protected by organisational policies and Processes that are underpinned by safeguarding principles i.e. good practice	• HR policies are up to date regarding safeguarding and voicing concerns • Ensure that Safeguarding policies are up to date • Ensure that the Mental Capacity Act and the DOLs framework is incorporated into Safeguarding training practice and intervention	Chief Nurse and Director of Nursing Associate Directors Safeguarding Children and Adults and Lead Nurse for Mental Health Law and Mental Capacity Act (MCA)	Sep 2021	Policies are updated in accordance with National and Regional guidance. Policy tracker	

2d	Ensure that staff receive appropriate support and training to be able to deliver high standards of Safeguarding practice and intervention	• Safeguarding Team to work in collaboration with the lead Mental Health Act nurse and MCA and DOLs advisor • Themes and trends regarding access to safeguarding supervision to be analysed and discussed in Trust SG committee • Develop opportunities for themed learning lessons events across directorates so the learning is shared across Community Health , Learning Disabilities and Mental Health services	Named Professionals for Safeguarding and directorate Safeguarding leads Associate Directors for safeguarding	Sep 2021	Safeguarding datasets Audit cycle Thematic case review dissemination	
No 3	**Improved Staff experience**	**Action required**	**Lead**	**Timescale**	**Evidence/ progress**	**Rag rating**

3	To ensure that staff are empowered to speak up and act when they see or suspect safeguarding issues by ensuring that they receive appropriate levels of training based on national and local guidelines.	• Undertake incident review of SGA and SGC on the DATIX system • Incidents shared and analysed at Trust SG committee meeting. • Monitor quality of referrals to social care	Safeguarding Team Data Analyst Associate Directors for safeguarding Corporate Safeguarding Team / Service Directors	Sep 2021	Safeguarding datasets Audit cycle Performance reports	
No 4	**Improved Value**	**Action required**	**Lead**	**Timescale**	**Evidence/ progress**	**Rag rating**

4a	To work in partnership with other agencies leading on health so that co-operation in a transparent and productive way progresses safeguarding	• Attendance at multi-agency meetings • Joint working in relation to inspections and working together • Promote joint learning lessons events regarding SCPRs and SARs • Share learning and evidence from SCPRs and SAR in relation to partnership working	Corporate Safeguarding Team and Service Directors Chief Nurse Service Directors Corporate Safeguarding Team	Sep 2021	Attendance at partnership meetings Joint audits Thematic case review dissemination	

4b	To develop a dataset of information to monitor safeguarding activities and ensure that the organisation has sufficient capacity in meeting their statutory requirements.	• Quarterly reports to be developed and presented at Trust SG committee to include themes and trends • CCG Dashboard to be further developed • Risk register to be maintained and presented at Trust SG committee • Multiple trust system and reporting issues to be resolved	Associate Directors of Safeguarding Associate Directors of Safeguarding / Safeguarding Team Data Analyst	Sep 2021	Audit cycle Safeguarding datasets	

4c	To promote a "Think Family" approach to safeguarding'	• Themes and trends regarding access to safeguarding team to be analysed and discussed in Trust SG committee • Develop joined up training for areas of training /supervision where a think family approach is appropriate, such as domestic abuse and Prevent • Develop clinical assessment by exploring risk to all adult and children family / household members • Develop transition arrangements from children to adult services where safeguarding concerns are identified • Joint quarterly associate director meetings with borough directors	Corporate Safeguarding Team Named Drs for safeguarding, Borough directors, Associate directors for safeguarding children.	Sep 2021	Safeguarding datasets Audit cycle Work continues on developing transitional arrangements from children to adult services where safeguarding concerns have been identified, otherwise all other actions have been met	

No 5	Improved Partnership working	Action required	Lead	Timescale	Evidence/ progress	Rag rating
5a	To ensure that there is clear accountability and transparency in delivering safeguarding priorities by building an effective governance assurance framework.	• Pro-active well attended safeguarding committees fulfilling terms of reference • Measure the quality of work and compliance against regulatory standards • Quarterly upward reports to Quality Assurance Committee	Director of Nursing	Sep 2021	Audit programme	
5b	Respond to both internal partnerships multi-agency requirements OfSTED, Inspections, CQC and Joint Targeted Area Inspections (JTAI)	• Contribute and assist with partnership requirements for SAB and LSCPs • Ensure robust safeguarding processes are in place for CQC requirements and inspection	Chief Nurse / Director of Nursing Associate Directors for Safeguarding Children and Adults	Sep 2021	Funding arrangements agreed Safeguarding datasets	
No 6	**Aim**	**Action required**	**Lead**	**Timescale**	**Evidence/ progress**	**Rag rating**

6	Single and multi-agency audits	• All audits and reports are collated in calendar and reviewed to establish gaps and repeat as appropriate. • Audit cycle to be reinvigorated • Reports are reviewed and any actions implemented	Corporate Safeguarding Team and Service Directors	Sep 2021	Audit cycle	

NHS
East London
NHS Foundation Trust

Safeguarding Work Plan (2022-25)

No	Improved Population Health Outcomes	Action Required	Lead	Timescale	Evidence/ Progress/Success Measures	Rag Rating
1	• The Corporate Safeguarding team will focus on Preventative and Early Intervention safeguarding practice to support staff to have knowledge, skills and confidence to protect all ELFT service users, regardless of age.	• Seek assurance that Safeguarding Policy and associated practice guidance is effectively embedded.	• SGA/SGC • NPs and ADs	• Ongoing	• Good practice case studies to be shared with staff. • Providing advice • Providing Datix responses • Action Plans from audits completed • By reviewing and updating policies and protocols.	
		• Support staff with areas of practice that needs strengthening to reduce repeat safeguarding referrals. •	• SGA/SGC • NPs and ADs	• Ongoing	• By delivering training to raise the awareness of Safeguarding • Providing safeguarding and complex case supervision to staff members. • By reviewing and updating policies and protocols.	

		• Produce guidance for staff around Homelessness, Domestic Abuse, Self-Neglect, Substance Misuse, Harmful Gambling.	SGA/SGC NPs and ADs	2022-23	• By delivering training and good practice workshops to raise the awareness of Safeguarding issues. • Ensure learnings from the SAR/DHR/PFDs is shared with staff and drives improvement in practice through quarterly learning events.	
		• SG team to work with the Trust Transition Lead to develop and review the policy and procedures around transition to ensure a more integrated approach	SGA/SGC NPs and ADs	2022-23	• Guidance produced; feedback from transitional lead • By reviewing and updating policies and protocols.	
		• Review current practice guidance regarding the interface between poor quality care and safeguarding	SGA/SGC NPs and ADs	2022-23	• Revised guidance in place. • Survey feedback demonstrating good understanding of the interface.	
No	**Improved staff experience**	**Action Required**	**Lead**	**Timescale**	**Evidence/ Progress**	**Rag Rating**

2	The Corporate Safeguarding team will ensure that its expertise is shared within and outside the organisation and the team engages in the dissemination of lessons learnt from safeguarding enquiries, Safeguarding Adult Reviews, Child Safeguarding Practice reviews, Domestic Homicide Reviews, PFD's LeDeR reviews and other relevant enquiries.	• IMRs and chronologies when requested to be prepared jointly by NP and Assistant Directors / Deputy directors / Directors	SGA/SGC NPs and ADs	Ongoing	• NP's to attend and actively participate in the SARS, DHRs, other as appropriate • Actively engaging and participating with its various partners and safeguarding sub groups to support and deliver the effective safeguarding service.	
		• Disseminating learnings from the reviews, through training, supervisions and newsletters.	SGA/SGC NPs and ADs		• Quarterly trainings • Safeguarding Supervisions • Six monthly news letters • Disseminate seven minute briefings and	
		• Monitoring how much impact learning lessons are having on changing practice and embedding learning	SGA/SGC NPs and ADs		• Undertaking regular safeguarding audits • Numbers of staff attending training and supervision • Periodical review of Trust wide and local policies and procedures • Utilising the safeguarding database to understand what the themes, trends and risks within services.	
		• Maintain an awareness of both national and regional learning to ensure this is disseminated.	SGA/SGC NPs and ADs		• Rolling programme of dissemination of learning as it is published via training, supervision or newsletter.	
No	**Improved staff experience**	**Action Required**	**Lead**		**Evidence/ Progress**	**Rag Rating**

2a	The Corporate safeguarding team will continue to engage and collaboratively work between services to ensure that the voice of the child/vulnerable adult is heard, and their circumstances safeguarded. Shared information must lead to shared understanding and thinking.	Deliver good practice training on self –neglect	SGA/SGC NPs and ADs	2022-23	Invite all partners to quarterly events / training being offered by ELFT Disseminate partner agency training to ELFT staff	
		Deliver training on hidden harm which includes; Drug and alcohol Misuse Domestic Abuse Harmful Gambling Mental ill health in the household.	SGA/SGC NPs and ADs	2022-24	Quarterly refresher trainings. Joined up safeguarding Supervisions. Feedback obtained from staff Findings disseminated and used to influence changes in practice and communication through the Safeguarding committee.	
No	**Improved staff experience**	**Action Required**	**Lead**	**Timescale**	**Evidence/ Progress**	**Rag Rating**
2c	The Corporate safeguarding team will ensure that their practice recognises and focuses on trauma informed care/practice across all the services as it is crucial to good integrated practice and effective support for staff and service users.	• NPs to attend Trauma Informed Care (TIC) training offered by the trust. • NP's to incorporate the principles of TIC into training, supervision and advice offered.	SGA/SGC NPs and ADs	Ongoing	• Updating trainings with the principles of TIC • Advice and supervision offered to include TIC	
No	**Improved Experience of care**	**Action Required**	**Lead**	**Timescale**	**Evidence/progress**	**Rag Rating**
3	The Corporate Safeguarding team will ensure that the ethos of Making Safeguarding Personal and Voice of the Child is totally embedded within the practice of all trust staff.	• Consultation and co-production with service users to understand peoples lived experience of safeguarding to raise the profile of safeguarding.	SGA/SGC NPs and ADs	Ongoing	• Undertake regular audits to seek evidence that the views and wishes of service users are at the heart of the safeguarding process • Deliver training and supervision to staff to equip them with the knowledge and skills required to	

					achieve MSP and Voice of the child • Developing forms/assessments that help to evidence MSP and Voice of the child. • Link with People Participation Leads to develop task and finish group to strengthen MSP.	
3a	The Corporate Safeguarding Team to ensure that proactive support is provided to carers to prevent carer breakdown and occurrences of abuse or neglect.	• Engage carers, and people's participation services to understand their perspective on the challenges they face and support needed. Develop recommendations for system improvement and action plan.	SGA/SGC NPs and ADs	2022-24	• Feedback from training sessions and the content of material provided • Reviewing, developing and designing training packages, leaflets,	
		• Seek carer's views and feedback and incorporate learnings into practice through co-production.	SGA/SGC NPs and ADs	2022-24	• Integrate service users experience of Safeguarding into training packages	
No	**Improved value**	**Action Required**	**Lead**	**Timescales**	**Evidence/progress**	**Rag rating**
4a	The Corporate safeguarding Team will continue to provide training and ensure that new and complex forms of abuse are addressed as and when they arise and formulate appropriate	• Monitor and identify the impact of Covid-19 on the prevalence of abuse, neglect and self-neglect across the Trust service users.	SGA/SGC NPs and ADs	Ongoing	• Provide advice • Provide Datix responses • Action Plans from audits completed • Safeguarding Dashboard data set	

	learning mediums to promote awareness.	• Raising awareness of the new forms of abuse and neglect and developing the knowledge to tackle these concerns at an early stage.	SGA/SGC NPs and ADs	Ongoing	• By delivering training and good practice workshops to raise the awareness of Safeguarding issues. • Ensure learnings from the SAR/DHR/PFDs is shared with staff and drives improvement in practice through quarterly learning events. • By reviewing and updating policies and protocols • Develop a safeguarding newsletter with identified new forms of abuse, SAR/DHR/other learning, to be published on the Trust intranet page.	
		• Raise awareness among professionals of the continuous and developing threat from neglect, self-neglect and financial abuse, especially among the elderly and the Learning Disabled service users.	SGA/SGC NPs and ADs	On going	• By delivering training and good practice workshops to raise the awareness of Safeguarding issues. • Ensure learnings from the SAR/DHR/PFDs/LeDer is shared with staff and drives improvement in practice through quarterly learning events.	

		Developing training to raise awareness about inter-generational safeguarding to ensure joined working across all services. Shared information, joint discussion, and shared thinking. Joint assessment and joined planning leading to shared formulation.	SGA/SGC NPs and ADs	2022-23	Develop training with a greater focus on intergenerational issues and transitions. Case studies of SARs/DHRs/SCRs Joint working protocol developed, reviewed and updated.	
4b	A robust data recording system to monitor and track information about Substance Misuse, Domestic Abuse, Harmful Gambling etc to ensure improvements in joint working with adults and children and opportunities for development	• Domestic abuse, Hidden Harms, Drug and Alcohol/Substance abuse, harmful gambling data set.	SGA/SGC NPs and ADs	Ongoing	• Data set agreed • Trends monitored • Information collected where substance misuse, domestic abuse and hidden harms are identified. • Findings disseminated and used to influence changes in multi -agency practice and communication	

Appendix list

1. **Appendix 1** - Organisational Chart for Safeguarding
2. **Appendix 2** - Assurance Structure
3. **Appendix 3 –** Learning from SARs
4. **Appendix 4 -** Learning from CSPRs
5. **Appendix 5 –** Key achievements, challenges and priorities

Appendix 1

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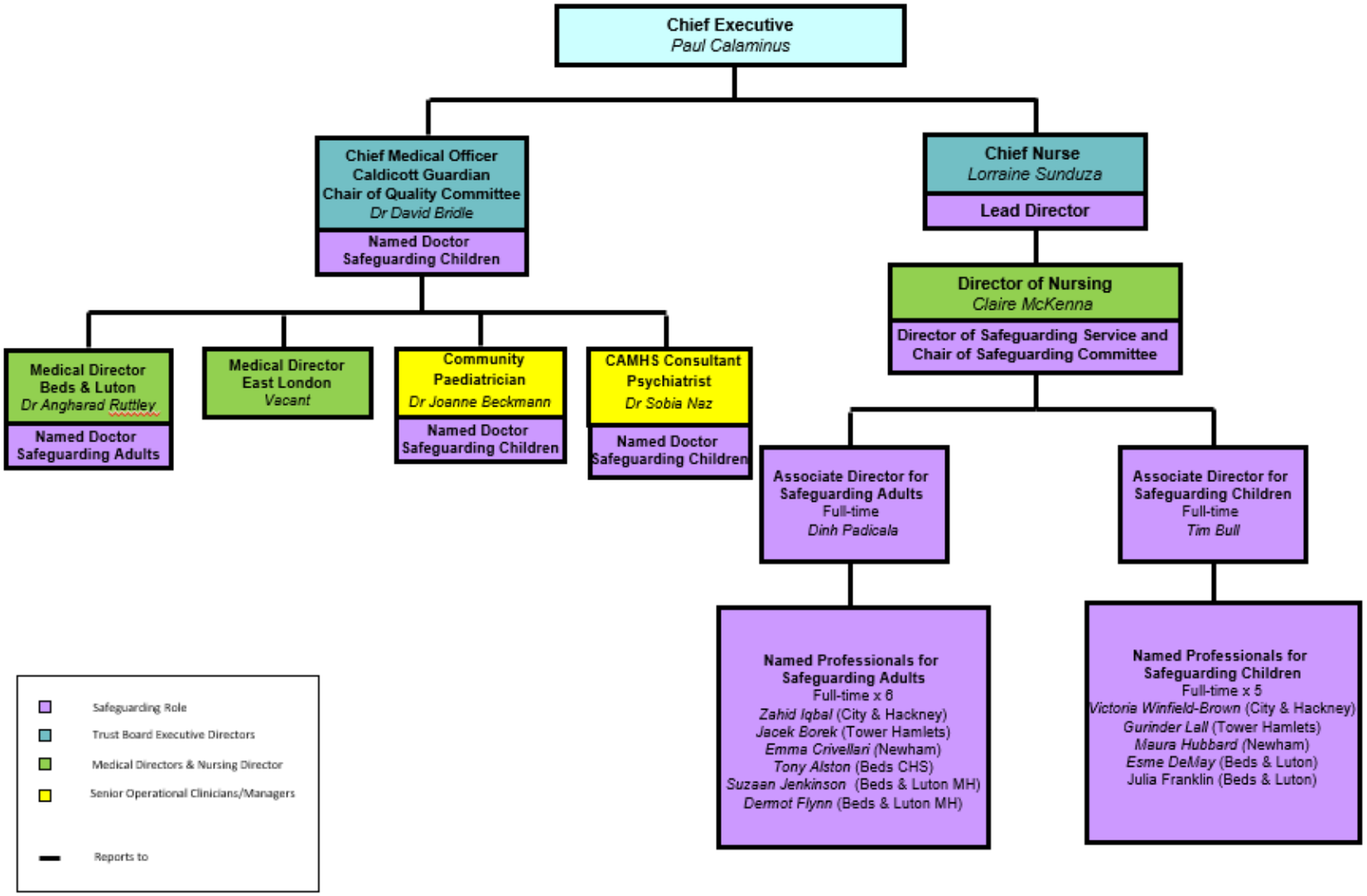
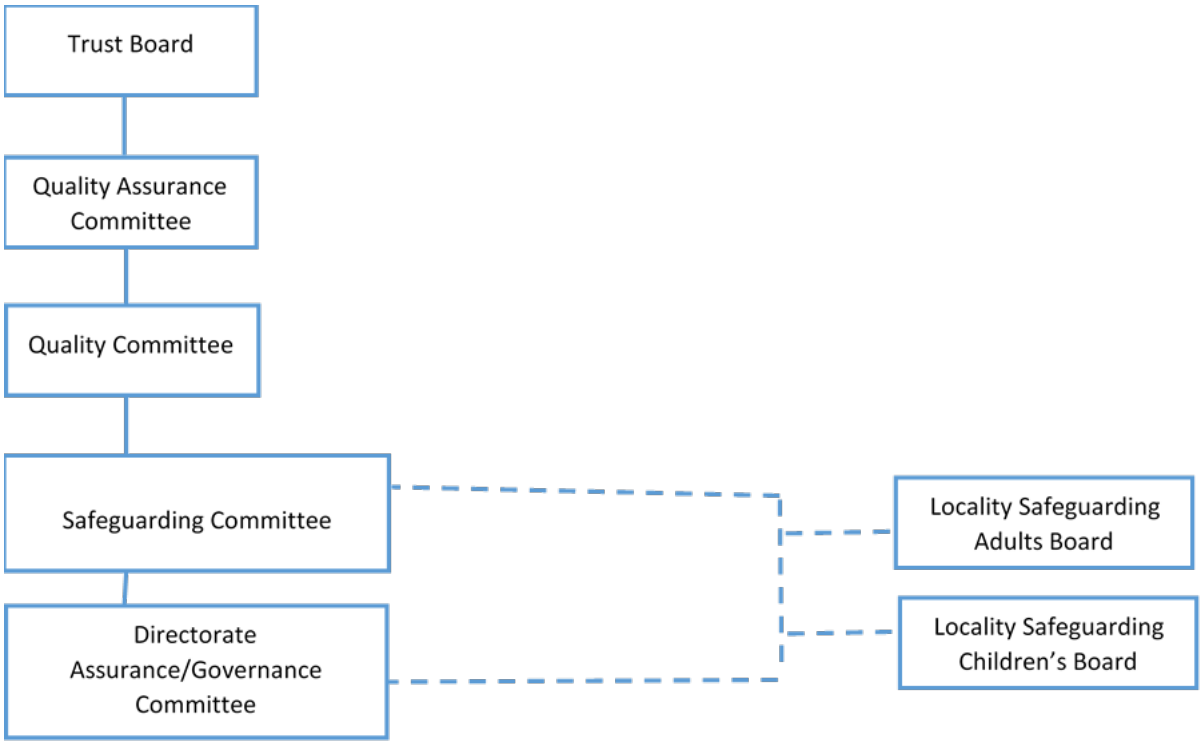
ORGANISATIONAL CHART FOR SAFEGUARDING



Appendix 2


Trust Board
Quality Assurance Committee
Quality Committee
Safeguarding Committee
Directorate Assurance/Governance Committee
Locality Safeguarding Adults Board
Locality Safeguarding Children's Board

Appendix 3 - Learning from SARs

Quality of direct practice with the individual;

- Mental capacity – missing or poorly performed capacity assessments, absence of explicit best interest decision making
- Risk – absence or inadequacy of risk assessment.
- Working with family – failure to involve carers.
- Cultural Competency.

Organisational factors that influence practice;

- Records and recording – key information absent or unclear, failure to consult records, technology shortcomings.
- Supervision and support – absence of supervision, focus on case management rather than reflection, absence of support.
- Legal literacy – insufficient organisational attention to considering legal powers and duties

Interagency or inter professional collaboration;

- Absence of "think family" approach to needs and risk
- Communication and information sharing – crucial information not shared, inadequate pathways and protocols
- Lack of Professional Curiosity – Poor understanding of services
- Lead Agency not identified

Access can be gained to any published SAR / DHR via the partnership websites below:

City and Hackney - https://hackney.gov.uk/safeguarding-adults-board

Newham - https://www.newham.gov.uk/health-adult-social-care/safeguarding

Tower Hamlets
https://www.towerhamlets.gov.uk/lgnl/health__social_care/ASC/Adults_Health_and_Wellbeing/Staying_safe/Safeguarding_Adults_Board.aspx

Bedford Borough - https://www.bedford.gov.uk/social-care-health-and-community/help-for-adults/partnership-boards/safeguarding-partnership-board/

Central Bedfordshire -
https://www.centralbedfordshire.gov.uk/info/22/information_for_professionals/334/safeguarding

Luton -
https://m.luton.gov.uk/Page/Show/Health_and_social_care/safeguarding/safeguarding_adults/Pages/default.aspx

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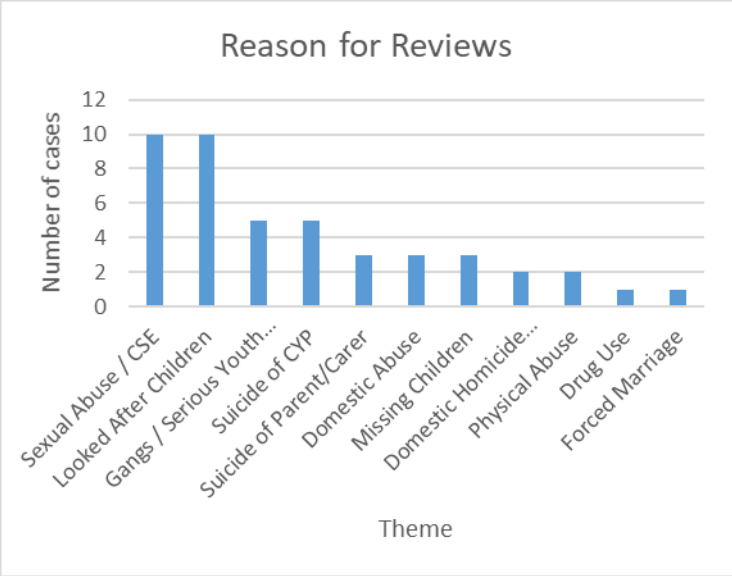
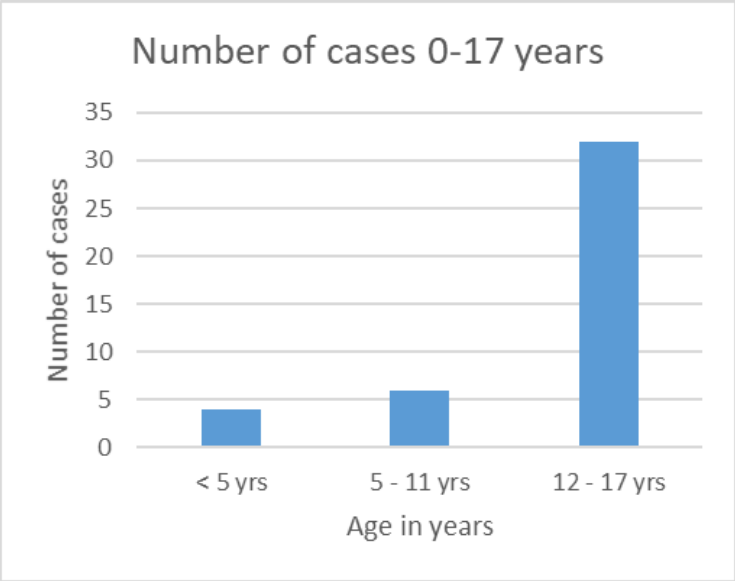
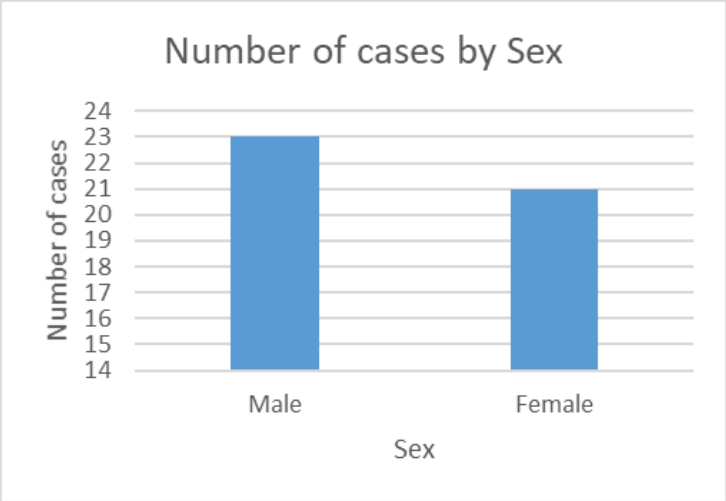
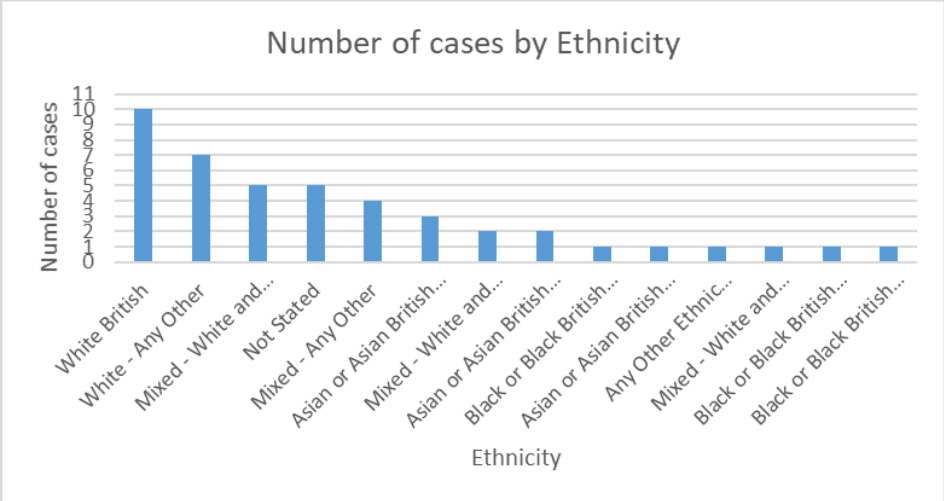
Appendix 4 – Learning from CSPRs









Appendix 4 – Learning from CSPRs

Think Family:

- Role of father
- Other household members
- Family members with additional needs
- Wider support network
- Criminality

Information Sharing:

- Safeguarding considerations override data protection laws.

- Effective sharing of information between practitioners and local organisations and agencies is essential for early identification of need, assessment and service provision to keep children safe. Consent to share information is not always required as the legal basis is much wider (i.e. not just Child Protection).

- Trust staff have a duty to cooperate with Children's Social Care (Social Services).

- Information shared should be relevant, proportionate and necessary.

- Lack of information sharing is a feature of many CSPRs.

Criminal Exploitation / Gangs / Serious Youth Violence:

- Children and young people aged 15-24 years old were disproportionately represented, making up almost 50% of those killed with a gun or a knife in London

- Children and young people (aged 10-17) were in court for being in possession of a knife or offensive weapon in 19% of cases. Also, of those people admitted to hospital for assault by sharp object, 17% were aged 18 or younger

- Approximately 20% of those involved in county lines are children.

Safeguarding risks associated with mental health of children and young people:

- Being a Looked After Child
- Suicidal thinking and self-harm
- Involvement in gangs
- Impact of parental suicide

Access can be gained to any published CSPRs via the LSCPs websites below:

City and Hackney - https://chscp.org.uk/case-reviews/

Newham - https://www.newhamscp.org.uk/serious-case-reviews-2/

Tower Hamlets – https://www.towerhamlets.gov.uk/lgnl/health__social_care/children_and_family_care/Safeguarding_Children_Partnership_Arrangements.aspx

Bedford Borough - https://www.bedford.gov.uk/social-care-health-and-community/children-young-people/safeguarding-children-board/serious-case-reviews/

Central Bedfordshire - https://www.centralbedfordshirelscb.org.uk/lscb-website/learning-from-experience/national-serious-case-reviews

Luton - https://lutonlscb.org.uk/serious-case-review-2/

Appendix 5 – Key achievements, challenges and priorities

Priorities across the safeguarding partnerships include:

- All age exploitation
- Mental Health and wellbeing within families
- Internet Safety and the use of social media
- Neglect
- Domestic abuse
- Implementing learning from SCR/CSPRs
- Children's Emotional Wellbeing and Mental Health
- Health & Stability of the Safeguarding Workforce
- The Voice of Children and Young People.
- Getting the Basics Right
- The Appetite to Learn
- Transitions
- Response to Covid-19
- Improving quality of assessment

The following are the key achievements of the safeguarding team in 2021-22:

- The compliance of adult Level 3 training has improved and it now stands at 87%.
- Adult Safeguarding Supervision has been successfully implemented in line with the Adult Safeguarding Supervision policy.
- The Named Professionals for Adult Safeguarding are chairing the Safeguarding Adults Boards sub-groups in.
- The Safeguarding team have successfully delivered the quarterly Safeguarding refresher training for staff across the trust.
- We have continued to build on our partnerships with other external agencies and strengthened working relations with our colleagues from Social care.
- We attend the Trust's patient safety meetings and transformation meetings to ensure that safeguarding is embedded and considered in all service reviews.
- We have achieved higher reporting of datix concerns where safeguarding was identified as a concern.
- The Named Professionals have received a number of positive feedback from services across the trust.
- Successfully implemented the safeguarding dashboard across the trust.
- Embedding a new approach to safeguarding children training and supervision
- Ensuring all ELFT staff have had uninterrupted access to safeguarding advice and support through planned and ad-hoc supervision
- Improved data collection systems to identify safeguarding themes and demographic data of the safeguarding cohort
- Close partnership working demonstrated in participation of multi-agency audits, case reviews, information sharing agreements and escalation of concerns

- Increased accuracy of key performance data
- Furthered access to multiple record keeping systems across the trust
- Positive feedback regarding the quality of safeguarding children supervision and training.
- Joint working alongside the safeguarding adult team within the Domestic Abuse steering group to promote the Think Family approach.

Challenges:

- Covid-19 presented with a number of new challenges and abuse has now become more hidden and the social media poses a risk to some of our vulnerable service users. The safeguarding team are aware of these concerns and are highlighting and raising awareness of these issues through training and supervisions.
- The safeguarding children team were not staffed to full establishment for the majority of 2021-22 due to issues recruiting new members of staff.
- Cases are often not bought for discussion at planned safeguarding children supervision sessions with a disproportionate amount of time spent on ad-hoc telephone and e-mail support.
- Domestic Abuse is an endemic that needs tackling and staff needs the knowledge to identify and act proportionately to tackle this abuse using the Trauma Informed Approach.
- Poor adherence and application of the Mental Capacity Act (MCA) poses a challenge and staff will be offered training to understand MAC and its application in Safeguarding.
- Action plans agreed at safeguarding supervision are documented and acted upon.
- Duplicate recordings of multiple systems poses a risk and staff are likely to miss recording of important information potentially putting service users at risk and this is being addressed with the Local Authorities across the trust.
- Poor implementation of SAR learning is a challenge and this is being addressed via trainings, supervision and newsletters.
- The cost of living crisis will impact on the vulnerable population leading to further health and economic inequalities and surfacing as safeguarding concerns.
- Cuts to services can lead to inappropriate placements and poor quality of care to our service users.

Key Priorities 2022-23:

- The safeguarding team will ensure that transition is robust between each team at the point of transition from child to adult services is a time of particular risk for vulnerable young people.
- Domestic abuse and violence will continue to have high priority within the work of the safeguarding team’s key priorities. Safeguarding team to support other teams

to embed and support Domestic Abuse screening in all the assessments completed by the trust staff.

- To put a system in place to receive service user feedback to understand service users experience of the safeguarding process.
- To ensure co-production in Level 3 safeguarding training offered by the trust.
- To ensure Trauma Informed care is embedded in the safeguarding supervision and training offered to all trust staff.
- To continue to raise awareness about hidden harms with a focus on Older People and Learning Disabilities.
- To meet the training trajectory for safeguarding children level 3 training
- Ensure any challenges associated with future peaks of Covid can be mitigated
- To improve safeguarding reporting data across several systems
- To ensure that the Trust 'Think Family' ethos and professional curiosity is embedded into everyday practice
- Continue to embed organisational learning through mandatory training, from serious incidents and adult/child reviews
- Making safeguarding personal and the demonstrating the voice of the child has been considered.
- Ensuring all mapped services are supported to receive safeguarding children supervision.

Key Priorities for "Think Family Approach":

- Corporate Safeguarding Adults and Children team to jointly work to ensure that the transitioning from child to adulthood are supported and safeguarded from abuse, exploitation and neglect.
- Corporate Safeguarding Adults and Children team to deliver 'Intergenerational' and 'Intersectional' Safeguarding training for staff.
- Corporate Safeguarding Adults and Children team to Champion named Professionals in areas to shared learning where they could lead on an area of interest and take the lead in developing resources.
- Corporate safeguarding Adults and Children team to ensure that Mental Capacity act is embedded in all Safeguarding practice.
- Corporate safeguarding Adults and Children team to ensure that they continue to raise awareness about hidden harm and exploitation.
- Corporate safeguarding Adults and Children team to ensure that they continue to raise awareness about Domestic Abuse and violence due to the detrimental impact it has on people's physical and mental health.

Partnership priorities:

Priorities across the safeguarding partnerships include:

- All age exploitation

- Mental Health and wellbeing within families
- Internet Safety and the use of social media
- Neglect
- Domestic abuse
- Implementing learning from SCR/CSPRs
- Children's Emotional Wellbeing and Mental Health
- Health & Stability of the Safeguarding Workforce
- The Voice of Children and Young People.
- Getting the Basics Right
- The Appetite to Learn
- Transitions
- Response to Covid-19
- Improving quality of assessment

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REPORT TO THE QUALITY ASSURANCE COMMITTEE
27 June 2022

Title	Annual Report on Safe Working Hours: Doctors in Training
Author/Role	Dr Nicole Eady Consultant Psychiatrist & Guardian of Safe Working Hours
Accountable Executive Director	Dr David Bridle – Interim Chief Medical Officer

Purpose of the report

The Committee is asked to note the annual report from the ELFT Guardian of Safe Working Hours, which provides data about the number of junior doctors in training in the Trust, details arrangements made to ensure Safe Working within the junior doctor contract and arrangements in place to identify, to quantify and remedy any risks to the organisation. This report is for information and assurance only.

Committees/meetings where this item has been considered

Date	Committee/Meeting
N/A	*N/A*

Key messages

- I am assured of junior doctor work schedules at ELFT being compliant with the junior doctor contract, according to data provided by medical staffing department.
- In 2021/2022, 158 exception reports were submitted (an increase compared with the 2020/2021 figure of 119 reports). Most exception reports are for working one or two hours over the rostered hours.
- There were 47 breaches of working hours contract rules leading to Guardian fines, the majority in Quarter 3 in the Luton and Beds higher training rota. The introduction in a second on-call rota in Bedfordshire at the end of Quarter 3 has reduced the number of breaches in Quarter 4.
- On call out of hours rotas were fully covered with a reduction in the use of agency doctors and no overall changes to working patterns for our trainees
- The overall vacancy rate for doctors in training is static.

Strategic priorities this paper supports

Improved population health outcomes	☐	
Improved experience of care	☐	
Improved staff experience	☒	Provides assurance about monitoring of working hours with impact on junior doctor morale and wellbeing.
Improved value	☒	Retention of staff with impact on agency spend

Implications

Equality Analysis	This report has no direct impact on equalities. Exception reporting applies to all doctors in training on the 2016 contract.
Risk and Assurance	Risks are associated with rota gaps and assurance is provided through monitoring.
Service User/ Carer/Staff	No concerns noted at present
Financial	There are no financial implications attached to this report
Quality	No concerns noted at present

1.0 Introduction

1.1 This is the fifth annual report of Guardian of Safe Working Hours at ELFT to be presented. The report has been prepared by the Guardian and covers reporting submitted from 1 April 2021 to 31 March 2022.

1.2 The board is asked to note the information contained in the report.

2.0 Progress during last financial year

2.1 Vacancies: Fill rate of posts remains stable. As of February 2022, there were 171 training posts for junior doctors in the Trust (information provided by medical staffing). Some posts are shared by less than full time trainees.

	Posts for doctors on 2016 contract			**Doctors in training on 2016 contract**		
	London	**Luton / Beds**	**Total**	**London**	**Luton / Beds**	**Total**
FY 1 - 2	17	10	27	16	10	26
GPSTR	15	11	26	15	11	26
CT1-3	48	10	58	50	10	60
ST4-6	52	8	60	53	8	61
	132	**39**	**171**	**134**	**39**	**173**

2.2 Exception reports (2021/2022): 158 reports in total in this 12 month period (compares to 119 in 2020/2021 and 183 in 2019/2020) can be considered a healthy number within the expected range. The data categories for Luton and Bedfordshire was combine from Quarter 3 onwards. Exception reporting has allowed us to identify and resolve issues with individual posts and wards.

Exception reports (by directorate) 2021/2022					
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Totals**
City and Hackney	4	17	9	17	47
Tower Hamlets	11	3	10	1	25
Luton	3	3	0	0	6
Bedfordshire	2	0	0	0	2
Luton / Beds	6	6	25	13	49
Newham	2	6	7	5	20
CAMHS	0	0	6	2	8
Total	28	35	57	38	158

2.3 Exception reports by grade (2021/2022): There has been a good spread across grades, which is positive. Foundation doctors are not involved in out of hours work, hence lower reporting numbers.

Exception reports by Grade 2021/2022					
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Totals**
FY	2	5	8	0	15
GP	3	7	7	8	25
CT	10	6	14	16	46
HT	13	17	28	14	72
Total	28	35	57	38	158

2.4 **Exception reports by action and response time (2021/2022).** Guardian fines follow breaches of working hours contract rules, and result in fines to the directorates, a proportion of which goes to a Guardian Fund. Of 47 fines the vast majority are from the Luton and Beds higher trainee rota where there were breaches of minimum rest requirement. The majority of reports take more than 7 days to address.

Exception reports by Action 2021/2022	
Guardian fine	47
Time Off In Lieu	39
Payment (standard rate)	79
No action required	4

Exception reports by Response Time 2021/2022	
Resolved in < 48	15
Resolved in < 7 days	37
Resolved in > 7 days	104

2.5 **Locum bookings:** Vacant shifts on on-call rotas are covered by locum bookings. Numbers over the period are tabled below, and charted in Appendix 2. There was a decrease in numbers of shifts requiring cover from 1556 in the previous year to 1008 in 2021/2022. There was a decrease in the % covered by agency from 17% in 2020/2021 to 14% in 2021/2022.

Locum bookings for on call shifts		**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Totals**
		Number (agency)	Number (agency)	Number (agency)	Number (agency)	Number (agency)
City and Hackney (incl. Forensics)	CT	29 (3)	28 (5)	52 (15)	29 (2)	138 (25)
Tower Hamlets	CT	17 (1)	9 (0)	34 (2)	29 (1)	89 (4)
Newham	CT	36 (5)	55 (14)	35 (6)	37(2)	163 (27)
City and Hackney (incl. Forensics)	HT	3 (0)	8 (3)	13 (1)	75 (10)	99 (14)
Newham / TH	HT	62(0)	51 (5)	47 (5)	53 (0)	213 (10)
Luton	CT	30 (8)	17 (7)	61(13)	102(11)	210 (39)
Beds	CT	22 (6)	0(0)	0 (0)	0 (4)	22 (10)
Luton / Beds	HT	49 (16)	22 (0)	27 (0)	0 (0)	98 (16)
CAMHS	HT	3 (0)	13 (2)	12 (9)	- (-)	28 (11)
Total		**251 (39)**	**203 (36)**	**229 (36)**	**325 (26)**	**1008 (137)**

3.0 Qualitative Information

3.1 The 2016 junior doctor contract from NHS Employers includes safeguards relating to working hours. Work schedules and on call rotas follow contract rules. Trainees report breaches in work schedules by exception reporting. Work schedule reviews can take place if needed. For some breaches of the working hours rules, fines are levied. The Guardian of safe working hours ensures compliance with the safeguards, acts on issues as they arise, and assures the Trust Board that working hours are safe. Exception reporting is considered a sign of a healthy training environment in which juniors feel able to identify when they have worked outside of rostered hours or patterns.

3.2 In 2021/2022 Junior Doctors continue to exception report at a reasonable rate across the ELFT. The CAMHS rota has a lower rate of reporting than would be expected. The

Guardian has run exception reporting refresher training in CAMHS to address this concern.

3.3 There was a decrease in on call shifts requiring locum bookings and a reduction in the percentage of agency rota. CAMHS rota data is not currently available, a rota co-ordinator has been recruited to this post to enable reporting from Q1 2022-2023.

3.4 Improvement could be made in response times to reports. Initial contact is made with most trainees within the 7 days, but delays to report sign off occur for a variety of factors. This can include a delay in the trainee meeting 1:1 with their clinical supervisor to review the exception report, a delay in the supervisor accessing the DRS system and a delay in trainees replying to the guardian with their requested outcome. The contractual response of 7 days is probably not feasible, and in the majority of cases, doctors report being content with the process and response from supervisors. All urgent quality or clinical safety issues are raised as a priority with the clinical directors and key stakeholders as and when required.

3.6 The Guardian runs a Junior Doctor Forum on a bi-monthly basis including BMA, medical staffing and medical education representation. The purpose of the forum is broadly to look at any and all issues pertinent to creating a more supportive working environment for junior doctors and includes as agenda items reports from each locality, information on rest facilities, timely access to rotas, and impact of rota gaps. The forum has been well attended. All meetings have gone ahead as planned and the forum has been positively received. Separate meetings with CAMHS trainees and with LTFT trainees have been held. All trainees have access to channels to report on patient safety issues and local concerns directly in addition to this forum. Maintaining an active forum, and engagement of supervisors in the exception reporting processes requires ongoing work.

4.0 Recommendations

4.1 Trainees continue to be actively encouraged to report variation to work schedules.

4.2 Guidance on reporting is regularly circulated to trainees and is included in induction as well as being located on the Medical Education web pages.

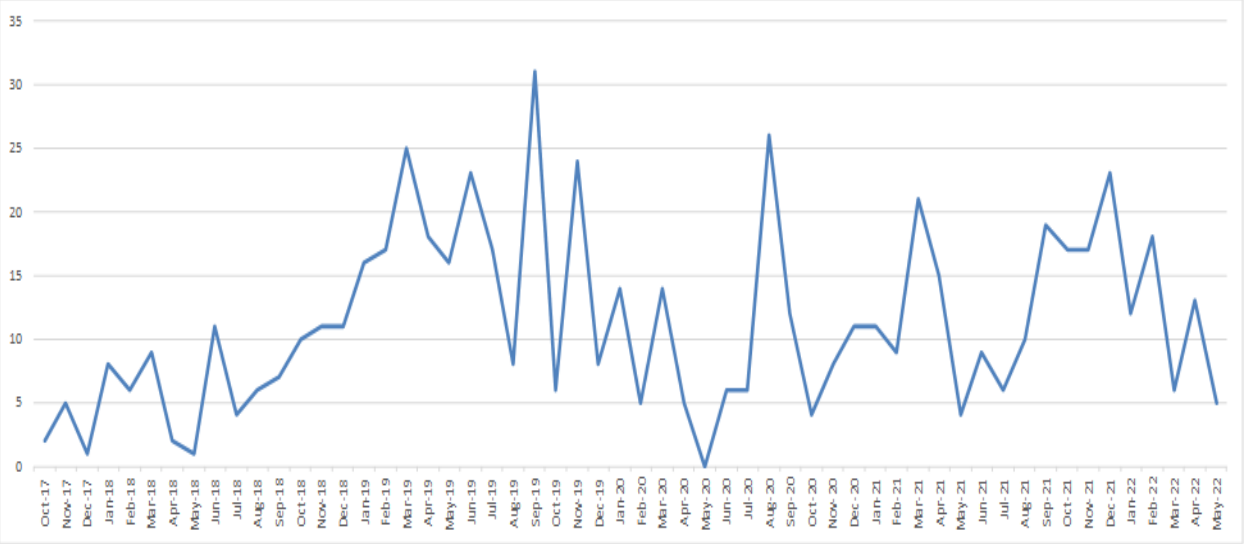
4.3 The Guardian will continue to support individual trainees and consultants to address issues with timetabling and workload, and with clinical directors over operational issues.

4.4 Medical education department will continue to support trainee representatives in their role as a voice for trainees, and in ensuring that trainees are aware of sources of support and remedy for concerns about safety and safe working.

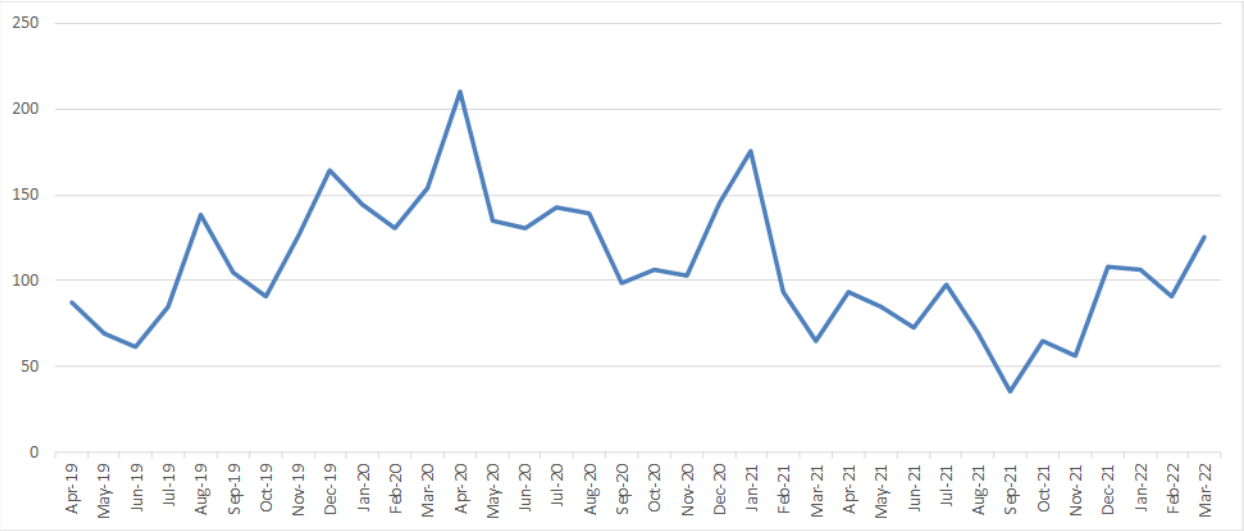
5.0 Action Being Requested

5.1 The Board/Committee is asked to **RECEIVE** and **NOTE** the report for information

Appendix 1
Total exception reports, by number, by month, October 2017 – May 2022
East London NHS FT



Appendix 2
Total number of vacant shifts offered as locums, April 2019 – March 2022, East London NHS FT



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REPORT TO THE QUALITY ASSURANCE COMMITTEE
27th JUNE 2022

Title	Freedom to Speak Up Annual Report
Author/Role	Anita Hynes, Freedom to Speak Up Guardian
Accountable Executive Director	Lorraine Sunduza, Chief Nurse/Deputy CEO

Purpose of the report

To brief the Trust Board on the Freedom to Speak Up activity from April 1st 2021 to March 31st 2022, to ensure it is meeting its objectives both locally and nationally and to set out proposed work plan for the coming financial year.

Committees/meetings where this item has been considered

Date	Committee/Meeting
N/A	N/A

Key messages

Freedom to Speak Up received 112 concerns in between 1st April 2021 to 31st March 2022.

The broad categories (reported to the National Guardian's Office (NGO)) under which these cases fall are cases with an element of:

- Patient safety/quality
- Bullying or harassment
- Worker safety
- Processes/Organisational Structure/Other and
- Cases raised anonymously

Administration, Clerical & Maintenance/Ancillary account for the largest proportion of concerns received.

The main theme emerging is around Processes/Organisational Structure/Other and relate to HR processes.

FTSU are working with People and Culture regarding the differences between FTSU and formal processes, and how to effectively communicate this work with staff.

Respectful Resolution is a resolution pathway that support all staff and managers to have conversations early, build confidence to discuss, defuse and ultimately defeat bullying through an informal process that creates a kinder culture and tackle poor behaviours.

Strategic priorities this paper supports

Improved population health outcomes	☒	Ensuring the Trust is Well Led and meets CQC regulation.
Improved experience of care	☒	Improved staff satisfaction positively correlates with improved service user satisfaction.
Improved staff experience	☒	The ability to raise concerns is key to a culture of trust and safety. There is potential to improve staff satisfaction through openness and transparency about how concerns are raised and dealt with.
Improved value	☒	Effective speak up processes reduce financial risk and exposure to the Trust through employee relations' cases, legal fees and redundancies.

Implications

Equality Analysis	This report has no direct impact on equalities
Risk and Assurance	Staff with protected characteristics are impacted by Trust policies, which can result in fear of speaking up. Trends are monitored, with a specific focus on improving the representation and experience staff.
Service User/ Carer/Staff	FTSU promotes the importance of staff speaking up; to providing high quality, cost effective, compassionate services and to continuously improve in partnership with people who use our services, their carer, families, friends and communities.
Financial	There are financial implications associated with Freedom to Speak Up, potential redundancies and tribunal claims resulting from organisational change.
Quality	Themes arising from Freedom to Speak Up can act as a driver for quality improvement work.

Glossary

Abbreviation	**In full**
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
FTSUC	Freedom to Speak Up Champion
NGO	National Guardian's Office
CQC	Care Quality Commission
HEE	Health Education England

1.0 Background/Introduction

All NHS Trusts are required to have a Freedom to Speak Up Guardian (FTSUG) in post following the Freedom to Speak Up Review undertaken by Sir Robert Francis and published in February 2015.

The Trust appointed a FTSUG in October 2017 and has implemented the 'standard integrated policy', which had been adopted in line with recommendations of the review by Sir Robert Francis into whistleblowing in the NHS.

1.1 National Guardian Office

The Trust reports quarterly data to the National Guardian's Office.

The data reported is as follows:

- Numbers of cases brought by professional level
    - worker, manager, senior leader, not disclosed
- Numbers of cases brought by professional group
- Number of cases raised anonymously
- Number of cases with an element of patient safety/quality
- Number of cases with an element of bullying or harassment
- Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment') is indicated
- Number of cases with an element of worker safety

1.2 Freedom to Speak Up Index

The Freedom to Speak Up (FTSU) Index was one of the indicators that helped to build a picture of what the speaking up culture feels like for workers. It was a metric for NHS Trusts, drawn from four questions in the NHS Annual Staff Survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns, and if they agree that they would be treated fairly if involved in an error, near miss or incident.

The NHS Staff Survey has undergone significant changes – in line with the People Plan. As a result, some of the questions, which comprised the FTSU Index, have been dropped. In light of this, the National Guardian's Office are no longer publishing the FTSU Index.

The 2021 NHS Staff Survey included two questions pertaining to speaking up, asking:

- I feel safe to speak up about anything that concerns me in this organisation
- If I spoke up about something that concerned me I am confident my organisation would address my concern

The National Guardian's Office will look at the results of these questions and others in the NHS Staff Survey as part of a broader and more holistic view of the speaking up landscape in healthcare.

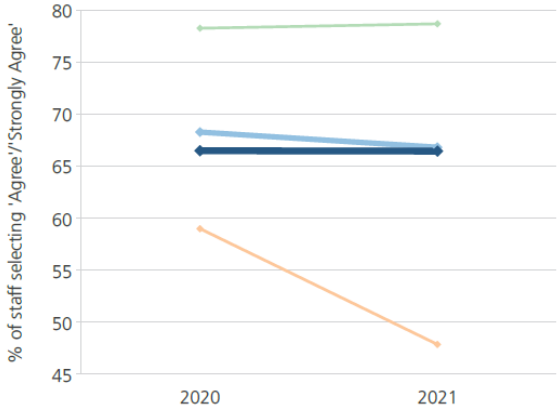
1.3 NHS Staff Survey Results – Raising Concerns

Survey Coordination Centre

2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We each have a voice that counts** – Raising concerns

NHS

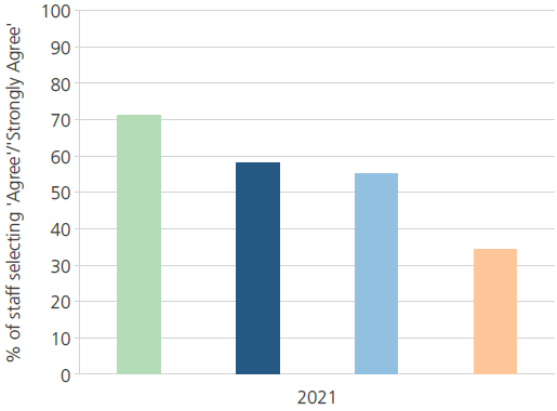
Q21e
I feel safe to speak up about anything that concerns me in this organisation



	2020	2021
Best	78.3%	78.7%
Your org	66.5%	66.5%
Average	68.3%	66.8%
Worst	59.0%	47.9%
Responses	2,535	2,483

Q21f
If I spoke up about something that concerned me I am confident my organisation would address my concern

No trend data are shown as this is a new question



	2021
Best	71.3%
Your org	58.1%
Average	55.1%
Worst	34.3%
Responses	2,483

In the NHS Staff survey, Question 21e tells us that 66.5% of colleagues feel safe when raising their concerns and Q21f that 58.1% feel confident that ELFT will address their concerns.

The results are representative of those who answered the NHS Staff Survey.

2.0 FTSU Headline Data

2.1 Broad themes of the concerns raised with FTSU

Concerns raised with an element of	Trust Wide 2021-2022 (Percentage)
Patient safety/quality of care	10.4
Processes/Organisational Structure/Other	42.7
Bullying and/or harassment	23.2
Worker safety	7.9
Related to COVID-19 concerns	1.2
Cases raised anonymously	*7.9*
Cases unknown	6.7
Total	**100.0**

The majority of concerns raised around Processes/Organisational Structure/Other relate to:

- Human Resources processes
- Role banding
- Recruitment processes
- Lack of supervision
- Preferential treatment
- Risk assessments
- Access to Work
- Reasonable adjustments
- Sickness monitoring
- Management support

All concerns raised are escalated to Service Directors, senior managers and/or HR, as appropriate to the nature of the concern.

The working done to resolve the concerns are fed back where possible (not always possible when raised anonymously).

Respectful Resolution was developed by the Trust in response to the number of bullying and harassment cases being raised (directly with HR, managers and FTSU). Respectful Resolution is a toolkit to support with resolving these concerns before they become a formal process (Dignity at Work).

We continued to monitor concerns directly related to COVID-19. Those concerns have decreased significantly since the pandemic began in 2020.

In 2020-2021, 20.8% of concerns raised were related to COVID-19, compared to 1.7% in 2021-2022.

From February 2022, we also monitored for any concerns coming through relating to the war in Ukraine. No concerns were raised with FTSU.

2.2 Concerns raised with FTSU by professional level

Concerns brought by professional level	Trust Wide 2021-2022 (Percentage)
Worker	60.7
Manager	28.6
Senior leader	0.9
Not disclosed	9.8
Total	**100.0**

The vast majority of concerns raised with FTSU were from workers.
The definitions from the NGO are as follows:

- Worker: Any individual working in any capacity, including volunteers, contract staff, bank/agency staff etc. Use this category unless one of the other categories applies.
- Manager: A line manager or anyone with managerial responsibility.
- Senior leader: Board-level or equivalent workers. In a Trust setting, this would usually be equivalent to a Band 9 and above.
  This category should be applied to clinical directors and above, executive and non-executive Board members, GP partners, dental partners, superintendent pharmacist and optician partners/owners.

2.3 Concerns raised with FTSU by professional group

Concerns brought by professional group	Trust Wide 2021-2022 (Percentage)
Administration, Clerical & Maintenance/Ancillary	25.0
Allied Health Professionals	11.6
Corporate Services	3.6
Medical and Dental	5.4
Not Disclosed	16.1
Nursing Assistants or Healthcare Assistants	8.9
Other	13.4
Registered Nurses and Midwives	13.4
Social Care	2.7
Total	**100.0**

The majority of FTSU concerns raised were from Administration, Clerical & Maintenance/ Ancillary staff, which mostly related to Processes/Organisational Structure/Other and Bullying and/or harassment.

Concerns raised by Allied Health Professionals related to Processes/Organisational Structure/ Other, Bullying and/or harassment, Patient safety/quality of care and Worker Safety.

2.4 Concerns raised with FTSU by Directorate

FTSU Concerns Raised by Directorate	2021-2022 (Percentage)
Bedfordshire Mental Health	12.5
City & Hackney Services	4.5
Community Health Services - Bedfordshire	6.3
Community Health Services - Newham	12.5
Community Health Services - Tower Hamlets	3.6
Corporate Services	12.5
Forensic Services	2.7
Luton Mental Health	1.8
Newham Mental Health	7.1
Primary Care Directorate	4.5
Specialist Services	7.1
Tower Hamlets Mental Health	17.0
Unknown	8.0
Total	**100.0**

The majority of concerns raised with FTSU were from Bedfordshire MH, CHS Newham and Corporate Service.

3.0 Progress against work plan during last financial year

3.1 Key achievements during last financial year

- FTSU Month October 2021, an opportunity to highlight the importance of 'Speaking Up' when it is felt that something is just not quite right.
  Good attendance at the virtual sessions held during the month.
- FTSU Champions - recruitment is ongoing and currently have 12 Champions across the Trust.
- FTSU Newsletter – shared by the Communications Team, in the 'What's New' bulletin
- Discussions are regularly occurring between with the Guardian of Safe Working Hours (GoSWH) for Junior Doctors and the FTSUG to see if there are any trends or similar themes identified in both areas of work.
  - No similarities found to date.
- FTSU Training requested and delivered:
  - Corporate Inductions
  - New Specialist District Nurse Student Training
  - BAME Network
  - Corporate Secretariat Team
  - Junior Doctor Forum
  - Primary Care Directorate
  - CHS - Tower Hamlets - SE Locality

- Business Partners C&H & Forensics
- Bedfordshire Wellbeing Service
- East Ham Care Centre

- Improved communication between FTSU and HR staff especially through grievances following FTSU concerns.

3.2 Review of Key Priorities April 2021 – March 2022

Key priorities April 2021 – March 2022	Timescale	Outcome
Triangulation of concerns and themes with Trusts' protected characteristics. • To add inclusion of ethnicity data collection when a concern is raised (unless raised anonymously) • Carry out analysis of concerns data, taking into consideration the protected characteristics	Commence capturing this information from April 2021.	Difficult to capture consistently, due to anonymous concerns or those that do not follow up once concern is raised. Reviewing to incorporate into the FTSU feedback survey.
The FTSU team to develop new ways of sharing learning from 'speaking up' across the Trust specifically explore learning that could benefit staff across all directorates.	Ongoing	Regular meetings with the Champions support this endeavour. FTSUG now meeting colleagues on site, which is also supporting.
Virtual Freedom To Speak Up conference Oct/Nov 2021	Oct/Nov 2021	This did not take place. Now planning for 2022 – 2023 and will consider to hold it in person.
Update the current FTSU Board self-assessment. Complete gaps identified by the self-assessment and report regularly within identified governance framework.	Currently reviewed to refresh roles and responsibilities in line with board member changes.	Completed. Will review again for 2022-2023.
Freedom to Speak Up e-learning modules, developed in association with Health Education England (HEE) and the NGO. Seeking to make this training mandatory for staff. 1. The first module – Speak Up – is for all staff. 2. The second module, Listen Up, for managers There is a targeted training module for leadership teams and stakeholders.	Planning is in conjunction with Training and Development. E-learning start date to be agreed for later this year.	Agreed with the L&D Teams that the modules will be added to the modules available to staff on the new platform, ELFT Learning Academy in 2022.
Complete a FTSU Pulse survey with all staff in the Trust to assess: i. Understanding of FTSU and what it is ii. How to access FTSU support iii. If they have availed of the service previously, their feedback on their experience of FTSU and how the service can be improved.	Still in planning – action carried forward to 2021/2022.	Did not take place. The FTSU Newsletter is moving to email format this year, which will be sent to all staff. This survey will be included.

Survey to be repeated 6-9 months later to ascertain improvements in understanding of and accessibility of FTSU, and to assess for further improvements.		

3.3 Key Priorities April 2022 – March 2023

As well as the priorities above that are ongoing or being carried forward:

- **Follow Up**
  The third Freedom to Speak Up e-learning module, Follow Up, was released earlier in 2022.
  It is aimed at all senior leaders including executive board members (and equivalents), Non-Executive Directors, and Governors to help them understand their role in setting the tone for a good speaking up culture and how speaking up can promote organisational learning and improvement.
  Will plan how to ensure this module is completed.

4.0 Action Being Requested

4.1 The Board/Committee is asked to:

a. **RECEIVE** and **NOTE** the report for information

NHS
East London
NHS Foundation Trust

ANNUAL SIRO REPORT TO THE QUALITY ASSURANCE COMMITTEE

27 June 2022

Title	SIRO annual report
Author	Associate Director of Information Governance – Chris Kitchener Chief Digital Officer – Philippa Graves
Accountable Executive Director	Chief Quality Officer – Dr Amar Shah

Purpose of the report

To set out progress against the workplan for the past financial year together with the proposed work plan for the coming financial year. The report encompasses information governance (IG) and Digital.

Key messages

Organisations are required to manage information risk. The SIRO report sets out risks and achievements for the year

Strategic priorities this paper supports

Improved population health outcomes	☒	
Improved experience of care	☒	Provides assurance personal information is processed in accordance with the law
Improved staff experience	☒	Increases awareness, confidence and personal responsibility for data handling
Improved value	☒	Minimises the likelihood of regulatory Information Commissioner fines

Committees/meetings where this item has been considered

Date	**Committee/Meeting**
	None

Implications

Equality Analysis	No direct impact
Risk and Assurance	Provides assurance information governance, data security and digital risks are identified and managed
Service User/Carer/Staff	Provides assurance personal information is effectively managed and processed
Financial	Reduces the likelihood of Information Commissioner fines
Quality	Ensures data is processed to high standards within a statutory framework

1.0 Background/Introduction

1.1 Public organisations must have a data security accountability framework including the appointment of a Senior Information Risk Owner (SIRO). The SIRO must provide assurance of practice, progress and developments in information risk management. ELFT does this through a bi-monthly Information Governance Steering Group meeting, chaired by the SIRO. The IGSG is accountable to Quality Committee. We take an annual SIRO report

to the Board via Quality Assurance Committee. QAC receives regular updates from Quality Committee.

1.2 Digital risk is managed via the Digital Strategy Board, which is a sub-committee of the Finance, Business & Investment Committee. Board Assurance Framework Risk 8, which describes and tracks the digital risks, is reported to the FBIC, and regular updates provided to the Trust Board by the Chair of the Committee when required.

2.0 Progress against workplan during last financial year

2.1 Key achievements

Data Security & Protection Toolkit – the previous year's 2020/21 deadline was deferred from March 31st to 30th June 2021. The Trust received a fully compliant rating across all Assertions. This was reported to QAC in September 2021. The revised timetable has an impact on the 2021/22 submission as the deadline has again changed to 30th June. We have been advised the submission date is likely to remain at 30th June in future years.

DSPT internal audit - organisations must have an annual independent information governance audit. Given the revised timetable for DSPT submissions the internal audit was put back to May 2022 (currently in progress at the time of drafting this report). Audit results will therefore be included in the DSPT annual report to be tabled at QAC in September 2022.

Clinical coding audit – the DSPT requires organisations to have an annual clinical coding audit. This helps improve the quality of the coded clinical record which in turn underpins the organisational management, planning and commissioning of services. The audit evaluates the accuracy and completeness of coded data against the clinical record. Our annual audit took place in February 2022 resulting in a compliance rate of 100% primary diagnosis coding (against a mandatory 85% compliance requirement) and 98% secondary diagnosis coding (against a 75% mandatory requirement).

Freedom of Information (FOI) – FOI activity remained high throughout the year with a 22% increase in the number of requests over the past three years. Similar to other Trusts there have been a considerable number of overdue requests due to a combination of factors including clinical priorities taking precedence over FOI handling, workloads of both subject matter experts and the information governance team and challenges in obtaining final approvals for disclosure. A plan was put in place to support improvement. As a result the number of overdue requests declined from 78 in September 2021 to 46 on March 31st 2022. 63% have been responded to on time. This is similar to the last financial year's 64% but lower than pre pandemic response rates of 79% on time.

FOI	2019 - 20	2020 – 21	2021 - 2022
Total no. requests received	362	342	442
Total no. closed	322	299	401
No. closed / responded to on time	251 (78%)	191 (64%)	251 (63%)
No. closed / responded to late	71 (22%)	108 (36%)	150 (37%)
No. where full exemptions were applied	21	30	103
No. where partial exemptions were applied	Not recorded	30	42
No. not relevant to the Trust	44	21	52
No. requests for review	03	01	01
No. escalated to ICO by requester	01	01	0

Access to records requests - The Trust has a devolved access to records function whereby requests are dealt with locally. This causes some variance in timeliness, completeness and standards of response and is addressed in part by an access to records lead network with regular meetings and training. Luton, Bedfordshire and (since October 2021) Newham Mental Health services requests are processed through the corporate information rights team where there is greater oversight and control. The number of requests has increased by 47% over the last three years from 1429 in 2019/20 to 2095 in 2021/22. 90% of requests have been responded to on time within one calendar month whilst a further six complex requests were processed with an agreed extension of up to three months (as permitted under the Data Protection Act.) The number of staff requests increased significantly from five in 2019/20 to 31 in 2021/22, are often in response to grievance or other action, and are time consuming and potentially litigious.

SARs	2019 - 20	2020 – 21	2021 - 2022
Total no. SARs received	1429	1672	2095
Total no. SARs responded to	1261	1362	1910
Total no. responded to on time within one calendar month	1115 (91%)	1292 (94%)	1720 (90%)
No. responded to with an agreed extension of 2 – 3 months	Not recorded	09	06
No. responded to late	146	70	190
No. staff requests	05	19	31
No. escalated to ICO by requester	Not recorded	Not recorded	08

Confidentiality and data security breaches - all incidents are scrutinised daily and appropriate action taken including Trust wide communications, individual support and targeted training. The Trust reports any confidentiality, data security or cyber security incidents via the DSPT incident reporting function, following a pre-determined matrix and set of questions. Thirteen incidents met the serious incident reporting framework, a decrease on the previous year's 20. Three of those met the threshold for notification to the Information Commissioner – one relating to inadvertent sharing of community Forensics patient data due to hidden columns on a spreadsheet, one where a staff sickness report was inadvertently shared with peers and one where an external contractor accessed information provided in a work context about service users for his personal use.

Data security breaches	2019 - 20	2020 – 21	2021 - 2022
Total no. data security / confidentiality incidents in period	582	520	556
Total no. data security / confidentiality 48 hour reports requested	Not recorded	35	32
Total no, reported to the DSPT	03	20	13
Total no. subsequently reported to ICO	0	01	04

ICO complaints / decision notices – eight complaints were made to the Information Commissioner. All related to handling of requests for personal information. Three related to Luton, three to Tower Hamlets, one to specialist services and one to City & Hackney. The ICO has agreed with the Trust's handling in all cases. No decision notices have been issued.

Information sharing - information sharing agreements are regularly reviewed to ensure sharing is current and appropriate. Since April 2020 we have introduced strong governance processes to record information sharing activity. 25 ISAs or third party access agreements have been approved during the year. This is a decrease as the need for individual ISAs is negated if there is already an ICS agreement in place.

ISAs	2019 - 20	2020 – 21	2021 - 2022
No. new ISAs approved	Not recorded	28	19
No. existing ISAs renewed	Not recorded	03	0

Total no. ISAs approved	Not recorded	31	19
No. new 3rd party access agreements approved	Not recorded	10	05
No. existing 3rd party access agreements approved	Not recorded	01	01
Total no. 3rd party access agreements approved	Not recorded	11	06
Total ISAs / 3rd party access agreements approved	Not recorded	42	25

Data Protection Impact Assessments – DPIAS are required where high risk processing could take place. 24 DPIAs have been completed during the year.

DPIAS	Previous year (2019 - 20)	Previous year (2020 – 21)	Current year (2021 - 2022)
Total no. DPIAs approved	Not recorded	31	24

Contracts – contracts must be compliant with data protection law. Where necessary there must be a Data Processing Agreement clearly setting out how data is managed and processed. Considerable work has taken place to establish communication links and processes between the Commercial Development and Information Governance teams resulting in the identification, scrutiny and approval of 106 contracts and associated Data Processing Agreements compared to 86 the previous year.

Contracts	2019 - 20	2020 – 21	2021 - 2022
No. contracts / DPAs approved - ELFT as Provider	19	27	48
No. contracts / DPAs approved - ELFT as Commissioner	39	59	58
Total no. contracts / DPAs approved	58	86	106

Business continuity – the DSPT requires Trusts to undertake **a**n annual exercise based on cyber security risk. This follows the WannaCry incident in May 2017. The Cyber X exercise is planned and will take place in June 2022.

Cyber Security - the Trust receives regular CareCert notifications from NHS Digital, and applies the security recommendations on a regular basis. The Trust was an early adopter of the Care Cert service and is signed up as a Cyber Accelerator – receiving additional audit and support from NHS Digital to support the Trust's cyber security agenda. The Trust has Cyber assurance partners such as IT Health and Sophos but urgently needs to expand its Cyber team to match the increasing risk in this critical risk area, and the 24/7 nature of the threat and response. The Trust has also enrolled into other NHSX programmes such as the Microsoft ATP deployment, Windows 10 and most recently the NHS Secure Boundary together ensure the Trust has taken appropriate measures given the available funding to address cyber risks. Cyber remains a key threat to the organisation, an area where ongoing focus must be increased with additional resources, structures and systems put in place over the coming year.

Phishing campaign - NHS Digital carried out a simulated phishing campaign in March 2021, 23% (1,019) opened the email and clicked the link, and 3% (133) of the 4,365 staff opened the email and entered their personal credentials compared with an NHS average of 1%. Staff who entered information received feedback and training from NHS Digital after entering their sensitive personal information. NHS Digital will carry out further phishing tests on behalf and at the request of ELFT to improve awareness and correct response.

Cyber security audit - 2020-2021 Cyber security audit was received by the SIRO, following a subsequent meeting with the Digital Team & CDO, an action plan was reviewed, and it was

agreed to carry out a follow up NHS Digital audit in July 2021, the CDO will update the relevant committees and SIRO accordingly. Further to this the Digital Strategy addresses the workforce structure and tools required to deliver a sustainable and secure service provision for the organisation in the face of ever increasing and complex cyber threats.

2.2 What went well, and what learning do we want to share from this?

Archiving – last year we worked with Iron Mountain on a small pilot to identify the state of records beyond statutory review and retention /deletion dates. This year we did the same with Restore to assess at a small sample of boxes / files to determine data quality and destruction potential (awaiting results). We re-negotiated our contract with iron Mountain. We also worked with Restore to provide digital records rather than paper in response to requests for retrieval to save on transport costs, speed up processes and increase records availability by attaching the records to RiO. We set up an internal financial viability records archiving group and have so far identified approximately 700 records in Tower Hamlets that should have been destroyed years ago. This is helping reduce internal storage and free up space for offices.

Information governance structure – we supported and developed our Information Governance Coordinator who has successfully secured a promotion with another organisation. Last year we promoted our Access to Records Assistants to Information Rights Officers. Both are currently acting up to other roles in the team, demonstrating the value of developing individuals.
An information governance restructure took place in 2021 to realign responsibilities and increase resilience. One post was deleted (Head of IG) to create two new posts (Information Rights Manager and Information Rights Coordinator) at lower and more appropriate bandings. This has been successful and has helped to manage the considerable increase in workload.
In October 2021 responsibility for Newham subject access requests was transferred from Newham to be under the direct management of the information governance function to provide professional support.

Agile working - A number of services and sites are now adopting the new models of agile working spaces developed for example East Ham Care Centre, People & Culture and Tower Hamlets CAMHS Greatorex Street site. As part of the Future of Work many others are reviewing their desktop layouts by moving to docking stations and laptops. This Digital adoption and transformation was accelerated in the Covid Response phase with over 2000 laptops deployed with VPN working numbers rising from 1,800 to 4,000+. Digital have had to scale out infrastructure, secure and expand our use of tools and solutions to mobilise our workforce. Remote working concurrency levels at peak have now increased tenfold, from 200 to 1,850. An example of digital enabling service continuity is ELFT IAPT services transferred to entirely virtual delivery.

Deployment of new video conferencing solutions - Webex, MS Teams, Zoom (for staff education events), AccuRx, Clinic.co and Attend Anywhere were deployed across the Trust to support virtual staff collaboration, team meetings, corporate events, patient consultations and group therapy and education events. The adoption of new flexible platforms is essential to continue to offer Trust services in these unprecedented times, however it is important to scale up the digital teams' capability to support this increased deployment and reliance on digital solutions. The substantial impact on the network utilisation that will occur when staff return to trust locations is being addressed as part of the network review.

IT service desk call queue – The IT ServiceDesk improvements have been sustained through the challenging increase in demands for support highlighted in 8.5 Covid Response.

A large amount of work in achieving this was carried out by the digital team and continues to support the Trust.

Windows 10 – The most recent report from NHSD on ELFT coverage of Windows 10 shows a healthy 100% coverage (9300 devices), with 100% coverage of enhanced support from Microsoft to cover our entire estate.

Cloud migration – A two-year programme of works to retire end of life data centre infrastructure in Alie St (6 years old) and disaster recovery at The Green (10 years old). Migrating all data services into cloud hosted platforms on Microsoft Azure and AWS via UKCloud. This is a key deliverable in the Trust Digital plan to utilise more secure, scalable and robust IT infrastructure. Azure migration has been completed, with 10 servers left to move to UK Cloud. The full benefit realisation and risk governance and tracking of this substantial investment in infrastructure. Uncertainty with the longevity of UKClouds presence in the marketplace has initiated a further migration of data to AWS to ensure resilience.

Digital Dictation – Dragon Medical One has been successfully deployed across ELFT with a return on investment of over £2 for each £1 spent and clinicians using the auto text function saving an average 30 minutes of time on each day of use. Winscribe has been successfully deployed to replace BigHand creating a closed document creation loop and reducing the risks associated with email transfer of draft clinical documents.

Patient Portal - ELFT worked in partnership with City and Hackney CCG to deploy the patient portal Patient Knows Best and was awarded "Highly Commended" by the Health Services Journal. This improves security of access by patients to their care plan.

PANDO – ELFT successfully deployed the WhatsApp replacement PANDO offering a secure messaging platform to support clinical care.

2.3 <u>What wasn't achieved, and what have we understood about the reasons for this?</u>

Archiving – although we had intended to continue our archiving pilots on a business as usual basis this has not been taken forward due partially to supplier engagement together with the need to create a robust in depth business case.

Locality audits – the information governance team routinely visits localities to undertake supportive data security audits. Although the programme has recommenced, given social distancing measures and clinical services priorities the number of audits has been small and mostly carried out via Teams than in person.

2.4 <u>Any notable risks further to the above</u>

There are five information governance risks currently being addressed:

Information asset registers – if the Trust does not have an up to date information asset register it will not have a record of processing activity and may contravene the GDPR. We are supporting teams to refresh their asset registers.

Subject access requests – if the Trust does not manage subject access requests effectively and respond appropriately, data subjects may complain to the ICO resulting in regulatory action. This risk is likely to significantly reduce given the new structure although locality SARs management will remain a challenge.

COVID data processing - if the Trust does not have an exit strategy for data processing agreed as a result of COVID it will contravene the DPA and other legislation. All data

processing agreements have an end date and will be scrutinised in line with timescales for Control of Patient Information Notices. COPI will not be extended beyond 30th June 2022.

DSPT - if the Trust does not comply with the requirements of the DSPT this may impact on the Trust's reputation, result in confidentiality breaches and ICO intervention. 95% training compliance is always a concern and is addressed through a variety of training delivery methods.

FOI – if the Trust fails to address the FOI backlog effectively it may encounter ICO regulatory action and reputational damage. This is being managed with senior oversight resulting in significant reduction of the numbers of overdue requests.

Digital risk register - the Trust faces three substantial risk domains around its IT services and infrastructure managed under item 8 of the Board Assurance Framework. All risks are subject to regular audit and internal action plans to address the ongoing nature of threats. Key mitigations include:

Cybersecurity risks

- IT System Health Check by NHS Digital and Dionach
- Patching and security updates – ongoing – software patching config needs updating during Covid
- Skills & capacity/tools to ensure compliance & response – work ongoing to assess suitable approach to address this – high importance

Infrastructure risks (datacentre) operations & security risks

- NHS secure boundary security operations centre
- Assessing all flows of PID that are occurring across the Trust, particularly following COVID – such as the IoT management and weaknesses in infrastructure of safe delivery of PID containing items.

Digital governance Risks

- New digital governance structure and processes with the creation of the Digital Solutions and the Digital Operational and Transformation Boards
- Creation of Digital Programme Management Office

2.5 <u>Action taken and planned in response to gaps in implementation or other risks identified</u>

All risks are routinely assessed and actions described above.

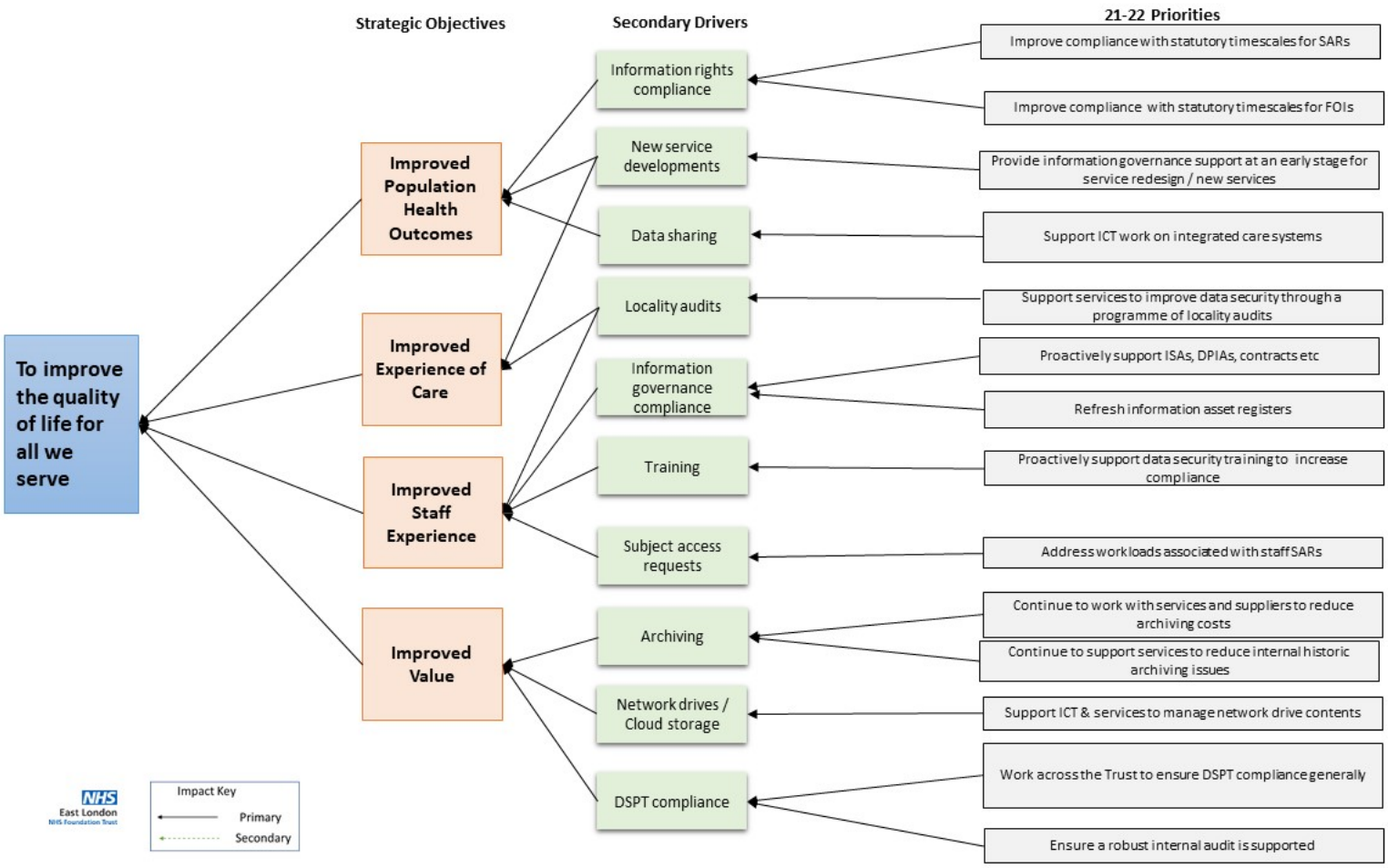
3.0 Workplan for the coming financial year

3.1 IG key priorities

Key priorities are:

- Achieve full DSPT compliance
- Comply with statutory requirements for information rights (FOI and SARs)
- Refresh information asset registers
- Deliver a data security & awareness training compliance programme
- Increase locality audits
- Support archiving projects
- Support service developments
- Work with partners to support integrated DIGITAL systems

3.2 IG links to Trust objectives

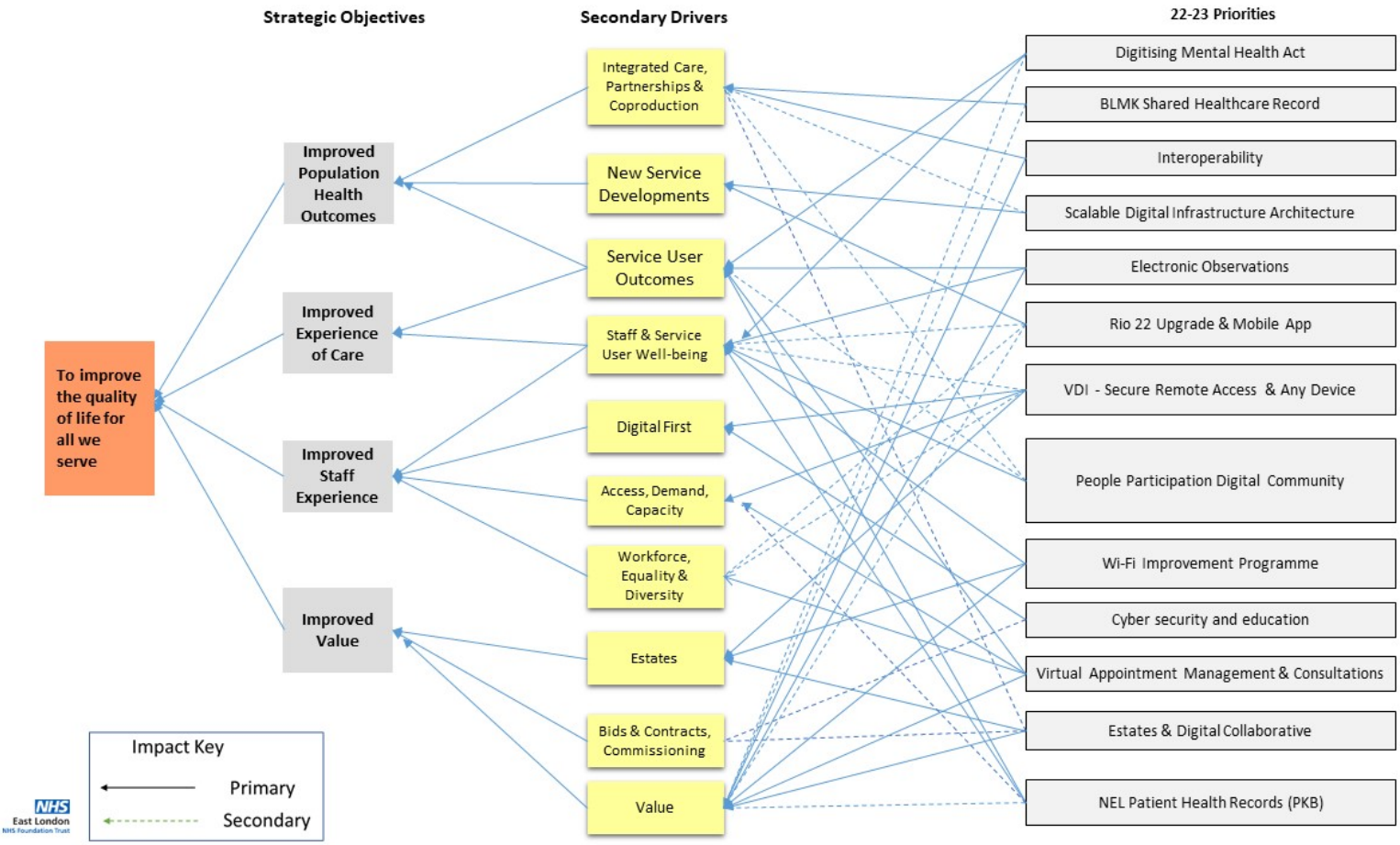


3.3 Digital key priorities

Key priorities are:

- Implementation of the Digital Strategy
- Digital workforce structure
- Cloud architecture
- Digital infrastructure & Wi Fi improvement programme
- Clinical system transformation programme & DMT annual plans
- Cyber Security function and tools
- Shared Care Records – BLMK ICS
- Patient Held Records – NEL ICS

3.4 Digital links to Trust objectives



3.5 What data will we be collecting to understand whether we are progressing against the plan?

An information governance dashboard is routinely tabled at IGSG including:

- ISAs / 3rd party access agreements
- Privacy Officer alerts
- Document removals
- Incidents
- FOIs
- SARs
- Clinical coding
- Training

3.6 How will we report on progress, and adapt the plan as needed in-year?

Information Governance Steering Group – a strategic information governance overview paper is routinely tabled at IGSG and adaptations discussed / approved as necessary.

Ops Group – Ops Group is updated on key issues especially in respect of training compliance.

Quality Committee – receives quarterly updates

Quality Assurance Committee – receives quarterly updates via Quality Committee

Ad hoc groups – relevant items are reported to various groups including Corporate Financial Viability, Heads of Admin, DMTs and specialist working groups.

3.7 Who will be our key stakeholders in delivering the plan, and how will we engage them through the year?

Key stakeholders are staff who will be engaged through the groups set out in 3.4 above, direct contact and regular communications briefings.

3.8 Resourcing requirements or other risks to implementation

Information rights resource - the information governance consultation addressed additional resourcing requirements for processing information rights requests. Given the increase in request numbers and requests complexity, additional resource may be required. There is also increasing evidence of the need for procurement of a software package to more effectively manage requests.

Information governance resource – given the significant increase in the number of contracts scrutinised and resourced, it is likely additional resource to manage this will be required. There is also a need to provide more support for services to complete DPIAs and ISAs.

Archiving - project resource will be required to support records review work.

Cloud storage / network drives - resource may be needed to support scrutiny and management of network drives pending a move to the cloud

4.0 Action Being Requested

4.1 The Committee is asked to RECEIVE and DISCUSS the report.

REPORT TO THE QUALITY ASSURANCE COMMITTEE
27 JUNE 2022

Title	Annual Infection Prevention And Control Report 1st April 2021- 31st March 2022
Author	Bernadette Kinsella – Deputy Director of Infection Prevention & Control/ Physical Health Lead Nurse
Accountable Executive Director	Lorraine Sunduza – Chief Nurse/Deputy CEO, Director of Infection prevention and Control.

Purpose of the Report:

The purpose of this report is to:

- Update the Trust Board on actions taken to ensure that high standards of Infection Prevention & Control (IPC) have been maintained during the past year.
- To keep IPC as a priority for everyone all of the time and continuously provide care in environments that are clean and safe provided by staff that are competent and standards are continuously reviewed.
- Regular reporting is a requirement to demonstrate good governance and public accountability. It provides assurance about systems and processes in relation to infection prevention and control.

Summary of Key Issues:

Key Achievements for 2021/22:

- The work of Infection prevention and Control involves being alert and responsive to new and emerging infectious diseases. However, on the 12 January 2020 it was announced that a novel coronavirus had been identified. This virus is referred to as SARS-CoV-2, and the associated disease as Coronavirus infectious disease (COVID-19).
- This highly infectious disease has resulted in a worldwide pandemic with an associated high mortality and morbidity which is especially prevalent in vulnerable groups and communities. This has led to increased demands on the service.
- The tables and graphs and narrative below tell the story of East London Foundation Trust from IPC perspective. This work in the pandemic has been achieved by engaging and working together in ELFT and with partners across the system and with the necessary structures, systems and processes in place.
- Outbreak management was followed in line with Public Health England (PHE) guidance whilst taking into account the fast-paced environment teams were working under as the new evidence emerged.
- Staff and patient contacts were identified and managed in line with Trust occupational health and PHE and internal Test and Trace processes (in case of COVID-19).
- Updated root cause analysis incident investigation tool for Covid-19 is evidenced in the detailed reports to the IPC Committee.
- Lessons learned are collated and disseminated within the organisation and regionally Notification of Infectious disease guidance (NOIDS) and PHE are completed on a regular basis.
- The Trust set up staff, patient and public services for COVID-19 vaccination
- The Infection Prevention and Control Board Assurance Framework was updated on a regular basis as new assurance were required.

- This IPC main work has meant being reactive to the pandemic, however as ELFT moved through the fast pace dynamic environment there was flexibility and adaption to new ways of working and ongoing learning with team and services in line with quality care.
- Quality improvements included piloting the LFD point of care testing for patients which has now replaced the DNA nudge technology has successfully been rolled out across ELFT to reduce time in isolation for patients while awaiting PCR testing from laboratory.
- An automated system of store control and ordering (ERP) set up to -improve the time response and availability of needed items for ELFT staff and- help with planning and managing stock levels is moving to a larger warehouse in June 22. This system also supports responding to National Patient safety alerts as required and appropriate.
- The IPC team remains vigilant in surveillance of other infections which reduced in the pandemic and reporting notifiable diseases as appropriate.
- A new audit programme was planned and successfully rolled out for PPE and Hand Hygiene on the Trust Envoy system to complement the quality improvement work of Covid Secure Bundles last year. The Environmental are part of a rolling programme of has been maintained as per appendix .The IPC policies, procedures and resources have been reviewed, updated and ratified to support staff and offer sources of guidance.
- Good communication with local NHS Trusts and UKHSA agency continue to reap the benefits through ensuring that timely information, regarding Health Care Associated Infection (HCAI), is passed from one organisation to another.
- Deaths from Covid-19 are investigated by the serious Incident Team working with support from the IPC Team as required and appropriate. There were no formal complaints or PALS concerns raised in relation to IPC during 2021/22.
- During 2021/22 the Trust Water Safety Group met quarterly.
- During 2021/22 the Trust AMR Group met quarterly.
- During 2021/22 the Trust IPC, Estates and Facilities Operational Group met quarterly.
- There was a new Quarterly Ventilation group established led by Director of Estates.
- During 2021/22 The IPC systems and process was reviewed to ensure compliance and assurance with the Health and Social Care Act (2008) *Code of Practice for the prevention and control of infection and related guidance* (updated 2015).

Cleanliness of the Environment:

- Cleaning audit scores across the Trust were reported between 95.70% and 98.8% during 21/22. However, in Newham Mental Health Services and Coburn the Cleaning score have been noted as being sub-optimal and there has been work carried out by IPC and facilities to improve on this situation as described below.
- The IPC team work closely with facilities monitoring the environment with visibility and frequent joint workarounds of the site with ELFT Facilities across the Trust
- The Facilities Team and cleaning contractors have been part of the Covid-19 Outbreak management response and have been responsive to extra cleaning and decontamination requests across services as required and appropriate.

Staff Health:

Due to the pandemic there has been staff whom have contracted Covid -19. Please see below data. There has been collaborative working with all directorates, internal departments and providers to provide support as required and appropriate. This included Team Prevent Occupational Health Provider, People and Culture, Health and Safety and Estates across the organisation.

Deaths for Staff: The data on Covid -19 cases and deaths for staff is held by Health and Safety and the People and Culture Department for Covid cases and Deaths.

ELFT provided a comprehensive range of support for staff in the pandemic as at infographic https://www.elft.nhs.uk/Professionals/Information-for-ELFT-Staff/People--Culture

In relation to Sharps, there were **43** inoculation injuries were reported to Team Prevent. A new service provision has been established in Luton and Bedfordshire, for management of high risk sharps incidents requiring post-exposure prophylaxis (PEP) treatment Please see below People and Culture records of staff affected by Covid -19.

Water issues:

- Water Safety Group oversees governance related to water safety issues across the Trust. Meetings are held on a quality bases. A water report is produced by the ELFT Estates and Facilities Team.
- During 2021/2022 111 sites were monitored for legionella. Remedial works were undertaken to rectify any water issues
- All water tanks had their annual disinfection programme in January 2021.
- There was a risk assessment carried out of Legionella at East Ham care Centre re remedial works in January, however due to the number of Covid-19 Cases a decision was taken to put mitigating action in place. These measures were successful and the works are no longer required and there is regular monitoring in place over seeing by the water and Safety groups.

Annual Work Programme 2021/2022

The annual work programme for 2021/22 has been completed with some areas requiring on-going action. These areas of activity have been incorporated into the annual work programme for 2022/2023

Risk Register:

The Risk Register with Mitigating actions and outcomes is documented in the appendix for 21/22.

Work Plan 2021 /2022: and CQC floor to Board assurance.

- Continue to deliver compliance within ELFT of national standards, in particular The Health and Social Care Act (2015) *Code of Practice on the prevention and control of infections and related guidelines.*
- Continue to further establish and embed Infection Prevention Control within community health services and focus on the national Gram negative Blood Stream infection reduction ambition.

Strategic priorities this paper supports (Please check box including brief statement)

Improving population health outcomes	☒	The information provided in the Infection Prevention and Control annual report supports the four strategic objectives of improving patient experience, improving population health outcomes, improving Staff experience and improving value for money. Information is presented to describe how we are assuring against and improving aspects related to These four objectives across the Trust.
Improving experience of care	☒	
Improved staff experience	☒	
Improved value	☒	

Implications:

Equality Analysis	Infection control is everybody's business. This work plan has no impact On individual groups. This report has no direct impact on equalities.
Risk and Assurance	Ensuring a safe clean environment for staff and service users is Fundamental to good quality care.
Service User/Carer/Staff	The new work plan will support staff to identify areas of concern to staff and service users and empower them to escalate and take action to Make improvements.
Financial	There will be financial implications in discharging its duties to keep Infections to a minimum in safe clean environments. Some of these costs Will be met with Directorate obligations. The Trust has funded a programme to improve staff compliance with hand hygiene by improved Access to facilities for hand washing through capital funds.
Quality	Providing quality care and continuously improving the environment

Supporting Documents and Research material

A. Infection Prevention and Control annual work programme 22/ 23 and Driver diagram for 21/22

NHS
East London
NHS Foundation Trust

Infection Prevention and Control

Annual Report 2021/22

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Glossary:

Abbreviations	
Antimicrobial Stewardship Group	AMS
Blood Borne Virus	BBV
Clostridioides difficile infection	CDI
Care Quality Commission	CQC
Clinical Commissioning Group	CCG
Carbapenem Resistant Organisms	CRO
Data capture system	DCS
Director of Infection Prevention & Control	DIPC
Deputy Director of Infection Prevention & Control	DDIPC
East Ham Care Centre	EHCC
East London Foundation Trust	ELFT
Gram negative Rod Blood Stream Infection	GNR BSI
Health Care Associated Infection	HCAI
Human Resources	HR
Infection Prevention & Control	IPC
Infection Prevention & Control Committee	IPCC
Infection Prevention and Control team	IPCT
Infection Prevention & Control Nurse	IPCN
Methicillin-resistant *Staphylococcus aureus*	MRSA
Needle stick injury	NIS's
Public Health England	PHE
Patient Led Assessment of Care Environment	PLACE
Quarter 1	Q1
Quarter 2	Q2
Quarter 3	Q3
Quarter 4	Q4
Single Use Devices	SUDS
Service Level Agreement	SLA

Green	85=100%	Compliance
Amber	60-84%	Partial compliance
Red	0-59%	Minimal Compliance

Red, Amber, Green (RAG) rating

1. *Executive summary*

This annual report provides an overview of the infection prevention and control (IPC) activities throughout the Trust over the past twelve months. This report provides evidence towards the regulatory requirements of The *Health & Social Care Act (2008) Regulation 12, detailed in the Code of Practice for the Prevention & Control of Infections*. The Director of Infection Prevention and Control (DIPC) reports quarterly to the Trust Board of Directors through the IPC report, however this was monthly in the pandemic. The Director of Infection Prevention and Control is the Chief Nurse. Operational delivery of the Infection Prevention and Control service is overseen by the Deputy Director of Infection Prevention and Control/ Physical Health Lead Nurse with support from the Director of Nursing _ London Community Health services. . The Infection Prevention and Control Team (IPCT) work plan focuses on implementing systems that embed IPC into the everyday practice of all East London NHS Foundation Trust (ELFT) staff.

2. *Key Achievements:*

***Coronavirus* infectious disease (COVID-19):**

- In light of the emerging infection- novel *Coronavirus* the IPC team was part of the Bronze, Silver and Gold Command Coronavirus preparedness meetings from April 2020.
- Due to the COVID-19 pandemic from April the IPC service was operating a 7 day a week service and between the hour's o 8am to 10pm changed to 10 am to 6 pm from June 2020 onwards to Support clinical team and service.
- There were regular meetings where service leads and nominated COVID-19 leads have an opportunity to feedback issues with relation to IPC.
- IPC nurses attended regular safety huddles for each borough to support teams
- Daily surveillance data on COVID-19 and dashboard have been maintained in conjunction with ELFT Quality Analytics team.
- Various communications leaflets have been developed by IPC team in conjunction with ELFT
- Outbreak Managements meetings have been held across the Trust to support services/wards with COVID-19 outbreak management in line with Trust policy and PHE guidelines.
- IPC have created and delivered several COVID-19 training presentation and webinars.
- New Fit Testing service was set up and rolled out.
- Track and Trace systems and processes in place across the Trust.
- Staff Lateral Flow Testing service continues and has helped with managing outbreaks.
- People and Culture set up a range of services to support staff working with other departments.
- .Medical device Lead continues to procure extra equipment for patient monitoring.
- Continued training on Covid-19 issues including the deteriorating patient.
- Regular weekly meetings with senior staff and IPC Team microbiologist to discuss Covid-19 advice as the pandemic evidence emerged in relation to ELFT services needs and respond as appropriate and required.
- This service was flexible and responsive ensuring adaption to the latest evidence and guidance In terms of 'Quality Care'.
  CQC Floor to Board' assurance document evidence was regularly updated

3. Introduction

The annual report provides information and evidence of the Trust's ongoing commitment to IPC, embedding these key principles and practices throughout the organisation. The report identifies the significant improvement the Trust has made within infection prevention and control in all areas of the organisation. This report is the annual report from the Director of Infection Prevention and Control (DIPC). The report will inform the Trust Board of the infection prevention and control (IPC) standards and risks within the organisation.

It will also provide assurance of the progress made against the Health and Social Care Act (2008) *Code of Practice for the prevention and control of infection and related guidance* (July 2015) and the Care Quality Commission standards over the last twelve months. The 2020/21 annual programme is attached to this report to show the previous agreed work plan. The overview of the IPC driver diagram for the annual programme for 2021/22 is appended to this report; this will provide an overview of the priorities for upcoming year (appendix 7). The DIPC report provides information and evidence of the Trust's ongoing commitment to IPC, embedding these key principles and practices throughout the organisation. The report identifies the significant improvement the Trust has made within infection prevention and control in all areas of the organisation.

At the end of the year 2021/2022, ELFT declared compliance in IPC practices. In the event that IPC non-compliance is demonstrated action plans, recommendation and timeframes are given to service lines to address IPC issues.
This Summary Record outlines what was found during an engagement call to discuss infection prevention and control arrangements, using standard sentences and explanatory paragraphs. We have found that the board is assured that the trust has effective infection prevention and control measures in place.

Monitoring of IPC practice is undertaken by audit, surveillance data, and the integration of IPC reporting mechanisms across the organisation. Reports are submitted to the Infection Prevention and Control Committee (IPCC), Quality Committee and to the Quality Assurance Committee/ Board. During the challenging year of the Covid-19 Pandemic significant progress has been made to ensure patients are cared for in a safe and clean environment, where the risk of healthcare associated infections are minimised.

4. Management and Governance Arrangements for Infection Prevention and Control

The Trust Board is accountable for ensuring that there are effective IPC arrangements within the Trust. The Chief Executive delegates operational responsibility to the IPC Committee. The IPC Committee oversees and directs IPC throughout the organisation and advises the Trust Board via the Quality Committee in line with statutory requirements.

The Trust Board receives quarterly reports on indicators of compliance with The *Health and Social Care Act Code of Practice for the Prevention and control of infection* and Estates and Facilities cleanliness audit reports.

To ensure compliance with the Health and Social Care Act (2008) Code of Practice for the prevention and control of infections and related guidance (updated 2015) the Trust is required to have a Director of Infection Prevention and Control. This ensures there is a clear governance structure and accountability that identifies a single lead for infection prevention (including cleanliness) accountable directly to the head of the registered provider. In addition to this, the post should report directly to the Trust Board to provide an oversight and assurance on infection prevention and control.

The role of Director of Infection and Control (DIPC) is held by the Chief Nurse.
The DIPC is responsible for the Trust's Infection Prevention and Control team.

The DIPC provides leadership within the organisation and enables the organisation to continuously improve its performance in relation to Infection Prevention and Control standards.
The DIPC devolves the day to day responsibilities and duties to the Deputy Director of Infection Prevention and Control. The Director of Nursing and integrated care provides leadership and management for the Infection Prevention and Control service.

The Deputy Director Infection Prevention and Control (DDIPC) has overall responsibility for:

- The IPC service within the organisation
- The implementation of IPC policies
- Challenging inappropriate IPC practices
- Undertaking the impact assessment of new and revised policies together with recommendations for change
- Integrating IPC together with clinical governance teams
- The production of an Infection Prevention and Control Annual Report
- The Deputy Director of Infection Prevention and Control (DDIPC) ensures that robust arrangements are in place in line with national policy and relevant legislation, and creating an environment of continuous quality improvement and development
- The DDIPC facilitates links and communication with all clinical areas
- The DDIPC is responsible for links with the wider health economy and representing the Trust at NHS London DIPC meetings and health protection forums.

The Trust Board is accountable for ensuring that there are effective infection prevention and control arrangements within the Trust. The Board receives an IPC report as part of the integrated governance report which highlights key work streams and areas of risk. The Board also receives and approves the annual IPC report and strategy.

5. Governance Framework for Infection Prevention & Control Committee

Governance arrangements for the Infection Prevention and Control are shown below:

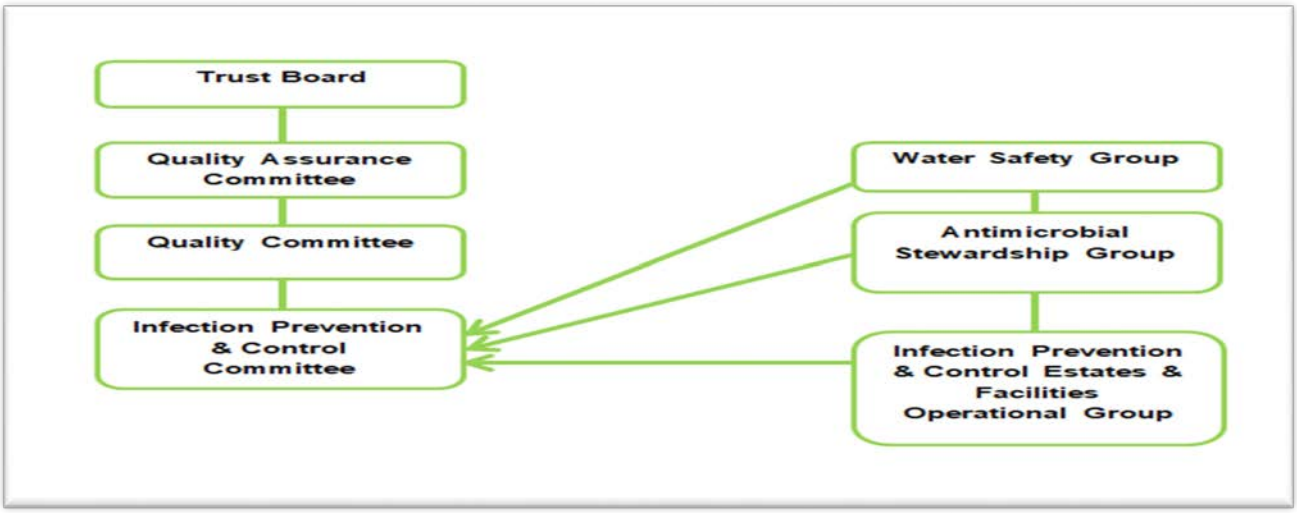


Figure 1 *Governance Framework for Infection Prevention & Control Committee*

5.1 Infection Prevention and Control Committee (IPCC)

The IPCC is a key forum for the development and performance management of the IPC agenda across the organisation. The IPCC met monthly in the pandemic and is chaired by the DIPC with key stakeholders from across the organisation. An overview of the IPC agenda and progress throughout the year is discussed at this meeting. A quarterly report is routinely submitted to the IPCC, however due to the pandemic there were exception meetings which were held monthly.
This enabled capturing HCAI's alert organisms, outbreaks, IPC audit programme and scoring therefore comparable data can be analysed. Since April 2022 the membership of the IPCC met Quarterly and is chaired by the Chief Nurse. In the absence of the DIPC, the meeting is chaired by the Director of Nursing. The committee is made up of representatives from a wide range of disciplines as follows:

- Chief Nurse /Director of Infection Prevention and Control (Chair)

- Director of Estates and Facilities
- Director of Nursing –Mental Health
- Director of Nursing- Community Health Service
- Chief Pharmacist
- Consultant Microbiologist /Infection Control Doctor
- Deputy Director of Infection Prevention and Control/Physical Health Lead Nurse
- Trust-wide Lead Infection Prevention and Control Nurse
- Deputy Infection Prevention and Control Nurse
- Infection Prevention and Control Nurses
- Infection Prevention and control administrators
- Lead IPC Nurses from Local clinical commissioning group
- Occupational Health (Team Prevent)
- Head of Communications
- Expert attendees: Public Health England Consultant

The Committees within the Trust's governance framework that have responsibilities/roles in relation to IPC are as follows: Quality Committee

- The Quality Committee monitors the work of the Infection Prevention and Control committee.
- The Quality Committee is chaired by the Chief Nurse and is attended by senior corporate staff and all clinical directors.
- *The Quality Committee oversees clinical governance activity across the Trust.*

5.2 Infection Prevention and Control Service

The aim of the Infection Prevention and Control Service is to promote a safe environment for patients, visitors and staff where infection risks are kept to a minimum. The organisational structure of the Infection Prevention and Control team (IPCT) is shown in appendix 1.
Trust microbiology services are provided by local acute hospitals via Homerton University Hospital NHS Foundation Trust and Bart's Health for London based services and Luton and Dunstable Hospital and Bedford Hospital for Luton and Bedford based services.

6 Healthcare Associated Infections (HCAI)

Healthcare Associated Infections (HCAI's) infections are infections that are acquired in hospitals and other healthcare facilities. These are further reported in the report with individual details of specific organisms. The Definition on this for Covid-19 came from NHSE/1 June 2020.

6.1 Surveillance of Health care associated infection (HCAI's)

The National Mandatory Data Capture System (DCS) was introduced by Public Health England (PHE) to monitor Health care associated infection (HCAI's) nationally. In the event of a bacteraemia from MRSA a post infection review (PIR) investigation is undertaken and for Clostridioides difficile (C. diff) toxin positive, a root cause analysis (RCA) investigation is undertaken. The rationale for undertaking RCA's is to highlight where lessons can be learnt and to demonstrate best practice in clinical fields. Please see summary of lessons learnt from RCA'S from Covid-19 further in the report.

6.2 Methicillin Resistant Staphylococcus aureus (MRSA)

Staphylococcus aureus is an organism whereby approximately one third of the population carry without any associated problems. Although Staphylococcus aureus is capable of causing infection, most of these are easily treated with antibiotics. However, some strains of Staphylococcus aureus have developed resistance to common antibiotics; these are known as Methicillin Resistant Staphylococcus aureus (MRSA). Patients in community intermediate care units are routinely screened for MRSA colonization (on the skin). This entails taking swabs on admission. Guidance can be found in the IPC policy. This is not a requirement for mental health services as stipulated by

the Department of Health Guidelines.

6.3 Clostridioides difficile (C. diff)

C. diff is a bacterium that lives harmlessly in the gut of about 3-5% of healthy adults. It is normally kept in check by the 'good' bacteria in the gut but when these are killed off by some antibiotics, the *C. diff* bacterium can multiply and cause diarrhoea. It especially affects the elderly, the debilitated, and patients who have had broad-spectrum antibiotics. Prevention of *C.Diff* infection relies on ensuring that patients do not become susceptible through disruption of their normal gut flora (e.g. through use of antibiotics), and on preventing as far as possible cross infection. Zero tolerance approach to avoidable HCAI's (MRSA and C.diff).

6.4 A zero tolerance approach to MRSA Bacteremia's is the current national target. A national target for *C. Diff* for Community Services and Mental Health Services has not been set nationally. It is accepted that not all HCAI's are avoidable; however, the Trust adopts a zero tolerance approach to all avoidable HCAI's.

6.5 MRSA Bacteraemia & C.difficile cases
There were no notifiable cases of MRSA or *Clostridioides difficile* cases across the Trust in 2021/22 *There were no cases identified to ELFT for 2021/2022*

6.6 Meticillin-sensitive Staphylococcus aureus (MSSA) Bacteraemia cases
Meticillin-sensitive *Staphylococcus aureus* (MSSA) is a type of bacteria which lives harmlessly on the skin and in the noses, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised. However, MSSA colonisation usually causes them no problems, but can cause an infection when it gets the opportunity to enter the bloodstream this can cause septicaemia.

6.7 Carbapenem-resistant organisms
These are groups of bacteria (germs) that produce carbapenemases (chemicals). These chemicals can destroy antibiotics called carbapenems. This makes the bacteria resistant to the antibiotic. Carbapenems are a powerful group of antibiotics that are often relied on for infections where treatment with other antibiotics has failed. CRO can live in the gut of humans and animals and they help us to digest food. In most cases CRO are harmless and cause no ill effects. However, if the bacteria get into the body for example, into the bloodstream or urinary tract it can cause an infection. There have been no cases of CRO recorded across the Trust for this year.
In **20 21-22** there were no notifiable Carbapenem Resistant Organisms (CRO's)

7.0 ***Outbreak Management***
An outbreak is often defined as two or more cases presenting with similar symptoms associated by time and place. In healthcare settings, the most common cause last year was Covid-19. The IPC policy outlines the processes to be followed and resources and leaflets are available on Trustnet.

8.0 Clusters of infections.
Clusters of infections are identified as potential groups of people or cases with apparent similar infections (e.g. flu, measles). Many apparent clusters have no specific cause. In rare cases, clusters may be related to common environmental exposures. Incidents of infections are listed below by month and Outbreaks for Covid-19 are discussed below for the last ye*ar.* This starts with other infections and then goes on to provide a narrative of the Covid -19 pandemic.

9.0 Healthcare associated Infection surveillance.

This below table shows number of 'Advice and Queries' for *other infections other than Covid -19*.

There was a considerable decrease in other reported infectious diseases compared to previous years. This may have been due to several factors i.e. that staff and patients were adhering to infection prevention and control measures and were less exposed to these due to lockdown measures of the pandemic.
The full details of these are presented in the IPC Committee monthly reports .However other infectious diseases are now re- emerging and we are updating our systems and process to surveillance to ensure we are capturing and responding to these in line with the Health and Social Care Act (2015).
As can be seen in the below Table there were advise and *thirty four* enquiries on Diarrhoea and Vomiting. *MRSA* screening queries and follow up was *fifteen* times, bed bugs on *thirteen* occasions, there were 7 queries related to *Tuberculosis,* and two related to Chicken pox. In relation to infestation five related to scabies and five related to body lice. There were advice and queries related to 7 lice and 6 related to pest control from rodents. The latter was in Tower Hamlets, City and Hackney and Bedford in patient's services.

9.1 Infection Prevention and Control incidents from 1st April 21 to March 31st 2022

Please see below table outlining Non-Covid surveillance and incidents Figure 2
The report then continues to describe the number of notifiable infectious diseases related to Cov-19 UK. This is followed by the numbers of Health care Acquired infections services and numbers.
There is then an analysis of the Covid-19 out breaks across the Trust together with the numbers Covid-19 cases staff and patients affected as part of the outbreaks.
This is followed up by an analysis of the Root cause and lessons learnt and being put into practice.
This work to date in not fully completed and further Root Cause analysis is ongoing and more information as it emerges will be reported at a later date.

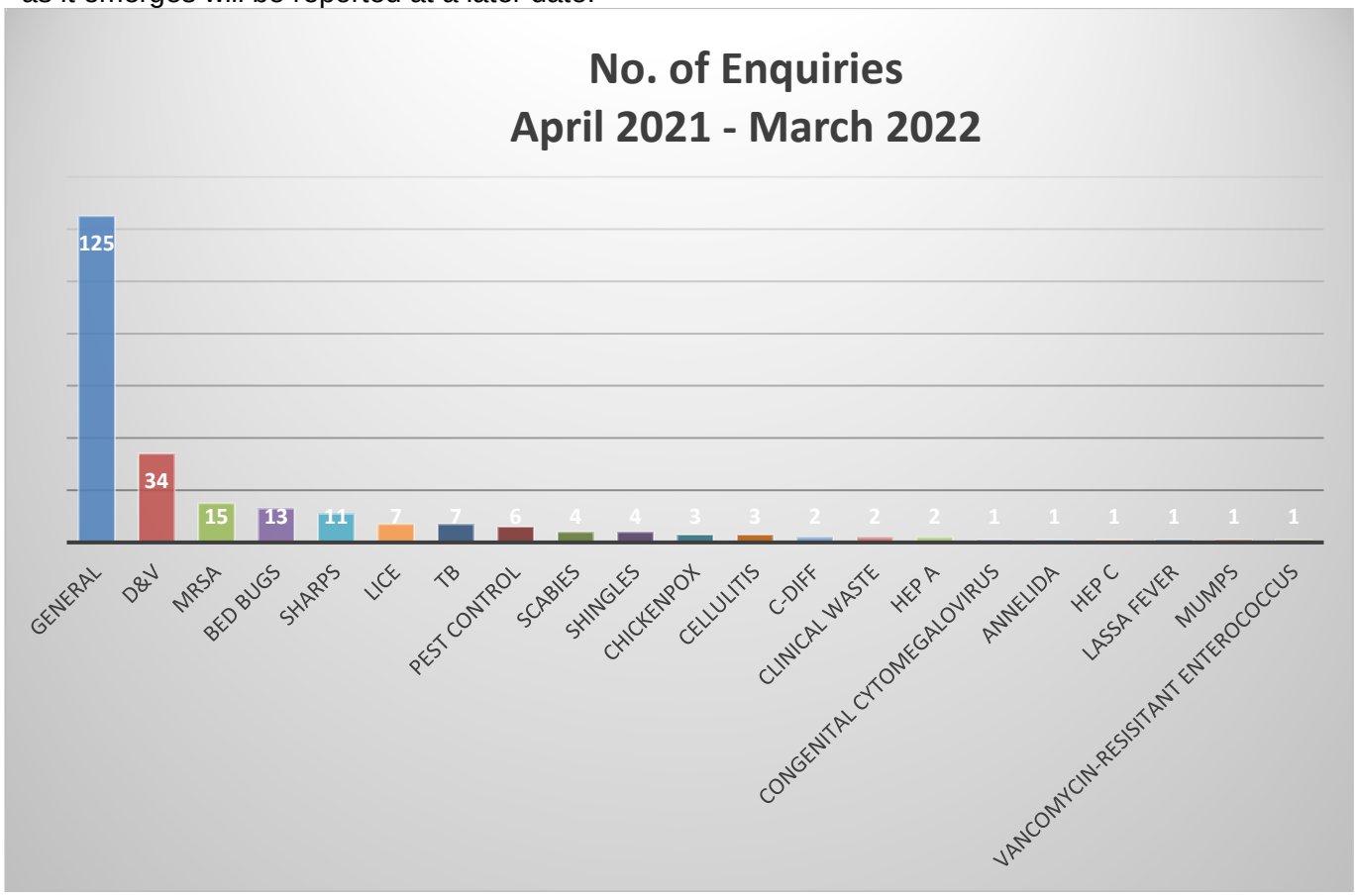


Figure 2 chart (IPC Enquiries) (non-Covid) responded to by the IPC Team

Figure 3: (IPC Enquiries) (non-Covid) responded to by the IPC Team

Infection	Q1	Q2	Q3	Q4	TOTAL
General	0	59	38	28	125
D&V	7	7	12	8	34
MRSA	2	5	7	1	15
Bed bugs	3	3	5	2	13
Sharps	4	2	3	2	11
Lice	1	4	1	1	7
TB	4	1	2	0	7
Pest Control	3	1	1	1	6
Scabies	1	1	1	1	4
Shingles	0	1	2	1	4
Chickenpox	0	0	0	3	3
Cellulitis	0	2	1	0	3
C-diff	1	1	0	0	2
Clinical Waste	0	0	0	2	2
HEP A	0	1	1	0	2
Congenital Cytomegalovirus	0	0	0	1	1
Annelida	1	0	0	0	1
HEP C	0	0	1	0	1
Lassa fever	0	0	0	1	1
Mumps	0	0	1	0	1
Vancomycin-Resisitant Enterococcus	0	1	0	0	1
TOTAL	27	89	76	52	

Enquiries) (non-Covid) responded to Via elft.infectioncontrol@nhs.net

COVID-19 Enquiries Via elft.infectioncontrol@nhs.net

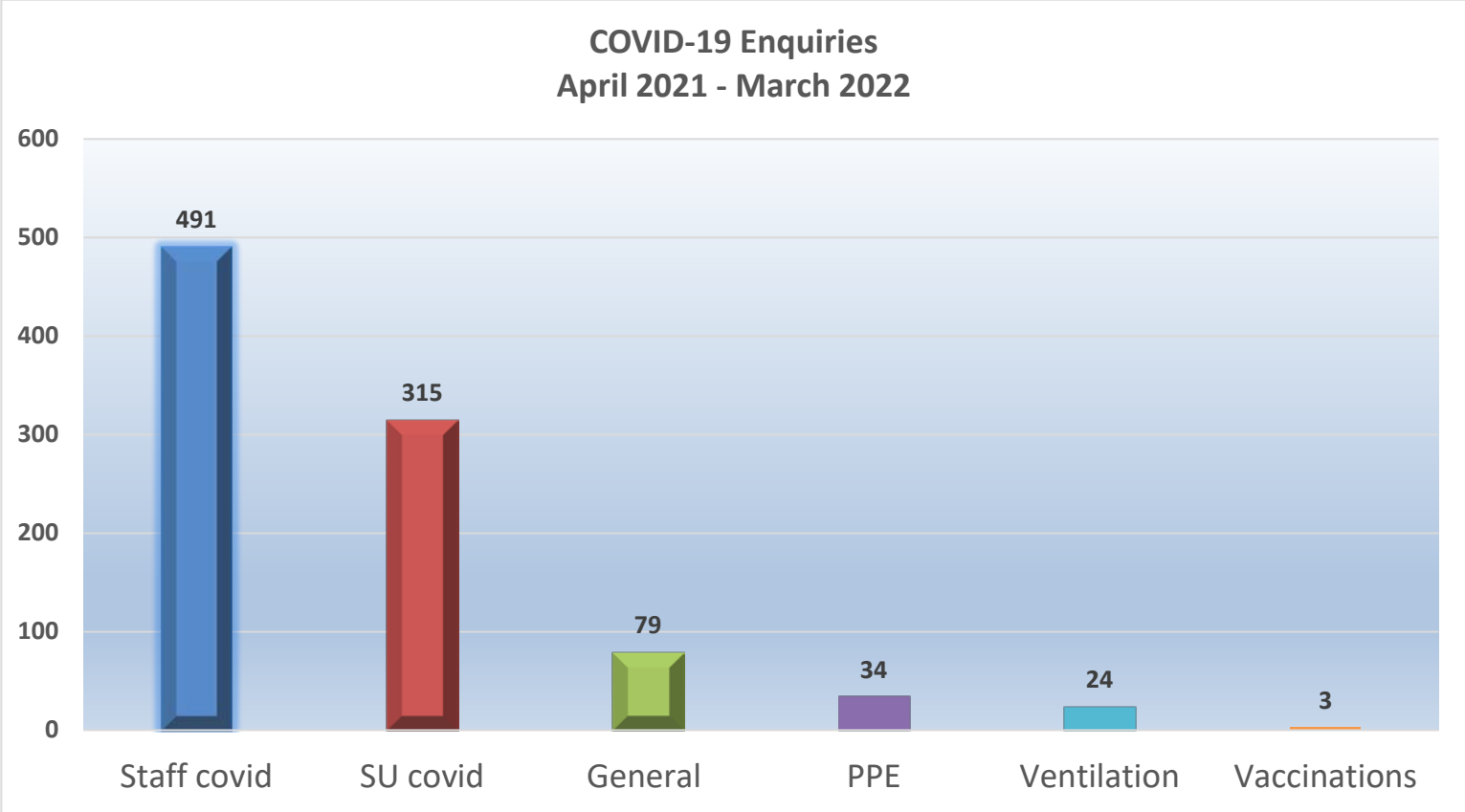


Figure 4 Last year, the IPCT responded to 491 covid-19 staff related queries in comparison to 315 covid-19 Service users' related queries.

Enquiries by quarter: Via elft.infectioncontrol@nhs.net

In quarter one; the IPCT responded to a 59 general covid-19 queries. These queries requested clarification around latest covid-19 guidance, policy and standard Operating procedures. In quarter two and three, the IPCT responded to a total of 369 staff covid-19 Related Queries and in quarter four, the IPCT responded to 141 covid-19 service user related queries. Please see the table below. **Figure 5**

COVID	Q1	Q2	Q3	Q4	TOTAL
Staff covid-19	36	195	174	86	491
SU covid-19	27	67	80	141	315
General	59	20	0	0	79
PPE	10	7	4	13	34
Ventilation	0	21	0	3	24
Vaccinations	2	1	0	0	3
TOTALs	**134**	**311**	**258**	**243**	946

9.2 The below ***notifiable diseases*** for Covid-19 were reported.

The work of Infection prevention and Control involves being alert and responsive to new and emerging infectious diseases. This work focused on the new virus referred to as SARS-CoV-2, and the associated

disease is Coronavirus infectious disease (COVID-19). This highly infectious disease has resulted in numerous infections for ELFT involving staff and patients in line with the worldwide pandemic and its associated high mortality and morbidity which is especially prevalent in vulnerable groups and communities. This has led to increased demands on the service. The tables and graphs and narrative below tell the story of East London Foundation Trust from IPC perspective.
In relation to Covid-19, the report mainly focusses on service users, however many staff were affected and were supported by IPC Team, People and Culture and Team Prevent Occupational Health provider. This **Figure 3** shows ELFT cases from April 2021 to March 2022

COVID-19
Local laboratories report results daily via the Infection, Prevention and Control team (IPCT) inbox (HOMERTON University Hospital, St, Bartholomew's, Luton and Dunstable Hospital). This process commenced in 2020 in response to the COVID-19 pandemic. In addition, IPCT receive update emails directly from the wards and outbreak meetings.

From April 2021 – March 2022, 514 patients tested positive for COVID-19. The chart below shows that in August 2021 and December 2021 – January 2022 there was an increase in reported positive cases across the Trust. Quarter 3 and 4, show the highest number of reported cases this year.

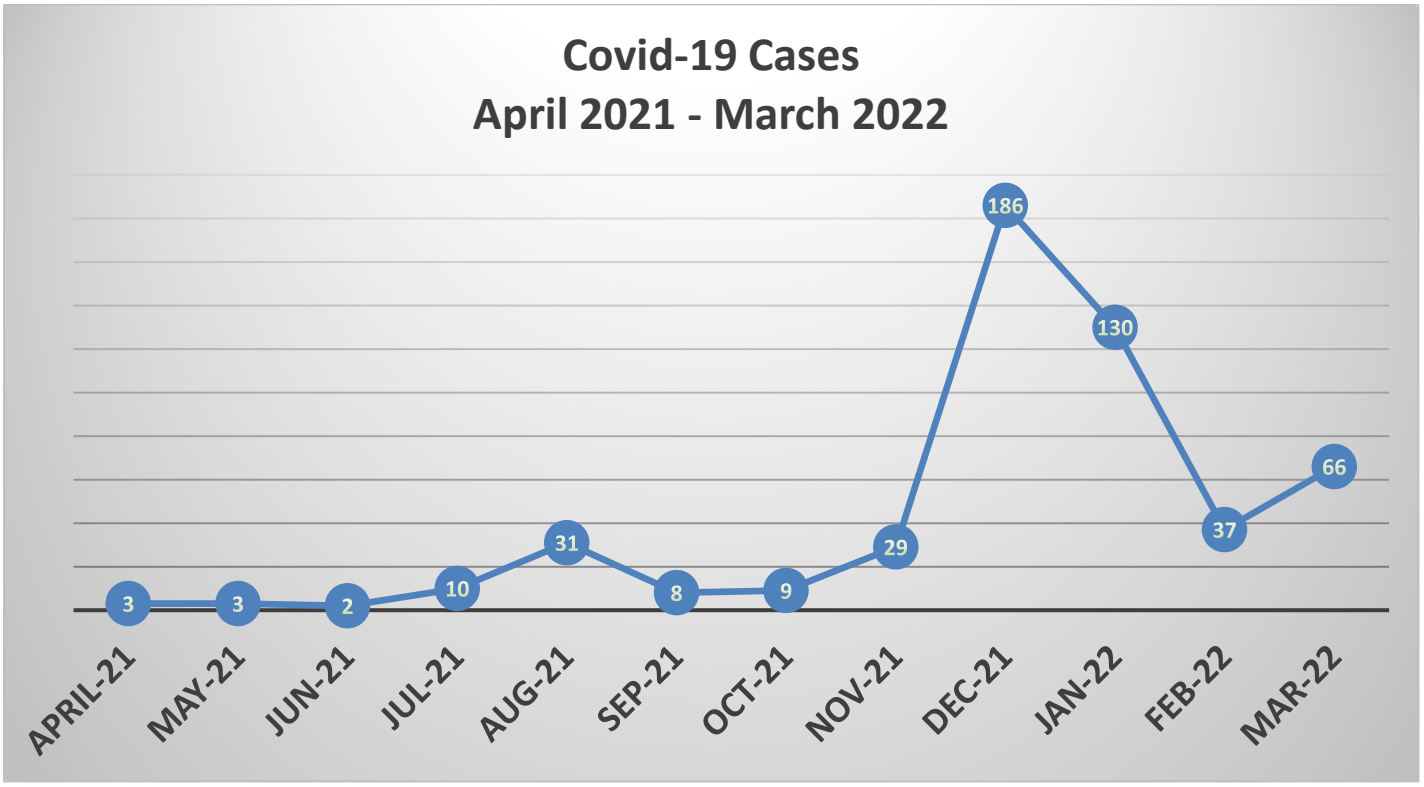


Figure 4 report for Covid-19 confirmed cases for in-patient wards at ELFT by laboratory by month.

April-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
3	3	2	10	31	8	9	29	186	130	37	66

Figure 5 shows of number of 'advice and queries' received and responded to via the elft.infectioncontrol@nhs.net from April 2021 to March 2022. The periods in the first and second waves of the Pandemic shows an increase in demand for the service and management of outbreaks.

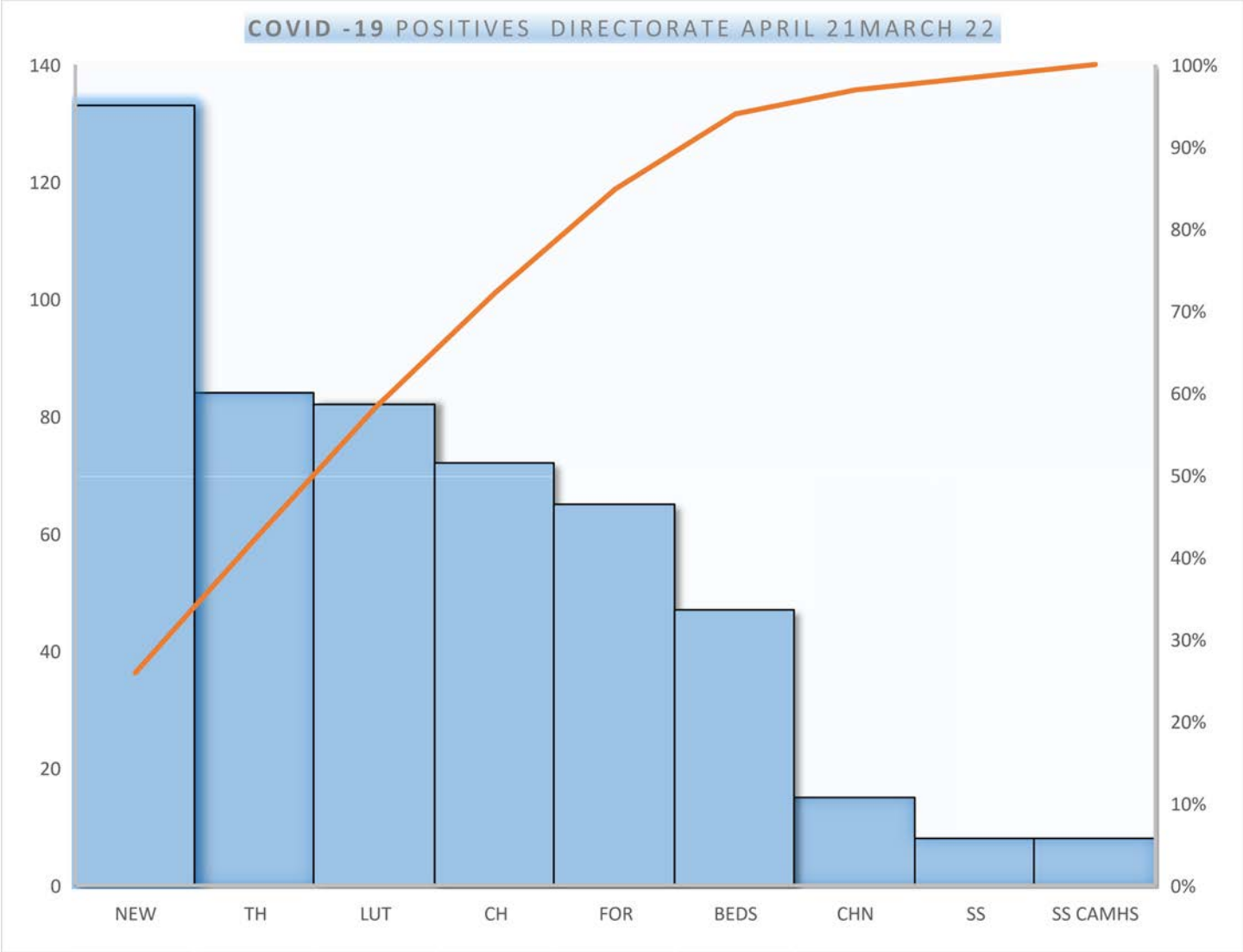


Figure 6; line graph of the laboratory confirmed cases ELFT in patient services by directorate showing highest number of cases peaked in Newham for COVID-19 .Source: Bart Health Laboratory

10.0 Covid -19 Health Care acquired infections: (HCAI)
Definitions: Hospital-Onset Probable and Definite Healthcare Associated COVID-19 infection:
A Hospital-Onset *Probable* Healthcare-Associated infection is defined as an infection where the first positive specimen was taken **8-14** days after hospital admission.

A Hospital-Onset *Definite* Healthcare-Associated infection is defined as an infection where the first positive specimen was taken **15** or more days after hospital admission. NHSEI CNO Letter (Ref No 001559) 19 May 2020.

These HCAI were reported on a daily basis to Public Health England as part of Sit Rep processes. The number of Health Care Acquired Infection (HCAI) Covid -19 April 2021 to March 2022 as reported below for in patients wards across ELFT.

Directorate	Ward	Diagnosed within 2 days admission	Diagnosed 3-7 days after admission2	Diagnosed 8-14 days after admission	Diagnosed after 15+ days after admission
Bedfordshire	Ash Ward	0	2	3	4
Bedfordshire	Cedar House	0	0	0	7
Bedfordshire	Fountains Court	0	1	0	14
Bedfordshire	Townsend Court	1	4	2	8
Bedfordshire	Willow Ward	0	0	1	0
CHN	Fothergill Ward	6	1	2	6
City & Hackney	Bevan Ward	1	1	0	11
City & Hackney	Brett Ward	1	3	0	6
City & Hackney	Conolly Ward	3	1	3	15
City & Hackney	Gardener Ward	0	0	0	1
City & Hackney	Joshua Ward	2	2	1	8
City & Hackney	Mother & Baby Unit	1	1	2	3
City & Hackney	Ruth Siefert Ward	1	2	1	2
Forensics	Aldgate Ward	0	0	0	1
Forensics	Bow Ward	0	0	0	6
Forensics	Broadgate Ward	1	0	0	19
Forensics	Butterfield Ward	0	0	0	1
Forensics	Clerkenwell Ward	0	0	0	1
Forensics	Hoxton Ward	0	0	0	7
Forensics	Loxford Ward	0	0	0	9
Forensics	Ludgate Ward	0	0	0	7
Forensics	Morrison Ward	0	0	0	2
Forensics	Shoreditch Ward	0	0	0	8
Forensics	Victoria Ward	0	0	0	2
Forensics	Westferry Ward	0	0	0	1
Luton	Coral Ward	14	7	5	6
Luton	Jade ward	1	2	1	9
Luton	LUT - Crystal Ward	0	4	3	9
Luton	Onyx Ward	1	0	0	9
Luton	Poplars Ward	0	0	1	10
Newham	Cazaubon Ward	0	0	2	10
Newham	Crystal Ward PICU	0	2	1	10
Newham	Emerald Ward	5	1	0	13
Newham	Ivory Ward	3	2	2	7
Newham	Opal Ward	0	3	4	16
Newham	Ruby Triage Ward	3	2	2	7
Newham	Sapphire Ward	4	0	3	7
Newham	Topaz Ward	1	2	4	17
Specialist Services	Sally Sherman Ward	0	0	0	8
CAMHS	Coborn Unit (Acute)	1	1	0	2
CAMHS	Galaxy Ward	1	1	0	2
Tower Hamlets	Brick Lane Ward	3	3	1	10
Tower Hamlets	Globe ward	1	1	0	11
Tower Hamlets	Lea Ward	4	1	2	7
Tower Hamlets	Leadenhall Ward	1	0	1	11
Tower Hamlets	Millharbour Ward	0	0	0	2
Tower Hamlets	Roman Ward	5	3	4	3
Tower Hamlets	Rosebank Ward	0	1	0	9
TOTAL		**65**	**54**	**51**	**344**

Figure 6 Health Care Acquired Infection (HCAI) for ***inpatients wards*** Covid -19 April 2021 to March 2022.

Hospital Onset COVID-19 (HOCI). The table below shows that from April 2021 – March 2022,

There have been **344** HOCI's reported 15 days+ after patient's admission date.

APRIL 2021 - MARCH 2022			
Diagnosed within 2 days admission	Diagnosed 3-7 days after admission2	Diagnosed 8-14 days after admission	Diagnosed after 15+ days after admission
65	54	51	344

APRIL 2021 – MARCH 2022					
Directorate	Diagnosed within 2 days admission	Diagnosed 3-7 days after admission	Diagnosed 8-14 days after admission	Diagnosed after 15+ days after admission	No. of patients
Bedford	1	7	6	33	47
CHN	6	1	2	6	15
City Hackney	9	10	7	46	72
Forensics	1	0	0	64	65
Luton	16	13	10	43	82
New ham	16	12	18	87	133
SS	0	0	0	8	8
SS/CAMHS	2	2	0	4	8
Tower Hamlets	14	9	8	53	84
TOTAL					*514*

Figure 7: Number of Health Care Acquired Covid-19 infections by Directorate.

11.0 Infection Prevention and Control Outbreak management

The Health and Social care Act requires us to be alert and responsive to new and emerging infectious diseases, hence it was crucial to be alert and responsive to new Covid -19 cases as they emerged and take appropriate action. Outbreak management was followed in line with IPC Policy manual and gov.uk website. In addition, a post infection review or root because analysis is completed on patients where a transmission has occurred / is suspected. Staff and patient contacts were identified and managed in line with Trust occupational health and PHE Test and Trace processes (in case of COVID-19).
There is evidence that the Infection Prevention and Control Board Assurance Framework is completed for COVID-19 hospital transmissions. There is evidence that the Infection Prevention and Control IPC policy outbreak management COVID-19 is followed and root cause analysis template as an incident investigation tool learning in reports to the IPC Committee; Evidence of completed actions are recorded on action plan template, with identified action owners and dates of completion. Lessons learned are collated and disseminated within the organisation. Notification of Infectious disease guidance (NOIDS) and PHE are completed on a regular basis.
There follows an analysis of out breaks in London and Root Cause Analysis (RCA) theme Analysis April 2021-March 2022. This work has also been completed for Bedford and shows separate analysis of themes.

11.1 COVID-19 outbreaks.

The below analysis is broken down in numbers for (ELFT)by Directorates
There were several incidents of COVID-19 affecting both in-patient and community facilities in ELFT during this pandemic. However not all incidents met the definition of an outbreak. An outbreak is defined as 2 or more cases linked by time and location. This report focuses on the reviews and findings from the outbreaks, the lessons learnt and changes made or measures re enforced as a result. Much care and diligence has been taken to present the data in this report as accurate as possible, using all the information available at the time of writing this report.

Quarter	Number of outbreaks	Probable HOCI (8-14 days)	HOCI (15 days+)
1	0	0	0
2	9	2	17
3	30	23	165
4	23	16	117
Total	62	41	299

Figure 8 Number of Outbreaks with probable and definite Health Care acquired infections.

11.2 Covid Outbreaks 21/22

There was no Covid -19 outbreaks in Quarter1, However due to emerging variants, In quarter 2, 3 and 4 there were 62 Patient outbreaks across East London Foundation Trust on in-patient wards. There was **368** confirmed Covid-19 positive patients in these outbreaks and **111** confirmed staff associated with the Outbreak. As part of these outbreaks there was **41** probable Covid-19 Health Care Acquired infections (HCAI) patients and there was **299** definite > 15 days Health Care Acquired Infections. East London Foundation Trust is a mental Health Trust. The patients are screened in line with UKHSA guidelines on admission, day 3 and days 5-7 and weekly since the beginning of the pandemic. Patients are mobile and socialise on the wards and routinely go on leave as part of their care and treatment so it is not always possible to say they are definite HACI as recorded above.

Please see break down below in charts by number of outbreaks by Directorate and number of patients confirmed by directorate and wards at East London foundation Trust. Outbreaks were managed in line with Infection Prevention and Control Policy and in line with UKHSA guidance.

Please see below breakdown in PYE charts showing distribution of probable and definite health care acquired infections by each in patient Directorate. Root Cause analysis is being undertaking for index cases related to these outbreaks and where indicated e.g. death of a patient within 28 days of diagnosis. There is further analysis of the outbreaks to identify possible causes and lessons learnt to improve Quality Care. These are shared at the IPC Committees and with Teams.

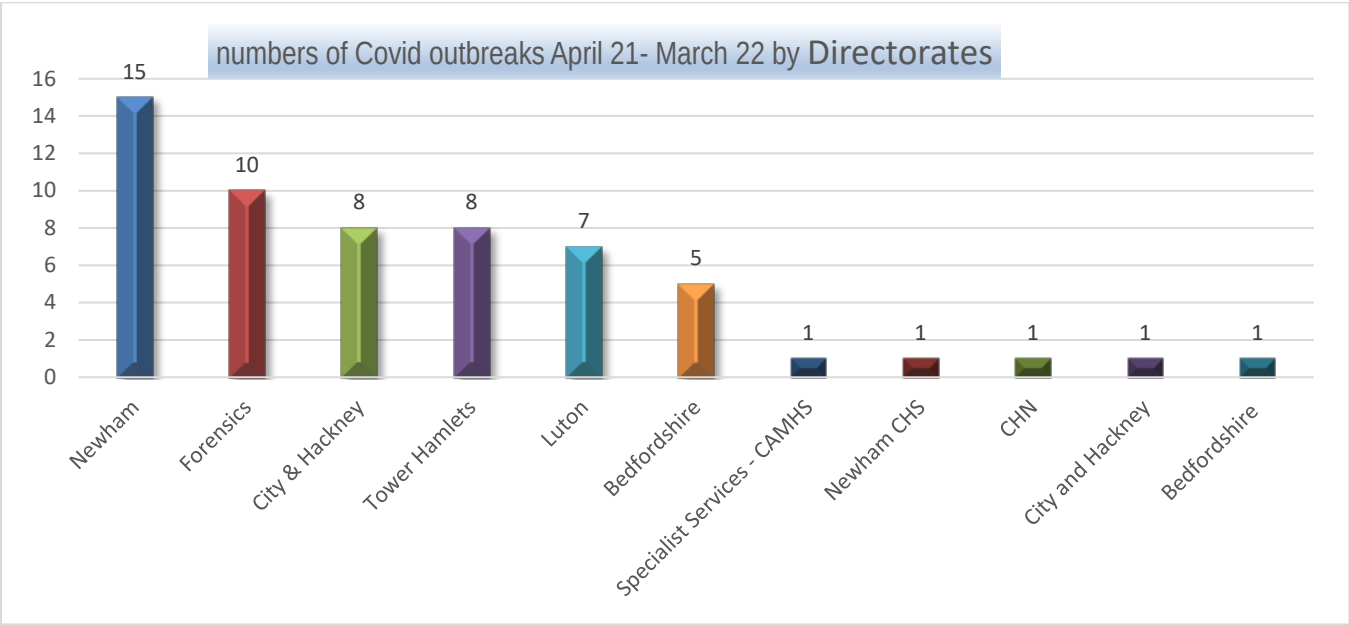


Figure 9 shows outbreaks by ELFT Directorate for in-patient services April 2021 to March 20 22. Newham had the highest number of outbreaks followed by City and Hackney and Forensics

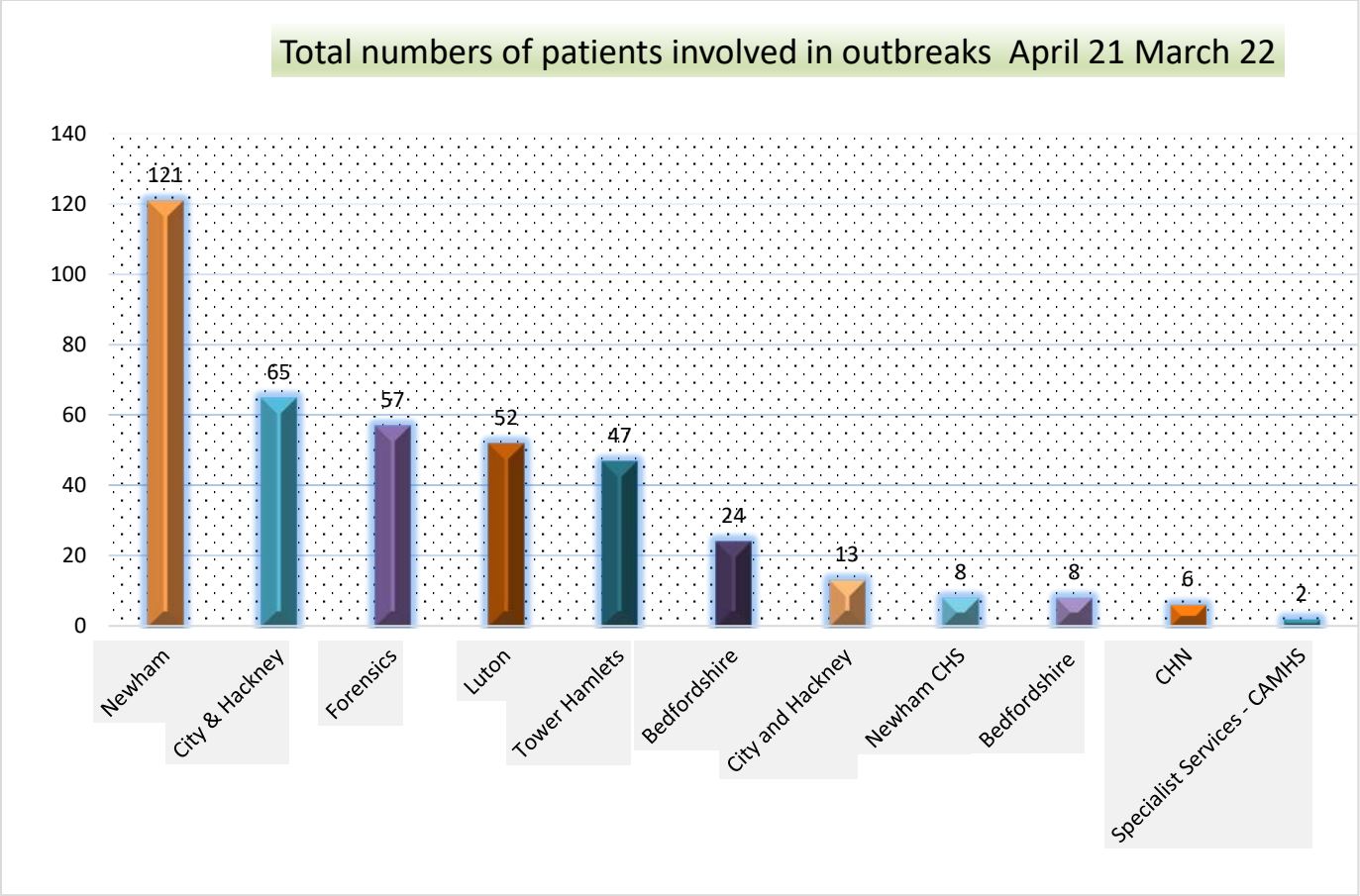


Figure: 10 Newham has the highest number of confirmed Covid-19 Patients, and highest number of outbreaks as above followed by City &Hackney and Forensics. This was reflective of prevalence in the community that was reported by Gov.UK.

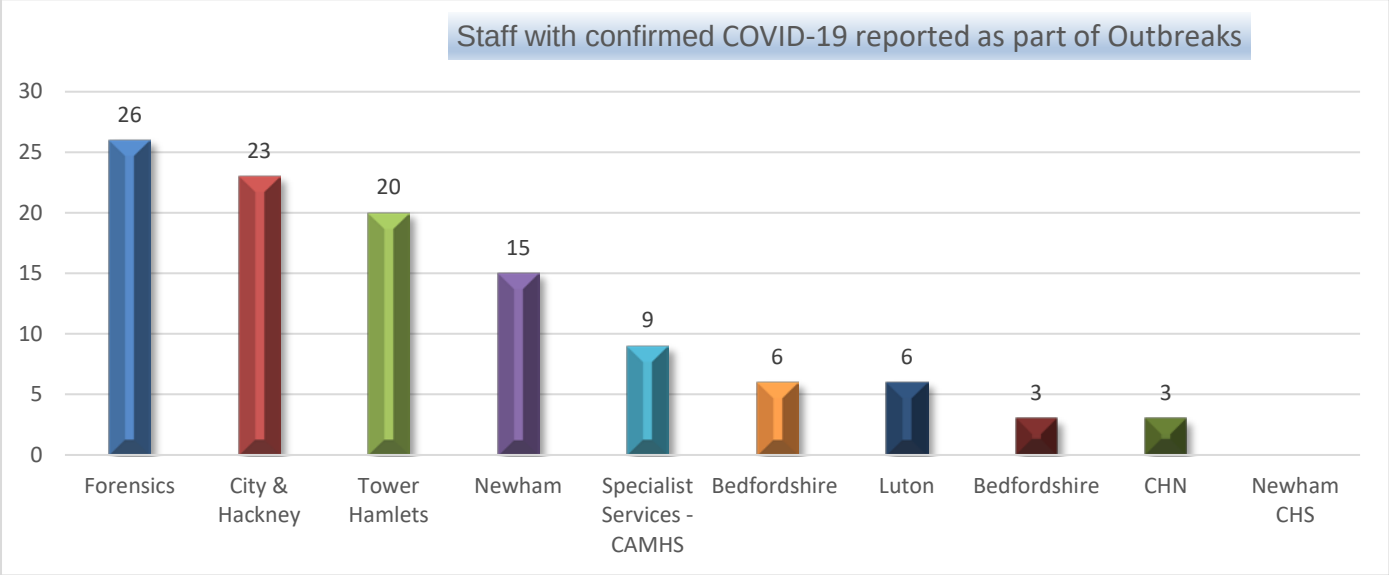


Figure11: shows the number of staff cases reported as associated with an outbreak. However does not represent all staff cases. This are reflected further in the report the People and Culture figures on staff absences with Covid-19,

The IPC Team visit the wards during outbreaks to ensure systems and process in place. ELFT also provide a range of services to support staff as mentioned below and Health and Safety as part of ensuring staff are supported to keep safe in line with Quality Care

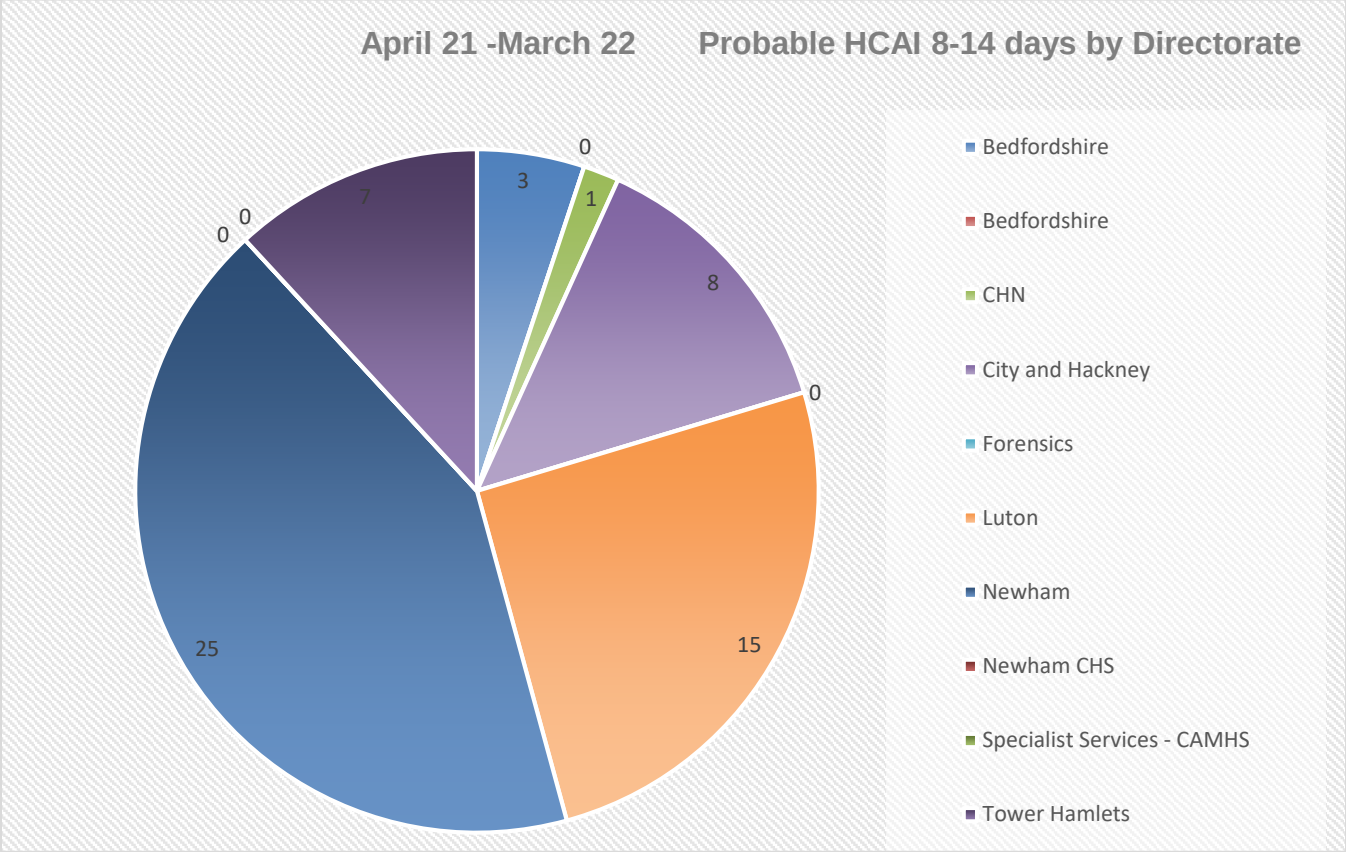


Figure 12: shows that numbers of probable Health Care Acquired infections by Directorate

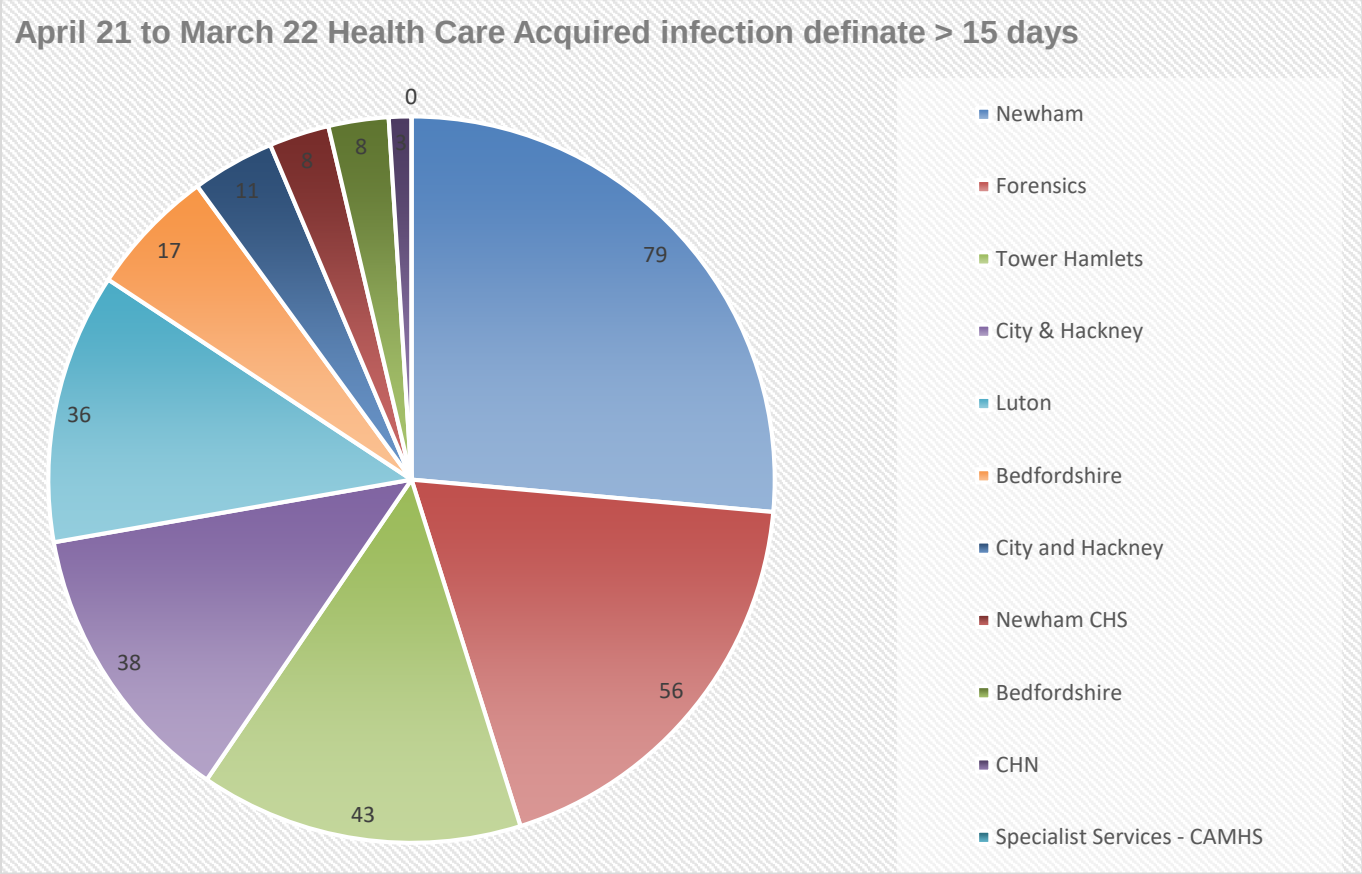


Figure 13: shows number of definite Health Care infection by directorate

12.0 RCA reviews

In a letter to all NHS providers in around summer 2020, NHS England/Improvement require all providers to carry out a review of Hospital onset cases of COVID-19 (positive cases identifies after 7 days of admission) to determine the actual source of acquisition and also to identify any issues that might have contributed particularly if found to be acquired in healthcare. Due to the increase number of cases particularly during the second wave of the pandemic, it has not been possible to conduct a review for all individual healthcare onset cases. However, the Trust has reviewed a number of the cases by carrying out RCA meetings.

During this period, priority for RCA has been given to the cases that resulted in outbreaks though other individual hospital onset cases were also reviewed. The outbreaks have had the source investigated and the root course and/or contributing factors gathered. Most of these have been done by conducting RCA. The review process is carried out using a locally agreed RCA document/tool. This document has been recently revised to help capture more relevant COVID-19 related contributing factors.

12.1 Themes drawn from RCA reviews

Though in most cases the specific root course for the cases were undetermined, a number of contributing factors were identified and addressed. There are 3 main themes emerging from the RCA reviews conducted so far which are classed under patient, staff and environmental factors.

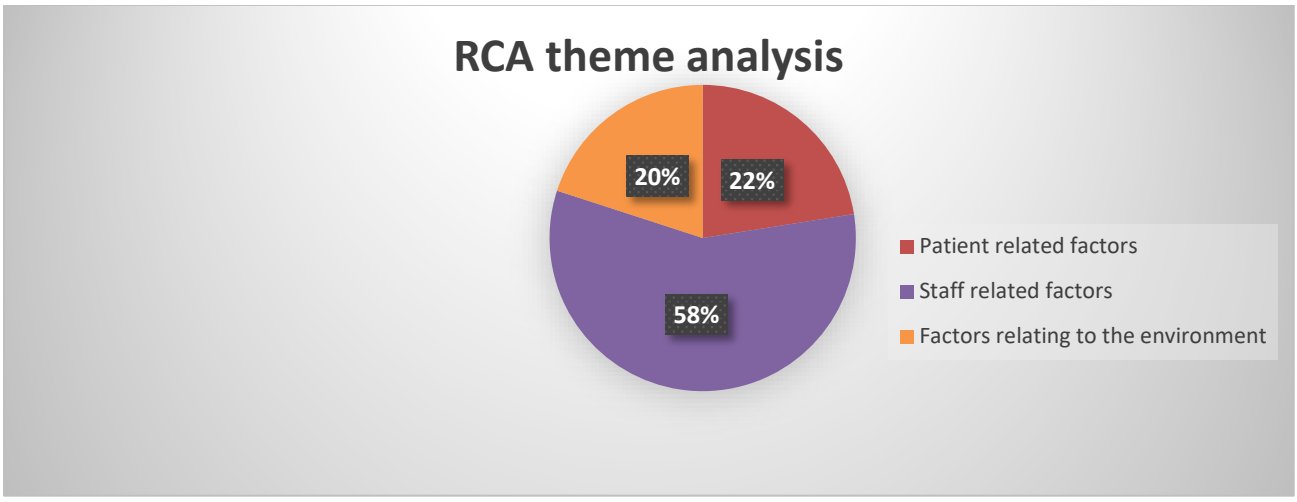


Figure 9. Staff related factors appear to be the most dominant occurring contributing factors- These factors include Staff related factors includes gaps in patient isolation, patient transfers and management of patient contacts. It also includes laboratory and specimen related issues ssignificant delay in knowing the result of the index case, contributing to transmission. This is followed by Patient related factors occurred followed by environmental factors occurring In some outbreaks, there was a combination of 2 or more contributing factors e.g. staff and patient factors or patient and environmental factors.

The patient related factors included, Patients- exposure to the virus during leave to the community - patient's interaction with each other makes it possible for transmission to others on the wards contributing to increase number of definite HOCI cases. Patients- refusal of admission swab and refusal to isolation due to lack of insight and likely to be incubating the virus on admission. Again patient's interaction with each other makes it possible for transmission to others on the wards contributing to increase number of definite HOCI cases. Service User leave as mentioned above is a known risk of transmission/onward transmission to others on the ward who do not have leave. There has been service users who share vapes between each other and swab refusal and challenges around isolation.

Environmental factors included, the impact of limpact of infrastructure/environment; e.g. the ward with the most prolonged outbreak (Broadgate) had 2/3 working toilets for 17 service users and had previously had a large outbreak in Q2. Air conditioning in sub-optimal in many NHS sites and the recirculating air system to keep medicines cool had to be switched off while staff and patients in the room and when in use for medication rounds during outbreaks. In line the hierarchy of controls and with the infectious nature of the omicron variant FFP3 were rolled out.

12.2 Some Lessons learning and changes following findings from outbreaks:

New cleaning definitions/terminologies are in use for clarity when staff are requesting different level of cleaning. Training on cleaning provided. Daily cleaning of patient's bedrooms and maintaining 3 times daily cleaning of communal areas and nurses station now in place as a routine to help reduce the viral load and reduce the risk of outbreak as a preventative measure as advised by IPCT.

There will be further sharing *lessons learnt* from outbreaks at ward away days and Trust wide reflection events to take place June 2022 on of the outbreaks to capture learning in a dynamic way and look at application of learning in and on practice locally and across the organisation as required.

A *formal PPE and hand hygiene* audit to monitor staff practices is now in use across the service on an electronic platform. Education provided and sessional use of gloves and aprons discouraged across the Trust. Monitoring of staff practices by PPE and hand hygiene audit encouraged.

Improving compliance of a COVID-19 swab documentation template on Rio and training for staff on how to use this has been provided. There was also the development of several new protocols guidance e.g. for services developed with IPC/COVID-19 precautions as per IPC quarterly committee reports. The IPCT Team are attending wards and away days and emphasising swabbing patients on admission, raising datix for patients refusing swabs and communicate with staff on risks and updating on ever changing guidance.

13.0 Staff Occupational Health:

Please see requirements under the Health and Social Care Act (2015). To meet ELFT'S Duty of Care on the Protection of staff People and Culture contract and Team Prevent as the Occupational Health (OH) provider whom report to the IPC Committee. Extra resources were contracted to respond to COVID-19 Line managers and staff carried out risk assessments and accessed support via helplines and referrals to OH were carried out for ongoing assessment and support. The regular services provide;

• Risk assessment of need for immunisation, in particular hepatitis B immunisation;
•Health screening for communicable disease, including tuberculosis and where appropriate, BBV screening for those undertaking exposure prone procedures;
• Post-exposure management, for example for inoculation injuries; and
• Circumstances under which staff may need to be excluded from work
Use of personal protective equipment (PPE), including staff training in the safe use and disposal of PPE;

Figure 10. Number of Staff off work with COVID-19 infection by month and reason recorded for sickness

Employee Numbers	Sickness	Reason	Reason	Reason	Totals
Month Sickness Started	COVID 19 Confirmed	COVID 19 Suspected	COVID 19 - no reason recorded	Long COVID	Grand Total
Jul-21	9	17	3	6	35
Aug-21	13	9	10	6	38
Sep-21	8	8	8	10	34
Oct-21	8	11	12	8	39
Nov-21	9	12	7	8	36
Dec-21	64	41	52	9	166
Jan-22	45	22	17	8	92
Feb-22	21	10	15	10	56
Mar-22	42	21	20	10	93

13.1 Occupational exposure:

The Health and Safety Executive (HSE) accepts that these are not easy criteria to apply in the unusual circumstances presented by the coronavirus (COVID-19) outbreak. When deciding if a report is required, the responsible person must make a judgement, based on the information available, as to whether or not a confirmed diagnosis of COVID-19 is likely to have been caused by an occupational exposure, i.e. whether or not there is reasonable evidence that a work-related exposure is the likely cause of the disease. The judgement should be made on the basis of the information available.
There is no requirement for RIDDOR reports to be submitted on a precautionary basis, where there is no evidence to suggest that occupational exposure was the likely cause of an infection.
Each staff member who was confirmed as COVID positive was cross referenced with Covid-19 positive patients on the ward by People and Culture and Health and Safety Team.

13.2 Fit Testing for face filtering particle masks (FFP3)

In line with Public Health England and Health and Safety Executive guidance, the Trust Fit Testing project has been established to deliver Fit Testing service for staff. This is to ensure Trust wide staff are protected from harmful viruses including Covid-19 whilst conducting their roles and responsibilities for aerosol generating procedures.
Please see below the most recent figures with updates on staff numbers fit tested
Source: **ELFT FIT Testing Service**

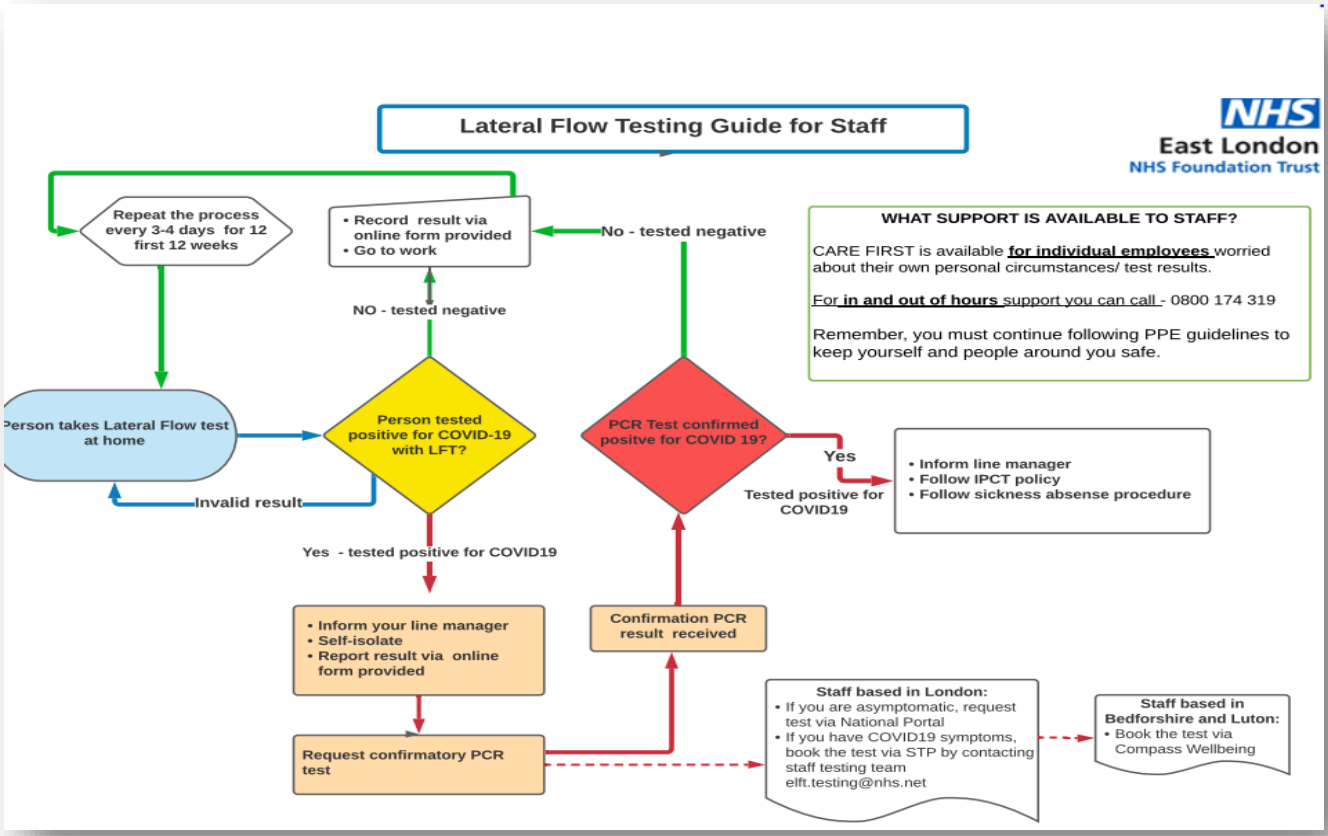
Fit Testing (Numbers update)
94% Overall
15% for low-priority, low risk staff. This includes work-from-home staff & those on leave

13.3 Tests used in ELFT for staff for Covid-19

Lateral Flow Test (LFT)

Rapid lateral flow tests were used as part of a screening process to help to find cases in staff and Persons who may have Covid-19 but be asymptomatic but are still infectious and transmit the virus to others. Please see below lateral flow testing services flow chart for staff and the response required when an outbreak Occurs as identified with managers using the LFT devices please see the below flow chart for staff guidance.

There is also a guide for managers designed by the by the staff testing team and IPC Team below **Figure** 18. People and Culture provided a range of services for staff working with other department including psychology. For Staff that are shielding, there was support for required equipment to work from home where possible or Travel to attend work safely in line with the changing 'National PHE Guidance' in line with Health and Safety.



Figures 11. LFT flow charts for staff guidance

COVID-19 ELFT Visual Summary

This graphic summarises information and guidance which may be useful to staff. As essential workers either providing direct patient care or supporting those who do, you are all critical to supporting the Trust and the NHS during these challenging times.

Stay at home to stop coronavirus spreading - if your job allows this

NHS East London NHS Foundation Trust

Things to do to stop infection from spreading

Do

WASH YOUR HANDS
Wash your hands with soap and water often – do this for at least 20 seconds

ALCOHOL-BASED SANITIZER
Use hand sanitiser gel if soap and water are not available

COVER YOUR MOUTH AND NOSE
With a tissue or your sleeve (not your hands) when you cough or sneeze

PUT USED TISSUES IN THE BIN
Do this immediately and wash your hands afterwards

KEEP YOUR DISTANCE
Stay 2 metres (3 steps) away from other people, if you need to go outside

Don't

DON'T TOUCH YOUR FACE
Do not touch your eyes, nose or mouth if your hands are not clean

In-house Emotional Support for Staff

These are intense times as we all make massive adjustments in our professional and personal lives. If you leave work frazzled, a bit tearful, or feel overwhelmed, book a chat with our in-house support service. A chance to talk to a psychology/therapy/experienced colleague for support. Find out more here or on the Staff Support COVID-19 web page.

Care First 24 hour Helpline: 0800 174 319
Advice for you, your partner and dependent family members on legal concerns, parenting issues, financial problems, relationship issues, etc.

Occupational Health Service Team Prevent Online
For health issues: call 01327 810777 | **Email:** elft@teamprevent.co.uk |
Managers Helpline: 01327 810739

Trust Updates on COVID-19

All COVID-19 information related to infection prevention and control, and advice for staff is available in daily staff email updates, on the intranet and for those who are working from home on the ELFT website, under Professionals/Information for ELFT Staff.

Printable Coronavirus Update
If some people in your team do not get access to a PC very often, please print and display the daily update for everyone to read.

Public Health England Coronavirus Posters
Please print & display full colour poster or black & white poster.

Quick Links and Advice for Staff

- Your questions answered
- Extremely Clinically and Clinically
- Pregnancy
- Book your COVID-19 Vaccine
- Pandemic Guidance
- A Complete Guide to Remote Working
- Working from Home Top Tips from the QI and QA Teams
- Infection Control
- NMC: COVID-19 Temporary Register for Ex Nurses
- Businesses that Support NHS Staff
- Keyworkers' Wellbeing Toolkit
- Emotional Support Service for ELFT Staff
- Travel and Parking
- Not Received Your Keyworker Letter for Your Child's School? Email ELFT
- Free Hotel Accommodation for NHS Staff

If you have familiarised yourself with the information and resources available and still have some questions unanswered, please let us know. **Email:** elft.communications@nhs.net **or go to:** Post Your Question on the Intranet.

Latest resources and videos

- WHO Advice for the Public - Basic protective measures
- Infection Prevention at Work
- Personal Protective Equipment
- Investigation and initial clinical management of possible cases
- Looking After a Patient with Confirmed or Suspected COVID-19
- Supported living services during coronavirus (COVID-19)
- COVID Testing
- COVID Vaccine Q&A
- Smoking & Coronavirus
- Domestic Abuse Support
- ELFT Clinical Guidance for Staff
- Bereavement Support
- Vitamin D Supplements
- Teaching & Childcare Support
- Yoopies
- Risk Assessment Form
- Wellbeing Conversation Guidance

From now on, all hospital/community trust staff who have to travel into work can access a lateral flow swab test – not just patient facing staff. Read more. For more information email elft.testing@nhs.net

Figure 12 above shows a range of services to support staff in the pandemic

14.0 Seasonal Influenza vaccination programme *Healthcare Workers and Patients*

In line with the National strategy ELFT has being promoting and delivering Immunisation to protect staff And service users from Influenza and Covid-19.
Please find below the final flu report for the 21/22 Flu season

The Trust has also vaccinated **217** staff that are not directly employed with ELFT.

Figures 13 Frontline staff reported to NHS England is currently at **76%**

Percentage table						
Directorate	**Yes**	**No**	**Total (Yes & No)**	**Total Staff**	**% Vaccinated at ELFT**	**% Including declines**
Bank	111	32	143	1459	**7.61%**	9.80%
Bedford	284	43	327	665	**42.71%**	49.17%
Bedfordshire CHS	202	8	210	437	**46.22%**	48.05%
City & Hackney	188	108	296	545	**34.50%**	54.31%
Community Services - TH	113	47	160	207	**54.59%**	77.29%
Corporate	194	11	205	660	**29.39%**	31.06%
Forensic Services	186	135	321	497	**37.42%**	64.59%
Honorary Contracts	110	8	118	1095	**10.05%**	10.78%
Luton	123	37	160	352	**34.94%**	45.45%
Newham	256	122	378	447	**57.27%**	84.56%
Newham CHS	139	58	197	429	**32.40%**	45.92%
Primary Care	40	18	58	105	**38.10%**	55.24%
Specialist CHS	90	31	121	131	**68.70%**	92.37%
Specialist Services	396	120	516	882	**44.90%**	58.50%
Tower Hamlets	314	177	491	556	**56.47%**	88.31%
VACCINATION	49	38	87	794	**6.17%**	10.96%
Grand Total	**2795**	**993**	**3788**	**9261**	**30.18%**	**40.90%**
Substantive Post Total				6012	50.00%	67.00%

14.1 The ELFT COVID vaccination programme

As well as the seasonal Flu programme the new Covid-19 Vaccination programme became available nationally in December 20 and was rolled out across the Trust for staff, patient and the public in line with national guidelines. A Bespoke service was set up at Stratford West field Centre with site visits re quality and assurance and IPC whom also supported the development of a Standard Operating procedure on Infection prevention and control precautions. See **Figure 12** for staff uptake as per March 2022. Please see below updated data March 2022. -

Substantive frontline staff headcount	**Substantive frontline staff vaccinated first dose**	**Substantive frontline staff vaccinated second dose**	**Substantive frontline, eligible staff vaccinated booster**
4510	4123	3493	940

Figure 14: Source: People and Culture HR team. At 11/02/2022 are as above.

15:00 Sharps injuries

There were **48** report by Team Prevent, ELFT Occupational Health provider. The IPC Team follow up and provide education and training in order to minimise risk associated with NSI's as below report from Team prevent shows. All sharps incidents that are reported are followed up on ELFT systems and Team Prevent Occupational Health Provider and in relation to learning from Incidents.

15.1 Safer Sharps Devices
The IPC team have been raising the profile on the safe disposal of used sharps, the management of NIS's, and the use of safer sharps devices (retractable needles) during IPC training sessions. There has been extensive work carried out in Bedford following incident there, in Quarter 2. In line with lessons learnt and alert was shared across in-patient services on Trust communications which involved removing any unsafe devices from the wards. Training also took place for new Trainee Doctors in December 2021.

Classification of Injury

Splash of blood/bodily fluid on intact skin

Mucocutaneous Exposure – where there is direct contact of blood/bodily fluid with eyes, nose or mouth or on broken skin e.g. uncovered cuts or eczema
not covered with waterproof dressing.

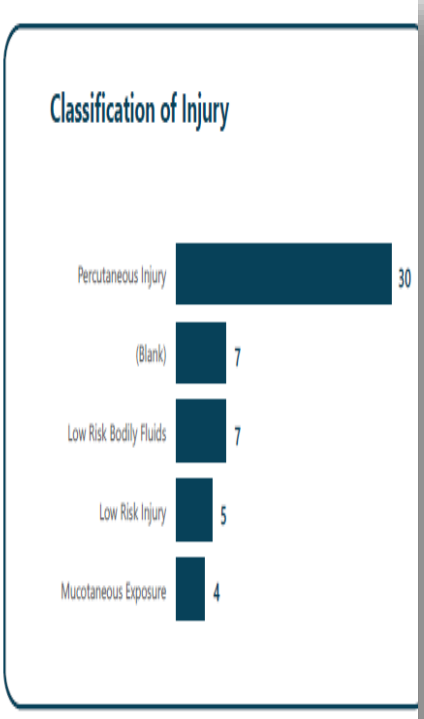
Percutaneous Injury – is an exposure incident in which penetration of skin occurs by a needle or sharp object which was in contact with blood, tissue or
other body fluid before the exposure including bites.

Figure 15 below gives a breakdown of different types of fluids which are discussed during the assessment. This is an important piece when deciding if the injury is
low or high risk. Other factors are the source and if they have any known BBV's or any high risk factors such as, drug user, sex worker etc.

15.2 Safer Sharps audits
Safer sharp audit is undertaken as part of the Environmental Audit s (Appendix 6) to ensure that services across the Trust are complaint with the safer sharps directive. The safer sharps directive legislation was effective from 13th May 2013. This legislation states that healthcare services must assess and review sharp devices that healthcare professionals use during clinical activity, and seek a safer alternative with a safety mechanism to reduce and prevent the risk of a sharps injury to the user. There is an ongoing monitoring to ensure Compliance with the IPC promote during teaching. Safer sharps devices are available for insulin pens for Nurses to use as appropriate in community services.

Number of Needlestick cases recevied by Month and Organisation Level

Customer Name	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Total
East London NHS Foundation Trust	7	2	6	3	3	5	3	2	1	2	8	6	48
Adult Social Care	1												1
363 Tower Hamlets Level 2		1				1	1						3
363 Specialist Services Level 2	1											1	2
363 Specialist - CHN	1												1
363 Newham Level 2	2						1	1		1			5
363 MHCOP - CHN	1			1									2
363 Luton Level 2			1			1		1				1	4
363 East London NHS Foundation Trust				1	1	1				1	2	1	7
363 Community Services - Tower Hamlets Level 2			1										1
363 City & Hackney Level 2			1	1							3		5
363 CHB Community Health Bedfordshire Level 2			2		2	1			1		3	3	12
363 Bank		1					1						2
	1		1			1							3
Total	7	2	6	3	3	5	3	2	1	2	8	6	48



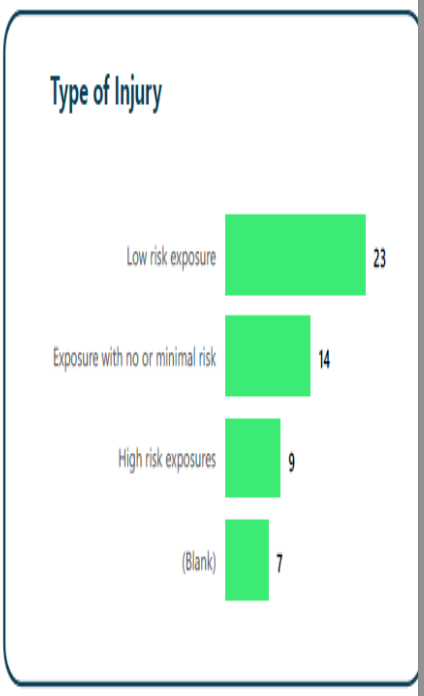


Figure 15: Number and classification and type of injury

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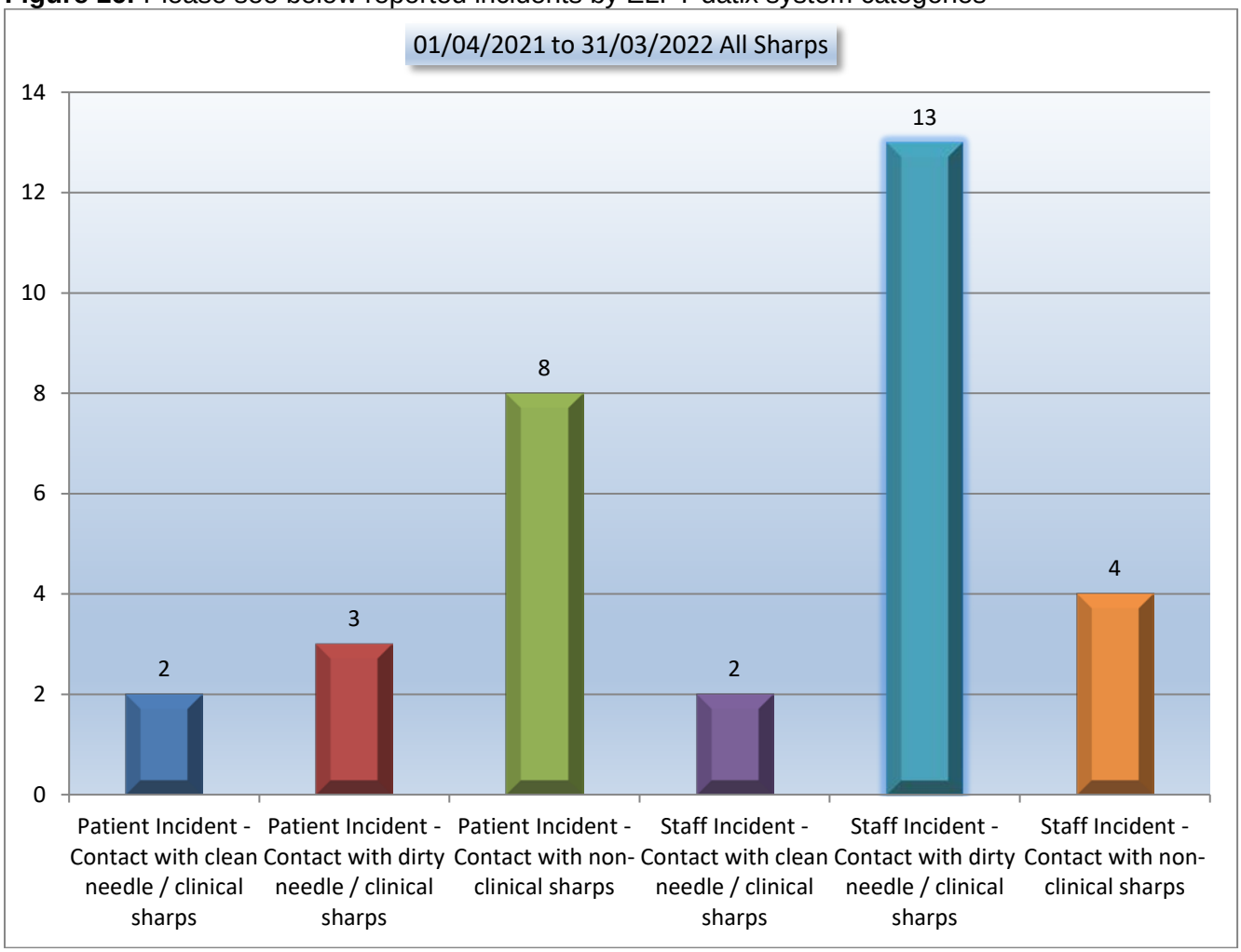
Figure 16: Please see below reported incidents by ELFT datix system categories



16.0 Annual Work Plan 2021/22

The annual work plan for was based on the requirements of the code of practice for infection control and stake holder feedback and infection Prevention & Control nurse visits. Key themes were used to formulate the action plan. See last year's summary diagram appendix. The requirements of the annual work plan were met last financial year. The IPC Plan was delivered apart from Validation Audits on older Adult wards by IPC Nurses. This year's plan has been submitted to the IPC Q4 Committee 22/23.

17.0 IPC audits programme.

Regular self-monitored IPC audits focusing on hand hygiene facilities and products, decontamination material, the appropriate use of personal protective equipment (PPE) and management of clinical healthcare waste are submitted by teams. The emphasis is on a quality improvement approach supplemented by robust monitoring. The results of the hand hygiene validation audits are shown in appendix 4

17.1 IPC Environmental Audits

There is an on-going annual rolling programme of clinical environmental audits undertaken across the Trust by the IPCN. It is the intention of the IPC team to encourage staff to undertake their own audits in low risk areas with support from IPCN. Recommendations and actions plans are formulated where required with timeframes for actions to be undertaken and sent back to IPCN. Results of environmental in **Appendix 6**

17.2 Hand Hygiene Audit. Please see Appendix 4.
The hand hygiene audit captures ten opportunities to decontaminate hands based upon the World Health Organisation (WHO) 5 moments of hand hygiene these are:

- Before touching a patient
- Before clean/aseptic procedures
- After body fluid exposure/risk
- After touching a patient
- After touching patient surroundings

There is an Audit plan for next year which includes Hand hygiene and PPE audits on Trust System.

18.0 Decontamination of Medical Devices
Inadequate decontamination can result in the transmission of a range of micro-organisms from blood-borne viruses such as human immunodeficiency virus (HIV) or Hepatitis B, to fungal and common bacterial infections. Safe and effective decontamination of all re-usable equipment between uses is imperative as an essential part of routine IPC practice.

Single Use Devices (SUDS) A single-use device is used on an individual patient, during a single procedure, and then discarded. The device is not intended to be reprocessed and used on another patient. The labelling identifies the device as disposable, and is not intended to be reprocessed and used again. All service lines across ELFT conform to European Legislation. The Trust uses single use non-invasive reusable medical devices.

All equipment in the Trust, including items such as beds, and commodes, are cleaned in-between use as per the Trust's Decontamination policy and monitored as part of the infection control audit programme. Compliance with the decontamination policy is monitored as part of the wider IPC policy audit. During 20 20/21, teams have been self- reporting 99% compliance with decontamination.

19.0 IPC Training and compliance

Infection Prevention and Control training forms part of the statutory induction programme which all new staff to the Trust participate in.

Annual updates are provided to staff using a variety of methods depending on clinical activity.

All non-clinical staff complete level 1 training on a 3 yearly basis.

Clinical staff members that carry out clinical procedures complete level 2 training annually. This is completed via e-learning programme. The IPCT have been facilitating ad-hoc/ bespoke face- to-face training sessions during Directives away days, at the request of clinical teams to improve clinical staff IPC training level compliance as **Figure 17** below shows compliance end of March 2022.

Directorate	Infection Control Level 1 -	Infection Control - Level 2
Bedford	92.70%	86.87%
Bedfordshire CHS	92.80%	89.47%
City & Hackney	85.94%	83.94%
CHS- Tower Hamlets	89.19%	76.67%
Corporate	84.50%	81.88%
Forensic Services	94.90%	88.60%
Luton	95.29%	86.61%
Newham CHS	93.89%	85.31%
Newham	91.34%	79.94%
Primary Care	88.71%	85.42%
Specialist CHS	92.00%	88.24%
Specialist Services	87.75%	79.68%
Tower Hamlets	93.33%	81.72%

19.1 Statutory and mandatory IPC training across the Trust in 2021/22: is reported by Learning and Development. Figure 23.

IPC statutory and mandatory training across the Trust is improving, the IPCT have been facilitating ad-hoc training sessions during Directive away days, and at the request of clinical teams to improve IPC training level compliance. There have been extra bespoke training sessions across all services by the IPC Team to respond to the pandemic. There are some examples as below, however there are too many to include in this report and there is an ongoing series of webinars to be more services proactive to future waves of the pandemic and to increase knowledge and skills in IPC across ELFT.

19.2 Other IPC Training

The IPC team have provided the following proactive services across the Trust:

19.3 Trust wide education programme, to further proactive and upskill staff from learning in the pandemic there is a Trust wide education programme on various topic to improve staff understanding of IPC measures have been planned. The following topics are being covered; Outbreak Management, Cleaning of the Environment, Diarrhoea & Vomiting management (Norovirus & C. Diff), Root Causes Analysis investigations, Hand Hygiene & PPE Audits, Environmental Audits, Tuberculosis MRSA Management Bedbugs, Scabies & Head lice followed by IPC questions & answers sessions at each webinar.

20.0 Cleanliness and the Environment

The Trust facilities monitoring team carries out audits relating to cleaning, linen, waste and main kitchens and Meal Service at ward level. The Team reports directly to the Service Provider, Matron, Lead Nurse and Centre Manager (in community sites), and quarterly to the Infection Prevention and Control Committee. Due to the continued COVID-19 situation all cleaning processes have been maintained using the SOP agreed with IPC.

- There have been few cleaning issues reported in HOMERTON, including bed bug infestations.
- Estates work are in progress and advice has been given by IPC Team
- . The Trust has cleaning and facilities services that are out-sourced as follows:

Sites	Provider
Newham Centre for Mental Health	Grosvenor Facilities Management
Tower Hamlets Centre for Mental Health	Serco Facilities Services under the Bart's Healthcare via service level agreement (SLA)
John Howard Centre and Wolfson House	G4S
City and Hackney Mental Health Service	ISS under the HOMERTON University Hospital SLA
Community Health Newham	Community Health Partnership, Outsource Client Solutions (OCS) and NHS Property Services
Luton and Bedfordshire Mental Health	G4S
Bedfordshire community Health services	NHS Property Services & Mitie

20.1 Cleaning audits scores for 2021/22

Summary of cleaning scores suggest that cleanliness standards across were of a good standard. The national average of 95%. Cleaning issues are closely monitored by the ELFT IPC team and ELFT. The IPC team work jointly, with increased visibility and frequent joint workarounds of the site with ELFT Facilities where there are concerns, to monitor for improvements.

A standard operating procedure document was written by the IPC team in conjunction with Estates and Facilities to ensure COVID-19 positive wards would have sufficient cleaning of the environment Annual Cleaning scores 2021 / 2022

Cleaning audit results 2021/2022 *Target is 95%	***Q1***	***Q2***	***Q3***	***Q4***
NHS Properties Services (Newham)	96%	96.7%	97.24%	96%
G4S (London)	96.39%	96.72%	96.95%	97.15%
G4S (Luton and Bedfordshire)	96.8%	96.89%	97.20%	87.66%
Serco (Mile End Hospital)	99.0%	97.3%	99%	98%
GFM (Newham Mental Health)	97.0%	95.%	89%	90%

Figure 18: Please see above data on facilities score for service areas starting with Forensics, City and Hackney, Mile End, Newham, Bedford and Newham

The cleaning scores were reported at >95% apart from Newham Q3 and Bedford Q4 where there was an action plan as outlined below to improve the standard and make improvements to the environment. Over all the data shows that cleanliness standards overall across the Trust are above the national average of 95%.

The cleaning scores were reported at >95% apart from Newham where there was an action plan as Outlined below to improve the standard and make improvements to the environment.

The cleaning scores for Newham are suboptimal for quarter 3 and for Luton and Bedford Q4.

Over all the Trust data shows that cleanliness standards overall were above the national average of 95%.

20.2 Environmental audits

These are carried out by the IPC Team alongside ward managers and Matrons on a rolling programme and were temporarily halted due to Covid-19 in quarter 1, however they re-started in quarter 2. The scores < 85%, and in progress of actions plans being revisited and will be re-audited for priority in-patient areas. This is a vital part of IPC Team work in prevention and controlling out breaks. These have action plans for matrons and line managers that require follow up in a timely manner in line with quality care. The conclusion is that East London NHS Foundation trust continues to provide care in safe clean premises where infection risks are kept to a minimum; much work has been implemented during year to achieve good standards of infection prevention and control, through shared working with the wider team (estates, clinical teams and contractors).

21.0 Management of Water systems

All Trust sites are monitored for water quality by the Estates & Facilities Department through external maintenance contractors, and specialist sub -contractors, in accordance with Health Technical Memorandum (HTM) 04 -01 and the control of legionella bacteria in water systems Approved Code of Practice and guidance (ACOP L8).

Water Safety Group oversees governance related to water safety issues across the Trust. Meetings are held on a quality bases. A water report is produced by the ELFT Estates and Facilities Team. The water monitoring services are out-sourced to the following providers:

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Water Safety Group oversees governance related to water safety issues across the Trust. Meetings are held on a quality bases. A water report is produced by the ELFT Estates and Facilities Team for the quarterly water and IPC Committee meetings.

Legionella testing takes place at various locations around the Trust. Every case of Legionella is a risk to any organization. However, there are robust proactive and reactive measures in place to manage Legionella. These are submitted each quarter as part of the IPC Committee processes.

Water Risk Assessments
Water Risk Assessments follow our 1, 2, 3 program
Tier 1 (in patient) – Annual
Tier 2 (health centres) – Bi-annual
Tier 3 (admin) – 3 yearly

The water monitoring services are out-sourced to the following providers at 111 sites

	Service Provider	***Number of Sites***
London Sites– Newham & TH	Clearwater	28
	CHP/G4S – Lift Co	6
	NHSPS	12
Forensic Sites + The Lodge & Alie Street	Rydon - sub contractor is Evolution	4
Tower Hamlets – Mile End + Health E1	Barts	2
City & Hackney	Homerton	1
Newham Centre for Mental Health	GFM – sub contractor WCS Group	1
Luton & Beds	Rydon – sub contractor is Evolution	33
	EPUT	1
	Bedford Hospital	1
Bedford Community	NHSPS	17
	Bedford Hospital	1
	CHP	1
	Central Beds	1
Primary Care		2

21.1 Legionella Testing

During 2021/22 the following water issued issues were identified:
Total buildings currently being monitored in London = 27. All serviced by Clearwater. Rydon have taken over responsibility for JHC, Wolfson House, The Lodge and Alie Street as of 1st April 2021.

Contractors have responsibility to maintain hot and cold water systems, completing monthly water temperature checks, and have implemented a programme of water sampling.
They are also completing water tank disinfection and shower head cleaning.

ELFT have appointed an authorised engineer to advice on water related issues.
Audits were completed at Newham Hospital, HOMERTON, Mile End and L&B sites during February with actions plans in place. To promote working together on water safety, ELFT are invited to attend Community Health Partnership (CHP) water safety group meetings. CHP have also requested a flushing sheet of little used outlets is completed monthly and sent to those so flushing can be carried out.

The below *water issues* were identified and actions plans in place for 21/22.

Legionella detected at John Warburton Building, JHC Q2. Low count in the OT kitchen and being Retested again. There is no requirement to carry out any intensive remedial work, however the tap was changed and the system is included on the flushing regime.
Legionella spp. is non pneumophila species, so generally not pathogenic for humans.
There was no requirement to carry out any intensive remedial work, however the services is included on the 'Flushing Regime'.

Service Provider Maintained Sites

All service providers were asked to report any positive legionella sampling for this quarter plus any water related issues. In Q3 Bartshealth reported two positive samples at Mile End site.

Kitchen 003 SK HWS @750 legionella cfu/a000ml (SG 1 & 2-14)
Toilet 016 WHB blended @ 1000 legionella cfu/1000ml (2-14)
There were several dead legs due for removal that have been identified in MHU where baths have been removed.
NHSPS domestic teams are tasked with flushing and recording any little used outlets – these are kept within cleaner's cupboards log books; across sites it is the tenant's responsibility to indicate any little used outlets. The water safety plan has been approved in Q4 at the IPC Committee .

22.0 Capital Projects
Estates and Facilities work in-conjunction with IPC team to ensure ward moves and new projects are compliant with infection control standards and that a clinical sign off takes place prior to all moves.

23.0 Antimicrobial Stewardship
During 2021/22 the Antimicrobial Stewardship Group (AMS) meet quarterly. The Antimicrobial Stewardship Group determines that there are robust arrangements in place for the provision of effective antimicrobial stewardship strategies in relation to The Health and Social Care Act. These meetings were set up are chaired by the Infection Control Doctor.
During 2021/22 the AMS group meet, reviewed audits are available via the in house prescribing system. Work was carried out with ELFT reporting services and a new Business intelligence dash board has been set up. Training has been carried out for Pharmacy and IPC Team with feedback sessions to improve reporting in line with quality care.

Work Completed:
There has been a reviewed practice of antimicrobial use within East London Foundation Trust (ELFT) and the meetings are scheduled to continue April 2022. /23.
There was a successful appointment of an AMR dedicated pharmacist.
Antimicrobial Audits for the year are available on the Trust dashboard and available via the Trust quality assurance Team for Mental Health in patient's services and via ELFT e prescribing.

Quarterly antimicrobial audit are completed across ELFT in-patient services. For each antimicrobial prescription found during the audit period, the clinical notes and medication chart are reviewed and compared against antimicrobial guidelines and / or microbiology advice provided. For each prescription compliance is measured against standards which are derived from the '*Start smart and then focus'* national Antimicrobial Stewardship guidance. This guidance defines the processes which ensure that antimicrobial prescribing within ELFT is safe effective and appropriate. The audit results are on the Trust Quality dashboard from pharmacy.

Q4 Antimicrobial Prescribing Audit Report 2021/22
This audit report summarises the key findings of the antimicrobial prescribing audit conducted in last year **Figure 19** below in March 2022 and it is used to monitor antimicrobial prescribing trends and quality indicators as part of the Trust wide Antimicrobial Stewardship initiatives.

Method and Standards:
The ELFT pharmacy team collect data across all sites every quarter during a two weeks period. For each antimicrobial prescription found during the audit period, the clinical notes and medication charts are reviewed and compared against antimicrobial guidelines and/or microbiology advice provided. For each prescription, compliance is measured against standards, which are derived from the ELFT Antimicrobial Stewardship Policy. This policy defines the processes, which ensure that antimicrobial prescribing within ELFT is safe, effective and appropriate. The audit standards are as follows:
1. Appropriate treatment choice: All antimicrobials prescribed should be in accordance with the recommendations in the relevant local or national guidelines or microbiology advice.
2. Completion of the allergy box: 100% of antimicrobial prescriptions should also have a clearly documented allergy status for the patient on the prescription chart.
3. Documentation: All antimicrobial prescriptions should have the clinical indication clearly documented in the patient medical record or on the prescription chart
4. Course length: All antimicrobial prescriptions should have a clearly documented duration (or review date) which is appropriate for the indication and is in accordance with recommendations in the relevant local or national guideline or microbiology advice.

Key Findings:

Bedfordshire & Luton: Overall results showed good compliance with audit standards. Compliance with the indication stated in RIO or medication chart in Q4 was 83% (two audit forms were not-compliant) and compliance with the stop/review date recorded on the medication chart in Q4 was 75% (three audit forms were not-compliant)
Tower Hamlets: This service has demonstrated good compliance with most audit standards this quarter. Compliance with the stop/review date recorded on the medication chart in Q4 was 67%, this was due to 1 audit form which was non-compliant
Newham, City & Hackney and CAMHS: Overall results showed excellent compliance with audit standards.
Forensics: This service has demonstrated good compliance with most audit standards this quarter. Compliance with the stop/review date recorded on the medication chart in Q4 was 50%, this was due to 1 audit form which was non-compliant
CHN Adults: No patients on antimicrobials at the time of the audit

Please see summary chart was developed for Q4, Q1, Q2 and Q3
Figure 19: Compliance scores summary Q1, Q2, Q3 and Q4

Action Plan

The following action plan has been formulated to address areas of non-compliance and concern as well as some overarching antimicrobial stewardship objectives in order to improve use of antimicrobials.

1 Circulate report to all Pharmacists, Prescribers, and Clinical Directors to discuss at respective quality and governance meetings.

2 Services with good to poor compliance (RAG rated as amber or red) will be asked to develop local action plans to improve antimicrobial prescribing. This will involve close working between local prescribers, pharmacy teams and the antimicrobial pharmacist.

24.0. Conclusion

This report recognises the challenging year this has been for all services and achievements that have been made during the year especially in the pandemic and the lessons learnt but acknowledges that HCAI Infection Prevention and Control within mental health and community will continue to present challenges.

Infection Prevention and Control in a mental health and community setting requires a different perspective and provides challenges dissimilar to those in an acute general hospital. East London NHS Foundation Trust staff are ready for this challenge and committed to providing a safe clean environment for patient staff and visitors and careers.

This report provides evidence that objectives within the Annual Plan 2021/2022 were met, however the service is now reflecting on lessons learnt in the pandemic and planning and reassessing and developing a plan for last year as per Driver diagram appendix and new work plan which outlines ELFT priorities for IPC (Appendix **2** Annual Work plan 22/23). The CQC assurance Board to Floor assurance document continues to be updated as new evidence and guidance emerges.

25.Summary of Annual work programme 2022/23

The national priorities for 2022/23, determined by the Department of Health and Public Health England are: responding to the COVID-19 Pandemic, Gram- negative Rod Blood Stream Infections and Hand Hygiene, with an overall objective of zero tolerance to avoidable HCAI's and Antimicrobial Stewardship, the annual work programme for 2021/22 will continue to deliver compliance within ELFT of national standards, in particular.

- The Health and Social Care Act (2015) Code *of Practice on the prevention and control of infections and related guidelines.* The CQC IPC and COVID -19 new assurance frame work will continue to be actioned, and evidence reviewed as the current pandemic unfolds.
- To fulfil our obligations under the Health and Social Care Act (2008) ELFT currently employ the Specialist workforce below in **appendix 1** whom oversee and deliver the Infection Prevention and Control service.

- Ensuring compliance with the Health and Social Care Act 2008, involves reducing healthcare associated infections, ensuring that IPC is high on the quality and safety agenda for all and working with colleagues to reduce antimicrobial resistance.

- This virus referred to as SARS-CoV-2, and the associated disease as Coronavirus infectious disease (COVID-19 is a highly infectious disease that has resulted in a worldwide pandemic with an associated high mortality and morbidity which is especially prevalent in vulnerable groups and communities. This and other infectious diseases will be part of ongoing surveillance and responded to in line with the evidence working with the UKHSA as required and appropriate,

26. References

- DH (2015) The Health and Social Care Act 2015- *Code of Practice on the prevention and control of infections and related guidelines*
- DH (2015) '*Start Smart - Then Focus*' Antimicrobial Stewardship Toolkit for English Hospitals
- DH (2013) UK Five Year Antimicrobial Resistance Strategy 2013 to 2018
- DH (2013) Water Systems. Health Technical memorandum 04-01: Addendum *Pseudomonas aeruginosa* – advice for augmented care units
- DH (2012) Updated guidance on the diagnosis and reporting of *Clostridium difficile.*
- DH (2011) Antimicrobial stewardship: 'Start smart – then focus'. Guidance for antimicrobial stewardship in hospitals (England).
- Health and Safety Executive (2013) Legionnaires' disease. The control of legionella bacteria and guidance on regulations
- NHS Improvement (2017) Preventing healthcare associated Gram-negative bloodstream infections: an improvement resource
- Public Health England (2015) Toolkit for managing carbapenemase-producing *Enterobacteriaceae* in non-acute and community setting
- The National Institute for Health and Care Excellence (NICE) (2015) Healthcare-associated infections: prevention and control in primary and community care

Action being requested by Committee

The author should use one of the following statements or variations thereof: "The

Board/Committee is asked to….

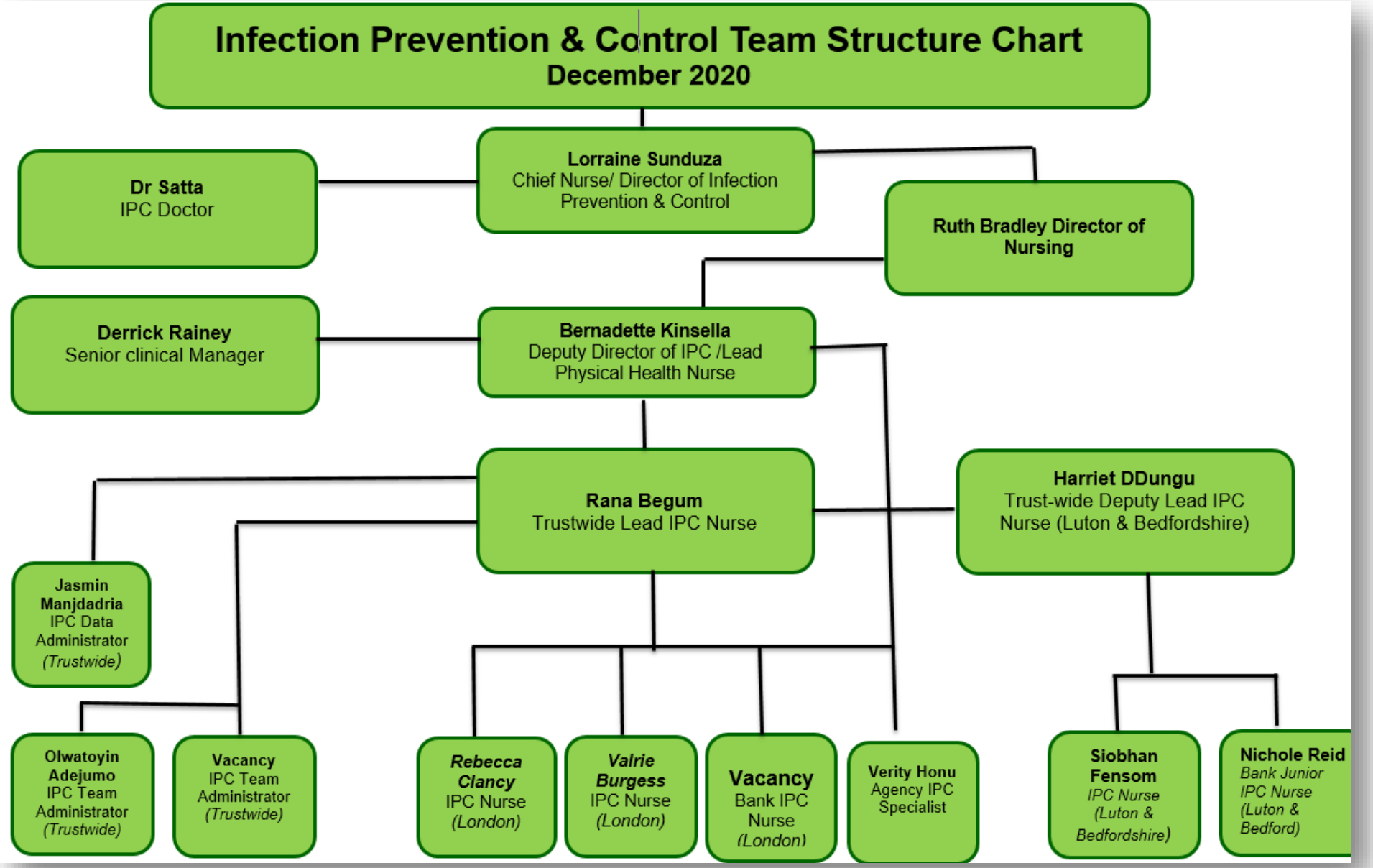
RECEIVE and DISCUSS the findings of the report

NB Definitions are as follows:

To "approve" - accepting recommendations etc. as satisfactory

To "ratify" - to approve an action/policy formally so that it can come into force

APPENDICES


Infection Prevention & Control Team Structure Chart
December 2020
Dr Satta
IPC Doctor
Lorraine Sunduza
Chief Nurse/ Director of Infection Prevention & Control
Ruth Bradley Director of Nursing
Derrick Rainey
Senior clinical Manager
Bernadette Kinsella
Deputy Director of IPC /Lead Physical Health Nurse
Rana Begum
Trustwide Lead IPC Nurse
Harriet DDungu
Trust-wide Deputy Lead IPC Nurse (Luton & Bedfordshire)
Jasmin Manjdadria
IPC Data Administrator
(Trustwide)
Olwatoyin Adejumo
IPC Team Administrator
(Trustwide)
Vacancy
IPC Team Administrator
(Trustwide)
Rebecca Clancy
IPC Nurse
(London)
Valrie Burgess
IPC Nurse
(London)
Vacancy
Bank IPC Nurse
(London)
Verity Honu
Agency IPC Specialist
Siobhan Fensom
IPC Nurse
(Luton & Bedfordshire)
Nichole Reid
Bank Junior IPC Nurse
(Luton & Bedford)

Appendix 2

IPC Annual work plan 2022-2023

The below work plan was developed and outlines objectives to ensure compliance with:

- The Health and Social Care Act [2015]
- The Care Quality Commission Outcome 8; Cleanliness and Infection Control and the CQC 'Board Assurance Floor Framework'2020
- National Institute for Clinical Excellence; Infection & Prevention Control Quality Statement 61[2014]
- National Institute for Clinical Excellence; Quality standard for Antimicrobial stewardship [2015]

The programme will be amended following any infection control issues that would be regarded as priorities by the Infection prevention and control (IPC) Team, internally or externally to the Trust.

The IPC Team works to ensure a clean and safe environment with robust systems of care which minimise the risk of infection to patients, staff and visitors. In addition, the IPC team aims to ensure that Infection Control is central to the quality and safety agenda with the Operational Directorates.

The work involves being alert and responsive to new and emerging infectious diseases. However, on the 12 January 2020 it was announced that a novel coronavirus had been identified. This virus is referred to as SARS-CoV-2, and the associated disease as Coronavirus infectious disease (COVID-19. This highly infectious disease has resulted in a worldwide pandemic with an associated high mortality and morbidity which is especially prevalent in vulnerable groups and communities. This has led to increased demands on the service and there has been a proposal for 21/21 year to increase and develop the workforce. The outcome of the Business case is still awaited.

To fulfil our obligations under the Health and Social Care Act (2008) ELFT currently employ a small corporate Team whom oversee and deliver the Infection Prevention and Control service. Ensuring compliance with the Health and Social Care Act 2015, involves reducing healthcare associated infections, ensuring that IPC is high on the quality and safety agenda for all and working with colleagues.

IPC is now a standing item on the Trust operations and Health and Safety Meeting to involve all directorates in working towards reducing Health Care Acquired infections. The work programme will be overseen by the IPC Committee where progress reports will be submitted. The Trust Quality Committee will receive an annual report outlining progress with the current IPC programme

Aim/ Goal	Current Assurance	Action required	Review date	Lead persons
To have in place management and governance systems to provide assurance of robust infection prevention and control standards across the Trust. *(Health and Social care act: Health and Social Care Act 1, 3,5,9)*	A Trust Wide Infection Prevention and Control (IPC) Committee is in place which meets quarterly and Monthly by exception. Terms of Reference to be reviewed in April 2021	None	April 2023	DIPC DDIPC Directors Lead IPCNS Review TOR
	Infection Prevention and Control Committee (IPCC) reports to the, Quality Committee and Quarterly to the Board of Directors. An IPC Annual Report also goes to the Board.	An IPC work plan strategy developed across the Trust.	Quarterly	DIPC DDIPC Lead IPCN
	IPC mentioned in all job descriptions	Currently in all job descriptions	Ongoing	Director of Human resources DDIPC
	IPC risk register is in place	For IPC risks to be registered on the Corporate risk register. Risks are regularly reviewed as a Team and at the IPC Committee	Ongoing	DIPC DDIPC Lead IPCN /Directorate management teams/ Heads of department
	The Trust wide Infection prevention and control team monthly team meetings to be arranged.	Standing items are addressed: risk register, work plan, mandatory training, feedback from Committee meetings, incidences and lessons learnt addressed	Ongoing	DDIPC Lead IPCN'S

2. Policy and Guidance development				
Aim/ Goal	**Current Assurance**	**Action required**	**Target review date**	**Lead persons**
To have an up to Infection Prevention & Control Manual	The IPC team have developed integrated policy manual. These are available on Trustnet.	IPC policy reviewed	April 2023 as needed in line with national guidance	DDIPC Lead IPCNs IPC Team
	Infection control team contribution to relevant committees, policy review and working groups	None	Ongoing	DDIPC Lead IPCNs IPC Team
		meeting arranged on a quarterly basis. Terms of reference to be reviewed April 2022	/Ongoing	Lead IPCNS Estates & Facilities
	IPC takes a lead and investigates and reports outbreaks/incidents.	Root because analysis is undertaken. In the event of a bacteraemia a post infection review (PIR) investigation is undertaken. Incidences are investigated from DATIX	Ongoing	DIPC DDIPC Lead IPCNS IPC Team Borough Lead Nurses
	Legionella monitoring of water systems in place. Including Legionella policy	Water Safety Group established. Terms of reference to be reviewed April 2022. Water Safety Groups meeting held on a quarterly basis.	Quarterly /Ongoing	Estates & Facilities DDIPC Lead IPCNS IPC doctor

3. Hand Hygiene				
Aim/ Goal	**Current Assurance**	**Action required**	**Target review date**	**Lead persons**
To achieve an overall improvement in hand hygiene technique and compliance across all clinical areas *(Health and Social Care Act: 1,2,9)*	Hand hygiene is a core component of all induction and mandatory training. The 5 moments of hand hygiene tool is on an electronic platform and IPad/tablets are being supplied to launch this and a PPE Audit for the Trust dash board.	E-learning completed on level for Level 1 and Level 2 training. IPC to provide training for at Trust induction via video	March 2023	IPCT Learning & Development

To increase staff awareness and satisfaction around hand hygiene resources available to them *(Health and Social care Act: 1,2,9)* *To provide advice on PPE as required and appropriate*	Glow boxes are available for local teaching in all Borough Directorates Awareness campaign during world hand hygiene day.	None	May 2023	DIPC DDIPC Lead IPCN,IPC Team Directorate management teams
		Hand hygiene facilities are monitored through PLACE assessments and though clinical environmental audits	Ongoing/ annually	DIPC DDIPC Lead IPCNs Estates & Facilities with support from the IPC Team Procurement
4. Training				
Aim/ Goal	**Current Assurance**	**Action required**	**Target review date**	**Lead persons**
To ensure all staff are suitably educated according to their role in the prevention and control of Health Care Associated Infections (HCAIs). *(Health and Social Care Act: 1,3,5,9)*	IPC mandatory training is undertaken on induction. Thereafter, clinical staff undertake mandatory training yearly and non-clinical staff undertake training every three years. E –learning is used for level 1 and 2 staff across the Trust. Quarterly mandatory training submitted to the IPCC quarterly report.	Service Lines to monitor training uptake quarterly. To continually contribute to the strategic direction of learning and development To use QI and every action counts/behaviour materials to encourage engagement in optimal IPC Practice	Ongoing	Directorate management teams Directors of nursing Learning & Development Ward Managers with support from the IPC team. Quality Improvement Corporate.

5. Audit programme				
Aim/ Goal	**Current Assurance**	**Action required**	**Target review date**	**Lead persons**
To have a robust and standardized system of audit and data management *(Health and Social Care Act: 1,5)*	The Current regular environmental audits have taken place and the audit tool is now on the envoy Trust platform. There are other visits to the wards e.g. in outbreak management, deep clean sign off and in supporting re IPC Covid risk assessments as services start to resume.	The plan is for the IPC Nurses to encourage staff in low risk unit to undertake their own self-assessment audits for hand hygiene and PPE e.g. IPC link Champions are embedded within services The audit tool needs to be rolled out via the champions to engage ward/service managers and matrons locally.	Ongoing /annually	Quality assurance Team DIPC DDIPC Lead IPCNS IPC Team Estates and facilities monitoring officers Ward staff/Matron/ Service leads
	A new audit tool has been devised to include Hand Hygiene and PPE		Ongoing /Quarterly	Nursing Directors IPCT Estates Champions
	Antimicrobial audits submitted quarterly for: East Ham Care Centre inpatient wards Mental Health Care of Older Adults inpatient wards. Pharmacy team submits Antimicrobial audits reports quarterly to the IPC Committee meetings	None	Ongoing /Quarterly	Pharmacy team DIPC DDIPC Lead IPCNs
	PLACE takes place annually in inpatient sites	None	Annually	Facilities with support from the IPC Team

6. Surveillance				
Aim/ Goal	**Current Assurance**	**Action required**	**Target review date**	**Lead persons**
To maintain compliance with national mandatory surveillance systems To ensure appropriate methods are in place to monitor risks and trends in infection	Data bases are maintained and surveillance data is reported to the IPC Committee meetings and also to the Trust board quarterly and annually	None	Ongoing	DDIPC Lead IPCN
	RCA and SI process for all relevant incidents including cases MRSA bacteraemia, infection, E. Coli bacteraemia surveillance and toxin positive C. *Difficile* are undertaken. Root cause analysis tool up dated for Covid-19 HCAI cases.	Undertake RCA's Post Infection Reviews (PIR) where required. Share outcome with teams. Submit report to borough governance meetings and IPC committee and Board.	Ongoing	DIPC DDIPC Lead IPCNs IPC Team Support from the IPC Doctor Lead nurses, ward managers and matrons.
	Mandatory reporting to the PHE of Health Care Associated Infection (HCAI's) outbreaks and notifiable disease are reported to the PHE. Notification of Infectious disease guidance (NOIDS) is available on trust-net.	Report to PHE where required	Ongoing	Directorate management teams Ward staff with support from the IPC Team IPCT Team
	Patients identified with MRSA are treated appropriately and promptly. MRSA screening leaflets available for printing on Trustnet.	None	Update as per national guidance	IPCT
	MRSA screening currently undertaken in physical health wards (East Ham Care Centre)	Distribute to patients on admission so that patients are aware the rationale for screening.	On-going	Service manager Ward staff with support from the IPC Team
Clostridium Difficile To reduce incidence To enhance prevention and management of C Diff in order to promote patient safety	Management of C Diff is available on Trustnet in IPC policy manual. Ensure compliance of isolation policy and hand hygiene through audit patients/staff	Ensure compliance of isolation policy and hand hygiene through audit patients/staff	Ongoing review	DIPC DDIPC Lead IPCNs IPC Team With support from the IPC Doctor

Norovirus *(Health and Social Care Act: 1,3,4,6,)*	Staff are competent in the management of an outbreak; PPE policy is known and the Policy available on the internet Outbreak management is always reviewed and relevant education given	Highlight where there may not be adequate isolation and hand washing facilities and put into building programme. Staff to attend IPC mandatory training as required ensuring compliance with policy. Policy to be reviewed if there are new national guidelines.	Ongoing	DIPC DDIPC Lead IPCNs IPC Team With support from the IPC Doctor and IPC Team Support from PHE where required.
Coronavirus	Staff are competent in the management of an outbreak; PPE policy is known and the Policy available on the internet Outbreak management is always reviewed and relevant education given	S/A	Ongoing	DIPC DDIPC Lead IPCNs IPC Team the IPC Doctor and IPC Team Support from UKHSA as required

7. Decontamination **Aim/ Goal**	**Current Assurance**	**Action required**	**Target review date**	**Lead persons**
To ensure effective systems are in place across the Trust, that provide safe decontamination of all medical devices and equipment, including furniture, beds and mattresses,	Policy available on Trustnet	None	As per national guidance	Medical Devices Lead
	Advice provided on decontamination products during ad-hoc IPC training sessions	Decontamination of medical devices addressed training sessions	Ongoing	IPCT

8. Cleanliness

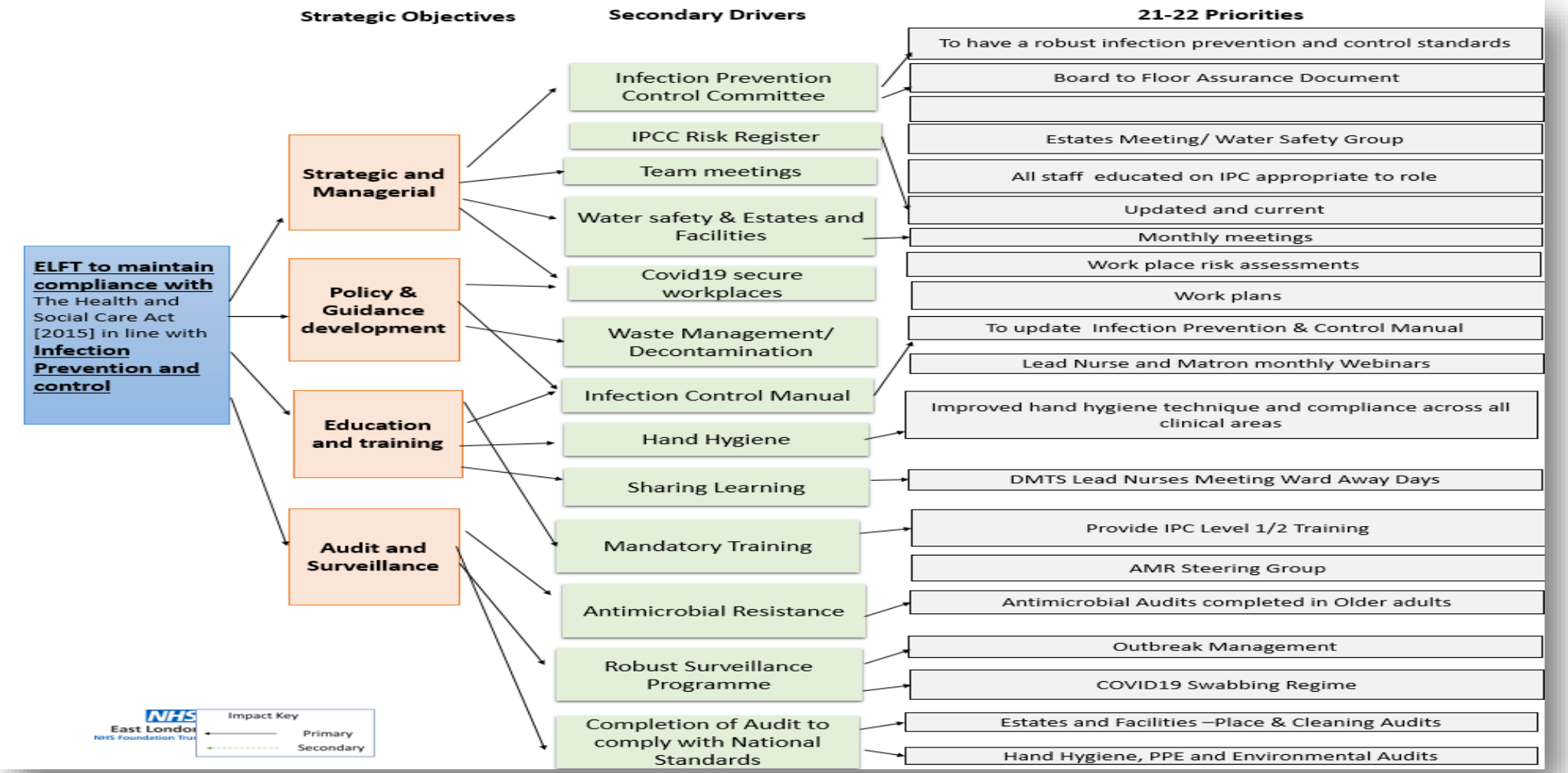
Aim/ Goal	Current Assurance	Action required	Target review date	Lead persons
To comply with national cleaning The National Specifications for Cleanliness in the NHS: The NHS Healthcare Cleaning Manual.	Cleaning audits undertaken across the Trust. The scores from these audits are reported to the IPC Committee on a quarterly basis. Across the Trust the figures are averaging around 95% which is the current target.	Escalate deficiencies in service. Infection control to be part of the contract review and monitoring process for external cleaners.	Quarterly	DIPC DDIPC Estates and facilities Directors of Nursing Directorate management teams Head of Facilities & Procurement with support from the IPC Team. Cleaning contractors (G4S, ISS, Serco)
	Hard FM meetings	IPC to be included in the contract review and monitoring process as and when required.	Monthly/ Quarterly	Estates & Facilities DDIPC Lead IPCN
	Soft FM meetings	IPC to be included in the contract review and monitoring process as and when required.	Monthly/ Quarterly	Estates & Facilities DDIPC Lead IPCN
	PLACE audits take place in all inpatient units annual	Audits to continue to be conducted and are reported locally, also to the contract review meeting and IPCC meetings	Annually	Estates Patient Participation Lead
	Monthly workarounds conducted by IPCN and Estates facilities monitoring officer.	Workarounds to continue on a monthly basis with Estates team.	Monthly	DDIPC IPCT Estates
		Ensure there are robust mechanisms in place for assurance to indicate that domestic staff has been trained in IPC.	Ongoing	Facilities and cleaning contractor.

9. Waste Management				
Aim/ Goal	**Current Assurance**	**Action required**	**Target review**	**Lead persons**
The risks from healthcare waste should be properly controlled. Systems should be put in place to ensure that the risks to patients, public and staff caused by healthcare waste present in the environment are properly managed and that duties under environmental law are discharged. *(Health and Social Care Act: 1,2,8)*	Waste Management Policy is available on Trustnet IPC policy which covers the safe handling of waste including sharps	None	On—going	Estates & Facilities DIPC/DDIPC Directors of nursing Directorate management teams All clinical and staff with support from the IPC Team.
	IPC policy which covers the safe handling of waste including sharps	None	On-going	DIPC/DDIPC Directors of nursing Occupational Health Service Leads All clinical and staff with support from the IPC Team.
	The waste management policy covers the safe handling of clinical waste. It also includes the safe handling and disposal of sharps.	To ensure mechanisms and systems are in place for the implementation, monitoring and the safe disposal of waste, including sharps are also available in the community teams.	Ongoing	DIPC/DDIPC Directors of nursing Service Leads Occupational Health All clinical staff with support from the IPC Team.
		Report any near misses or any needle stick injuries on DATIX. Share lessons learnt.	Ongoing/ quarterly reviews	DIPC/DDIPC Directors of nursing Service Leads Occupational Health All clinical staff with support from the IPC Team
	There are robust mechanisms in place for the registration of all sites with the Environment Agency and waste producers	None	Annually	Head of Facilities and procurement
	There is ongoing management and review of waste contracts	None	As required/ ongoing	Head of Facilities and procurement
	Clinical waste training included at IPC training. Waste training available via E-learning.	None	As required/ ongoing	ICPT

10. Management of antimicrobials Aim/ Goal	Current Assurance	Action required	Target review	Lead persons
Microbiology Management of antimicrobials	Antimicrobial audits are completed in East Ham Care Centre inpatient wards. Antimicrobial prescribing policy has been developed based on local antimicrobial guidelines (Public Health England). Prescribing harmonised with that in the *British National Formulary*. However, local guidelines may be required in certain circumstances. Procedures are in place to ensure prudent prescribing and antimicrobial stewardship. Antimicrobial Steward Group developed which meets quarterly. Terms Of Reference for antimicrobial steward group reviewed in April 2022	None	Quarterly/ Ongoing	Pharmacist Department IPC doctor DIPC DDIPC Lead IPCNs
	Antimicrobial quarterly audits are undertaken.	Quarterly antimicrobial audits to be conducted for high risk areas	Monthly/on-going	Pharmacy department Infection Control Doctor

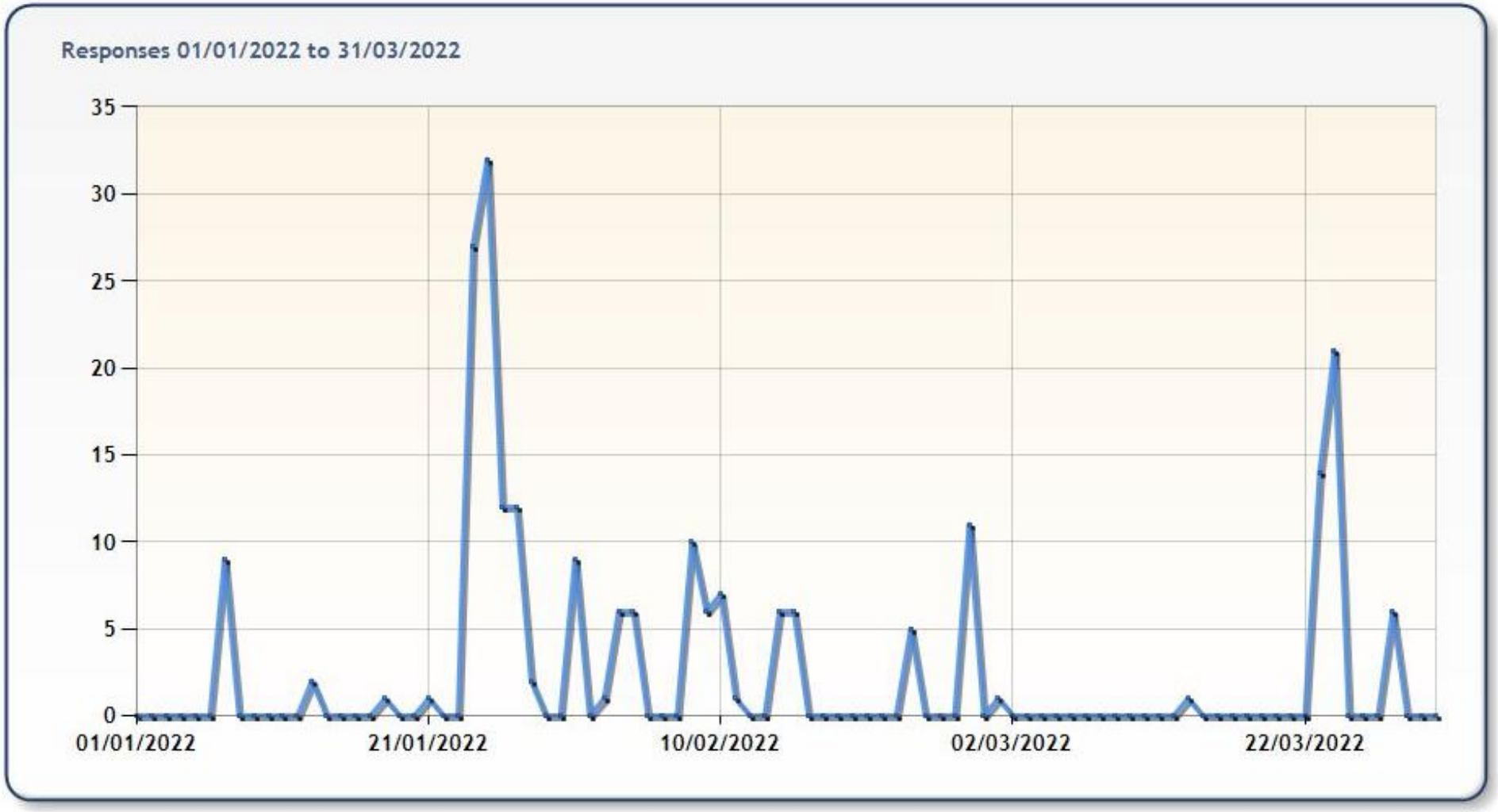
11. Sharing learning and collaboration				
Aim/ Goal	**Current Assurance**	**Action required**	**Target review date**	**Lead persons**
Sharing learning across the organisation identifying priorities, areas for development, and cross service line collaborations *(Health and Social care Act: 1,3,5)*	Limited IPC link practitioner/ Champion network across trust There are plans to work with the Directors of Nursing reenergising this priority to be more proactive and prepared for emerging infections including the current covid pandemic. Lessons learn shared across the organisation from outbreaks management and on the Trust Communications.	IPC link champions programme to be embedded across all service lines. Link Champions to attend extra training provided in house and externally.	November 2023	Nursing Directors, and IPC Team
		Encourage link Champion to attend link Champion meetings so that they are aware of the IPC agenda which in turn can disseminate to their teams.	Quarterly meetings	Borough Lead Nurses/ Matron/ Ward managers with support from IPCT
		To ensure that Trustnet web and social media accounts- Twitter pages remain dynamic and is reviewed regularly.	Monthly/ Ongoing	ICP Team Communications Department
		To develop an IPC e-newsletter to share lessons learnt / IPC initiatives	April 2023	IPC Team

Aim/ Goal	Action required	Target review date	Lead persons	Rag Rating
Promote Glove awareness week	Tweets and Social media Communications poster for circulation PPE section on intranet	April 2 - May *2022*	IPC team with support from Communications department	
Promote World Tuberculosis day	Tweets and Social media Communications poster for circulation	March 2023/24	IPC team/with support from Communications department	
Promote World hand hygiene day	Tweets and Social media Road shows across trust	May 2022	IPC team with support from Communications department	
Promote World Hepatitis Day	Tweets and Social media Communications poster for circulation	July 2022	IPC team with support from Communications department	
Promote World Sepsis day	Undertake promotional activities Tweets and Social media	September 2022	IPC team with support from Communications department	
Promote Infection Prevention and Control awareness week	Tweets and Social media Communications poster for circulation on communication bulletin Road shows across trust	October 2022	IPC team with support from Communications department	
Promote European Antibiotic awareness day	Tweets and Social media Communications poster for circulation ? AMS training for staff that are prescribers	November 2022	IPC teamPharmacy department support	



Annual work plan Driver diagram

Appendix 3 Hand Hygiene Audits


Responses 01/01/2022 to 31/03/2022
35
30
25
20
15
10
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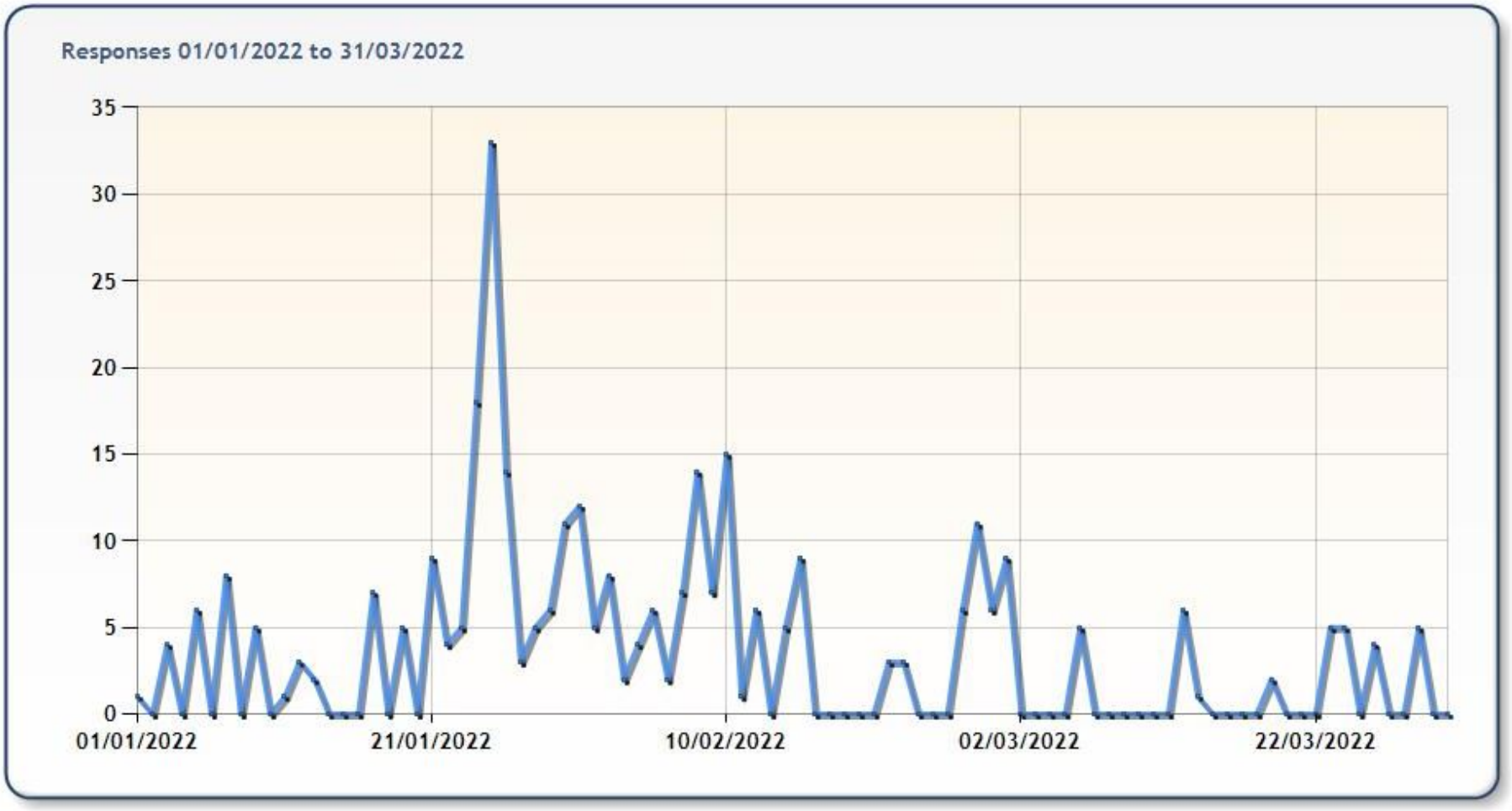
01/01/2022
21/01/2022
10/02/2022
02/03/2022
22/03/2022



Appendix 4- Personal Protective Equipment PPE Donning and Doffing audits numbers results

Source ELFT Envoy Platform. Quality Dashboard - Completion of Hand Hygiene infection control audit 21/22

Appendix 5 Risk Register 21/22 summary

Objective	Risk Description	RR	Controls	Assurance	RR	Mitigating Actions	Lead	RR	Status
Improving outcomes Improving experience of care Improving value Improving experience of staff	Risk of increased Needle Stick injuries and non-compliant with the EU safer sharps directive. Trust wide assurance on the use of safer sharps devices (retractable needles)	12	• Sharps audit to be undertaken of all services lines that use sharps devices by IPC team • Raise awareness via communication department on the purchasing of retractable needles. (Outstanding) • IPC to promote during teaching sessions. Sharps awareness (face-to-face sessions) • Visits carried out by IPCT • Safer sharps devices are available for insulin pens for Nurses to use as appropriate in community services. A poster has been devised with the Diabetic Specialist Nurse on the inpatient pathway for diabetes. This outlines the use of safer sharps. QI project in process.	IPC and Health and Safety committee monitors risk.	12	DDIPC with support from IPC team. This risk to remain on the risk register and monitored by the IPCC. • There are sharps audits across inpatient units. • IPC have issued an alert re unsafe sharps from incidents and put together a webinar on safer use of sharps, promoted on Communications. Sharps audits part of regular review by contactor sharps smart and IPC team environmental audit. With actions for follow up by wards Team are using correct sharps across sites. Work with Diabetes Specialist on flowcharts and diabetes webinars	Medical Devices/ IPC team	4	On going Monitoring

Objective	Risk Description	RR	Controls	Assurance	Mitigating Actions		RR	Status

Improving outcomes Improving experience of care Improving value improving population health	Sub-optimal decontamination of re-usable medical devices across Tower Hamlets Community Health services	9	Lack of assurance on robust decontamination of re-usable medical devices across Tower Hamlets Community Services. Currently clinell wipes and green clinell stickers are used for assurance.	IPC Committee/ THCHS QAG monitor risk	9		Deputy Director of THCHS /Clinical Director of THCHS with support from IPC team	2	New contract in place April 22
Improving outcomes Improving experience of care Improving value Improving	Risk of cross infection and failure to provide a clean safe environment due to environmental cleaning on dedicated COVID-19 wards	12	Interim measures include clinical staff are cleaning COVID-19 positive wards. Ward orderly's have been recruited for inpatients areas to support with COVID-19 pandemic and environmental cleaning	IPC committee monitors risk. Risk monitored locally at COVID-19 IPC work stream meeting. IPC team are conducting walkabouts of high risk areas/sites	12	Director of Estates, Facilities and Contracts, Facilities department with the support from IPC team. Frequent Joint walk around visits with ELFT Facilities department, Infection Control team and Contractors and Sub-contractors to monitor for improvements.	Covid-19 Lead , Borough Lead Nurses, Facilities, with support from IPC team	2	Completed Cleaning Contract New April 22 National Minimum standards in place
Objective	Risk Description	RR	Controls	Assurance	Mitigating Actions			RR	Status

Improving outcomes Improving experience of care Improving value Improving	Inadequate staffing of specialist IPC nurses, due to high levels of sickness within the team, to provide a robust IPC service. High service demand for IPC support and expert advice required due to COVID-19 pandemic.	12	Current actions taken to mitigate risk: • All services line across are aware of how to contact IPC team should IPC input required. • IPC policies, resources available on Trustnet • Ad-hoc training and IPCN visits undertaken in areas of concern/ poor IPC practice • Recruitment of IPC team in progress •On-call senior manager rota in place to cover weekend periods	IPC committee monitors risk. Risk monitored locally at infection control team meeting.	12	Staff can access IPC support via director on call on Saturday and Sunday 10-6pm.	IPC Team	2	This has now resolved, And 3 Band 6 Nurses recruited
Improving outcomes Improving experience of care Improving value	Delay of receiving prompt microbiology results for COVID-19 testing across Luton and Bedford for patients.	16	Current actions to mitigate risk • IPC team call Microbiology labs twice a day to follow up results • Access to microbiology results using electronic system with external organisation.	IPC committee monitors risk	9	Deputy Director of IPC to review microbiology contracts.	Deputy Director of IPC & Contracts team	2	This is now resolved and LFD used to support processes
Improving outcomes Improving experience of care Improving value	Lack of robust occupational health service support for ELFT staff during outbreak management of COVID-19/.	12	Management of staff outbreaks co-ordinated and supported by IPC team.	IPC committee monitors risk	12	People and Culture department to commission additional services from Team Prevent.	People and Culture department		Extra in put provided by Team prevent

Improving outcomes Improving experience of care Improving value	Lack of robust data surveillance system	12	To mitigate risk, on daily basis a dedicated data administrator is allocated to manage the manual data surveillance system	IPC committee monitors risk	12	Recruitment in process for additional Data administrator QI Project on MRSA surveillance	DDIPC/IPCT Reporting services and BI Team	2	New Microsoft Power BI dashboards in place for further development as required and appropriate

Appendix 6 - Environmental audit calendar

Ward Inpatient	2021-22 Q1	2021-22 Q2	2021-22 Q3	2021-22 Q4
Bevan Ward				98%
Brett Ward				81%
Conolly Ward				90%
Gardner Ward				94%
Joshua Ward				88%
Mother and Baby Unit				96%
Ruth Seifert Ward		82%	81%	95%
Bow Ward				90%
Broadgate Ward			90%	
Shoreditch Ward				Due
Clerkenwell Ward				94%
East India Ward			92%	
Limehouse Ward				Due
Ludgate Ward				80%
Victoria Ward				84%
Morrison Ward				89%
West ferry Ward				Due
Aldgate Ward				88%
Moorgate Ward				88%
Loxford Ward				94%
Woodberry Ward				93%
Hoxton Ward				99%
Butterfield Ward				Due
Clissold Ward	95%			
Crystal Ward			87%	
Emerald Ward			86%	
Ivory Ward				80%
Opal Ward		90%	90%	
Ruby Triage Ward		91%		
Sapphire Ward		85%		
Topaz Ward			87%	
Coborn PICU				88%
Coborn Acute Ward				90%
Galaxy Ward				84%
Sally Sherman Ward	94%			89%
Fothergill Ward	82%			91%

Cazaubon Ward	74%		92%	
Globe Ward			86%	
Lea Ward				84%
Leadenhall Ward				86%
Millharbour PICU Ward		85%		
Roman Ward				85%
Rosebank Ward		89%		
Brick Lane Ward				Due

AREA Inpatient	2021-22 Q1	2021-22 Q2	2021-22 Q3	2021-22 Q4
Coral Ward			88%	
Crystal Adult Ward			89%	
Jade PICU Ward			99%	
Onyx Ward			97%	
Poplars Ward			97%	
Ash Ward			100%	
Cedar House			96%	
Fountains Court Acute		99%		
Townsend Court Adult			93%	
Willow Ward			100%	

- The above environmental audits were carried out by the IPC Team alongside ward managers and Matrons on a rolling programme and were temporarily halted due to Covid-19 in quarter 1, however they re-started in quarter 2 as above.
- The scores < 85%, and in progress of actions plans being revisited and will be re-audited for priority in-patient areas.
- This is a vital part of IPC Team work in prevention and controlling out breaks. These have action plans for matrons and line managers that require follow up in a timely manner in line with quality care.

NHS
East London
NHS Foundation Trust

REPORT TO THE QUALITY ASSURANCE COMMITTEE
27 JUNE 2022

Title	Annual Report 2021/22 - Emergency Planning, Resilience and Response (EPRR) and Business Continuity
Author	Richard Harwin – Health, Safety, Security and Emergency Planning Manager
Accountable Executive Director	Edwin Ndlovu, Chief Operating Officer

Purpose of the report

The purpose of this report is to provide an account of ELFT's Emergency Planning, Resilience and Response (EPRR) and business continuity arrangements for 2021/22 and to review how the Trust meets its statutory and mandatory obligations in relation to EPRR and business continuity.

The progress against the EPRR Work Plan of 2021/22 will also be reviewed and any outstanding actions will be considered and potentially incorporated in the work plan for 2022-23.

In addition to this section **8.0** is also included providing an overview and update in relation to the Trust response to COVID-19.

Committees/meetings where this item has been considered

Date	Committee/Meeting

Key messages

- The Trust's arrangements for Emergency Planning, Resilience and Response (EPRR) and business continuity continued to be strengthened during 2020/21. This was primarily through creating a framework of plans that address the highest risks and carrying out exercises to test plans.

- The Trust participated in the Assurance exercise carried out by NHS England (London) EPPR Team in November 2021. This annual assurance process marks compliance against the NHS England Core Standards for EPRR 2013. Based on the 2021 annual assurance submission to NHS England (London), the Trust did not receive any amber or red ratings and therefore rated as **FULLY COMPLIANT**.

- NHS England and Improvement (London) concluded in the Assurance Report that ELFT continues to maintain a high standard for EPRR arrangements, evidenced through the assurance submission and by the submitted plans/policies. It was noted that the high quality of submitted plans, schedule of training and exercising, highlighted a robust emergency preparedness and business continuity arrangement.

- The Trust also participated in the Assurance exercise carried out by NHS England (East of England) EPPR Team in October 2021. The Trust made two submissions against the NHS England Core Standards for EPRR, for Bedfordshire & Luton Mental Health Services and Bedfordshire Community Health Services (BCHS). NHS England (East of England) also rated ELFT as **FULLY COMPLIANT** for both community and mental health services in Luton & Bedfordshire. NHS England & NHS Improvement acknowledged the hard work undertaken to achieve the additional standards whilst in the pandemic.

• Throughout the pandemic, the Trust has fully maintained its Incident Response Strategy led by the Accountable Executive Officer (refer to section 8.2 of this report). The 2020 the Trust's Response Team (Gold group) was mobilised meeting regularly and timescales adapted according to need. The last gold group met in August 2021 with any COVID-19 issues escalated and discussed at DMTs and if required, escalated to the Directors' Huddle on Mondays

Strategic priorities this paper supports

Improved population health outcomes	☒	Ensuring business continuity throughout any emergency or major incident.
Improved experience of care	☒	Through identifying risk and providing the control measure to remove or reduce them to ensure service user safety.
Improved staff experience	☒	Empowering and supporting staff in providing them with policies, procedures and training to carry out their roles safely.
Improved value	☒	Ensuring the Trust meets its statutory obligations of the Civil Contingencies Act 2004 and is compliant with NHS England EPRR Core Standards 2015.

Implications

Equality Analysis	This report has no direct impact on equalities.
Risk and Assurance	The Trust has a statutory duty to comply with the Civil Contingencies Act 2004 and may be subject to penalties if found not to be compliant. Mitigating actions are in place in relation to the risks identified within the report.
Service User/ Carer/Staff	Implications for service users, carers and staff. Consider implications of the paper across all directorates and service groups in the Trust and explain if any directorates/services are excluded from the scope of the paper.
Financial	There are no financial implications relating to the EPRR activity of 2017/18. In general terms, poorly controlled emergencies or lack of business continuity planning may have financial implications for the Trust in the event of emergencies.
Quality	There are no implications for Quality Improvement raised in this report.

Emergency Planning, Resilience and Response (EPRR) and Business Continuity Annual Report 2021/22

1.0 Background

1.1 The Trust under the Civil Contingency Act 2004 as a Category 1 Responder and Department of Health 'Emergency Planning' Regulations, has the following responsibilities:

- Carry out a risk assessment
- Have in place plans to respond to emergencies
- Have in place business continuity plans
- Collaboration and co-operation with other agencies
- Warn and inform the public and other agencies
- Training and exercising.

1.2 The Trust has a statutory obligation to train and exercise with a live exercise every three years, and annual tabletop exercise and a six-monthly test of the communication cascade.

1.3 The NHS England Core Standards for EPRR 2015 set out how NHS organisations are to meet their responsibilities and the NHS England EPRR Framework (2015) states that NHS provider organisations are required to have appropriate systems in place.

1.4 With the implementation of the Health and Social Care Act 2012, the responsibility for overseeing EPRR arrangements passed from Primary Care Trusts to NHS England. Local Health Resilience Partnership Groups (LHRP) were established.

1.5 The Trust's EPRR responsibilities are managed and overseen by:

- Accountable Emergency Officer – Chief Operating Officer
- Health, Safety, Security and Emergency Planning Manager
- Emergency Planning and Business Resilience Officer for Luton and Bedfordshire (Mental Health and Community Services)
- Associate Director of Governance & Risk Management – overseeing the work of the Emergency Planning Manager.

2.0 Trustwide EPRR Plans

2.1 Incident Response Plan (IRP) is modelled against the NHS England Core Standards for EPPR and was evaluated as part of the NHS England and NHS Improvement Annual Assurance process. The subsequent EPRR Assurance Report described the IRP as 'comprehensive in content, of a very good standard and considered as good practice'.

2.2 The Trust Wide Business Continuity Plan has been created and reviewed, with focus on infrastructure.

2.3 The following plans were reviewed as part of the annual review cycle:

- Incident Response Plan
- Heatwave Plan
- Business Continuity Policy
- Surge Plan
- Pandemic Flu Plan
- Emergency Contacts List
- Communication during Major Incident Strategy and Plan
- Flood Plan

2.4 Business continuity plans have been refreshed by all Directorates as part of the Trust's response to COVID-19 and will be reviewed again considering any lessons learnt from the After-Action Review (AAR) or de-brief.

3.0 Annual EPRR Assurance

3.1 <u>London</u>

The Trust participated in the Assurance exercise carried out by NHS England (London) EPPR Team in November 2021. This annual assurance process marks compliance against the NHS England Core Standards for EPRR 2013 and ensures that NHS organisations in London are prepared to respond to an emergency and have the resilience in place to continue to provide safe patient care during a major incident or business continuity event.

Based on the 2021 annual assurance submission to NHS England (London), the Trust did not receive any amber or red ratings and therefore rated as **FULLY COMPLIANT**.

NHS England and Improvement (London) concluded in the Assurance Report that ELFT continues to maintain a high standard for EPRR arrangements, evidenced through the assurance submission and by the submitted plans/policies. It was noted that the high quality of submitted plans, schedule of training and exercising, highlighted a robust emergency preparedness and business continuity arrangement. Furthermore, the Trust's Incident Response Plan and EPRR Policy were identified as being of a very high standard and continue to be included on a national EPRR database of good practice.

3.2 <u>Luton and Bedfordshire</u>

The Trust also participated in the Assurance exercise carried out by NHS England (East of England) EPPR Team in October 2021. The Trust made two submissions against the NHS England Core Standards for EPRR, for Bedfordshire & Luton Mental Health Services and Bedfordshire Community Health Services (BCHS).

NHS England (East of England) also rated ELFT as **FULLY COMPLIANT** for both community and mental health services in Luton & Bedfordshire. NHS England & NHS Improvement acknowledged the hard work undertaken to achieve the additional standards whilst in the pandemic.

4.0 Training

4.1 Training was delivered against the 2021/22 training plan.

4.2 Strategic Leadership in a Crisis Training

In July and September 2021, NHS England and NHS Improvement provided the Trust 'Strategic leadership in a Crisis' training sessions to our on-call directors, receiving excellent feedback from the participants.

4.3 Initial Operational Response (IOR) Training

Training has been provided to community teams for Hazardous Material (HAZMAT)/Chemical Biological, Radiological and Nuclear materials (CBRN) response, as required by NHS England. A six-week HAZMAT/CBRN virtual training programme was rolled out Trust wide in
September 2021. The training was aimed at administrative staff who would potentially be the first responders in the case of self-presenters coming to their respective sites. The training incorporated advice on responding to a presentation of an acid attack, and which necessary measures should be taken to deal with the situation safely and adequately.

The training was carried again out in January 2022 after numerous requests from various teams. Staff feedback has been positive, with many delegates requesting more advanced training in the future. The trust is currently in discussions with NHS England (London) EPRR team to provide this jointly with us

4.4 Business Continuity Plan Workshops

The EPRR team delivered a workshop on the 9th June 2021 in Luton and Bedfordshire aimed at providing an understanding about business continuity plans. (BCPs) The format was virtual with scenario-based exercises for attendees to consider at operational, tactical and strategic levels.

The aim of the workshop was to provide an understanding of our legal obligations under the Civil Contingencies Act 2014 and the Health & Social Care Act 2012. The purpose and scope were to enable services to recover or maintain activities in the event of a disruption by considering critical activities, timescales, and recovery levels of each critical activity.

The BCP workshop also presented an opportunity for attendees to consider the structuring of their BCPs in terms of triggers, escalations and crisis management. These workshops were very well attended and received very positive feedback.

Further trustwide BCP workshops will be arranged as part of the annual work plan 2022/23.

4.5 On-Call Director and On-Call Manager Training

The EPRR team has recently compiled an On-Call Director training package which will be added to the Trust Learning Academy portal, requiring all On-Call Directors to complete the training online with a view to supporting them in their role. This training package is expected to go live by the end of summer 2022.

An On-Call Manager training will also be made available online as part of the annual workplan.

4.6 Loggist Training

The emergency planning officer attended the United Kingdom Health Security Agency (UKHSA) loggist train the trainer training in February 2021. Suitable staff for the proposed loggist training will be identified throughout the Trust and training provided by the EPO in Q2 2022-23.

5.0 Testing and Exercising

5.1 With effect from July 2013, NHS England (London) EPRR had been conducting communication exercises whereby the Director on-call is contacted for a response to a pager message within ten minutes or as soon as is practicable – good practice being to respond within thirty (30) minutes and best response within ten (10) minutes. The Trust's response times are below:

	July 2021	Sept 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Response Time	**31**	**5**	**5**	**33**	**12**	**2**

To ensure a timely response to these exercises, and as a response to the COVID-19 outbreak, the director on-call pack is now accessed remotely via Microsoft Teams and any pager messages being diverted to the director's mobile telephone.

5.2 The Trust's annual exercise has been scheduled for 17th June 2022. Exercise Artemis will be held virtually with anticipated participation from NHS England, NE London CCG, BLMK CCG and representation from strategic, operational and tactical level trust staff.

An exercise report will be available post exercise - any lessons learned with accompanying actions will be added to the 2022-23 workplan.

6.0 Major Incidents and Activation of Emergency or Business Continuity Plans

6.1 There was a significant incident at the Whitchurch building (Twinwoods, Bedford) on the 10th January 2022. The incident was caused by a mains water pipe, which had burst under the building. The water board isolated all water services on site, and ground excavation was done to locate the pipe for repairs.

Staff were relocated to Admin Block "C" at Twinwoods until the 3rd February 2022 when repairs had been completed. There was minimum impact on patients as there are no patient wards/clinics at the Whitchurch. All work was completed by contracted service providers.

6.2 In September 2021, a national fuel shortage was experienced which was predominantly due to a driver shortage. The National Fuel Plan was not invoked, and teams reported minimal impact on their service delivery. Local business continuity plans were refreshed to plan for any possible disruption.

7.0 Multi-agency Working

7.1 Emergency Planning Network Forums

The Emergency Planning Manager is a member of the following meetings and attends regularly, contributing accordingly.

- Tower Hamlets, Newham, Hackney and Bedfordshire Local Resilience Forums
- NHS England (London) Northeast North Central (NENC) Network Meetings

7.2 The Trust's Emergency Planning Officer leads operationally for L&B Mental Health and Community Services with full participation in their Local Health Resilience Partnership Forum

7.3 The AEO attends the London wide Local Health Resilience partnership meetings whilst four strategic leads share the responsibility of attendance at the Bedfordshire Local Health Resilience Partnership.

8.0 Coronavirus (COVID-19) Pandemic

8.1 <u>Emergency Preparedness</u>

8.1.1 On 25th March 2021, NHS England and NHS Improvement downgraded the UK's overall Covid alert level from Level 4 (National) to Level 3 (Regional). Subsequently, due to the emergence of the Omicron variant and the requirement to deliver the COVID-19 vaccination booster programme, the alert level returned to Level 4 on 13th December 2021. The level then returned to 3 on 19th May 2022 in response to the sustained decline in community cases and inpatient numbers, in part due to the success of the spring booster vaccines.

8.1.2 In February 2022, the Trust's COVID-19 Infection Prevention and Control Policy was updated in line with PHE Infectious Diseases Strategy 2020-25 and other national guidance.

8.1.3 Both the Trust Incident Response Plan and trust wide Business Continuity Plan were fully updated in November 2021 and will be reviewed again as part of the COVID-19 accompanying lessons learnt.

8.1.4 Local services business continuity plans were updated by March 2021 and were held both local and centrally. They were continually reviewed by local services in response to the pandemic.

8.1.5 Arrangements have been put in place to enable a 'remote' handover of the director on-call pack. This can now be accessed remotely via Microsoft Teams and any pager messages/calls to the director on-call mobile are diverted to the director's work mobile telephone.

8.1.6 NHS England and NHS Improvement provided the Trust 'Strategic Leadership in a Crisis' training sessions to our on-call directors in September 2021.

8.2 Emergency Resilience and Response

8.2.1 On 9th March 2020 the Trust's Response Team (Gold group) was mobilised, being held at 08:30 and 16:30 hours on a daily basis.

The frequency of the gold meetings throughout 2021-22 is outlined in the table below:

Date	**Frequency of Gold Meetings**
From 8th February 2021	Mondays, Wednesdays and Fridays at 4:30pm
12th April 2021 to 6th August 2021	Mondays and Fridays at 4:30pm

8.2.2 The last Gold meeting took place on Friday 6th August and from Monday 9th August, any COVID-19 issues were to be escalated and discussed at Directorate Management Teams (DMTs) and if required, escalated to the Directors' Huddle on Mondays. The Gold meeting invites remained as shadow invitations in the case of a surge in cases and a requirement to reconvene the emergency response.

8.2.3 The Gold commander was responsible for chairing the trust response team which is responsible for co-ordination of:

- The strategic management of the emergency
- Establishing and maintaining effective management arrangements to support the management of the incident
- Liaising with STP partnership arrangements.
- Co-ordinating the Trust response to meet NHSEI requirements.
- Strategic management and co-ordination of Trust approach to recovery.

The Trust response team consisted of:

- Executive Directors
- All Directors of Nursing
- All Medical Directors
- All Borough Directors
- Deputy Director of Population Health
- Communications Manager
- Deputy Director of Infection Prevention and Control
- Lead Nurse for Infection Control
- On-Call Director
- Emergency Planning Officers
- Loggist
- People Participation
- Staff side
- Incident Room Business Manager

8.2.4 In addition, the following work streams reported to the Trust incident response team:

<u>People and Culture</u>

Lead: Director of People and Culture.

Executive Lead: Director of People and Culture

- Establish effective working relationships with trade unions to support the Trust response to COVID19
- Establish mechanisms to identify staff who may be particularly vulnerable to COVID19, Keep updated and make use of staff risk assessments
- Provide effective policy and operational HR frameworks that support the operation of business continuity plans
- Ensure that effective sickness management policies and associated pay frameworks are in place to support the effective operation of the Trust response plan
- Ensure that effective policies to support childcare arrangements
- Effective policies regarding subcontracted staff
- Effective process regarding staff testing and liaison with Occupational Health
- Develop effective support responses for staff affected by the trust response plan

Infection Control:

Lead: Director of Nursing (Community Health Services) and Director of Nursing (Luton Bedfordshire MH).

Executive lead: Chief Nurse

- Provide expert infection control strategic and operational advice and guidance
- Develop and support trust training requirements
- Support the guidance and provision of suitable PPE and any other required equipment
- Liaise with microbiologist regularly for expert advice.

Communications:

Lead: Communications Manager.

Executive Lead: Chief Medical Officer and Chief Nurse.

- Ensure effective internal and external communication about COVID19 and plans for its management
- Develop and maintain effective patient and staff information
- Ensure that communication material is effectively joined up with both STP systems

Operations: Community Health:

Lead: Service Director – Community Health Service.

Executive lead: Chief Operating Officer

- Ensure that Business Continuity arrangements are in place at DMT level
- To ensure effective liaison with Northeast London and Bedfordshire Luton and Milton Keynes STP arrangements

Operations, Forensic:

Lead: Head of Forensic Services.

Executive lead**:** Director of Integrated Care

- Ensure that Business Continuity arrangements are in place
- To ensure effective liaison with STP and Secure estate arrangements.

Operations, Bedfordshire and Luton:

Lead: Service Director – Luton and Bedfordshire MH

Executive lead: Chief Digital Officer

- Ensure that Business Continuity arrangements in place at DMT level
- To ensure effective liaison with BLMK STP arrangements.

Operations, London:

Lead: Service Director City and Hackney MH, Director of Nursing London MH and Medical Director London MH

Executive lead: Chief Financial Officer

- Ensure that Business Continuity arrangements in place at DMT level
- To ensure effective liaison with NEL STP arrangements.

Operations, Learning Disability:

Lead: Clinical Director, Learning Disabilities and Operational and Strategic Lead for Learning Disability

Executive lead**:** Chief Nurse

- Ensure that Business Continuity arrangements cover learning disability are in place
- To ensure effective liaison with STPs and Local authorities.
- Support silver work streams

Clinical and Operational advice and guidance:

Lead: Chief Quality Officer.

Executive Lead: Chief Quality Officer

- Develop guidance for the challenges of clinical and non-clinical scenarios relating to the response to COVID-19.

Operations, Primary Healthcare:

Lead: Medical Director Primary Care and Clinical Director

Executive Lead: Executive Director for Commercial Development

- Ensure that Business Continuity arrangements in place at Practice level
- To ensure effective liaison with Primary Care Networks..

Staff support:

Lead: Director of Therapies and Associate Director of People and Culture

Executive Lead: Director of People and Culture

- Ensure mechanism are in place to support staff

Testing and Vaccinations

Lead: Director for Strategic Service Transformation

Executive Lead: Chief Medical Officer

- Coordinate and manage the delivery of tests and the Covid vaccinations

8.2.5 Several silver group meetings were also established for each of the above work streams to enable operational staff to have the means, direction and co-ordination to deliver services. These meetings were led by the executive lead for the work stream – they initially met on a predominantly daily basis with the frequency changing to accommodate the needs of the service.

8.2.6 There were also COVID-19 Weekend Briefings established for on-call managers and consultants. These began on the weekend of 21st and 22nd March 2020 and were held at both 08:30 and 16:30 – subsequently changed to 10:00 from the weekend of 2nd and 3rd May and were stopped as of the weekend of 24th April 2021.

8.2.7 The AEO (or designated officer) attended regular system-wide meetings with both NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (CCG) and NHS Northeast London CCG. The frequency of these meetings changed to accommodate demand and risk. Furthermore, borough directors, or their deputies, also attended their relevant Local Resilience Forums - their aim being to provide a multi-agency response to identify risk, produce emergency plans and to mitigate the impact on the local communities.

8.2.8 The Trust continues to provide the following Situation Reports (Sitrep) to NHSEI as part of its response to the pandemic:

- Mental Health, Learning Disability and Autism and Community Services Sitrep (7 days per week)
- Community Discharge Sitrep (7 days per week)
- Staff Asymptomatic Coronavirus Lateral Flow Test Device Sitrep (weekly)
- Staff Lateral Flow Device Test Results Sitrep (weekly)
- Community Health Services Sitrep (monthly)

A daily situation report continues to be provided to senior managers providing data on the number of inpatients diagnosed with covid and their location, number of patients awaiting results of swabs, the number of patient deaths from covid and the number of covid-related staff absences.

8.2.9 ELFT Pandemic Communications

The Communications team was represented at all Gold meetings. They developed and produced a daily communication at the beginning and height of the pandemic to inform staff of key information they needed. These are still employed but were reduced to twice weekly. The information was sectioned under titles: Clinical Guidance, Infection Prevention and Control, People and Culture (HR) and Staff Wellbeing. The content was

informed by the daily Gold incident meeting, Silver meetings, regional meetings and London/National meeting.

- *Clinical Alerts*: Additionally, ELFT's Clinical Alert system was employed to cascade national updates, new instructions, and guidance.

- *Questions and queries*: The bulletin provided the communications team email for staff to ask any questions. This was well used and quickly responded to individually. The Communications team had access to all leaders and could draft responses speedily. The team published these and the responses on its platforms so that all staff could view them.

- *Feedback*: These communications had a high staff readership of over 60% some days. An audit highlighted that staff found the bulletins helpful and depended on them, especially those working from home - it kept them connected and updated. In the audit, staff also reported that they liked the 'tone' of the communication – they were not alarmist but calm and factual. People stated they trusted these as a reliable source of information above other platforms.

Leadership

The Communications team filmed the CEO and other trust directors to provide short updates to staff, supporting them, urging them to rest when possible and thanking them throughout. The CEO personally called almost 500 staff to say a personal thank you. Webinars were well attended and kept staff connected.

Webinars have taken place about a variety of topics and issues that arose: PPE, Race and Privilege, COVID Vaccine, Return to Work planning and Day of Remembrance event.

Staff Stories and Support

The bulletins also featured staff stories so that the whole workforce had a sense of what was happening in other parts of the organisation. For example, a fire safety officer delivering PPE and an autism specialist working on the mental health crisis line. Also, stories of support from local people and businesses sending scrubs, food and treats to support staff morale.

The Trust also set up a peer-to-peer support service for staff who were distressed or overwhelmed to enable then to talk to someone. This was publicised widely and grew into regional support hubs which continue today.

Website and Intranet

Staff: The ELFT Intranet is not web-based so is only visible to staff on a Trust device with remote access permissions. This meant information on the intranet could not be seen by all staff. The Communications team created a 'secret' section on the website and linked to information here so that information was visible to all staff. (At the time the new website/intranet was being commissioned and became live in May 2022)

The intranet and website were highly active during the pandemic. The Communications team ensured the information on both platforms were up to date and that staff were informed in the bulletins of the specific changes.

Public: There was a great deal to communicate to the public and service users - to stay at home, not to attend sites if they had symptoms, the pausing of visiting, arrangements to keep in contact with inpatients, and mental health support. The Communication team added a pop-up to the website so that people did not have to search for key information.

Social Media

Facebook and Twitter were used extensively to further the reach of national and local messages to the public about staying at home and the government restrictions as well as what steps to take if they became ill or in mental health crisis. National NHS imagery and messaging was replicated to reinforce messages.

8.3 The UK COVID-19 Inquiry

The UK COVID-19 Inquiry has been set up to examine the UK's preparedness and response to the COVID-19 pandemic, and to learn lessons for the future. The Inquiry's final Terms of Reference have been presented to the Prime Minister for approval.

The management of the health and care sectors will play a pivotal part in the Inquiry

9.0 EPRR Arrangements at ELFT

9.1 EPRR arrangements for communication during an emergency were reviewed and refreshed as part of the annual work plan. Furthermore, each plan, including the Incident Response Plan, will be reviewed as part of the response to, and recovery from, the COVID-19 outbreak.

9.2 Mobile Telecommunication Privileged Access Scheme (MTPAS) – the mobile phones of directors and key managers are registered with the MTPAS so that calls can be made or received during mobile network restrictions.

9.3 All plans and guidance are shown on the intranet.

9.4 A generic email address has been established to be used in the event of a major incident or emergency.

10.0 ELFT EPRR progress against work plan 2021/22

KEY ACTION	STATUS AT 31/03/2022
Review all plans relating to emergencies and business continuity to ensure they reflect current guidance and legislation.	Completed
Update emergency contact list to ensure it is up to date.	Completed
Continue multi-agency working (LHRPs, Luton and Bedfordshire patch LHRP, Borough Resilience Forums, NHS England (London) NENC Network Meetings)	Completed
Annual audit of all Trust Incident Control Centres and their emergency boxes.	Completed
Review and updating of all service business continuity plans	Completed
Gold (strategic) training to be provided to directors on-call	Completed
Undertake Immediate Operational response training (Hazmat) to community health centres.	Completed
Conduct six monthly communication exercise – trust wide and directorate level	Carried forward
Carry out an exercise to involve all levels of staff affected by ICT outage, as mandated by The DSP (Data Security and Protection) Toolkit	Carried forward
Quarterly reports to Quality Committee	Completed
Identify further staff to attend PHE loggist training.	Completed
Identify staff to attend the PHE 'loggist train the trainer 'course	Completed

10.1 During the pandemic, the substantive Emergency planning officer for Luton and Bedfordshire resigned but we successfully recruited into the role and the current EPO has developed professionally and the emergency planning team continue to deliver against our planned objectives.

10.2 A new Sitrep work stream was established to undertake the requirement of 7-day reporting of three specific reports to NHSEI. These were successfully completed throughout the pandemic, and continue to do so, without additional resourcing.

10.3 The Emergency Planning Team were able to complete 80% of actions against the workplan for this reporting period.

11.0 Work plan for 2022/23

Key Action	Outcome measure	TCD	Lead
Review all trust wide plans relating to emergencies and business continuity to ensure they reflect current guidance and legislation.	Approved trust wide policies and plans in place.	September 2022	Emergency Planning Manager
Continue to review and develop local business continuity plans.	Local plans in place.	November 2022	Service Directors / Senior Managers
Review emergency contact list to ensure it is up to date.	Maintained contact list in place and available to key staff.	Bi-Monthly	Emergency Planning Manager
Continue multi-agency working (LHRPs, Resilience Forums, NHS England (London) NENC Network Meetings)	Partnership relationships effective.	Quarterly	Emergency Planning Manager
Annual audit of all Trust Incident Control Centres and their emergency boxes.	All boxes complete.	October 2021	Emergency Planning Manager with senior managers
Identify further staff to attend in-house loggist training.	Staff complete the training.	December 2022	Emergency Planning Manager/EPO
Carry out an exercise to involve all levels of staff and outside agencies affected by ICT outage, as mandated by The DSP (Data Security and Protection) Toolkit	Completed exercise and lessons learnt	June 2022	Emergency Planning manager and IT

Conduct a communication exercise of the IT system	Completed exercise and lessons learnt	August 2022	Emergency Planning manager and IT
Undertake Immediate Operational response training (Hazmat) to community health centres.	Identified staff complete the training	September 2022	Emergency Planning Manager
Director on-call training	Directors complete training	September 2022	Emergency Planning Manager/Officer

11.1 We were able to deliver and support against the Trust strategy work in relation to population health requirement.

11.2 We have been able to provide routine assurance to the Trust, NHSEI and our commissioners on the EPRR Framework to respond to both business continuity and major incidents.

11.3 All progress against the work plan will be reported to the Quality Committee in the form of quarterly reports.

12.0 Action being requested

12.1 The Committee is asked to RECEIVE and APPROVE report and the associated work plan for 2022/23 set out in section 12.2.

REPORT TO THE QUALITY ASSURANCE COMMITTEE
27 JUNE 2022

Title	Health, Safety and Security Annual Report 2021-22
Author	Richard Harwin, Health, Safety, Security and Emergency Planning Manager
Accountable Executive Director	Lorraine Sunduza, Chief Nurse

Purpose of the report

To brief the Trust Board on progress made to ensure the Trust is meeting its obligations under the Health and Safety at Work Act 1974.

Committees/meetings where this item has been considered

Date	**Committee/Meeting**
15.06.2022	Health, Safety and Security Committee

Key messages

The attached report identifies the work undertaken during the period 01.04.2021 to 31.03.2022. The following key points are detailed:

- In response to the COVID-19 Pandemic the Health, Safety and Security Committee was held monthly - it has now returned to the original bi-monthly schedule. The Committee is well attended by relevant departments including a strong representation from staff side.
- A total of 50 RIDDORs were reported, of which physical assaults accounted for 74%. This was a reduction from 77 for the same period in 2020-21
- There has been a significant reduction in physical violence against staff from 429 (2020/21) to 265 (2021/22) at the Coborn Unit. This can be attributed to their Violence and Aggression QI Project and the introduction of their Senior Management Group RAG rating.
- Bedfordshire Police has retained its Mental Health Crime Investigation Officer who works directly with the Trust's inpatient sites across the county, providing direct support to mental health inpatient staff and service users. In recognition of this partnership work, we were awarded the Violence Reduction Initiative Award from the National Association for Healthcare Security (NAHS) for both 2020 and 2021.
- The Trust has adopted the People Safe Lone working Smartphone App with compliance across the Trust ranging from 43% (THCHS) to 100% (CAMHS) with 1105 staff having access to the App. A full implementation and training programme has taken place including extensive publicity on the intranet. A series of webinars has also taken place to further improve compliance and to raise awareness. Each directorate has assigned a single point of contact to further improve compliance.

Strategic priorities this paper supports

Improved population health outcomes	☒	Ensuring the Trust meets HSE Statutory regulations and CQC guidelines.
Improved experience of care	☒	Through identifying risk and providing the control measure to remove or reduce them.

Improved staff experience	☒	Empowering and supporting staff in providing them with the tools, correct policies and procedures, documentation, and training to carry out their roles safely.
Improved value	☒	Ensuring the Trust meets HSE Statutory regulations and CQC guidelines. Reducing potential risk where possible by providing robust control measures and in house training.

Implications

Equality Analysis	This report has no direct impact on equalities
Risk and Assurance	Mitigating actions are in place in relation to the risks identified within the report.
Service User/ Carer/Staff	Monitoring and supporting health and safety at work is fundamental to good staff and service user experience.
Financial	There are no direct financial implications associated with the report.
Quality	There are no implications for Quality Improvement raised in this report.

Annual Report 2021/22

1.0 Introduction

Following the introduction of the Health and Safety at Work Act 1974 (HASWA) various Approved Codes of Practice (ACOP), guidance and regulations have been introduced to compliment the Act.

'Successful health and safety management' (HSG65) was first prepared by the Health and Safety Executive (HSE) accident advisory unit (now operations unit) in 1991 as a practical guide for directors, managers, health and safety professionals and employee representatives who want to improve H&S in their organisations.

The Regulatory Reform (Fire Safety) Order 2005 came into effect in October 2006 and consolidated all fire safety legislation for non-domestic premises into a single Order. Whilst it abolished the requirement for healthcare premises to hold a fire certificate, under the Order, NHS Trusts are required to actively pursue and maintain fire safety and take responsibility for staff and others visiting their premises.

Health and safety, fire and NHS Protect (now disbanded) guidance also cites that as 'good practice' health and safety should appear regularly on the agenda for board meetings. It recommends that the Chief Executive can appoint a Health and Safety 'champion' to represent the board and act as a scrutiniser to ensure processes to support H&S are robust, delivered, monitored, and reviewed effectively.

2.0 Background

The Trust has a statutory duty under the HASAWA (1974) to (in particular):

- **Section 2** General duties of employers to employees
- **Section 2(3)** To provide a H&S Policy
- **Section 2(4) to (7)** Functions of safety representatives and the H&S committee
- **Section 3** Duties to other persons other than employees
- **Section 7** General duties of employees at work
- **Section 37** Offences by bodies corporate

Additionally, the Trust has a statutory duty under the management of Health and Safety at Work Regulations 1999 to (in particular):

- **Regulation 3** Provide suitable and sufficient risk assessments
- **Regulation 5** Provide health and safety arrangements
- **Regulation 10** Provision of information to employees
- **Regulation 13** Assurance of the employees' capabilities and provide training

Furthermore, the Trust has a duty under the Regulatory Reform (Fire Safety) Order 2005 to focus on risk reduction and fire prevention. The instrument to fulfil this responsibility are mandatory detailed Fire Risk assessments for all Trust premises which are duly submitted to the local Fire Authority.

The Department for Communities and Local Government (CLG) provides additional guidance to assist with the preparation of fire risk assessments in specific premises – including healthcare (Department of Health).

3.0 The Health, Safety and Security Team

The Chief Nurse is the Executive Director who is responsible for Health & Safety (H&S) and Security activity. The H&S and Security team sits within the Governance and Risk department and consists of two staff members - currently the Trust's Health, Safety, Security and Emergency Planning Manager and Health, Safety and Security Advisor.

Within the Estates, Facilities and Capital Development Directorate are three Fire Officers who are responsible for carrying out Fire Risk Assessments, fire investigations, training of staff, in addition to advising on a wide range of matters relating to fire safety across the Trust.

4.0 The Quality Committee

The Quality Committee, chaired by the Chief Nurse, meets monthly. An exception report is presented to the Committee by the Health, Safety and Security Team every quarter providing H&S updates and proposals for action.

5.0 The Health, Safety and Security Committee

In addition, a Trust wide Health and Safety Committee, chaired by the Chief Nurse has been established and is attended by staff side representatives, Chief Operating Officer, Director of People and Culture, Director for Estates and Facilities and the Health and Safety Lead for the Trust. This group discusses and promotes trust wide health and safety issues which remain unresolved at directorate level. This group also promotes a culture of understanding and co-operation across the Trust to ensure the health, safety and welfare of all staff, patients, and visitors. Feedback from this committee is highlighted at the Quality Committee.

During the Covid-19 pandemic, its frequency was increased to monthly to strengthen arrangements - the intention is now to return to bi-monthly.

6.0 Health & Safety Policy

Within the H&S policy and in line with H&S guidance it is recommended that each service area has a risk officer, and each directorate has a risk facilitator who oversees each directorate's H&S issues. Each risk officer is invited to the local H&S meeting, which is chaired by the facilitator. Any issues which require escalation, are taken to the respective Directorate Management Team DMT and then to the trust wide H&S Committee if required.

The H&S policy was reviewed in February 2021, in line with HSE guidance, and ratified by the Quality Committee. This periodic review also included the inclusion of the workplace risk assessment template.

7.0 Security Policy

The Security policy was reviewed in May 2020 in line with relevant guidance and ratified by the Quality Committee. This periodic review included removing the CCTV appendix so it would become a stand-alone policy.

8.0 Incident Reporting and Follow Up

The Trust electronic incident reporting database (Datix) pertaining to health and safety related incidents includes the following mandatory fields which require a yes or no answer:

- Likelihood and severity of reoccurrence
- Is the incident RIDDOR reportable? ('over seven days' incapacitation - not counting the day on which the accident happened or specified injuries).
- Has the incident been reported to the police?
- Were the police contacted to attend in the event of an emergency?

The Trust monitors every incident of actual or potential violent acts. These are reported via the Datix system and act as a trigger, at the time of the incident, for the H&S and security team to determine appropriate follow up.

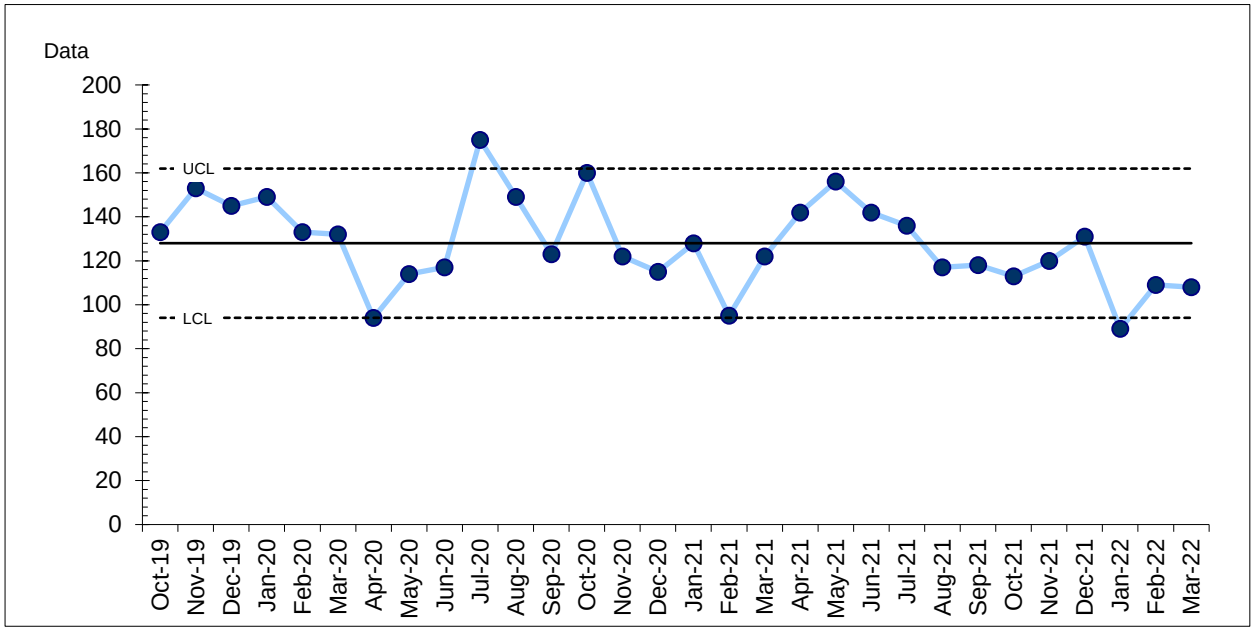
Additionally, the H&S and Security Team is automatically notified of all H&S and security incidents so that they can be followed up to ensure that appropriate action is being taken to implement assessments and control measures to minimise future reoccurrence of similar situations.

Highlighted below is a summary of the reporting period for:

- Health, safety and security incidents by month and directorate (involving staff and patients)
- Smoking in an unauthorised area by month and directorate
- Fire incidents by month and directorate
- Non-clinical slips, trips and falls by month and directorate
- RIDDOR incidents by directorate (involving staff and patients)
- Security incidents by month and directorate (involving staff and patients)
- All incidents of violence and aggression by month and directorate (involving staff and patients)
- Physical violence towards staff by month and directorate

<u>Health, Safety and Security incidents</u>

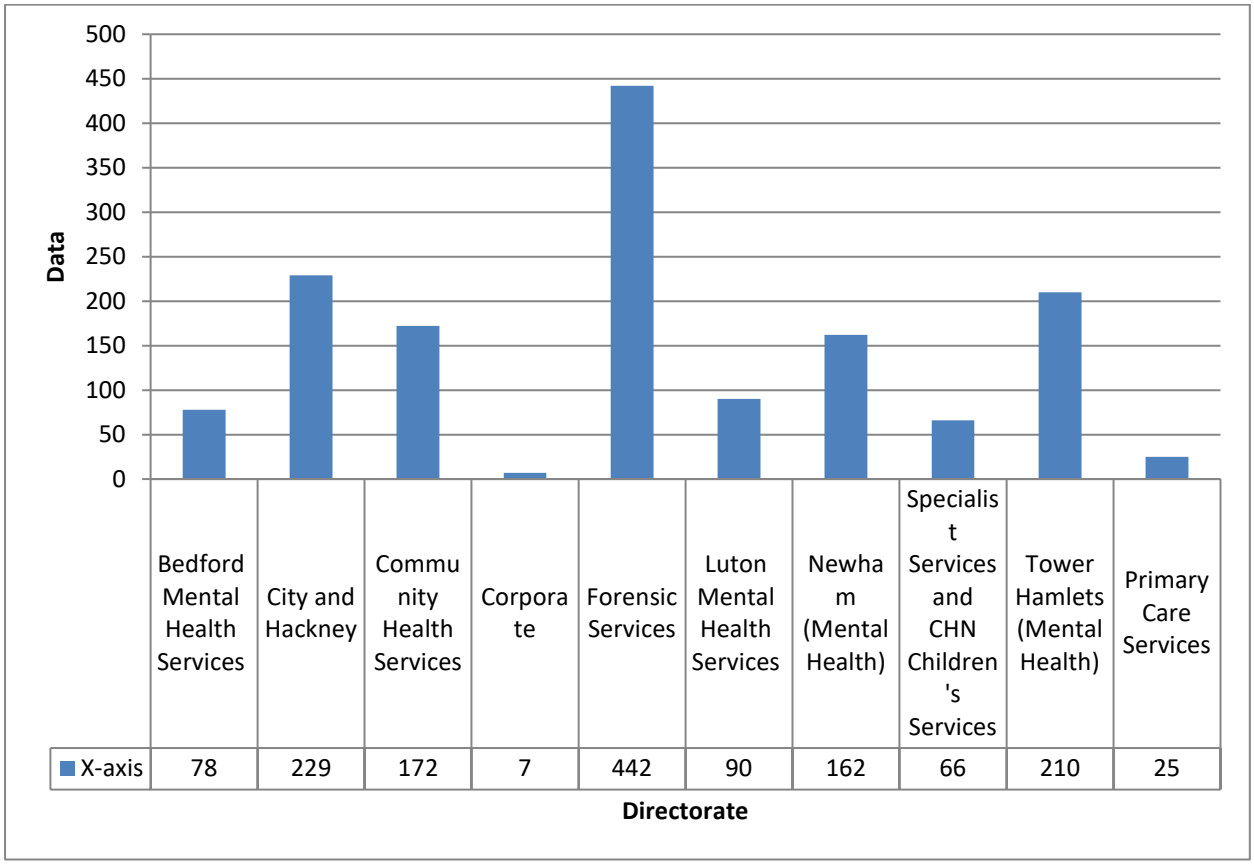
All reported Health, Safety and Security incidents – Trust wide:



A total of 1481 Health, Safety & Security incidents were reported for 2021/22. This has dropped in comparison with the 1517 reported incidents in 2020/21.

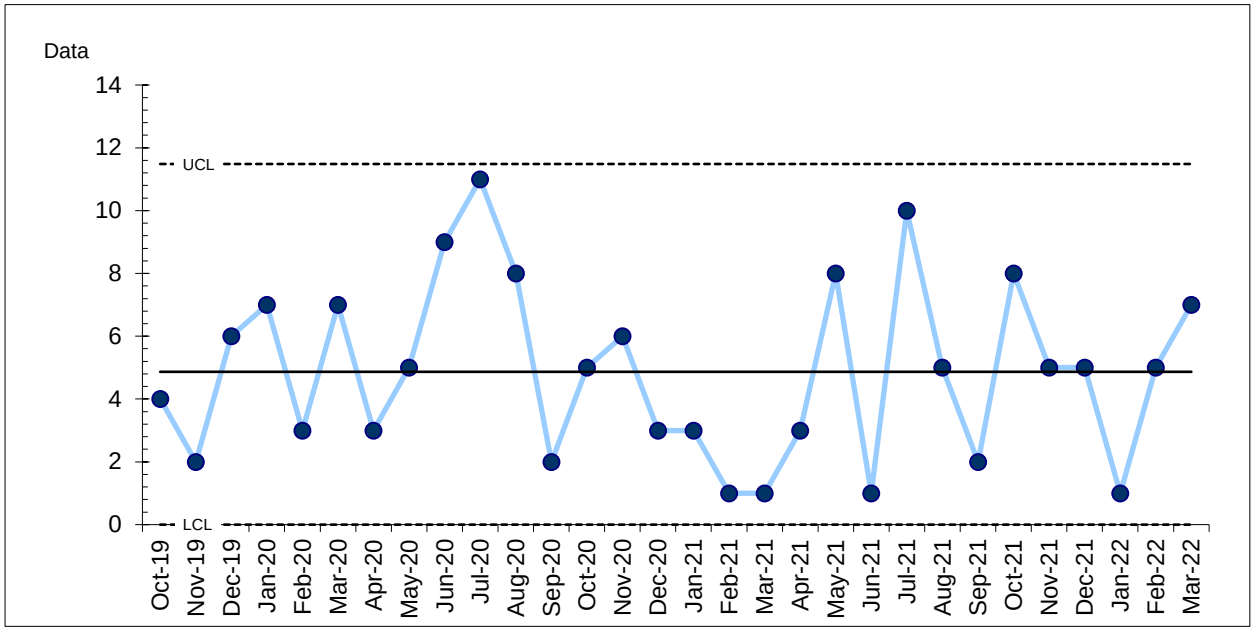
There was no obvious trend for site or type for the peak in May 2021.

All reported Health, Safety and Security incidents by Directorate April 21- March 22



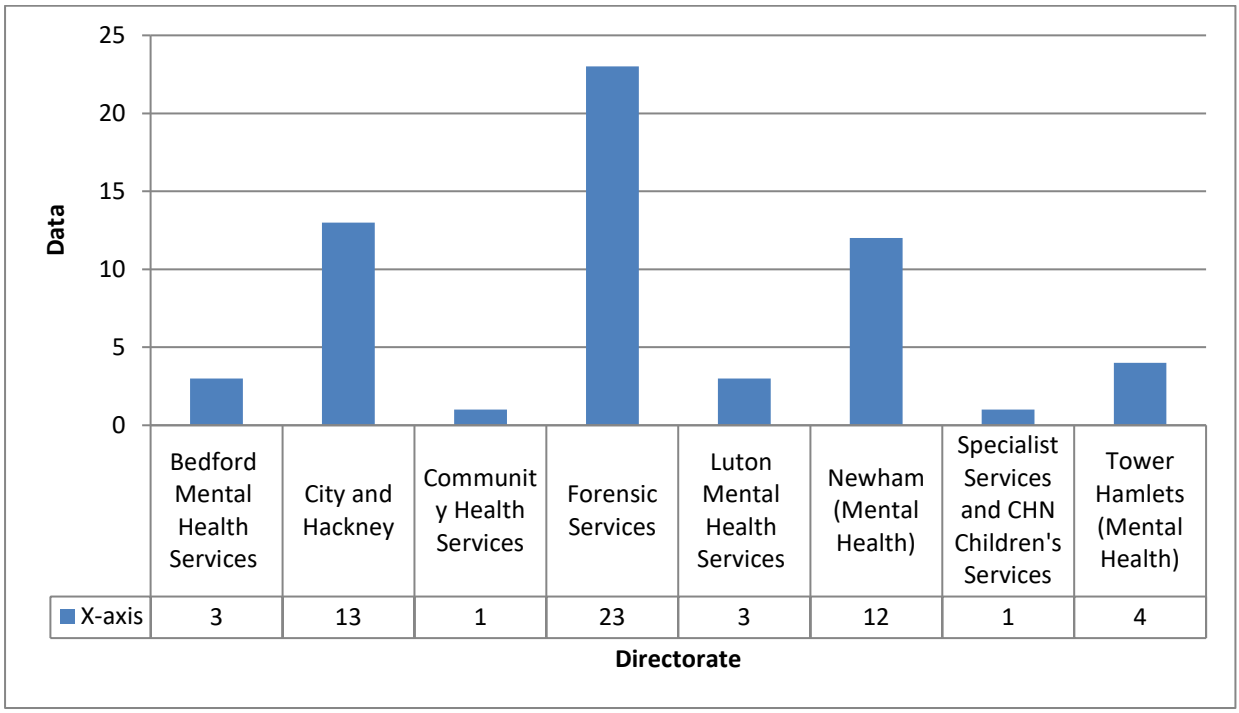
The significantly larger number of incidents within forensic services reflect security breaches such as reports of finding prohibited items as well as other breaches such as doors being left unlocked and associated housekeeping. The comparatively large number of these incidents within forensic services is not unusual due to the acuity of the patients/services users and the larger number of wards in that service.

Smoking in an unauthorised area Trust-wide



There was no obvious trend of site for the peak in October 2021.

Smoking in an unauthorised area by Directorate April 21- March 22

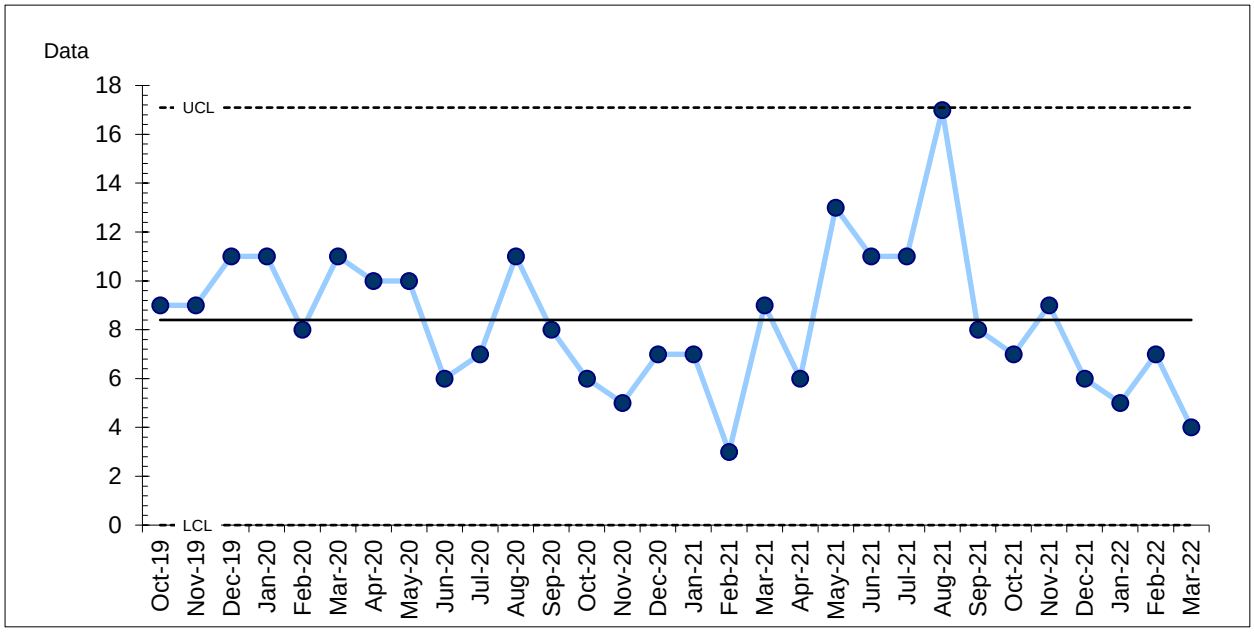


Most incidents of smoking in an unauthorised area tend to occur in the forensic directorate predominantly due to the nature of the service and its patient population.

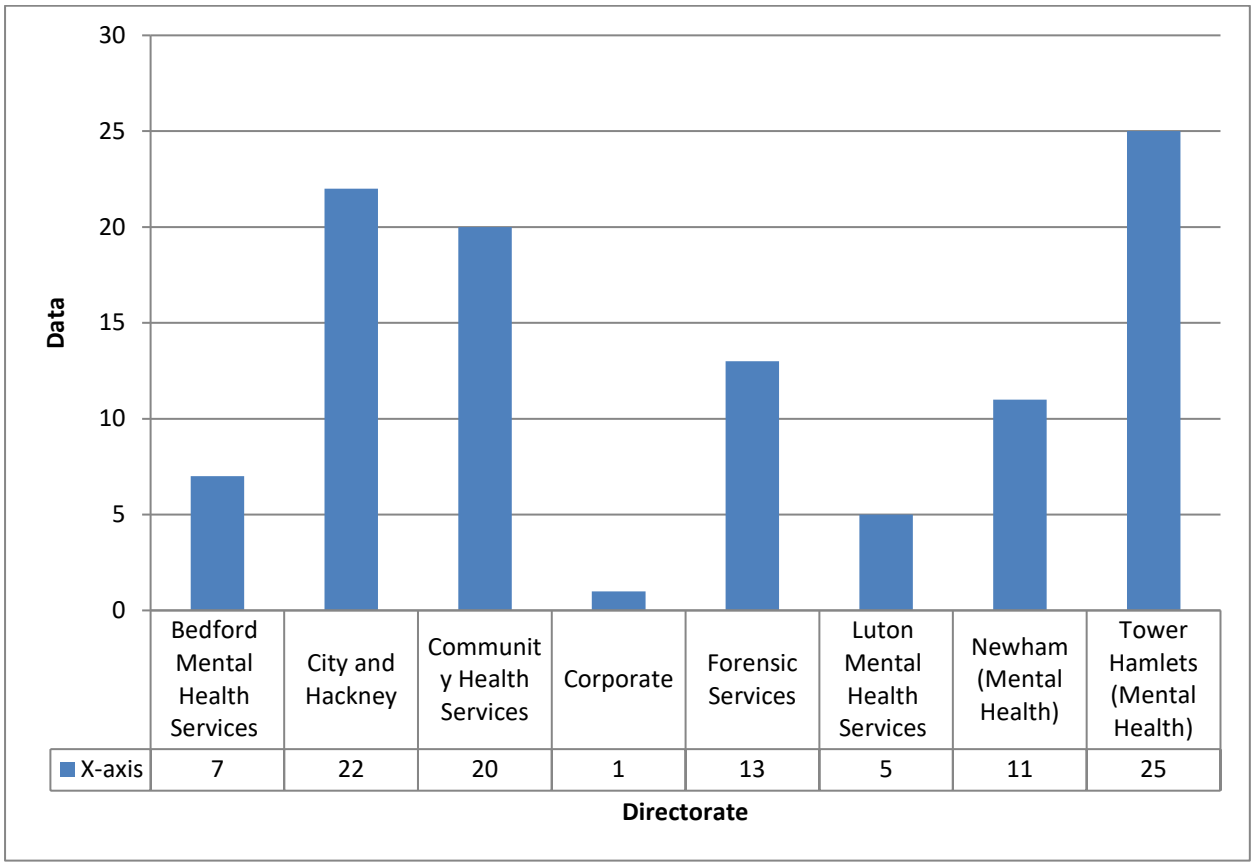
Since 2016, the Trust has moved to a no-smoking environment on all sites.

Fire incidents - All fire incidents reported

All fire incidents (including false alarms) reported Trust-wide:

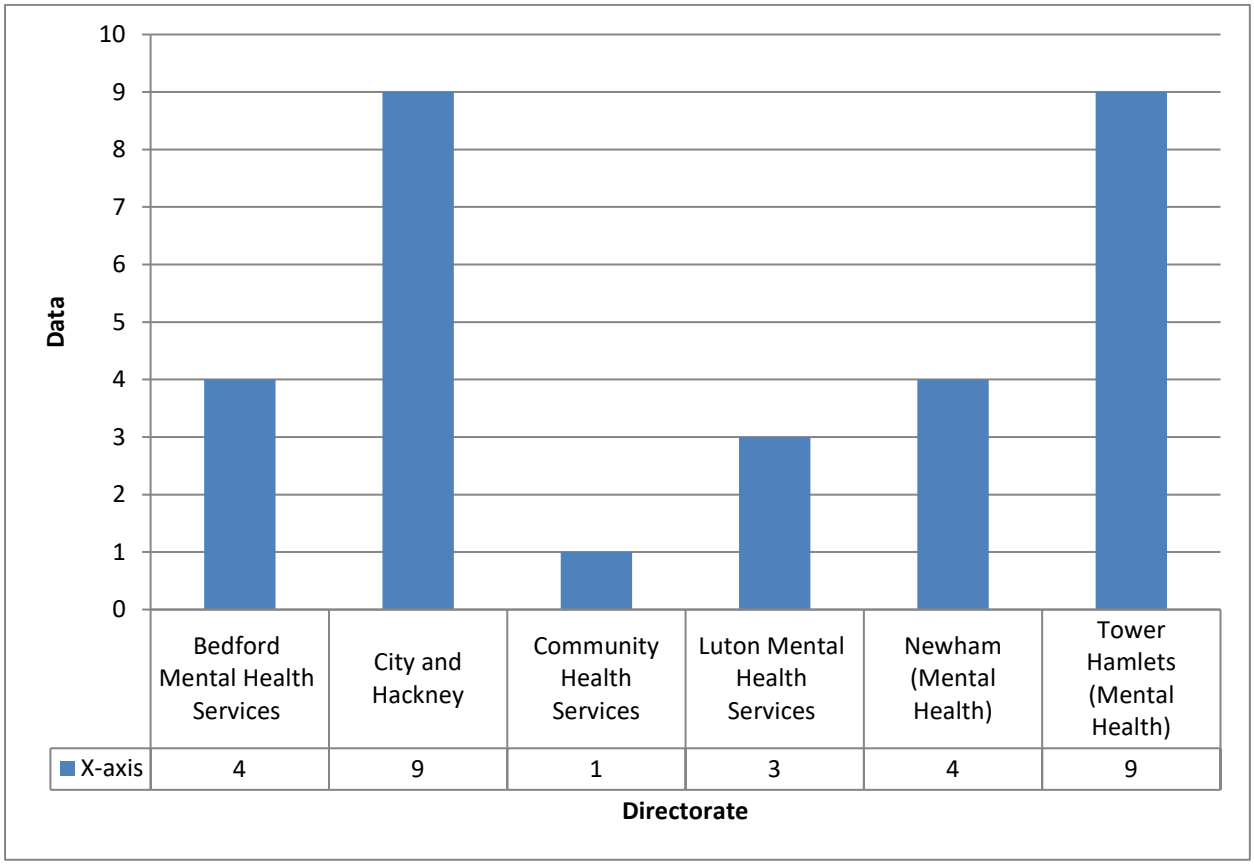


All reported fire incidents (including false alarms) by Directorate April 21- March 22



Most fire incidents relate to 'false alarms' such as a smoke detector being activated by covert smoking in bed areas or set off from steam from ensuite shower rooms.

All reported actual fires by Directorate April 21- March 22:

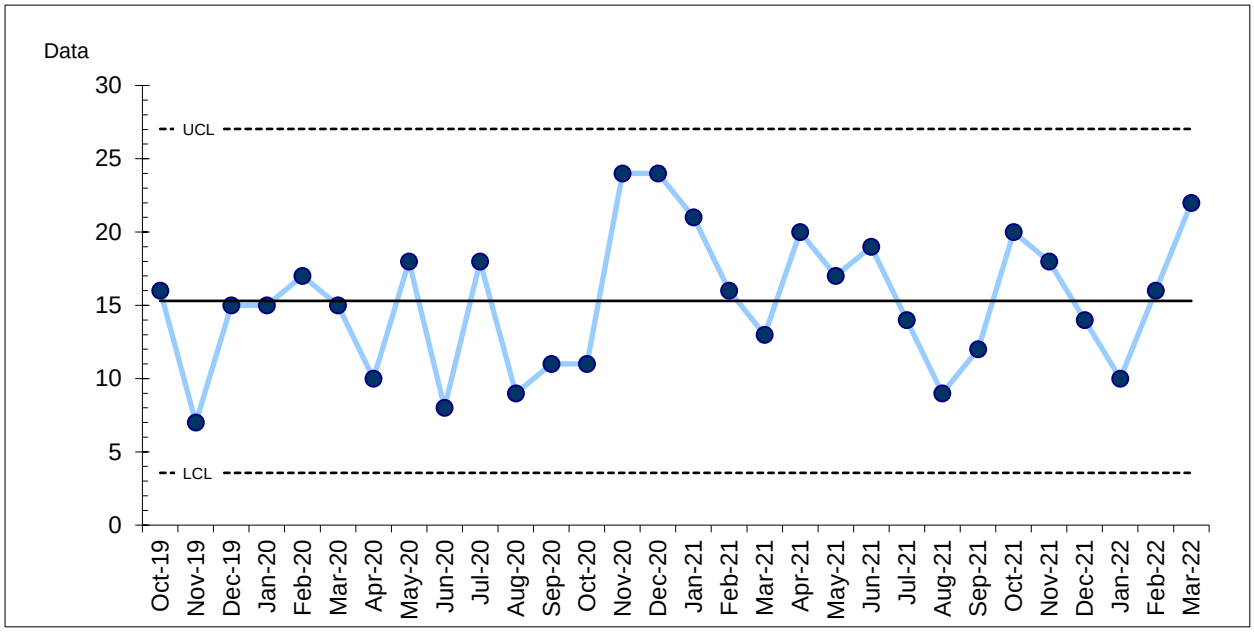


All fire incidents reported are reviewed by the Trust Fire Safety Advisors and, where deemed appropriate, a fire investigation is carried out with a report detailing the details of the occurrence, the cause and any issues relating to building or staff performance. From this, recommendations may arise.

Whilst the number of actual fires in City & Hackney and Tower Hamlets are more than elsewhere in the organisation there is no prominent attributable cause. The number of actual fires in each Directorate varies in subsequent years and can sometimes be accounted for by repeated incidences involving a small number of individual patients.
Of the thirty actual fire incidents during this reporting period, thirteen of those were initiated by patients on wards across directorates. There were no incidents within the category of a 'serious nature' (i.e., with patient or staff injury).

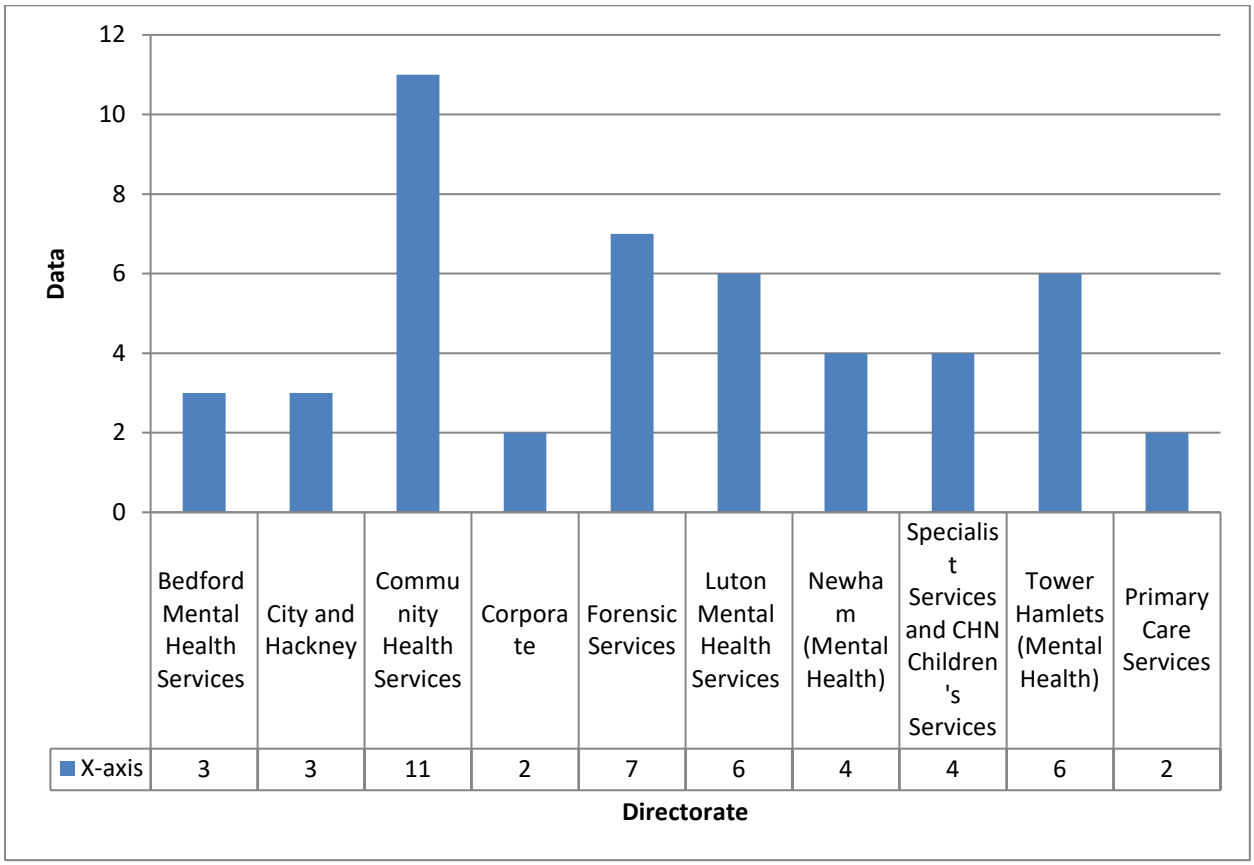
Slips, trips and falls – non-clinical (as a result of accident or hazard)

All reported non-clinical slips, trips and falls – Trust-wide:



There is no obvious trend of site or reason for the peaks in October 2021 and March 2022.

All reported non-clinical slips, trips and falls by directorate April 21- March 22:



Regarding the higher number of reported incidents in Community Health Services, there is no obvious trend identifying this occurance with respect to team location or causation of slip or trip.

The statutory health and safety duties of the Trust include an absolute duty to provide floor surfaces and working environments that are safe and without slip and trip hazards.

Staff are encouraged to report all slips, trips, and falls to enable the H&S leads locally and corporately to investigate, where practicable and helpful, to look at ways to prevent reoccurrence of such incidents.

RIDDOR

Directorate	2019/20	2020/21	2021/22
Bedfordshire Community Health Services	**7**	**5**	**0**
CAMHS	**0**	**4**	**6**
City & Hackney	**13**	**9**	**4**
Community Health Newham	**6**	**3**	**1**
Corporate	**3**	**0**	**0**
Forensic Services	**22**	**23**	**14**
Luton & Beds (Mental Health)	**10**	**11**	**5**
Newham (Mental Health)	**8**	**14**	**13**
Specialist Services	**0**	**0**	**0**
Tower Hamlets (Mental Health)	**7**	**6**	**7**
Tower Hamlets Community Health Services	**1**	**2**	**0**
Primary Care	**-**	**0**	**0**
Total	**77**	**77**	**50**

The Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) require the reporting of work-related accidents, diseases and dangerous occurrences to the Health and Safety Executive (HSE). RIDDOR puts duties on employers, the self-employed and people in control of work premises to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences

Each RIDDOR report that is submitted to the HSE is categorised by type. Physical assaults on staff are the most widely reported H & S related incident and this is reflected by the number of RIDDOR reports for assaults submitted to HSE.

Assaults accounted for 74% (37) of all RIDDOR reports in 2020/21 - of these, 14 were reported from Forensic Services. This is not unusual due to the nature of the service and acuity of this client group. The second most common type of H & S related incident reported within the Trust were slips, trips and falls which accounted for 10% (5) of all RIDDOR reports submitted to HSE. The remaining incidents were related to lifting/handling, being struck by an object and needle stick injury which accounted for 16% (8). The total number of RIDDOR reports for the period were 50.

RIDDOR Report of COVID-19

The Health and Safety Executive (HSE) has published guidance which states that these are only reported under RIDDOR if a person at work has been diagnosed as having COVID-19 and it can be attributed to an occupational exposure to coronavirus. When deciding if a report is required, a judgement has to be made as to whether or not there is reasonable evidence that a work-related exposure is the likely cause of the disease.

The Health and Safety Executive (HSE) accepts that these are not easy criteria to apply in the unusual circumstances presented by the coronavirus (COVID-19) outbreak. When deciding if a report is required, the responsible person must make a judgement, based on the information available, as to whether a confirmed diagnosis of COVID-19 is likely to have been caused by an occupational exposure, i.e., whether there is **reasonable evidence** that a work-related exposure is the likely cause of the disease.

For a death or confirmed staff covid case to be reportable under RIDDOR to HSE, there must be reasonable evidence that this was caused by occupational exposure to coronavirus. Factors to consider include:

- Whether or not the nature of the person's work activities increased the risk of them becoming exposed to coronavirus?
- Any identifiable incident that led to an increase of exposure.
- whether or not the person's work directly brought them into contact with a known coronavirus hazard without effective control measures, as set out in the relevant PHE guidance, such as personal protective equipment (PPE) or social distancing

Additionally, for an occupational exposure to be judged as the **likely** cause of the disease, it should be more likely than not that the person's work was the source of exposure to coronavirus as opposed to general societal exposure. Such cases may not be easy to identify when COVID-19 is prevalent in the general population.

HSE have confirmed that responsible person does not need to conduct extensive enquiries in seeking to determine whether a COVID-19 infection is work-related. The judgement should be made based on the information available.

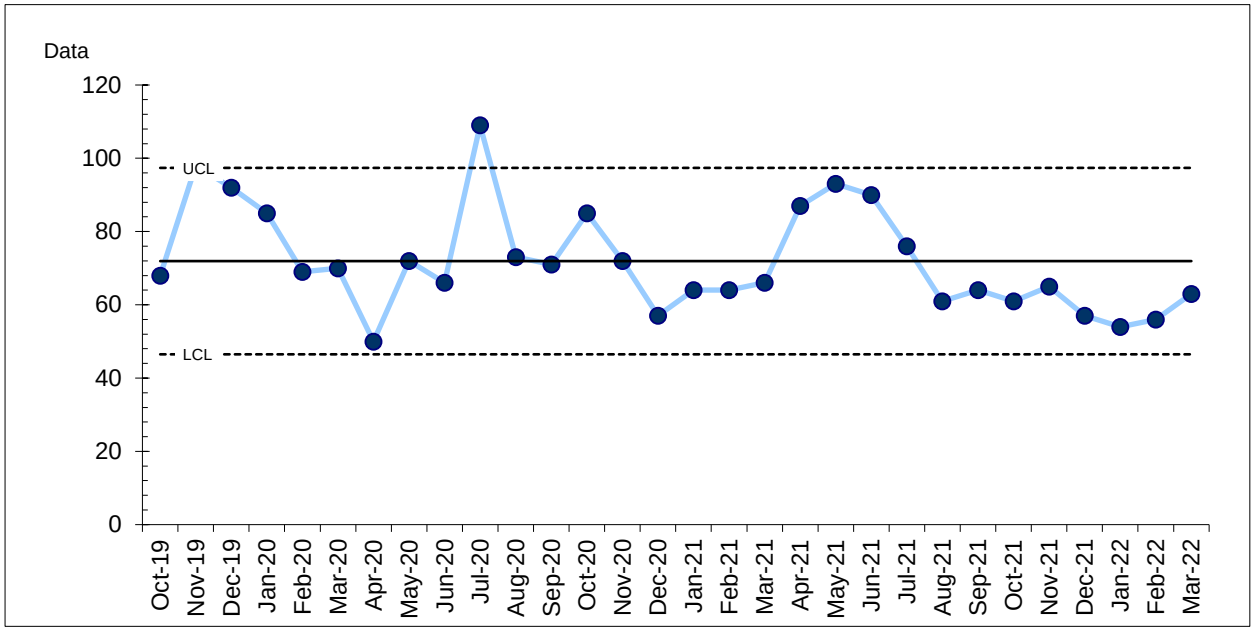
Furthermore, the latest communication from HSE stated: "HSE do not anticipate many cases of RIDDOR reportable incidents, as such cases will not be easy to identify, and are anticipated to be rare, especially as prevalence of COVID-19 increases in the general population."

In response to this, the H&S team established a process to investigate each staff member diagnosis of COVID-19 to ascertain if there is reasonable evidence that it had been due to exposure whilst at work resulting in serious illness or death.

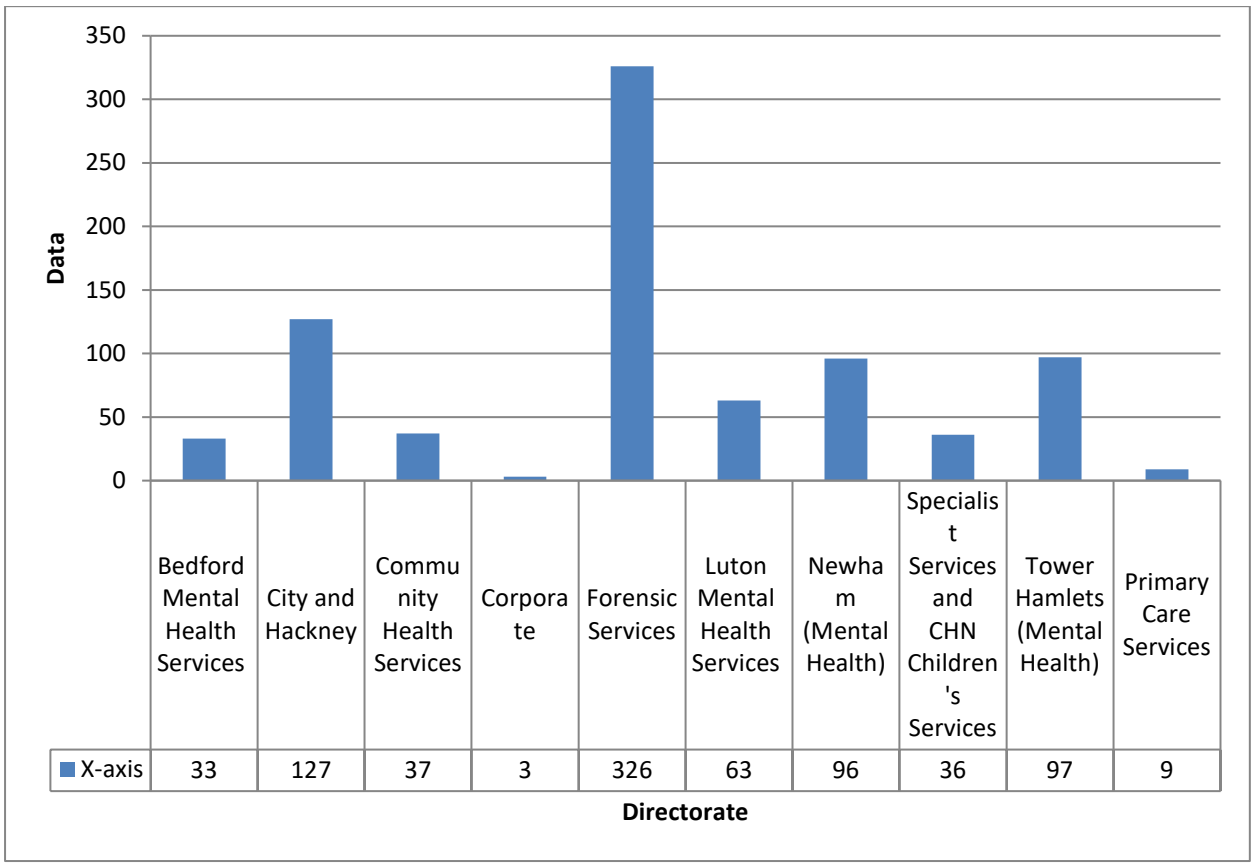
To date no cases have been identified which would meet the HSE criteria for reporting under RIDDOR requirements.

Security Incidents

All reported security incidents – Trust-wide:



All reported security incidents by directorate April 21- March 22:

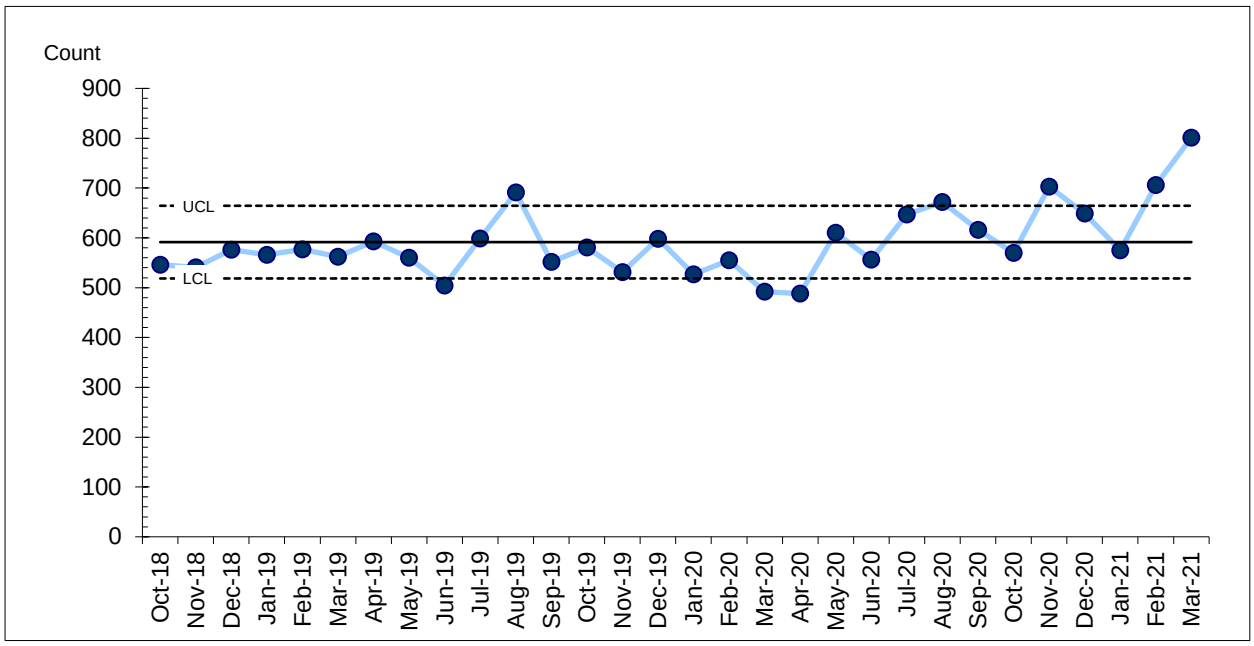


The higher numbers in forensic services reflect security breaches such as reports of the finding of prohibited items, e.g., lighters and tobacco, during both random searches, in line with medium and low security safety procedures and as part of risk management initiatives. Other breaches include internal doors being left unlocked in buildings and associated general

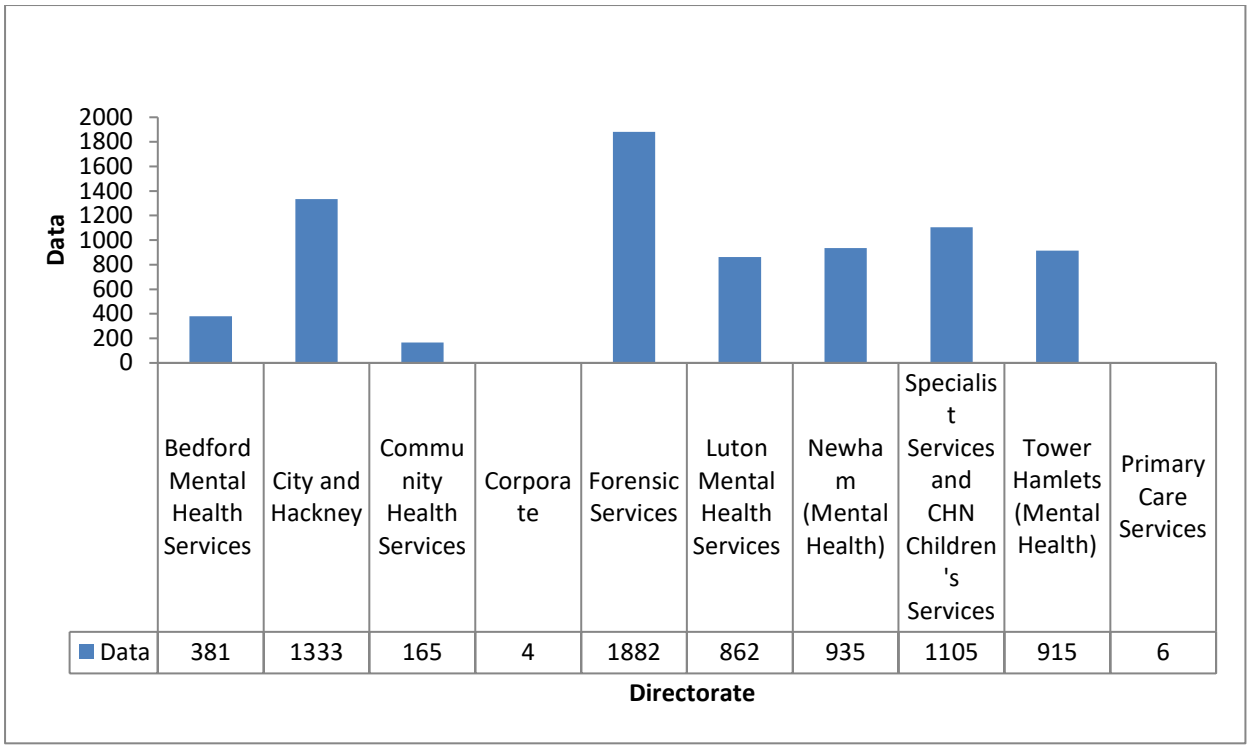
housekeeping. There are two fully staffed security teams – located both at the John Howard Centre and at Wolfson House who review and investigate all reported security incidents.

Violence and Aggression

All reported violence and aggression (staff and patients) – Trust-wide:



All reported violence and aggression incidents by directorate April 21 - March 22



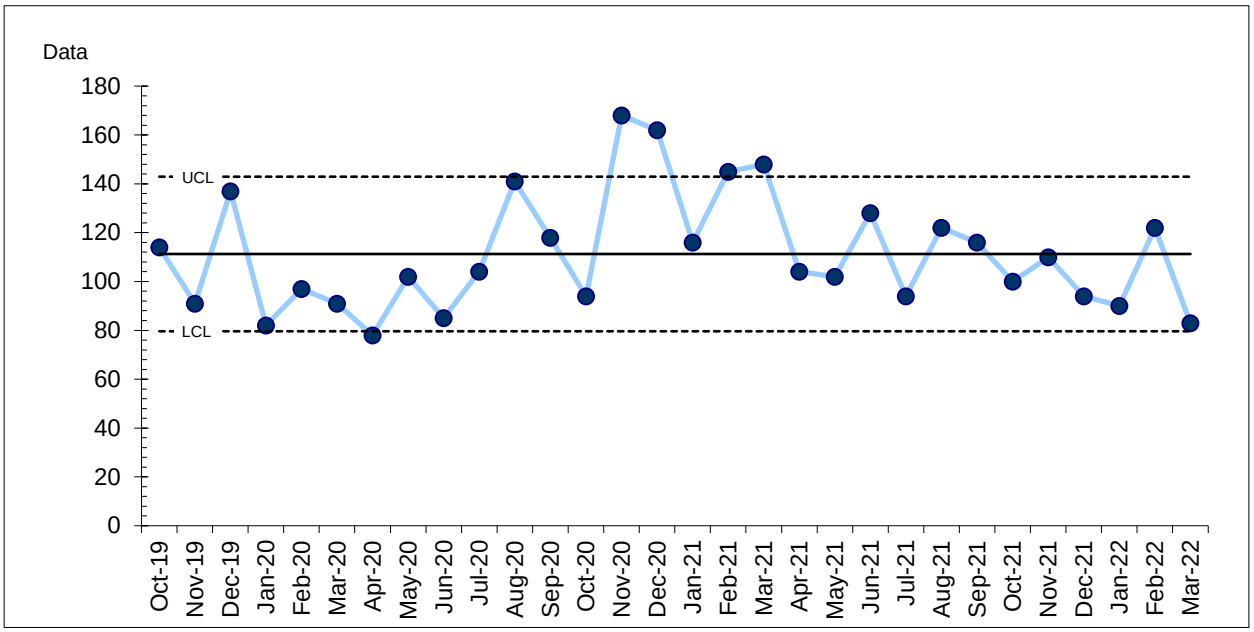
All Violence and Aggression Incidents comparison

Directorate	Incidents Reported 2019/20	Incidents Reported 2020/21	Incidents Reported 2021/22
Bedfordshire Community Health Services	**43**	**36**	**36**
Bedford (MH)	**456**	**381**	**360**
City & Hackney	**1174**	**1333**	**1197**
Community Health Newham	**115**	**106**	**121**
Corporate	**0**	**4**	**2**
Forensic Services	**1636**	**1882**	**1795**
Luton (MH)	**693**	**862**	**729**
Newham (Mental Health)	**943**	**935**	**1093**
Tower Hamlets (Mental Health)	**1125**	**915**	**1110**
Tower Hamlets Community Health Services	**48**	**23**	**39**
Specialist Services and CHN Children	**543**	**1105**	**680**
Primary Care Services	**-**	**6**	**16**
Total	**6776**	**7588**	**7179**

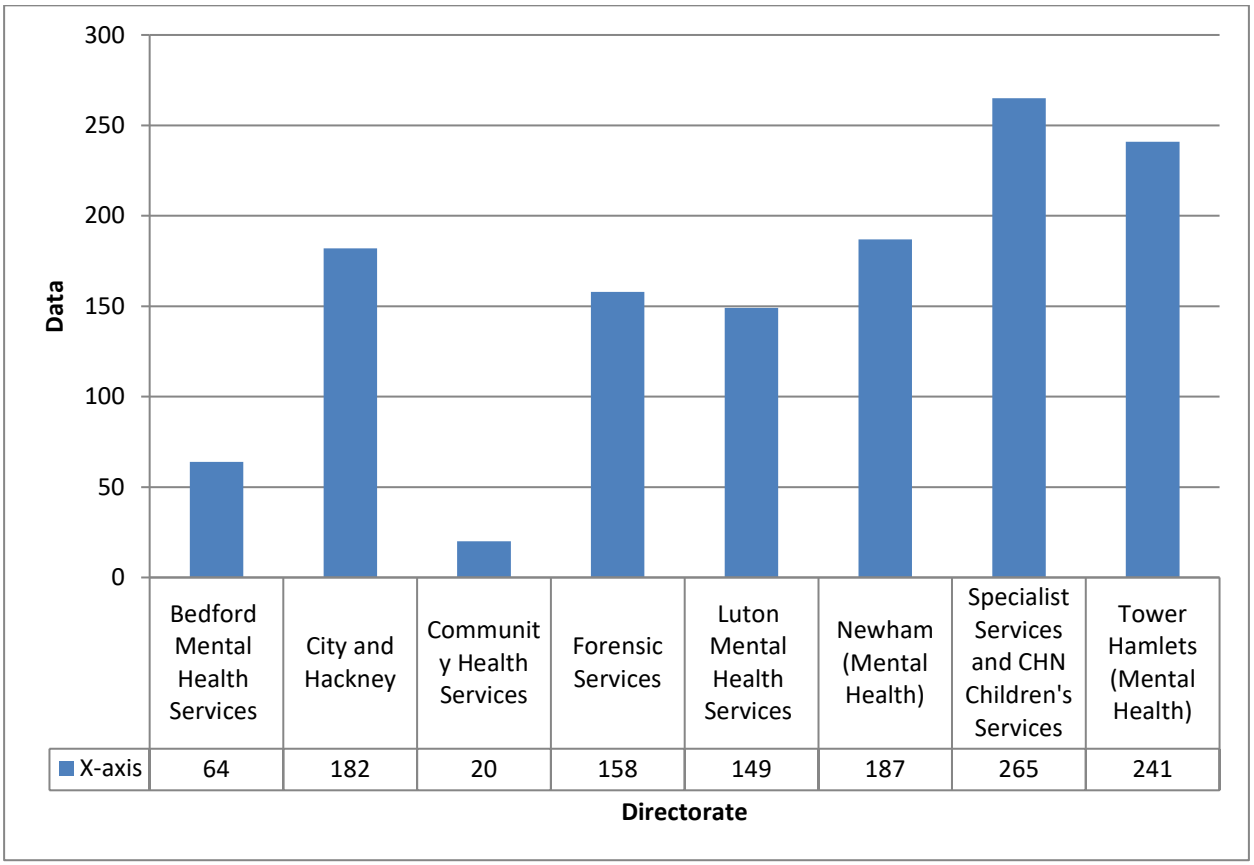
Directorates actively report criminal damage and non-physical incidents, such as threatening and verbally abusive behaviours as well as racial aggression. Furthermore, staff are actively encouraged to report all incidents where they, a colleague or a service user has felt threatened or intimidated.

Violence and Aggression – Actual Physical Violence towards staff

All reported actual physical violent incidents towards staff – Trust-wide:



All actual physical violence towards staff incidents by directorate April 21- March 22:



The peak in February 2022 is mainly attributed to the Coborn Unit and was related to a young person in PICU with complex needs who was very assaultive towards staff.

In contrast, there has been a significant overall reduction in physical violence against staff from 429 (2020/21) to 265 (2021/22) at the Coborn Unit. This can be attributed to their Violence and Aggression QI Project with the introduction of both safety huddles and safety crosses. Safety huddles can be called by any clinician at any time of the day to discuss a concern or a patient who might be getting unsettled. The aim is to quickly have a meeting and agree a proactive intervention to mitigate the risk of escalation.
Safety crosses are mainly managed by nurses daily to capture any incident of violence and colour code it. This is to help engage the young person in discussion about the day and how together they can turn a red or amber shift into green.

In addition, the Coborn Unit has recently introduced a Senior Management Group RAG (Red, Amber, Green) rating where the red (high risk) cases are discussed which constitutes about 20% of their patients and agree a plan of who will seek to minimise the risk. This could be a small team, OT assessment and intervention, psychological and nursing input, or a medical/pharmacological intervention. The presence of senior management means a prompter response to the needs of the young person.

Throughout the pandemic, there were also reports trust wide of increases in general levels of anxiety and frustration – resulting in a rise in acuity of illness. Furthermore, outbreaks of COVID-19 on wards and higher prevalence of coronavirus in the community have resulted in higher levels of staff absenteeism.

9.0 Police Liaison

9.1 Police liaison for ELFT

This falls under the role of the Trust's Health, Safety, Security and Emergency Planning Manager, previously the Trust's Police Liaison Advisor. The post holder is both a qualified mental health nurse and ex-police officer from the Metropolitan Police Service – his last post there being Mental Health Liaison officer for Hackney Police.

The post holder is also the Trust's Local Security Management Specialist (LSMS) and sits within the Risk and Governance Department.

Since the appointment of the Trust's Security and Police Liaison Advisor (now called Health, Safety, Security and Emergency Planning Manager) there continues to be a marked increase in reporting of incidents to the police.

For the period of 2021-22, 507 incidents of violence and aggression were reported to the police for further investigation – this was a decrease from 596 for 2020-21. The Health & Safety team continues to monitor the progression of these police investigations to ensure they are proportionately investigated and are not closed inappropriately. Furthermore, there continues to be an improvement in the support available to staff and patients who are victims of assault. This has ranged from support when reporting incidents to police right up to and including support whilst giving evidence at court.

9.2 Metropolitan Police Mental Health Liaison Teams

The Trust continues to maintain and develop very close collaborative working relationships with the relevant London policing boroughs.

Hackney and Tower Hamlets policing Boroughs have now merged to form the Central East Basic Command Unit (C.E. BCU) whilst Newham and Waltham Forest Police Forces merged to form The Northeast Basic Command Unit (N.E. BCU).

Each BCU attends a bi-monthly police liaison meeting held in each borough where a range of topics are discussed, issues raised and lessons learnt – this would range from section 136 (police) detentions, presentations at A&E, section 135 MHA Assessments, and incidents on our inpatient wards. These meetings provide a forum with which to ensure that any collaborative work between ELFT and the Metropolitan Police Service (MPS) supports both staff and service users.

Currently C.E. BCU consists of a sergeant and two police officers for incidents occurring in Forensics, City & Hackney and Tower Hamlets. They do not investigate any of the crimes but will generally facilitate a response. The investigations would be carried out by the initial response officers – unlike previously when they would have been carried out by a dedicated team of investigators. Additionally, there is a single supervising point of contact for all crimes reported within mental health services in City & Hackney and Tower Hamlets. Below is the current work stream to further develop ELFT's collaborative work with C.E. BCU.

N.E. BCU currently has one MH liaison officer who is part of their safeguarding team. She has recently been appointed to the post and has established monthly crime management meetings with senior staff at Newham Centre for Mental Health as well as engagement work with the young people at the Coborn Unit.

There has been an emerging issue of individuals who have committed a serious offence, such as grievous bodily harm, whilst acutely unwell and the police are either not arresting and simply detaining on Section 136 Mental health Act or initially arresting for the serious offence but then de-arresting on arrival at the police custody suite – subsequently no police investigation is being carried out. There have been three such recent incidents for this period. These have all resulted in the individuals requiring forensic admission. Such circumstances place our staff and others in a high-risk situation. In addition, involving the criminal justice system in such circumstances, has clear advantages in the future management of risk.

This has been escalated to senior officers at the Metropolitan Police which has resulted in an initial meeting with senior police officers and Trust senior management to reach a resolution for such future cases as well as a defined escalation process to ensure that all risk information is communicated in a timely manner.

Furthermore, the quarterly senior police liaison meeting with the Trust will be re-established to ensure continued collaborative working at a strategic level.

9.3 Operation Cavell

Following a three-month pilot, the NHS, MPS and Crown Prosecution Service (CPS) launched Operation Cavell in May 2021 with the aim to protect NHS staff from risks of both physical and verbal aggression. As well as senior police officer involvement in reviewing all assaults, senior NHS staff will be included to support those who have been a victim of such crimes.

This multi-agency response to ensure safety and security for both our staff and service users will further build on our current relationship with the MPS. We are currently in the process of establishing a local implementation plan together with our police mental health liaison teams to embed this into the Trust.

9.4 Bedfordshire Police

In July 2019, the Bedfordshire Police Mental Health Hub was formed. This Hub was born from an already excellent relationship between Bedfordshire Police and ELFT who had formed the Mental Health Street Triage Team and Liaison and Diversion services. Bedfordshire's Police and Crime Commissioner supported the Hub with funding to make this happen. The vision was to bring together all mental health practices linked to Police and Mental Health Services under

one team to support vulnerable members of our community. The aim was that a more collaborative approach would ultimately result in a better outcome for service users.

The Hub connects a range of services including the Street Triage Team, a mental health nurse in the Force Contact Centre who provides advice to officers attending mental health incidents, and a Mental Health Crime Investigation Officer.

Covering Luton and Bedfordshire, there is a joint police and health-led monthly Mental Health Operational Deliver Group and a quarterly Mental Health Strategic Group with service user, third sector, commissioner, ambulance service and emergency department representation. These in turn feed into the Crisis Care Concordat Strategic Group meetings.

9.5 Mental Health Crime Investigation Officer

Bedfordshire Police has its own Mental Health Investigator who has been in the role since February 2020. He forms part of the Bedfordshire Police Mental Health Hub and works directly with the Trust's inpatient sites across the county, providing direct support to mental health inpatient staff and service users.

The aim was for him to work collaboratively with ELFT to ensuring that staff can work, and patients recover, in a safe and secure environment. His role has been to provide a visible police presence to staff and service users, provide a single point of contact for mental health inpatient teams and to investigate any incidents of anti-social or criminal behaviour.

He follows through investigations – including any racially aggravated incidents affecting staff or patients – and helps with education and awareness.

The methodology used is to create a uniformed community policing type presence on the wards where both staff and service users can have equal access to him and thus building professional relationships and rapport. Service users soon became used to seeing an officer on the wards, with an overwhelming positive reaction from service users who saw the officer as independent from ELFT and who they could reach out to for advice on almost any topic. He also attends service user community meetings with the service users' consent.

He also facilitated an increase in reporting of crimes to the police which should be seen in a very positive light as this significant increase in the reporting of incidents by staff and patients is due to the increased confidence in the process. This was one of the key aspirations for introducing the role. He also investigates each alleged incident, providing support to both staff and patients and ensuring that the outcome of the investigation is proportional and appropriate.

Such partnership working between the police and mental health services can transform patients' lives, improve the experience of staff as well as improving the quality of life for the community.

In recognition of this partnership work, we were awarded the Violence Reduction Initiative Award from the National Association for Healthcare Security (NAHS) for both 2020 and 2021.

9.6 Joint Mental Health Training (Bedfordshire Police)

ELFT currently support Bedfordshire Police with their two-day mental health training for the Initial Police Learning Development Programme for police recruits. Day one is trainer led with representation from collaborative work streams – Mental Health Street Triage, mental health nurses in the Force Control Centre and Police MH Investigator in mental health settings.

Day two concentrates on improving understanding of those with mental health disorders and how to engage with them as police officers. Bedfordshire and Luton Recovery College support Bedfordshire Police providing an insight into mental health disorders, how to recognise signs

and how to open conversations. As we begin to move out of restrictions the People Participation Team at ELFT will be invited to share their lived experiences of mental health with the officers.

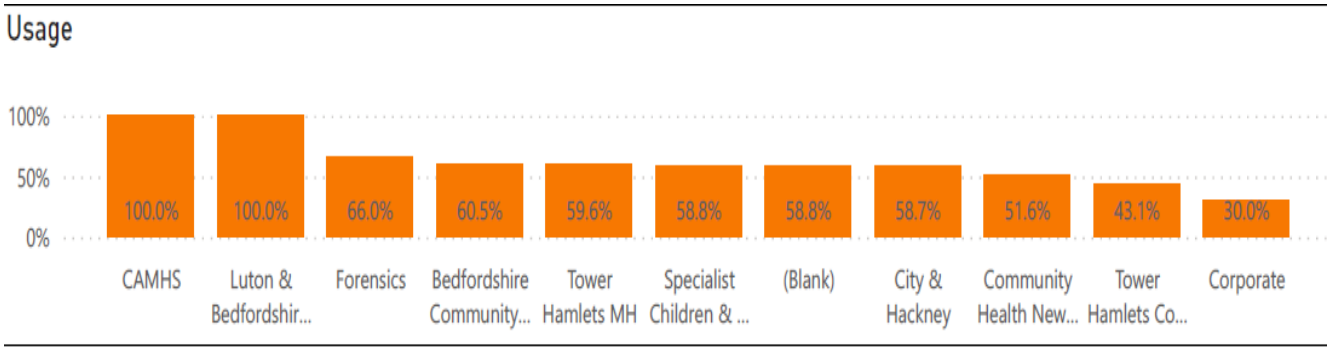
ELFT staff within the Bedfordshire Police Mental Health Hub have also supported the police with several bespoke training days for response officers and the Force Contact Centre.

10.0 Lone Working

There has been a drive to improve Lone Worker safety at ELFT, with the development of new safety initiatives and encouragement of improved protocols and practice. Part of this drive has included the dissemination of Peoplesafe Lone Worker Apps across our services which have replaced our previous lone worker devices.

This new app with the latest GPS technology tracks the whereabouts of staff and includes an alarm system to support safe working with patients out in the community. Any alarm calls are sent to controllers at an incident management centre who can use the device to have a two-way conversation with the user or listen to what is happening. They can then decide a course of action, for example calling the emergency services. The application can also be used in conjunction with a Bluetooth Smart Button accessory for an even easier, more discreet personal protection.

Staff identified as a lone worker have been provided with the app and have received the relevant training by the Health & Safety Team in both their use and administration. The chart below shows the current percentage compliance by directorate for 2021-2022.



We currently have 1105 lone workers who have uploaded the app. To further increase compliance, the Health & Safety team have carried out the following actions:

- Worked collaboratively with the Peoplesafe communication team in overseeing the uploads of users and presenting compliance reports for each individual service.
- Contacting both service leads and individual staff to offer support to those staff still to upload the app and escalating where appropriate.
- The H&S team regularly attend local health and safety meetings of all the directorates to raise awareness and to present compliance reports.
- Single points of contact for each directorate have been identified and a series of online training has been provided to these individuals to enable them to access their team portals. This enables them to compile reports with a view to further improve uptake and usage of the app – allowing local teams to take ownership.
- A rolling and extensive training programme being provided to end users and Peoplesafe leads in directorates

To date, Trust-wide compliance for the Lone Worker App is at 73% which is a slight increase from 70% for the same period last year.

11.0 Monthly Health & Safety Bulletin

The H&S Team are now publishing a series of monthly newsletters on the trust's intranet entitled '**ELFT and SAFETY** 'highlighting and focusing on key features of managing health and safety risks including use of the Peoplesafe app, Display Screen Equipment advice as well as sharing staff stories. The first edition celebrated Health & Safety at Work Awareness Day 2022.

12.0 Health, Safety and Security Inspections

Each area/ward/department is required to undertake an annual health, safety and security inspection, usually being carried out by each risk officer. The risk officer training has been revised to ensure it meets current legislation and requirements. Currently, the findings are reported both locally and at corporate Committees. This provides a framework for actions to be undertaken to maximise the delivery of a safe workplace.

The common concerns raised are:

- Across directorates, a small number of teams have been identified as having no identified risk officers in place or with a requirement for refresher training – risk officers will be confirmed for each site and training provided by the Health & Safety Team as part of the workplan for 2022-23.
- A small number of teams across the Trust have requested up to date HSE law, LSMS or Trust anti-violence posters for their sites – the H&S team are distributing Trust posters to sites for completion by August 2022.

13.0 Workplace Risk Assessments

Workplace risk assessments (WPRA) must be carried out under Regulation 3 of Management of Health and Safety Work Regulations 1999. There is a legal requirement for every employer to assess health & safety risks arising out of their work and these must be recorded.

These have been completed for sites in the Trust and have now been reviewed considering the additional risks from the COVID-19 pandemic. Where services and sites were closed due to the pandemic, the Health & Safety team are now supporting teams in reviewing their risk assessments to ensure that their workplace is safe, especially in relation to covid. Further training will be provided to the health and safety risk officers to ensure these are continually reviewed as central guidance changes.

Whilst services have completed their workplace risk assessments, work is still required to ensure that there are no gaps and that any risk assessments are indeed reviewed and updated when required. The Health and Safety team are working closely with local services to identify any such gaps.

In addition, the following actions have been taken to address this:

- This has been added as a standing agenda item at local H&S meetings for gaps to be identified and for support to be offered to sites to either complete the WPRA or to assist in any review.
- The completed WPRAs are currently held within a shared drive centrally as well as being held locally. The H&S team have created a live SharePoint document on MS Teams to provide assurance and governance of completed assessments. The leads of each directorate have been given access to upload and declare when risk assessments have been completed for their sites.

- An online health & safety software system is being considered to digitalise this process. This will streamline our risk assessments and simplify how we identify hazards and assess and manage risk, whilst increasing staff engagement with health & safety.

14.0 Remote working/Display Screen Equipment

As an employer, we have the same health and safety responsibilities for home workers as for any other workers. To assist our staff who worked from home during the pandemic, the remote working guidance was created in collaboration with People & Culture and the H&S team.

Staff are encouraged to complete the Display Screen Equipment (DSE) Assessment training package on the Learning Academy as well as conducting a self-assessment of their workspace. Any identified equipment required could then be ordered through the agreed Trust process.

15.0 Training

15.1 Health & Safety/Security awareness

The Trust provides several e-learning courses for this area via its Learning Academy including H&S Awareness and Display Screen Equipment Use. The courses are determined by the roles the individual staff member carries out and are pre-agreed by their line manager and the Training and Development Team.

The H&S Team also carry out several bespoke training sessions, namely for H&S risk officers and staff who are lone workers.

15.2 Fire training

There are two alternative pathways for fire training dependent on staff responsibilities, namely ward-based and non-ward-based staff

The structure of training is as follows:

Fire Training	Structure	Content
Fire Safety Mandatory for non-ward-based staff)	• Annual requirement • E-learning programme	• Fire awareness • Fire extinguisher (theory)
Fire Warden Designated staff for non-ward areas / departments / out-patient premises	• Two yearly qualifications • At central venue or online • 1 hour • With Fire Safety Advisor	• Fire awareness presentation • Disability equipment familiarisation • Fire extinguisher familiarisation
Fire Competency Assessment (FCA) All ward-based nursing staff	• On induction to the ward then at 6-monthly intervals • With line manager in supervision /	Q & A on all aspects of fire safety: • Fire alarm system and local operational procedures • Duties and responsibilities in relation to fire incidents on the site of employment • Fire extinguisher (theory)

Fire Training	Structure	Content
	appraisal meeting at site of employment	
Fire Course (ward staff) All ward-based nursing and OT staff	• Annual qualification • On site or online • 1 hour • With Fire Safety Advisor	• Fire awareness presentation • Local fire procedures • Disability equipment familiarisation • Fire extinguisher familiarisation

Those with direct responsibilities for patient welfare and safety, undergo a higher standard of training in response to the high-risk environment of mental health in-patient facilities. All courses for ward-based staff are site specific and are currently organised locally according to need.

16.0 Progress against Work plan 2021/22

KEY ACTION	STATUS AS AT 31/03/2022
Review all policies relating to health & safety to ensure they reflect current guidance and legislation.	Completed
Quarterly/exception reports to Quality Committee	Completed
RIDDOR reports submitted to timescale	Completed
Risk facilitators and officers in place	Carried forward
Risk officer training needs analysis completed, and training completed	Completed
Ensure completion of all annual H&S environmental inspection forms	Completed
Ensure review of all workplace risk assessments considering COVID-19.	Completed
Full implementation of Peoplesafe Smartphone App alarm	Completed
Delivery of Peoplesafe smartphone app training and webinars	Completed
Delivery of staff safety workshops to community staff	Carried forward

16.1 Key Achievements

- Trust-wide implementation of Peoplesafe lone working smartphone app.
- Delivering a full health & safety service despite enhanced work of the emergency planning manager during the covid pandemic.
- Providing increased support to services who have a seen a rise in violence and aggression.
- Awarded the Violence Reduction Initiative Award from the National Association for Healthcare Security (NAHS) for both 2020 and 2021.

Note: Due to the pandemic, there was a delay in achieving 100% uptake of the Peoplesafe smartphone app. However, there is an action plan in place to address this.

17.0 Key Priorities to be taken forward during 2022-23

Key Action	Outcome measure	TCD	Lead
Review all policies relating to health & safety to ensure they reflect current guidance and legislation.	Approved Trust wide policies in place.	December 2022	H&S Manager
Quarterly/exception reports to Quality Committee	Submission of reports	Ongoing	H&S Manager
RIDDOR reports submitted to timescale	Submitted to HSE to timescale	Ongoing	H&S Manager
Risk facilitators and officers in place	All officers in place for the sites	July 2022	H&S Manager
Risk officer training review and delivered	Training delivered and attendance recorded	July 2022	H&S Manager
Ensure completion of all annual H&S environmental inspection forms	Completion of all annual H&S inspection forms	July 2022	H&S Manager
Ensure review of all workplace risk assessments considering COVID-19.	Completion of review of all workplace risk assessments	August 2022	H&S Manager
Continued implementation of Peoplesafe Smartphone App alarm	Trust wide implementation completed.	September 2022	H&S Manager / IT
Delivery of Peoplesafe training Webinars	Delivery of webinar	September 2022	H&S Manager
Delivery of staff safety workshops to community staff	Workshops delivered and attendance recorded	October 2022	H&S Manager
Procurement of software package to manage workplace risk assessments	Software package in place	September 2022	H&S Manager / IT
Co-lead on QI project to improve reporting of assaults to police	QI team in place with presentable data	September 2022	H&S Manager / Ward team

17.1 During 2022/23 the Health and Safety advisor will undertake QI training and will lead on a QI project for the team.

17.2 In order to deliver our forthcoming plan the Health & Safety team will engage with Staff side, Clinical services, Estates, Infection Control Team and People & Culture throughout the year and formally at the Health, Safety & Security Committee.

18.0 Action

18.1 The Committee is asked to RECEIVE and APPROVE the report and the associated work plan for 2022/23 set out in section 17.

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QUALITY ASSURANCE COMMITTEE - 27 JUNE 2022

Title	Mental Health Law Annual Report
Author	Guy Davis - Associate Director of Mental Health Law
Accountable Executive Director	David Bridle – Interim Chief Medical Officer

Purpose of the report

Provide an update on mental health law related activity in 2021-22 and to set out work-plan for 2022-23.

Summary of key issues

This annual report sets out the Trust's management of/performance within the mental health law framework, legal developments and future priorities.

Although MHA activity has been broadly similar to activity last year, there is an emerging challenge with S136 activity (resulting in some patients being detained in Health Based Places of Safety beyond statutory time limits). This issue is being actively monitored and addressed through the Mental Health Law Monitoring Group.

The Trust has procured and is currently in the process of implementing Thalamos, an end-to-end digital Mental Health Act solution which is an exciting innovation that will free up staff time in our services by reducing administrative tasks and ensuring safer, more efficient Mental Health Act administration.

In terms of legal developments, work has been taking place in the Trust implementing the Mental Health Units (Use of Force) Act 2018, which took effect from 31 March 2022. Plans will also need to be put in place to implement the new Liberty Protection Safeguards (which will replace DOLS) when the final code and regulations are published (potentially after the end of 2022) – this will be a significant future piece of work.

Strategic priorities this paper supports

Improved population health outcomes	☒	See work plan at 3.1
Improved experience of care	☒	See work plan at 3.1
Improved staff experience	☒	See work plan at 3.1
Improved value	☒	See work plan at 3.1

Committees/meetings where this item has been considered

Date	Committee/Meeting

Implications

Equality Analysis	The report has no direct impact on equalities.
Risk and Assurance	The report highlights what the Trust needs to be doing to assure itself that service users are cared for within the legal framework.
Service User/Carer/Staff	The report emphasises the need for staff to understand the legal framework within which they work and what that means for service users in practice.
Financial	The report highlights potential future resource requirements.
Quality	Work plan identifies some of the means to drive up quality re working within legal frameworks.

Supporting documents and research material

Abbreviation	In full
AHM	Associate Hospital Manager
CQC	Care Quality Commission
CTO	Community Treatment Order
DoLS	Deprivation of Liberty Safeguards

HM	Hospital Managers
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983
LPS	Liberty Protection Safeguards
Tribunal	First-Tier Tribunal (Mental Health)
Use of Force Act	Mental Health Units (Use Of Force) Act 2018

1.0 Background/Introduction

1.1 The Mental Health Law (MHL) department assists in ensuring that the Trust manages its responsibilities in relation to the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (MCA), the MCA Deprivation of Liberty Safeguards (DoLS), and related legislation and case-law, and that the Trust's practitioners provide all care and treatment in accordance with the relevant legal framework. It is a corporate department and the executive lead is the Chief Medical Officer.

1.2 The MHL department is managed by the Associate Director of Mental Health Law assisted currently by the Lead Nurse in Mental Health Law (the designated Trust lead for the MCA and DoLS). There are a further twenty-one staff who administer the MHA & DoLS and provide legal advice/support to clinical teams and other stakeholders.

1.3 The function of the Hospital Managers power of discharge set out in section 23 of the MHA, is managed by the Associate Director and overseen by the Mental Health Act Sub-Committee which is chaired by the Trust Chair. The consideration of whether or not to discharge patients from detention and Community Treatment Orders (CTOs), is a function that cannot be carried out by any employee of the organisation, so it is carried out by the Trust's appointed Associate Hospital Managers (AHMs). As of 31st March 2022 there were thirty appointed AHMs and the Trust once again extends its thanks for the valuable service that these volunteers give.

1.4 All other mental health law functions are overseen by the Mental Health Law Monitoring Group which reports to the Trust's Quality Committee. The MHL Monitoring Group is in place to:

- Have oversight of all local and national mental health law related developments and to refer to relevant committees and individuals as appropriate;
- Monitor, plan and implement relevant new legislation, case-law and guidance;
- Monitor the administrative and clinically-facing elements of the Mental Health Act, Mental Capacity Act, Deprivation of Liberty Safeguards and associated legislation, case law and guidance;
- Monitor and act on mental health law issues identified by the Care Quality Commission's inspectors;
- Draft and review all mental health law related policies;
- Review all policies that contain mental health law related directions;
- Assist in identifying what the Trust needs to be assured of (i.e. through CQC reports),
- Identify how data should be gathered and presented, identify trends and ensure accuracy of reports prior to submission to committees and the Trust Board;
- Review the findings of other relevant organisations.

1.5 The general MHA functions of the Trust are covered in chapter 37 of the 2015 version of the MHA Code of Practice, whilst the Hospital Managers power of discharge is covered in chapter 38.

1.6 The COVID-19 pandemic continues to have a practical impact on a number of mental health law related functions; all of which are overseen by the MHL Monitoring Group. These included:
- Tribunals being conducted via their bespoke video service;
- Hospital Managers hearings being conducted via Teams video;
- Second Opinion Appointed Doctors from the CQC performing their function remotely;
- MHA Reviewers from the CQC performing their function remotely, but then recently returning to some face to face visits after establishing an absence of covid cases in the relevant area.

1.7 Through Service Level Agreements, the department also provides Mental Health Act administration for the Royal London Hospital, Barts Hospital, Newham University Hospital, Homerton University Hospital, Luton & Dunstable Hospital and Bedford Hospital.

1.8 The Mental Health Act Sub-Committee was reconfigured in 2021 and now reporting to the Mental Health Law Monitoring Group it is known as the Associate Hospital Managers Forum. This forum chaired by the Chief Medical Officer, has the singular responsibility of overseeing the function of the Hospital Managers (HM's) power of discharge that is found in section 23 of the MHA; including policy and guidance development, appointment of Associate Hospital Managers and case discussion. The HM's power of discharge can only be exercised by three (in the majority) non-executive directors or other people appointed for the purpose who are not employees of the Trust (known as Associate Hospital Managers).[1] Patients subject to compulsory powers may ask for a review at any time, but there is discretion exercised by the 'executive' in the Trust as to if and when a review will take place.

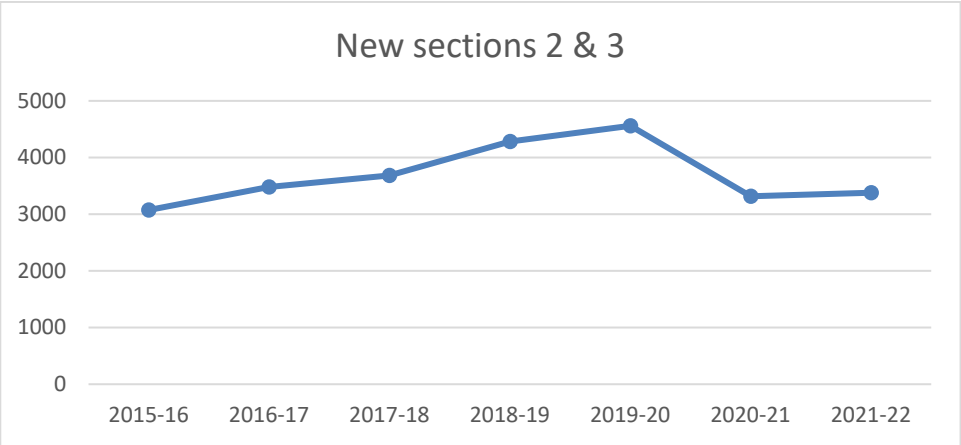
1.9 The above function is distinct from the First-Tier Tribunal (Mental Health), which is a branch of Her Majesty's Court & Tribunal Service overseen by the Ministry of Justice and wholly independent of the responsible Trust (therefore satisfying the United Kingdom's obligation to satisfy Article 5 of the European Convention on Human Rights; right to an independent and speedy trial). Unlike the HM's power of discharge, the Tribunal's proceedings are governed by the MHA with a formal framework of statutory rules, regulations and practice directions. Patients may appeal to the Tribunal once within certain defined time periods, and those who do not appeal are referred by the Trust at intervals fixed by law.

1.10 In 2022-22, there were no patients discharged from detention via the HM's power (same in in 2020-21) and 1 discharged from a community treatment order (none in 2020-21). Overall, 281 HM's review episodes were started with 153 reviews taking place. See comparison with Tribunals in table below (2020-21 in brackets).

	Episodes started	**Number of Reviews that took place**	**Discharge from detention**	**Discharge from CTO**
Hospital Managers	281 (284)	153 (146)	0 (0)	1 (0)
Tribunals	1033 (1049)	394 (571)	38 (47)	1 (3)

1.11 As per the charts below, MHA activity was broadly similar to activity during the previous year (when there was a significant reduction in detention episodes under sections 2 and 3). There was an emerging challenge with s.136 activity linked to challenges facing the Trust's in-patient service provision, resulting in some patients being detained in our health-based places of safety (sometimes in emergency departments) beyond the statutory time limits. The Mental Health Law Monitoring Group is overseeing this and is receiving monthly exception reports on specific cases to consider how best to escalate and resolve those cases and prevent future adverse incidents.

[1] Section 23(6) Mental Health Act 1983


New sections 2 & 3
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4000
3000
2000
1000
0
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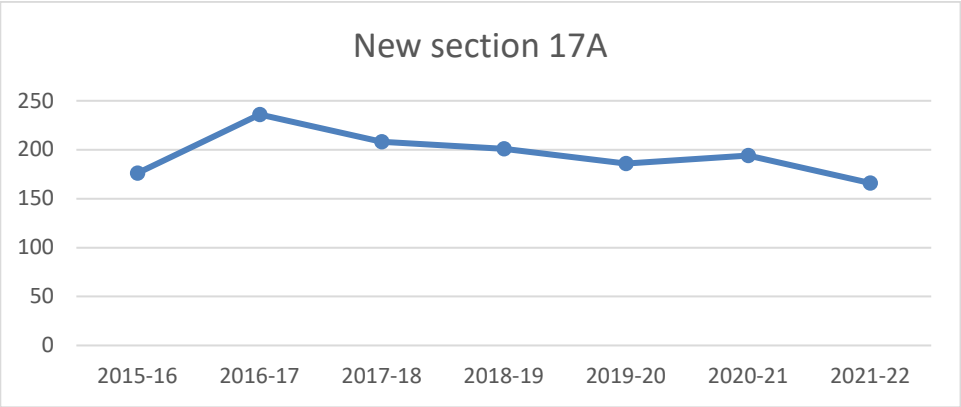
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22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2016-17
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2018-19
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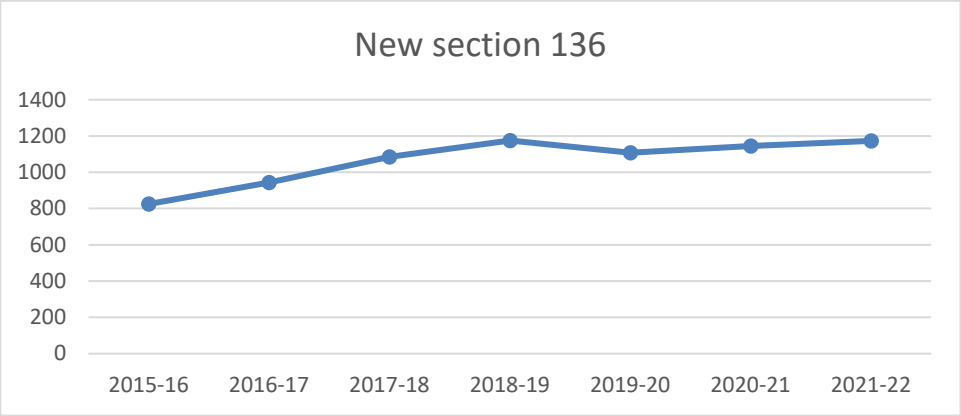
2020-21
2021-22


New section 136
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2015-16
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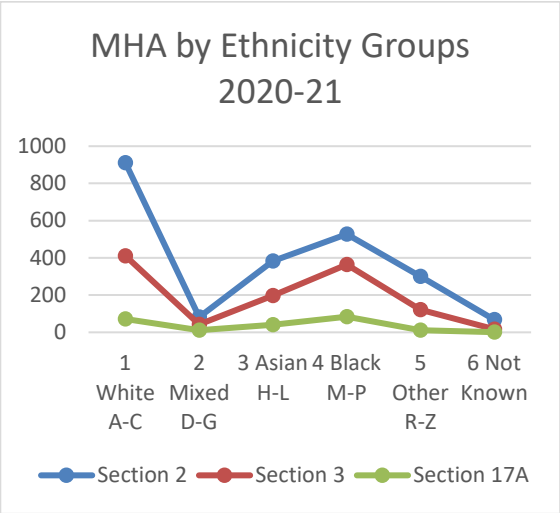
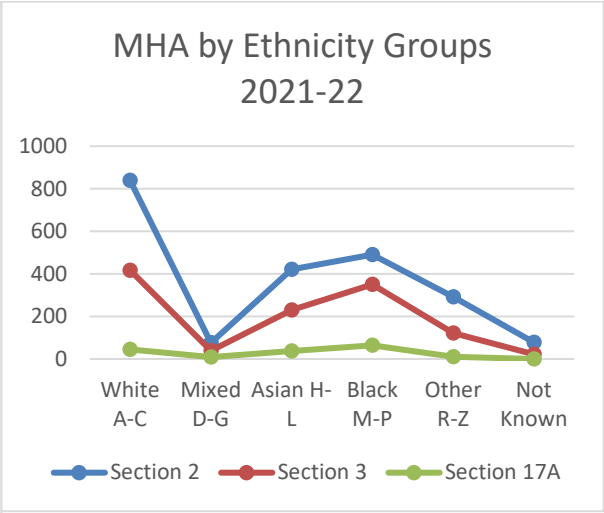
2017-18
2018-19
2019-20
2020-21
2021-22


MHA by Ethnicity Groups 2020-21
1000
800
600
400
200
0
1 White A-C
2 Mixed D-G
3 Asian H-L
4 Black M-P
5 Other R-Z
6 Not Known
Section 2
Section 3
Section 17A


MHA by Ethnicity Groups 2021-22
1000
800
600
400
200
0
White A-C
Mixed D-G
Asian H-L
Black M-P
Other R-Z
Not Known
Section 2
Section 3
Section 17A

1.12 Deprivation of Liberty Safeguards Data for 2021-22 (2020-21 in brackets)

:

Area	Number of Applications made:	Number Granted:	Number in Place 31/03/22	Applications Outstanding 31/03/22
Bedford Borough Council	20 (32)	9 (21)	3 (1)	1 (2)
Central Bedfordshire Council	11 (10)	5 (5)	0 (0)	3 (0)
Luton Borough Council	12 (9)	2 (1)	2 (0)	1 (0)
LB Hackney	10 (7)	8 (4)	2 (0)	1 (2)
LB Newham	24 (14)	14 (11)	6 (3)	4 (0)
LB Tower Hamlets	12 (4)	6 (0)	3 (0)	0 (1)
Out of Area	2 (1)	0 (1)	0 (0)	0 (0)
Total	**91 (77)**	**44 (43)**	**16 (4)**	**10 (5)**

1.13 As of 31/03/2022, 26 DoLS authorisations were active, 16 standard authorisations were in place and 10 'urgent' applications were pending and awaiting outcome. On average it took 3 to 4 weeks for outcomes and authorisations to be reached. Factors for non-authorisations included patients being discharged prior to an outcome, patients placed under MHA section in the meantime and patients being transferred to different wards/sites, necessitating fresh applications being made.

1.14 Legal Developments during 2021-22

- On the back of the white paper public consultation in 2021, through 2021 and 2022, the Department of Health and Social Care held a number of private consultation sessions on specific potential reforms to the MHA, in which the Trust had some representation. It is still unclear as to exactly what some of the reforms will be or the specific detail of some of the reforms that we know are likely to be put forward. A (draft) Bill is expected during 2022 which should mean any changes are likely to come into effect no earlier than 2024/2025. The MHL Monitoring Group continues to oversee developments.

- The Liberty Protection Safeguards which replace the DoLS, were scheduled to come into force in April 2022, but delays in producing an accompanying draft code of practice and associated draft regulations means that this has been put back again with no indicative date given. However, at the time of writing the draft code and regulations have been published with a public consultation running until 7th July 2022, so implementation is unlikely to be before the end of 2022. Plans for implementation in ELFT are being overseen by the MHL Monitoring Group.

- Further to a number of previous annual reports, the Mental Health Units (Use Of Force) Act 2018 took effect from 31st March 2022 after guidance was published at very short notice. The Trust established an implementation group chaired by the chief medical officer to identify gaps and take steps to address them and the nursing directorate are incorporating the Acts provisions into existing Trust policies.

2.0 Progress against work-plan during 2021-22

As noted in the previous year's annual report, the pandemic and uncertainty over potential legislative changes meant that work-planning was somewhat tentative, but some of the broader issues that were identified as needing to be addressed during 2020-21 were:

- Shaping the future of the MHL department including staff development, 'Enjoyment at Work' and well-being;
- Development of digital solutions; including for things like patient's Hearings;
- Development of MHL reports to assist with clinical improvement work;
- Training needs analysis review and training provision;
- Monitoring and communication of mental health legal developments (see 1.13 above).
- Co-Production

2.1 The key achievements:

- Shaping the future of the Mental Health Law department has been challenging in terms of short and long term planning; in part due to the two most senior managers being about to leave the Trust in June and July 2022. However, in light of that and the operational changes that needed to be made anyway, some temporary measures have been put in place to ensure that the department continues to run smoothly and sufficient assurances re mental health law can be given going forward.
- Some successful 'enjoyment at work' developments were made during the year (i.e. setting aside time for the 20 or so members to meet up and engage in fun/team-building exercises) and these are being embedded into the department going forward.
- The pandemic instilled a far greater awareness of the need for 'well-being' to be higher up on the department's general agenda and this forms a standing item on agendas at all levels.
- Digital ways of working in respect of patient's hearings are now well established for both Tribunals and Hospital Manager's reviews and there are no plans to reintroduce face to face hearings for either at the time of writing.
- The Trust has now procured and is implementing, an end to end digital Mental Health Act solution (Thalamos), giving the Trust the ability to manage internally and externally generated MHA documents through a central electronic hub; making administration of the MHA a lot easier, quicker and safer (i.e. in terms of documents going missing and containing significant errors) and with a view to making MHA reporting easier and more accessible. This product has also been adopted by the CQC for their SOAD service, the Metropolitan Police for section 136 episodes and other Trusts in England. It will also interface with the Trust's electronic patient records system(s) and e-prescribing package.
- Steps to improve co-production have been taken with the establishment of mental health law service-user and carer groups.

2.2 Some of the unmet challenges:

- A small amount of progress was made with the development of MHL reports for Trust oversight using Power BI, but once again, very little in respect of assisting with clinical improvement work. A more focussed approach with key stakeholders is required if this work is to make any further progress, which the Mental Health Law Monitoring Group can assist with.
- Work began on establishing a mental health law communications strategy, but stalled due to competing priorities. The MHL department will pick this up and work with the MHL Monitoring Group.

3.0 Work-plan for 2022-23

3.1

No.	Key Priorities	Key Milestones	Lead(s)	What corporate/DMT is required?	Expected Delivery date / Progress
1	Assist executive, multi-disciplinary and clinical teams to develop meaningful mental health law data reports to improve care.	Report requirements identified by forums, MHL staff assist in production and validation.	MHL Managers	Produce in partnership with relevant clinical and management leads.	31/03/2023
2	Identify and implement enhanced means of communication re MHL matters.	Establish a MHL communications strategy.	Associate Director of Mental Health Law	Communications Team.	31/12/2022
3	Monitor and prepare for implementation of Liberty Protection Safeguards.	Finalise outline project plan; Upon government's response to LPS and MCA Code of Practice consultation, produce outline LPS summary for Trust.	Associate Director of Mental Health Law and Deputy		31/12/2022
4	Continue to assist in roll-out of Thalamos MHA digital for ELFT and partner practitioners.	See ELFT / Thalamos Implementation Group reports.	Associate Director of Mental Health Law	Digital systems, directorate and clinical managers.	Various and on-going for the time being
5	Finalise the workforce establishment of the MHL team.	Review current temporary structure arrangements and associated operational requirements; Finalise work-base requirements; Undertake necessary reorganisation.	Associate Director of Mental Health Law		31/03/2023

3.2 Reports on progress will be made via the MHL Monitoring group and escalated and adapted accordingly.

3.3 The work plan will be contingent on potential financial resourcing implications, both in respect of local savings requirements and legislative impacts. Financial impacts will have to be weighed against the risks associated with day to day running of the Mental Health Law department, day to day assurance and the associated implementation and roll–out to clinical services of potentially major legislative changes.

4.0 Action Being Requested

4.1 The Board/Committee is asked to approve this report.

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REPORT TO THE QUALITY ASSURANCE COMMITTEE
27 JUNE 2022

Title	2021/22 Quality Accounts
Author	Duncan Gilbert, Head of Quality Assurance
Accountable Executive Director	Dr Amar Shah, Chief Quality Officer

Purpose of the report

To provide a final draft of the trust annual Quality Accounts for approval prior to publication.

Committees/meetings where this item has been considered

Date	Committee/Meeting

Key messages

The draft reviewed by the committee in May 2022 has been amended to reflect feedback received, wherever possible.

The document is now complete with the exception of the statement from commissioners in North East London. This is expected w/c 20th June and will be added as soon as received.

Strategic priorities this paper supports

Improved population health outcomes	☐	
Improved experience of care	☒	Quality accounts provide assurance regarding the meeting of strategic quality priorities
Improved staff experience	☒	Quality accounts provide assurance regarding the meeting of strategic quality priorities
Improved value	☐	

Implications

Equality Analysis	No immediate equality implications
Risk and Assurance	The report provides assurance in relation to production of a Quality Report document that is of good quality and compliant with statutory requirements. Failure to deliver this would have a negative impact on the reputation of the trust.
Service User/ Carer/Staff	No direct implications
Financial	There are no direct financial implications
Quality	The Quality Report is an important means of sharing information about the quality of services provided by the trust

1.0 Action Being Requested

1.1 The Committee is asked to **RECEIVE and APPROVE** the report.

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QUALITY ACCOUNTS 2021/22

East London NHS Foundation Trust

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Contact with the Trust

If you require any further information about the 2021/22 Quality Accounts please contact: ELFT Communications Team on 0207 655 4000

Services and Developments 2021/22

Our Services

East London NHS Foundation Trust (ELFT) provides a wide range of community and inpatient services to children, young people, adults of working age and older adults to the City of London, Hackney, Newham, Tower Hamlets, Bedfordshire and Luton. Additionally, we provide Talking Therapy Services in Richmond. We also provide primary care services in two GP practices in Bedfordshire along with primary care services to homeless people from three practices, one each in Tower Hamlets, Hackney and Newham.

The Trust provides forensic services to the City of London and the London Boroughs of Hackney, Newham, Tower Hamlets, Barking and Dagenham, Havering, Redbridge and Waltham Forest. The specialist Forensic Personality Disorder Service serves North London.

The Trust's specialist Mother and Baby Psychiatric Unit receives referrals from London and the South East of England.

ELFT provides local services to an East London population of 820,000 and to a Bedfordshire and Luton population of 630,000. We provide Forensic Services to a population of 1.5 million in North East London. East London is one of the most culturally diverse parts of the country but is also one of the most deprived areas, as is Luton. The county of Bedfordshire is a predominantly rural area with some of the most affluent communities in the country living alongside some of the most low-income and deprived groups. Both areas therefore pose significant challenges for the provision of mental health, community health and primary care services.

The Trust operates from over 100 community and inpatient sites, employs just over 6500 permanent staff and has a total annual income of £552million. The Trust provides Mental Health, Community Health and Primary Care services. Mental Health Services provide the greatest proportion of ELFT income, however current ‘block’ funding arrangements, instituted in response to the COVID pandemic mean it is not currently possible to calculate a breakdown of income by service type.

As during 2020/21 the Covid19 pandemic has cast a shadow over the country, and impacted on all health providers, with 2021/22 bringing some sense of consolidation and recovery as the year progressed.

Increasing integration of services, and greater partnership working, has continued apace, exemplified by the Mental Health Community Transformation project taking place across East London and Bedfordshire.

The project aims to deliver:

More joined-up care
We've been working more closely with Primary Care, Local Authority and Voluntary, Community and Social Enterprise (VCSE) partners to deliver more integrated and flexible care, to better support people with their mental health as well as to address some of the wider determinants of their health.

Care closer to home
We've been developing a more localised model of care built around neighbourhoods, and bringing care closer to home. By building our partnerships we're also able to offer more treatment and support in primary care or community settings.

Tackling inequalities
By working in closer partnership with service users and local communities, we've been able to focus on tackling some of the inequalities in access, experience and outcomes that some groups face.

Coproduction
Bringing these different partners together with people who have lived experience of mental health services, we are aiming to embed a more coproduced and collaborative approach to how services are designed and delivered in the future

Over the course of 2021/22 we have been scaling up our new model of care from a handful of 'pioneer' sites, to being the standard model of community mental health care that is delivered across all 24 of our Primary Care Networks in East London. This means people accessing care today see a wider range of staff including new roles like Community Connectors, Clinical Associates in Psychology (CAPs), Mental Health Practitioners in Primary Care, and GP Mental Health leads.

Services are also working much more closely together to reduce people's experience of being 'bounced around'. By having frequent (sometimes daily) multi-agency mental health huddles, professionals have developed stronger relationships and improved communication, and enabled more timely access to joined-up care.
We have also invested in some brand new services, including a Community Eating Disorder service which will cover all three East London boroughs and will be opening later this year.

In support of our growing partnership approach, we have run two grant schemes with the support of Compass Wellbeing CIC – one was a microgrant scheme to support hyper-local organisations, and the other was a larger programme of Voluntary Sector investment with two focus areas – inequalities and resilience. The total number of grant recipients of these two programmes was over 50, and total investment approximately £1.9m, all of which is enabling really focussed and often innovative community-based support for residents.

The Transformation Programme within the East London NHS Foundation Trust provided an opportunity to identify and address the unmet mental health needs of BAME people within local communities in Tower Hamlets, Newham and City and Hackney.

Between February and March 2021, we ran a series of BAME "Let's Talk" focus groups in each of the three boroughs respectively. The aim of these groups was firstly to understand the experience of Black, Asian and minority ethnic people with lived experience of accessing mental health services, or caring for someone accessing services. And following on from

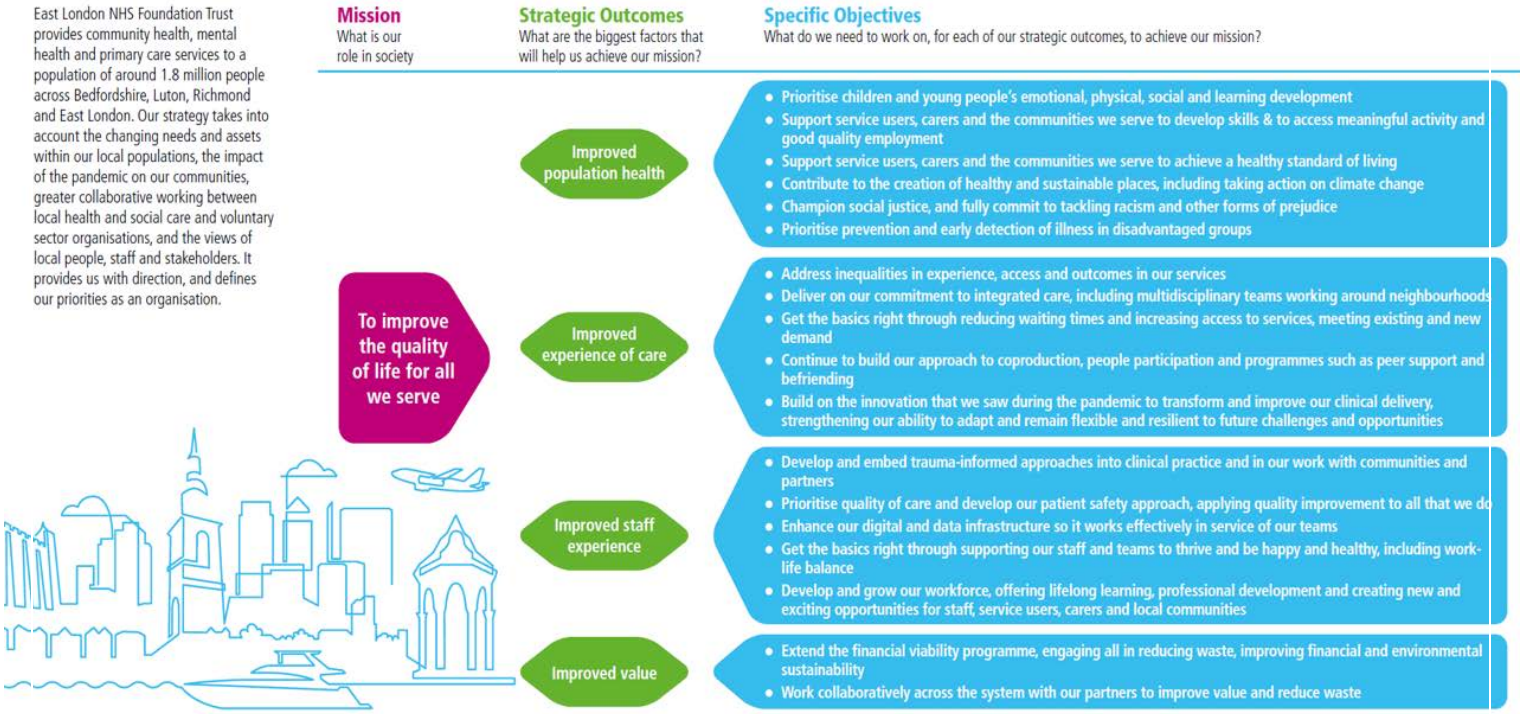
that understanding, to generate ideas for change, building on the momentum of the wider Transformation work within the Trust. We've also been fully focussed on delivering the recommendations of the 'Let's Talk' report, and each of the boroughs has a BAME Implementation Group established to oversee its delivery.

Our Trust Strategy

The ELFT Board commissioned a refresh of the Trust strategy in early 2021. Our existing strategy was developed in 2017 and reached through to 2022. Given the immense change and challenge brought by the pandemic, the advent of integrated care systems across England and the changing demographic and needs in our local communities, the refresh of our strategy ensures that we are adapting to our changing environment and focusing on the priorities of our service users, local communities and system partners.

Between June and August 2021, we undertook a 'Big Conversation' to engage a range of stakeholders, both within and outside the Trust, to help us understand what our priorities should be in a refreshed strategy through to 2026. We have utilised a range of methods (online workshops, paper forms, online survey, existing meetings) to engage key stakeholders in helping us understand where to focus in the future, and have heard from almost 400 people.

The new strategy that has been shaped by that big conversation retains the mission "To improve quality of life for all" and four strategic outcomes (improve population health, experience of care, staff experience and value – the triple aim) from our previous strategy – during the big conversation we had substantive feedback that these remain relevant and recognised by service users, staff and partners, and they align with the triple aim, which will become a statutory duty of NHS providers and Integrated Care Systems from July 2022.



Part 1 – Statements on Quality

1.1 Statement on Quality from Paul Calaminus - Chief Executive Officer

The 2021-22 financial year has been one in which working to improve service users experience of care and the health of the population have never been more important. The impact of COVID-19 has been felt not only directly as a result of the virus, but also in the way that this has affected the wider physical and mental health of the population. This has been true of our staff as well as those who use our services.

The Quality Accounts outline how we have approached our continued goal to improve the quality of life for all we serve, and how we have aimed to improve and develop our service offers, as well as to tackle some of the backlogs that have resulted from the impact of COVID-19. In doing so, we have continued to develop and implement new models of service, and to work in partnership with service users across the range of services that we provide. We have continued to work to embed quality improvement methodology, and to bring a focus on inequalities into our work across the Trust. We have continued too to provide support for our staff, many of whom have also experienced significant impacts as a result of COVID-19. It was pleasing to see this work recognised by the Care Quality Commission in both primary and secondary care services in the Trust.

We remain focused on how to improve services and the quality of life for all we serve; to learn lessons when things go wrong and make improvements; to continue to develop new services, working with those who use our services, and, through this work, to try and address inequalities in our local populations

1.2 Statement on Quality from Dr Amar Shah - Chief Quality Officer

I am pleased to introduce the quality account for East London NHS Foundation Trust for 2021-22. The year has continued to be dominated by the impact and response to the global pandemic, which has changed so much about our world, the lives of our local citizens and service users and the working lives of our staff.

We are immensely proud of the extraordinary lengths that our staff and service users have gone to, to support our local communities and keep people safe and well during the covid-19 pandemic. 2021-22 has been a year of rebalancing – ensuring we remain alert and responsive to the impact of covid, whilst also reorientating ourselves to a world in which we need to live with the virus.

We have been paying particular attention to ways of managing the increased demand that our services have been experiencing, both in our community-based services and for inpatient care, to ensure that people can access care and treatment when needed. Waiting lists for our services have grown over the last two years, as staff have understandably needed to prioritise their time and expertise to manage the acute phases of the pandemic. Our teams have adapted to innovative new ways of working, some of which offer us much potential to be able to support people more effectively and provide more access. We have been utilising our quality improvement capability to help us navigate this challenge, supporting teams to think creatively about potential solutions, rather than simply trying to work harder.

Whilst supporting our teams to rest and recuperate, to manage the longer waits and higher demand that we are experiencing, we are still maintaining our energy to innovate and push the boundaries of what an NHS provider can do, in order to improve outcomes for our local communities. 2021-22 has seen the emergence of exciting work to become the first 'Marmot Trust' in the country, working with our local partners in order to implement the eight Marmot principles to address inequity and create a fairer society. A new quality improvement programme on Pursuing Equity launched in April 2022, supporting teams to work with service users and carers in order to identify and tackle disparities in experience, access and outcomes. The community mental health transformation programme has extended to Bedfordshire and Luton, and is already testing a number of innovative ideas to ensure people can access a wider range of support in order to improve access to expertise and support that can make a difference to people's quality of life.

Importantly, in the Summer of 2021, we refreshed our Trust strategy for the next 5 years. It has been an important time to reflect and regroup, with the emergence of integrated care systems, the widening of inequalities through the pandemic and the radical change in ways of delivering care. Through the Big Conversation, we engaged with a wide range of stakeholders, including citizens in our local communities, and local partner organisations, as well as our own service users, carers and staff, to develop our priorities for the five years ahead.

Providing high quality care remains at the heart of our ambitions at ELFT, and gives us the platform on which we can influence and engage wider, in order to impact on the many factors that create and sustain health for people in our local communities. We are proud to have received a third consecutive Outstanding rating from the Care Quality Commission in 2021.

There remains much for us to improve, involving people with lived experience as equal partners, and using quality improvement to keep testing and learning…

Part 2 – Priorities for Improvement and Statements of Assurance

In this section the Trust updates on progress on delivering our priorities for improvement for 2021/22, along with statements of assurance from our Trust Board.

Our mission is to improve the quality of life for all we serve, and our commitment to delivering the highest quality care remains. We continue to place the service user at the heart of everything we do, and are working tirelessly with our partners to achieve our mission.

This annual Quality Report provides the platform to share both our progress and achievements during 2021/22 and our plans and priorities for 2022/23.

During 2021/22 the Trust provided and/or sub-contracted 143 relevant health services. The Trust has reviewed all the data available to them on the quality of care in all 143 of these relevant health services. The income generated by the relevant health services reviewed in 2021/22 represents100% of the total income generated from the provision of relevant health services by the Trust for 2021/22.

2.1 Reflections on 2021/22 – Progress Against Priorities

As set out in last year's report, our annual plan for 2021/22 focused on the following priorities aimed at progressing our aim to improve the quality of life for all we serve.

- *Triple Aim*
- *Enjoying Work*
- *Demand, Capacity and Flow*
- *Building QI capability*
- *Service user involvement*

The Trust's quality improvement plan (figure 1), demonstrates how Quality Improvement (QI) work across the Trust was organised to support delivery of the Trust's annual plan. Building the QI knowledge and skills with our staff, service users and across partner organisations in our two integrated care systems is crucial to embedding a culture of quality improvement. In support of this, we made the 'Pocket QI' introduction to quality improvement training available for external participants to join.

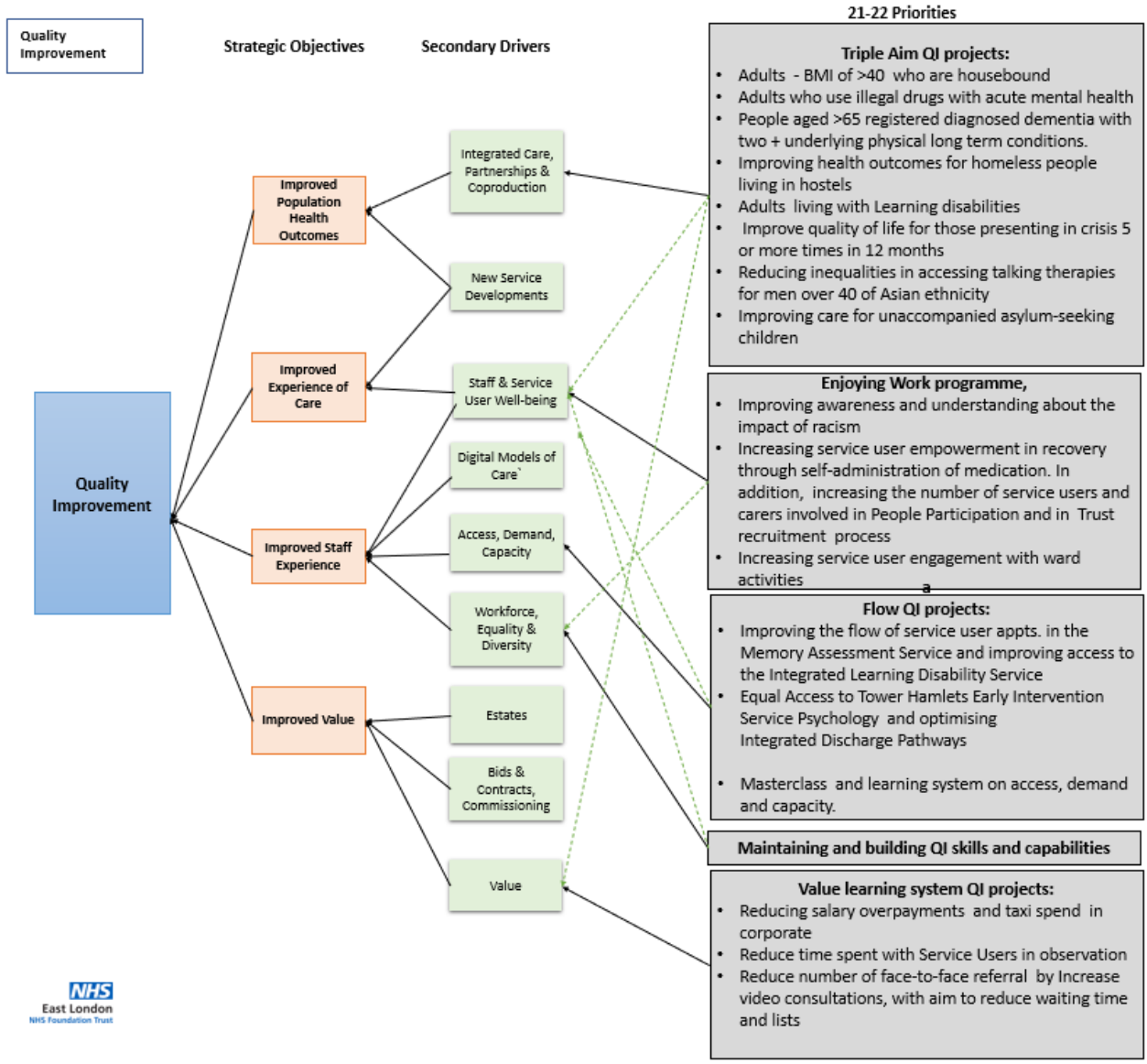


Figure 1. Trust annual quality improvement plan for 2021-22

Improving Population Health:

Triple Aim

The 'Triple Aim' learning system restarted in June 2021. The Triple Aim approach aims to simultaneously improve health outcomes, experience of care, and value for specific populations. This involves working with local external partners to effect better outcomes for population segments. In 2021, nine teams from across the organisation utilised the triple aim and QI to improve outcomes for specific populations. Triple Aim projects take a multi-year approach to improving outcomes. Of the nine Triple Aim projects, five progressed to the point of starting to test change ideas. Two new projects started in January 2022, one is working on reducing inequalities in school age children in the South Luton neighbourhood and the other for children in North, East and Central London are still working to identify a specific population. These projects are aligned to the Trust's commitment of becoming a 'Marmot' Trust that works to improve social justice, health and sustainability in order to maximise individual and community potential. The other projects were focused on:

- Improving the health outcomes of people over the age of 65 with Dementia with two or more complex physical health conditions in Leighton Buzzard
- Improving the quality of life, and what matters to housebound adults who have a (body mass index) BMI of over 40 living in Newham
- For frequent users of crisis pathway services in Newham to thrive, be socially connected and receive the right support at the right time
- Improving health outcomes for homeless people living in Tower Hamlets' hostels
- Improving quality of life of care home residents across 5 care homes in Tower Hamlets
- To build health and social opportunities for armed forces veterans and their families to ensure acceptance and adding value to the Veterans Community
- Reducing health and life inequalities for Asian men over 40 living in Bedford

Marmot Trust

ELFT has committed to becoming a Marmot Trust. This involves working across sectors and organisational boundaries in a place-based way to improve population health in the communities we serve. In Luton, the initial priority area of focus will be to ‘c*reate fair employment and good work for all’* in line with the council’s initiative to become a Marmot Town. In Newham, the initial focus will be on the wellbeing of children and young people in Newham by focusing on the two principles, ‘giving every child the best start in life’ and to ‘enable all children, young people and adults to maximise their capabilities and have control over their lives’. We will be looking to apply QI approaches where it would enhance collaboration and improve outcomes, most likely around collaboration with a bias to action so we can test and learn in a deeper way, identifying a portfolio of projects, developing a measurement plan and supporting the testing and scaling of ideas. This work launched in February 2022 with a workshop in partnership with the IHI (Institute for Healthcare Improvement) and a stakeholder round-table event with partners in Luton to coproduce high impact areas of focus to enhance employment and skills. A similar session was held in Newham in March 2022.

Improving Experience of Care:

Addressing Inequalities

A new quality improvement programme aimed at ‘Pursuing Equity’ was designed in partnership with public health, people participation and the staff networks and launched in April 2022. The programme will support teams to understand what contributes to inequity within the population they serve, use improvement methods to test meaningful change ideas and develop measurement plans to know if they are making an improvement.

There are more than 20 QI projects across the Trust that aim to improve the experience of care through addressing inequalities and inequity in service users’ experience, access to care and outcomes. Below are a few examples:

Quality improvement aim	Team
Tackling racism against staff	East India Ward in Forensics service
Increasing representation of the South Asian community in the cancer, palliative care and clinical health psychology service	Clinical Health Psychology Service in Bedfordshire Community Health Service
Improving access to preconception counselling for women with severe mental illness	City and Hackney Perinatal Team
Improving health outcomes for homeless people living in Tower Hamlets' hostels	Tower Hamlets Mental Health
Reducing inequalities by improving cervical screening uptake	Primary Care - all teams
Increasing access to mental health services for Black, Asian and minority ethnic service Users	Dean Cross team in Tower Hamlets Mental Health
Improving access for people with a learning disability to receiving electrocardiograms	Bedfordshire and Luton Learning Disability Services
Veterans Community at ELFT: meeting the required standards of the Veterans Healthcare Alliance	Veterans Alliance Team in Corporate services
Improving COVID vaccination uptake and reducing vaccine inequalities amongst ELFT staff	Trust Wide

Reducing waiting times and improving access to services

In 2021, four workshops were run to equip teams who were tackling long waiting lists and backlogs for assessment and treatment with the theory of flow management and quality improvement tools. Twenty-seven teams participated in these sessions. Some of the improvement seen by six out of the eighteen teams that were coordinating their improvement efforts through QI projects were:

- Bedfordshire Wellbeing Service increased the percentage of service users entering low intensity groups from 17% to 42%
- Bedfordshire community mental health team reduced the wait for occupational therapy appointments from 14 weeks to 3 weeks
- Luton crisis resolution and home treatment team reduced unnecessary pharmacy interventions from an average of 5.2 to 2.5
- City and Hackney integrated learning disabilities service reduced time from referral to assessment from 304 days to 81 days
- City and Hackney mother and baby unit reduced time from referral to screening from 464 minutes to 67 minutes
- Bedfordshire pharmacy team reduced the time taken to produce reports from 24 days to 10 days.

Given the strategic importance of tackling waiting lists and demand in the wake of the pandemic, a new year-long quality improvement programme on 'Optimising Flow' is currently being recruited to. This programme will launch in June 2022 and provide support to accelerate work across pathways of care to manage demand, develop creative ideas to enhance capacity and reduce waiting times.

People participation

A continuing priority was to strengthen meaningful service user and carer involvement in improving services. At the end of the financial year, the data was still showing random variation (figure xx) for the trustwide combined Big I (equal partnership and co-production) and Little I (consultation and feedback) levels of service user involvement. The work will be continuing in 2022-23. Some of the change ideas that were tested in directorates include:

- Co-designing and co-delivering all QI training related to service user involvement
- Standing agenda item on improving service user involvement at QI Forums and QI coaches' community meetings (Bedfordshire Community Health Services)
- Co-producing the directorate's QI Plan with service users (Bedfordshire & Luton Mental Health Inpatients).
- New projects presenting their proposal to the local Working Together Group and inviting service users to join the project (Community Health Newham)
- Inviting the Head of People Participation to help corporate teams think about how to involve service users in services that are not patient facing (Corporate)
- The QI Forum to have a service user as a co-chair (Bedfordshire & Luton Mental Health Crisis pathway)
- New QI projects required to have service user involvement in order to be approved (City and Hackney Mental Health)

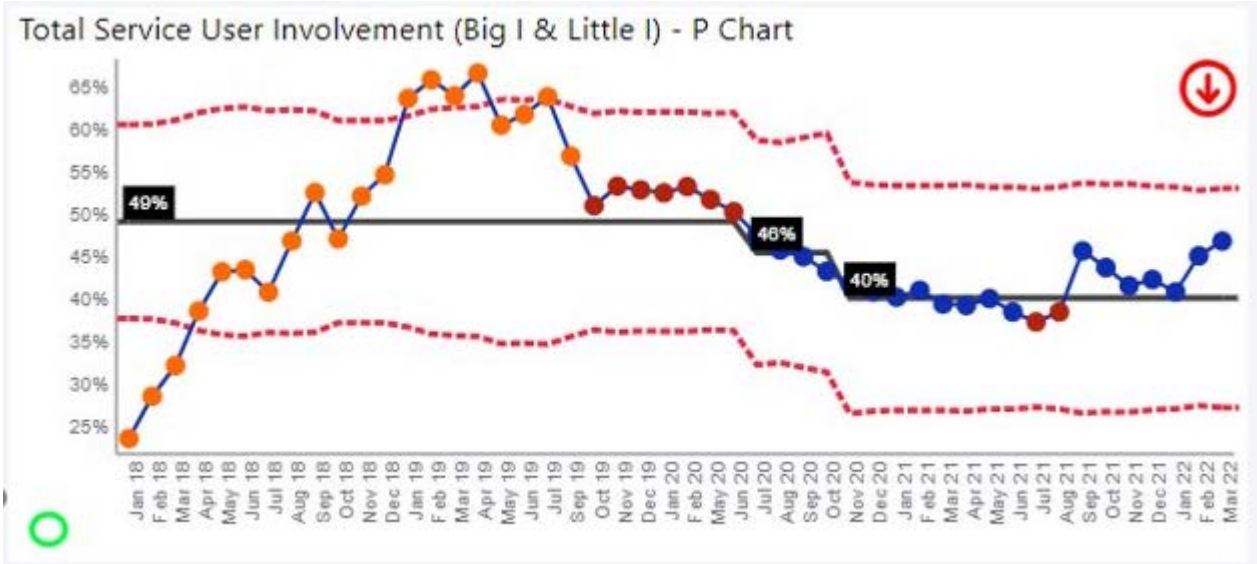


Figure 2 - Percentage of total service user involvement from across the Trust – P Chart

Reducing pressure ulcers

Improving patient safety is a key part of our efforts to improve quality and patient experience. During the acute phase of the pandemic, the number of acquired pressure ulcers increased across the Trust for a variety of reasons that included the reduced ability to enter people's homes and support good skin care. Quality Improvement was utilised by the community nursing teams from Tower Hamlets, Newham and Bedfordshire in February 2021, with the aim of reducing the number of pressure ulcers by 10% by December 2021. The team tested a range of change ideas including the use of telehealth and improved referral and triage process. More recently the Newham team have been testing a pressure ulcer passport with service users. Results demonstrate a sustained 30% reduction in pressure ulcers across the Trust over the period of the project (figure 3).

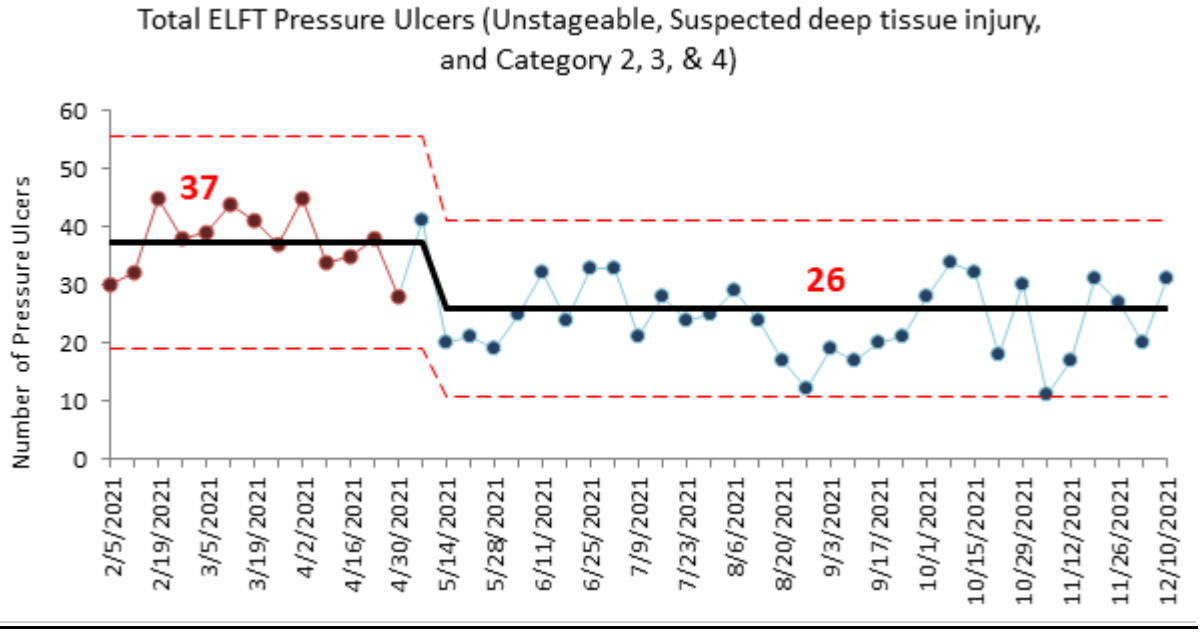


Figure 3 - Total ELFT pressure Ulcers - C Chart

<u>Improving Staff Experience:</u>

New starter project

In 2021, a quality improvement project brought together a number of corporate teams to collaborate on improving the experience of new starters at ELFT. The project has achieved their original aim of all staff receiving access to clinical systems within five days (figure 4). Change ideas tested include allocating the smartcard before the start date and ensuring IT equipment orders are received from line managers 10 days before the start date. The project team are now working towards ensuring all have their IT equipment and an active smartcard within five days of starting.

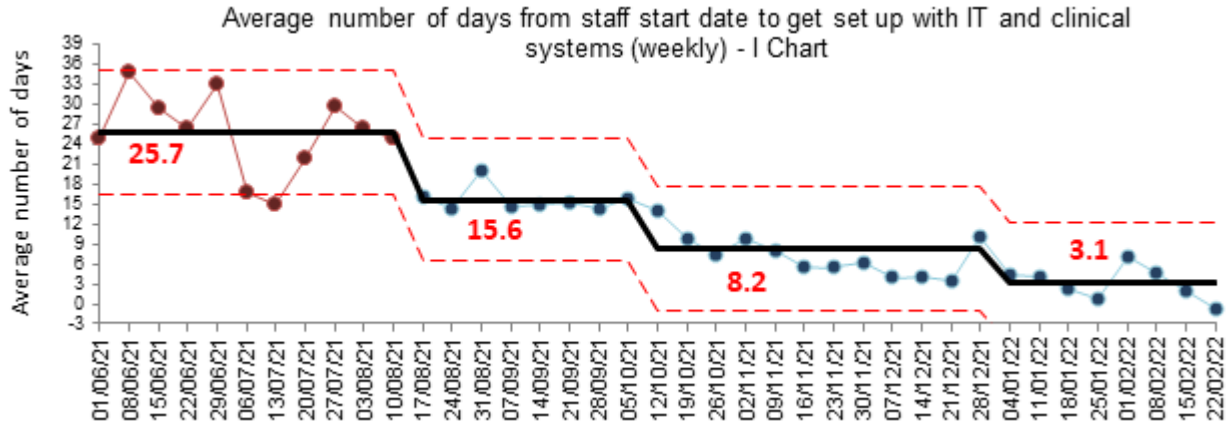


Figure 4 - Average number of days from staff start date to getting set up on IT and Clinical Systems - I Chart

Capability building:

Ensuring that all staff have the skills and confidence to improve the system in which they work, is core to delivering our Trust strategy. Quality improvement training and opportunities to apply the methods are offered to all staff and service users. These opportunities to grow and learn have a meaningful impact on improving staff experience. The graph below shows the number of staff and service users who have been trained each year through the three core offerings*. Pocket QI,* a one-day foundation course was delivered to 290 staff and service users in 2021.

An average of 26 people complete this training each month. The *Improvement leaders programme,* a six-month course to support specific improvement work was delivered to 159 staff and service users in 2021. There were 119 participants who started in 2021 and due to complete the course in April 2022. The *Improvement coaching programme*, a six-month course designed to develop QI coaches within ELFT who can support teams to apply quality improvement to a real-life issue, has developed a further 53 coaches in 2021. There were 35 coaches who started in 2021 and due to graduate in May 2022 and will join the 124 active coaches that make up the ELFT QI coaching infrastructure.

Figure 5 - Total number of people trained in quality improvement each year

The annual staff survey for 2021 shows that 66% of ELFT staff reported that they are able to make improvements in their area of work, compared to the national average of 59%. This is similar to the previous year. This was identified as one of the top 5 scoring areas for the organisation. Among other things, this is in part a related to the Pocket QI training which roughly 1 in 6 existing staff have completed and has enabled them to contribute to the improvement their service using a trusted and shared model. Despite the change in the delivery method of the training at different stages of the pandemic, an average of 92% of attendees continue to report that they would recommend it to others as shown in the chart below (figure 6).

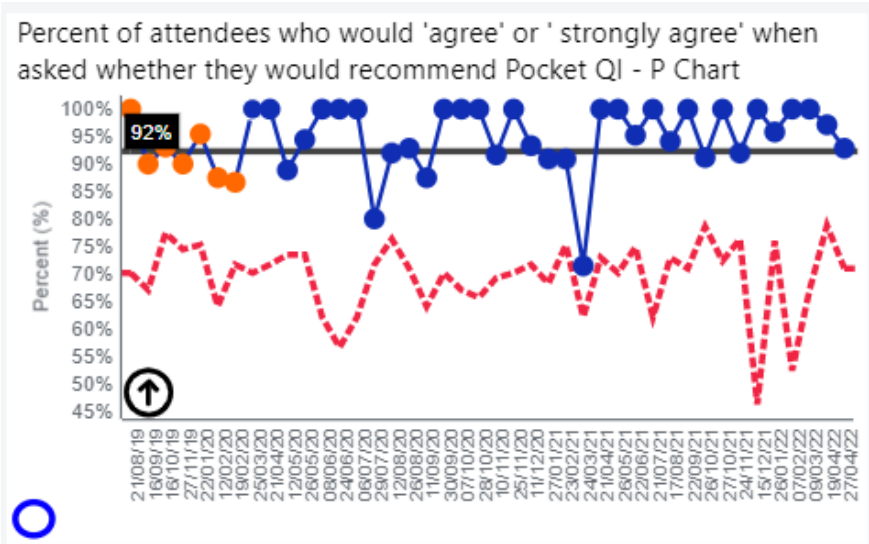


Figure 6 - Percentage of attendees who would recommend Pocket QI Training - P Chart

<u>Improving Value:</u>

Environmental Sustainability

The Trust has committed to contributing to the creation of healthy and sustainable places, including taking action on climate change. The aim of the 'ELFT Green Plan' is to reduce

direct and indirect carbon emissions at ELFT by 2025. The project started in late 2021 and have created a driver diagram to visualise their theory of how to achieve the aim. They are now in the process of trying to understand key factors impacting on sustainability as well as how to measure and evidence progress when they start testing new ideas. Six workstreams have been agreed that will bring together teams working on similar areas: estates & facilities, medicines, procurement, sustainable models of care, travel and transport and workforce leadership. Each workstream will have a driver diagram and measurement plan. The work will initially focus on estates and sustainable models of care.

Reducing Agency Spend

A team is working towards reducing spend on agency staff by 25% by December 2022. The greatest area of opportunity for improvement is around systems and controls that are in place, or in some cases, not being applied consistently, or not in place at all. The team have run process mapping sessions with the temporary staffing team, customer feedback sessions with matrons and have sought feedback from recruiting managers and staff who have started on the bank in the last 6 months. Some of the impactful change ideas that have been tested include:

- Monthly contract monitoring meetings for reviewing invoices – this has led to a refund of £30k from a supplier due to high commissions
- Creating separate budget codes for services across a directorate – this allows for a better understanding of agency costs by service
- Coaching for Clinical Directors by Finance business partners – this has resulted in a price cap being applied for locum hourly fees which can only be exceeded with the express authorisation of the Chief Medical Officer
- A process for booking agency staff using a main supplier – this has resulted in a reduction in the use of non-framework agencies
- Targeted recruitment onto the staff bank - two doctors have agreed to join ELFT bank from agency
- Regular review of aggregated data from agency usage – some rates have been re-negotiated with suppliers as a result

The changes have not yet impacted the percentage of agency spend (figure 7) and the project will be continuing in 2022-23.

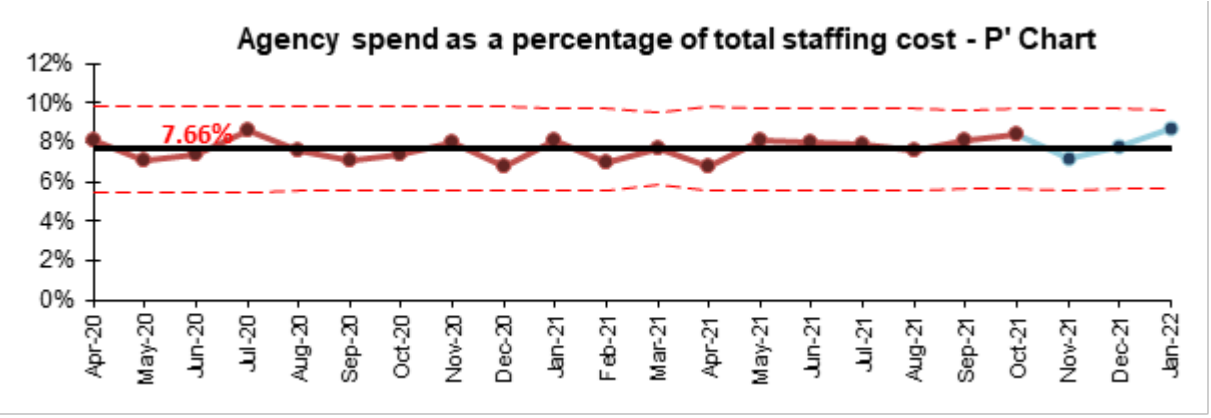


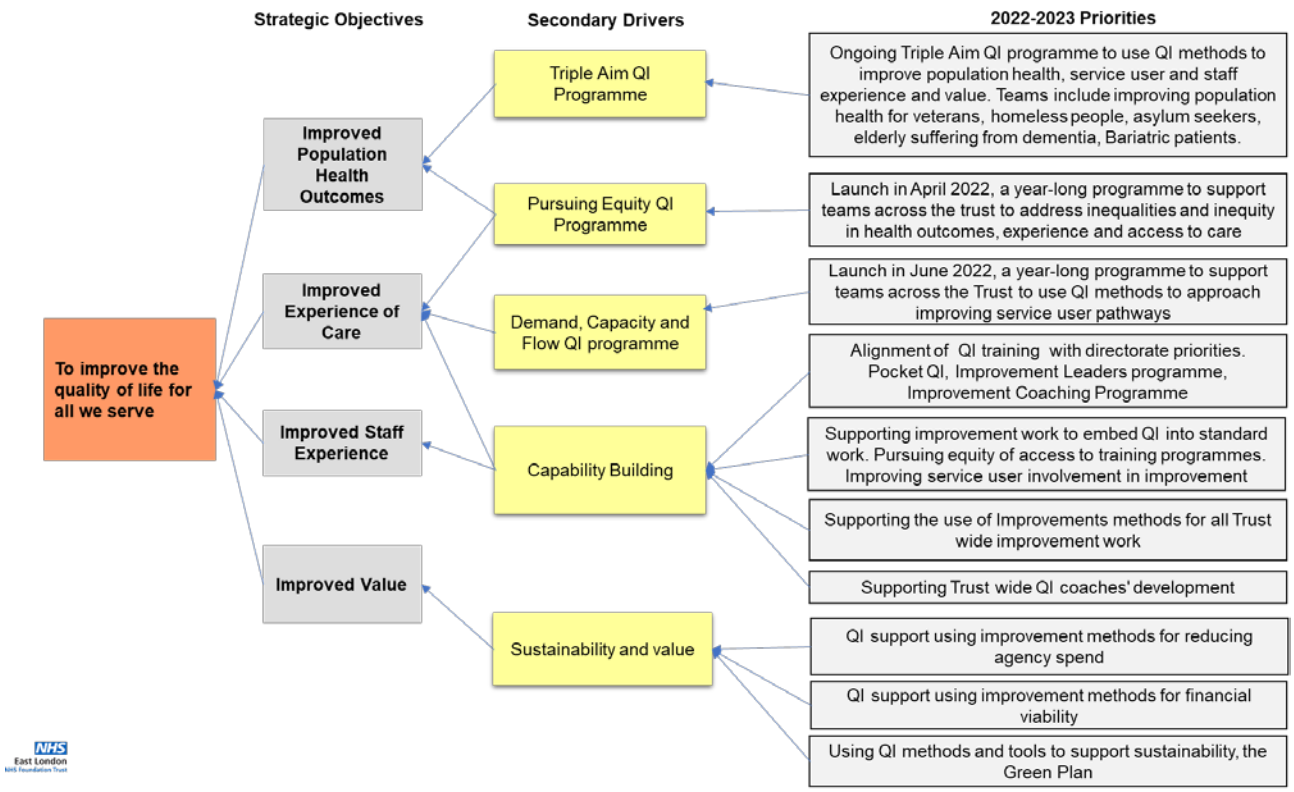
Figure 7 - Agency spend as a percentage of total staffing cost - P Chart

IHI Annual Visit

ELFT's strategic partner, the Institute for Healthcare Improvement (IHI) conducted their annual visit in February 2022 and met with staff, service users and carers to learn about improvement work happening across the Trust. They gave much commendation for how improvement work was being openly shared, the leadership on people participation, the commitment to equity and taking a trauma-informed approach to staff wellbeing, safety and dignity. They offered some opportunities about extending quality improvement (QI) beyond projects and into daily work within teams and into larger-scale change across the Trust, and about having a clear line of sight between the new Trust strategy and improvement work.

2.2. Quality Priorities for the coming year – looking forward to 2021/22

The driver diagram below sets out our priorities for the coming year, and shows how quality improvement projects across the Trusts link to the key strategic priorities for ELFT and the annual plan for 2022-23.



2.3 Participation in Clinical Audits

2.3.1 National Audit

Throughout 2021/22, East London NHS Foundation Trust participated in 6 national clinical audits and 1 national confidential inquiry which covered services that East London NHS Foundation Trust provides. A list of these are provided below, along with the organisation which relevant data was submitted to.

Description of National Audit/Confidential Inquiry	Submitted to
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists
National Clinical Audit of Psychosis (NCAP)	Royal College of Psychiatrists
National Audit of Dementia (NAD)	Royal College of Psychiatrists
National Inpatient Diabetes Audit (NaDIA)	NHS Digital
National Diabetes Audit Programme	NHS Digital
National Audit of Cardiac Rehab (NACR)	University of York
Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)

Data was submitted to 7 national clinical audits and 1 national confidential inquiry. A breakdown of the number of teams involved and cases submitted is displayed in the table below where available. Each national audit is assigned Clinical Lead who oversees and supports data collection, and is also responsible for the sharing back of audit findings and identifying actions for improvement.

TOPIC	TRUST PARTICIPATION		NATIONAL PARTICIPATION		Lead
	Teams	Submissions	Organisation	Submissions	
POMH-UK Quality Improvement Programme (QIP) 19b: Prescribing for depression in adult mental health services	22	73	Report due to be published May 2022	Report due to be published May 2022	Dr Dominic Dougall
POMH-UK Quality Improvement Programme (QIP) 1h & 3e: Prescribing high dose and combined antipsychotics	Currently ongoing	Currently ongoing	Report due to be published September 2022	Report due to be published September 2022	Dr Phil Baker
NCAP: Early Intervention in Psychosis Audit 21/22	4	350/350 (100%)	Report due to be published Summer 2022	Report due to be published Summer 2022	Dr Olivier Andlauer
NAD: Spotlight audit in community-based memory assessment services	4	203/200 (102%)	Report due to be published August 2022	Report due to be published August 2022	Dr Walid Fawzi

TOPIC	TRUST PARTICIPATION		NATIONAL PARTICIPATION		Lead
	Teams	Submissions	Organisation	Submissions	
NHS Digital: National Inpatient Diabetes Audit (NaDIA)	23	23	Report due to be published May 2022	Report due to be published May 2022	Kate Corlett Bernadette Kinsella Eleanor Thompson
National Audit of Cardiac Rehab	1	458	191	Data not made publicly available	Kelly Read
National Diabetes Audit Programme: Core National Diabetes Audit	Data is extracted via GPES (general practice extraction service)	Data is extracted via GPES (general practice extraction service)	Data not made publicly available	Data not made publicly available	N/A
National Confidential Inquiry into Suicide and Safety in Mental Health: Mental Health Clinical Outcome Review Programme	N/A	20	Data not made publicly available	Data not made publicly available	N/A

In 2021/22 the preliminary results for 1 national audit and the national report for 1 national confidential inquiry ELFT participated in.

The Trust received the preliminary results for participation in the NCAP EIP Audit 21/22, pending release of the national report in summer 2022. The results were heavily caveated however, this enabled Early Intervention services to review their results, reflect on the findings and focus on improvement planning prior to release of the national and local reports in summer 2022.

The data, similar to the previous year, reflects service provision during COVID-19, where EIP services experienced disruptions and lockdowns. Services found it difficult to deliver interventions such as Carer Support and Education and Family Interventions due to avoiding face to face contact during this time however, such programmes have since been re-established. Teams are expecting to see improvements reflected in the following years audit results.

Teams also reported challenges around delivering Family Interventions due to demand on the team exceeding capacity and have actively addressed this by implementing actions such as training programmes to ensure BFT training for all care coordinators and psychology staff and have made amendments for families to opt out rather than opt in for BFT to increase uptake.

The Mental Health Clinical Outcome Review Programme published their National Confidential Inquiry into Suicide and Safety in Mental Health Annual Reports in May 2021 and April 2022.

The Cardiac Rehab team participate in the National Audit of Cardiac Rehab on an annual basis. For the last 5 consecutive years ELFT Cardiac Rehab team have been certified as green meaning the service provision meets the audit standards.

2.3.2 Trust Clinical Audit Activity

Throughout 2021/22 the Quality Assurance team has continued to facilitate the trustwide Clinical Audit Programme. During 2021/22 it was decided that the frequency of audit cycles is to be reduced from 4 to 3 times per year. As the timelines for the audit cycles have been adjusted, there were 4 audit cycles in 2021/22, carried out in April, July, November and February. From 2022/23 onwards clinical audit cycles will take place in June, October and February.

One medicines audit, Controlled Drugs, will continue to be audited 4 times per year, at the start of each quarter.

The clinical audit programme consists of a mixture of Pharmacy related audits, Infection Control audits and Directorate specific audits. All of the audits are listed below, along with a breakdown of where they are reported to and which directorates they apply to.

Audit Priority	Lead Committee	Directorate
Medication Audits – Controlled Drugs, Safe and Secure Handling of Medication, Transcribing Procedures and Clinical Use of Medication	Quality Committee / Medicines Committee	All
Infection Control Audit	Quality Committee / Infection Control Committee	All
12 x Individual Directorate Audits (NICE/Safety Critical Standards)	Quality Committee / Directorate DMTs	All

The newly formed Primary Care directorate has during 2021/22 implemented their medical equipment audit and specifically designed pharmacy audits. These were audited 3 times in 2021/22.

The Trust has a clear process to support learning and improvement from clinical audit. All audit results are communicated to Directorate Management Teams, Audit leads, local Quality Assurance Leads and Lead Pharmacists. Local audit leads disseminate audit results after each audit cycle and once teams have discussed their audit results, the expectation is that they agree priorities for improvement and associated actions.

Agreed priorities and associated actions are expected to be logged on an audit action tracker. Each action have an allocated owner who is responsible for completing the action and update the tracker accordingly.

To provide an example, in the City and Hackney Mental Health directorate audit results are discussed at the Senior Nurses' Meeting as well as the Community Managers' meeting, and managers meetings for urgent and specialist teams. They are also discussed at quality DMT.

Actions are agreed and discussed with individual teams where applicable. All agreed actions are documented on their designated action tracker.

Another great example is the Forensics directorate; they discuss audit results in both Forensics Quality Committee and Clinical Improvement Group meetings. The directorate have a shared live document where any actions in response to gaps found in the data are documented.

2.3.3 Service User Led Accreditation

The Trust's pioneering Service User Led Accreditation programme, launched in 2019, has continued in 2021/22. Clinical services volunteer to participate in the process. The process consists of a self-assessment against service user defined standards for excellence, followed by a visit by service user assessors to test the self-assessment and assess compliance with the standards. Following the visit an Accreditation Panel award the service Gold, Silver or Bronze depending on the number of standards met during the assessment visit. Services that do not meet the required 70% of standards are offered a package of support to work towards accreditation. The service is invited back to the panel once improvements have been made and they can provide evidence of meeting the required number of standards.

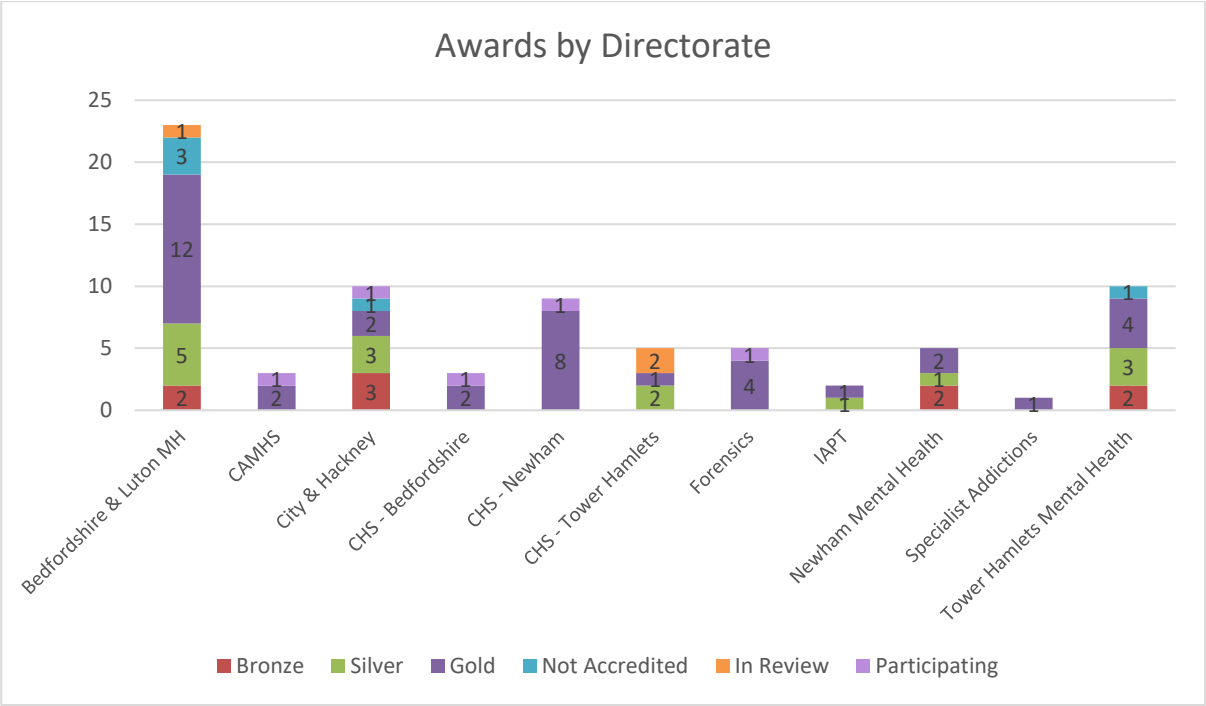
The programme has been impacted by the Covid-19 pandemic and the move to virtual working. Visits have continued to be conducted virtually throughout 2021/22. All service users and staff have been given additional support to undertake virtual visits. This includes additional training and technology support. All virtual visits include a Quality Assurance 'Tech person' whose role is to be in the background of the visit for extra support. The additional support has ensured that clinical services and service users continue to benefit from participating.

Prior to 2021/22 registrations to participate in the programme opened quarterly. During 2021/22 the decision was made to change this to allow registrations on an ongoing basis. This increases the availability of opportunities for service users on a regular basis, and further allows flexibility for services to identify the best dates for their self-assessment deadline as well as their visit.

In the past year, 20 clinical teams have registered to take part. Out of these, 8 teams have completed their assessment and visit, 3 teams have dropped out of the process before its conclusion. 9 teams have requested to defer starting the process until spring 2022. On average, the conversion rate of teams starting their self-assessment and fully completing the process during 2021/22 was 62%.

A total of 79 clinical teams have participated since the start of the programme.
Outcome of assessments

The accreditation awards are summarised below. All teams are encouraged to take steps to improve based on the outcome of their assessment, and, when they feel the time is right, to put themselves forward for a further assessment.



Impact of the programme

As part of the accreditation process, feedback is routinely collected from the clinical teams and assessors involved. Feedback is discussed weekly at team meetings. In 2021/22 we have established processes of also providing feedback to our assessors following their participation in an assessment visit, to ensure they are supported to reach their full potential within the programme.

Feedback collected from clinical services showed that all would recommend other services to take part and rated the experience as valuable. One example of service feedback:

"Receiving the positive feedback from the assessors and being told that we are doing an excellent job and providing a valuable service is priceless"

The impact of the programme has further been explored via storytelling. So far 3 clinical teams have been interviewed to share what participating meant to them. We are hoping this will encourage other teams to participate.

We have continued to host regular 'Assessors together' sessions with our assessors. This provides a space for shared learning and connections between assessors.

In May 2022 we will be hosting an external event where we will share how we developed and implemented the programme. The event will include the impact the programme has had on service users, clinical teams and on the trust as a whole. The content is co-produced with service user assessors who have been part of the programme since it launched. We hope the event will inspire other organisations to develop something similar, spreading the impact beyond ELFT.

We are continuously working on improving and developing the programme and it is a main QA priority for the next year. We will continue to partner with our service users to review and develop our processes. We are planning to resume in-person visits where appropriate from summer 2022.

2.3.4 External Accreditation

The Trust has gained national accreditation for the quality of services provided in many wards and teams.

Accreditation scheme	Location	Services Accredited
AIMS WA ACCREDITATION FOR WORKING AGE INPATIENT MENTAL HEALTH SERVICES CCQI	Newham	Emerald Ward Ivory Ward Opal Ward Ruby Ward Sapphire Ward Topaz Ward
	Tower Hamlets	Globe Ward Roman Ward Brick Lane Ward
	Bedfordshire & Luton	Willow Ward Ash Ward Coral Ward Onyx Ward Crystal Ward
CAMHS QUALITY NETWORK FOR INPATIENT CAMHS CCQI	East London	Coborn Centre for Child and Adolescent Mental Health
PERINATAL QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES CCQI	East London	Mother and Baby Unit
	City and Hackney	City and Hackney Perinatal Outpatient Service
	Tower Hamlets	Tower Hamlets Perinatal Service
	Bedfordshire & Luton	Bedfordshire and Luton Perinatal Service
QUALITY NETWORK FOR OLDER ADULTS MENTAL HEALTH SERVICES CCQI	East London	Cauzabon Ward
AIMS PICU ACCREDITATION FOR PSYCHIATRIC INTENSIVE CARE UNITS CCQI	City & Hackney	Bevan Ward
	Bedfordshire & Luton	Jade Ward
FORENSIC QUALITY NETWORK FOR FORENSIC MENTAL HEALTH SERVICES CCQI	East London	John Howard Centre/ Wolfson House
	Newham	Newham South

ACOMHS ACCREDITATION FOR COMMUNITY MENTAL HEALTH SERVICES CCQI	Tower Hamlets	Bethnal Green CMHT
CAMHS QUALITY NETWORK FOR COMMUNITY CAMHS CCQI	City & Hackney	City & Hackney CAMHS
	Newham	Newham CAMHS Community Team
	Tower Hamlets	Tower Hamlets CAMHS Community Team
	Bedfordshire & Luton	Bedfordshire CAMHS Luton CAMHS
	East London	East London Eating Disorder Service for Children and Young People
HTAS HOME TREATMENT ACCREDITATION SCHEME CCQI	City & Hackney	City & Hackney Home Treatment Team
	Tower Hamlets	Tower Hamlets Home Treatment Team
ECTAS ECT ACCREDITATION SERVICE CCQI	East London	Tower Hamlets ECT Clinic
	Bedfordshire & Luton	Luton ECT Suite (28/02/22)
MSNAP MEMORY SERVICES NATIONAL ACCREDITATION PROGRAMME CCQI	City & Hackney	City & Hackney Memory Service
	Newham	Newham Diagnostic Memory Clinic
	Tower Hamlets	Tower Hamlets Diagnostic Memory Clinic
	Luton & Bedfordshire	Luton Memory Assessment Clinic
PLAN PSYCHIATRIC LIAISON ACCREDITATION NETWORK CCQI	City & Hackney	Homerton Psychological Medicine
	Tower Hamlets	Tower Hamlets Department of Psychological Medicine

	East London	Changing Lanes Community Team

2.4 Research and Innovation

Innovation and research is a key part of the work of the NHS, ensuring that patients in the UK continue to benefit from improved and modern services, and helping to deliver better

outcomes to patients across the country. Evidence shows that the engagement of clinicians and healthcare organisations in research is associated with improvements in healthcare performance. Furthermore, clinical trials activity is associated with improved Care Quality Commission (CQC) ratings.

ELFT is now two years into a five-year plan to transform Research & Innovation (R&I) into a corporate function supporting our services to deliver the improvement agenda, and broaden the spectrum of what we mean by 'R' to include not just clinical research trials, but also service evaluations, case studies, audit, and QI (Quality Improvement).

Although there were fewer studies actively recruiting participants during 2021/22; we still enrolled 560 participants into 21 studies from the Department of Health and Social Care's (DHSC) National Institute for Health Research (NIHR)[1] research Portfolio.[2] The highest recruiting study was the ELFT-sponsored Effectiveness of group arts therapy: Randomised controlled (ERA) trial (N=234) – a significant achievement enabling service users to engage actively in a wide range of face-to-face group therapy interventions throughout a pandemic.

A commitment to meaningful public engagement

In 2021, we created an additional Clinical Studies Officer[3] post specifically for a person with Lived Experience both to provide employment opportunities for people on their recovery journey as well as to bring additional depth and breadth of lived experience to the team. This has been an extremely successful appointment, with the new team member one of our most prolific at enrolling study participants.

Working in collaboration with the experts

A significant part of research at ELFT is conducted in collaboration with a range of academic partners. In 2021, we welcomed Prof Liz Sampson of UCL as joint clinical lead for Liaison Psychiatry. Her expertise in epidemiology and health services research for older people will bring new focus to this clinical area.

In addition to Prof Sampson, two more senior academics are joining ELFT in the coming year, thus expanding our expertise in population health, older people's mental health, and learning disabilities – all new areas for ELFT in terms of research and innovation.

Consultant Psychiatrist Dr Afia Ali is a clinical-academic with a track record on stigma research and clinical trials of psychosocial interventions in people with learning disability from her previous post as Associate Professor at University College London.

While new head of Queen Mary University of London's (QMUL) Centre for Psychiatry and Mental Health[4], Prof Claudia Cooper is a jointly appointed clinical-academic interested in the epidemiology of older people's mental health, happiness and wellbeing, and in the mental health of carers of people with dementia.

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[1] The NIHR was established in 2006 to "create a health research system in which the NHS supports outstanding individuals, working in world-class facilities, conducting leading-edge research focused on the needs of patients and the public". It is funded by the Department of Health and Social Care. Working in partnership with the NHS, universities, local government, other research funders, patients and the public, the NIHR funds, enables and delivers health and social care research focused on early translational research, clinical research and applied health and social care research.

[2] NIHR Clinical Research Network (CRN) support is available to all studies, regardless of location, study type, study size, therapy or research area, provided they meet the Department of Health and Social Care established eligibility criteria. Those that do, are considered part of the *NIHR Portfolio.*

[3] The CSO team is a group of research assistants, assistant psychologists and – in the future – nurse and allied health professionals (collectively referred to as 'Clinical Studies Officers', or CSOs) whose principal objective is to increase opportunities for ELFT service users, staff, carers and wider community to participate in relevant research.

[4] The Centre for Psychiatry and Mental Health is part of QMUL's Institute for Population Health Sciences

[5] Accessibility and acceptability of perinatal mental health services for women from Ethnic Minority groups (PAAM)

Sharing our findings

In October 2021, we relaunched the annual Health Research in East London conference, delivering it entirely on-line. Attendance at this half-day conference topped 300 people logged in live to hear brief presentations on the results from a wide range of research projects conducted in the Trust, ranging from epidemiological studies to clinical trials and qualitative work.

Twitter has proven to be a useful tool as a means to recruit and inform our followers - whether they be colleagues or service users - about the different studies the trust is supporting and ways they can get involved. In the last year we have gained over 300 followers and our profile has been viewed over 1300 times. Our engagement levels have doubled since this time last year.

One of our top tweets is a short interview with Professor Stefan Priebe, viewed over 1800 times where he talks about the PAAM study[5] and how research can be viewed as *"the daily work of challenging existing wisdom".* We are optimistic that our growing number of followers will be inspired by the power of research through these stories and remain informed about the benefits their involvement could bring.

2.5 Regulatory compliance - Care Quality Commission (CQC) Inspection

ELFT is required to register with the CQC and its current registration status is 'Registered with no conditions applied'.

The Trust has no conditions on registration and the CQC has not taken enforcement action against the Trust during 2021/22

The Trust received an inspection of Older People Wards and Forensic Services during September 2021. The CQC also conducted a Well Led inspection of the Trust in October 2021. The outcome of this inspection provides assurance to the Trust Board in relation to the Trust's provision of Regulated Activities, and identifies areas for continued improvement.

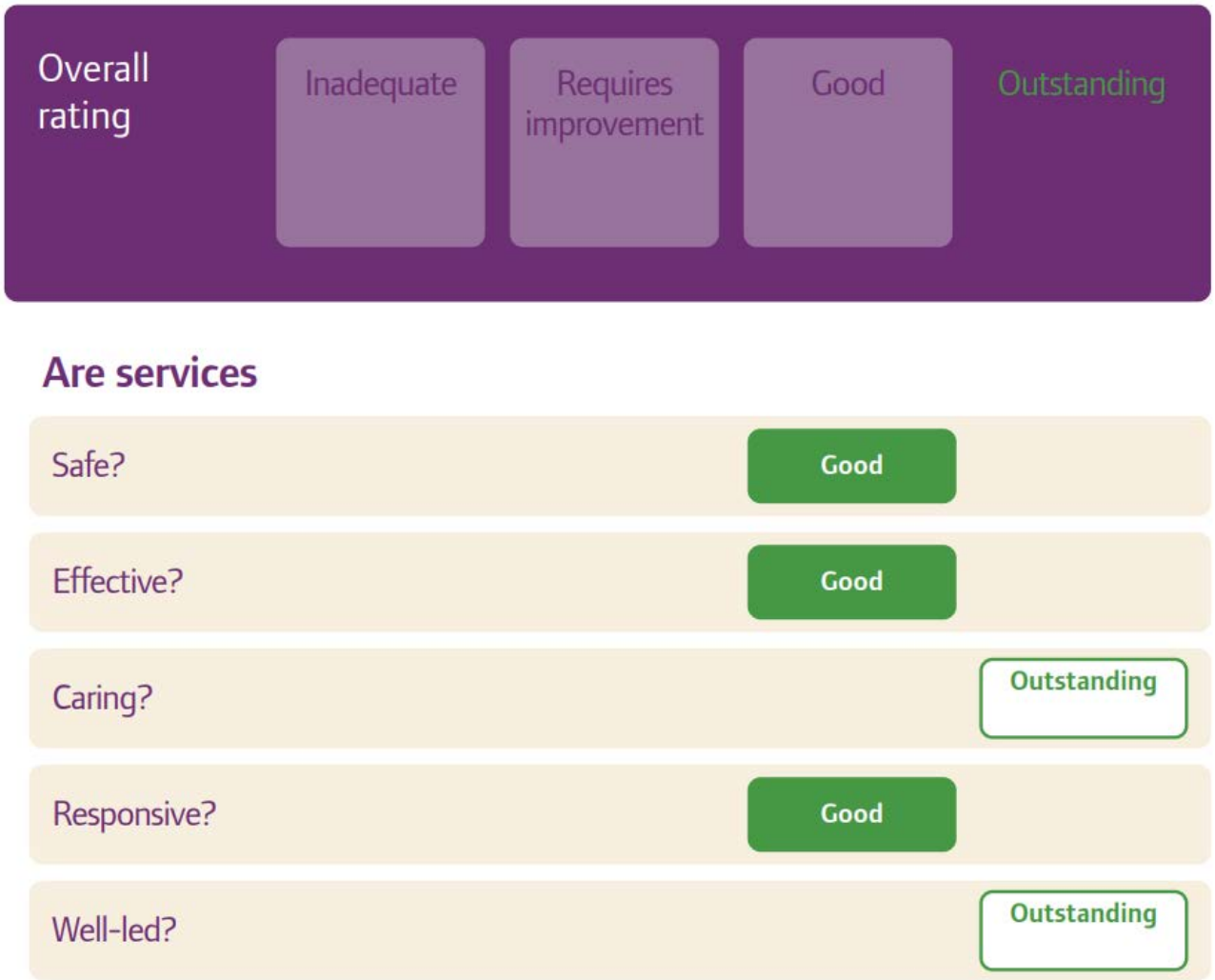
The findings of these inspections have been published and the trust has maintained its Outstanding rating for a third time. The Trust has had three comprehensive inspections in 2016, 2018 and now 2021.
The CQC found areas of positive practice:

- Inspectors found an overwhelmingly positive culture across the trust. Staff told us that they felt proud to work for the trust and we heard many examples of how they put the people who use services at the centre in their work.
- People participation had been extended since the last inspection and we heard of many examples where co-production was taking place. The CQC described the befriending service and Service User Led Accreditation Programme as examples of innovative co-production
- The CQC were inspired by the work being undertaken on race and privilege connected to the Black Lives Matter movement and the work taking place to improve staff wellbeing
- Quality improvement continued to be embedded and developed further across all areas of the trust.
- Work to refresh the Trust Strategy was almost complete and had been done with a wide range of internal and external consultation. The strategy on a page was clear and accessible.
- The trust had made a significant contribution to this work through its delivery of the vaccination programme in North East London.
- Partnership working had developed significantly since the previous well led review. We heard about the active participation and leadership roles by members of the trust leadership team in the two care systems where the majority of trust services were located.

The CQC also recognised challenges and areas for improvement:

- CQC stated they would like to see the progression of the work to achieve sustained improvements in recurring themes from serious incidents.
- Recognised the adverse impact some environments/estates are having on patient care and will continue to monitor short and longer term work to make improvements.
- Challenges staff report in daily use of IT equipment and platforms.

The CQC inspection identified 1 Must Do action in relation to Mixed Sex Accommodation in Older People Inpatient Services. There were also 13 Should Do actions identified within the report. An action plan is now being implemented to address each of the recommendations.



Special Reviews

The Trust has not participated in any special reviews during 2021/22.

2.6 Staffing

2.6.1 Staff engagement

The 2022-2026 Trust People plan was signed off in March 2022 at the Appointments and Remuneration Committee. and has been created to support the delivery of the Trust's strategy

- Looking after our people;
- Belonging in the NHS;
- Growing and developing;
- New Ways of working and delivering care.

Progress on delivery of the People Strategy is reported on regularly to the Trust Board. I key measure of progress is the annul NHS Staff Survey.

NHS Staff Survey

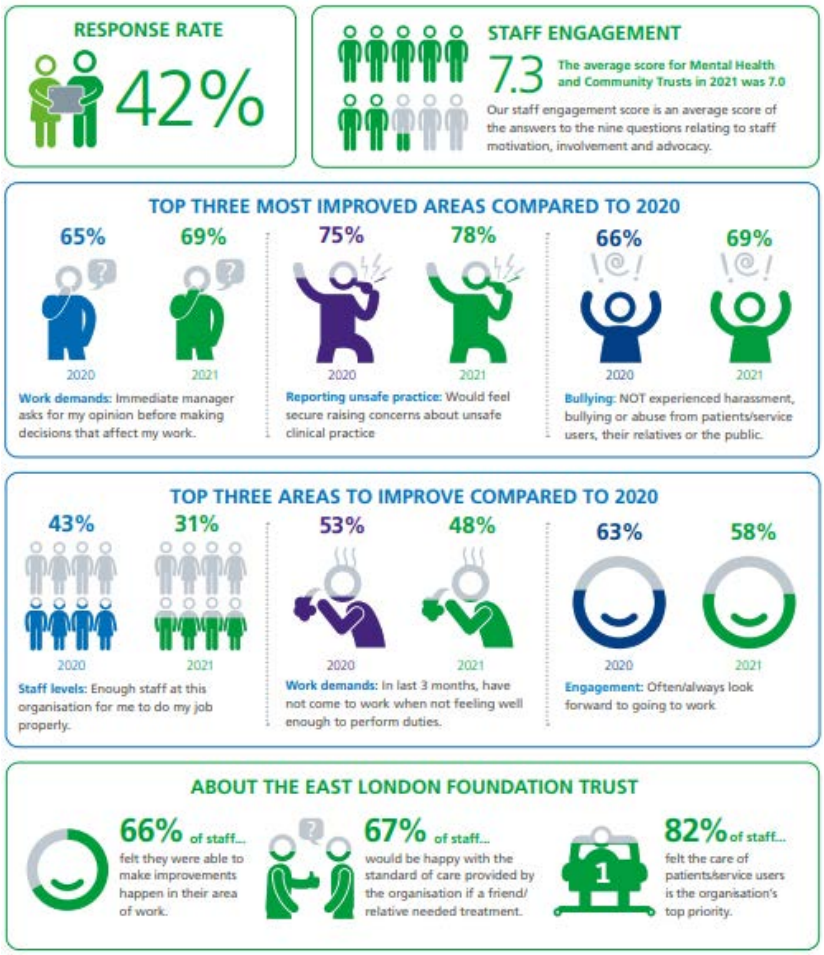
The Trust has recently received its 2021/22 staff survey results. The overarching themes emerging are:

- Equality, diversity and inclusion.
- Retention and Morale.
- Staff wellbeing.

The Staff Survey draws on 9 questions from the overall survey in order to create a staff engagement score. These questions measure aspects such as recommending the organisation as a place to work/receive care, looking forward to coming to work/being absorbed in work and being involved as well as being able to have a say. Below the dark

blue line represents ELFT. Indicating that in terms of staff engagement, we have tracked above average, when compared to other Trusts, since 2017. We are currently at a staff engagement score of 7.3, with the average trust in our comparator group being 7.0.

The infographic provides a handy overview of the trusts report.



As part of the delivery of the people strategy, there is a range of work ongoing that address the 3 dominant themes of staff feedback.

Equity

The 'Pursuing Equity' QI programme was launched in April with the aim of supporting teams to identify inequities in access, experience, and outcomes for service users and staff and to use quality improvement to generate and test ideas to address this.
The first session was attended by 40 participants, representing 24 teams across the Trust. The teams are working towards improving access and equity in health services for service users and staff from the Black, Asian, and Minority Ethnic (BAME) community, the LGBTQ+ community, women, veterans, and the elderly. Below are a few examples of the teams that attended and what they are working on:

- Newham mental health services are seeking to improve access to care for children and young people from diverse ethnic communities.

- The Veteran's Alliance is working towards improving accessibility for veterans and their families to IAPT services and have successfully tested staff identifying veterans at the point of referral.
- Forensics are working towards improving equity for female inpatients so that they have access to the same facilities for physical activity as males
- The LGBTQ+ network is working on increasing awareness of the network and improving their reach
- Bedfordshire and Luton services are aiming to increase representation in the eating disorder service.
- Mental health services in Newham and Tower Hamlets are aiming to improve access for those from ethnic minorities
- The Bedfordshire and Luton people participation working together group are working on an anti-racism project
- Primary care is working to improve access to cervical screening and are testing using outreach centres

Recruitment and retention

The Trust generally carries a vacancy rate of between 6 to 9% which is 'healthy'. However, there are areas and/ or roles that are particularly difficult to recruit to, and retain staff in, leading to a vacancy rate higher than this; for example Community Health Services can be higher than 15%. We also know that community nurses, GPs, psychologists, occupational therapists are all shortage skills within the labour market.

To address the areas and professions that experience particular challenges a Trust recruitment and retention strategy exists, a delivery group is Chaired monthly by the Chief Operating Officer and reports to the board via people delivery board and REMCO. It also has working sub-groups in various localities. The purpose of the group is to take a locality/ place-based approach to reviewing and enabling strategies that contribute to

- Agency reduction/usage
- Bank transfers to perm contracts
- Scrutiny of and support for the Workforce Plan of new roles/services as a result of new monies
- Recruitment strategy more generally for existing vacancies, ensuring that ELFT has a strong employer brand and a reputation for the best place to work
- The Trust's 'anchor institution' agenda
- Reduction in turnover

Currently the working sub-groups are prioritising 2 x QI Projects; one of which aims to reduce time to hire and the other aims to improve candidate experience by ensuring everything is ready for new starters on day one.

Newham specifically have delivered 40 successful appointments for local Newham residents and the Coburn Centre have achieved a step change from reporting regular staff shortages to a healthy vacancy rate.

The group are also working to increase involvement in a Trust wide Work Experience Programme and T-levels to encourage young people into NHS careers.

The group are working on increasing awareness of new role such as Physicians associates and prescribing nurses that may be able to offer an alternative means of closing staffing gaps. Remuneration also features as a workstream and 'career progression grades' and 'golden hellos' are currently being reviewed and scoped as possible incentives for candidates to choose ELFT.

Challenges still remain, particularly recruiting to medical vacancies in Luton and Bedfordshire mental health services.

Wellbeing

The Trust has long recognised the connection between staff wellbeing, satisfaction and happiness, and the care and treatment we provide, and this forms a central pillar of our strategy.

Our 2020/21 Quality Accounts set out at some length the support offer to staff at the time, and much of that continues. In the meantime, more has been done to make attention to wellbeing business as usual. Regular wellbeing bulletins are provided to staff offering information and tips, signposting guidance and support available, reminding of available benefits and promoting ongoing conversation around wellbeing. In February, the Trust launched #howareyoureally? - an invitation to all our staff to have wellbeing conversations at every interaction with their manager. To help with these conversations, the Wellbeing Team created two guides, one for the employee and one for the manager.

There remains a focus on helping staff utilise their leave, and to get proper rest. Managers and leaders continue to pay close attention to staff sickness, to ensure that there is adequate staffing. As the situation has allowed, teams are beginning to return back to in-person away days, which have not been possible since March 2020, yet are critical to team effectiveness. Throughout the pandemic, teams have been applying their QI skills to redesign the way they work and find ways to enhance wellbeing, through the Enjoying Work programme.

2.6.2 Raising concerns - Freedom to Speak Up

ELFT staff have clear, confidential and safe processes to raise concerns about any matter that is damaging to patient care or which puts patients at risk.

- ✓ Contact the FTSU Guardian – personal email or FTSU ELFT inbox (elft.freedomtospeakup@nhs.net)

- ✓ Contact a FTSU Champion – there are 10 Champions around the Trust
- ✓ By Phone: call FTSU Guardian directly
- ✓ Online Referral: All referrals are treated in the strictest confidence and seen only by the FTSU Guardian.
- ✓ The FTSU (Whistleblowing) Policy also outlines how and who to raise concerns with. The purpose of this policy is to also provide a safe mechanism for anyone who works for the Trust to come forward and raise any concerns they have about any aspect of the Trust's work, and to be able to do so without fear of detriment or reprisal.
- ✓ In addition, staff can contact the Senior Independent Director
- ✓ They can also raise whistleblowing concerns via **Protect – Speak Up, Stop Harm** (https://protect-advice.org.uk/)
- ✓ Via Staff side/Trade unions

Depending on the nature of the concern raised, feedback is given via the FTSU Guardian or by HR if an investigation was commissioned.

Once the case is closed, a feedback survey is given so that those that have used the service can feedback anonymously on the FTSU service, process and whether they suffered detriment as a result of raising the concern.

ELFT Staff have access to the following Employee Relations, Advice & Support

- ✓ Mediation Service – where to get support
- ✓ Bullying & Harassment – contact an advisor
- ✓ Employee Assistance - https://www.carefirst-lifestyle.co.uk/

Concerns raised

112 concerns were raised to the Freedom to Speak Up Guardian during 2021/22. The most common themes of concerns raised are related to processes and organisational structure, and staff reporting experience of behaviours that amount to bullying and harassment.

FTSU Data: 1st April 2021 to 31st March 2022

	1st April 2021 to 31st March 2022	
FTSU Concern Themes	**Number**	**Percentage %**
Element of patient safety/ quality of care	17	11.6
Element of bullying/harassment/behaviours	38	25.9
Processes/ Organisational Structure/ Other	69	46.9
COVID19 related	2	1.4
Unknown	8	5.4
Worker Safety*	13	8.8
Total Number of Themes Raised**	**147**	100%
Total Number of Cases Raised	**112**	100%

***Worker Safety** added as a category by the National Guardian's Office as of July 2021.

****Total number of themes** *does not always correspond* with the total number of cases raised, as a concern raised by one member of staff can relate to multiple themes.

All concerns raised are escalated to Service Directors and/or HR, as appropriate to the nature of the concern.The work done to resolve the concerns are fed back to who raised them, where possible (as not always possible when raised anonymously).

Themes are reviewed, and where it is possible to respond at a more system level the trust will do so. A good example of this is the implementation of 'Respectful Resolution' Training, which was developed by the Trust in response to cases of bullying and harassment cases being raised (directly with HR, managers and FTSU), to support with resolving these issues/concerns before they come to the point of a formal process.

2.7 Goals Agreed with Commissioners for 2021/22

Use of the CQUIN Payment Framework

In light of the impact on the Covid Pandemic the CQUIN scheme for Providers was suspended, and this will remain the case until 2022/23.

2.8 Data Security and Quality

Clinical coding accuracy was audited this year. The results of the audit demonstrate an excellent standard of diagnostic coding accuracy in the classification of both primary and secondary diagnosis coding, with both areas exceeding Information Governance requirements for Level 3.

IG Audit	Primary diagnosis correct %	Secondary diagnosis correct %	Primary procedure correct %	Secondary procedures correct %	Unsafe to Audit %
2017/18	96.00%	95.00%	N/A	N/A	0
2018/19	98.00%	94.53%	N/A	N/A	0
2019/20	98.00%	97.00%	N/A	N/A	0
2020/21	98.00%	98.01%	N/A	N/A	0
2021/22	100.00%	98.00%	N/A	N/A	0

ELFT's Data Security & Protection Toolkit Assessment Report overall score for 2020/21 was 'Standards met'. Due to the pandemic the timetable for the 2021/22 submission is 30 June 2021. ELFT's overall score for this year is therefore unavailable at this time.

2.9 Learning From Deaths

Numbers of Patient Deaths Reported by ELFT in 2021/2022

During the reporting period 1 April 2021 to 31 March 2022, ELFT reported a total of 2,184 patient deaths of which 1866 were reported as expected and 318 were reported as unexpected. This showed a decrease in deaths by 706 compared to the previous reporting period (2020/2021), when 2890 patient deaths were recorded by the Trust. Overall expected deaths were higher than unexpected deaths.

Table 1 Total deaths reported by ELFT 01 April 2021- 31 March 2022

Period	Number of reported deaths
Quarter 1	523
Quarter 2	464
Quarter 3	602
Quarter 4	595
Totals	2,184

**Due to potential delays in the Trust being notified of some deaths, this figure may change if a further report is produced.*

Patient Deaths Subject to an Investigation

During this period a total of 51.51% (1125) of all reported deaths were subject to an investigation. 854 investigations were conducted using the Trust's Structured Judgment Review/Case Record Review process (SJR/CRR) and 238 investigated through the Trust's internal Serious Incident Review process including; 152 48hr Reviews; 21 Concise Reviews; 65 Comprehensive/Serious Incident [SI] Reviews) .

There were 33 Learning Disabilities Mortality Reviews (LeDeR). The youngest was an 18 year old male who had a degenerative condition and was under the care of the specialist Diana Team.

Table 2 Investigations per quarter and types

Period	Reported deaths	Investigation Type				Total Investigations (%)
		SJR/CRR	48hr	Concise/SI	LeDeR	
Quarter 1	523	241	18	1 concise 18 SI	8	286 (54.68%)
Quarter 2	464	240	36	1 concise 15 SI	4	296 (63.79%)
Quarter 3	602	196	56	10 concise 14 SI	7	283 (47.0%)
Quarter 4	595	177	42	9 concise 18 SI	14	260 (43.69)
Totals	**2,184**	**854**	**152**	**86**	**33**	**1,125 (51.51%)**

Patient Deaths Investigated and Adjudged to be Potentially Due to the Patient Care Provided

None of the 854 SJRs undertaken during the reporting period concluded that poor care provision was contributory to the patient deaths.

A total of 91 Coroners Inquests were concluded. Suicide accounted for 26 of the unexpected deaths. There were 5 Prevention of Future Death (PFD) reports issued by HM Coroners to the Trust during the reporting period.

Reviews of the 91 unexpected deaths heard and concluded at inquest were undertaken and the following themes identified. Associated recommendations and action plans have been developed to address these findings.

Themes:

- Poor or lack of communication
- Inadequate telephone response
- Inadequate assessments
- Failure to carry out observations according to policy
- Failure to record information
- Failure to complete an adequate search
- Failure to understand and provide emergency medical support

Table 3 Estimated deaths adjudged to be potentially due to patient care provided by quarter

Period	Deaths reported	Deaths likely to be related to care provide	%
Quarter 1	523	3	0.57%
Quarter 2	464	0	0%
Quarter 3	602	0	0%
Quarter 4	595	2	0.336%
Totals	**2,184**	**5**	**0.228%**

Summary of ELFT Learning from Case Record Reviews and Investigations Undertaken in 2020/2021

Themes & Trends

Themes and trends from both expected and unexpected deaths across the Trust were considered. The highest number of overall mortalities related to patients under Community

Health Services. The highest numbers of expected deaths in Community Health and Community Mental health Services were between the ages of 76 years and 100 years. This was consistent in Q1, Q2, Q3 and Q4.

A total of 49 patients died, during the reporting period, Trust Wide who had tested positive for COVID 19 in the 28 days prior to death, one of which was an inpatient death.

The remaining 48 deaths took place in the community where death occurred either in a care home; an acute hospital; or in the patient's own home.

The number of COVID 19 deaths declined from 380 after the second peak in January /February 2021 and continued to fall to 128 during Q2. There was a rise in deaths during Q3 and Q4, where deaths remained under 200.

There were no deaths where COVID 19 was the primary Cause of death and where 1a COVID 19 was recorded on the patient death certificate.

COVID 19 deaths were investigated within the samples of SJR's reviewed. These deaths were 'of patients who were on an End of Life Pathway prior to contracting COVID 19 and were not for resuscitation or for ventilation. All had authorised Do Not Attempt Resuscitation (DNAR).

Overall, there were more expected deaths than unexpected deaths.

End of Life Pathway (ELP) and Preferred Plan of Care (PPC)

Over the period 1 April 2021 to 31 March 2022 there has continued to be a steady increase in the number of patients with an End of Life Plan (ELP) in place. Patients that did not have an ELP in place and available for review had either; deteriorated unexpectedly requiring an emergent hospital or hospice admission or the patient was referred to ELFT and died before being seen or they were patients who had contracted and died from COVID 19. Patients without an ELP were not specific to a single directorate or geographical area.

Age

Overall expected deaths were higher in Community Health Services as they include more patients', in contact with Trust services, over 65 years of age and older, terminally ill patients and patients in receipt of palliative or end of life care.

Patients whose expected deaths resulted in an SJR tended to be older and were either accessing Community Health Services or Mental Health Services such as the Memory Clinics and therapies. Many of the older Mental Health Service users were also under continence, podiatry and diabetic services.

The highest mortality rates were observed in the 76 – 100 year old age group. Deaths that occurred in patients under the age of 18 were all under Specialist Children's Services and all had life limiting conditions.

Gender

Differences in the numbers of deaths in males and females were noted monthly throughout the reporting period. Variations in gender were minimal and when observed as a collective showed that overall only 6 more deaths were recorded in males than in females.

Standard of care

Care of the dying person was reviewed using the East London Foundation Trust (ELFT) Dignity in Care at the End of Life Practice Guidance and the Gold Standard Framework (GSF) Guidance.

Reviewers look at the quality of information being reported on the daily DATIX notifications incident report: missing information, missing patient details and any other required information.

Case notes on the Trust's electronic patient recording systems (RiO; EMIS and SystmOne) are reviewed and look at the care a dying person has received. Reviews are guided by the East London Foundation Trust (ELFT) Dignity in Care at the End of Life Practice Guidance and the Gold Standard Framework (GSF) Guidance.

Dignity in Care at the End of Life Practice Guidelines enables teams to develop a person-centred holistic plan of care enabling patients to make their own choices on where they wished to be cared for and their preferred place to die.

The GSF sets out 7 domains of guidance communication; co-ordination; control of symptoms; continuity of care; continued learning; care support and care in the dying phase. The domains are reviewed under the SJR process.

Between April 2021 and March 2022 the case notes reviewed under the SJR process showed that in general the care delivered across the Trust met the requirements expected when caring for a dying person and had a GSF EoLP or a Co-ordinate My Care plan (CMC) in place.

Patients that did not have an EoLP in place that was available for review had either: deteriorated unexpectedly requiring a hospital or hospice admission and end of life care was not provided by ELFT, or the patient was referred and died before being seen.

Diagnosis and Cause of Death

The highest number of deaths arose in patients with cancer and organ failure. Cancer related deaths were higher in all age ranges followed by deaths from organ failure. Older patients also died from causes related to end stage dementia and symptoms of COVID 19, not all cases were confirmed COVID 19.

Actions Taken and Planned based on Learning from Deaths

The Learning from Deaths Panel review process for the Trust evolved during the course of 2021/2022. The panel is responsible for overseeing the SJR process and during the course

of the year the group identified repetitions in themes arising following mortality reviews and moved to focus in greater depth on learning and driving improvements to end of life care planning and the revision of services where necessary.

Going forward, The Learning from Deaths Group 2022- 2023 plan is to focus on;

I. Reviewing and evaluating End of Life Pathways to determine whether patients' preferences, including their wishes related to where they wish to die, have been met or not.

II. Engaging in Partnership Learning from Deaths together with ELFTs partner healthcare providers, including GPs and Hospices.

III. Engage with Homeless Services, Rough Sleepers Mental Health Project (RAMHP) and St Mungo's Homeless Charity to identify themes and issues in accessing palliative care and support at the end of life.

IV. Reviewing, with the aid of the Structured Review of Deaths Toolkit;

- deaths on the national personal demographics spine against those reported on the Trust's incident reporting database (Datix)
- individual case reviews
- Themes and trends identified from the process of care

V. Conducting High Level Strategic Reviews of all deaths to inform systems and planning processes.

VI. Embracing learning from PFD reports issued to other organisations where the patient safety of ELFT patients can be further enhanced.

VII. Consider ways of providing enhanced support to ELFT staff emotionally affected by the death of long-term patients'/service users. The Trusts team of Serious Incident Reviewers will receive training in bereavement awareness to improve the support offered to families.

At the time of writing, the Trust has responded to 4 of the issued PFD's and has taken appropriate actions to address the issues raised in the PFD's. The PFD yet to be formally responded to by the Trust is currently being reviewed to develop appropriate action plans to address the issues raised.

2.10 Reporting against core indicators

2.10.1 NHS Improvement Assurance

This section of the report sets out indicators that are part of the Single Oversight Framework (SOF) which has replaced the Monitor 'Risk Assessment Framework' and the NHS Trust Development Authority 'Accountability Framework'.

East London NHS Foundation Trust considers that this data is as described for the following reasons: The Trust has data quality arrangements in place which ensure the Trust's Commissioners, Trust Board and Information Governance Steering Group receive regular reports on data quality and completion rates against agreed targets. The IG Steering group receive and review performance on data quality benchmarked across London and nationally including the use of the Data Quality Maturity Index dashboard information.

2.10.2 Single Oversight Framework Indicators

These indicators form part of appendices 1 and 3 of the Single Oversight Framework. The table below details each of the Trust's Performance against the Quality of Care Indicators and the Operational Performance Metrics (if not shown elsewhere in this report):

Quality of Care Indicators	**Target**	**Actual 2017/18 (Q4)**	**Actual 2018/19 Q4**	**Actual 2019/20 Q4**	**Actual 2020/21 Q4**	**Actual 2021/22 Q4**
Admission to adult facilities of patients under 16 years old	0	0	0	0	**1**	**9 (During Q4)**
Meeting commitment to serve new psychosis cases by early intervention teams' measure. People experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	50%	94%	88.24%	70.2%	50.7%	73.3% (During Q4)
Operational Performance	**Target 2018/19**	**Actual 2017/18 (Q4)**	**Actual 2018/19 Q4**	**Actual 2019/20 Q4**	**Actual 2020/21 Q4**	**Actual 2021/22 Q4**
Cardio Metabolic Assessment &Treatment a) inpatient wards	90%	77.1%	70%	64%	**This CQUIN is no longer monitored**	
b) early intervention in psychosis services	90%	90%	87%	85%		
c) community mental health services (people on Care Programme	60%	83.7%	84%	82%		

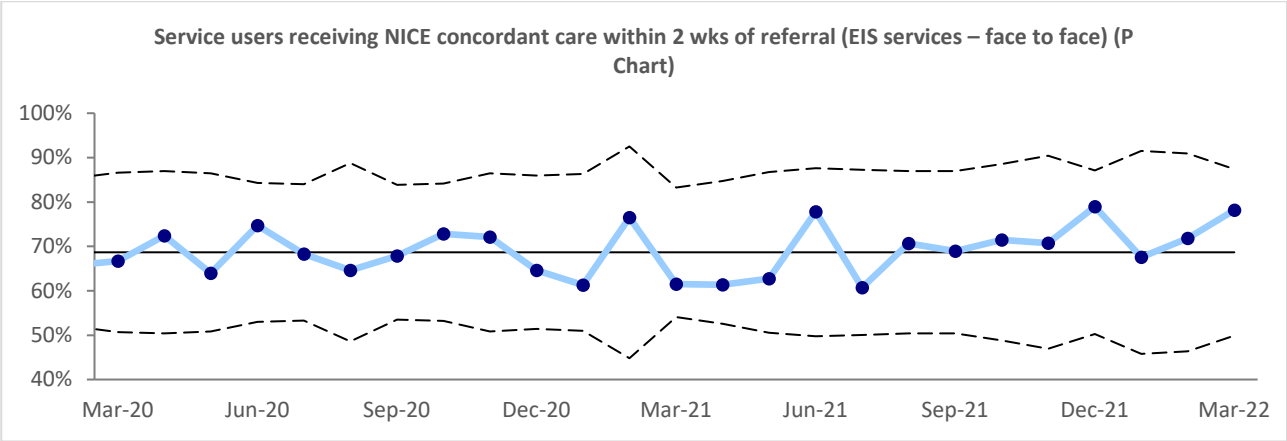
Approach)						
Proportion of people completing treatment who move to recovery (from IAPT MDS)	50%	50.1%	53.2%	51.6%	**55%**	52% (During Q4)
Improving Access to Psychological Therapies - Patients referred with 6 weeks measure	75%	98.1%	97.1%	98.1%	**99.6%**	Now reported as average weeks waited – 0.9 end of Q4
Improving Access to Psychological Therapies - Patients referred with 18 weeks measure	95%	99.9%	99.6%	100%	**100%**	Not reported – see above
Inappropriate Out of Area Placements for adult mental health services	n/a	0	0	2	**3**	Not reported

		Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q4 2021/22
Inappropriate Out of Area Placements for adult mental health services		3	0	2	3	4
Admission to adult facilities of patients under 16 years old		1	2	2	4	2

2.10.3 Quality of Care Indicators

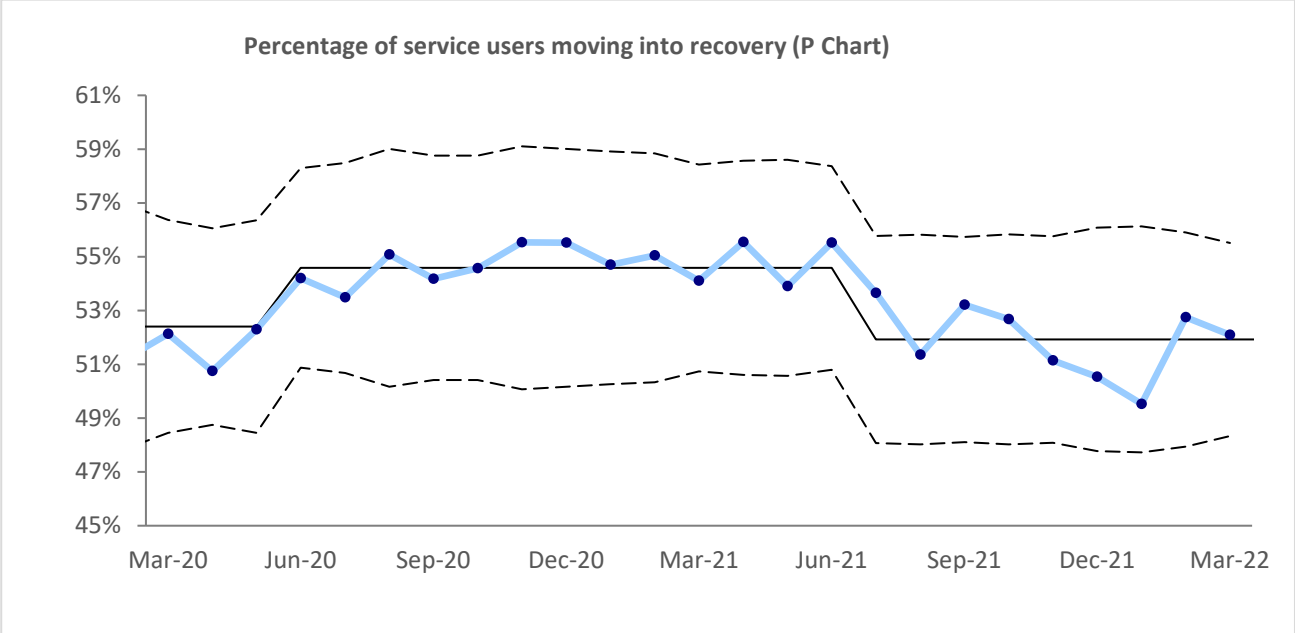
1. **Meeting commitment to serve new psychosis cases by early intervention teams' measure. People experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral**

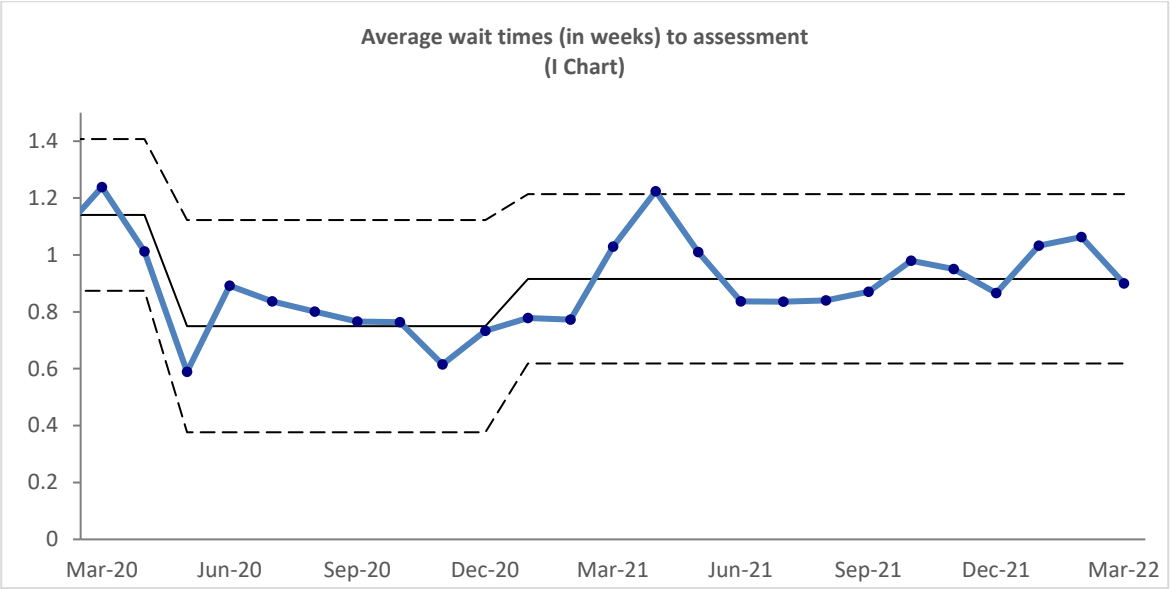
Percent of service users receiving NICE Standard treatment within two weeks of referral to early intervention in psychosis service – *excludes telephone or face to face contacts as per current definition* (Trustwide)

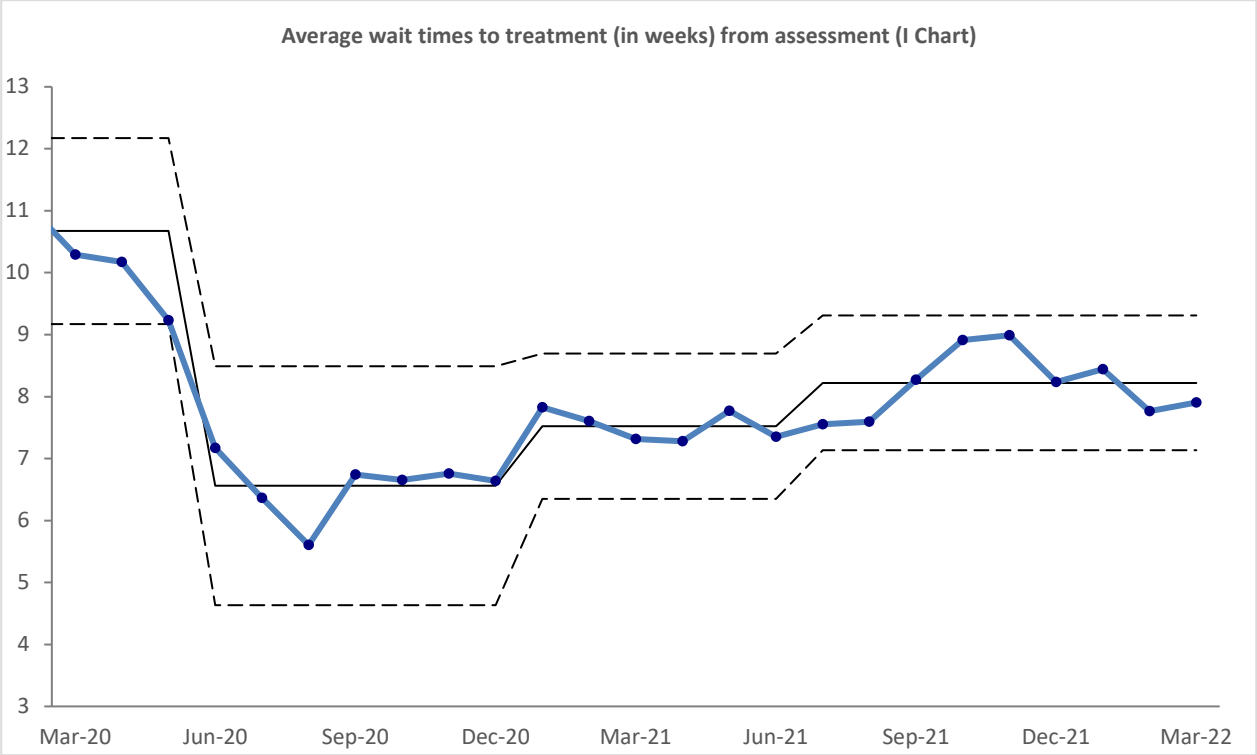


Operational Performance

2. Psychological Therapies







2.10.4 Care Programme Approach (CPA)

The CPA is the framework through which care and treatment is delivered for a large proportion of the Trust's service users. The table below contains locally defined indicators and targets agreed with commissioners.

Indicator	Target	Actual 18/19 Q4	Actual 19/20 Q4	Actual 20/21 Q1	Actual 20/21 Q2	Actual 20/21 Q3	Actual 20/21 Q4	Actual 21/22 Q4
Indicator	**Target**	**Actual 18/19 Q4**	**Actual 19/20 Q4**	**Actual 20/21 Q4**	**Actual 21/22 Q1**	**Actual 21/22 Q2**	**Actual 21/22 Q3**	**Actual 21/22 Q4**
CPA patients – care plans in date (documents 12 months old)	95%	87.4%	88.3%	48.7% 1987/4080	60.2% 2514/4176	61.8% 2560/4145	62.0% 2476/3996	58.7% 2061/3510
CPA patients – care plans in date (documents 6 months old)	N/A	73.5%	67.2%	42.3% 1708/4034	49.3% 2058/4176	48.5% 2009/4145	45.7% 1824/3996	42.5% 1492/3510

Trust services embed the new process and the use of RiO and continue to monitor reviews regularly focusing on supporting teams that are not meeting the target.

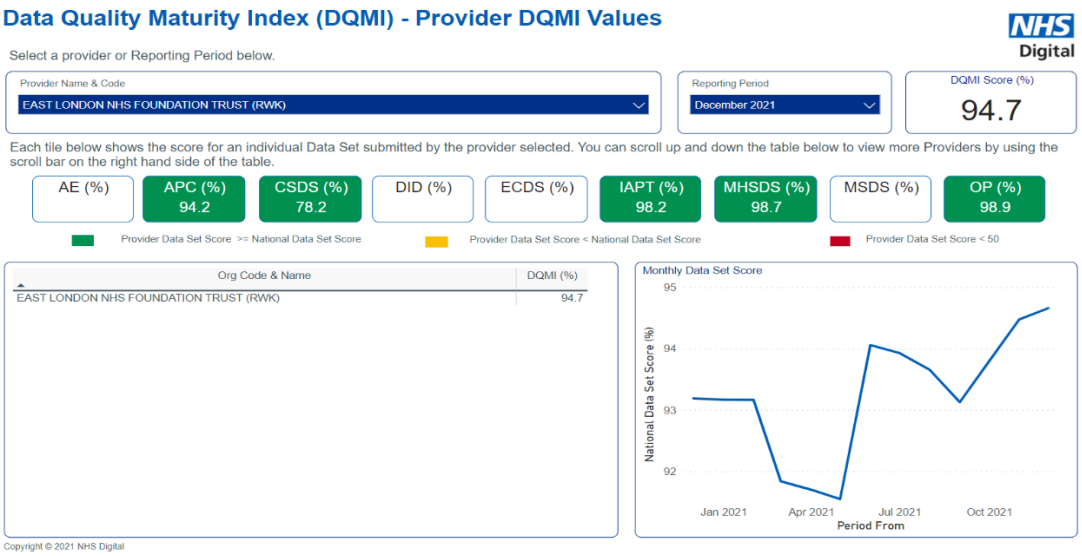
2.10.5 Data Quality Maturity Index reporting

Data quality metrics and reports are used to assess and improve data quality

The datasets the Trust submits are:

- Mental Health Services Data Set (MHSDS)
- Community Services Data Set (CSDS)
- IAPT Data Set
- Admitted Patient Care
- Out Patients

The visual below shows the DQMI scores published on the NHSI website and can be found here (DQMI)



PART 3 – Other Quality Performance Information 2021/22

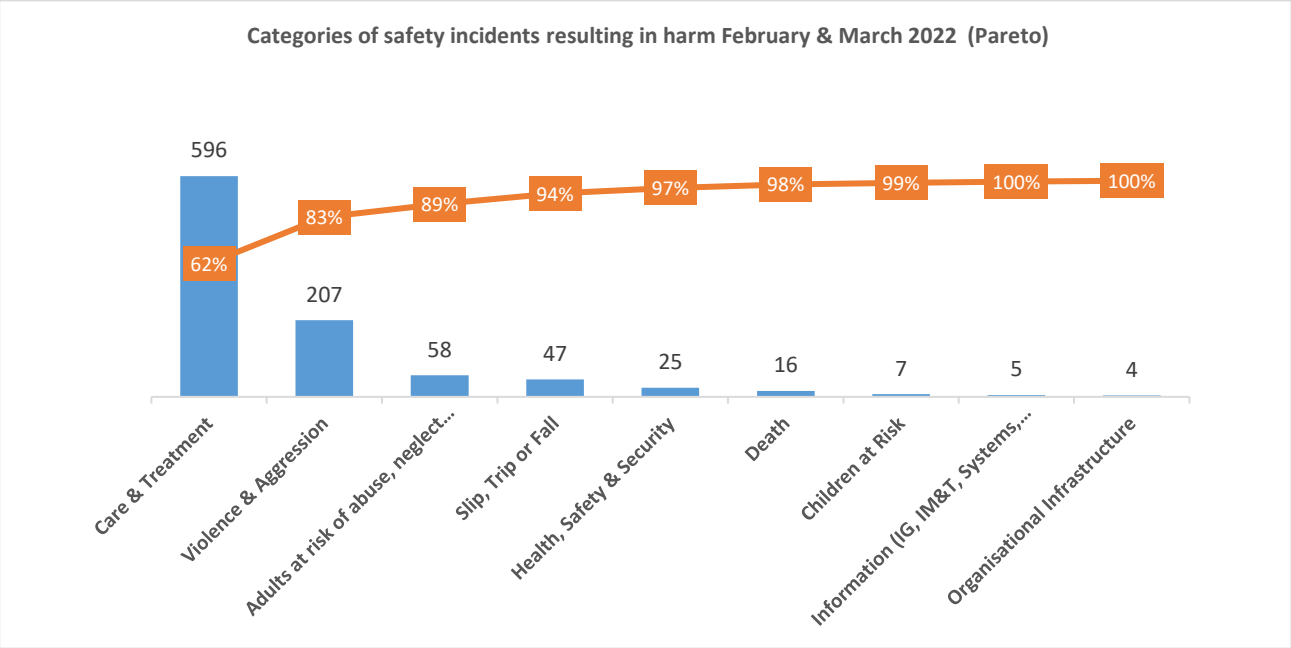
3.1 An Overview of Key Dimensions of Quality During 2021/22

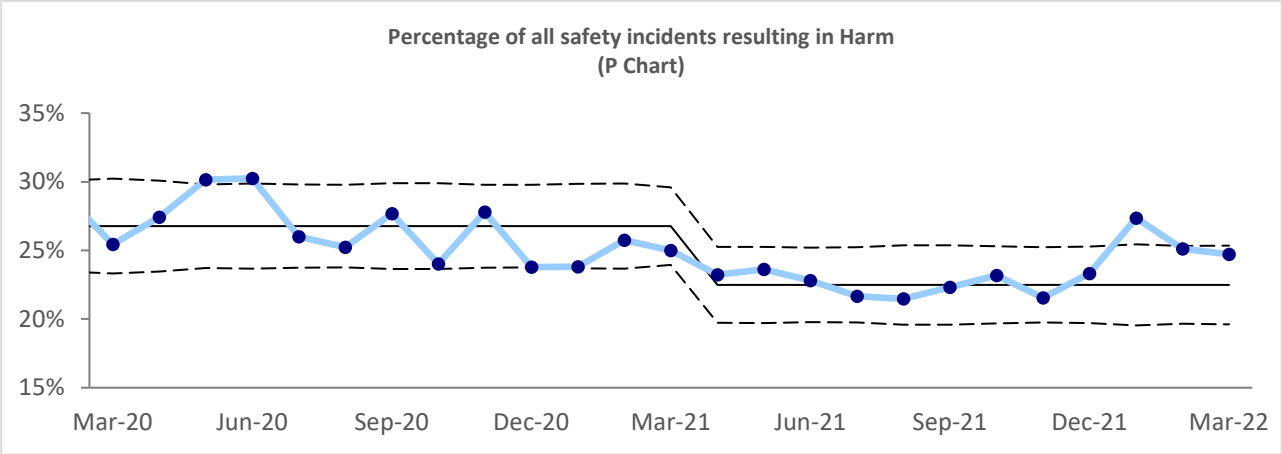
The Trust pays close attention to a whole range of a set of quality measures. The Trust Board monitors measures that enable oversight of delivery of the Trust strategy. A broader selection of quality and performance measures are available to all staff at Trust-wide, Directorate and Service level via our real-time dashboards.

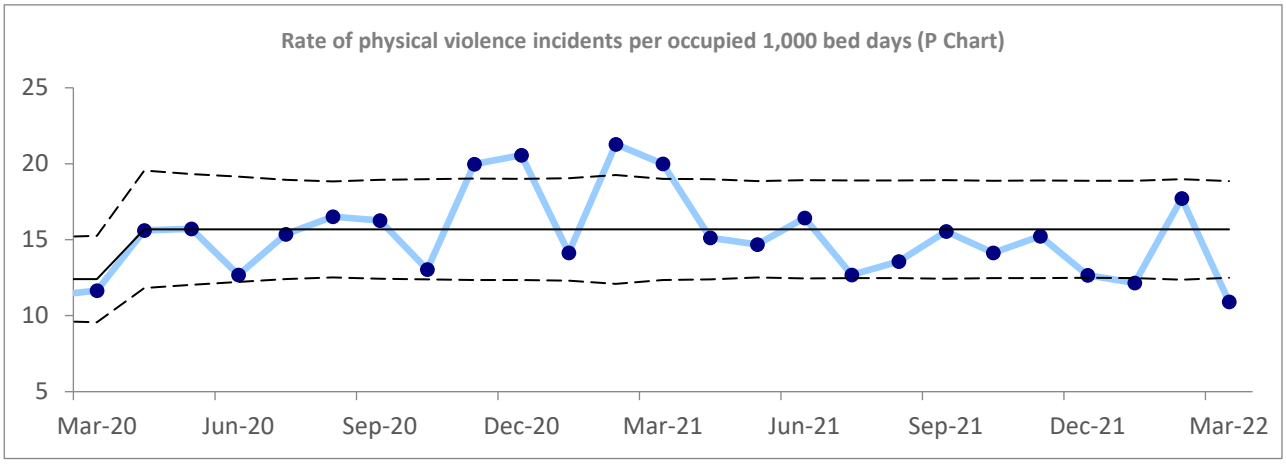
Key metrics in the domains of patient safety, clinical effectiveness and patient experience are drawn from both dashboards and set out below as a Trust-wide view. They are intended to give a flavour of the quality data that the Trust generates and uses, and, read alongside the other content of this report, of the prevailing quality of Trust services. Some measures are Mental Health specific, others relate to Community Health Services, reflecting the increasing diversity of the Trust. Each is relevant to priority areas for the Trust, encompassing improving physical health, access, experience of care.

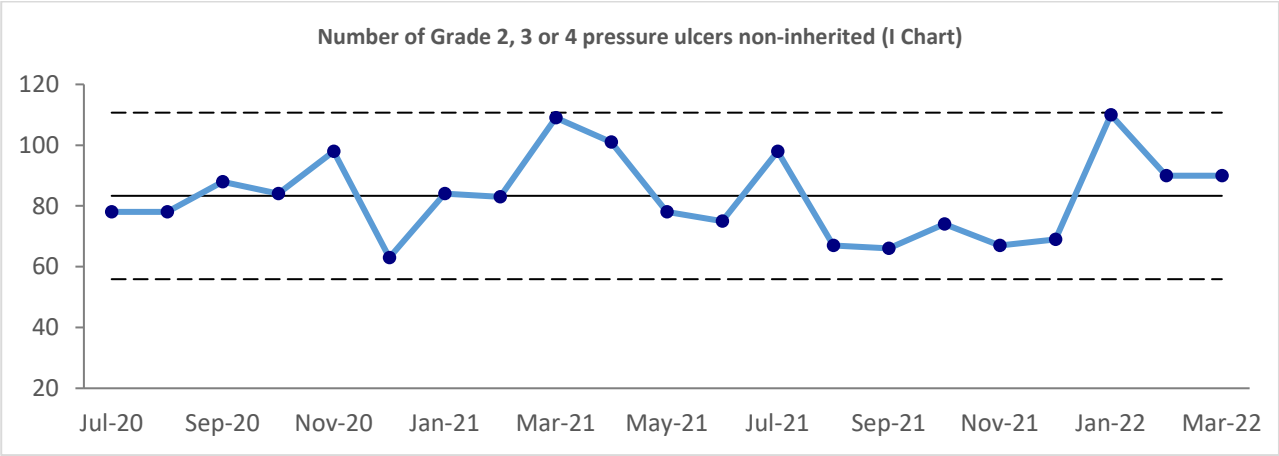
Data shows progress over time, enabling informed decision-making in relation to assurance and improvement. Data is generated from the Trust's internal reporting systems; it is not benchmarked but triangulated with relevant internal data to build an accurate picture of the quality of services.

3.1.1 Patient Safety









The Pareto chart above shows the distribution of reported incidents by category during February and March. This highlights that 62% of all reported incidents related to care and treatment, 21% related to violence and aggression and 6% related to adults at risk of abuse or neglect. The main care and treatment themes were pressure ulcers, self-harm incidents, moisture associated skin damage and overdose of medication.

The last three months have seen an increase in the percentage of safety incidents resulting in harm. This is believed to be linked to increased levels of complexity and acuity experienced by services..

Patient safety incidents resulting in harm are reviewed to ensure appropriate remedial action, but also to understand underlying causes and systemic issues that may be contributing to their occurrence, enabling improvement actions to be put in place.

The overall number of pressure ulcers remains stable although some teams continue to struggle with staffing vacancies and increased complexity of service users on the caseload who are at risk of developing pressure ulcers despite preventative measures being in place. Across Bedfordshire, low harm pressure ulcers (category 2 and Suspected Deep Tissue Injury - SDTI) are showing an increase, but these have not deteriorated into moderate harm pressure ulcers (category 3 and unstageable), which is reassuring.

However, there are early signs that the number of moderate pressure ulcers are starting to increase across Tower Hamlets and Newham in the last few weeks. This is believed to partly relate to a focused piece of work on improving accurate pressure ulcer categorisation and reliability of skin checks being completed at every contact. This has included Datix training and services often report a rise in the number of recorded incidents after training and awareness sessions are delivered.

Further investigation on three weeks of data for moderate harm pressure ulcers (category 3 & unstageable) indicate that all equipment and preventative measures were in place for those patients on the end-of-life pathway. Additional support was provided to the team to correctly categorise the pressure ulcers utilising wound photography. Investigations are also being conducted where there has been a delay in documentation at the first assessment and where residential staff did not escalate a delay in equipment.

The rate of physical violence on our inpatient units continues to fall as a result of a range of initiatives that had been detailed in previous reports. The rate of restraints increased above normal levels during February as a result of higher occupancy levels and a few service users with complex needs.

The Trust is committed to providing a safe environment for its staff, service users and visitors, as well as delivering high standards of care. It acknowledges that sometimes, in the course of providing healthcare, incidents can occur. Some of these incidents may have serious consequences for service-users, their carers, families, staff and the public. In some cases, even where human error is involved, incident investigation may reveal other related organisational failings which need to be addressed.

The Trust positively encourages open and honest reporting of risks, hazards and incidents regardless of the level of harm caused. The Trust is very committed to promoting a culture of openness and has adopted the Being Open principles.

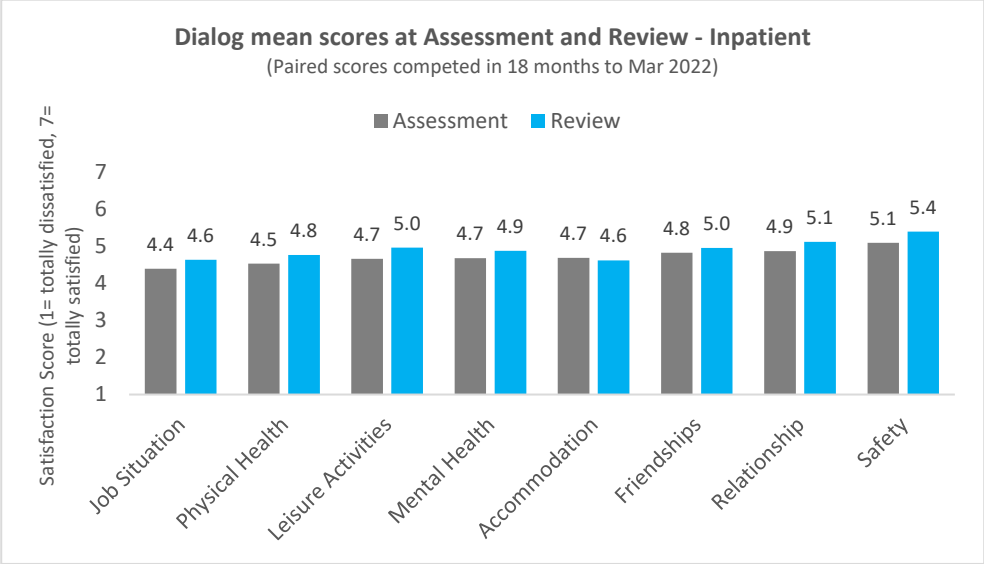
In order to deliver improvements in incident reporting the following have been undertaken to ensure;

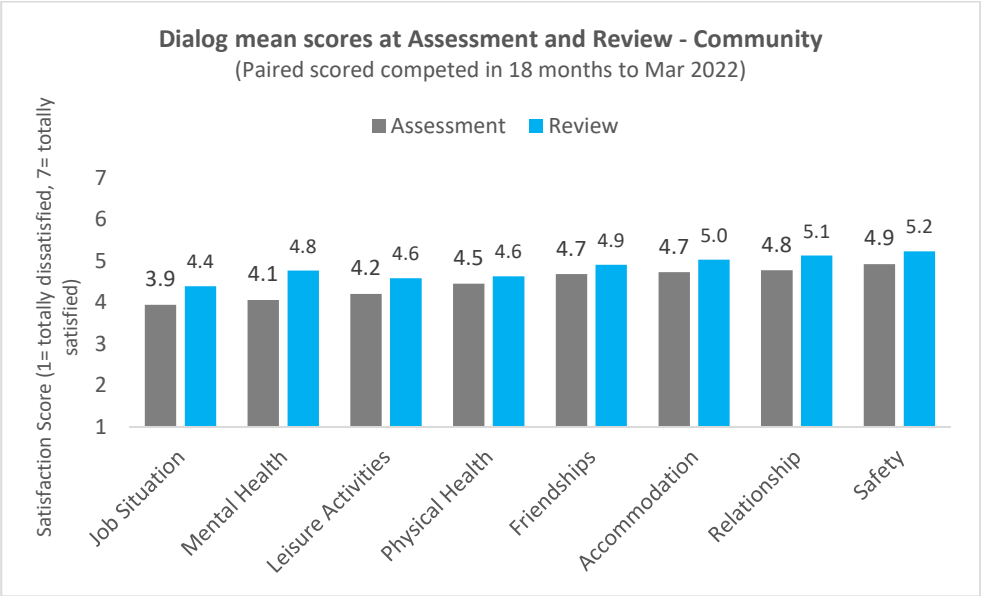
- Continual development of the Datix risk management software system
- Targeted training programmes at all levels
- Leadership training
- Induction training for new services
- Improved literature to support increased levels of incident reporting
- Addition of new reporting categories i.e COVID
- Improvements to the incident reporting system to more effectively deliver Duty of Candour requirements.

3.1.2 Clinical Effectiveness

The Trust monitors a range of measures of clinical effectiveness as part of its view on the quality of its services. The measures feed into our understanding of patient experience and value within our strategy. The charts below show some of the measure the Trust Board sees every month as it tracks progress towards our objectives

Measuring outcomes

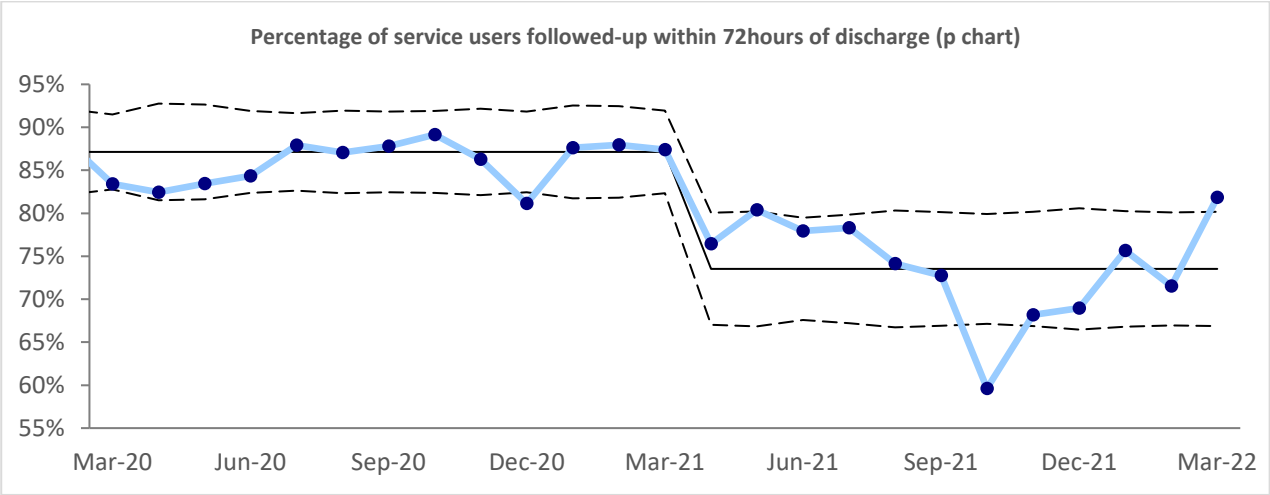




The Dialog outcome charts show the results of paired outcome measures for service users who have received care from both community and inpatient mental health services. For inpatient services, the top three dissatisfaction domains are employment, physical health, and leisure activities, whereas, for community services, it is primarily related to employment, mental health, and leisure activities. This is based on 2136 outpatient and 401 inpatients paired scores.

Overall, the data shows improvement in average scores between initial assessment and subsequent review for both cohorts of service users across all dissatisfaction domains, more pronounced in community teams. It should be noted that inpatient analysis is based on a relatively small cohort of service users with paired scores. Furthermore, most inpatient services are still working to integrate the use of Dialog as part of a single care planning tool for the whole multidisciplinary team.

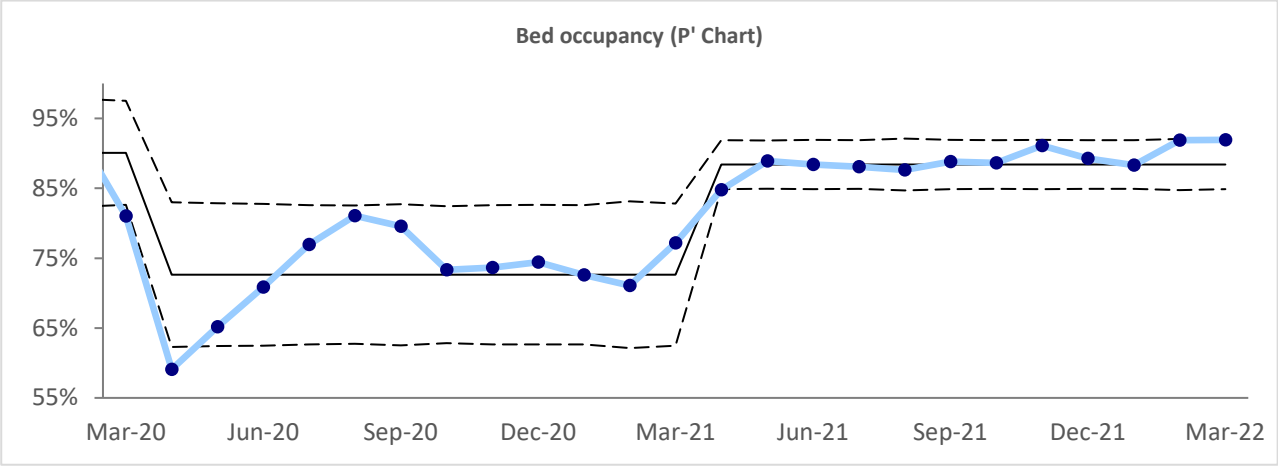
The Care Programme Approach (CPA), which governs current care management, is being replaced with a new care model that is yet to be announced. It is believed that this refresh will support mobilising Dialog further across mental health services for all service users. Over the next two months, teams will be able to view change in Dialog scores over time, at service user level and at service and directorate level, through PowerBI. This will enable clinicians and teams to be able to better monitor impact on outcomes and quality of life.

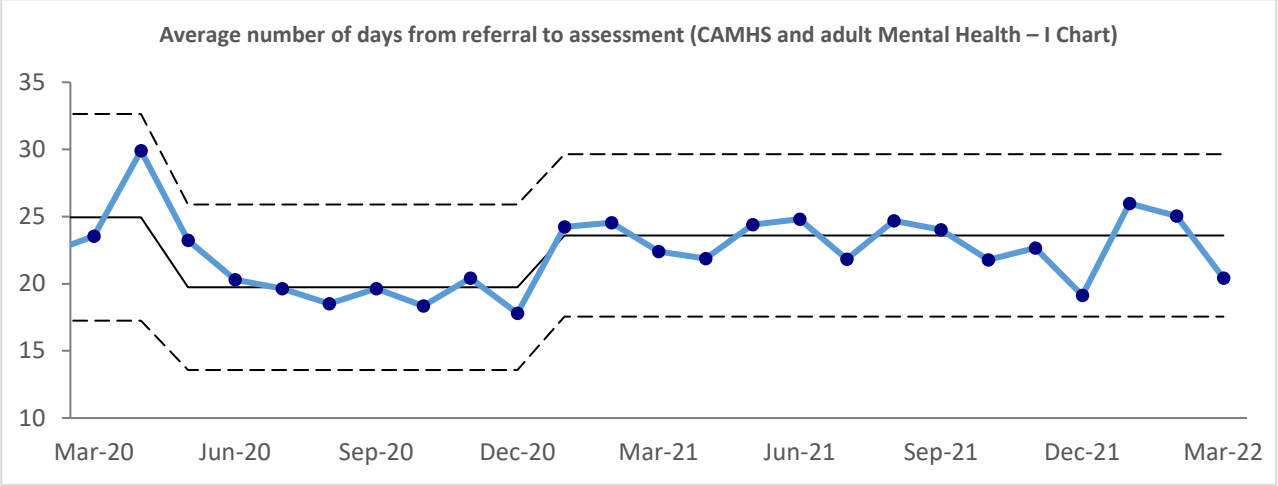


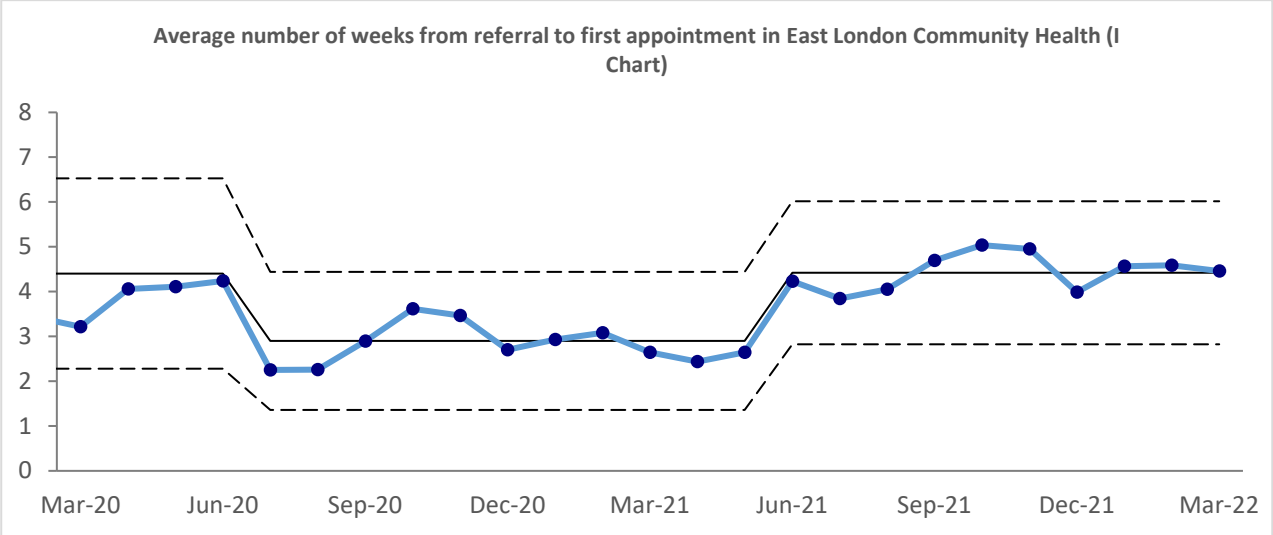
The percentage of service users followed up within 72 hours of discharge has continued to improve, reaching 82% in March and exceeding the national 80% target for the first time. This reflects improvements across all services, particularly in City and Hackney. City & Hackney held a “reset” meeting in January and have implemented new processes similar to other services, where wards were given responsibility to follow up all discharges. This led to the introduction of named 72-hour follow-up champions to oversee follow-up care.

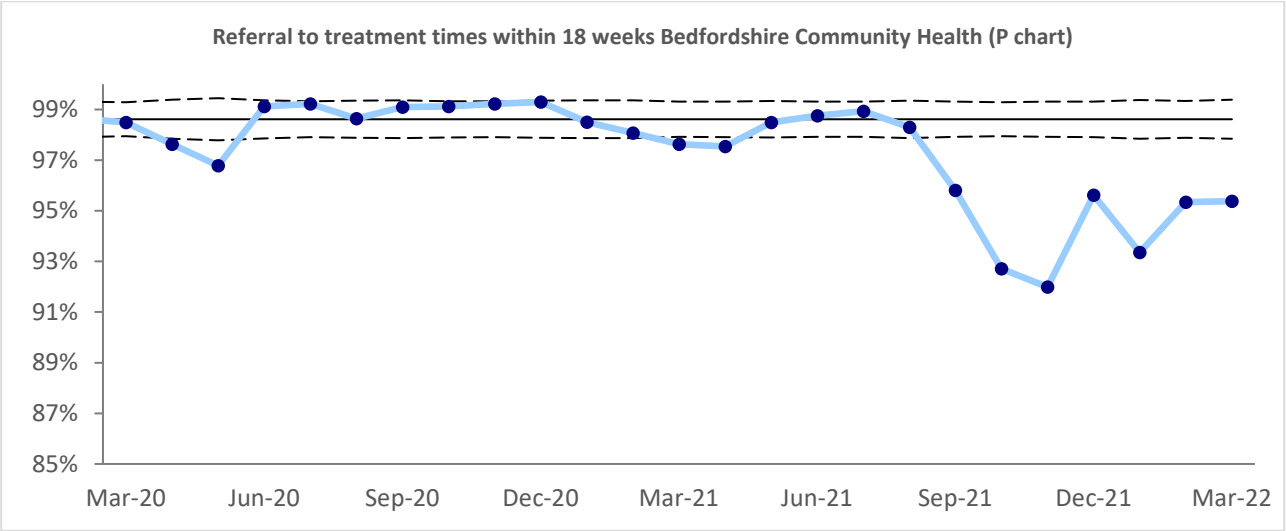
The service is working with these champions to improve monitoring procedures, reviewing any instances where standards are not met and feeding their findings back to their teams regularly during team huddles.

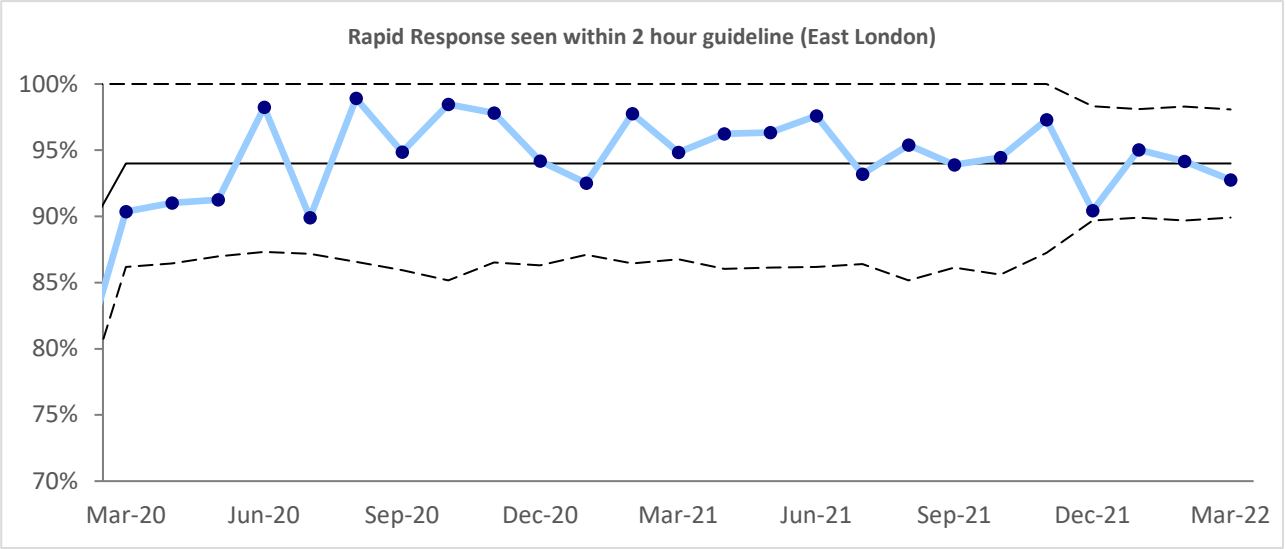
Access to services

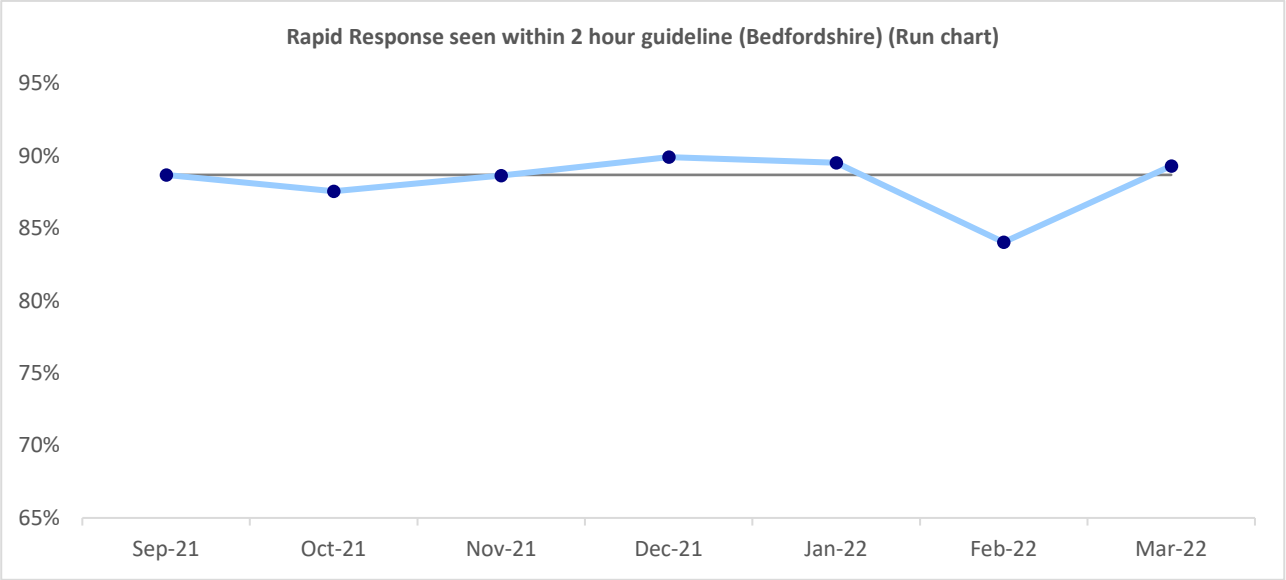












The charts above provide a summary of the total number of service users waiting to be seen across the Trust. The overall waiting list for assessment and treatment is decreasing. There

has been progress in reducing waiting lists and backlogs across several services including Tower Hamlets Mental Health and Memory Assessment Services across Luton & Bedfordshire. Across CAMHS, ADHD and autism services, the total number of service users waiting continues to rise.

The services that have large waiting lists have produced recovery plans to help plot trajectories based on their current demand and capacity estimates, and are utilising quality improvement to develop and test creative ideas. A Trustwide Quality Improvement (QI) programme on flow is due to start in June to support to improve flow, manage demand and redesign pathways to enable greater access.

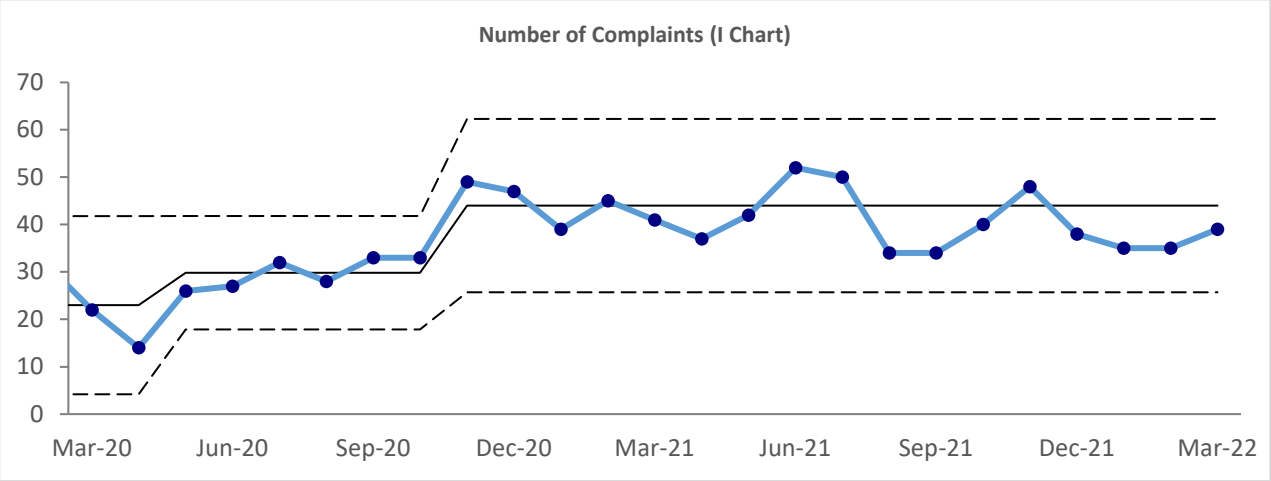
Forty-three services across the Trust have developed recovery plans for their waiting lists, 15 of these are seeing a reduction, 9 remain stable, and 19 are increasing. Of those experiencing a reduction, Memory Services across Luton and Bedfordshire and Tower Hamlets Learning Disabilities have seen the greatest reduction.

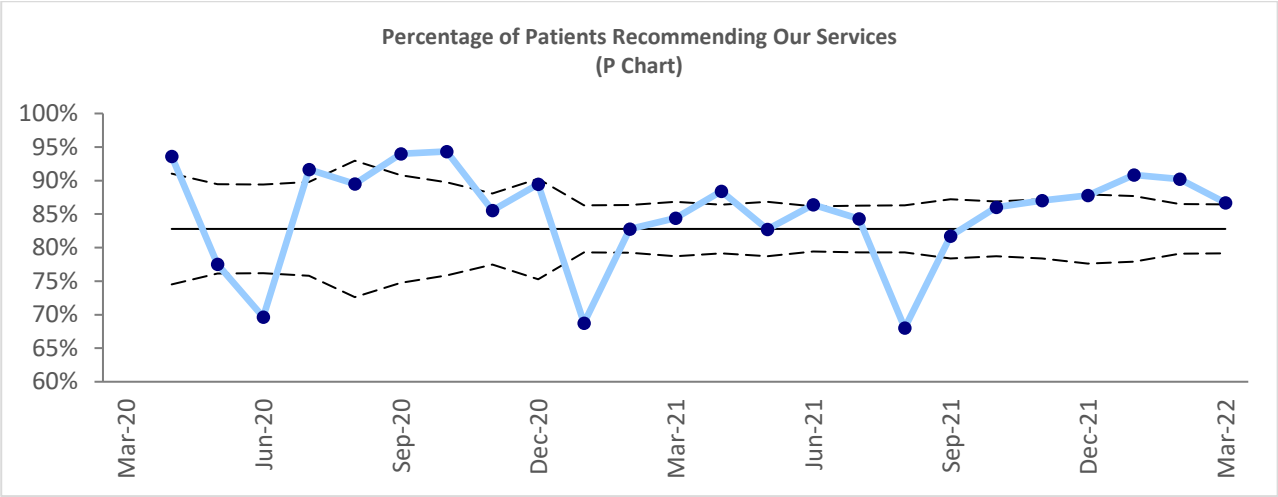
The Memory Services in Bedfordshire managed to secure additional clinic space to increase their capacity in January and a funding proposal for additional staffing was submitted this month to expand the number of appointments the service can offer. The service is working with primary care colleagues in Central Bedfordshire to provide early diagnosis for service users that do not have co-morbid conditions.

In Tower Hamlets, the Learning Disabilities service has started working with the CAMHS team to understand the complexity of service users that are likely to enter the service in the future, in order to plan for future demand and improve the young person's transition from CAMHS to the Learning Disability service.

3.1.3 Patient Experience

Central to the delivery of the Trust's Strategy is the belief that all people who use the services provided by the Trust should have the opportunity to leave feedback regarding their experience. The charts below provide assurance across a range of service user experience indicators.





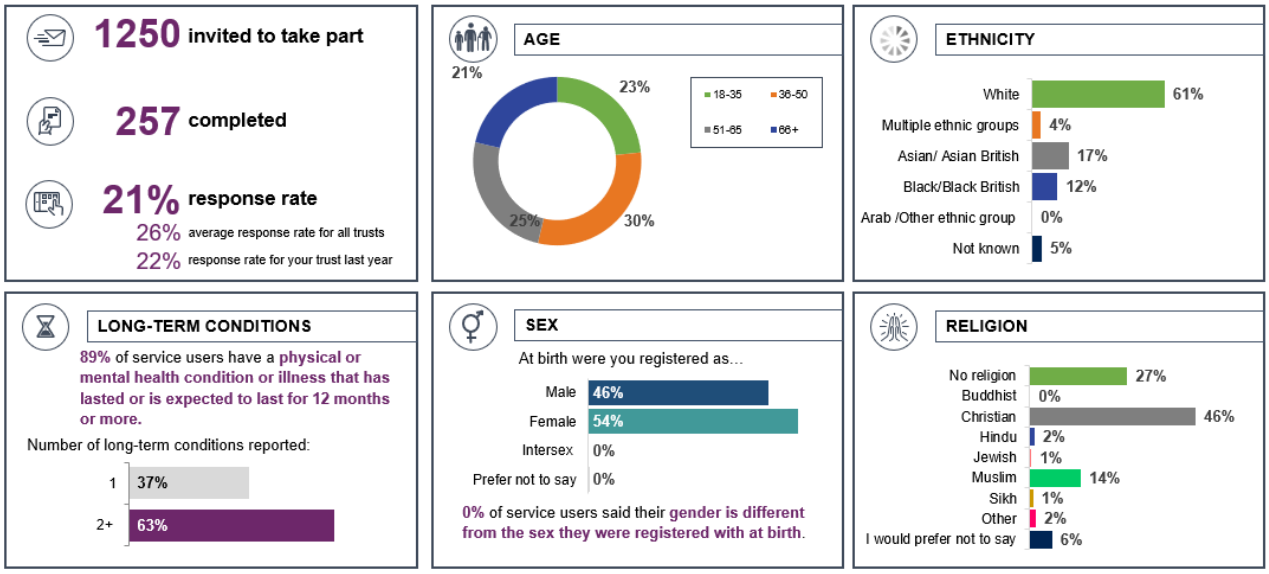
The number of complaints remains stable and has now been below the average of 44 for seven of the past eight months. The top complaint themes continue to relate to communication, attitude of staff, assessment, access to services and clinical management. Lessons are routinely shared across different forums to support improvement.

The percentage of service users who would recommend our services remains high at 87% in March. There has been a further 3% increase in number of responses received monthly, largely related to Newham, Tower Hamlets and Specialist Children & Young People's Services. The Quality report contains a deep dive analysis into the themes from service user experience feedback, triangulated with other forms of service user and staff feedback.

Externally, the Trust also receives feedback on service user experience via the annual Mental Health Community Service User Survey. This is an annual postal survey that provides a snapshot of service user experience, it administered by an appointed contractor and sponsored by the Care Quality Commission.

The National Service User Survey was undertaken for East London NHS Foundation Trust between February and June 2021.

The figures below summarise participation and the findings of the report.



Where service user experience is best

- ✓ **Crisis care contact:** service users knowing who to contact out of hours in the NHS if they have a crisis
- ✓ **Medicines review:** NHS mental health services checking how service users are getting on with their medicines
- ✓ **Views on quality of care:** NHS mental health services asking service users for their views on the quality of their care
- ✓ **NHS Talking Therapies:** staff explaining NHS talking therapies in a way service users can understand
- ✓ **Seen often enough:** service users being seen by NHS mental health services often enough for their needs

Where service user experience could improve

- **Enough time to discuss treatment:** service users being given enough time to discuss their needs and treatment
- **Who organises care:** service users being told who is in charge of organising their care and services
- **Crisis care help:** services users getting the help needed when they last contacted the crisis team
- **Communicating changes in care due to Covid-19:** informing service users of changes in care due to Covid-19
- **Mental health needs:** staff understanding how service user mental health needs affect other areas of their life

As set out in the introduction to this report , it's anticipated that the transformation work taking place across community services will serve to improve patient experience.

In addition to the range of work in support of the strategic objective to improve experience of care, during 2022/23 the Trust will be enhancing it's understanding and ability to respond and improve through the Care Opinion platform, opening up far greater functionality and support. The Quality Assurance Team is currently leading a project, working with clinical services, and their service users, to engage with the platform and optimise it as a means of understanding, learning from and responding to patient experience.

The project will also include a focus on bringing together the full range of patient experience feedback, and putting in place structures to share, make sense of, and make use of the information in the round.

3.2 Achievements and Awards

The Forward Healthcare Award: Workforce & Staff Engagement
Multiple trust teams and colleagues led by the People & Culture team won The Forward Healthcare Award for the category Workforce & Staff Engagement for their work to create and deliver the Learning Activities programme for staff children and families during lockdown in November.

Royal Society for Public Health Health and Wellbeing Awards 2021
Professor Michelle Heys, a Consultant Paediatrician based within the Trust's Newham Specialist Children & Young Peoples' Services (SCYPS), is part of a team that won the Royal Society for Public Health Health and Wellbeing Awards 2021 for their work on the Nurture Early for Optimal Nutrition (NEON) programme

Violence Initiative Award
The National Association for Healthcare Security award for Violence Reduction Initiative went to ELFT's Richard Harwin and Bedfordshire Police for their collaborative work to ensure safety on inpatient wards for staff and patients in November 2021.

Queen's Nursing Institute
The Queen's Nursing Institute International Award went to Newham based nurse Mark Rodruguera in December 2021.

Zenith Global Award
A Zenith Global Health Award went to ELFT's Director of Nursing Ruth Bradley for her work promoting excellence in healthcare in December 2021.

HSJ Workforce and Wellbeing Initiative
Winners of the HSJ Partnership Awards 2021, for the category Workforce & Wellbeing Initiative of the Year. Digital innovators Improve Well and ELFT's QI team worked together to develop a staff wellbeing app.

Positive Practice in Mental Health (PPiMH) Awards 2021
Three ELFT Winners:

- The Trust's team leading the Community Mental Health Transformation project were joint winners for the Quality Improvement and Service Transformation Award.
- The John Howard Centre's Clerkenwell Ward won the Learning Disability, Autism and ADHD Services Award.
- The Peer Support Services Award went to the Trust's Telephone Befriending Service based in Luton and Bedfordshire.

BMJ Awards 2021 for the Diversity & Inclusion Team Award
East India Ward, John Howard Centre were winners for the BMJ Awards 2021 for the Diversity & Inclusion Team Award, for their work in Recognising Racism. October 2021.

HSJ Value Awards 2021
The HSJ Value Awards 2021 saw the City & Hackney Specialist Psychotherapy Service win for their work to create A Digital Recovery Platform for Severe Mental Illness with partners in the local Integrated Care Partnership, North East London CCG, The Advocacy Project and Core Arts.

Additionally, ‘The Darzi Seeds of Change Project for the People by the People’ won for the HSJ Value Pilot Project of the Year Award. This collaboration involved ELFT clinicians and the Trust’s Tower Hamlets Recovery College take part.

3.3 An Explanation of Which Stakeholders Have Been Involved

The Trust has a long history of working collaboratively with our service user and carer groups, the Trust Governors and local stakeholder groups. There is significant service user and carer participation in all of the Trusts key overview and reporting mechanisms, e.g. the Trust Board, Quality Committee, People Participation Committee and the Patient Experience Committee meetings.

3.4 Statements of Clinical Commissioning Groups (CCGs)

BLMK
Integrated Care System

NHS
Bedfordshire, Luton and Milton Keynes
Clinical Commissioning Group

Statement from Bedfordshire, Luton & Milton Keynes Clinical Commissioning Collaborative (BLMK) to East London Foundation NHS Trust (ELFT) Quality Account 2021 – 2022

BLMK Commissioning Collaborative acknowledges receipt of the 2021/2022 Quality Account from East London Foundation Trust (ELFT). The Quality Account was shared with BLMK's Executive Directors, Contract, Performance and Quality Teams and systematically reviewed by key members of the CCG's Quality Committee & Performance, as part of developing our assurance statement.

The CCG have been working closely with the Trust during the year, gaining assurance on the delivery of safe and effective services. Across Bedfordshire we have worked closely with ELFT and Partners (LA, Healthwatch and ELFT senior leaders) in gaining assurances and updates. In line with the NHS (Quality Accounts) Regulations, BLMK CCG have reviewed the information contained within the ELFT Quality Account and checked this against data sources, where this is available to us as part of our existing monitoring discussions and confirm this to be accurate.

BLMK CCG would like to commend ELFT on their efforts to manage and support patients and staff through the ongoing and relentless challenges of the COVID-19 response over 2021/22. We recognise the significant increase in demand on both the Community and Mental Health services which includes recovery and restoration of services alongside the joint work from ELFT with other local providers to reduce system pressure. We are appreciative of the continued efforts undertaken to remodel wider services to meet patient demand, endeavouring to provide a positive patient experience. BLMK CCG will continue to work collaboratively with ELFT to support these endeavours.

It is pleasing to note the findings from the CQC inspections during 2021 and that the trust has maintained its Outstanding rating for a third time. The CQC also recognised challenges and areas for improvement which include recurring themes from serious incidents, adverse impact some environment/estates have on patient care and the challenges staff report in daily use of IT equipment and platforms.

BLMK CCG welcomes the description of the Trusts modelling and examples provided within the report to describe progress against the 2021/22 priorities, identifying the work with local external partners via the 'Triple Aim' approach. Priorities for 2022/23 are clear in

methodology for improvement illustrating how the organisation plans to improve population health outcomes, experience of care, staff experience and value.

ELFT Quality Account 21/22 appropriately celebrates successes and recognises areas which are challenging. The CCG is encouraged by the refresh of the Trust's Strategy and 'Big Conversation' to understand the priorities through to 2026, retaining the mission "To improve quality of life for all we serve".

The Trust's ambition to become the first 'Marmot Trust' in the country to address inequity and create a fairer society supports the adapting health and social care landscape of Population Health Management. The CCG welcomes the work to improve access and equity in health service users and staff from the BAME community, LGBTQ+ community, women, veterans, the elderly and specifically the pan Bedfordshire people participation working together group who are working on an anti-racism project

The CCG also notes that the Trust are actively committing to the creation of healthy and sustainable places which includes climate change, with the aim of reducing direct and indirect carbon emission by 2025.

Workforce has been increasingly challenging over 2021/22, the CCG recognises ELFT's ambitions plans to reduce spend on agency staff by 25% by December 2022. The CCG acknowledges the continued system management of the Children and Adolescent Mental Health Service waiting times and looks forward to further work over 22/23 to reduce and support children and young people and their families.

As the CCG moves into the Integrated Care system, we look forward to working increasingly closely with the Trust in the improvement of patient safety in their efforts to improve quality and patient experience. We note the continued Quality Improvement work relating to pressure ulceration. With the increased levels of complexity and acuity services are experiencing it is positive that the Trust encourages open and honest reporting of risks, hazards and incidents, this has been evidenced during the commencement of quality visits to the Trust services.

As Strategic Commissioners and System Partners we recognise the challenging period we have been in and acknowledge the ongoing commitment from the Trust to keep our local population and health workforce safe in the coming year. We look forward to working with ELFT across our Integrated Care system in 2022/23 and beyond.

Anne Murray
Chief Nurse /Executive Director Nursing & Quality
BLMK Commissioning Collaborative

CO-PRODUCTION COMMUNITY COMPASSION COLLABORATION COMMITMENT

3.5 Feedback

If you would like to provide feedback on the report or make suggestions for the content of future reports, please contact the Chief Quality Officer, Dr Amar Shah, on 020 7655 4000.

A copy of the Quality Report is available via:

- East London NHS Foundation Trust website (https://www.elft.nhs.uk)

2020/21 Statement of Directors' Responsibilities in Respect of the Quality Accounts

The Directors are required under the Health Act 2009 and the National Health Service (Quality Report) Regulations to prepare Quality Report for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Accounts (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting 2019/20 and supporting guidance

- the content of the Quality Account is not inconsistent with internal and external sources of information including:

    - Board minutes and papers for the period April 2020 to May 2021, papers relating to quality reported to the Board over the period April 2020 to May 2021

    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009

    - the national patient survey within Quality Account

    - the national staff survey within Quality Account

- the Quality Account presents a balanced picture of the NHS foundation trust's performance over the period covered

- the performance information reported in the Quality Account is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

  and

- the Quality Account has been prepared in accordance with NHS Improvement's Annual Reporting Manual and supporting guidance (which incorporates the Quality Report regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

Signature

Mark Lam
Chair

Date

Signature

Paul Calaminus
Chief Executive

Date

CONTACT US

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Email: elft.communications@nhs.net

Your opinions are valuable to us. If you have any views about this report, or if you would like to receive this document in large print, Braille, on audio tape, or in an alternative language, please contact the Communications Department on phone 020 7655 4066 or email elft.communications@nhs.net

NHS
East London
NHS Foundation Trust

THE QUALITY ASSURANCE COMMITTEE
27 JUNE 2022

Title	Patient Safety Learning from Complaints, PALS & Compliments Annual Report 2021/2022
Author	Abiola Ajayi-Obe, Associate Director of Risk & Governance Fiona Whittell, Head of Complaints and PALS
Accountable Executive Director	Lorraine Sunduza, Chief Nurse / Deputy Chief Executive

Purpose of the Report

To provide the Trust Board with an update of the Trust's management of the Complaints & Patient Advice and Liaison Service (PALS) over the past financial year.

Committees/Meetings where these items have been considered

Date	**Committee/Meeting**
27 June 2022	Quality Committee

Key messages

- **497** formal complaints were raised in this reporting period, an increase of **21%** (91) compared with the previous year of 408.
- The Trust closed 436 formal complaints, an increase of 10% (67) compared with 369 in the previous year.
- Of the complaints closed, **86%** (362) were resolved under Stage 1 local resolution process, with an average response of 28 working days (13 working days being the mode response time).
- The Trust adapted working practices during Wave 1 and 2 of the Covid 19 pandemic and some investigations were paused in line with NHSE guidance. The revised thresholds for investigations resulted in an average complaint response time of **59** working days (1, 2 and 13 days being the mode response time).
- In the previous year (Wave 1 of Covid-19) the average response time was **58** working days (with a mode of 27 working days).
- **1093** PALS inquiries were received by the Trust. (<55).
- **635** compliments were formally recorded (<24).

Complaints top 10 themes:

1. Communication/Information
2. Attitude of Staff*

PALS top 10 themes:

1. Communication/Information
2. Appointment Delays/Cancellation

3. Assessment
4. Clinical Management (Mental Health)
5. Access to Services
6. Support in the Community
7. Diagnosis
8. Medication
9. Appointment Delays/Cancellation
10. Care Planning / CPA (Mental Health)

3. Assessment
4. Clinical Management (Mental Health)
5. Attitude of Staff
6. Access to services
7. Support in the Community
8. Clinical Management (Physical Health)
9. Medication
10. Care Planning / CPA (Mental Health)

Strategic priorities this paper supports

Improved population health outcomes	☒	Identifying learning from patient experience that will improve service, improving patient experience by preventing a reoccurrence.
Improved experience of care	☒	Ensuring the Trust meets NHS Regs 2009, providing timely, fair and quality responses with learning identified where possible.
Improved staff experience	☒	Empowering and supporting staff in providing them with the correct tools, policies, procedures, documentation and training to improve service.
Improved value	☒	Ensuring the Trust meets Statutory regulations and CQC guidelines. Monitoring accidents and incidents. Reducing potential risk where possible by providing robust control measures and in house training.

Implications

Equality Analysis	This report has no direct impact on equalities.
Risk and Assurance	This report provides assurance that complaints are appropriately reported and investigated with learning identified that can be embedded across the Trust.
Service User/Carer/Staff	The recommendations and action plans pertaining to complaints have implications for service users, carers, staff and services across the organization.
Financial	There are financial implications regarding resource management & potential for litigation.
Quality	There are no implications for Quality Improvement raised in this report.

Supporting Documents and Research material
ELFT Complaints and PALS Policy Version 9.0; October 2020.
The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Glossary

Abbreviation	In full
CAMHS	Child and Adolescent Mental Health Service
CEDS	Community Eating Disorders Service
CHS	Community Health Services
CPA	Care Programme Approach
CQC	Care Quality Commission
Datix	Trust incidents and complaints reporting and management system
ELFT	East London NHS Foundation Trust
MHS	Mental Health Services
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
REGS 2009	The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

1.0 Background/Introduction

1.1 East London NHS Foundation Trust (ELFT) has contractual and statutory obligations to report on and appropriately manage all complaints raised to the Trust. This report fulfils ELFT's obligations under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 to produce an annual report on all formal complaints raised to the organization.

1.2 The Trust is committed to improving the services and care that we provide; feedback we receive from patients, their families and carers, helps us to identify the areas where we need to improve and ensure that action is taken to prevent the same things happening again.

Concerns, complaints & compliments are overseen and supported by a dedicated, corporate Complaints & PALS team to ensure that processes and outcomes are impartial, fair, flexible and conciliatory. This arrangement supports those wishing to complain, or make a comment about the services received, being listened to, and remaining confident that they will not be discriminated against for making a complaint.

Complaints can be managed in two stages. At stage 1 the locality will appoint someone appropriate to review the complaint, conduct a preliminary investigation and contact the complainant to discuss their concerns. At this stage it might be possible to resolve the complaint and identify any learning without further investigation.

If it is not possible (or appropriate) to resolve the complaint under stage 1, it will progress to stage 2 where an investigating officer will be appointed, whose day-to-day function sits outside that of the team subject to the investigation. They review the concerns raised, investigate them with the service cited and provide a full response, identifying any learning.

The Trust's Chief Executive Officer personally oversees and reviews every Stage 2 – complaint response i.e. [a managed complaints process with the appointment of an investigating officer from a different service and where the final response is signed by the Trust CEO] to assure service users, carers and families of the importance the Trust places on complaints at the most senior level of the organization. The Trust also has the support of service users from the People Participation Team overseeing complaint final responses to ensure that the responses are written in a kind and user friendly way.

1.3 This report covers the period from 1 April 2021 to 31 March 2022.

2.0 Learning from complaints

2.1 Complaint outcomes

Of the cases investigated and closed in this period the key outcomes were as follows:

87 Resulted in changes to Trust policies and processes (+51%)
29 Recommended training for staff (+44%)
42 Recognized errors or gaps in care and full apologies were given (+20%)
365 Provided explanations of services, treatment, plans or processes (+38%)

2.2 A sample of what we have learnt from complaints

Stage 1 [Locally managed complaints via local directorate management teams]

Complaint Issues:
Complaint made with regard to mental health advice provided via Mental Health Crisis Line (also known as NHS 111 option 2) in Bedfordshire
Learning:
Staff have received additional training to continue to develop their practice surrounding crisis response. Work has taken place with the charity MIND who run the Crisis Café and work is ongoing to improve communication and notifiying patients when the service will not be available.

Complaint Issues:
Complaint about lack of compassion during Mother's Palliative Care

Learning:
Training has been provided for staff on management of breathlessness. All staff have received communication training and completed a palliative care course.

Complaint Issues:
Complaint regarding clinical care in older adults CMHT

Learning:
All new nurse starters are “buddied” with with an experienced social worker who will provide Care Act peer support during the inductyion period. All new starters will receive a formal Care Act supervision session with the Social Care Lead. Regular team-wide Care Act peer support/reflective practice sessions have been introduced to the team.

Stage 2 [Investigated by exernal IO from outside service]

Complaint Issues:
Complaint regarding a patient being assaulted whilst on an inpatient unit

Learning:
A working group has been established to review CCTV preservation and new CCTV systems have been installed. Training to be provided to staff members for trauma informed care training. The Access to Records Policy will be referred to for all new requests and local access to records leads contact details are detailed on the ward. The number of matrons in the Directorate has increased to four which enhances the senior clinical leadership.

Annual Lessons Learned Event:
Lessons learnt from complaints are shared at Directorate events and at the annual Trust wide Learning Lessons Event.

The Annual Complaints Learning Lessons Seminar took place on 14 December 2021. This highlighted themes, lessons learnt from complaints and changes to practice and services which resulted from complaints information. The seminar was structured around Communication, which is consistently the most prevalent theme of complaints accounting for a third (70) of the complaints received at the time. Five directorates shared their experiences of an investigation and identifying the learning. It was a very well attended event and created much discussion amongst different types of services.

Subsequent Directorate Learning Lessons Events in Tower Hamlets, Newham and City & Hackney Mental Health Services have also included updates on the complaints process and details of local changes to practice as a result of complaints information. Local Services are supported to deliver their learning lessons events with assistance and contributions from corporate directorates in the conceptualisation and delivery of these events.

3.0 Service developments

3.1 Trust wide monthly complaints training continued throughout the year; focusing on legislation and guidance underpinning the process, investigative practice, response writing, learning/action plans and regular report updates. The schedule is communicated monthly via the intranet, communications emails and directorate governance leads.
The Stage 1 local resolution process has been fully embedded and embraced by the directorates; this has resulted in a greater number of resolutions completed in less time, whilst still capturing learning.

A Trustwide monthly Complaints Meeting was established early in the year comprising of the complaints team and governance leads, which in addition to the Governance Network Meeting provides a regular forum to share information and discuss any complex cases or process issues.

3.2 How we have developed and are developing the team

The team continues to receive regular counselling and psychology support on a bi-monthly basis.

A Head of Complaints and PALS has been appointed to the team. A further 2 substantive were successfully recruited and focuses on PALS enquiries enabling the rest of the team to focus on the Stages 1 and 2 complaints process

Due to lockdown in 2021-22 many complaint responses could not be completed due to Trust staff focusing on Covid-19 emergent matters and remote working capacity. A concerted effort was made from 20/09/2021 to 08/10/2021 to resolve and close as many overdue complaints as possible. Resulting in 92 complaints being actioned and closed during this period.

We will continue to build upon the team's knowledge of newly acquired and existing services, and build on relationships with staff across the Trust.

3.3 Key priorities

2021/22

Learning from complaints:
A key priority for 2021/22 continues to be action plans; monitoring, implementation and learning. The complaints team has led a two phase process of collating action plans (both at the initial and completed stage) and updating complainants. Phase one of this process is almost complete. Phase two commenced on 31 May 2021 and involved transferring completed actions and themes onto Datix; enabling triangulation with serious incident trends and themes.
Some directorates regularly share learning via Learning Lessons newsletters, the format of which has been shared with other directorates. However, regular cross directorate learning needed strengthening. Complaints learning lessons seminars took place place in summer 2021 and future sessions are planned for Autumn 2022 and Spring 2023.

Staff training programme:
Training has continued to be delivered virtually on a monthly basis. This is well attended every month and provides staff with the opportunity to discuss and respond to queries about the process and highlight areas of improvement.

Datix:
The complaints action module was successfully implemented. Further work will take place with the Directorates and Datix teams to ensure data is captured to monitor the complaints process accurately.

Response times:
Despite the positive response times overall, there are some directorates which are consistently significantly exceeding the statutory response time of 6 months (as stipulated in the NHS Complaints Regulations 2009). The corporate complaints team has initiated communications with these directorates in relation to this, and will be looking at how to best support these directorates to avoid unnecessary and avoidable delays.

Complaints pathway:
Local resolution can be attempted, to resolve a complaint, at any stage in the complaints process pathway with the outcome recorded for future reference and details provided for PALS and Complaints. The team routinely works with governance leads to raise awareness of this. This requirement will be incorporated into the monthly complaints training.

Re-opened complaints:
Previously Datix did not facilitate retrospective reporting on re-opened complaints. However the Datix database was updated in May 2021 and now provides this function.

PALS Clinics:
The team are working toward re-introducing both face to face and virtual clinics to enable patients and their families/carers to directly raise PALs issues with staff.

Complaints back-log:

Due, primarily, to the on-going impact of two waves of Covid-19 and a key staff vacancy within the team. a number of complaints had not progressed to final response completion. In September, the Chief Nurse / Deputy CEO initiated and supported the team in a concerted effort to resolve and close overdue complaints with a target of achieving 90 closures in three weeks. In that period, 92 complaints were actioned and closed. This was achieved by three team members dedicated work in supporting their colleagues across Trust departments to complete outstanding complaints. The cooperation and positive attitude of all staff across the Trust in achieving these case completions should be recognized.

Response times:

Overall, the response time continues to be a challenge and has not greatly improved (+2 days average compared to the year 2020/21). However, a number of recent changes have been made to improve this.

- A live complaints tracker was introduced in early September 2021, which all senior staff and governance leads have access to. It has a RAG rated system of complaints overdue, almost overdue and those in QA stage. It also has a tab on re-opened and closed complaints. It is consistently updated with the status of a complaint, which can be monitored by all of those with access.
- Complaints officers now attend weekly/monthly governance meetings within directorates to provide swift advice to overcome obstacles which contribute to delays.
- A weekly meeting takes place with the Director of Nursing for Mental Health (London) reviewing the status of all overdue complaints and to act as a point of escalation.
- A weekly email is sent to the Chief Nurse / Deputy CEO to appraise her of the current number of overdue and due complaints by directorate.

Complaints Re-Set QI Project:

A Complaints Re-set QI Project has been initiated to refine and positively improve the complaints process. The first meeting took place in January 2022 inclusive of Service User involvement.

The January 2022 Meeting agreed the Terms of Reference and preliminary change ideas for this Qi Project and identified project participants.

Roles and Responsibilities:

Concerns about who is responsible for which aspect of a complaint's resolution under stages 1 and 2 of the complaints process were addressed in a Complaints Leads Roles and Responsibilities Paper titled; Stage 1 and 2 Complaints Handling: Roles and Responsibilities for - Corporate Complaints Team, Directorate Governance Leads and Investigating Officers.

This document has now been disseminated Trust wide and is also available on the Trust's Governance and Risk Intranet Page to ensure ease of access to anyone engaged in any aspect of resolving a complaint.

Update on Complaints Quality Improvement (QI) Project

The three key aims of The Complaints Quality Improvement Project were as follows:

1. To increase the average percentage of formal complaints being responded to across the Trust within timescales from 47% to 70% by September 2020.
2. To reduce the number of re-opened complaint responses by improving the overall quality of initial responses.
3. Increase the number of complaints managed by local resolution (Stage 1 Complaints Process)

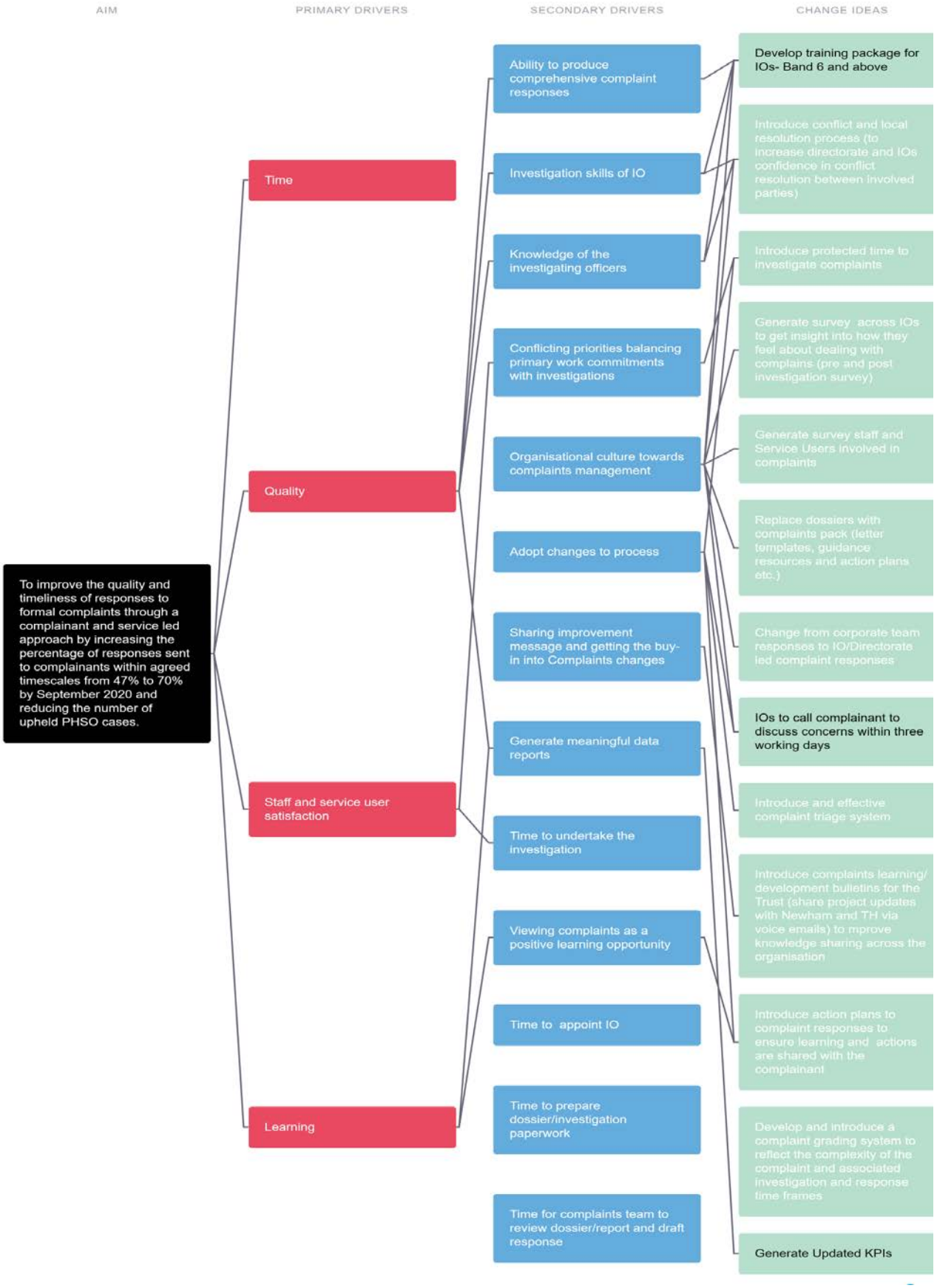
The aims of this project are being realised as follows:

1. The rate of complaints responded to within timescale has increased to 55% within timescale.

2. 65 complaints were re-opened in this reporting period (average of 5 per month).

3. 86% of complaints have been managed via local resolution (Stage 1) in this reporting period.

4. Complaints Driver Diagram


AIM
PRIMARY DRIVERS
SECONDARY DRIVERS
CHANGE IDEAS
To improve the quality and timeliness of responses to formal complaints through a complainant and service led approach by increasing the percentage of responses sent to complainants within agreed timescales from 47% to 70% by September 2020 and reducing the number of upheld PHSO cases.
Time
Quality
Staff and service user satisfaction
Learning
Ability to produce comprehensive complaint responses
Investigation skills of IO
Knowledge of the investigating officers
Conflicting priorities balancing primary work commitments with investigations
Organisational culture towards complaints management
Adopt changes to process
Sharing improvement message and getting the buy-in into Complaints changes
Generate meaningful data reports
Time to undertake the investigation
Viewing complaints as a positive learning opportunity
Time to appoint IO
Time to prepare dossier/investigation paperwork
Time for complaints team to review dossier/report and draft response
Develop training package for IOs- Band 6 and above
Introduce conflict and local resolution process (to increase directorate and IOs confidence in conflict resolution between involved parties)
Introduce protected time to investigate complaints
Generate survey across IOs to get insight into how they feel about dealing with complains (pre and post investigation survey)
Generate survey staff and Service Users involved in complaints
Replace dossiers with complaints pack (letter templates, guidance resources and action plans etc.)
Change from corporate team responses to IO/Directorate led complaint responses
IOs to call complainant to discuss concerns within three working days
Introduce and effective complaint triage system
Introduce complaints learning/ development bulletins for the Trust (share project updates with Newham and TH via voice emails) to mprove knowledge sharing across the organisation
Introduce action plans to complaint responses to ensure learning and actions are shared with the complainant
Develop and introduce a complaint grading system to reflect the complexity of the complaint and associated investigation and response time frames
Generate Updated KPIs

3.4 Covid-19 response

During Wave 2 of the Covid-19 pandemic, clinical services were stretched and the ability of staff to carry out additional duties was limited. During this period, the Trust continued supported a flexible approach to response times. This inevitably meant that a number of investigations breached the statutory time limit of six months, and increased the overall response times. This created a backlog of complaints resulting in a concerted effort to close 90 complaints in a three-week period in September to October 2021.

Concerns and feedback directly related to Covid 19 in 2021/22 included:

- 17 Formal complaints
- 60 PALS enquiries
- 35 compliments

3.5 Triangulated Governance and Risk Intiatives:

Reviews of the Trust's Serious Incident Reviews and Complaints have identified similarities in the issues being raised across both these areas. These include;

Complaints:	Incidents:
1. Communication/Information 2. Attitude of Staff* 3. Assessment 4. Clinical Management (Mental Health) 5. Access to Services	1. Admin/process tasks 2. Issues relating to clinical care/failure to follow up 3. Issues with training, induction & supervision 4. Poor record keeping/ IT connection 5. Poor transition between services

These themes have been used to inform the schedule of Learning Lessons events that have been planned for 2022/23 as follows;

- Inpatient Management (incl. Observations)
- Physical Health Management
- Medication
- Referral Criteria
- Service Adaptability
- Out of Area Inpatient Placement
- Discharge
- Safeguarding
- Clinical Risk Assessment
- Online Medication Purchase
- Autism

- Never Events and Near Misses

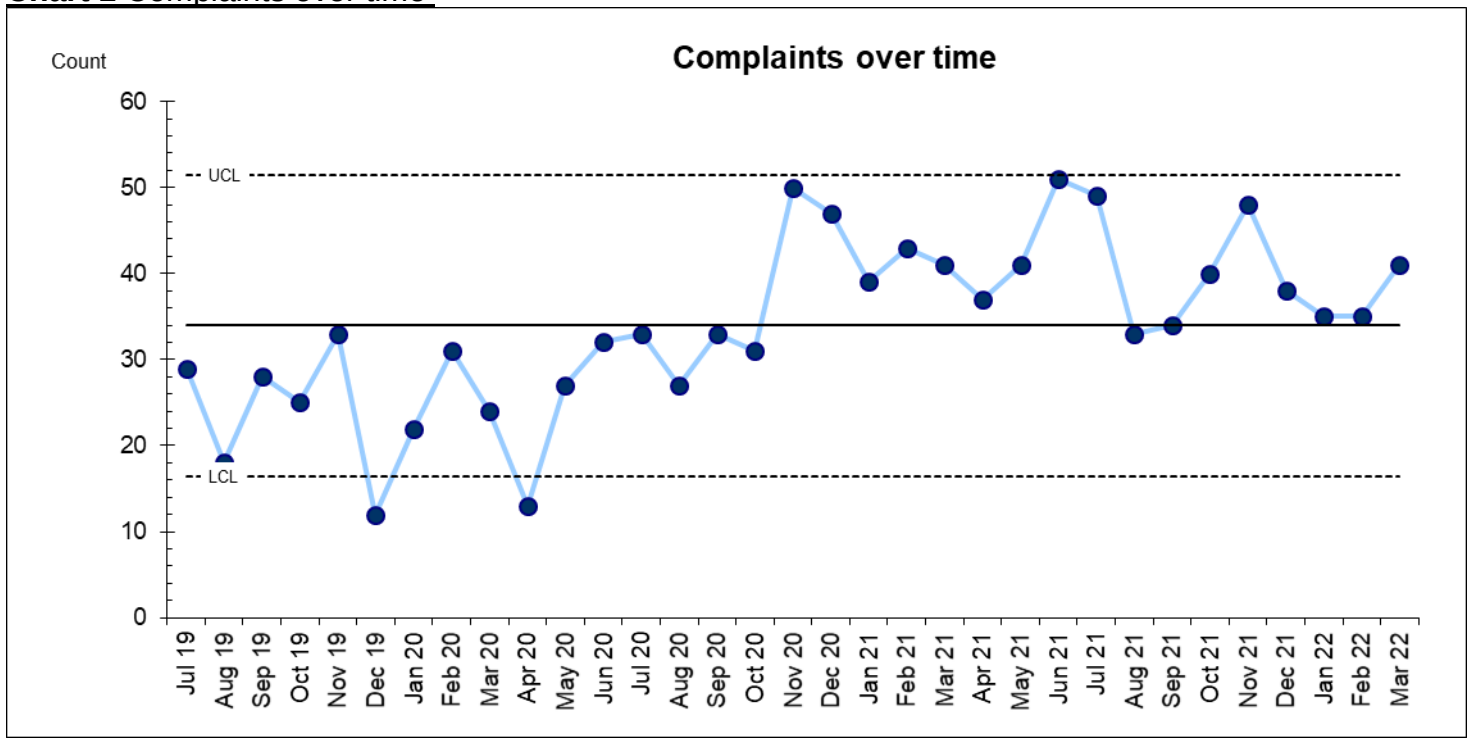
3.6 Service User Support:

The Governance and Risk Team also routinely receive support from Service Users. We have one dedicated service user who is embedded in the complaints team who provides oversight to complaints responses and manages the complainant feedback survey. And another Service User who routinely provides editing oversight to complaint responses.

5.0 Complaints Metrics

5.1 Total number of formal complaints

Chart 1 Complaints over time



497

Formal complaints were received by ELFT during this reporting period.

The average monthly number of complaints received was **35,** compared with an average of **34** per month in the previous year.

Table 1- Complaints to population ratio (No. Complaints: 100,000)

Period	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Population (approx.)	1,659,900											
Total Complaints	37	41	51	49	33	34	40	48	38	35	35	41
Ratio:100,000	0.8	1.6	1.6	1.9	1.6	2.0	1.9	3.0	2.8	2.4	2.6	2.5

Table 2- Complaints by Directorate

Directorate	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Bedfordshire MHS	5	9	10	9	9	4	5	6	7	12	6	4	7	4	9	9	6	7
City & Hackney MHS	3	8	5	7	7	9	4	5	5	6	7	5	11	6	3	3	2	9
CHS Combined	6	7	6	4	3	5	6	7	9	5	2	3	4	8	8	5	6	9
Corporate	0	1	0	0	1	0	0	1	3	1	0	0	0	0	0	1	0	0
Forensic Services	1	0	1	2	2	1	0	4	1	3	2	2	1	0	0	2	2	0
Luton MHS	2	5	2	0	5	3	6	3	5	8	5	5	2	7	2	0	4	4
Newham MHS	4	5	5	5	5	4	4	4	7	1	4	3	5	8	3	5	3	4
Specialist & CHN Children's Services	5	9	10	7	6	2	6	4	2	4	3	1	3	5	6	3	6	5
Tower Hamlets MHS	4	6	8	5	4	12	6	6	12	7	4	10	6	9	7	7	6	1
Primary Care	0	0	0	0	0	1	1	1	0	2	0	1	1	1	0	0	0	2
Total	**31**	**50**	**47**	**39**	**43**	**41**	**37**	**41**	**51**	**49**	**33**	**34**	**40**	**48**	**38**	**35**	**35**	**41**

Table 3

Top complaint themes:

1. Communication/Information
2. Attitude of Staff
3. Clinical Management (Mental Health)
4. Assessment
5. Access to Services
6. Support in the Community
7. Diagnosis
8. Medication
9. Appointment Delays/Cancellation
10. Care Planning / CPA (Mental Health)

Complaints by Source	Complaint distribution
Email	415
Letter	50
Phone Call	47
Via PALS	14
Via an Advocate	35
Via an MP/Councillor	32
Via Solicitor	2
Via CQC	59
Via another NHS Trust	16
Other	8
TOTAL	**678**

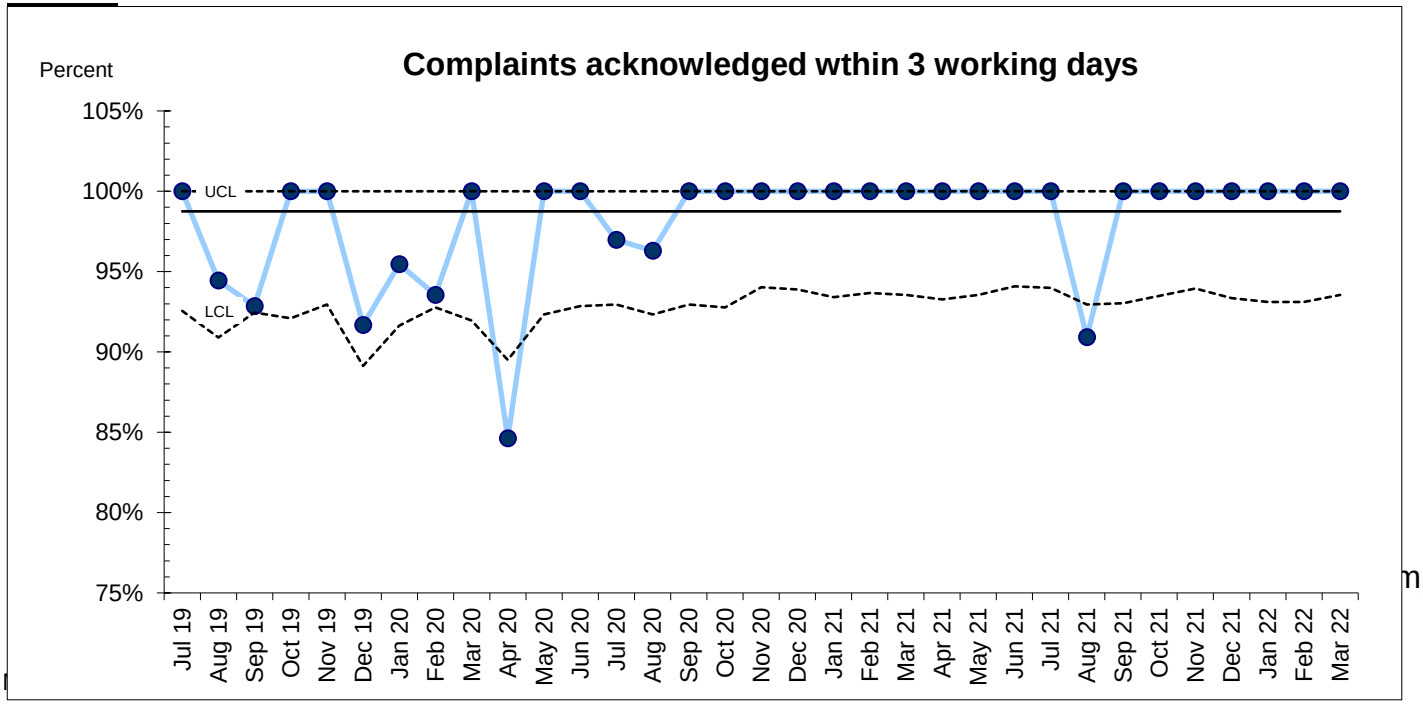
5.3 Adherence to complaints process and timescales*

The 2009 Complaints Regulations do not stipulate a specific timescale within which to respond formally to a complaint; however, they do stipulate that all formal complaints must be acknowledged within three working days of receipt.

Table 4- Formal complaints acknowledged within three working days

Period	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Total Complaints	37	41	51	49	33	34	40	48	38	35	35	41
No. Acknowledged in three working days	37	41	51	49	33	34	40	48	38	35	35	41
Percentage	100%	100 %	100%	100%	100%	100%	100%	100%	100%	100%	100 %	100%

Chart 2



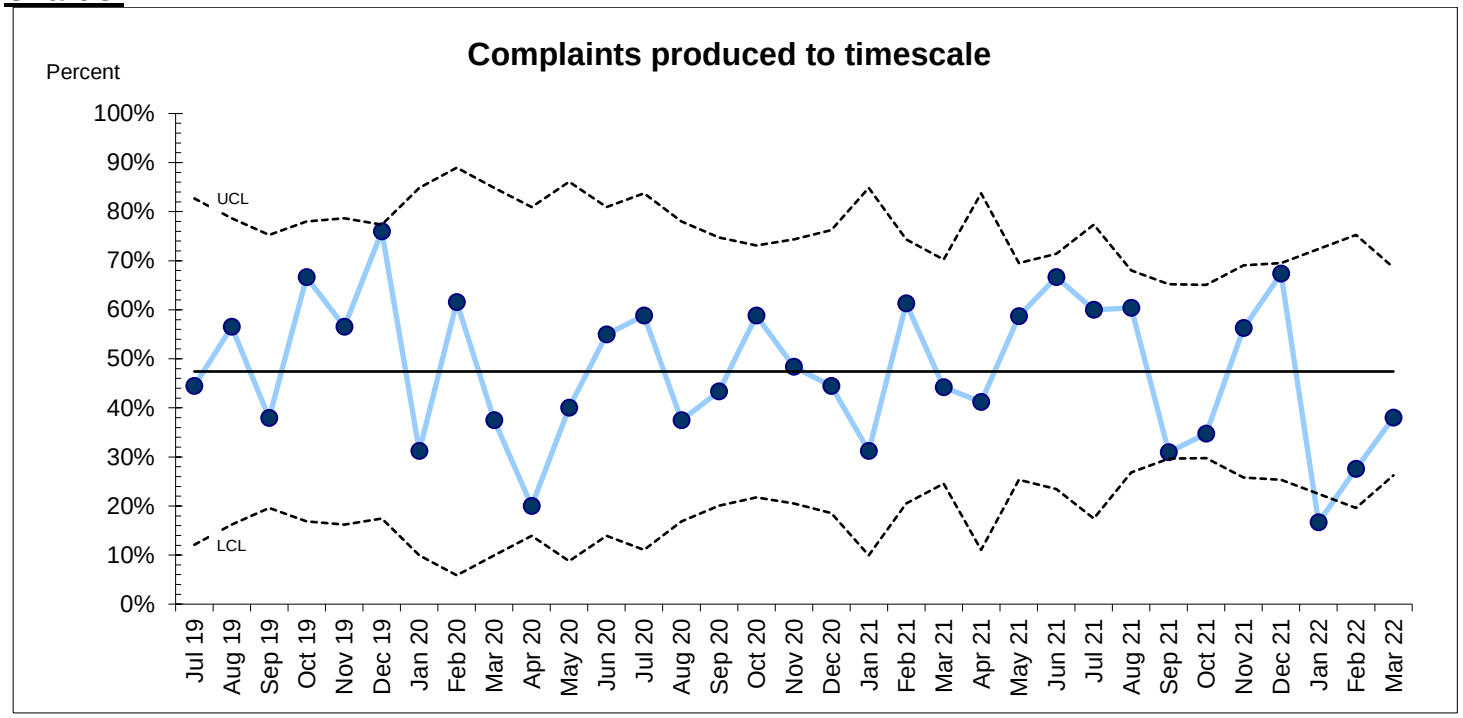
mplaint.

Table 5 – Complaints timescales

	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Total Complaints closed	17	46	39	25	53	71	72	48	46	36	29	50
No./% Response sent within agreed timescale	7 41%	27 57%	26 67%	15 60%	32 60%	22 31%	25 (35%)	27 (56%)	31 (40%)	30 (83%)	21 (72%)	31 (62%)
No/% Response breached agreed timescale	10 59%	19 43%	13 33%	10 40%	21 40%	49 69%	47 (65%)	21 (44%)	15 (60%)	6 (17%)	8 (28%)	19 (38%)

During the reporting period, the Trust responded to/closed **417** formal complaints of which **51%** (212) were closed within their agreed timescale and 205 (49%) breached their agreed timeframe*.

Chart 3


Complaints produced to timescale
Percent
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
UCL
LCL
Jul 19
Aug 19
Sep 19
Oct 19
Nov 19
Dec 19
Jan 20
Feb 20
Mar 20
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
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Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22

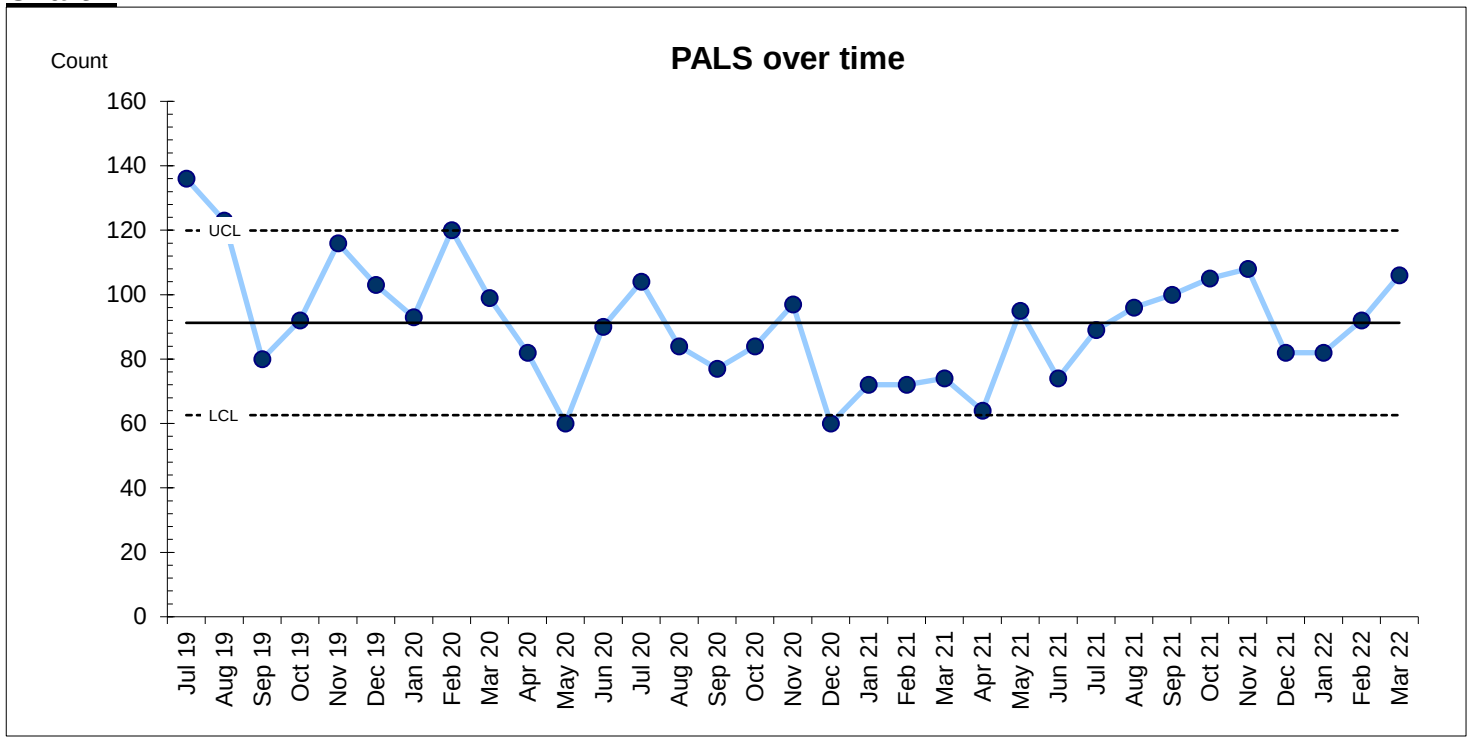
6.0 Patient, Advice and Liaison Service (PALS) inquiries

PALS inquiries are processed and managed by the Trust's Corporate Complaints & PALS team and come in a variety of methods including email and telephone inquiries. Notably, the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 do not stipulate a time frame to respond to PALS inquiries (or informal complaints), the Trust aims to resolve these within 48hrs.

Table 6- PALS inquiries by Directorate

Directorate	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Bedfordshire MHS	15	18	10	19	18	15	13	14	13	10	8	12	11	15	14	6	8	11
City & Hackney MHS	10	8	3	4	3	5	7	8	6	8	10	8	7	12	12	16	8	7
CHS Combined	10	16	13	9	10	18	12	15	9	22	15	22	17	17	17	13	23	36
Corporate	12	24	10	12	8	2	0	5	1	2	2	3	1	2	4	1	3	1
Forensic Services	2	2	3	1	1	1	0	1	0	3	8	10	3	4	3	3	5	2
Luton MHS	13	9	4	11	5	8	6	4	5	9	10	7	9	10	3	14	13	12
Newham MHS	10	8	3	6	8	10	4	9	6	7	16	7	11	11	6	8	10	11
Specialist & CHN Children's Services	9	4	7	5	6	9	5	5	6	8	4	9	10	9	4	6	4	16
Tower Hamlets MHS	3	7	7	5	12	4	10	12	8	7	13	7	10	8	16	13	16	9
Primary Care	0	1	0	0	1	2	7	22	20	13	10	15	26	20	3	2	2	1
Total	**84**	**97**	**60**	**72**	**72**	**74**	**64**	**95**	**74**	**89**	**96**	**100**	**105**	**108**	**82**	**82**	**92**	**106**

Chart 4



1093 PALS inquiries were logged & handled, an average of 91 inquiries per month.

7.0 Parliamentary and Health Service Ombudsman (PHSO) contacts and investigations

As part of the complaints regulations 2009 if the complainant is dissatisfied with the way their complaint has been managed by the Trust and local resolution of their complaint is not achievable, the complainant has the option to take their complaint to the PHSO and request an independent review of the Trust's complaint response and investigation.

During 2021/22 the Trust has received **3** new contacts from the PHSO based on complainants expressing dissatisfaction with the Trust's response/outcomes of their complaint. This compares to **9** received in 2021/21. During this reporting period, **3** PHSO enquiries were closed; **2** without progressing to an investigation and **1** fully investigated.

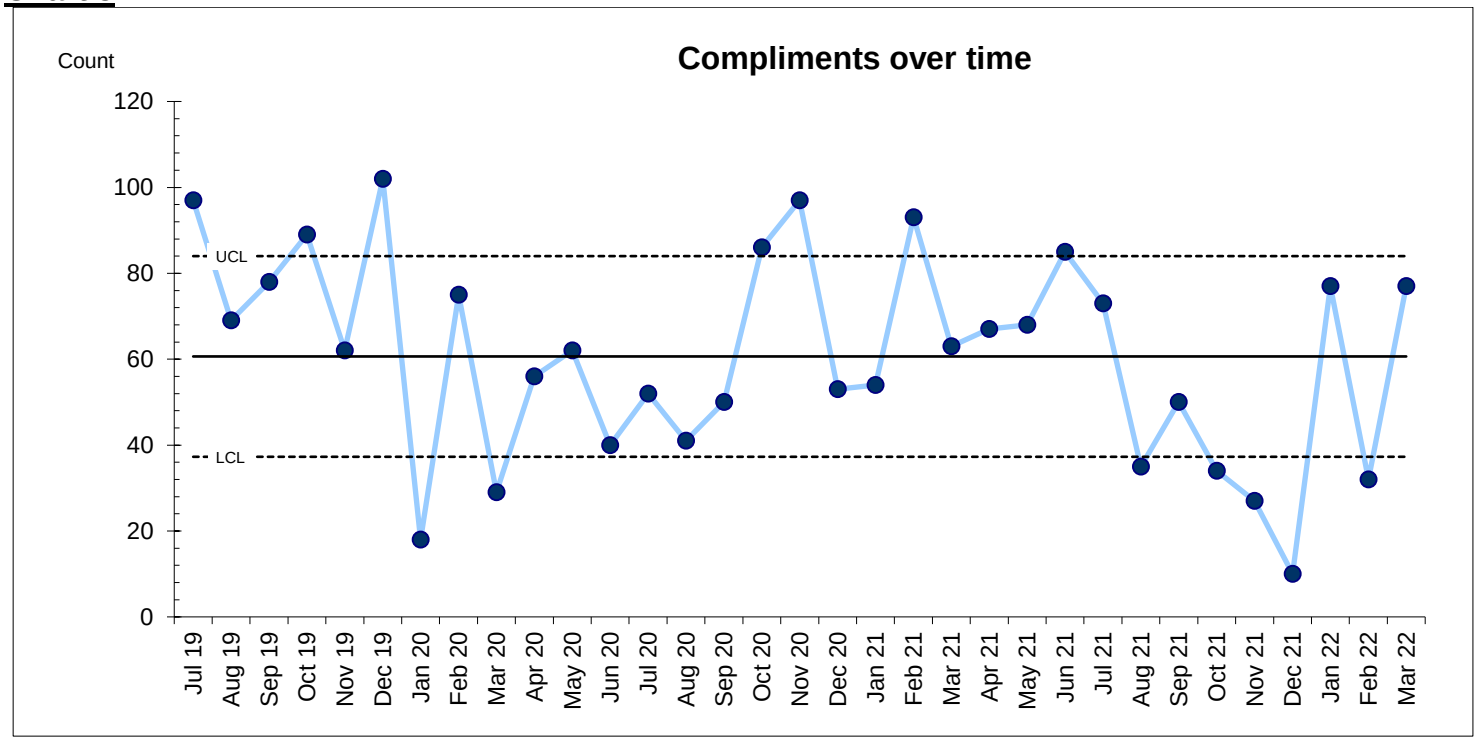
8.0 Compliments

The Trust routinely responds to all reported compliments that are subsequently shared with the relevant teams and publicised in the Trust's weekly news bulletins. The majority praise the care received generally whilst a high proportion will specifically name staff that have provided excellent service.

Table 7- Reported compliments recorded by Directorate

Directorate	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Bedfordshire MHS	16	6	21	4	18	11	21	10	23	20	9	11	1	2	2	9	4	9
City & Hackney MHS	0	0	0	26	2	2	5	7	1	0	1	0	0	0	0	1	0	1
CHS Combined	21	23	14	1	25	12	33	20	21	16	17	20	22	13	4	14	21	14
Corporate	0	0	0	0	0	0	0	2	1	1	0	0	0	0	0	0	0	0
Forensic Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Luton MHS	1	0	0	1	2	1	4	2	1	1	0	1	2	2	0	1	0	1
Newham MHS	13	2	1	8	13	1	0	7	0	1	0	1	1	4	0	21	4	21
Specialist & CHN Children's Services	21	0	14	0	10	25	0	11	32	15	0	9	0	3	0	17	0	17
Tower Hamlets MHS	12	15	3	12	6	9	0	7	2	1	0	3	8	2	4	2	0	2
Primary Care	0	0		2	17	2	4	2	4	18	8	5	0	1	0	12	2	12
Total	**86**	**97**	**53**	**93**	**63**	**748**	**67**	**68**	**85**	**73**	**35**	**50**	**34**	**27**	**10**	**77**	**32**	**77**

Chart 5



In this reporting period

635

Formal compliments were recorded by the Trust but it is recognized that many more informal compliments would have been received by individuals and teams across the organization where these were not formally recorded.

Compliments Sample

TOWER HAMLETS – Early Intervention Service
The service did save my life- I was in a really bad place and I was able to get support. I don't think I'd be here and in the position I'm in without the service- I'm really grateful for the support.

Having a care-coordinator to talk to when things are difficult means I can process negative situations a lot better.

I find the medical reviews really helpful; as things change my treatment changes.

TOWER HAMLETS Mental Health – Inpatient Ward
As a current inpatient under ELFT the difference in frontline staff morale and cohesion is breathtaking.

NEWHAM Community Health Service (CHS) - MSK Physiotherapy
X has been a great help in assisting me even when I had a next day appointment. Great customer service, efficient, kind and helpful.

BEDFORD MENTAL HEALTH - Dunstable CMHT
I just wanted to drop you a line to let you know how much I appreciate the support you're giving me. I don't think I'd be here without it. Knowing you're at the end of the phone has given me the strength to carry on. The tips and mindfulness you have shared is invaluable to me. You have stepped in and supported me above and beyond what was expected of you, whilst I wait for my turn to have a thorough mental health check by your psychologist. Hopefully I am nearing the front of the queue now.

LUTON MENTAL HEALTH – Inpatient Ward
I just wanted to say thank you for the care given to X during her recent stay with you. Thank you for the extra adjustments you made allowing me extended visits in her room. It made such a difference and helped name to manage a difficult situation.

NEWHAM Primary Care
The Dr who attended to me was very good, she listened to me and provided me will all the necessary advice and support. She was the best Dr I have ever met very human and professional.

9.0 Service User Involvement

The Chief Nurse and Chief Executive introduced a Quality Assurance process whereby a service user, independent of the team, conducts bi-monthly audits of five random complaint responses and provides feedback to the Joint Incidents and Complaints Managers. From the five audits that have been carried ourt since July 2020, the feedback has been extremely positive, with only minor errors observed, usually grammatical in nature. Overall the responses are deemed to be of a good quality, and more compassionate than those reviewed previously by the same service user.

To compliment the existing service user who is a London based mental health patient, we are in the process of recruiting a service user from Bedfordshire Community Health services, to offer further support and development to the team.

10.0 Recommendations

None.

11.0 Actions being requested

11.1 The Trust Board is asked to:

a. Receive and note the report
b. Note the assurance provided and consider if further sources of assurance are required.

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REPORT TO THE QUALITY ASSURANCE COMMITTEE
27 June 2022

Title	Annual Report on Research & Innovation
Author	Karin Albani, Associate Director of Research & Frank Röhricht, Medical Director R&I and Medical Education
Accountable Executive Director	David Bridle, Chief Medical Officer

Purpose of the report

To present to the QAC (to receive and note) the Research & Innovation (R&I) activities taking place within the Trust over the last year and give the committee an update on the progress on our five-year plan to transform into a corporate function supporting our services to deliver the improvement agenda, and broadening the spectrum of what we mean by 'R' to include not just clinical research trials, but also service evaluations, case studies, audit, and QI (Quality Improvement).

Committees/meetings where this item has been considered

Date	Committee/Meeting
12 May '22	Research Committee

Key Messages

While the volume of study activity has contracted during the COVID pandemic, ELFT has focused on those delivering novel and sometimes complex interventions, overall providing very good value for money as measured by the local Clinical Research Network.

While there have continued to be notable achievements over past year particularly in bringing lived experience expertise into the team, much effort has been working towards goals which should come to fruition in the coming months - most significantly signing a memorandum of understanding with one of the country's leading universities to establish a joint research team in community and primary health care.

Nevertheless, significant opportunities remain to be seized or missed due to both lack of data being recorded about the research activity taking place in Trust, and inability to interrogate and integrate the data we do have for research and evaluation purposes.

Strategic priorities this paper supports

Improved population health outcomes	☒	Research based in the Trust can facilitate the understanding of factors impacting on population health, and the development and evaluation of novel interventions for the benefit of the local population. Some evidence suggests that participating in research studies is beneficial for patients.
Improved experience of care	☒	Engagement of clinicians and healthcare organisations in research is associated with improvements in healthcare performance.
Improved staff experience	☒	High quality research activities and the presence of research groups enables staff to acquire new skills for enquiry & critical

		appraisal. It may provide some "buzz" to services making working in the Trust more attractive, which should facilitate recruitment and retention of committed and qualified staff and strengthen a general atmosphere of enthusiasm, creativity and positive change.
Improved value	☒	Research directly contributes to improve efficiencies in health economy. In addition, successful researchers generate direct and indirect external grant income, thus minimising the financial risk for the Trust in supporting research. The reputational advantage of successful research and a WHO Collaborating Centre may help business development.

Implications

Equality Analysis	No equality impact assessment has been carried out. Research carried out however should aim to improve access to treatment.
Risk and Assurance	Research should assist in the mitigation of Trust risks.
Service User/Carer/Staff	The scope of research should extend as widely as possible, therefore all directorates and service groups are potentially impacted.
Financial	Trust investment required but full details are not laid out in this paper.
Quality	Impact on quality and effectiveness of service provision and care of patients.

Supporting documents

a. How Research & Innovation supports delivery of the Trust Strategy

1.0 Introduction

1.1 Innovation and research is a key part of the work of the NHS, ensuring that patients in the UK continue to benefit from improved and modern services, and helping to deliver better outcomes to patients across the country. The Government expects us to promote and support participation by NHS organisations, patients and carers in research.

1.2 Evidence shows that the engagement of clinicians and healthcare organisations in research is associated with improvements in healthcare performance. Furthermore, clinical trials activity is associated with improved Care Quality Commission (CQC) ratings.

1.3 Service Users generally find satisfaction in participating in research studies. Playing an active role in their own healthcare is empowering, and research volunteers gain a sense of gratification from their contributions to society.

1.4 ELFT is now two years into a five-year plan (App A) to transform Research & Innovation (R&I) into a corporate function supporting our services to deliver the improvement agenda, and broaden the spectrum of what we mean by 'R' to include not just clinical research trials, but also service evaluations, case studies, audit, and

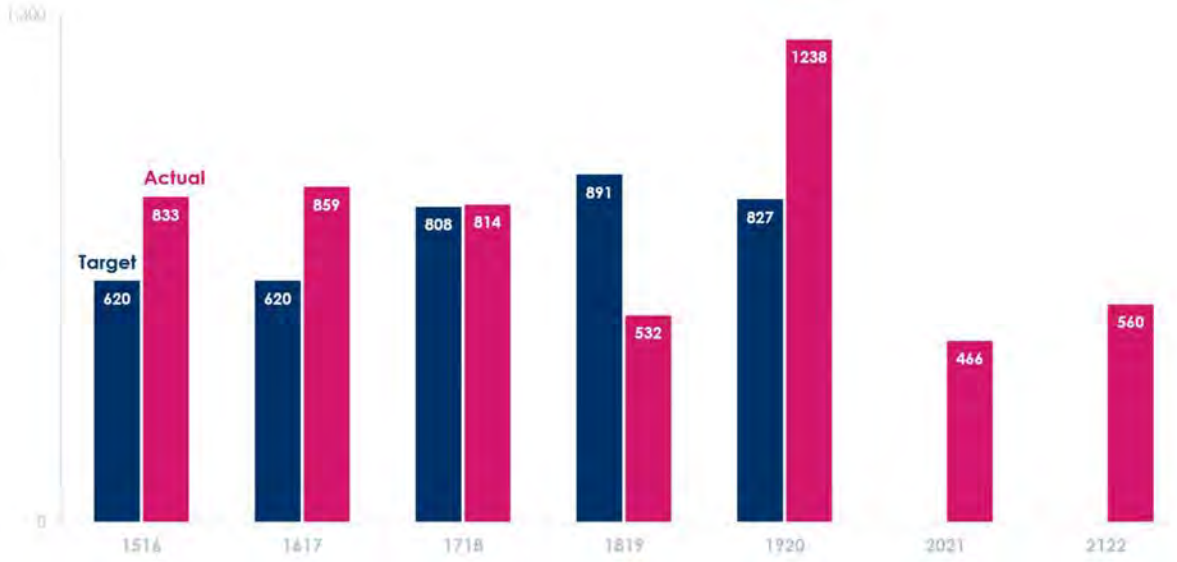
QI (Quality Improvement). This report provides an overview of the progress we have made over the past year.

2.0 Summary of study activity

2.1 There were far fewer studies actively recruiting participants during 2021/22; we enrolled 560 participants into 21 studies from the Department of Health and Social Care's (DHSC) National Institute for Health Research (NIHR)[1] research Portfolio.[2] The highest recruiting study was the ELFT-sponsored Effectiveness of group arts therapy: Randomised controlled (ERA) trial (N=234).

2.2 Overall, although in past years ELFT has consistently exceeded targets set by the NIHR for recruitment of participants into research studies, more recently our recruitment has been running 1/3rd less than our average. While this decrease is largely an expected impact of COVID – and one shared by many community and mental health Trusts, we aim to increase recruitment back up to pre-pandemic levels in the coming year.

Fig 1: Actual Recruitment Compared to Target Recruitment[3]



2.3 Hidden in the raw figures of participants enrolled, is the significant proportion of interventional studies active at ELFT during 2021/22 as compared to observational or survey studies. To account for this variability when comparing performance across different NHS organisations, the NIHR first weights enrolment into such resource-intensive interventional studies more heavily and then divides these weighted

[1] The NIHR was established in 2006 to "create a health research system in which the NHS supports outstanding individuals, working in world-class facilities, conducting leading-edge research focused on the needs of patients and the public". It is funded by the Department of Health and Social Care. Working in partnership with the NHS, universities, local government, other research funders, patients and the public, the NIHR funds, enables and delivers health and social care research focused on early translational research, clinical research and applied health and social care research.

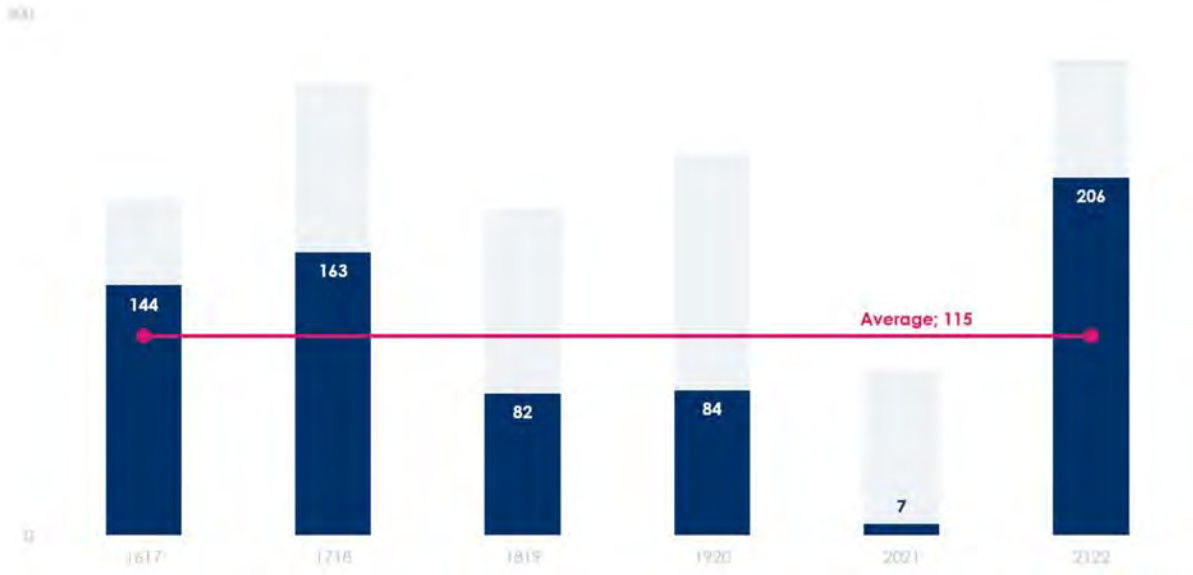
[2] NIHR Clinical Research Network (CRN) support is available to all studies, regardless of location, study type, study size, therapy or research area, provided they meet the Department of Health and Social Care established eligibility criteria. Those that do, are considered part of the *NIHR Portfolio.*

[3] No target was set for the last two financial years due to the expected detrimental effects of the COVID-19 pandemic, this is expected to resume in the 2022-23 financial year.

recruitment figures by the funding allocation awarded to derive a value for money KPI (key performance indicator).

2.4 By this measure, ELFT earns the second-best value for money score among community and mental health Trusts in the North Thames local CRN (Clinical Research Network)[4] and even comes in better value than most of the acute and teaching hospitals in the region. There's still room to grow our ambitions, however – ELFT has had a better value for money in past years, and NELFT (which is a pretty comparable Trust) has performed significantly better.

Fig 2: Recruitment to Interventional Studies[5]



2.5 One challenge to increasing activity is that it appears clinical services have been overwhelmed and have fewer resources available to engage in research following the pandemic; for example, our Improving Access to Psychological Therapies services have declined a number of potential studies – including one grant sponsored by ELFT – citing lack of available staff to support the required activity.

2.6 Notable in this discussion is that we can only consistently measure enrolment into NIHR Portfolio studies because this recruitment is recorded by the CRN. From an ELFT perspective there is much additional research activity, both from studies to which we merely refer potential participants[6] and from studies which fall outside the NIHR's

[4] The CRN is comprised of 15 Local Clinical Research Networks and 30 Specialties who coordinate and support the delivery of research both by geography and therapy area. The CRN enables health and care research in England by meeting the costs of additional staff, facilities, equipment and support services so that research is not subsidised with funding that has been provided for health and care treatments and service.

[5] ELFT have recruited to interventional studies at a higher level than any of the previous 5 years, in fact, it was 80% above the average.

[6] For most studies, the Trust is asked not only to enrol participants but also to collect data and deliver the intervention / activities defined in the study protocol; in this case, we are a research site. Other studies consolidate the delivery of the protocol activities in one Trust and simply canvas across a range of other Trusts for potentially eligible participants who will be referred to the hub to be enrolled. In this case the hub (delivering the protocol) is a research site, but the referring Trusts are acting merely as *Participant Identification Centres (or PICs).*

Portfolio.[7] However, within the Trust's electronic medical records there is no consistent means or practice of recording – and thus no means of measuring – research participation.

3.0 Highlights (and challenges) of 2021/22

3.1 **Research Grants:** While a number of grants ELFT is managing have been granted extensions to deal with the disruption of COVID, half of those currently active will have completed by March 2023. Since the previous report on research activity, the Trust has been awarded one new NIHR Programme Development Grant to begin developing and evaluating a new care pathway to improve outcomes for people with complex trauma which will be led by Prof Steve Gillard.

3.2 **Public & Patient Involvement:** In 2021, we created an additional Clinical Studies Officer[8] post specifically for a person with Lived Experience both to provide employment opportunities for people on their recovery journey as well as to bring additional depth and breadth of lived experience to the team. This has been an extremely successful appointment, with the new team member one of our most prolific at enrolling study participants.

3.3 **Academic Partnerships:** The Trust has also welcomed Prof Liz Sampson of UCL as joint clinical lead for Liaison Psychiatry. Her expertise in epidemiology and health services research for older people will bring new focus to this clinical area.

3.4 **Staff turnover:** For a variety of reasons – pursuit of further education, career promotion, and the end of fixed-term contracts – the R&I department saw over 80% staff turnover in the second half of the year which caused significant disruption to the support we were able to provide. By June 2022, however, we expect to have filled all vacancies.

3.5 **Conference:** In October 2021, we relaunched the annual Health Research in East London conference, delivering it entirely on-line. Attendance at this half-day conference topped 300 people logged in live to hear brief presentations on the results from a wide range of research projects conducted in the Trust, ranging from epidemiological studies to clinical trials and qualitative work.

3.6 **R&I internet microsite:** As part of revamp of the ELFT website, the R&I content was unexpectedly hived off into a separate microsite, much of which was rendered initially unusable. Since this somewhat rocky launch, we have been working closely with the Communications Team to ensure the information is presented in a clear and user-friendly way in order support those wishing engage in research at our Trust.

3.7 **Social Media:** Twitter has proven to be a useful tool as a means to recruit and inform our followers - whether they be colleagues or service users - about the different studies the trust is supporting and ways they can get involved. In the last year we have gained over 300 followers and our profile has been viewed over 1300 times. Our engagement levels have doubled since this time last year.

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[7] Although unfunded and thus excluded from the NIHR Portfolio, such studies can be significant in size and impact. For example, the ELFT-led survey to find out how the pandemic challenges have affected NHS staff recruited nearly 200 participants from our Trust alone, far outstripping anything included in the Portfolio.

[8] The CSO team is a group of research assistants, assistant psychologists and – in the future – nurse and allied health professionals (collectively referred to as 'Clinical Studies Officers', or CSOs) whose principal objective is to increase opportunities for ELFT service users, staff, carers and wider community to participate in relevant research.

3.8 One of our top tweets is a short interview with Professor Stefan Priebe, viewed over 1800 times where he talks about the PAAM study and how research can be viewed as *"the daily work of challenging existing wisdom".* We are optimistic that our growing number of followers will be inspired by the power of research through these stories and remain informed about the benefits their involvement could bring.

4.0 On the Horizon

4.1 Much of the activity during 2021/22 has been working towards goals which should come to fruition in the coming months:

4.1.1 We have signed a memorandum of understanding with one of the country's leading universities to establish a joint research team in community and primary health care.

4.1.2 In addition to Prof Sampson, two more senior academics are joining ELFT in the coming year, thus expanding our expertise in population health, older people's mental health, and learning disabilities – all new areas for ELFT in terms of research and innovation.

Consultant Psychiatrist Dr Afia Ali is a clinical-academic with a track record on stigma research and clinical trials of psychosocial interventions in people with learning disability from her previous post as Associate Professor at University College London.

While new head of Queen Mary University of London's (QMUL) Centre for Psychiatry and Mental Health[9], Prof Claudia Cooper is a jointly appointed clinical-academic interested in the epidemiology of older people's mental health, happiness and wellbeing, and in the mental health of carers of people with dementia.

4.1.3 With these new posts and partnerships, we hope to finally have a critical mass of research expertise and studies to bring the opportunities in Luton & Bedfordshire up to a par with the activity taking place in East London.

4.1.4 There has been an increased volume of research grant applications coming our academic partnership with City, University of London. In addition to the Prof Gillard's successful award mentioned above, he has submitted NIHR programme grant application to develop, pilot and trial and peer support group clinic intervention to reduce cardiovascular risk in people with severe mental illness. Emulating the integrated care systems model, this proposal is a collaboration of experts in acute, primary, and mental health care.

4.1.5 We have launched a review of the various PPI initiatives in which R&I is involved with a view to bringing them together in a new *People in Research Panel* with a broad membership of people currently using ELFT services incorporating mental and physical health, young people and from across our communities. Opportunities to be involved in research activities, to which members express interest depending on their experiences and expertise, will be circulated to group members in three workstreams: SUGAR (research advisory); POPULAR (service user-led research); and research training and skills (two year rolling programme).

[9] The Centre for Psychiatry and Mental Health is part of QMUL's Institute for Population Health Sciences

4.2 The most significant challenge and opportunity on the horizon is we have yet to integrate routine clinical data sets to use for research and evaluation purposes. Working groups have been set up both internally at ELFT and in the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS)[10] similar to the Discovery Project in Tower Hamlets which is attempting to link primary, acute, mental health care and local authority data.

5.0 Action being requested

5.1 The Committee is asked to RECEIVE and NOTE the report for information.

[10] Which we hope to replicate in the North East London (NEL) ICS

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REPORT TO THE QUALITY ASURANCE COMMITTEE
2 March 2020

Title	Research and Trust Strategy
Author	Karin Albani, Associate Director of Research & Frank Röhricht, Medical Director for R&I and Medical Education
Accountable Executive Director	Dr Paul Gilluley, Chief Medical Officer

Purpose of the report

To present to the QAC the final draft of a five-year plan for how the Research & Innovation function can support the delivery of the ELFT Strategy; the Committee are asked to RECEIVE and DISCUSS the proposal.

Once any suggested amendments are made, the plan will be resubmitted to the QAC to APPROVE the recommendations.

Summary of key issues

This report gives details on how through research the trust will achieve its strategic outcomes. The aim is to change the culture within the organization such that research and innovation is seen as a vehicle to achieve the strategic outcomes that have been set.

This proposal is laid out in three parts: the first describes our vision for R&I; the second lays out the actions to deliver it; and lastly appendices with supporting information.

Strategic priorities this paper supports (please check box including brief statement)

Improved population health outcomes	☒	Research based in the Trust can facilitate the understanding of factors impacting on population health, and the development and evaluation of novel interventions for the benefit of the local population. Some evidence suggests that participating in research studies is beneficial for patients
Improved experience of care	☒	Engagement of clinicians and healthcare organisations in research is associated with improvements in healthcare performance.
Improved staff experience	☒	High quality research activities and the presence of research groups enables staff to acquire new skills for enquiry & critical appraisal. It may provide some “buzz” to services making working in the Trust more attractive, which should facilitate recruitment and retention of committed and qualified staff and strengthen a general atmosphere of enthusiasm, creativity and positive change
Improved value	☒	Research directly contributes to improve efficiencies in health economy. In addition, successful researchers generate direct and indirect external grant income, thus minimising the financial risk for the Trust in supporting research.

		The reputational advantage of successful research and a WHO Collaborating Centre may help business development.

Committees/meetings where this item has been considered

Date	Committee/Meeting
20 Feb'20	Research Committee

Implications

Equality Analysis	No equality impact assessment has been carried out. Research carried out however should aim to improve access to treatment.
Risk and Assurance	Research should assist in the mitigation of Trust risks.
Service User/ Carer/Staff	The scope of research should extend as widely as possible, therefore all directorates and service groups are potentially impacted.
Financial	Trust investment required but full details are not laid out in this paper.
Quality	Impact on quality and effectiveness of service provision and care of patients.

Supporting documents and research material

Part A: Vision
Part B: Action Plan
Part C: Appendices

How Research & Innovation supports delivery of the Trust Strategy

FY2020/21 – FY2024/25

Contents

Vision 1
I) Executive summary 2
II) The wider context: Research benefits the NHS and supports ELFT strategic outcomes 3
a) External and internal influences 4
III) ELFT's academic partnerships: Working in collaboration with the experts 5
IV) Research & Innovation at ELFT: The journey so far 6
V) Plan for the future: Support continuous improvement of our services 7
a) Working together creatively to deliver 8
VI) Conclusion 10

Vision

ELFT's mission is to improve the quality of life for all we serve. Our vision for the Research & Innovation (R&I) function in ELFT is to work together with, and in support of, our care services' objectives to continuously improve.

This represents a fundamental shift away from Research units fulfilling a parallel function alongside the healthcare services with the primary aim of adding to the evidence base, assisted by those in the Trust with a specialist interest.

Instead, the R&I function – as part of a broad innovation portfolio, encompassing Quality Improvement, service evaluations, trainees' degree projects, right up to externally funded research grant programmes – is driven by the improvement needs of the Trust's Places and Clinical areas.

R&I is thus transformed into a corporate function supporting our services to deliver their improvement agenda.

This proposal is laid out in three parts: the first describes our vision for R&I; the second lays out the actions to deliver it; and lastly appendices with supporting information.

I) Executive summary

1) Historically, efforts to promote research at ELFT have been mainly focused on investing in academic teams in partnership with higher education institutes (HEIs). These teams collaborate on or lead studies at a national and international level, contributing to the evidence base and enabling progress in the understanding of underlying factors for disease development, diagnostic tests, and treatments of disorders.[4, 10] Universities measure success by the award of grant funding from governments and research councils and by publications in peer-reviewed journals, but for a healthcare provider like ELFT this is only the halfway point.[i]

2) As a healthcare provider, ELFT's vision is to lead on the delivery of integrated care, always striving toward continuous improvement. Therefore, to be of maximum benefit to the Trust, research should lead to innovations in service delivery so that we improve the quality of life for all we serve.

3) This paper proposes building on the successes of the Quality Improvement (QI) programme in ELFT towards an understanding that research and innovation (R&I) in its broadest sense, from QI to epidemiology and clinical trials, is everyone's responsibility and a core part of clinical care. It is important that every clinician working in the NHS is research active, whether this is identifying new issues to explore, enrolling patients into studies, supporting colleagues, or leading trials themselves. Facilitation of research in trusts should be part of core activity and seen as a key indicator of improving patient care.[9]

4) NHS staff can make important contributions to research, but enabling those contributions is no easy task. Many barriers stand in the way but an evidence base on the mechanisms that enable engagement is now emerging. For example, it's important that leadership within organisations and professional networks champions research.[5, 8, 13, 14, 19]

5) And, while we can observe that psychiatric trainees engage in research activities less often when compared to those of other medical disciplines[6, 16, 17] and the number of early career psychiatrists engaging in research appears to be reducing,[30] there is also evidence that opportunities to receive mentorship and access to research funding can facilitate engagement.[21]

6) Our overall objective is a cultural transformation of R&I in ELFT from the current perception of a department asking overburdened clinical care teams to support an external elite undertaking academic studies into a Corporate support function helping

   - our six Places deliver their portfolio of locally-led projects;
   - the Trust-wide learning networks bring together local place-based work for specific populations to enable learning and sharing;
   - staff to deliver the ELFT Promise to continuously improve by pursuing research activity as far as they wish to; and
   - more patients than ever have the opportunity to be involved with or benefit from clinical research.

7) We propose to work together creatively to minimise resource impact; however, success will depend on leadership across the organisation from the Trust's Executive Team, through Directorate and Place, as well as Corporate functions such a People & Culture, Quality, and Communications.

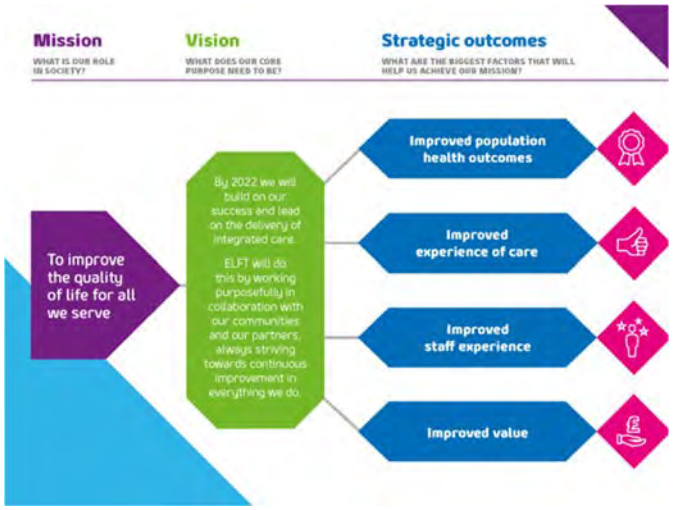
[i] References are listed in Appendix F

II) The wider context: Research benefits the NHS and supports ELFT strategic outcomes

1) Innovation and research in its broadest sense, from quality improvement to epidemiology and clinical trials, is recognised as crucial to ensuring that patients in the UK continue to benefit from high quality, evidence-based and efficient services, helping to deliver empathic and compassionate care to achieve better outcomes for patients across the country.

2) Evidence shows that the engagement of clinicians and healthcare organisations in research is associated with improvements in healthcare performance.[30] Patients cared for in UK trusts with strong research activity have **improved health outcomes** – lower mortality and less post-operative complications.[11] Moreover, the benefits apply not just for patients enrolled in the research, but other patients with the condition who didn't take part in studies. Clinical trials activity is associated with improved Care Quality Commission (CQC) ratings.[20] Research underpins continuous Quality Improvement Programmes, contributing a wide range of evidence base change ideas.

3) Patients express strongly positive experiences of participating in research, highlighting their empowerment and the strength of their relationship with clinical teams, an **improved experience of care**. In 2018/19, the National Institute for Health Research (NIHR) conducted its annual survey on the experience of those taking part in clinical research which found that 90% had a good experience of participating.[25] Staff who conduct research also report positive outcomes for themselves, an **improved staff experience**. The Royal College of Physicians now stresses the importance of research as part of direct clinical care for doctors.[9]



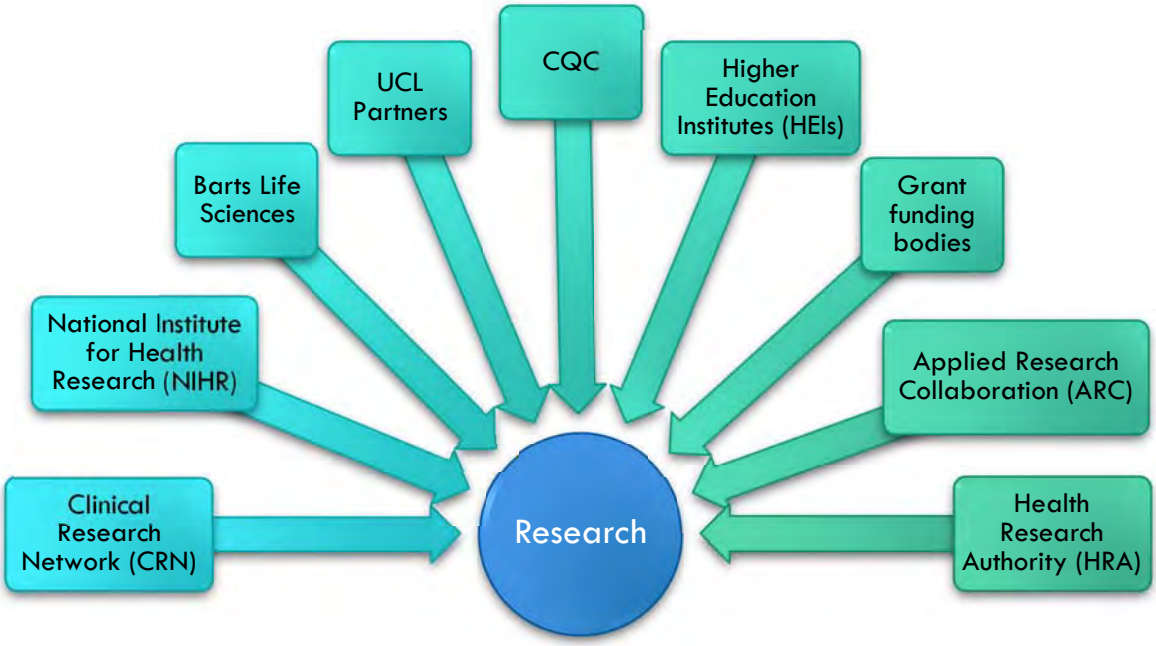
4) Research is now recognised in the NHS constitution[27] and is a key objective in NHS England's long-term plan.[32] The NIHR took this evidence to the Care Quality Commission who recognised its contribution to **improving value** and from 2019 now include questions about research in the "well-led" domain of their assessments of trusts.[7]

5) Thus being research active supports ELFT in the achievement of all four of ELFT's strategic outcomes.

a) External and internal influences

1) The main stakeholders that currently influence Research at ELFT are illustrated in the figures below. It is important to be aware of and engage with all our stakeholders in order to meet competing demands as we strive for excellence. We will be working with these teams to ensure the R&I function supports the Trust Strategy to delivery continuous improvement.

External



Internal

III) ELFT's academic partnerships: Working in collaboration with the experts

1) The Unit for Social and Community Psychiatry (USCP) was originally established in partnership with the Strategic Health Authority and the Barts and the London School of Medicine and Dentistry at Queen Mary, University of London (QMUL) to improve the reputation of mental health services in East London, attract staff, and support service evaluation and development. By any measure, the Unit has attained these goals: research success in the form of grants, clinical success developing new and innovative treatments, and international recognition as a World Health Organisation (WHO) Collaborating Centre.

2) The USCP (now part of the new Institute of Population Health Sciences) is one of only 14 mental health-related WHO Collaborating Centres in Europe and the only one specifically for 'mental health services development' in the world. The role of the Unit included significant contributions to service developments, the introduction of evidence based and participatory outcome measures (e.g. DIALOG+), and involved the publication of a *Technical Guidance for Mental Health Promotion and Mental Health Care for Refugees and Migrants*, which the WHO issued to all Governments in Europe (authors Domenico Giacco and Stefan Priebe), and the advisory role of Professor Priebe on the National Mental Health Strategy for Malta which was launched in December 2018.

3) The Centre for Psychiatry (CfP, Wolfson Institute of Preventive Medicine, QMUL) has a significant track record on cultural and environmental aspects of public mental health research as well as psychological medicine (association of chronic physical disease and mental illness); CfP is leading on schemes providing high quality teaching for under- and postgraduate medical education.

4) A new joint venture between ELFT and Maltepe University in Istanbul, Turkey led to the development and launch of a master programme (MA) in Clinical Psychology with Body Psychotherapy Certificate. The programme is the first of its kind in Europe and Asia, bringing years of successful research conducted in East London in the area of body-oriented psychological therapies (BPT) to the international community. Future plans include the involvement of BPT/DMP (dance movement psychotherapy) practitioners from ELFT in supervising placements for students in London as well as teaching contributions. Discussions have started to develop a sister programme at Queen Mary, University of London.

5) ELFT is furthermore benefiting from a close collaboration with the School of Health Sciences at City, University of London; the Centre for Mental Health Research (CMHR) is leading on research on the delivery of recovery-focused care planning, peer support, communication, and conflict resolution in inpatient settings. The CMHR has an international reputation for involving service users and carers in research and is also at the centre of the Joint Institute of Nursing (JIN). The JIN's primary aims are to ensure evidence-based practice is at the heart of community and mental health nurse education and to enable nursing staff to maximise their potential in practice, research, and teaching expertise.

6) With the increase in Trust provision of community health and the move towards more integrated care there is work to develop partners to promote research in this field. Since 2012, the Trust has underwritten a post researching self-management of long-term conditions at City, University of London's Centre for Health Services Research (CHSR) with somewhat limited results. A stronger emphasis on population health research has been linked to the new Institute of Population Health Sciences which has been formed within QMUL. The Unit for Social and Community Psychiatry is a major part of the new Institute which also features strong research in Primary Care. Professor Priebe, who leads the USCP, is also the Research Director of the new Institute which underlines the links with ELFT.

IV) Research & Innovation at ELFT: The journey so far

1) Research activities can be divided into four distinct categories:

   - Research conducted and/or assisted by ELFT clinical staff
   - Academic partnerships in which we choose to invest and collaborate[ii]
   - Research projects/programmes commissioned from ELFT and funded by external bodies;[ii] and
   - Corporate oversight and management function.[iii]

2) Since 2018, the Trust began strengthening the managerial oversight for research and innovation with a view to support and strengthen the research culture; create better links between frontline clinical, Quality Improvement, and research teams; and the interface between medical education and research. ELFT appointed Prof Frank Röhricht to the new role of Medical Director for Research, Innovation and Medical Education and enhanced the role of the research manager to an Associate Director of Research.

3) While ELFT benefits from our affiliation with highly successful HEI-based investigators who provide a centre of gravity both generating and attracting research activity, the intention is to leverage their expertise and momentum to encourage a culture of enquiry and innovation more broadly, and to develop more widely the skills and opportunities for those with interest and expertise in engaging in research alongside their clinical activities (see Appendix C: Research Plan, approved by Trust Board September 2018).

4) Elaborating on that Plan, this proposal was developed following over a year of exploration of the benefits and methods to promote a research culture in the NHS. It is based on advice published by the Royal College of Physicians, NHS England, the National Institute for Health Research, the Academic Health Services Networks, and the NHS Research and Development Forum.

5) The document has been subject to a broad consultation and incorporates observations and suggestions from:

   - Ken Batty, Trust Board Non-Executive Director and Chair of the Research Committee
   - Paul Binfield, Associate Director of People Participation
   - Paul Calaminus, Chief Operations Officer & Deputy CEO for Bedfordshire & Luton
   - Robin Campbell, Associate Director – Commercial Development Directorate
   - Ravinder Rana, Director of Therapies
   - Stephen Sandford, Professional Lead for Allied Health Professionals
   - Lorraine Sunduza, Chief Nurse
   - Donna Willis, Associate Director of People & Culture

6) It is designed to work within the framework of Trust-wide planning to deliver our strategy (orientated around the six places in which we operate) developed by Amar Shah, Chief Quality Officer and Richard Fradgley, Director of Integrated Care, including the priorities set by the Long Term Plan and by our Working Together Group and Council of Governors.

7) The document will be updated on an annual basis in order to align the R&I function dynamically with ELFTs evolving strategy and priorities.

8) Implementation will be driven by the R&I function, working together with all parts of the Trust. Outcomes will be monitored by the Research Committee, which is accountable to the Trust Board via the Quality Assurance Committee.

[ii] Appendix A: Funding of academic posts and research studies
[iii] Appendix B: Current structure of Research & Innovation function in ELFT

V) Plan for the future: Support continuous improvement of our services

1) The table below shows our strengths, weaknesses, opportunities and threats. It is important to acknowledge our status in order to determine areas for improvement and development.

Strengths	**Weaknesses**
Internationally renowned research unit which is a WHO Collaborating Centre for MH Service Development Partnership with Barts Life Sciences and new Institute of Population Health Sciences Partnerships with leading research universities Track record in service user / people participation	Localised pockets of excellence, not general expertise Perception of research as elitist and 'too complex' compared to QI leading to lack of engagement Lack of resources, including protected time and skilled staff Poor interface between QI, Research, and other improvement efforts such as service evaluations
Opportunities	**Threats**
Government prioritising mental health and primary care Increase activity in areas where there is little current research Leverage expertise to mentor other staff Conduct research which matters to the populations we serve	Individual academics move on and are hard to replace Improved efficiencies are necessary to meet increased demands on NHS Brexit effect on both staff recruitment and grant funding Waste money, effort and opportunities for shared learning

2) One of the four aims of the ELFT Strategy is to **improve population health outcomes** by helping people lead healthier lifestyles and improve prevention of ill health. Research studies can provide evidence on ways to achieve our service delivery aims.[iv] Supporting activities planned in R&I include fostering:[v]

   - population health research projects
   - Public and Patient engagement as authors, investigators, and champions

3) By increasing the numbers of people positively participating in their care and in service improvement, R&I at ELFT seeks to **improve the experience of care**. At the same time, a broad 'culture of enquiry' as fostered through research is well placed to **improve staff experience** by developing skills. Other supporting activities proposed include:

   - Promoting the benefits of research to encourage adoption in our provision of care
   - Make research activity rewarding
   - Attract, develop and retain research leadership and skills

4) Our intention is to create an environment where the maximum number of service users have the opportunity to engage in research (both as participants of studies receiving innovative care, and as research advisors / assistants contributing to the shaping of research questions and design). We want to create opportunities for staff to have the time, knowledge and confidence to ask about research, as well as a culture where all staff - from management to healthcare assistants - champion research and innovation as something that improves outcomes for those receiving care.

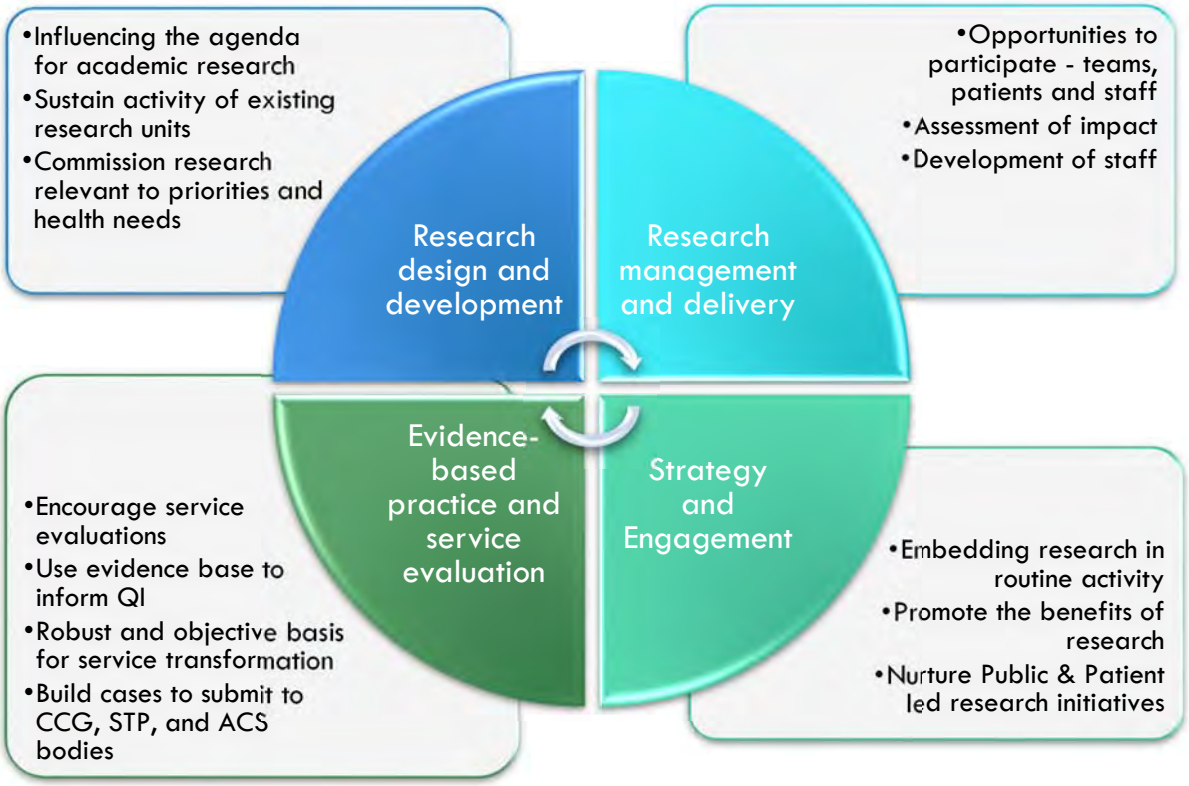
5) Finally, Research directly contributes to improve efficiencies in health economy thus helping to achieve our goal of **improved value**. Our aspiration is to ensure that the populations

[iv] See Appendix D: Examples of research activity which could support delivery of ELFT aims
[v] See Part 2 for more details of the specific outcomes and supporting activities of R&I for each Trust Strategic Outcome

we serve have access to the best care possible by encouraging innovation and incorporating the latest evidence into practice. For example, by

- Harnessing routine "big data" sets for population-based research
- Establish economic analyses as intrinsic aspects of research activities
- Enhance the utilisation of evidence to drive improvements in care

6) Thus R&I actively supports ELFT in the achievement of all four strategic outcomes in ways which are inter-related and serve to support each other.



a) Working together creatively to deliver

1) We want to expand our research activity beyond mental health to better reflect how ELFT has evolved and engage new clinical areas and professional groups. For example, to effectively engage with nursing staff (who are under-represented in the research dimension), we can use existing channels/events aimed at nurses to promote research opportunities. The same goes for the established meetings of Psychological Therapies, AHP, PPE, and the new place-based DMTs. The goal is to make R&I everyone's business.

2) There are simple ways for staff to get involved at every level of effort and experience – from helping to **publicise** awareness of studies taking place in ELFT, to **recruiting** patients into trials, or even **participating** in a study themselves for example by being interviewed or completing a survey. Staff can also help **deliver** an innovative treatment as part of a research trial and thus benefit from learning new skills. Those with an interest can be the local **lead** in our Trust for a national study, acting as the liaison between the central research team and ELFT care services.

3) Staff naturally focus on what is measured; therefore we need to incorporate R&I into the appraisal cycle, for example asking in relation to the ELFT Promise to continuously improve our services: What did you do? What could you do? What obstacles prevent you from innovating?

4) Psychology trainees fulfil their thesis requirements via QI projects; trainees in Deancross fulfil theirs by undertaking service evaluations. But the organisation as a whole doesn't have a coherent approach to harness trainees as a resources to drive innovation.

5) ELFT has invested in a variety of HEI partnerships with varying impact on delivery of services; we could leverage this expertise for example to support CCG bids, and provide advice to Trust staff on their study ideas.

6) The following items have been identified as crucial support. In line with the overall vision of embedding R&I as part of our routine business, wherever possible we propose taking advantage of synergies available from existing staff with the necessary skills in Coms, QI, Assurance, IMT, People & Culture, and etcetera. However, this requires commitment from the Executive Team to ensure that support for R&I is made part of their core remit, without which delivering these objectives will not be possible.

Item	Delivered by
R&I Delivery Manager • Service Support resources (CSO team) • Research Governance assessment (Noclor) • Portfolio study pipeline (CRN) • GECSE administration • Succession planning for R&I function	Creation of new post
Communications Plan; Details in Appendix E	ELFT **Coms Team**
Website / Intranet upgrade	Functionality for R&I scoped into existing Trust plans

Item	Delivered by
Training webinars (promote knowledge & skills)	Delivered by ELFT **People & Culture** via ELFT Online Learning Module (OLM)
Conference & Events Management	**QI** Communications & Events Officer
Promotional videos (success stories, benefits, impact of research)	Contracted out to production company
R&I Incentive Fund for research sessions, small grants, fellowships	Allocation from Trust charitable funding pot
National Data Opt-out	Administered by **Information Governance** (Assurance)
Access to Dedicated Data Analyst / Statistical Support, e.g., QMUL Clinical Effectives Group (CEG)	Joint investment and jointly beneficial for R&I / **Assurance** / **QI**
CRIS	System administered in ELFT by **IMT team**
PP Research Champions	Paid role, incorporated into recovery journey
Access to space to conduct research enrolment and delivery activities	Incorporated into **Estates** planning
Research Apprenticeships	Apprenticeship Levey
Advance Clinical Practice (ACP) in Research	Delivered via Nurse / Psychological Therapies / AHP Preceptorships programmes

VI) Conclusion

1) ELFT is a leader in QI, hosts a globally renowned research Unit for Social and Community Psychiatry, has a seat on the board of UCL Partners, among other strengths – but we have yet to harness these disparate elements into a cohesive innovations programme. If we work together, however, we can benefit, for example:

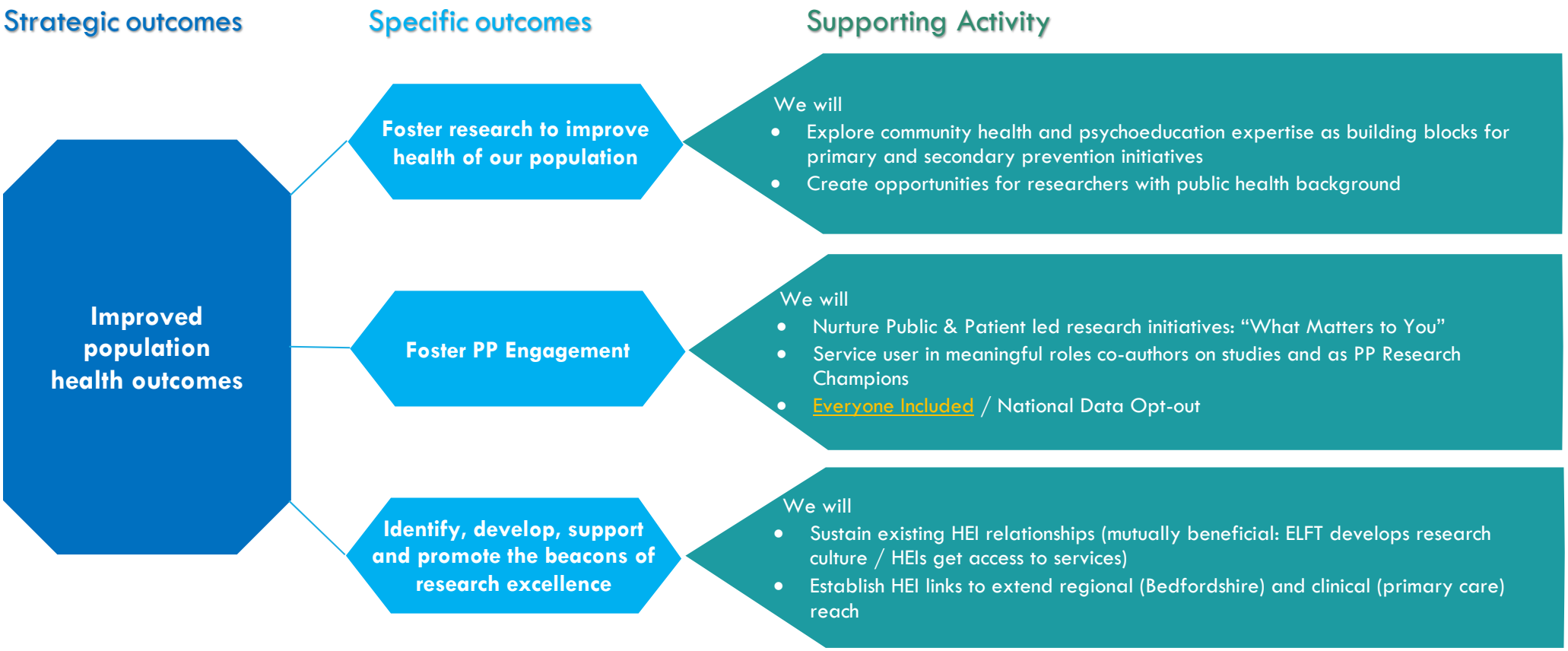
   - TRIALOG: Staff supervision tool mapped onto DIALOG tool developed from a research programme
   - Violence Prevention research grant application grew out of QI projects
   - Research on Medically Unexplained Symptoms has helped identify predictors of success in IAPT
   - Community Transformation would benefit from a systematic review on models of community care to provide an evidence base in its support, and expertise in outcome measurement to ensure the proposal is designed in such a way that the results can be effectively evaluated.

2) The R&I function cannot operate in isolation or impose change; if we are to achieve these objectives, the Trust as a whole must work together. Innovation needs to be everyone's responsibility to deliver, and R&I should support those improvement objectives.

3) Part 2 of this proposal is an early stage Action Plan laying out the specific outcomes and supporting activities to deliver this vision.

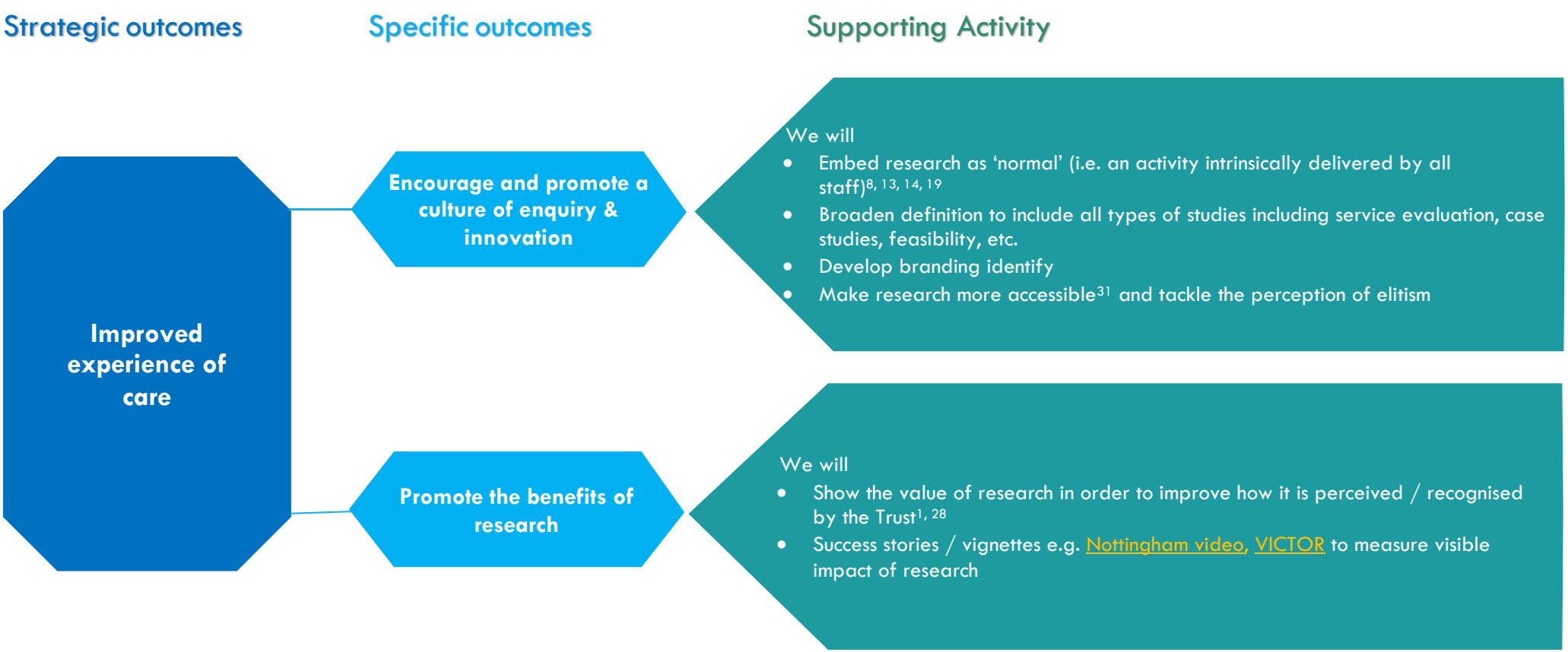
Action Plan: Transformation of Research & Innovation function

FY2020/21 – FY2024/25



Measured by:

- How often research led by ELFT is cited; contributions to NICE guidelines
- Number of studies led / sponsored by ELFT
- More PP researchers trained; PP-led studies initiated



Measured by:

- Increased activity – number of active studies and number of enrolled participants

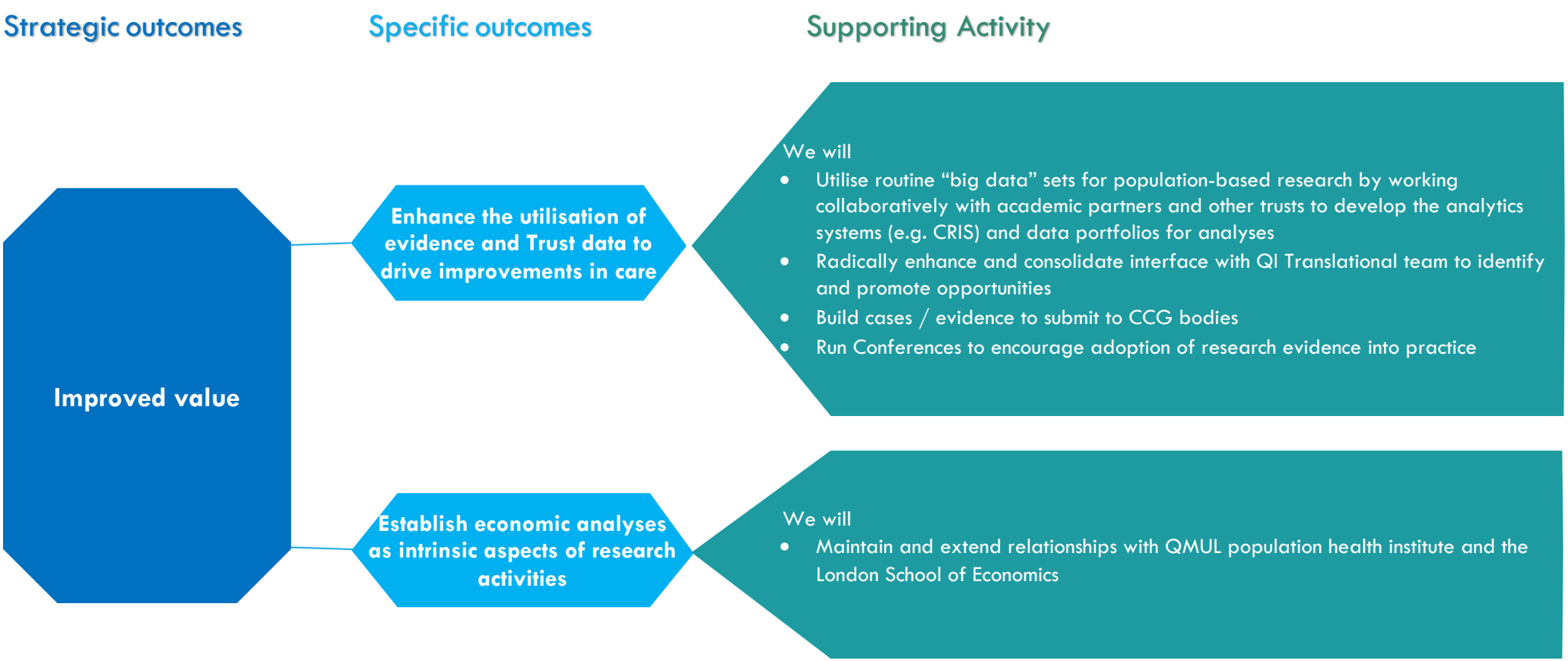
Strategic outcomes	Specific outcomes	Supporting Activity

Improved staff experience	**Attract, develop and retain research leadership and skills**	We will
		• Create more 'hybrid posts' (e.g., clinical posts with research sessions) across all professional groups with a development pathway, e.g.,
		  o Apprenticeships
		  o Advanced Clinical Practice (ACP)
		  o Clinical Academic Fellowships (pre- and post-doctoral)
		• "Research Design Service ELFT" [2, 8, 15, 24]
		• Promote service evaluation as a pathway to research
		• Address skills gaps by creating a register for training opportunities including research methodologies, evaluation, being a local study lead[8, 18, 19, 23, 24, 29]
		• Address resource issues via an R&I Incentive Fund for research sessions, small grants, fellowships – all tied to outcomes of driving delivery[21]

	Make research activity rewarding	We will • Recognise research contributions in job plans, appraisal systems, and career pathways[13, 22, 24, 33] • Create opportunities for recognition and reward; e.g., Staff Awards; send 'thank you' for supporting enrolment; create competition / award for most active team[3, 13, 15, 22, 24, 28] • Honorary positions at partner universities

Measured by:

- Research is raised in every job advert and interview
- Staff contribution to innovation efforts incorporated into the performance appraisal system
- How many staff seek a research opportunity in their first year at ELFT



Measured by:

- What research developments are being used in our services
- Number of grants awarded to ELFT

Appendices

Appendix A: Funding of academic posts and research studies

1) From its inception, the East London NHS Foundation Trust (ELFT) has made strategic investments into clinical-academic posts and research infrastructure where no income existed and where benefits are not always directly financial. The majority of ELFT's financial investment in research goes to jointly underwrite the cost of posts at our academic partners, with minimal investment in supporting infrastructure.

2) Currently, the Unit for Social and Community Psychiatry (USCP) generates enough external income to be more or less self-funding, the other investments are paid for either from general corporate funds or – in case of long-term conditions – from related services. Each investment was made for different reasons, and to take advantage of different opportunities.

3) Individual projects or larger multi-part programmes are funded by specific research grants awarded by funding bodies (e.g., government agencies, charities, research councils). A team of investigators, led by a key academic, will submit an application describing the work to be undertaken, justification, outputs, milestones, collaborators, and detailed cost to deliver.

4) Funding for successful applications will be awarded to a single lead organisation that works with collaborating institutions and is responsible for delivering the promised outputs. Staff members (e.g., research assistants, trial managers) are employed to work on a research grant, paid from that funding, on fixed-term contracts that end with the delivery of the outputs.

5) The Trust increasingly is acting as the lead organisation (rather than just a collaborator) for a number of research grants. In the last decade, over £15m of research grant funding has been awarded to ELFT.

6) Grants from the NIHR that are awarded directly to the Trust attract Research Capability Funding (RCF) from the Department of Health. This is an allocation calculated as a percentage of the NIHR research income paid to the Trust in the previous calendar year and can be used to offset the paycosts of research staff not already covered by other external income.

7) The Trust can also agree, as a collaborator on a national study, to contribute to a grant led by another organisation and to employ research staff paid from funds included in collaboration agreements between the parties. Grants on which the Trust collaborates, rather than leads, do not attract RCF.

8) Each grant or collaboration agreement is a separate funding arrangement with individual requirements and reporting, so each is ring-fenced in an individual cost centre.

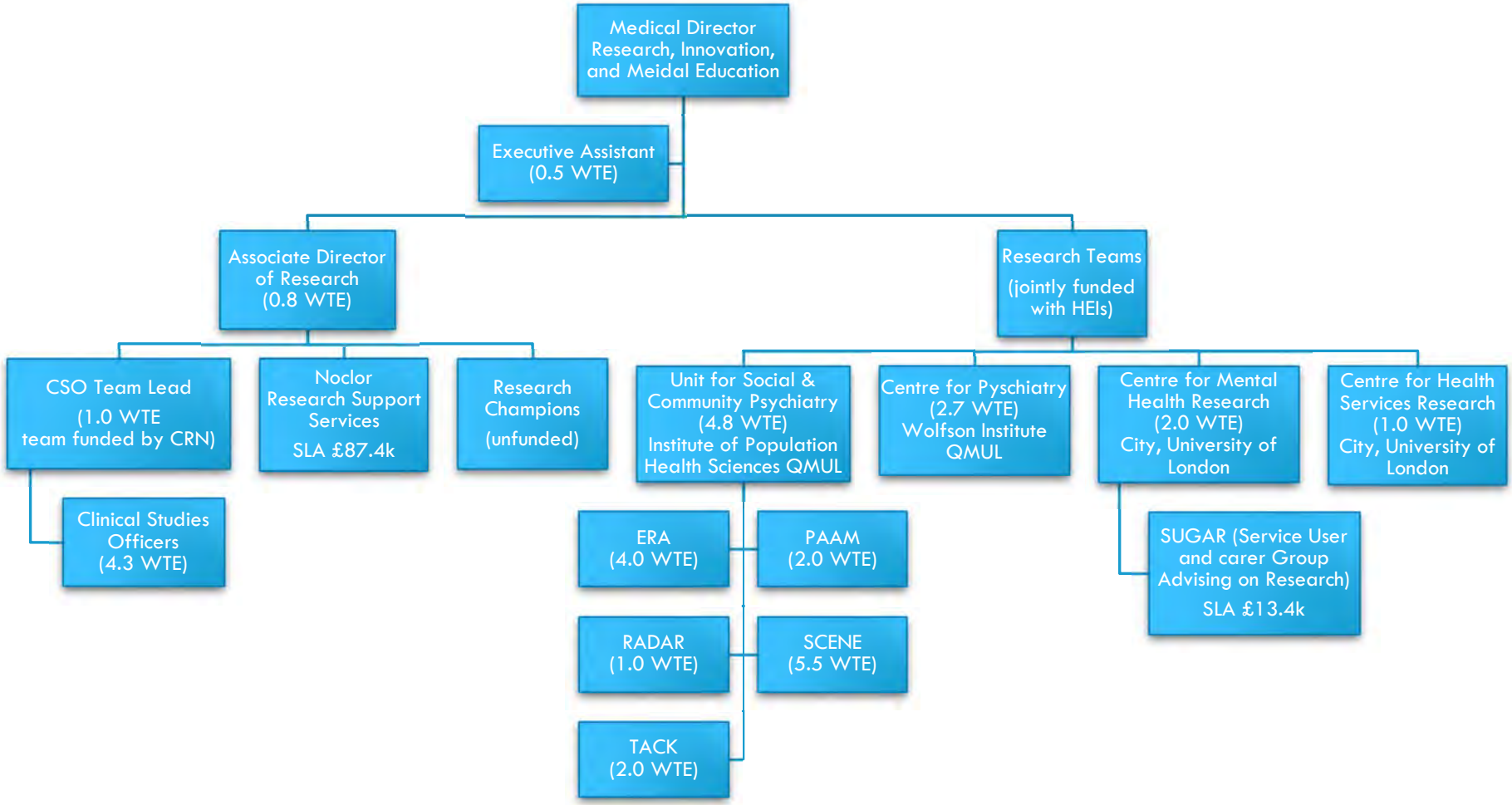
Appendix B: Current structure of Research & Innovation function in ELFT

1) Beyond the partnerships which develop ideas and undertake studies to add to the evidence base, all NHS providers are required to facilitate external studies that wish to recruit locally, even if we were to discontinue investment in generating research ourselves. Specifically, we must ensure that all studies active in our Trust fulfil the requirements of the DoH's *UK Policy Framework for Health and Social Care Research*. Research Management & Governance (RM&G), therefore, is a corporate function (in the same way as Communications, HR, or IT) for which there is no specific income stream; the budget comes from general funds.

2) Similarly, since all NHS organisations are expected to support and encourage research, our care services are required to provide support for enrolment into and associated treatment delivery of both our own and external studies. The CRN (Clinical Research Network) disburses funding where study treatment costs are deemed by the NIHR to exceed the contribution expected from commissioned clinical service income.

3) The CRN also funds paycosts of specific named individuals – including our Clinical Studies Officers (CSOs) – who are tasked with providing support within our services for research recruitment. While the Trust is the substantive employer and responsible for line management of these resources, the investment is at the unilateral discretion of the CRN which determines how many posts we employ, whether vacancies can be filled, and sets study enrolment targets the Trust is expected to fulfil using these resources.

Structure of Research & Innovation function in ELFT



Appendix C: Plan for how research supports delivery of the overall Trust strategy

This paper lays out the strategic plan for the trust in how it aims to initiate, support and partake in research which directly or indirectly benefits patients and improves the delivery of the overall Trust strategy. It was approved by the Trust Board in September 2018.

Appendix D: Examples of research activity which could support delivery of ELFT aims

The Trust's plan is to use a place-based focus to deliver the Strategy with corporate support, e.g., QI, business intelligence – we propose a role for R&I in the form of intelligence about the current evidence base, focused analysis in the form of trainees' service evaluations, and opportunities to participate in studies (which we know improves patients' experience of care).

ELFT aim	**Research study**
New women will be supported to access community perinatal care	Accessibility and acceptability of perinatal mental health services for women from Ethnic Minority groups (PAAM)
More CYP accessing CAMHS	Engaging unaccompanied asylum seeking children (UASC) in developing a pathway to meet their needs
People with common MH problems	TACKling chronic depression - adapting and testing a technology supported patient-centred and solution-focused intervention (DIALOG+) for people with chronic depression
People with SMI: providing a stronger psychosocial offer	SCENE: Improving quality of life and health outcomes of patients with psychosis through a new structured intervention for expanding social networks
Crisis services for adults	ASsuRED: Improving outcomes in patients who self-harm - Adapting and evaluating a brief pSychological inteRvention in Emergency Departments

Appendix E: Communications Plan for ELFT Research Department

Aim: to ensure that ELFT colleagues understand the remit of the Research team, what they do and how people can engage with them.

Objectives	Internal Communications	IC Action	Timeline/ Frequency	External Communications
Improving Research page visibility	• Move the Research page to a more prominent/intuitive location on the intranet.	• Move the page from Corporate & Governance/Corporate Services & governance to Clinical & Patient Care.	December 2019	Social media: build a presence through the Medical Education Twitter account
Fostering a 'Culture of Enquiry'	• Ensure that ELFT staff understand what it is that makes the Research dept. unique – the advantages wrought, methodology used, support available and the range of benefits accrued. • Promote Research support/training available • This will require an internal Comms campaign involving a range of news stories over a set period of time that get across the core messages.	• Update intranet page content to align with messaging around 'culture of enquiry. • Create more dynamic, visual content, use and promote existing video resources where possible. • Quotes & images of existing staff involved in Research on Research page linked to news stories on the core messages. [1] • Embed Research Twitter feed onto the Research page.	December 2019 Jan/Feb 2020 December 2019	Align a public facing news campaign and utilise social media platforms as well as ELFT website. Approach specialist clinical journals and local news press for potential coverage.
Sharing Stories of Success	• Publish stories/interviews on the benefits for staff to get involved with research • Research showcase, case studies/'real life stories' • TT Mailer campaign to embed the core messages	• The Core Messages to revolve around: We are Active/Where to Go/The Benefits of Being Involved in Research as a Service User and as a Clinician/What is Different to Research from QI/Involving and taking part is good for career progression/You get support from other professionals [2] • Targeted email messaging to specific audiences: existing audience currently undertaking research projects and target groups to capture new audiences.[3]	Monthly April & September – focus prior to key events.	Publish stories/interviews on the benefits for service users to get involved with research It will be necessary to identify some 'Research success stories' that are engaging for clinicians and the public
Improving understanding	• Create subsections and align all available content on the intranet	• Explore ways to make content more dynamic e.g. have rolling updates of 2-3	Set up Dec/Jan 2020,	Revamp the Research website pages.

Objectives	Internal Communications	IC Action	Timeline/ Frequency	External Communications
of what Research does	Research page to 2 categories (based on the target audiences): 'What we do' and 'Get involved'	items highlighted for each of the 2 categories, e.g. 'Top Research Projects of the Month', 'Surveys taking place this month' + 'Get Involved This Month'.[4]	launch Feb 2020	
Promoting Research Events	• Publicise the events on the intranet • Promote the events in the weekly bulletin; • Write articles based on the brief received from the event + photos/presentations. • Target event specific audiences	• World Research Conference 02.05.20 • Be Part of Research 20.05.20 • Research Conference 03.10.20 • Other	Following Event dates	Press releases for national events to approach the local press Tweet at the event tagging @NHS_ELFT and the comms team will retweet through the ELFT Twitter account

1. Quotes & images of existing staff involved in Research on Research page linked to news stories on the core messages:
   - Story + Quote w/c 13 Jan - existing staff involved in Research TBC
   - Story + Quote w/c 27 Jan - existing staff involved in Research TBC
   - Story + Quote w/c 10 Feb - existing staff involved in Research TBC
   - Story + Quote w/c 24 Feb - existing staff involved in Research TBC
2. Core Messages
   - We are Active – Mar, April & Sep 2020
   - The Benefits of Being Involved in Research as a Service User and as a Clinician – Apr & Oct 2020
   - Involving and taking part is good for career progression – Apr & Oct 2020
   - What is Different to Research from QI – Jun 2020
   - Where to Go – July 2020
   - You get support from other professionals – Aug & Nov 2020
3. Targeted email messaging to specific audiences:
   - April Theme: Get Involved - Be Part of Research, incl. we are active, The Benefits of Being Involved in Research as a Service User and as a Clinician, Involving and taking part is good for career progression.
   - September Theme: ELFT Research Conference, incl. Where to Go, You get support from other professionals, etc.
4. 2-3 items highlighted on the intranet for 'What we do' and 'Get involved': Selection TBC.

Appendix F: References

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With additional thanks to R&I colleagues at other NHS Trusts, including

Dr Navjot Ahluwalia, Executive Medical Director and Heather Rice, Assistant Director of Research at Rotherham Doncaster and South Humber NHS Foundation Trust

Hannah Antoniades, Associate Director of R&D, Avon & Wiltshire Mental Health Partnership NHS Trust

Prof Susan Corr, Head of R&D at Leicestershire Partnership NHS Trust

Angela Topping, Head of Newcastle Joint Research Office, Newcastle University/The Newcastle upon Tyne Hospitals NHS Foundation Trust

NHS
East London
NHS Foundation Trust

REPORT TO THE QUALITY COMMITTEE & QUALITY ASSURANCE COMMITTEE
27th June 2022

Title	Legal Claims Annual Report- 1st April 2021 to 31st March 2022
Author/Role	Christina Helden- Interim Associate Director of Legal Affairs
Accountable Executive Director	David Bridle- Interim Chief Medical Officer

Purpose of the report

To provide an overview on claims activity under the Clinical Negligence (CNST), Liability to Third Party (LTPS) (this is made up of Employer Liability and Public Liability claims) schemes and financial implications. The report covers the period between 1st April 2021 and 31st March 2022. This report does not include Employment Tribunals.

Committees/meetings where this item has been considered

Date	Committee/Meeting
27 June 2022	Quality Committee

The number of claims has remained stable in comparison to 2020/2021.

The top category of clinical negligence claims is deaths by suicide. This is consistent with previous years. The top category in liability to third party claims is information governance breach. This is a trend that started to appear last year and has clearly taken hold.

The Interim Associate Director of Legal Affairs will arrange a "Learning from Claims meeting" with the other Trust Associate Directors (in mid-September) in order to highlight the new themes (Information Governance and Estates matters) that have arisen over the past two years, the associated costs and to explore learning outcomes with a goal of mitigating future claims.

Since the limitation period for all claim types was extended due to the Covid – 19 pandemic, the Legal Affairs Team anticipated a decrease in number of incidents reported as claims (and a sudden and temporary increase in reported claims over the next two years). The limitation period extension may therefore be masking an increase in incidents resulting in claims.

Strategic priorities this paper supports

Improved population health outcomes	☒	Appropriate dissemination of learning from clinical negligence claims to Directorates enabling the identification of incident trends within populations.
Improved experience of care	☒	Appropriate management of clinical negligence claims leads to confidence that the Trust is open and transparent and willing to learn from incidents.
Improved staff experience	☒	Appropriate management of claims received from staff leads to confidence that the Trust is open and transparent and willing to learn from incidents.
Improved value	☒	Appropriate and timely management of claims minimises the financial impact on the Trust.

Implications

Equality Analysis	This report has no direct impact on equalities.
Risk and Assurance	Appropriate handling to claims ensures that any financial redress is appropriately managed.
Service User/ Carer/Staff	Appropriate handling of claims ensures that anybody who is disadvantaged by the action so of the Trust is appropriately compensated.
Financial	Robust management of claims ensures that financial implications are effectively managed.
Quality	No direct impact on Quality Improvement Programme

2.0 BACKGROUND

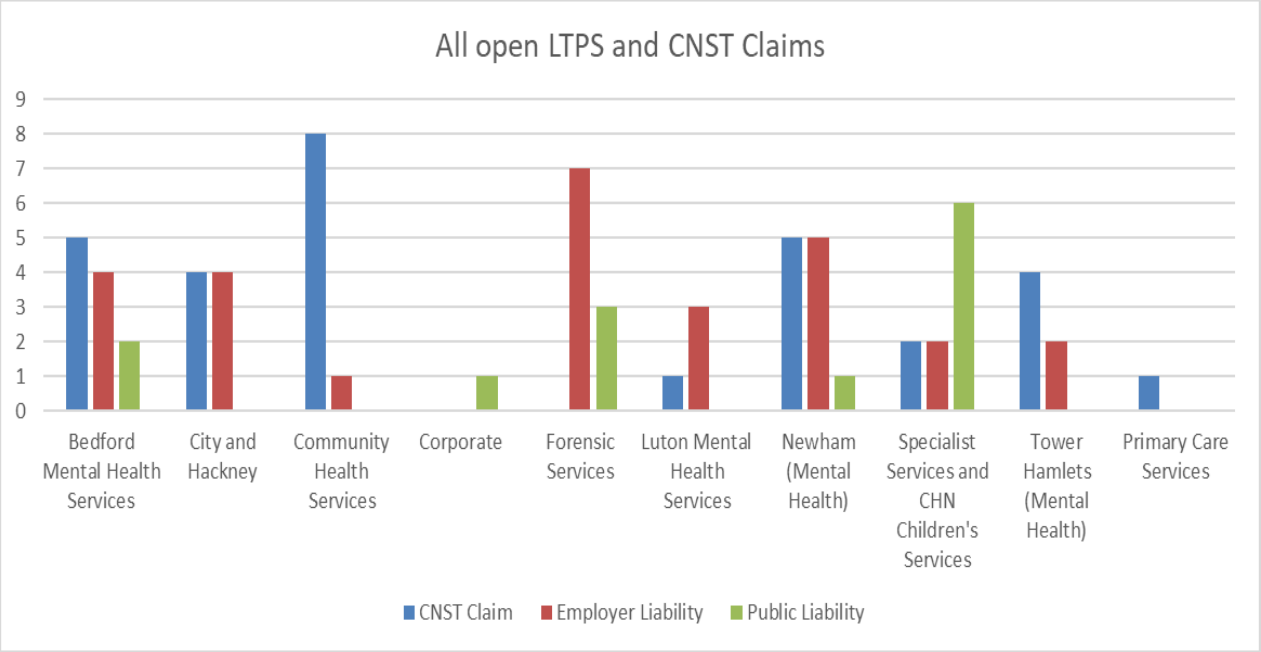
2.1 This report will focus on the claims activity under the Clinical Negligence (CNST), Liability to Third Party (LTPS) schemes between 1st April 2021 and 31st March 2022.

3.0 CLAIMS OVERVIEW

3.1 Open Claims

3.2 There are currently 71 open claims across all schemes. Of these, 30 are CNST and 41 are LTPS claims. In the previous financial year, there were 78 claims. 28 were CNST claims and 50 were LTPS claims.

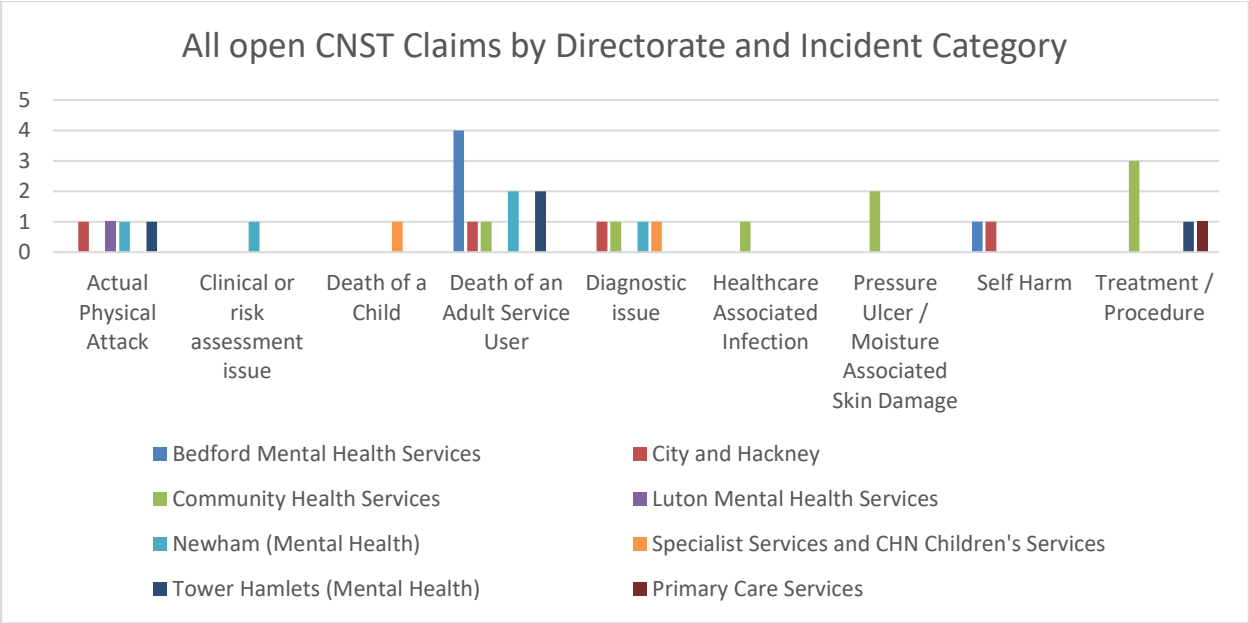
3.3 The graph below shows the number of open CNST and LTPS claims, split by Directorate.



3.4 All claims are categorised on receipt based on the categorisation used in the recording of incidents.

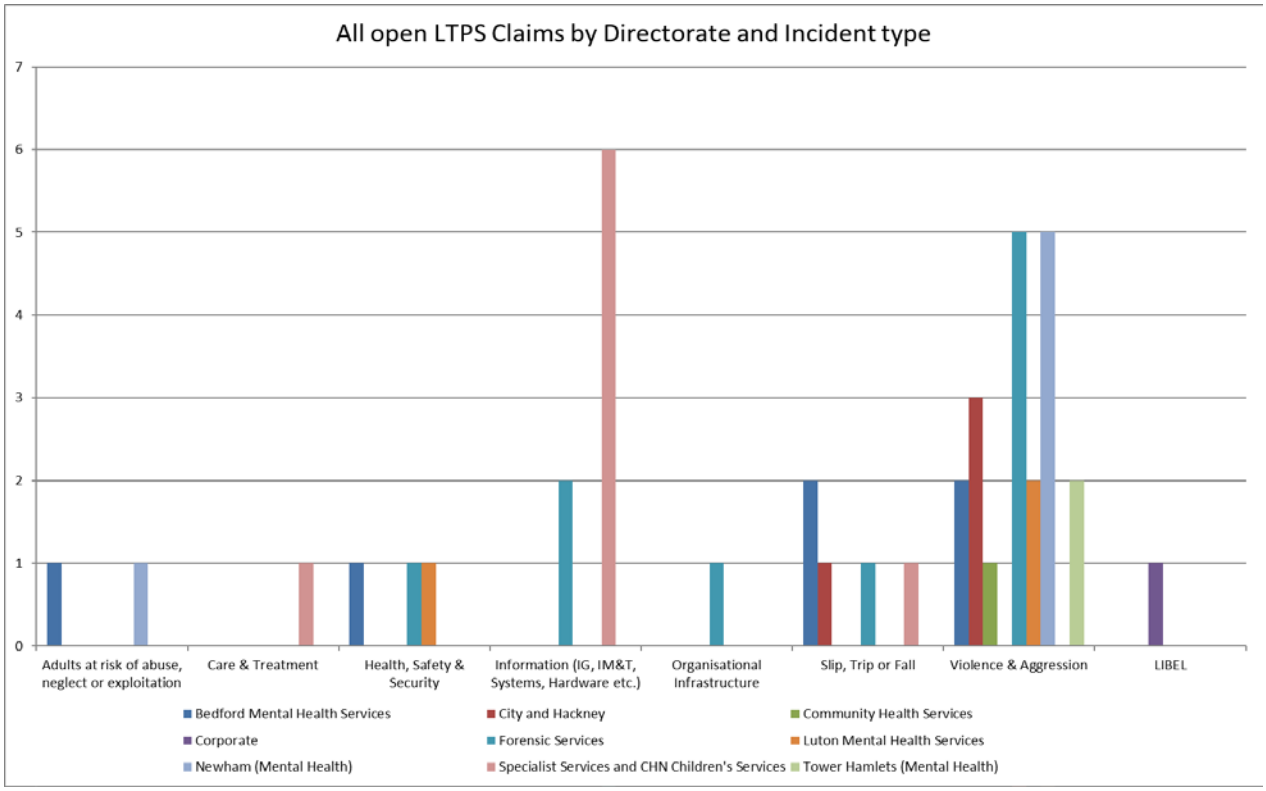
3.5 Open CNST claims

3.6 The graph below shows the number of all open CNST Claims as of 17th June 2022.



3.7 **Open LTPS claims**

3.8 The graph below shows the number of all open LTPS Claims as of 17th June 2022

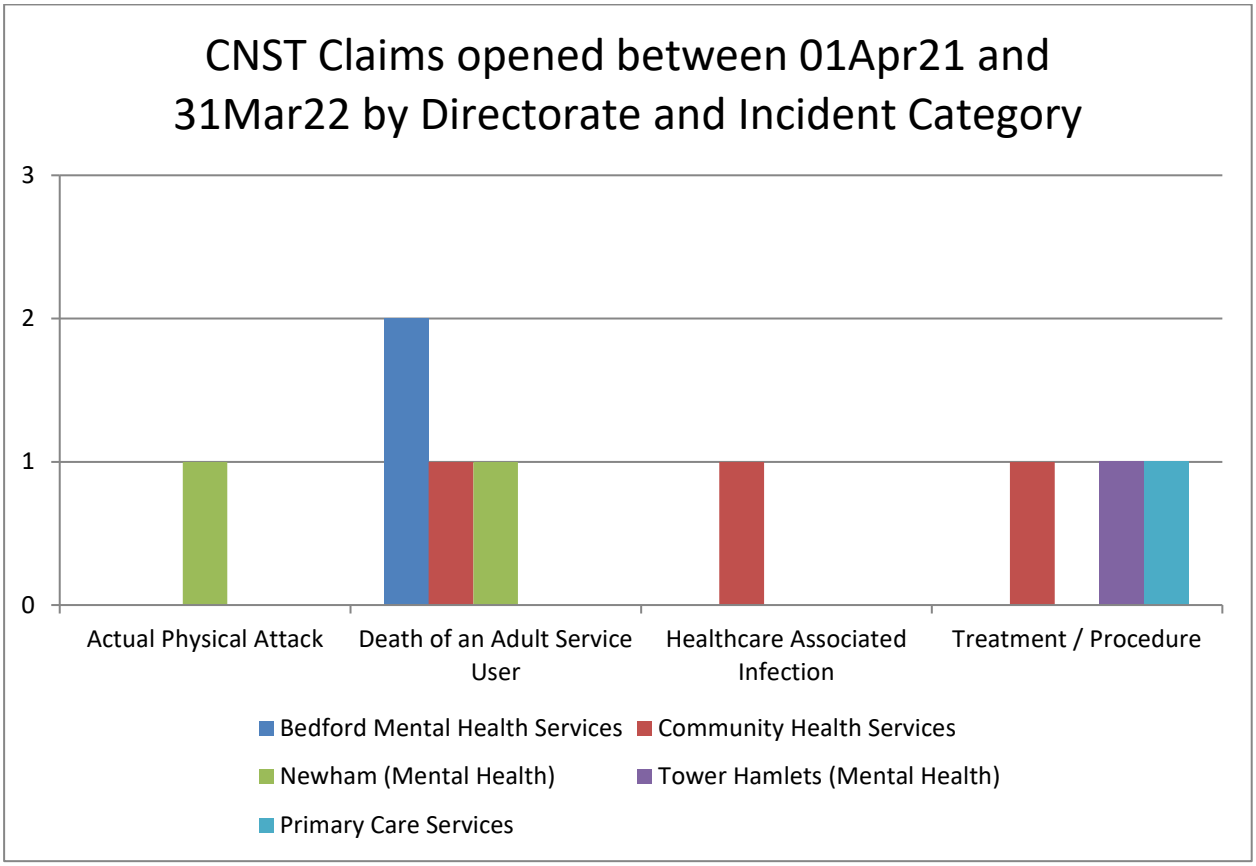


4.0 NEW CLAIMS

4.1 CNST Open Claims

4.2 Between 1st April 2021 and 31st March 2022, 9 new CNST claims were received.

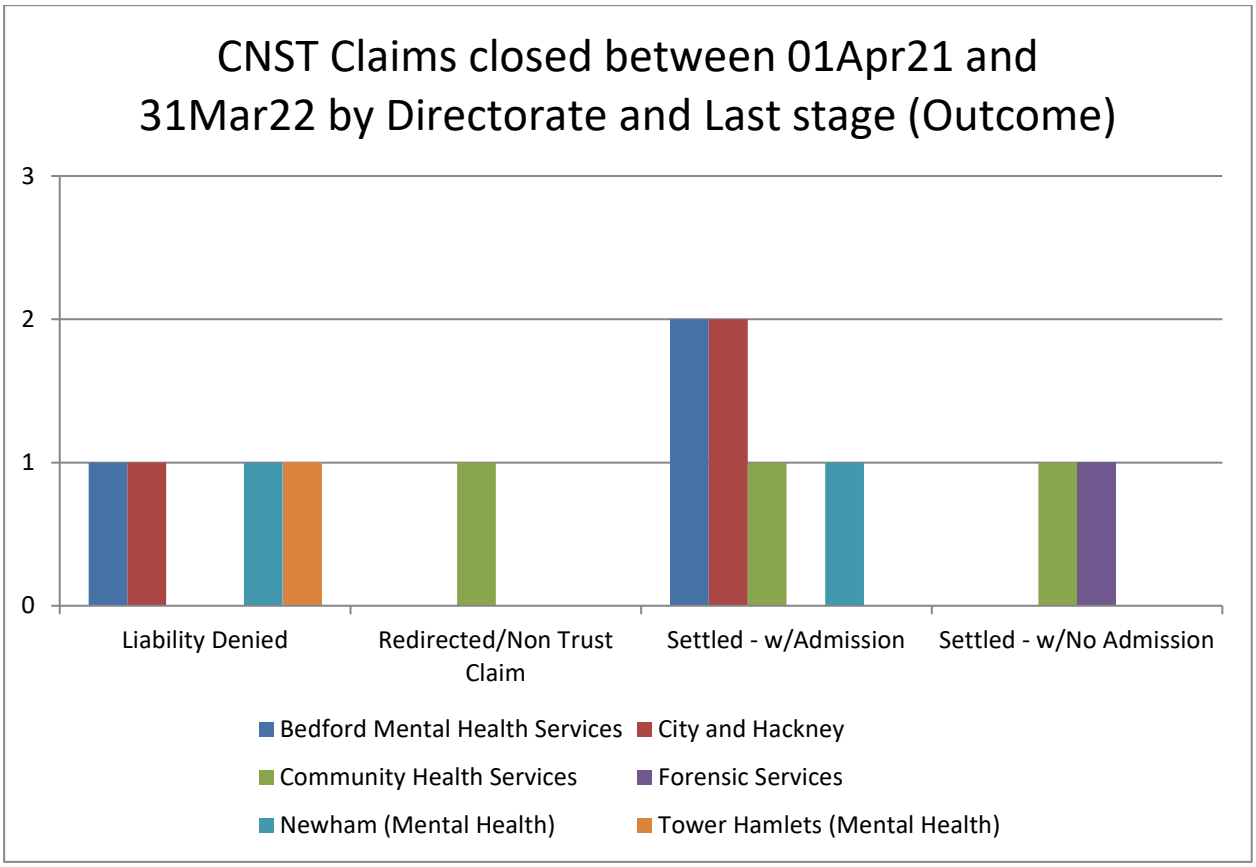
4.3 The graph below shows the number of claims received during this period broken down by incident category and Directorate.



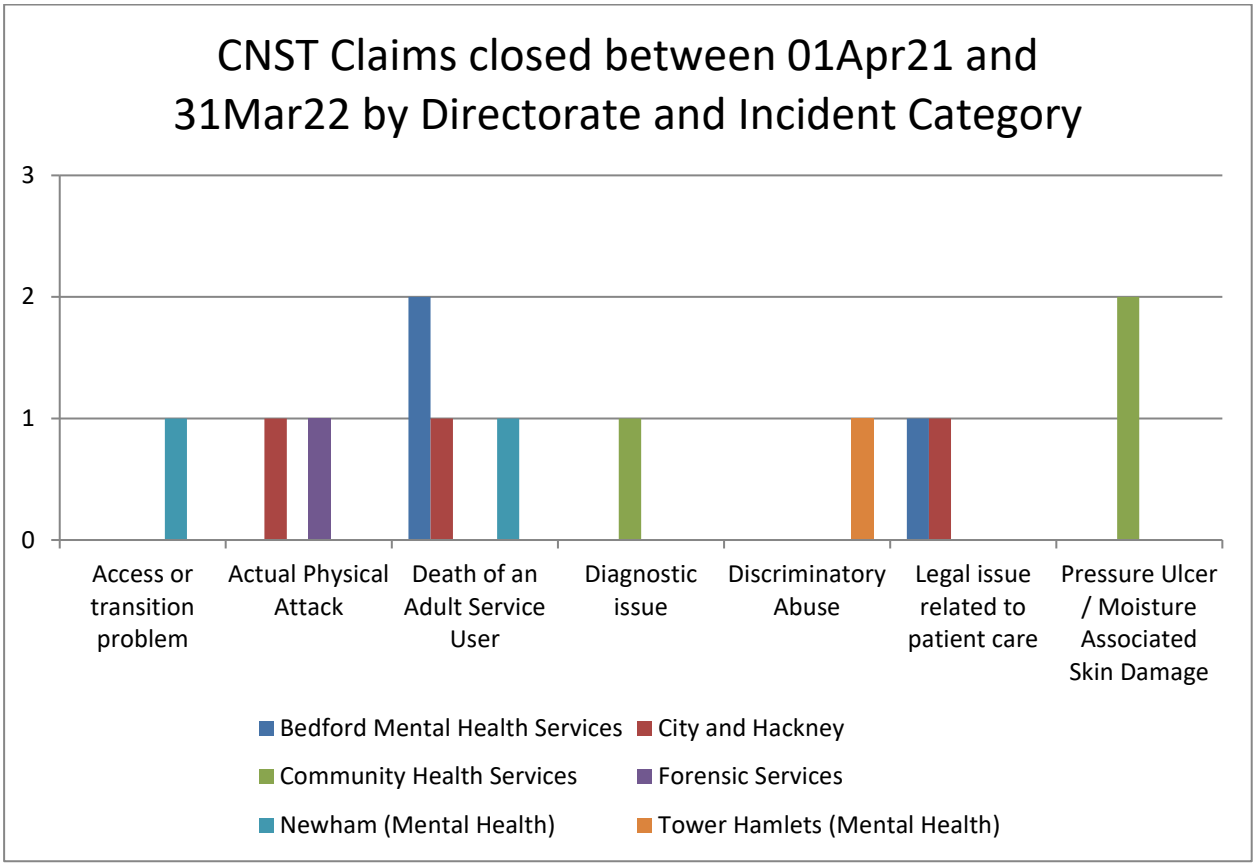
4.4 **Closed CNST Claims**

4.5 Between 1st April 2021 and 31st March 2022, 13 claims were closed under the CNST scheme.

4.6 The graph below shows number of claims closed during this period broken down by outcome and Directorate.



4.7 The graph below shows the number of claims closed during this period broken down by incident category and Directorate.



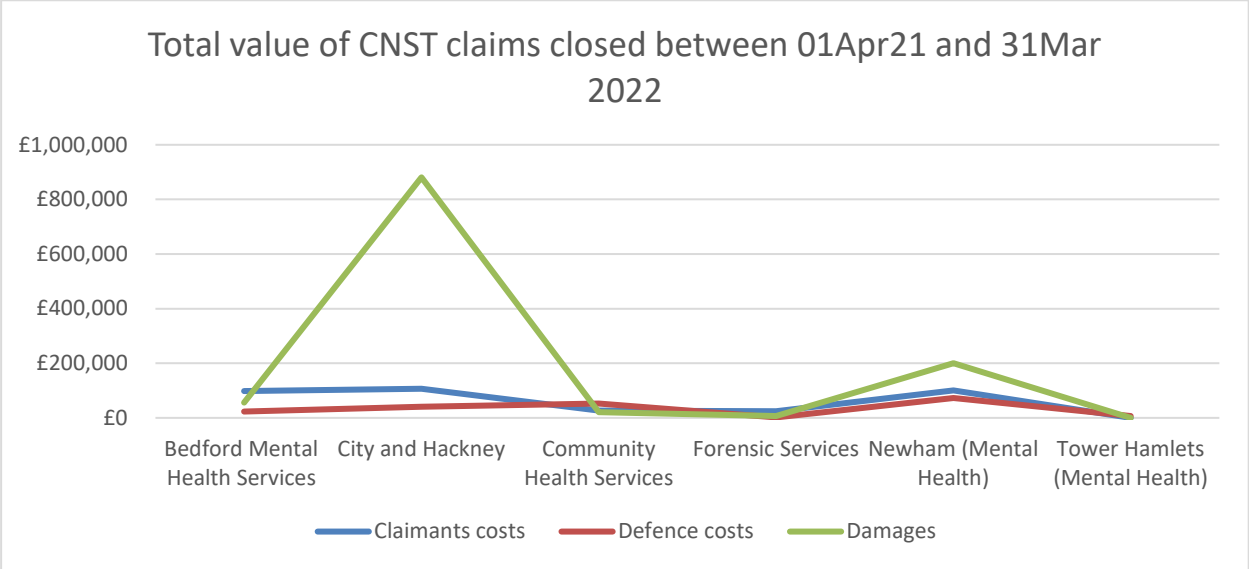
4.8 Of the 6 claims settled with admission during this period, 4 related to death. The 2 claims that were settled without admission related to: 1) a service user attacking another service user; and 2) care and treatment provided at Newham Urgent Care (which no longer comes under the remit of the Trust). The Trust intended to deny liability in both cases. However, the seriousness of the breaches of duty increased the risk that a Court may be persuaded by the Claimant that causation followed breach, consequently a decision was made to settle on best possible terms.

4.9 **Total value of CNST claims closed between 1st April 2021 and 31st March 2022**

4.10 All CNST claims have a nil excess.

4.11 The number and value of claims each year has an impact on the Trust's contribution to NHSR's CNST scheme the following year. The NHSR site states that *"individual member contribution levels are influenced by a range of factors, including the type of trust, the specialties it provides and the number of "whole time equivalent" clinical staff it employs. Claims history is also taken into account meaning that members with fewer, less costly claims pay less in contributions."*[1]

4.12 The graph below shows the total value of claims closed between 1st April 2021 and 31st March 2022.



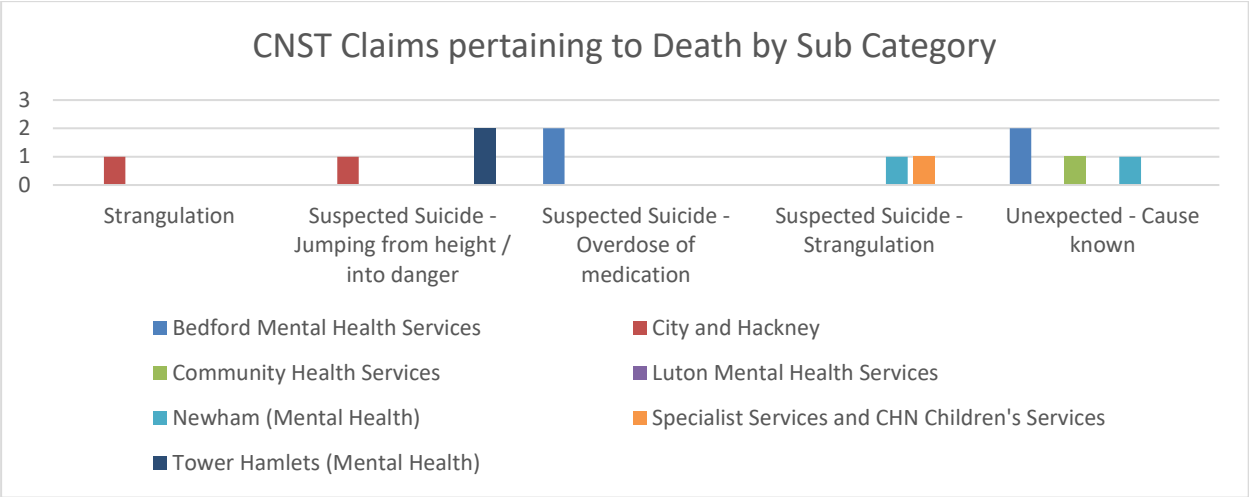
4.13 **Qualitative information regarding CNST claims**

4.14 For the purposes of this section, we will discuss the top 3 categories from all open claims. This includes new claims received in 2021 and 2022. The top 3 subcategories of claims are: deaths, actual physical attacks and diagnostic issues. The first 2 categories are the same as of last year. The 3rd category from last year was Adults at Risk.

4.15 **Death**

4.16 The graph below shows the number of claims relating to death of a service user by sub-category.

[1] https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/



4.17 Of the 11 claims, the Trust admitted liability in 3 cases. We await the details of final damages and costs. A fourth claim pertains to the death of child and damages have already been paid. The defence and claimant costs are still outstanding. The remaining 7 cases are currently under investigation.

4.18 There are 4 claims relating to deaths that were unexpected with a known cause.

4.19 One of the claims relates to an in-patient death where a service user (on section) was not observed for a 2 hour period post rapid tranquilisation. At inquest, an expert report ordered by the Coroner concluded that if the deceased had been observed in accordance with Trust Policy, on the balance of probabilities, the death would have been prevented. Subsequently, the jury determined that the cause of death was drug related, contributed to by negligence. Counsel for the Trust advised that there was scope for the jury to conclude gross negligence manslaughter or unlawful killing. However, the jury decided the threshold was not met. The Trust was issued with a Prevention of Future Death (PFD) report around patient searches, rapid tranquilisation observations and intermittent observations. Liability has been admitted in this case. Incident Date: 13 December 2018

4.20 The remaining 3 cases pertain to community deaths.

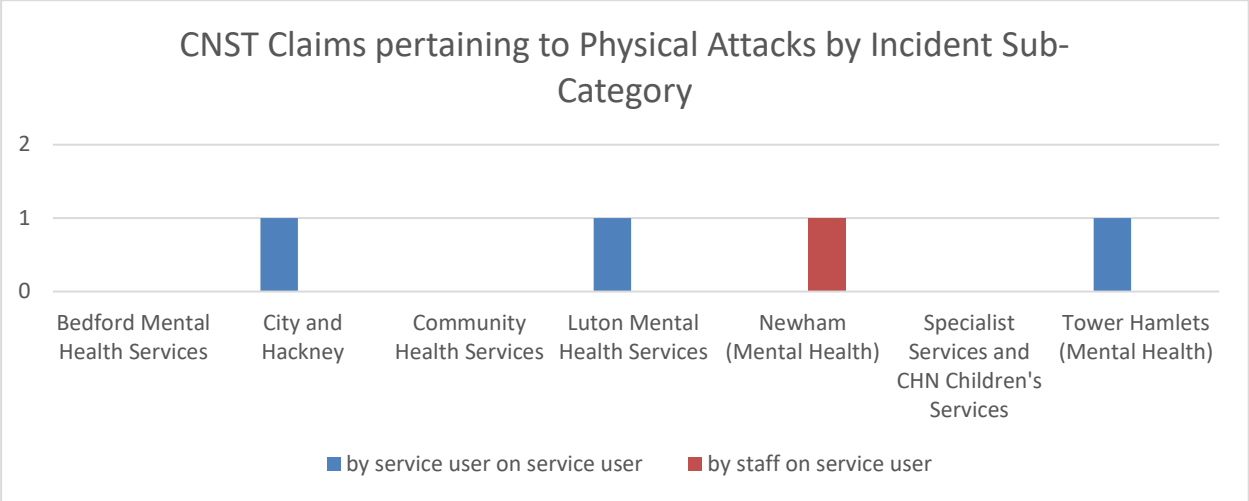
4.21 One of the claims involved a service user who hung himself. The deceased had self-referred to psychological services with suicidal ideation a few days prior to death, A miscommunication resulted in the deceased not being seen. At inquest the Coroner was of the view that communication between the relevant community teams was poor. A PFD was not issued on this occasion. However, the Trust was asked to provide assurances to the Coroner (in writing) that communication between teams had been addressed following this incident. Incident date 16 Jan 2020

4.22 Another claim pertains to a vulnerable Autistic adult who had not been transitioned fully from Child & Adolescent to Adult Mental Health services upon turning 18. This, alongside the repeated failure of services to assess his care needs, resulted in the deceased living in unsuitable accommodation with inappropriate support him at risk of harmful activity, including drug use. At inquest, the Coroner concluded that the lack of transition services for young autistic adults, and the failure to properly assess the deceased's capacity amounted to neglect. A PFD report was issued to the Trust in this matter. Incident date 22 May 2020

4.23 The final claim involves a service user who was under the care of community health services for her pressure ulcers. At inquest, the deceased's cause of death was noted as Pulmonary Emboli, Dementia, Sacral Pressure Sore and Type 2 Diabetes. The Coroner subsequently concluded that the death was the result of the natural cause (pulmonary embolism). However, the Coroner stated that the pulmonary embolism was likely to have been, in part, contributed to by a pressure ulcer and immobility both of which had developed whilst under the Trust's care. A PFD was issued in this matter and the Trust has admitted liability in this claim. Incident date 20 March 2019

4.24 **Physical Attacks**

4.25 The graph below shows the number of claims relating to physical attacks



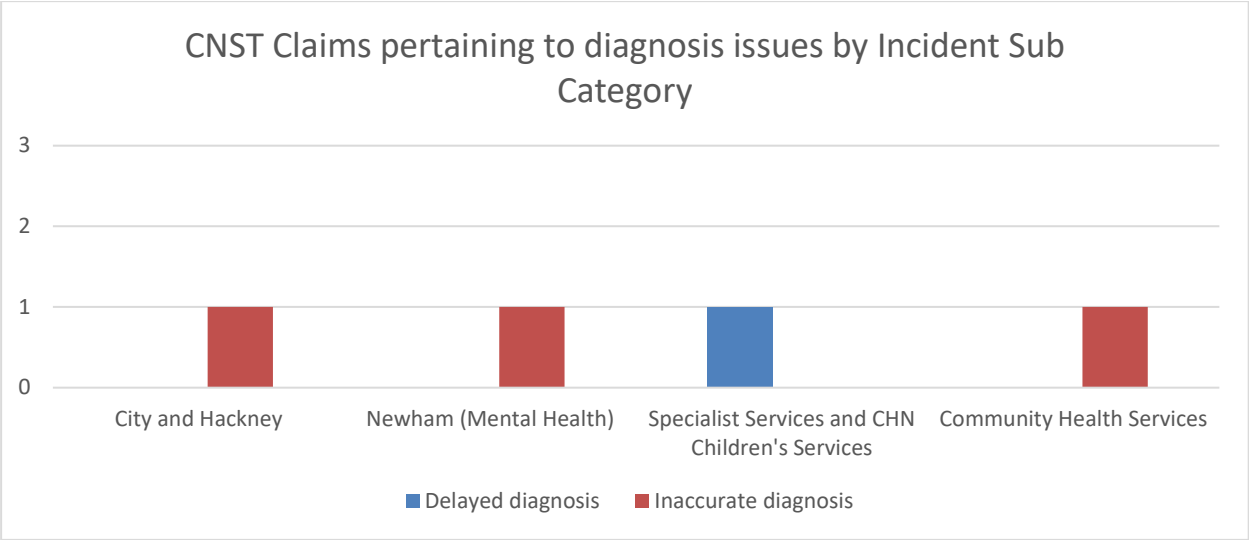
4.26 These claims concern service user attacks on other service users in an inpatient setting. Two of the claims have recently been received and are currently under investigation. Liability has been admitted in the 3rd claim. The 4th claim has been settled and is awaiting a final costs summary.

4.27 The claim where the Trust has admitted liability pertains to a service user who was a victim of an unprovoked physical assault by the perpetrator, on the ward, resulting in injuries. Mainly a broken nose, severe cuts and bruising to the face and a head injury. The maximum potential value of this claim is around £180k (this includes damages and costs). Incident date 4 October 2016

4.28 The claim that has been settled is a fairly historic case. This matter dates back to 2010 where a service user was grievously injured by another service user. He passed away with his injuries in hospital. Damages have been paid in the amount of £165k to the deceased's family and now legal costs are awaited. Incident date 9 April 2010

4.29 **Diagnosis issues**

4.30 The graph below shows the number of claims relating to diagnosis.



4.31 Of the four claims above only one has been settled to date. This claim pertains to a patient who attended Newham UCC complaining of foot pain and was prescribed anti-biotics and advised to see GP. He presented to his GP after 8 days, with worsening symptoms and was sent to hospital where his foot was amputated due to a blood clot. This claim was brought against the GP and two other Trusts (involved in the amputation). ELFT admitted a breach of duty in the standard of care provided as the treating clinician fell below the expected standard. The clinician failed to palpitate pulses and/or assess the circulation in the patient's and then did not clearly document the patient's assessment. ELFT however does not admit that amputation would have been avoided in the future. This current value of this claim around £556,550 (this includes damages and legal costs). Incident date 26 January 2015

4.32 ***Non death CNST High Value Claim***

4.33 We do need to bring to your attention a further potential high value claim outside of the above 3 subcategories. This concerns a claimant who was under the foot health services in the community. It is alleged that between 2018-19 there was a failure to diagnose, treat, and adequately refer the Claimant with sepsis and foot blister which could have avoided the amputation of her entire right leg. The maximum potential cost of this claim has been estimated at £1,180,000**.** Incident date 24 July 2019

4.34 **Qualitative information regarding closed CNST claims brought against the Trust**

4.35 We have closed 13 cases this financial year. The Trust denied liability in 4 claims while it accepted liability in 6 claims. 2 claims were settled without admission of liability and the final claim was redirected to another organisation after it was determined that ELFT was not the correct defendant.

4.36 Of the 6 claims where liability was admitted, 2 pertained to inpatient deaths, one to service user on service user attack within an inpatient setting, 2to deaths in the community and 1 to pressure ulcer care in the community.

4.37 2 claims related to in-patient admissions on Ruby Triage Ward (Ruby Ward) at Newham Centre for Mental Health . In one, a 49 year old service user was admitted to Ruby Ward on 17 December 2014 following an overdose of Diazapam. Whilst in triage, the deceased attempted an overdose with Citalopram. She was subsequently admitted informally and then detained. On 19 December 2014, she was found hanging in the shower (using her bra strap). She was under 15 minute observations at the time. At inquest, the jury

delivered a critical narrative conclusion. In particular, it focused on the Trust's observations practice. The Trust acknowledged that the failures relating to observation practice meant that it was difficult to ascertain the adequacy of treatment. Damages have been paid in the amount of £32k and total legal costs have amounted to £62,807. Incident date 20 October 2017

4.38 In the second claim, a service user left Ruby Ward stating that he would be back in an hour. He never returned and was found hanging at his home 2 days later following a welfare check. At inquest, the Coroner delivered a critical narrative conclusion. The Trust admitted that no timely welfare checks were undertaken, the deceased was discharged whilst AWOL having not been assessed by the early intervention team for support post discharge (having initially been recommended for intervention by the Home treatment team which was refused). Damages have been paid in the amount of £200k and legal costs have amounted to £146,886. Incident date 15 August 2014

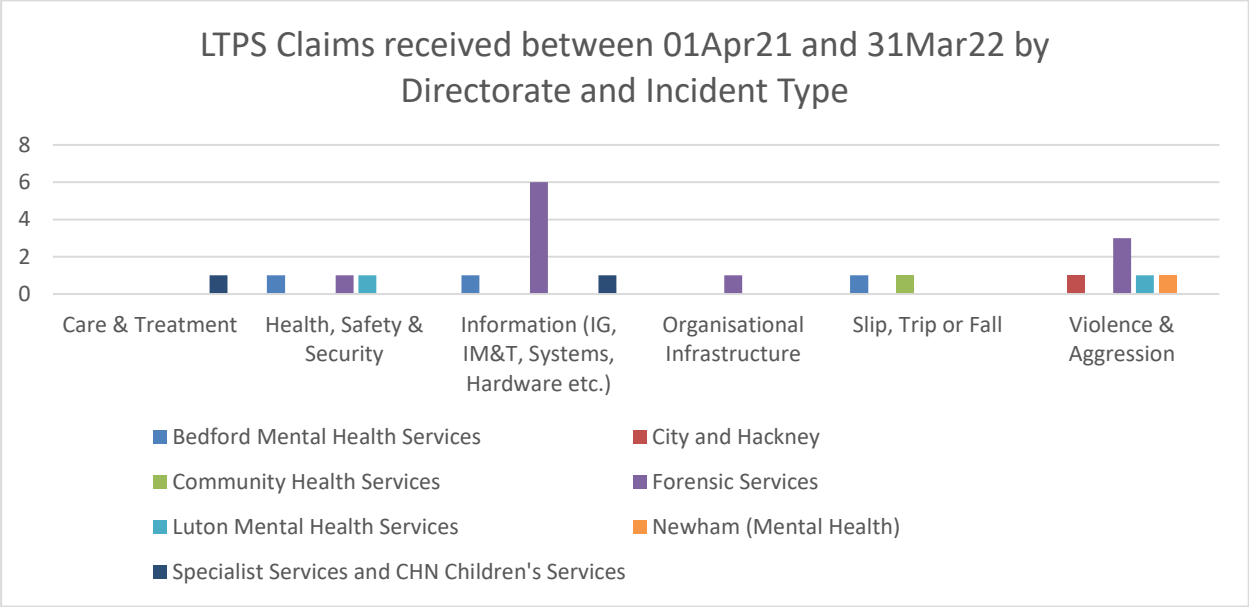
4.39 The claim with the highest value pertains to well established property developer who committed suicide whilst under the care of the Trust. The deceased's family initially requested payment of over £1,000,000 but after detailed negotiations damages in the amount of £850k were agreed on and have now been paid to the family. The legal costs in this matter amounted to £130,921. Incident date 8 December 2016

5.0 EMPLOYER LIABILITY AND LIABILITY TO THIRD PARTIES (LTPS)

5.1 New LTPS Claims

5.2 Between 1st April 2021 and 31st March 2022, 21 claims were received under the LTPS scheme.

5.3 The graph below shows number of claims received during this period broken down by type and Directorate

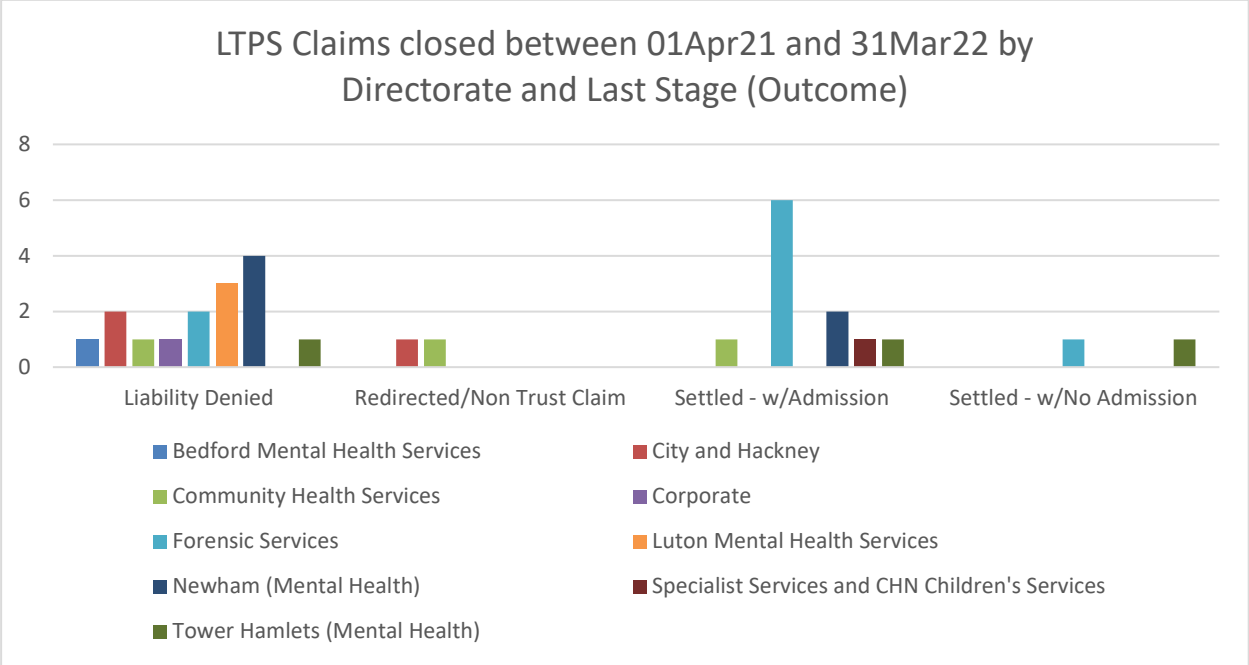


5.4 The highest number of claims received during this period were for data breaches and violence and aggression.

5.5 **Closed LTPS claims**

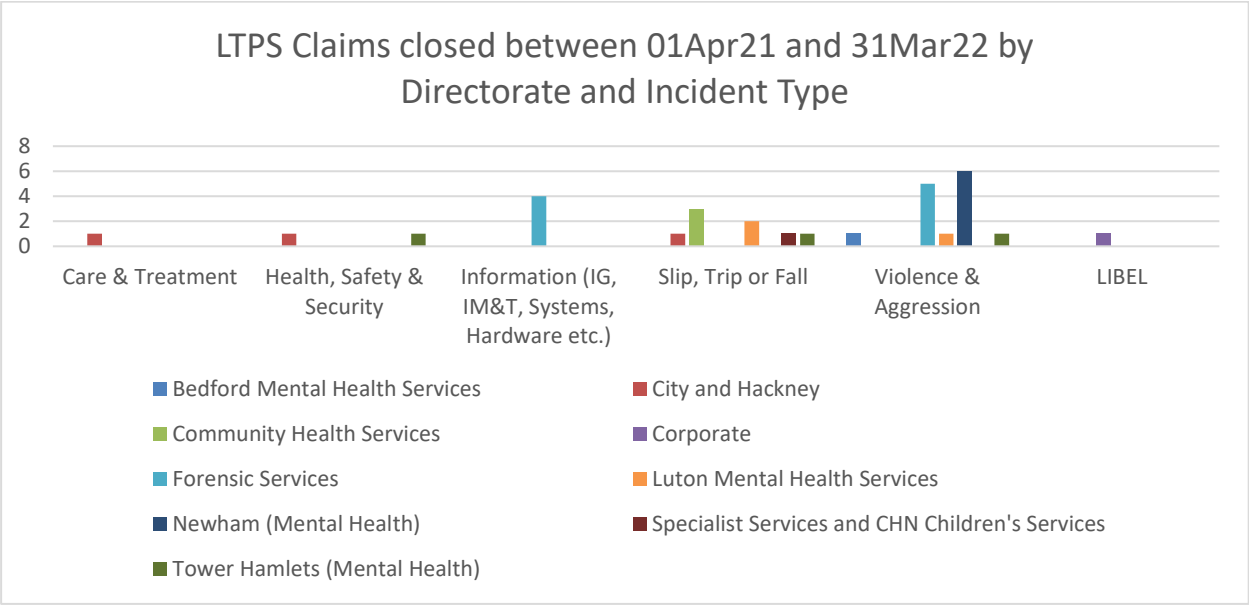
5.6 Between 1st April 2021 and 31st March 2022, 30 claims were closed under the LTPS scheme.

5.7 The graph below shows the number of claims closed during this period split by outcome and Directorate.



5.8 Following the investigation of these cases liability was denied in approximately 50% as investigation showed no breach of duty.

5.9 The graph below shows the number of claims closed during this period broken down by Incident type and Directorate

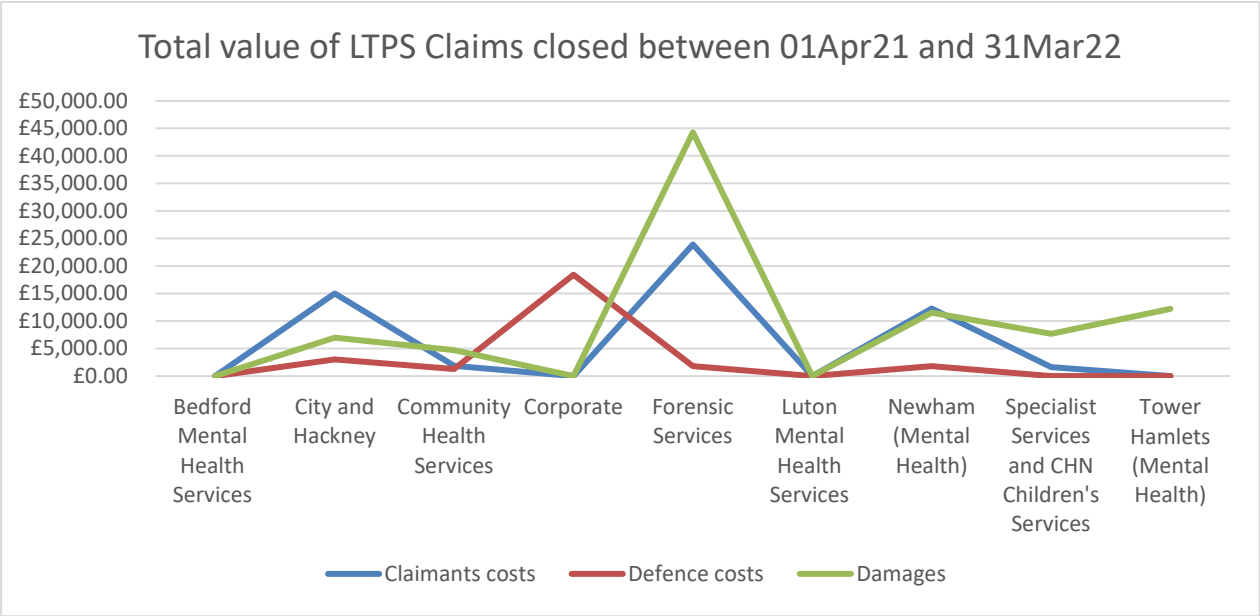


5.10 **Total value of LTPS claims closed between 1st April 2021 and 31st March 2022**

5.11 The Trust pays an Excess only on LTPS claims. This is £10,000 for staff claims and £3,000 for other LTPS claims

5.12 The number and value of claims each year has an impact on the Trust's contribution to NHSR's LTPS scheme the following year.

5.13 The graph below shows the total value of the claims closed between 1st April 2021 and 31st March 2021

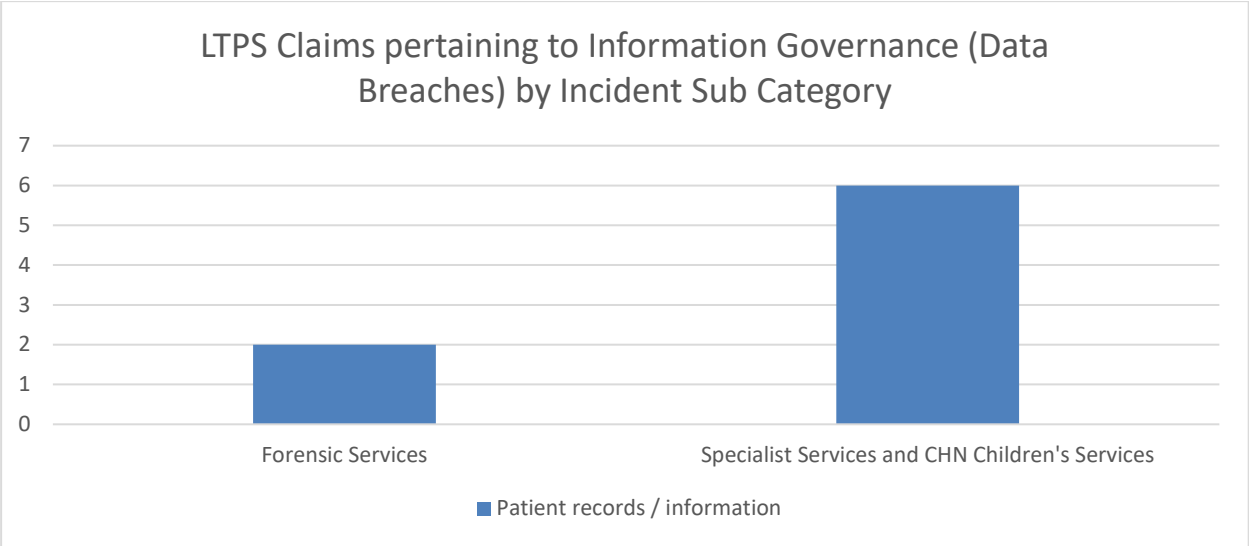


5.14 **Qualitative information regarding LTPS claims brought against the Trust.**

5.15 The top three categories of all open LTPS CNST claims as of 12th June 2022 (set out in the graph at paragraph 2.5) are: Information Governance (data breaches), Slips, trips and falls and Violence and Aggression

5.16 **Information Governance (data breaches)**

5.17 The graph below shows the number of claims relating to Information Governance (data breaches)



5.18 Of the 6 claims that have fallen under specialist services and CHN Children's Services, 5 of them fall under CAMHS while the remaining claim falls under IAPT Services.

5.19 Damages have now been paid in 5 of the CAMHS claims. Two of these five claims are from one family where the mother and father brought individual claims following information that was shared to a third party. The claimant's where the parents of a young boy that was previously under the care of young person's mental health services. Following an appointment, a member of staff wrote a letter detailing her opinion of a diagnosis she felt the parents (not the service user) may have. This letter was then circulated to different individuals and organisations. The parents claimed for damages for distress and other losses arising out of the disclosure of their personal data. Total damages have been paid in the amount of £6,000 (£3000 for each claim). Legal costs are awaited.

5.20 Two further CAMHS claims where briefly discussed in the last report and damages have also been paid out in the total sum of £4,500. This first claim relates to a child whose details were shared with a 3rd party. It was discovered that a referrals spreadsheet was uploaded in error, instead of a blank new referral form. This spreadsheet contained the names and review outcome details of 206 newly referred CAMHS service users. The claimant was one of the 206 new referrals. As breach of data claims fall under the category of automatic settlement, we asked NHSR to settle this matter on best possible terms. The 2nd claim relates to the first claim in which the child's mother brought her own claim stating that she suffered undue stress due to the breach. Legal costs are awaited. Breach date 19 May 2021

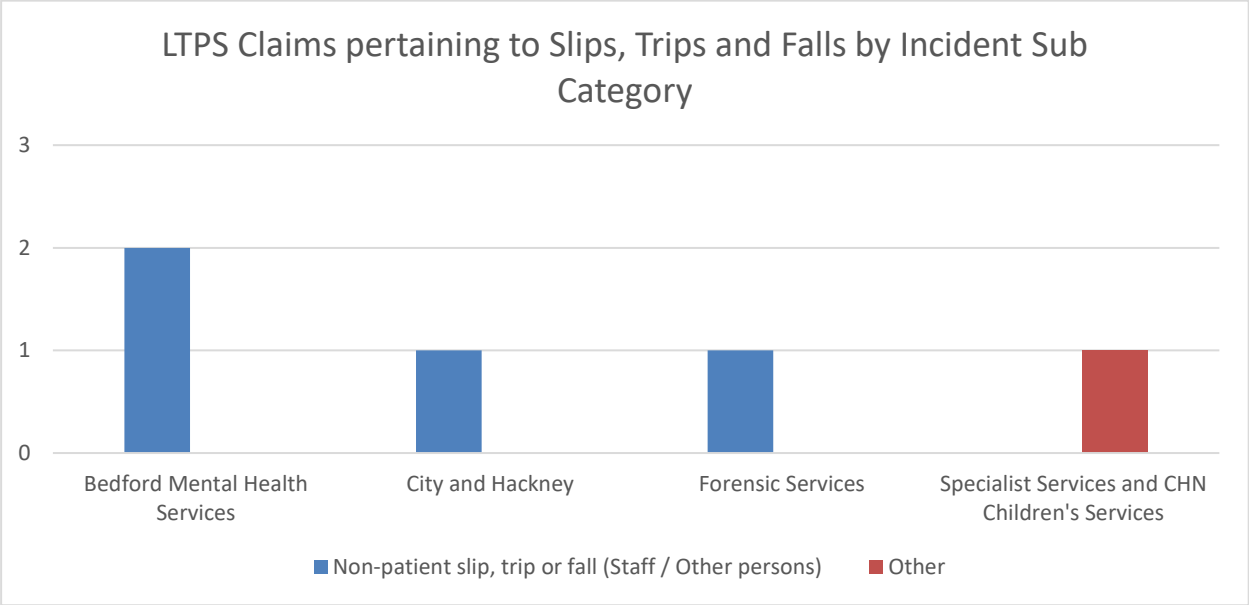
5.21 Another, CAMHS data breach claim has recently been received by the Trust is currently under investigation. Breach date 21 November 2021, 3rd January 2021 (same client).

5.22 The IAPT data breach claim pertains to a service user stating that there was a breach of confidentiality when staff sent her GP an update from an appointment she had attended after she had explicitly state that information from her appointments should not be shared with her GP. Damages in the amount of £5000 have been paid and legal costs are awaited. Notably, another identical data breach claim with another IAPT service has just been raised. Breach date IAPT 5 June 2018

5.23 The 2 (6 in total) Forensic data breach claims have arisen from an incident that was mentioned in last year's report. You will recall that a staff member accidently sent a spreadsheet containing details of 85 forensic patients to a relative of a patient via email. The Trust has admitted liability in these claims and payment will be made shortly. As liability has been admitted straightaway, no legal costs will be incurred in these cases. Breach date 5 March 2021

5.24 **Slips, trips and falls**

5.25 The graph below shows the number of claims relating to Slips, trips and falls



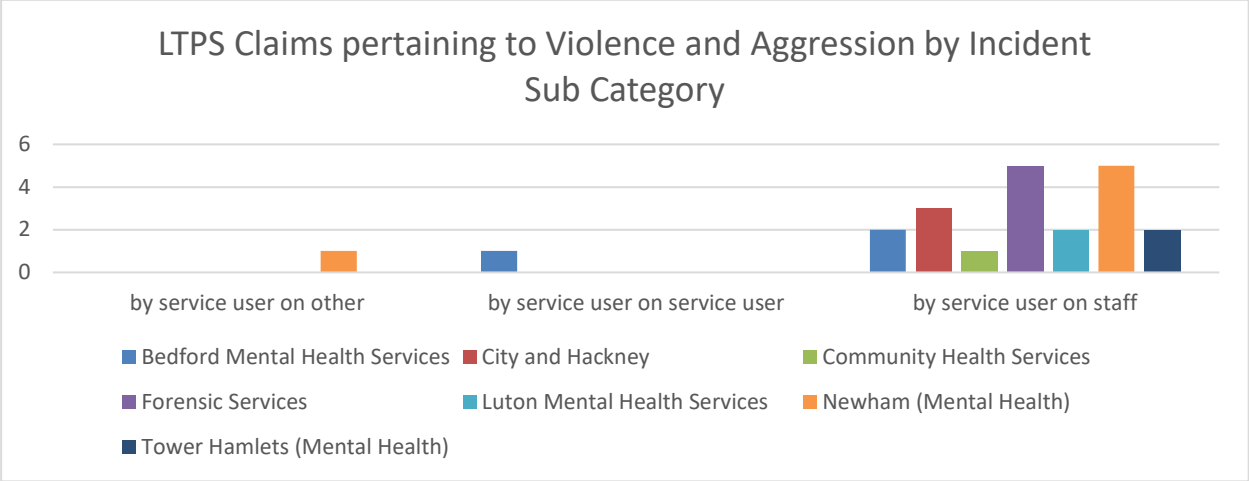
5.26 The key claims to note are those from Bedford Mental Health Services. The first claim relates to a member of the public who was accompanying her daughter to a hospital appointment at Florence Ball House. After the appointment, they were walking through a small park (known to the Claimant as Florence Ball Garden) when the Claimant tripped on a metallic hoop which was fitted to a bench, causing her to fall heavily and injure herself.. The hoop was protruding out 10cm from the bench at a height of 10cm. Incident date 26 September 2019.

5.27 The 2nd claim relates to staff member slipped on some black ice as she walked from her car to her office. She fell on her back hitting her head on the ground. Incident date 25 January 2021.

5.28 The incidents in both claims have taken place at sites where the Trust is the tenant and NHS Properties is the landlord. These claims should be straightforward (resulting in a quick admission of liability, thereby minimising the claimant's costs). However, they have become difficult as it has transpired that, the Trust and NHS Properties do not have a full contract in place which clearly states who has responsibility for grounds maintenance. NHS Properties has denied liability stating any responsibility will be for the Trust. Importantly, the longer it takes to establish responsibility, the higher the claimant's costs will be, resulting in increased settlement fees for the responsible party. There are several other non-slip, trip and fall LTPS claims where this scenario is also playing out.

5.29 **Violence and Aggression**

5.30 The graph below shows the number of claims relating to Violence and Aggression.



5.31 Of the 20 service user on staff attack claims, we have admitted liability on 4 of the claims, denied liability on one of the claims while the remaining 15 are still under investigation.

5.32 **Qualitative information regarding closed LTPS claims brought against the Trust**

5.33 Liability was denied in 50% of claims closed during period. 11 claims have been settled with admission, while 2 were settled with no admission and 2 claims were re-directed to the correct defendant organisations.

5.34 Four of the eleven claims that have been settled pertain to the forensics data breach that was reported in the last report. A total of £1600 has been paid out in damages and as liability was admitted immediately, no legal costs have been incurred.

5.35 **Conclusion**

5.36 The number of claims has remained stable in comparison to 2020/2021.

5.37 The top category of CNST claims is deaths by suicide. This is consistent with previous years and expected in a mental health trust. There has been an increase in the number of in-patient suicides under investigation at inquest this year. The Team expect to see these translate into claims over the next two years.

5.38 The top category in LTPS claims is information governance breach. This is a trend that started to appear last year and has clearly taken hold. It is likely a consequence of the increased reliance on information technology and at home working during the Covid-19 pandemic. It will be interesting to see if this remains stable or decreases as staff start returning to work.

5.39 The Interim Associate Director of Legal Affairs will arrange a “Learning from Claims meeting” with the other Trust Associate Directors (in mid-September) in order to highlight the new themes (Information Governance and Estates matters) that have arisen over the

past two years, the associated costs and to explore learning outcomes with a goal of mitigating future claims.

5.40 It is important to note that since the limitation period for all claim types was extended due to the Covid – 19 pandemic, the Team anticipated a decrease in number of incidents reported as claims (and a sudden and temporary increase in reported claims over the next two years). The limitation period extension may therefore be masking an increase in incidents resulting in claims. The Team will be monitoring this and report on it at the next annual review.

6.0 Action Being Requested

6.1 **The Board/Committee is asked to:**

a. **RECEIVE** and **DISCUSS** the findings of the report

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REPORT TO THE QUALITY ASSURANCE COMMITTEE

27 June 2022

Title	Supporting the Armed Forces Community Annual Report 2022
Author	Jane Kelly Trust Clinical Lead for Recovery Trust Clinical Lead for the Armed Forces Community
Accountable Executive Director	Dr David Bridle, Interim Chief Medical Officer

Purpose of the report

To provide information to the Trust Board that delivers assurance that the Trust continues to meet both its moral and legal obligations to the United Kingdom Armed Forces Community who often face disadvantage and both health and social inequalities.

Summary of key issues

1. The Trust has achieved the Veterans Covenant Healthcare Alliance (VCHA) Standards and is due for revalidation in July 2022. The standards continue to be fulfilled by the Trust, so it is anticipated that there will be a successful revalidation process.

2. The Trust has a continuing commitment to meet Gold Standard status with the Defence Employer Recognition Scheme (DERS). We have achieved Silver Award in June 2022 and are on track to fulfil the requirements for Gold Standard status.

3. With the implementation of the Armed Forces Bill (2022) a strategic response to the implementation across the Trust and more widely in the ICS is required so that the actions, plans and targets set out in the recent Government publications: Veterans Strategy Action Plan 2022 – 2024 and the UK Armed Forces Families Strategy 2022-32 are met. A business case and proposal has been submitted to the ICS to establish an Armed Forces Lead from the Veteran's community to achieve this in a meaningfully co-produced manner.

Strategic priorities this paper supports (please check box including brief statement)

Improved population health outcomes	☒	This proposal supports the Trusts commitment to improve health outcomes for Veterans and their families. This will also include providing employment and development opportunities. This will improve local population health outcomes and the experience of care provided to our Veterans. Staff will be informed and empowered to provide appropriate care
Improved experience of care	☒	
Improved staff experience	☒	
Improved value	☒	

Committees/meetings where this item has been considered

Date	

Implications

Equality Analysis	Positive. Adheres to the equality statements as outlined in the Armed Forces Covenant and ensures that the Trust complies with The Armed Forces Bill (2022) which enshrines the Armed Forces Covenant in law and places a legal obligation on public bodies to improve access to services. Recognition that the Armed Forces Community are considered as a group that are at risk from health inequalities (NHSE) that requires support from the ICS and the Trust.
Risk and Assurance	Positive. Provides assurance and reduces risk of non- compliance to legislation and enables the organisation to evidence the improvements / developments. As a Trust we need to ensure that we comply with the covenant manifesto and as part of the wider equality agenda compliance to the Armed Forces Act by implementing the actions plans and targets set out in the recent Government publications: Veterans Strategy Action Plan 2022 – 2024 and the UK Armed Forces Families Strategy 2022-32.
Service User/Carer/Staff	Positive. Enables improved experience of employment and treatment for service users and staff.
Financial	Cost implications for supporting the employment of Veteran's Champions and sourcing appropriate training. The employment of a Veterans Lead who has lived experience of the Armed Forces will ensure that all future work is coproduced and implemented with the veterans voice being central
Quality	Positive.

1. Introduction

a. A UK Armed Forces Veteran is defined as any individual aged 16+ who have previously served at least one day in the UK Armed Forces.

b. NHSE recognises that Veterans are considered a group at risk of experiencing health inequalities*.

c. Although many people leave a successful career in the armed forces and go on to lead a happy productive life as a veteran; many veterans report developing mental health problems after leaving service: such as difficulty in making the transition to civilian life, marital problems, and loss of family and social support networks. Younger veterans are at a high risk of suicide in the first two years after leaving service. Veterans are also vulnerable to social exclusion, homelessness and alcohol misuse (mentalhealth.org.ok / armed forces and mental health 2020).

d. The Veterans Covenant Healthcare Alliance (VCHA) was established following the implementation of the Getting It Right First Time (GIRFT) programme, which is now part of the NHS Improvement in partnership with the Royal Orthopaedic Hospital and the Chavasse Report.

e. With the implementation of the Armed Forces Bill (2022) a strategic response to the implementation across the Trust and ICS is required so that the actions plans and targets

* https://www.england.nhs.uk/wp-content/uploads/2017/01/armedforces-participation-frmwrk.pdf

set out in the recent Government publications: Veterans Strategy Action Plan 2022 – 2024 and the UK Armed Forces Families Strategy 2022-32 are met. These strategies outline 5 focal points for success:

- Delivering a step-change in support for veterans and their families
- Maximising veteran employability as the key to positive life outcomes
- Listening, learning and addressing with compassion the historic hurt or disadvantage that sections of the veteran community have experienced
- Dealing with historic operations, recognising that these continue to impact on veterans
- Making sure veterans receive the same high standard of support, across the whole UK

2. Progress so far and Future Plans

a. ELFT Veterans Alliance was originally set up to co-ordinate the agreed work streams that would support the Trust in meeting the standards required to gain accreditation for the National Veterans Health Care Accreditation scheme (VHCA). This was achieved last year when ELFT became one of the first Trusts in London to become an accredited Veteran Aware NHS Provider. Reaccreditation is due to start in July 2022. The author is assured that the Trust will continue to meet the standards and maintain its accreditation.

b. To monitor quality improvements within this specific community; the establishment of a Triple Aim Project Group that is coproduced with the armed forces voice being central to all change ideas. Members of this group from the armed forces community have successfully completed the QI Leadership Course and actively participate in the Triple Aim Project and Trust wide learning sets.

c. We need to ensure the correct resources and processes are in place so that the Trust and its partners continue to provide quality services to the Armed Forces Community; complying with The Armed Forces Act (2022) and the actions plans and targets set out in the recent Government publications: Veterans Strategy Action Plan 2022 – 2024 and the UK Armed Forces Families Strategy 2022-32.

d. To take this work forward the Veterans Alliance is seeking funding to establish an Armed Forces Lead from the Veterans Community who can support the current and future work streams. A business case and proposal for this funding has been submitted to the ICS. We have learnt from the Triple Aim Project that success has been achieved when we have a bespoke approach that is totally coproduced so that the voice of those with lived experience of military culture and language can help bridge the gap between this and the NHS World.

e. With the quality improvements made to the recruitment process we have successfully moved from Bronze Award with the Defence Employment Recognition Scheme (DERS) to achieving Silver Status (June 2022) – Through the continuing recruitment and retention work streams for Veterans the author is assured that the Trust will meet the criteria to receive their Gold award Status when applications can be made. Our aim is to increase the number of Veterans employed across all services in Trust and to develop and establish an Armed Forces Staff Network.

* https://www.england.nhs.uk/wp-content/uploads/2017/01/armedforces-participation-frmwrk.pdf

f. The establishment of an Armed Forces Network that will offer support and opportunities for new and existing members of staff who may identify as Veterans, reservists or cadets. It is widely acknowledged that members of the Armed Forces community benefit from having the opportunity to attend peer groups and networks. This mutual support and camaraderie is an important aspect of military culture that if replicated within the Trust could improve the retention rates and development of the Armed Forces community we employ. It is essential that this network is led by a Veteran

g. To improve the quality of care and service user satisfaction ELFT is an active partner in the OpCourage Pan London Collaborative leading on trusted assessments and partnership working to ensure Veterans who require high intensity services receive timely appropriate referrals to and from specialist services (OpCourage.)

h. To reduce the number of Veterans who are deemed as a delayed transfer of care on the inpatient wards we are ensuring staff are aware of the unique needs of the Armed Forces community and the “military human”. This increased awareness can lead to a more seamless transition and engagement in tailored care packages and improve the referral rates to specialist commissioned services such as OP Courage.

i. It is predicted that a greater awareness among both inpatient multi-disciplinary teams and community staff, resource acquisition from the dedicated charities such as the Royal British Legion, Poppy Factory, and Help for Heroes and the Veteran Trauma Network could improve care packages, reduce length of stay on inpatient wards, delayed stays on inpatient wards and delayed discharges from our services.

j. We need to ensure that relevant staff in the Trust are trained and educated in the unique strengths and needs of Veterans. In ELFT this is being undertaken via the Veterans Alliance group and the Recovery Colleges (In collaboration with H4H). All awareness training is being co-produced from its design, delivery and evaluation with the Armed Forces communities and our partners. Staff report that having the Veteran voice as part of the training has been both inspiring and educational.

Recommendations

The Committee is asked to **RECEIVE** and **NOTE** the report for information

* https://www.england.nhs.uk/wp-content/uploads/2017/01/armedforces-participation-frmwrk.pdf

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REPORT TO THE QUALITY ASSUARANCE COMMITTEE
27 June 2022

Title	Medical Education Report
Author	Prof. Frank Röhricht, Medical Director R&I and Medical Education Neetu Klair, Head of Medical Education & Medial Staffing
Accountable Executive Director	Dr David Bridle, Interim Chief Medical Officer

Purpose of the report

We last presented in April 2021, and the purpose of this report is to highlight key updates of relevance to the board regarding medical education, in line with our departmental 5-year plan, objectives and HEE governance.

Committees/meetings where this item has been considered

Date	Committee/Meeting
27 June 2022	Quality Assurance Committee

Key messages

This report details the good progress made against the departmental objectives – this has included a strong focus on service user involvement being embedded in medical education which supports the development of positive therapeutic relationships in trainees. The capacity for more innovative, multi-professional learning has been enhanced by the soft opening of the Experiential Learning Centre since the last update - this has allowed regular learning in this new, uplifting environment to commence.

There has been an increase in the demand for undergraduate student placements from universities (whose experience as students will influence their decision about training in psychiatry). And all core trainee posts have been filled in the Trust. Therefore, focus has moved to ensure high rates of recruitment to higher trainee posts going forward. Aligned with all of this have been initiatives to improve the training experience. There has also been a focus on Faculty Development for Educational Supervisors to enhance their capability in delivering training.

Support for Staff and Associate Specialist Grade (SASG) doctors has improved with the development of a new tutor role.

Ultimately all the above ensures a growing cohort of well supported, well-trained psychiatrists with the values that matter to ELFT working in our services.

Health Education England conducted learner reviews in two cohorts following the 2021 GMC survey results – attention is being given to the recommendations for areas to improve.

Adapting and expanding the Medical Education team sufficiently to meet the expanding needs has been a challenge – this is being explored further currently.

Strategic priorities this paper supports

Improved population health outcomes	☒	Training of next generation of psychiatrist according to trust values to contribute to ELFT's overarching population health strategy

Improved experience of care	☒	By innovating and focusing training and teaching on positive therapeutic relationships and utilising service user lived experiences, we are creating an environment of learning that puts patient care at the heart of all learning.
Improved staff experience	☒	Exposing staff to multi-professional learning, developing our profile as a lead provider in teaching and training and developing a culture that shows positive feedback, that is shared and acted upon, internally and via external surveys such as the GMC survey.
Improved value	☐	

Implications

Equality Analysis	This report has no direct impact on equalities.
Risk and Assurance	Report provided assurance to the committee on medical education actives.
Service User/ Carer/Staff	This Medical Education plan promotes an active involvement with service user representatives in the development of our programmes, and will aim to provide simulation training across all professional groups.
Financial	No financial implications are related to the report.
Quality	Quality is measured by compliance with departmental objectives as well as through regular and systematic evaluation of learning outcomes according to objectives; that includes feedback for teachers / lecturers regarding teaching style, engagement and inclusiveness.

1.0 Background/Introduction

1.1 ELFT is a major educational provider for the undergraduate and postgraduate medical education for psychiatry in the North and East London and East of England regions.

1.2 The Trust employs over 400 medical staff including consultants, specialty and associate specialist (SAS) doctors and doctors in postgraduate training. We also provide clinical placements to 400-500 medical students every year attached to Barts and The London School of Medicine and Dentistry (Queen Mary University of London), Cambridge University and University College London. Plans to expand the undergraduate teaching in collaboration with internationally operating medical schools are under way, for example the University of Cyprus.

1.3 Doctors in postgraduate training at ELFT are attached to Health Education England North Central and East London and Health Education East of England. The training programmes include core and specialty psychiatry training, GP specialty and Foundation training programmes.

1.4 Our ambitious forward going plans emphasise the educational contribution to the overarching trust strategy: improve the quality of life of all we serve. Therefore, the service user perspective features in all multi-professional learning sets; we integrate a range of new technologies and innovative experiential learning methods to prepare the medical workforce for a radical shift of practice that relies in great parts on co-production, interpersonal skills and artificial intelligence. The main objective is to deliver personalised health care and 'precision medicine' across population health footprints rather than within narrow frameworks of specialist services.

2.0 Report Content

2.1 The purpose of this report is to highlight key updates since our last report in April 2021 within the department and how we are progressing against our objectives in line with the Trust Strategy.

3.0 Objectives

5-Year Plan Objectives		Progress made
1	Improve the experience of all people in accessing care (Focusing teaching and training on positive therapeutic relationships)	• Service user involvement in projects such as Foundation Year Sim • Talking Heads/Human Library • Medical Student Teaching Inc. clinical skills labs • COVID-19 Webinars • Barts Academic Afternoons • Playing ON projects
2	Develop innovative experiential learning tools (Multi-professional learning; Utilising service user lived experiences)	• Simulation Lead appointed • Development of Education Suite of 2nd Floor at THQ in collaboration with L&D and AHP Leads • Virtual Clinical skills workshops for medical students • virtual CASC mock exams and workshops • Lived experience now central to most teaching arrangements • Foundation Year Simulation training.
3	Increase number of students and fill postgraduate posts (Tackling stigma and enhancing profile of psychiatry)	• Foundation Year Tutor appointed • Student selected components (SSC's) for 5th year students continuing despite pandemic. • Expansion of overall placement capacity to accommodate increased student numbers from Barts and the London, Queen Mary University. • SAS Tutor role created, senior doctor appointed and we will soon appoint an SAS Advocate • Core Trainee posts all filled; specific focus upon Higher Trainee recruitment now initiated. • Development of external facing website, strengthening of ELFT/NELFT collaboration; • Programme of mentoring support for doctors.
4	Improve the experience of training for all (Achieving highest satisfaction rates in national and local surveys)	• Online tailored induction programme • Medical Education Awards for outstanding achievements • Aligning MRCPsych programme towards the curriculum • Establishment of core Postgraduate Leads in each locality

		• Work in partnership with clinical directors to achieve meaningful placements and achieve the right balance between clinical work and teaching • Development of Medical Education Website • Reviewing medical student curriculum and learning objectives and assessments.
5	Faculty Development (Establishing a culture of "All-Teach, All-Learn")	• Lead roles developed, including Staff and Associate Specialist (SAS) Tutor with protected time in job plans. • New formats through online learning/webinars established. • Educational Supervisor trainings.

4.0 Experiential Learning Centre (ELC)

4.1 Within our last report we informed you that refurbishments were underway on 2nd floor of THQ for the new ELC which will consist of an agile working space, a Large multi-purpose room to be used for simulation and arts-based education, including somatic learning opportunities (e.g. drama, movement and music work) and 2 simulation rooms equipped with state-of-the-art equipment (including observation mirror features, special cameras for short teaching videos and reflection exercises).

4.2 We are now very pleased to say that despite lockdown measures, we were able to successfully deliver a soft opening of the ELC where limited attendees took part in Musical Introductions, movement exercise, Simulation session (with participation from the Chief Executive) and creative feedback drawing.

4.3 The space is now regularly used for all types of learning and provides a fresh, light atmosphere to be able to fully imbed oneself in experiential learning.

Image above: group attending soft opening

Image to the right: group's feedback via creative drawing

5.0 GMC / HEE Governance

5.1 We are yet to hear back on the findings from the 2022 GMC survey, however we have attached least year's GMC survey results for info – GMC-NTS-results-2021-BoardLevel-over

5.2 Following last year's GMC survey results, HEE have conducted two Learner reviews within the CAMHS Coburn unit and for Core Trainees working in Forensics and Tower Hamlets.

5.3 Medical Education will be working with Trainees, Trainers and Service leads to ensure the recommendations set out by HEE are addressed and become business as usual to ensure trainee placements are of high quality.

5.4 Results show that Foundation Year Trainees are reporting a positive experience. A deep dive has been conducted with CAMHS trainees, and our key focus areas are Educational Governance/Supervision, Feedback and Workload.

6.0 Faculty Development

6.1 After a number of task and finish groups with medical leads, we now have a process by way of appraising Educational Supervisors and signing off their Faculty Development Domains – needed to be a supervisor.

6.2 In order to support Clinical and Educational Supervisors we have also planned a series of workshops throughout the year to ensure supervisors have access to the courses available to continue professional development in this area.

7.0 Medical Education Team

7.1 The Medical Education team have gone through a number of changes since the end of 2021 with a significant high turn-over within the department. This in turn affected the workload of the team having to train new staff and cover gaps.

7.2 Increased work load as a result of increased Medical Students, Simulation Training, Physician Associates, supporting Staff and Associate Specialist Grades, Educator Appraisers etc. has meant that the department capacity is being stretched.

7.3 A business case has been submitted as part of the wider People and Culture request, and the team are unable to confirm permanent support for these initiatives until finance approval has been granted. We are yet to hear the outcome of this.

8.0 Action Being Requested

8.1 The Board/Committee is asked to:

a. **RECEIVE** and **NOTE** the report

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GMC NTS Results 2021

Programme Group by Trust/Board

(not by site)

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Key

	A green outlier is a score in the top quartile of the benchmark group, and the confidence interval does not overlap with that of the benchmark mean		A score in the top quartile, but the confidence interval overlaps with that of the benchmark mean.
	A score in between the top and bottom quartiles of the benchmark group.		
	A score in the bottom quartile, but the confidence interval overlaps with that of the benchmark mean.		A score in the bottom quartile of the benchmark group, and the confidence interval does not overlap with that of the benchmark mean.
	Fewer than three results		No results

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FY1 Trainees

Programme Group	Trust / Board	Indicator	2017	2018	2019	2021
Psychiatry F1	East London NHS Foundation Trust	Clinical Supervision	92.92	88.13	91.06	94.00
Psychiatry F1	East London NHS Foundation Trust	Educational Supervision	92.13	82.29	86.06	84.90
Psychiatry F1	East London NHS Foundation Trust	Induction	82.41	77.92	84.23	83.75
Psychiatry F1	East London NHS Foundation Trust	Supportive environment	74.44	77.92	76.15	78.75
Psychiatry F1	East London NHS Foundation Trust	Overall Satisfaction	83.44	70.33	83.46	77.92
Psychiatry F1	East London NHS Foundation Trust	Educational Governance	79.63	69.45	75.64	77.08
Psychiatry F1	East London NHS Foundation Trust	Work Load	62.04	70.14	68.11	74.30
Psychiatry F1	East London NHS Foundation Trust	Rota Design		64.77	66.67	74.17
Psychiatry F1	East London NHS Foundation Trust	Curriculum Coverage	70.37	56.94	68.27	72.92
Psychiatry F1	East London NHS Foundation Trust	Teamwork	81.02	72.57	80.13	72.22
Psychiatry F1	East London NHS Foundation Trust	Reporting systems	72.86	73.13	71.63	70.50
Psychiatry F1	East London NHS Foundation Trust	Facilities				69.00
Psychiatry F1	East London NHS Foundation Trust	Adequate Experience	74.44	51.88	74.81	66.67
Psychiatry F1	East London NHS Foundation Trust	Feedback	84.26	77.92	85.07	64.06
Psychiatry F1	East London NHS Foundation Trust	Clinical Supervision out of hours	76.67			

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FY2 Trainees

Programme Group	Trust / Board	Indicator	2017	2018	2019	2021
Psychiatry F2	East London NHS Foundation Trust	Clinical Supervision	94.69	90.18	91.09	97.14
Psychiatry F2	East London NHS Foundation Trust	Educational Supervision	70.84	88.39	85.94	94.64
Psychiatry F2	East London NHS Foundation Trust	Feedback	75.00	68.75	89.06	90.83
Psychiatry F2	East London NHS Foundation Trust	Overall Satisfaction	82.00	73.00	81.75	84.29
Psychiatry F2	East London NHS Foundation Trust	Teamwork	84.38	65.97	85.42	82.14
Psychiatry F2	East London NHS Foundation Trust	Educational Governance	62.50	72.62	85.94	82.14
Psychiatry F2	East London NHS Foundation Trust	Rota Design		71.43	71.62	81.25
Psychiatry F2	East London NHS Foundation Trust	Supportive environment	81.25	75.71	83.75	77.86
Psychiatry F2	East London NHS Foundation Trust	Adequate Experience	66.88	68.57	86.25	75.00
Psychiatry F2	East London NHS Foundation Trust	Curriculum Coverage	60.42	64.29	88.02	73.81
Psychiatry F2	East London NHS Foundation Trust	Induction	71.88	70.00	87.50	72.86
Psychiatry F2	East London NHS Foundation Trust	Study Leave	54.17	65.00	60.77	69.94
Psychiatry F2	East London NHS Foundation Trust	Clinical Supervision out of hours			77.78	68.75
Psychiatry F2	East London NHS Foundation Trust	Reporting systems	78.75	72.50	83.57	68.00
Psychiatry F2	East London NHS Foundation Trust	Work Load	60.42	58.93	62.50	66.67
Psychiatry F2	East London NHS Foundation Trust	Handover		63.54	78.13	65.18
Psychiatry F2	East London NHS Foundation Trust	Facilities				56.00

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GP Trainees

Programme Group	Trust / Board	Indicator	2017	2018	2019	2021
GP Prog - Psychiatry	East London NHS Foundation Trust	Educational Supervision	85.31	79.91	70.49	89.58
GP Prog - Psychiatry	East London NHS Foundation Trust	Clinical Supervision	86.32	86.06	81.53	86.64
GP Prog - Psychiatry	East London NHS Foundation Trust	Clinical Supervision out of hours	78.68	84.30	80.88	86.15
GP Prog - Psychiatry	East London NHS Foundation Trust	Feedback	78.06	76.92	61.11	83.71
GP Prog - Psychiatry	East London NHS Foundation Trust	Local Teaching	74.89	82.26	71.02	75.09
GP Prog - Psychiatry	East London NHS Foundation Trust	Reporting systems	64.71	72.79	71.40	75.00
GP Prog - Psychiatry	East London NHS Foundation Trust	Teamwork	70.61	72.76	69.12	73.15
GP Prog - Psychiatry	East London NHS Foundation Trust	Supportive environment	67.89	65.71	68.06	72.50
GP Prog - Psychiatry	East London NHS Foundation Trust	Educational Governance	69.30	73.21	69.45	70.83
GP Prog - Psychiatry	East London NHS Foundation Trust	Adequate Experience	71.84	73.57	66.81	69.44
GP Prog - Psychiatry	East London NHS Foundation Trust	Curriculum Coverage	64.03	67.26	65.74	69.44
GP Prog - Psychiatry	East London NHS Foundation Trust	Overall Satisfaction	71.47	69.93	64.72	69.17
GP Prog - Psychiatry	East London NHS Foundation Trust	Induction	67.76	57.50	70.28	68.06
GP Prog - Psychiatry	East London NHS Foundation Trust	Regional Teaching	76.18	78.93	56.39	61.57
GP Prog - Psychiatry	East London NHS Foundation Trust	Study Leave	54.28	51.12	54.04	59.93
GP Prog - Psychiatry	East London NHS Foundation Trust	Rota Design		56.89	52.43	59.84
GP Prog - Psychiatry	East London NHS Foundation Trust	Handover	54.82	58.18	52.78	57.87
GP Prog - Psychiatry	East London NHS Foundation Trust	Facilities				57.31
GP Prog - Psychiatry	East London NHS Foundation Trust	Work Load	53.95	51.79	59.38	51.39

NHS
East London
NHS Foundation Trust

Core Trainees

Programme Group	Trust / Board	Indicator	2017	2018	2019	2021
CPT	East London NHS Foundation Trust	Clinical Supervision	91.14	93.04	89.16	90.63
CPT	East London NHS Foundation Trust	Clinical Supervision out of hours	86.77	89.09	88.24	86.32
CPT	East London NHS Foundation Trust	Adequate Experience	81.80	83.78	81.65	77.91
CPT	East London NHS Foundation Trust	Teamwork	75.50	76.24	75.00	77.71
CPT	East London NHS Foundation Trust	Overall Satisfaction	80.00	82.26	78.68	77.67
CPT	East London NHS Foundation Trust	Curriculum Coverage	73.08	78.71	78.54	76.07
CPT	East London NHS Foundation Trust	Local Teaching	76.54	80.46	76.82	75.78
CPT	East London NHS Foundation Trust	Feedback	78.84	84.03	73.93	75.34
CPT	East London NHS Foundation Trust	Induction	73.88	69.04	73.70	75.29
CPT	East London NHS Foundation Trust	Educational Supervision	82.33	78.68	78.54	74.71
CPT	East London NHS Foundation Trust	Study Leave	60.92	64.09	67.27	73.86
CPT	East London NHS Foundation Trust	Educational Governance	70.67	73.76	73.90	71.90
CPT	East London NHS Foundation Trust	Supportive environment	69.60	72.34	72.83	71.28
CPT	East London NHS Foundation Trust	Reporting systems	76.22	77.22	74.07	67.94
CPT	East London NHS Foundation Trust	Rota Design		63.96	65.63	66.67
CPT	East London NHS Foundation Trust	Handover	68.92	66.52	63.08	63.59
CPT	East London NHS Foundation Trust	Facilities				55.20
CPT	East London NHS Foundation Trust	Regional Teaching	71.81	71.11	66.37	55.14
CPT	East London NHS Foundation Trust	Work Load	47.96	50.00	45.99	50.39

NHS
East London
NHS Foundation Trust

CAMHs Higher Trainees

Programme Group	Trust / Board	Indicator	2017	2018	2019	2021
Child and adolescent psychiatry	East London NHS Foundation Trust	Clinical Supervision	98.06	91.88	94.88	94.22
Child and adolescent psychiatry	East London NHS Foundation Trust	Regional Teaching	86.05	75.56	76.67	88.54
Child and adolescent psychiatry	East London NHS Foundation Trust	Clinical Supervision out of hours	92.22	89.58	88.66	88.02
Child and adolescent psychiatry	East London NHS Foundation Trust	Study Leave	74.31	70.49	90.83	79.95
Child and adolescent psychiatry	East London NHS Foundation Trust	Curriculum Coverage	86.11	84.03	84.58	79.69
Child and adolescent psychiatry	East London NHS Foundation Trust	Teamwork	75.46	68.33	84.58	79.17
Child and adolescent psychiatry	East London NHS Foundation Trust	Feedback	88.54	93.34	88.10	76.39
Child and adolescent psychiatry	East London NHS Foundation Trust	Overall Satisfaction	91.44	76.83	81.20	75.00
Child and adolescent psychiatry	East London NHS Foundation Trust	Adequate Experience	86.11	85.00	84.50	75.00
Child and adolescent psychiatry	East London NHS Foundation Trust	Induction	86.11	79.17	72.50	74.38
Child and adolescent psychiatry	East London NHS Foundation Trust	Rota Design		61.46	74.22	73.21
Child and adolescent psychiatry	East London NHS Foundation Trust	Educational Supervision	90.74	80.21	82.50	72.66
Child and adolescent psychiatry	East London NHS Foundation Trust	Supportive environment	75.56	70.00	79.50	71.25
Child and adolescent psychiatry	East London NHS Foundation Trust	Handover	77.08	68.75	75.46	70.83
Child and adolescent psychiatry	East London NHS Foundation Trust	Local Teaching	76.11	76.67	72.67	66.87
Child and adolescent psychiatry	East London NHS Foundation Trust	Reporting systems	75.56	68.00	75.13	64.29
Child and adolescent psychiatry	East London NHS Foundation Trust	Educational Governance	75.00	68.06	78.33	62.50
Child and adolescent psychiatry	East London NHS Foundation Trust	Work Load	41.44	42.71	43.96	49.48
Child and adolescent psychiatry	East London NHS Foundation Trust	Facilities				40.63

NHS
East London
NHS Foundation Trust

Forensic Higher Trainees

Programme Group	Trust / Board	Indicator	2017	2018	2019	2021
Forensic psychiatry	East London NHS Foundation Trust	Clinical Supervision		89.79	94.38	95.83
Forensic psychiatry	East London NHS Foundation Trust	Adequate Experience		79.17	85.00	93.75
Forensic psychiatry	East London NHS Foundation Trust	Clinical Supervision out of hours		89.58	89.24	90.97
Forensic psychiatry	East London NHS Foundation Trust	Study Leave		59.72	66.67	90.97
Forensic psychiatry	East London NHS Foundation Trust	Feedback		61.11	85.42	90.84
Forensic psychiatry	East London NHS Foundation Trust	Overall Satisfaction		74.33	77.83	90.83
Forensic psychiatry	East London NHS Foundation Trust	Educational Supervision		72.92	73.96	90.63
Forensic psychiatry	East London NHS Foundation Trust	Curriculum Coverage		77.78	79.17	88.89
Forensic psychiatry	East London NHS Foundation Trust	Teamwork		70.00	77.78	85.00
Forensic psychiatry	East London NHS Foundation Trust	Local Teaching		75.00	81.11	80.28
Forensic psychiatry	East London NHS Foundation Trust	Induction		65.00	82.50	80.00
Forensic psychiatry	East London NHS Foundation Trust	Regional Teaching		68.89	68.61	76.39
Forensic psychiatry	East London NHS Foundation Trust	Supportive environment		60.83	62.50	75.83
Forensic psychiatry	East London NHS Foundation Trust	Educational Governance		59.72	73.61	72.22
Forensic psychiatry	East London NHS Foundation Trust	Rota Design		57.50	57.92	71.88
Forensic psychiatry	East London NHS Foundation Trust	Reporting systems		73.75	75.00	70.00
Forensic psychiatry	East London NHS Foundation Trust	Handover		57.64	62.85	67.71
Forensic psychiatry	East London NHS Foundation Trust	Facilities				67.29
Forensic psychiatry	East London NHS Foundation Trust	Work Load		45.83	47.92	54.17

NHS
East London
NHS Foundation Trust

Higher Trainees GA

Programme Group	Trust / Board	Indicator	2017	2018	2019	2021
General psychiatry	East London NHS Foundation Trust	Clinical Supervision	93.23	95.04	93.19	95.30
General psychiatry	East London NHS Foundation Trust	Feedback	84.00	80.67	77.67	91.18
General psychiatry	East London NHS Foundation Trust	Clinical Supervision out of hours	92.19	88.94	88.62	91.03
General psychiatry	East London NHS Foundation Trust	Study Leave	71.21	73.66	74.93	87.95
General psychiatry	East London NHS Foundation Trust	Curriculum Coverage	85.12	79.84	80.78	82.33
General psychiatry	East London NHS Foundation Trust	Overall Satisfaction	84.43	83.26	81.03	82.20
General psychiatry	East London NHS Foundation Trust	Adequate Experience	87.05	85.08	81.21	82.00
General psychiatry	East London NHS Foundation Trust	Local Teaching	68.68	78.12	74.09	78.87
General psychiatry	East London NHS Foundation Trust	Educational Supervision	83.95	76.21	73.99	78.75
General psychiatry	East London NHS Foundation Trust	Induction	73.36	73.39	73.87	78.40
General psychiatry	East London NHS Foundation Trust	Educational Governance	75.60	72.85	72.04	77.67
General psychiatry	East London NHS Foundation Trust	Reporting systems	78.21	78.75	74.72	77.50
General psychiatry	East London NHS Foundation Trust	Supportive environment	72.68	70.32	69.84	74.80
General psychiatry	East London NHS Foundation Trust	Teamwork	74.70	80.11	77.55	74.67
General psychiatry	East London NHS Foundation Trust	Rota Design		63.51	62.28	73.70
General psychiatry	East London NHS Foundation Trust	Handover	74.38	69.03	67.75	70.17
General psychiatry	East London NHS Foundation Trust	Regional Teaching	66.80	71.02	63.82	65.17
General psychiatry	East London NHS Foundation Trust	Facilities				63.84
General psychiatry	East London NHS Foundation Trust	Work Load	48.88	51.01	52.76	58.83

NHS
East London
NHS Foundation Trust

ID Higher Trainees

Programme Group	Trust / Board	Indicator	2017	2018	2019	2021
Psychiatry of learning disability	East London NHS Foundation Trust	Clinical Supervision	96.25	93.33	97.19	98.33
Psychiatry of learning disability	East London NHS Foundation Trust	Study Leave	96.36	78.47	71.88	97.92
Psychiatry of learning disability	East London NHS Foundation Trust	Curriculum Coverage	85.42	100.00	86.46	97.22
Psychiatry of learning disability	East London NHS Foundation Trust	Adequate Experience	89.38	100.00	88.75	95.83
Psychiatry of learning disability	East London NHS Foundation Trust	Clinical Supervision out of hours	85.31		86.98	93.75
Psychiatry of learning disability	East London NHS Foundation Trust	Overall Satisfaction	79.75	100.00	89.25	91.67
Psychiatry of learning disability	East London NHS Foundation Trust	Teamwork	75.00	100.00	72.92	90.28
Psychiatry of learning disability	East London NHS Foundation Trust	Educational Governance	91.67	100.00	83.33	88.89
Psychiatry of learning disability	East London NHS Foundation Trust	Supportive environment	68.75	98.33	80.00	86.67
Psychiatry of learning disability	East London NHS Foundation Trust	Regional Teaching	84.75	94.44	82.09	86.11
Psychiatry of learning disability	East London NHS Foundation Trust	Educational Supervision	94.79	100.00	90.63	85.42
Psychiatry of learning disability	East London NHS Foundation Trust	Rota Design			68.75	85.42
Psychiatry of learning disability	East London NHS Foundation Trust	Induction	79.69	90.00	83.75	85.00
Psychiatry of learning disability	East London NHS Foundation Trust	Reporting systems	77.50	100.00	73.75	84.58
Psychiatry of learning disability	East London NHS Foundation Trust	Local Teaching	72.00	100.00	78.33	79.44
Psychiatry of learning disability	East London NHS Foundation Trust	Handover	55.56	100.00	70.83	77.08
Psychiatry of learning disability	East London NHS Foundation Trust	Feedback	87.50	95.83	85.42	63.89
Psychiatry of learning disability	East London NHS Foundation Trust	Work Load	43.75	68.75	50.00	47.92
Psychiatry of learning disability	East London NHS Foundation Trust	Facilities				

Focus Areas

Key points of focus will differ when we drill down at a local level.

This table is based on the overview at Trust/Board level

Domain	no. of red/pinks
Educational Governance	**2**
Educational Supervision	**2**
Feedback	**2**
Work Load	**2**
Clinical Supervision out of hours	1
Induction	1
Local Teaching	1
Reporting systems	1
Adequate Experience	0
Clinical Supervision	0
Curriculum Coverage	0
Facilities	0
Handover	0
Overall Satisfaction	0
Regional Teaching	0
Rota Design	0
Study Leave	0
Supportive environment	0
Teamwork	0

NHS
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REPORT TO THE TRUST BOARD IN PUBLIC
July 2022

Title	Quality Report
Author/Role	Auzewell Chitewe, Associate Director of Quality Improvement Katherine Brittin, Associate Director of Quality Improvement Duncan Gilbert, Head of Quality Assurance
Accountable Executive Director	Dr Amar Shah, Chief Quality Officer

Purpose of the report

The Quality Report provides the board with an overview of quality across the Trust, incorporating the two domains of assurance and improvement. Quality control is contained within the integrated performance report, which contains quality measures at organisational level.

Committees/meetings where this item has been considered

Date	**Committee/Meeting**
	None

Key messages

The quality assurance section focuses on the topic of record-keeping, which appears regularly as an issue in serious incident reviews (31% of the serious incidents in 2021). The report takes a deep-dive into this issue, understanding the themes within record-keeping, the work already undertaken to support safer, more reliable record-keeping, and identifying some opportunities for improvement.

The board can take assurance from significant work which has already taken place to optimise the safety and completeness of record-keeping in our electronic clinical record systems, within the constraints of our ability to make changes. The use of standardised forms has enabled more complete and accessible data in a single place for specific topics, such as physical health checks. The use of mobile technology, such as for EMIS, has allowed our community health teams to document in real-time whilst in the community and in patient homes. This enables more accurate and timely record keeping, whilst also improving staff experience.

There are some interesting developments in Newham mental health, which has been utilising quality improvement to involve staff and service users in improving the quality and reliability of observations in our inpatient wards. The introduction of mobile technology to directly document observations into the clinical record will further strengthen the real-time documentation of this important clinical safety practice.

Actions that we will be taking to further improve the reliability of record-keeping include amending the way we learn from investigations, so that we better understand the factors impacting on poor or incomplete record-keeping, and utilise actions on the stronger end of the action hierarchy following serious incident investigations. Progress on these actions and a deeper-dive into systemic factors contributing to record-keeping errors and omissions will be shared at a Trustwide learning lessons seminar and to Quality assurance committee.

The quality improvement (QI) section provides a summary of how we are applying QI to achieve our strategic objectives as a Trust. The Marmot work is applying quality improvement to the two focus areas of employment in Luton, and children and young people in Newham. The Luton work now has co-designed priorities, with groups meeting regularly to develop and test ideas.

The Pursuing Equity programme is now underway, with 20 teams taking part. These teams are being supported to identify areas of inequity, and apply coproduction and quality improvement to address these. A programme on Optimising Flow has launched, which is supporting services and pathways to utilise coproduction and quality improvement to manage demand and improve access in innovative ways. Both of these programmes tackle topics that are of high strategic relevance for the Trust, and learning will be shared routinely both within the organisation and with the Trust board.

Quality improvement is being applied to complex topics related to staff experience, on improving the new starter experience and time to hire. Within our priority work on improving value, our Green plan, agency spend work and financial viability are all applying quality improvement with dedicated support, in the way that they deliver their programmes of work. All of these are large, complex and involve multiple directorates and corporate departments working together.

Finally, our quality work at ELFT continues to be recognised externally through a range of awards, both within and outside healthcare.

Strategic priorities this paper supports

Improved population health outcomes	☒	Triple aim and Marmot Trust work
Improved experience of care	☒	Large scale QI programmes on pursuing equity, and tackling waits and flow
Improved staff experience	☒	Supporting team health and wellbeing, and improving the experience of new starters
Improved value	☒	Environmental sustainability and reducing agency spend

Implications

Equality Analysis	Many of the areas that are tackled through quality assurance and quality improvement activities directly or indirectly identify or address inequity or disparity.
Risk and Assurance	There are no risks to the Trust based on the information presented in this report. The Trust is currently compliant with national minimum standards.
Service User/ Carer/Staff	The Quality Report provides information related to experience and outcomes for service users, and experience of staff. As such, the information is pertinent to service users, carers, and staff throughout the Trust.
Financial	Much of our quality improvement activity helps support our financial position, through enabling more efficient, productive services or supporting cost avoidance. However, nothing presented in this report which directly affects our finances.
Quality	The information and data presented in this report help understand the quality of care being delivered, and our assurance and improvement activities to help provide high quality, continuously improving care.

1.0 Quality Assurance

The quality assurance section takes a closer look at one of the prominent themes of serious incident recommendations over the past few years, which is clinical record keeping. During the 2021 calendar year there were 42 serious incidents reviewed in which record keeping was identified as an issue. This represents 31% of the 134 serious incidents within the year. The breakdown of those incidents by service line is set out below:

Service Line	Community MH Services	Crisis MH Services	In-patient MH Services	IAPT	Community Health Services
Incidents	19	6	11	2	4

1.1 Of the 42 incidents, there was one that identified record keeping as having a significant impact on the occurrence (part of the 'root cause'). Twenty-four identified record-keeping as a 'care or service delivery problem' (germane to the occurrence), and 17 that identified record-keeping in the 'lessons learnt' (significant, but not material to the occurrence).

1.2 Analysis of the incidents has focused on the root cause and care/service delivery problems. Review of the incident reports and recommendations highlights a degree of variation as to what constitutes clinical record keeping, but the recommendations could be characterised as below:

	Omission	Delay	Deficit in quality and/or accuracy
Documentation of consultations, progress and decisions	13	5	2
Completion of forms/documentation of events	7	2	3
Documentation of plan	2	0	1

NB. Some incidents have more than one record keeping issue identified. The above includes all issues and so adds up to more than 25.

1.5 Whilst acknowledging the individual nature of each of the incidents, typical examples of the issues identified are:

"*The Psychiatric Liaison Service and Crisis Resolution Home Treatment teams commenced and updated the risk assessment template in RiO, however there was no further update made to the risk assessment following the home visits by the Community Mental Health Team*"

"*The failed telephone contacts from the Consultant Psychiatrist to Mr A were not documented in the RiO records but these were stored in the patient's filed letters*."

1.6 Each care and service delivery problem comes with a recommendation for action, which is then translated by the service and relevant stakeholders into their action plan for improvement. The review process routinely included the digital team, and the Chief

Clinical Digital Officer, to offer their perspective and to identify potential system improvements to address the issues identified.

1.8 Review of the incident reports and recommendations has highlighted that, whilst the reviews are very good at surfacing omissions, delays or deficits in the quality of record keeping, our insight into what underlies these problems remains limited.

1.9 The sequelae is that recommendations and actions end up at the weak end of the action hierarchy, such as more checking via audit, reminders to staff about policy, and more follow up via supervision. This is consistent with one of the findings in the March 2022 board quality report, which looked at the effectiveness of our learning from serious incidents.

2.0 Actions already taken to improve record keeping

2.1 Action has focused, in the main, on designing and configuring digital systems to better enable and support good recording practice, and on practical support and oversight of record-keeping.

2.2 Feedback from the digital team makes it clear that every effort is being made to make best use of RIO and EMIS systems, despite the numerous limitations in our ability to amend the electronic clinical record systems. There is some flexibility in designing forms in order to standardise record keeping, but a lack of a sophisticated interface which might enable user-centred notifications or interventions to guide a user's individual workflow.

2.3 A range of work has been undertaken to improve the functionality of electronic patient records to support staff in safe and effective record keeping:

- The adding of both service specific, and occasionally, Trust-wide forms to capture structured data. For example, structured forms for physical health observations and monitoring, infection control, and diabetic glucose monitoring all reduce the use of paper records and reduce the risk of critical clinical information being held in separate places
- A revised hospital discharge form has reduced the inputting of information to promote more timely completion
- Implementation of a shared care record in East London (soon to follow in Luton and Bedfordshire) means that information that would previously have required liaison is now available rapidly through a link in RiO

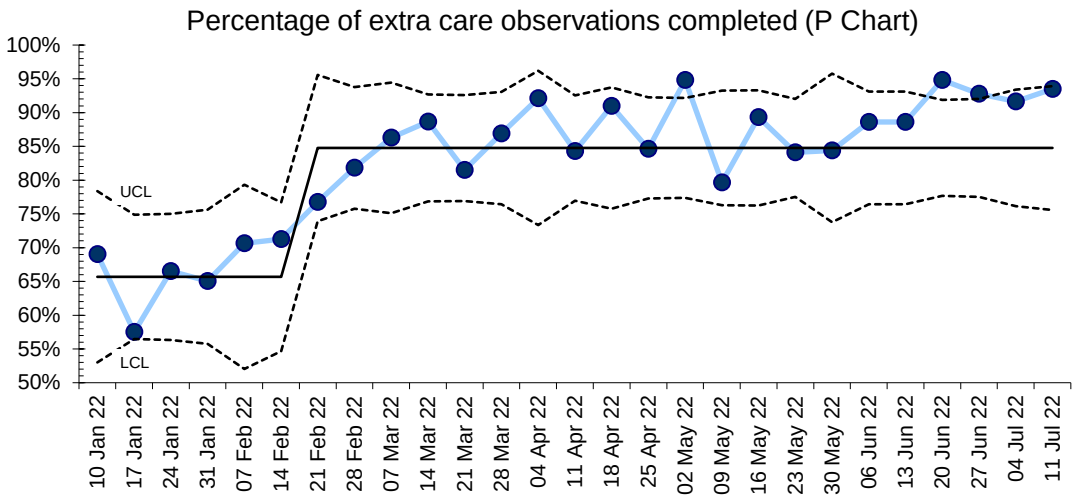
Work in progress includes.

- Replacing the Care Programme Approach: setting clear expectations for services and professional groups about what is expected in terms of carrying out specific interventions and their documentation. This offers an opportunity to clarify and communicate expected practice and aim for greater consistency, which would translate into increased timeliness, accuracy and completeness of information being recorded in RiO
- The patient safety agenda and clarification of risk assessment practice outwith the CPA framework within community mental health
- Integration of Dialog+ within a patient-held record (which will be Patients Know Best for North East London ICS) so that service users have more autonomy and ownership of their care plan, and will be encouraged to populate this data themselves before and in-between clinical encounters.

2.4 It should also be noted that there has been a stability and consistency in clinical record systems, and how they fundamentally operate, for some years now that is helpful to users. It is apparent that a huge range of work has been undertaken to provide the best possible platform for clinicians to maintain effective records.

2.5 In Community Health Services a real benefit from use of digital technology has been the implementation of mobile EMIS, enabling nurses to add to patient records in the community in real time, no longer having to wait until the end of the shift in order to return to their team base to document clinical notes. Services have supported this with training, and the use of Standard Operating Procedures (SOPs), and associated checklists and crib-sheets. Service leads report a really positive impact on standards and staff satisfaction as result.

2.6 The documentation of observations on a ward is a scenario in which real-time recording is a challenge, and this has been identified as an issue within serious incidents. In Newham mental health, they have responded to this by undertaking a QI project to 'improve the effectiveness and quality of observation practice at the Newham Centre for Mental Health to 95% by August 2022'. The team have now defined what good quality looks like – service user involvement, a clear rationale for observations, clear escalation process, clarity on how often checks should be done, and what actions the observer should take when carrying out the checks. The team have developed and tested a number of ideas to enable this, and are measuring the percentage of extra care observations that are completed. This has increased from an average of 65% to approaching 95%.



The introduction of mobile solutions to document observations into the electronic clinical record is in our digital plan, and will also support real-time documentation, preventing the need to return back to the nursing station to access a computer in order to document observations at a later time.

2.7 The record keeping practice of individuals is also supported by trust policy, professional standards and regulatory bodies, and management structures.

2.8 Record keeping is typically a feature of supervision. Clinical leads report routinely using audit and spot check to monitor record keeping standards and identify risks/areas for improvement, and share good practice.

2.9 One of the more recurrent challenges has been related to the record not being fully integrated, meaning that some records are kept outside of the main record, and have then not been added or reconciled, for example where records of sub-team meeting discussions, duty calls, or referrals have not been added to RiO. Management arrangements, SOPs and retrospective checking mechanisms are employed to try to address this and reduce risk.

2.10 It should be noted that, whilst documentation of notes in the electronic clinical record was previously the major way to handover important clinical information between staff and across shifts, the last few years has seen the evolution of regular huddles across most teams, and the use of additional digital platforms in order to handover important clinical information between staff. Huddles were originally introduced within our adult inpatient wards as part of the safety culture bundle, which enabled us to reduce the incidence of physical violence across our wards. The huddles now form a core component of many teams' quality control system (across inpatient and community settings, and now beyond mental health settings into community health, primary care and corporate teams), enabling the team to share concerns, handover critical information, escalate risks and take action in a much more fluid way than having to rely on staff to read and respond to documented clinical notes.

3.0 Conclusions and further actions being taken

3.1 The evidence-base on the factors that impact on record keeping practice show that most are external – related to workload, environment, availability and functionality of equipment. Others are process-related - understanding expectations and what is important, knowing where to find and record information.

3.2 We also know that the vast majority of people contributing to patient records want to do it well, and that those responsible for digital systems and for managing people want to support them, and make it as easy as possible to keep high quality records that make a positive impact on quality of care and patient safety.

3.4 Much work has been done through the serious incident process, but also through quality improvement and transformation, across the clinical and digital realms, to improve standards of record keeping, reduce variation and improve safety.

3.3 Analysis of serious incident reviews and conversation with stakeholders indicates that a more detailed understanding of the underlying system barriers to good record keeping is required to bring further improvement and removal of those barriers. The following steps are being taken in order to achieve this:

- The Risk & Governance team are leading a 'system review' of record keeping, involving key stakeholders, to fully understand the specific systemic causes of failures in clinical record-keeping
- The findings of the review will be shared via a Trustwide Learning Lessons seminar, and will be utilised to identify further opportunities to improve the reliability and safety of record-keeping. This will then be brought back to the Quality Assurance committee, through the routine reports on serious incidents
- Following the March 2022 quality report, the Risk & Governance team will be introducing human factors training for all serious incident reviewers, and action plans will be weighted towards systems factors at the stronger end of the action hierarchy

4.0 Quality Improvement

ELFT has a long history and culture of applying the systematic approach of quality improvement (QI) to solve complex problems. Most QI work is identified by the service around what matters most to service users and staff. Directorate QI forums help create alignment with strategic priorities. This report provides assurance to the Board on the application of quality improvement within the delivery of the Trust's four strategic objectives.

5.0 Improved Population Health

5.1 *Marmot Trust*

The Marmot work centres on two areas: employment in Luton and Children and Young people in Newham. In Luton, work has been co-designed through several workshops with partner organisations including Luton Council, Voluntary Sector Organisations, OCS soft facilities management and members of the population. Four priority areas have emerged:

- Promoting access to employment & apprenticeships at ELFT for service users and others in the community who may experience potential barriers to employment
- Increasing the number of people with lived experience of mental health conditions, both service user's and non- service user's, in good employment
- Engaging with employers to advocate for good quality employment
- Engaging with young people to raise aspirations and promote entry to healthcare careers

Currently two project groups have been established on supporting access to banking for vulnerable populations, which is a barrier to employment, and looking at accessible and inclusive recruitment to increase the number of ELFT service users in employment. Both groups have a range of stakeholders involved and the next phase of the work will be to follow the QI method by developing an aim, driver diagram, some simple measures and tests of change.

In Newham, the public health team have been utilising quality improvement in running partner engagement workshops to help develop a vision and identify priorities for the work. Work already happening in this area includes a project to tackle child poverty in the borough, which is one of the highest in the country. For the next phase of the work, the team are looking at testing the Healthy Wealthier Families intervention, first piloted in Scotland, which is designed to provide access to financial advice and benefits support in the community. Currently the project team are working with members of the population to understand how to tailor the intervention locally.

6.0 Improved Experience of Care

6.1 *Addressing inequalities*

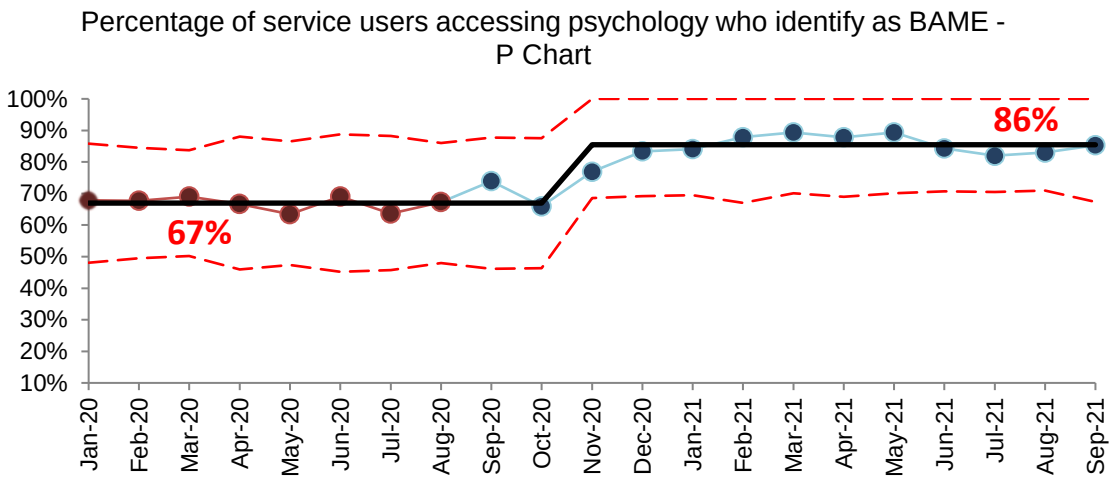
The 'Pursuing Equity programme' is supporting teams to use QI to address inequality and inequity in the communities they serve. Currently 20 teams are taking part in the programme, tackling a range of issues across the geography of the trust.

Place	Team	Topic

Bedfordshire & Luton	Bedfordshire Wellbeing Service	Identifying and tackling health inequalities of Asian/Asian British Men over 40 years old that live in Bedford to improve their overall wellbeing, quality of health and life
	People Participation	Improving experience, access and health outcomes for people who identify as LGBTQ+ in accessing care
	Community Eating Disorders service	Improving access to care for people with eating disorders from the BAME community
Hackney	Shoreditch Ward (Forensics)	Adopting a trauma-informed approach to tackle racism
	Bow Ward (Forensics)	Improving sexual and reproductive health care for women in the forensic service
	Community Service (Forensics)	Access for BAME groups
	John Howard Psychology Department	Increasing staff knowledge of diversity and inclusion in Psychology services to provide informed care for inpatients
	Ruth Siefert Ward	Improving experience for those identifying as LGBTQ+ on the ward
	Perinatal Service	Improving access to perinatal mental health care for women with severe mental illness
Newham	Newham Transitional Practice (Primary Care)	Increasing access to cervical screening
	SCYPS (Specialist Children's and Young People's Service) Community Paediatrics	Improving income optimisation for children by supporting them and their families to ensure they receive all benefits they are entitled to
	Community Mental Health Transformation Programme	Improving access to perinatal peer support for new fathers
	Emerald Ward	Gender equity access for women to psychiatric intensive care unit beds
	Newham Psychology	Improving access and service provision for Afro-Caribbean residents
Tower Hamlets	ELFT LGBTQ+ Network	Raising awareness and improving outcomes for staff and service users who identify as LGBTQ+
Cross-borough	East London Transformation Programme (Newham, City & Hackney, Tower Hamlets)	Access to psychology services for BAME groups
	Trust wide female medical staff	Reducing the gender pay gap in doctors

Teams have been working to ensure they have the foundations for success established, including service user involvement and understanding the issue they are tackling. For instance, the Community Forensics Team are working on improving diversity within their service. To help them further understand the issue, they have held three service user focus groups and a weekly diversity meeting with staff. Going forward, teams will be supported to develop driver diagrams and begin to develop measurement plans to help them know if they are seeing improvement.

One team who have already seen improvement are the Tower Hamlets Early Intervention Service who provide psychosocial intervention for 18–35-year-olds with psychosis. They identified that members of the Black Asian and Minority Ethnic (BAME) group were under-represented in terms of access to their service. Since January 2020 they have been working to increase access and have prioritised service users who have been discharged from the ward by offering them family therapy. The chart below highlights that they have seen an increase in the percentage of service users from BAME background who are accessing psychological therapy.



6.2 *Reducing waiting times and improving access to services*

In June 2022, the Optimising Flow QI programme was launched to support teams to improve patient pathways and manage increased demand. Designed in collaboration with the people participation, quality improvement and performance departments, attendees are being supported to learn how to match demand and capacity, and how to alleviate bottlenecks and backlogs within their pathways. Below is a summary of the themes that teams are working on.

Quality of Assessments	**Reducing waiting times**
·Ruby Triage Ward, Newham Centre for Mental Health ·Specialist Psychotherapy Services, City and Hackney	·Extended Primary Care Team, Tower Hamlets ·Occupational Therapy, (Bedfordshire Community Health Services) Children with Autism in Newham - Diagnosis Service and Neuro Disability Service, Specialist Children's and Young People's Services (SCYPS) ·Tower Hamlets CAMHS ·Improving Access to Psychological Therapies (IAPT) ·East London community eating disorders ·Bedford CAMHS
Increasing the amount of time spend on clinical work	**Increasing Group Support**
·Hackney Integrated Learning Disability Service	·Richmond Wellbeing Service
Recruitment	**Understanding types of demand**
·Leighton Road Surgery, Primary Care ·Primary Care Management team ·Extended Primary Care Team, Tower Hamlets	·Leighton Road Surgery, Primary Care ·Specialist Psychotherapy Services, City and Hackney
Mapping the needs of sub-populations	**Extending triaging**
·Newham CAMHS ·Living Well, Community Health Tower Hamlets ·Tower Hamlets talking therapies, IAPT	·Tower Hamlets CAMHS ·Richmond Wellbeing Service

Reducing referral to treatment time	Unblocking bottlenecks at discharge
Children's Speech and Language Therapy, SCYPS ·Tower Hamlets CAMHS	·Ruby Triage Ward, Newham Centre for Mental Health
Improving staff retention	**Improving referrals**
·Ivory Triage Ward, Newham Centre for Mental Health	·Continuing Care, Tower Hamlets ·Biggleswade Community Mental Health Team ·OCEAN (Offering Compassionate Emotional Support for those Living Through Birth Trauma & Birth Loss), Maternal Mental Health Service ·Psychiatric Liaison Team, Luton and Dunstable Hospital
Building relationships with partners	
·Continence Service, Mile End Hospital ·Admission Avoidance and Discharge Service, Mile End Hospital ·Leighton Road Surgery	

Broader than the specific themes that teams are tackling, the programme is designed to help them consider the patient journey and optimise flow across systems. For instance, the Specialist Psychotherapy Service in City and Hackney have analysed their referral data and have been building relationships with the community and neighbourhood teams, with the aim of improving local services' understanding of who would benefit most from referral. Some teams are already seeing signs of improvement, with vacancy rates in Primary Care reducing from 21% in April 2022 to 16% in June 2022.

The year-long programme will support teams until April 2023. Teams will be supported by QI coaches and improvement advisors to progress their testing and learning. Teams will be brought together at regular intervals to support learning and sharing of ideas.

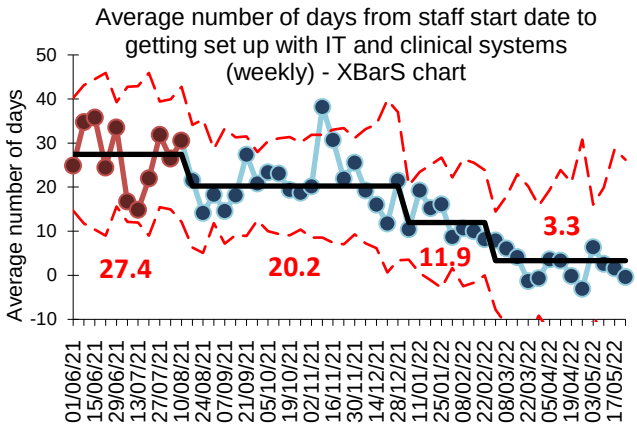
7.0 Improved Staff Experience

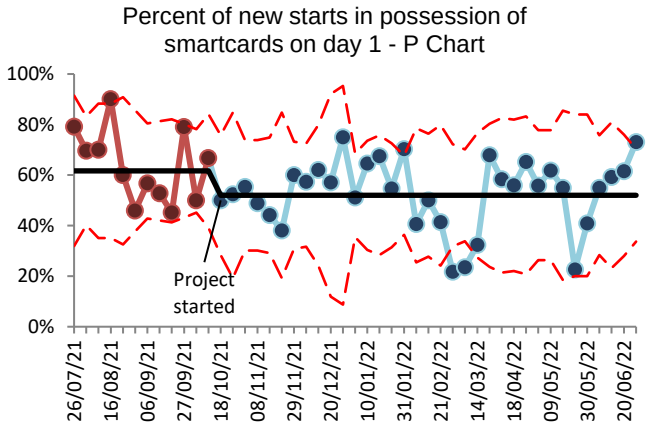
7.1 *Improving the experience of new starters*

Improving the experience of new staff starting at ELFT is important for them to feel valued and be equipped to be able to do the job they were employed for. A team comprising of people and culture, digital and the IT helpdesk are working together to ensure that staff have all the equipment they need, including clinical systems access, IT equipment and their 'smartcard' which enables new staff to access the electronic systems they require for their role.

The team have achieved the original aim of ensuring staff have access to clinical systems within 5 days as shown in the chart below. From an original average time of 27 days, it is currently taking an average of 3.3 days for staff to have access to clinical systems.

The possession of smartcards has been a longstanding and challenging issue. Going forward, the focus of the project will be on trying to achieve the aim of 100% of people on their first day having an activated smartcard. As shown in the chart below, currently the average percentage of people with a smartcard on day one is 52%.





The project team have worked closely with the recruitment team to help them to use improvement to test the selected change idea of changing the recruitment process so that staff are identified on the system quicker and allocated their smartcard earlier. There are early signs in the data above that this may be starting to make a difference. In addition, a line manager checklist is being tested to help managers ensure that all elements of the recruitment process are being completed prior to the start date. To accelerate this work, a bespoke Pocket QI session is being planned for the whole People and Culture department in September.

7.2 *Time to Hire*

The People and Culture team are working on reducing time to hire. They are developing tests in three high impact areas: (1) shortlisting to be completed within 48 hours of the advert closing date, (2) setting the closing date of job adverts to occur on Wednesdays to allow for shortlisting within the working week, and (3) recruitment training for appointing managers. The team is now developing a test on inpatient wards in Luton & Bedfordshire which will help them understand the impact of these three ideas when tested individually and in different combinations. This will allow them to then scale-up to other services the most effective way of deploying these change ideas.

8.0 Improved Value

8.1 *Environmental Sustainability*

The Green Plan is a coordinated effort to improve environmental sustainability across the organisation. The plan is being designed and delivered using quality improvement. The six workstreams that have been identified at this stage to help achieve the Green Plan are medicines, estates and facilities, workforce, leadership, procurement and transportation. Within these workstreams, some teams have started to come forward to test ideas:

- There are two teams from pharmacy that may start working on waste reduction and re-cycling of medication and packaging.
- A community health services team is looking at re-cycling of ambulatory aids and a broader reduction of waste.
- A ward at the John Howard Centre is exploring how to reduce the use of plastics

As more teams are identified and they start to form, a challenge with this work will be to also develop system-wide change ideas that extend beyond individual teams. One such idea that is

being developed is a green scorecard system representing core elements of the green plan and specific outcome measures around carbon or energy usage. Work has begun to identify teams which can test the green scorecard system. Another idea that is being developed to effect system-wide improvement is the mileage reduction project with the Estates and Facilities department. A core dependency of this idea, the new Electronic Staff Records (ESR) system for tracking mileage used, is still being implemented out across the trust. This will provide data to understand areas that can have the most impact for reducing mileage.

8.2 *Agency Spend*

The agency spend project is being supported by the temporary staffing, procurement & contracts, finance, workforce and health roster teams with the aim to reduce agency spend by 25% by December 2022. The project team have tested some change ideas over the last seven months, however, these have not specifically led to a reduction in agency spend and are unlikely to help achieve the aim. Redesign of parts of the system will be required. Other work on drivers related to recruitment have led to some agency spend reductions. In discussion with the sponsors of the work, the project team are working on:

- A director of nursing and a clinical/service director to join the project team to facilitate tests of change in their directorate, such as enhanced Bank staff pay rates to encourage use of Bank nursing staff instead of agency nursing staff.
- Some research and insights are being sought from other organisations and internal stakeholders to put together an options appraisal for a future temporary staffing service
- Establishing whether the budgeted establishment is right for safer staffing levels when teams are booking agency staff.

8.3 *Financial Viability*

In May 2022, a number of corporate teams came together to use improvement to reduce waste in their area. The emergent work included reducing mileage, reducing printing, improving infection prevention processes and diary management. The teams used the ‘waste walk’ tool, gathered some data around their issues, and will be supported locally by QI coaches to progress their work.

9.0 Celebration

The following teams have been recognised for their quality improvement work:

- The Quality Department (Quality Improvement and Quality Assurance) were awarded the Quality Team of the Year 2022 award at the International Quality Awards. This is the first time a healthcare organisation has won this cross-industry global award.
- The City & Hackney Integrated Learning Disabilities Service have been shortlisted for the Learning Disabilities Initiative of the Year in the HSJ Patient Safety Awards 2022.
- The Bow Ward Trauma Informed Care project has been shortlisted for the Nursing in Mental Health category in the Nursing Times Awards 2022.

10.0 Action Being Requested

The Board is asked to consider assurance received and any other assurance that may be required.

Performance report

July 2022

NHS
East London
NHS Foundation Trust

Title	Performance report
Author Name and Role	Amrus Ali, Associate Director of Performance Thomas Nicholas, Associate Director of Business Intelligence & Analytics
Accountable Executive director	Dr Amar Shah, Chief Quality Officer

PURPOSE OF THE REPORT

To provide assurance to the Board on overall performance of the organisation, in delivery of the Trust strategy.

KEY MESSAGES

The performance report provides a strategic overview of performance on four key themes (safety; access and responsiveness; effectiveness and outcomes; children and young people). Each theme includes a small number of Trustwide measures, together with a narrative to describe progress, challenges and actions. The appendix contains our system performance dashboard, with measures related to population health, quality of care and value for each of the key populations that the Trust serves. This helps us understand the performance of each population that we serve. Narrative to explain unusual variation is contained in the overview of performance within the relevant theme.

Where are we doing well, and what have we learned?

While the overall number of reported incidents has continued to rise, which reflects a positive reporting culture, the percentage of incidents resulting in harm has returned to normal levels. The main themes are related to care and treatment incidents, particularly relating to pressure ulcers in Community Health Services, which remain stable.

Across Perinatal services, there has been a increase in the number of service users from minority groups accessing the service. This reflects improvements made by the team to accurately capture demographic information for all service users. Perinatal Services are also continuing to successfully capture outcome measures and are exceeding the national (CQUIN) target of 40%.

The number of service users supported into employment by Individual Placement Support (IPS) services remains stable with a small increase in May across mental health services. Our Substance Misuse Team in Bedfordshire have also seen an increase in service users entering employment once discharged from the service. This reflects the work under way across the Trust to support service users into employment. In addition, there has been a small rise in the percentage of service users in employment across adult mental health services during May.

Early Intervention Services continue to exceed the national target of 60% of services users commencing treatment within 2 weeks of referral, achieving 73% in May.

KEY MESSAGES (continued)

Following a successful campaign to increase responses across Bedfordshire GP practices, the overall number of Friends and Family test responses has increased by 50%. However, during the reporting period, the proportion of service users who would recommend our services fell below normal levels, owing primarily to responses from Primary Care services. The main dissatisfaction theme related to waiting times and access to services. A range of initiatives have been put in place to address the issues including increasing workforce capacity, improving telephony system to handle calls more efficiently, reorganising triage and screening and administrative processes to improve flow and enhance support for clinicians.

The quality and experience indicators for SCYPS continue to highlight that 100% of parents and service users are satisfied with the service The percentage of people being seen within IAPT who achieve recovery has exceeded the national 50% target, achieving 51% in May. Responses to the standard Patient Experience Questionnaire in IAPT and access to services continue to remain stable.

Overall, paired Dialog scores over 18 months show that in both community and inpatient settings we are supporting an improvement in quality of life and outcomes. CAMHS services continue to progress well with capturing paired outcomes for service users, achieving 79% in May. In the equity section of this report, we focus on looking at Dialog quality of life scores for inpatients through the dimensions of gender, ethnicity and deprivation. This shows a number of interesting findings, such as poorer satisfaction with mental health amongst our white inpatients, service users from particular areas of deprivation showing little or no improvement in outcomes during an inpatient admission, and female service users expressing lower satisfaction with their mental health than males. This section of the report shares our theories about what might underlie these findings, and what is in place to start addressing these inequities.

Where are we identifying challenges, and what are we doing about it?

Bed occupancy has risen over the past few months, reaching 95% in May. While high bed occupancy is common nationally, this sustained increase over the last few months is unusual for the Trust. The average length of stay has also increased during the past four months, exacerbated by socio-economic factors and wider health system pressures across A&E, community and crisis services, and local authorities. A range of initiatives are underway to improve flow including strengthening community and crisis services, focusing on prevention, and working more closely with system partners to allocate resources more efficiently around the needs of service users.

The percentage of service users who were followed up within 72 hours of discharge from an inpatient service remains below the 80% goal, but we are getting closer towards this.

KEY MESSAGES (continued)

Over the last two months, the rate of physical violence has shown some increased variation, and the rate of restraints has increased. This is thought to be due to increased bed occupancy and high acuity levels, as well as some staffing gaps caused by sickness absence during this time period, which had an impact on the therapeutic environment on the wards.

The total waiting list across the Trust has seen a rise, which is related to a few teams across Community Health Services, CAMHS, Autism and ADHD services. In some community-based services, average waiting times have increased as teams prioritise those who have been waiting the longest. Twelve of the 37 teams with recovery plans are seeing their waiting lists reduce, despite most teams facing challenges with capacity versus demand. Waiting lists remain stable in 12 services that have developed recovery plans, and 17 are seeing a rise in their waiting list. The main factors beneath this relate to high demand, capacity challenges caused by staffing gaps, and difficulties with recruiting to our vacancies. The People report gives more detail about this issue of attracting and recruiting people to fill our vacancies, and what we are doing to address this. Over 30 teams with waiting list challenges are part of the Optimising Flow QI programme which commenced in June, supporting teams to apply coproduction and quality improvement to identify and test creative solutions to address their challenges.

Executive Summary

Strategic priorities this paper supports (please check box including brief statement)

Improved patient experience	☒	The performance reports supports assurance around delivery of all four strategic priorities. The Board performance dashboard includes population health, patient experience and value metrics for each of the main populations that we serve. Metrics around staff experience are contained within the Board People report.
Improved health of the communities we serve	☒	
Improved staff experience	☒	
Improved value for money	☒	

Committees/meetings where this item has been considered

Date	Committee and assurance coverage
Various	Various sections of this report are submitted to the Service Delivery Board, Finance Business and Investment Committee and other Trust committees. Some of the performance information is submitted to commissioners and national systems.

Implications

Impact	Update/detail
Equality Analysis	Some of the metrics in this report are designed to improve equalities by ensuring access to services and good outcomes. Analysis of the experience of different groups is undertaken as part of the Trust's inequalities work stream and population health task and finish group.
Risk and Assurance	This report cover performance for the period to the end of May 2022 and provides data on key compliance, NHS Improvement, national and contractual targets.
Service User/Carer/Staff	This report summarises progress on delivery of national and local performance targets set for all services.
Financial	The performance summary will escalate the areas where targets have not been met or areas of noncompliance against the main contracts and could pose a financial risk to the Trust.
Quality	Metrics within this report are used to support delivery of the Trust's wider service and quality goals.

Introduction: How this report is structured

1

Summary of organisational performance

The report is organised around a small number of key themes (safety; access and responsiveness; experience and outcomes; children and young people). Each section contains 3-5 indicators aggregated at Trust level, together with a summary of current performance (progress, issues and actions).

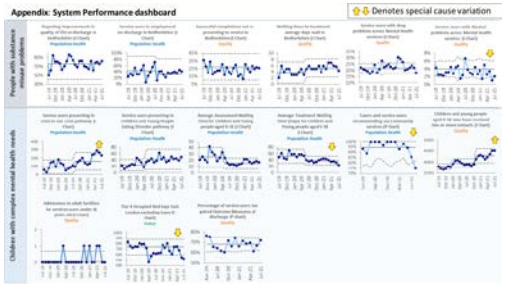
Key indicators related to the performance theme

Narrative describing current performance – including progress, challenges and actions

2

Appendix 1 – System performance dashboard

This dashboard demonstrates our impact on key measures of population health, quality of care and value for the main populations that the Trust services. Highlighted arrows draw attention to areas where we are seeing change (improvement, deterioration or instability)



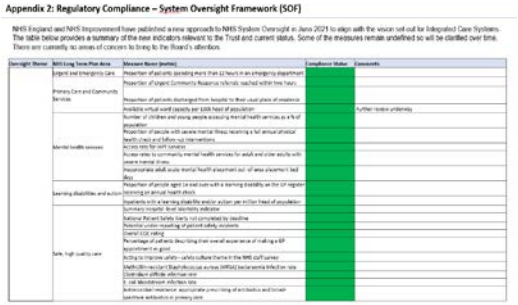
Each row contains the measures related to a population that we serve

Highlighted arrows to show areas where we are seeing instability, with assurance of actions provided in the initial narrative

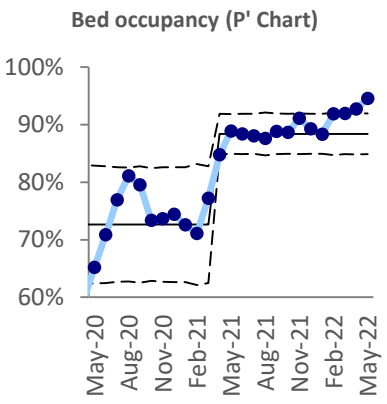
3

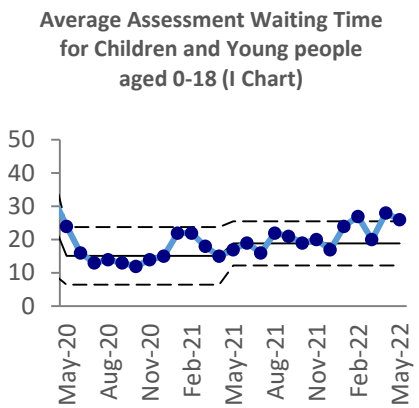
Appendix 2 - What is our performance against national assurance indicators?

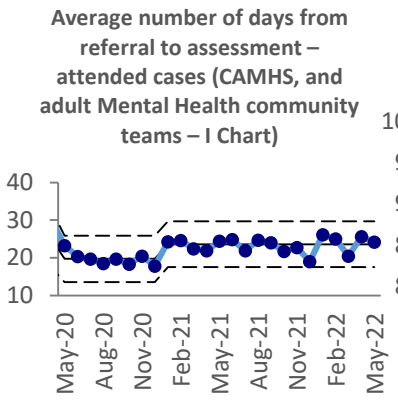
This provides the Board with assurance of our performance against the measures that form the new System Oversight Framework within the NHS

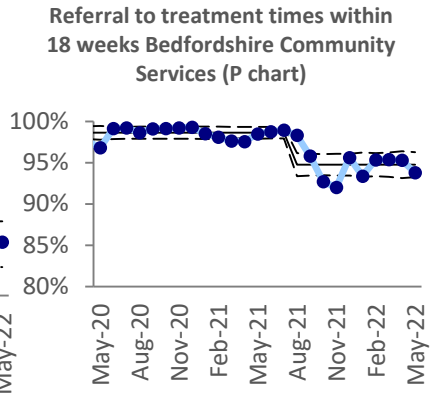


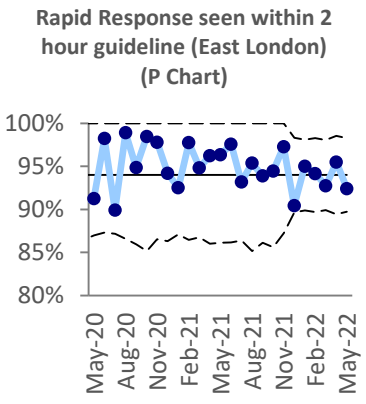
Access and Responsiveness

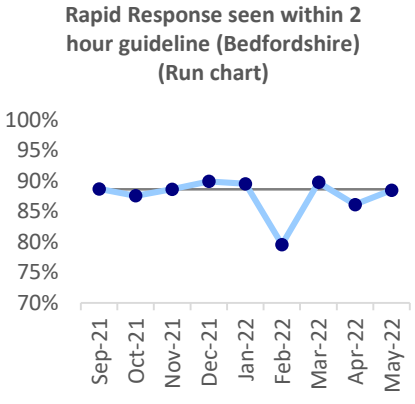












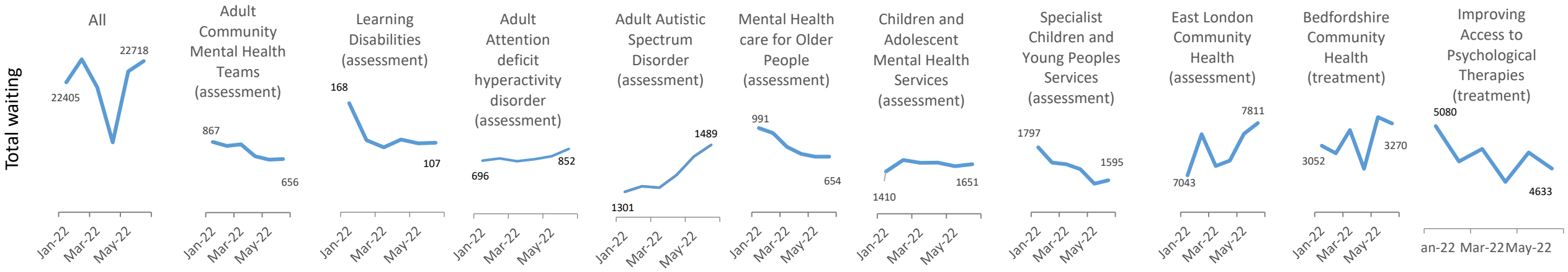
Inpatient bed occupancy across all services has continued to rise to unusually high levels, with an average of 95% in May. While this level of bed occupancy is common nationally, this sustained increase over the last few months is unusual for the Trust. The average length of stay has also increased during the past four months, exacerbated by socio-economic factors and wider health system pressures across A&E, community and crisis services, and local authorities. The key challenges highlighted in the previous report continue to persist, particularly regarding out of area admissions, increased levels of acuity, social care delays and limited availability of specialist placement accommodation for service users with complex needs.

A number of initiatives are under way across all services to optimise flow, including a focus on preventing admissions through strengthening community partnership arrangements with local authorities and system partners to better allocate and align resources around the needs of service users, strengthening escalation procedures internally and externally with key partners, reviewing high impact winter plan initiatives that could be restarted, improving crisis plans and ensuring community crisis and urgent care pathways are appropriately utilised. In addition, all services are reviewing how they identify delayed discharges earlier, to improve visibility of barriers before these cases are formally agreed as delayed transfers of care with local authorities. There has also been an acknowledgement of the need to assist staff, particularly junior staff, to adopt positive risk management strategies to ensure that service users with manageable risks avoid unplanned hospital admissions that can sometimes be inappropriate and harmful.

Plans are also being formulated to run a “Perfect Day/Week” exercise in Bedfordshire and Luton in the next two months. This is similar to a major incident exercise, where teams across the system are focused entirely on how to optimise patient flow for a brief period. This exercise helps demonstrate the potential of collaboration and opportunities to improve system performance. This approach has been used successfully across many acute hospitals over the last few years. This initiative aims to generate energy for change by doing things differently to support patient flow and consequently improve patient experience, safety and staff morale.

Responsiveness of the ELFT Rapid Response Team continues to remain stable achieving 92% across East London and 89% across Bedfordshire during May.

Access and Responsiveness



The waiting list charts above provide a summary of the total number of service users waiting to be seen across the Trust. The overall waiting list for assessment and treatment has increased again. 37 services across the Trust have developed recovery plans for their waiting lists - 8 of these are seeing a reduction, 12 remain stable, and 17 are increasing. All services have a process to prioritise referrals based on urgency and complexity, and are reviewing their waiting lists to manage the risk of harm. The services that have large waiting lists have produced recovery plans to help plot trajectories based on their current demand and capacity estimates. The Optimising Flow QI programme has begun to assist services in systematically understanding demand, coproducing solutions and testing new ideas.

Across Luton & Bedfordshire Mental Health services, Community Mental Health Teams (CMHTs) are seeing an increase in their waiting lists. These include Biggleswade, Dunstable, and Leighton Buzzard CMHTs. In Biggleswade, waiting lists for assessment have increased from 242 to 266 over the last 3 months. Across the CMHTs, recruitment is the main challenge and teams are using agency staff who are familiar with current procedures and systems as a temporary solution to maintain capacity. Direct corporate performance support is ongoing with Dunstable CMHT, where the assessment waiting list has increased from 83 to 107 over the last 3 months. The team is collaborating with People Participation to introduce befriending for service users who are waiting for long periods of time to be seen. The team is currently identifying and referring ten service users who are particularly isolated on the waiting list to the befriending service as a means of ensuring safety and support. While the newly established Primary Care Network (PCN) mental health teams have begun to embed new models of care, a data validation exercise is being carried out to accurately report waiting lists that reflect the new service offer and pathways, where service users can access and select a variety of interventions in a fluid manner based on need.

Memory Assessment Services in Luton are seeing an increase in their treatment waiting lists from 98 to 120 in the past 3 months and in Bedfordshire the service is experiencing an increase in their assessment waiting list from 44 to 74 in the same period. A Luton and Bedfordshire dementia forum has been established, providing a platform for all the services to collectively share their challenges and collaboratively explore solutions for improvement.

Access and Responsiveness

Memory Services across East London continue to remain stable. In City & Hackney, the service is planning to employ a GP with “special interest” for 2 days a week to improve the quality of referrals. Short term funding for 2–3-months has been agreed for a dementia liaison nurse who started last week. With the support of corporate performance, an East London-wide workshop was held in early July to help streamline pathways and processes. The Newham Memory Clinic has also seen improvement in the waiting list due to successfully filling vacant positions, including a new admin lead who has recently joined. The team anticipate that all positions will be filled within 4-6 weeks.

Older People CMHTs remain largely stable or have decreasing waiting lists. As the graphs show, waiting lists for Mental Health care for Older People are reducing overall. The teams are currently reviewing internal processes with clinical and administrative staff to ensure best practice in allocation of cases, roles of duty personnel and conducting a mental state and risk assessment.

In East London, City & Hackney ADHD service continue to see growth in waiting lists. Within the last 3 months, the waiting list for assessment has increased from 491 to 545. Additional investment for staffing capacity ended in March, however the teams continue to prioritise follow-up appointments for people who have started their assessments. A 0.8 whole-time equivalent doctor is due to start in July which will increase staffing capacity and help to reduce the waiting list. Bedfordshire and Tower Hamlets ADHD services are also experiencing a steady increase in assessment waiting lists. The services are undertaking a data review to plot demand against capacity, in order to develop a plan.

Specialist Psychotherapy Services (SPS) in Newham and City & Hackney also continue to see growing waiting lists. In the last 3 months, waiting lists for assessment in Newham have increased from 181 to 201 and in City & Hackney from 102 to 133. Within SPS, to address service users waiting above 18 weeks, the clinical team are starting to provide extra time and capacity to this cohort to prioritise and review long waiters that remain on the waiting list. Newham SPS continues to use bank staff to support assessments and is currently encouraging a system whereby 3rd-year psychology trainees can support assessment work whilst on placement. City & Hackney SPS has seen a reduction in their waiting times for treatment which is largely attributable to the promotion of a population health approach within the Primary Care Networks to better meet the needs of individuals and communities. An example of this is the community connectors in Shoreditch who have identified a cluster of Farsi-speaking male asylum seekers who all present with symptoms of trauma. This community-based approach is currently improving the accessibility of the service for local communities. In Tower Hamlets, the SPS waiting lists are decreasing slightly. To prevent people waiting longer than 18 weeks, the clinical team is starting to dedicate additional time to this stage of the pathway.

The waiting list graphs show that Autism services across the Trust are seeing an increased waiting list. Corporate performance are offering direct support to these teams. The Tower Hamlets Autism service is experiencing an increased waiting list for assessment from 110 to 124 in the last 3 months, however the waiting lists remain stable for treatment. Several ideas from the QI project have been implemented including a pre-assessment self-report questionnaire which enables a faster triage process. The EQUIP Psychology team has a stable waiting list. The team is currently looking to reduce the number of sessions an individual receives from an average of 20 to 16 to increase the team’s capacity. A business case is also in the process of being developed for a Family Therapy worker.

Access and Responsiveness

There is a slight increase in Newham Learning Disability waiting lists as a result of significant workforce challenges. The team are in the process of actively recruiting new staff members, which is having an impact on the capacity within the team to see service users within the specified times. There is also now an agreed protocol around consistent data recording and active data cleansing being carried out to ensure that the correct outcomes are being reported. Tower Hamlets are also experiencing some recruitment and retention issues, and are developing new roles to enhance the skill mix within the team to manage high levels of Continuing Healthcare cases and those with complex needs. The team have created a Transition caseload to ensure that there is clear oversight for the young people moving into adult services.

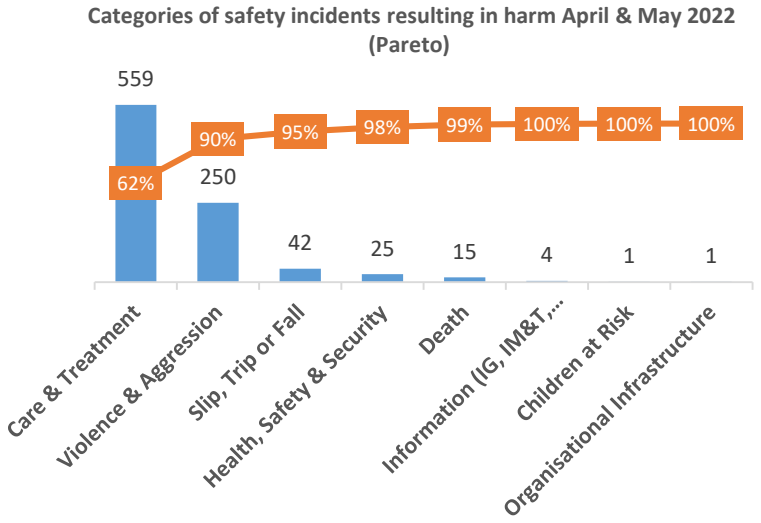
Within Specialist Services, IAPT waiting lists for treatment are decreasing overall. The Bedfordshire Cognitive Behavioural Therapy (CBT) service is the only team experiencing an increase in waiting lists from 589 to 617 in the last 3 months. The Tower Hamlets CBT waiting list has decreased from 202 to 131 in the same period. In Tower Hamlets, with the use of Xyla and agency staffing, the service has increased the average number leaving the waiting list from 16 each week to 22 each week. In Bedfordshire, the service continues to share ideas and thoughts with other IAPT services across the region in treating the level of complexity at Stage 3, including additional training for staff and signposting to more specialist services where appropriate.

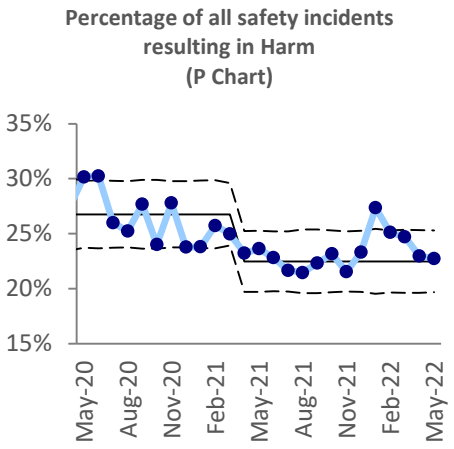
CAMHS waiting lists remain largely stable. Newham CAMHS is currently the only team experiencing an increase in waiting list in the past 3 months, from 528 to 573. Eating Disorder services across the Trust remain stable. In East London, the service has reconfigured the assessment clinic to ensure capacity for at least one urgent assessment each week. SCYPS Autism Spectrum Disorder (ASD) has managed to reduce its long waiting lists, as a result of a one-year recovery plan. The Speech & Language Therapy waiting list continues to remain stable. Additional information about children's services waiting lists can be found on the Children and Young People section.

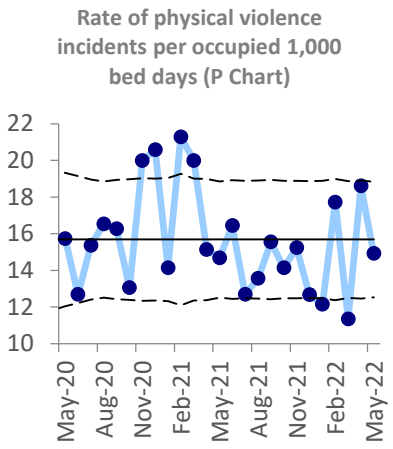
Waiting lists across Community Health Services in both East London and Bedfordshire continue to rise, except for Newham Diabetes and Bedfordshire's Physiotherapy Service. The Newham Foot Health service is particularly struggling due to a national shortage of podiatrists. They have seen an increase in their waiting list over the last three months from 1527 to 2023 people waiting for first appointment. The service is liaising with Tower Hamlets for additional support and is exploring the purchasing of external capacity. Despite experiencing an increased waiting list from 3621 to 3694 in the past 3 months, the Physio MSK service forecast that their waiting list will be resolved by October. This is largely due to successfully recruiting an additional physiotherapist in the last month, translating to a 30% increase in capacity. By October, the service expects that all service users will be seen within 30 days of referral.

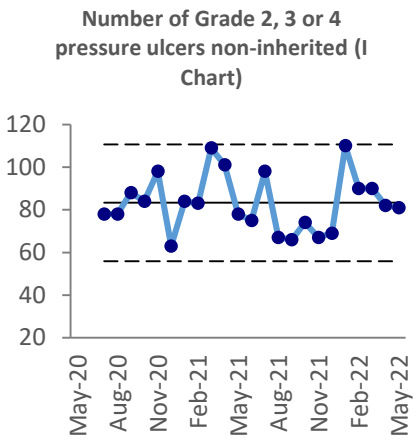
In Bedfordshire, the Adult Speech and Language Therapy (SLT) service estimate that by the end of July, two therapists will be recruited to increase capacity. The Podiatry service continues with their routine caseload cleansing, however, across Adult podiatry 80% of patients are seen within 18 weeks. The team have commenced a recruitment campaign this month with the hope to fill all vacancies. The Wheelchair service in Bedfordshire has experienced an increased waiting list from 254 to 272 in 3 months. Delayed waiting times for equipment is no longer an issue, but approved repair services are still struggling to recondition and provide equipment to the service.

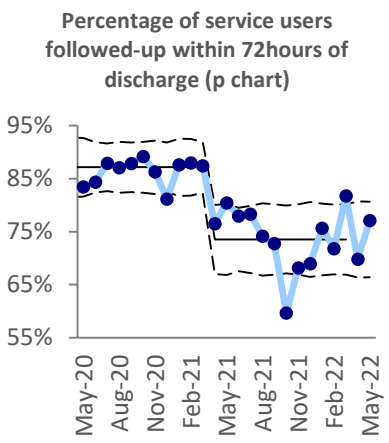
Safety











While the overall number of reported incidents has increased, which reflects a positive reporting culture, the percentage of incidents resulting in harm has returned to normal levels. The Pareto chart above shows the distribution of reported incidents by category during April and May. This highlights that 62% of all reported incidents related to care and treatment, 28% related to violence and aggression and 5% related to slip, trip or fall. The main care and treatment themes were pressure ulcers, moisture associated skin damage self-harm incidents and delay in treatment.

The last few months has shown greater variation in the levels of physical violence on our inpatient units The April increase is thought to be the result of higher acuity and occupancy levels. The majority of these incidents involved a small number of service users and were related to severity of illness and personality clashes that resulted in arguments and altercations. During this time period, some wards also reported higher levels of sickness, which limited capacity for ward-based therapeutic activities. Sickness levels have since improved.

Increased bed occupancy and high acuity levels have also had an effect on the rate of restraints, which has risen in the last two months. Most general acute wards have reported an increase in service users with Emotionally Unstable Personality Disorder (EUPD) and substance abuse, leading to impulsivity and intentional self-harm. There was a slight increase in restraints across our Older Adult wards, which was due to a small number of service users who needed to be restrained to administer medication and a service user with dementia who was extremely agitated upon admission, and required restraint under the Mental Capacity Act to provide personal care.

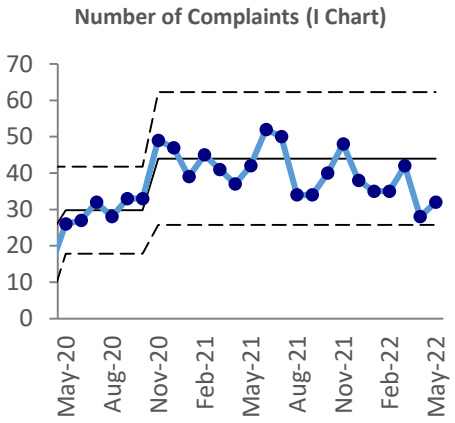
Safety

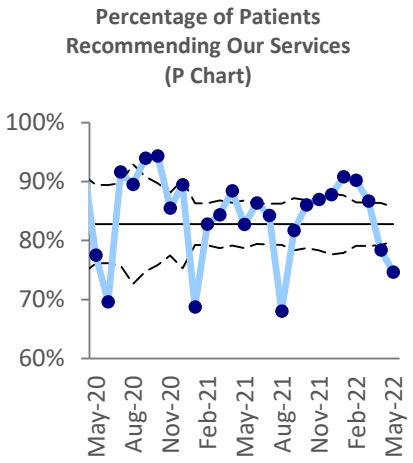
Services continue to use daily safety huddles to proactively identify triggers and prevent issues from escalating. Staff continue to optimise medication in order to manage risks and maintain safety. Wards have reviewed the availability of therapy sessions to help engage service users in meaningful activities to avoid behaviours escalating. Staff are also being supported through regular supervision and debriefs following all incidents to learn and improve practice.

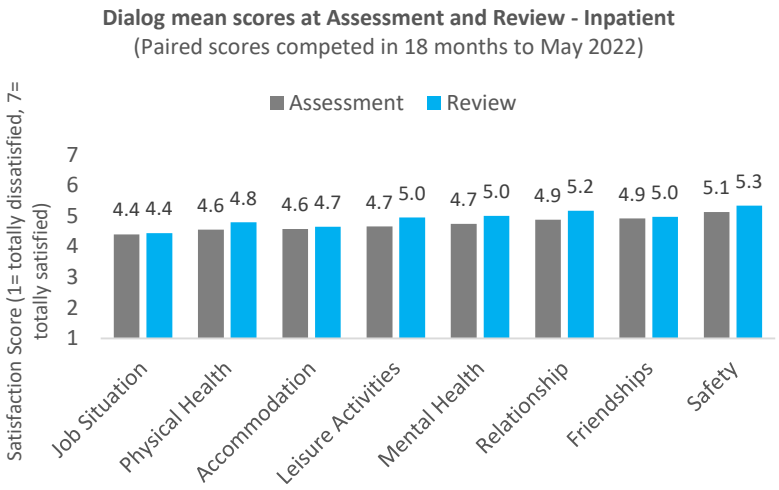
The percentage of service users followed up within 72 hours of discharge is nearing the goal of 80%, but still remains unstable. Improving the reliability of follow-up contacts is discussed regularly in several forums, including daily ward huddles. The local performance teams send out reminders of service users who are awaiting a contact to help coordinate timely follow-up. Some of the 72-hour follow-ups were not successful despite the ward and services reaching out to services users on multiple occasions. Local data quality audits exploring the factors that have contributed to delays is underway in all teams. One factor associated in deteriorating performance has been movement of senior ward staff. Training and awareness sessions have been scheduled with the new team members around the follow-up processes and procedures, and it is anticipated that there will be further improvements in the coming months.

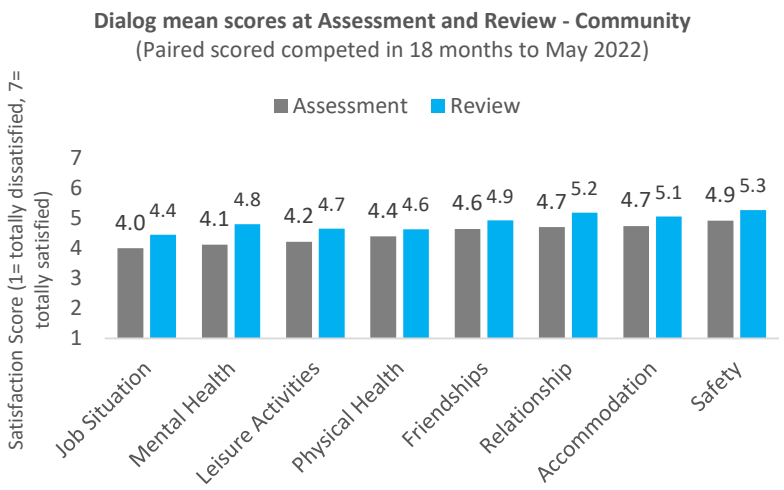
The overall number of pressure ulcers continues to remain stable. This reflects the positive impact of a range of initiatives underway including utilising wound photography applications to monitor wounds, training and awareness sessions to improve the quality of reporting, and audits to share learning routinely across teams. Tower Hamlets saw an increase in moderate harm pressure ulcers for April and May. This is attributed to improved reporting and referral and triage processes following training sessions and additional support offered to the services to monitor standards. Feedback from a root cause analysis audit showed that some service users failed to follow the recommended advice. However, the team continued to offer support to these service users to adhere to the recommendations to prevent further harm.

Experience and Outcomes









The number of complaints is showing signs of potential reduction, with 9 out of the last 10 months seeing numbers below the average of 44 complaints. The top complaint themes remain communication, staff attitude, assessment, access to services, and clinical management. Lessons are routinely shared across various forums to aid in improvement.

Over the last two months, the percentage of service users who would recommend our services has decreased from 87% in March to 75% in May. The overall number of responses has increased from 1008 to 1545 during this period, owing primarily to a campaign across Bedfordshire Primary Care services. However, Bedfordshire Primary Care has also contributed to the overall decline in positive responses, owing to dissatisfaction with waiting times and access to services, availability of face-to-face appointments and delays in calls being answered. Services have developed a plan to address the issues highlighted by service users, including increasing the medical, nursing and administrative workforce to offer more appointments, including face to face appointments, improving triage and screening processes to ensure every call is taken by the right person at the right time, deploying new telephony systems to handle calls more efficiently, and consolidating administrative resources and functions through establishing a new GP Support Unit (GPSU) to serve both practices in Bedfordshire. This will improve cross cover arrangements and enhance support available to teams.

The Dialog outcome charts show the results of paired outcome measures for service users who have received care from both community and inpatient mental health services. For inpatient services, the top three dissatisfaction domains are employment, physical health, and accommodation, whereas, for community services, it is primarily related to employment, mental health, and leisure activities. This is based on paired outcome measures for 2295 outpatient and 443 inpatients. Overall, the data continues to show improvement in average scores between initial assessment and subsequent review for both cohorts of service users across all dissatisfaction domains, although greater across community teams. This might suggest that community services are able to have more of an impact on the quality of life of service users than inpatient services. In the previous report, a summary of notable variations across different directorates, as well as details of initiatives underway to address the dissatisfaction themes, were provided. In this report, further analysis of Dialog scores from an equity perspective is included in the equity section of this report.

Experience and Outcomes

The percentage of service users receiving support from employment services through Individual Placement Support (IPS) remains stable, with a small rise from 10% in March to 14% in May. In addition, there has been a small rise in the percentage of service users in employment across adult mental health services during May.

Across mental health services, the percentage of service users in settled housing has fallen below normal levels. The data has been skewed by incomplete recording of accommodation status, particularly related to new referrals received by services. Where records have been completed, 94% of service users are in settled accommodation. The teams are still cleaning up data and training clinical and administrative staff on how to properly record this information into the patient record system. We anticipate that this will take another 2-3 months to resolve.

The percentage of service users who achieve recovery within our IAPT services has increased above the national 50% target over the past two months, reaching 51% in May. There has been a small improvement in staffing levels which has increased capacity, although recruitment challenges continue to persist, especially in Bedfordshire. Across IAPT services, 91% of service users who completed the Patient Experience Questionnaire responded positively during March. The overall access to IAPT continues to remain high and the percentage of service users from minority ethnic groups accessing IAPT remains stable.

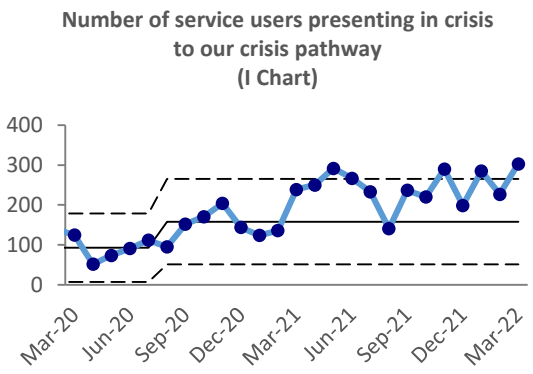
Our frail and long-term conditions indicators show that patient experience has increased from 88% in March to 91% in May. Learning Disability services are showing 100% positive recommendation of the service. CAMHS continues to progress well with capturing paired outcomes for service users, achieving 79% in May.

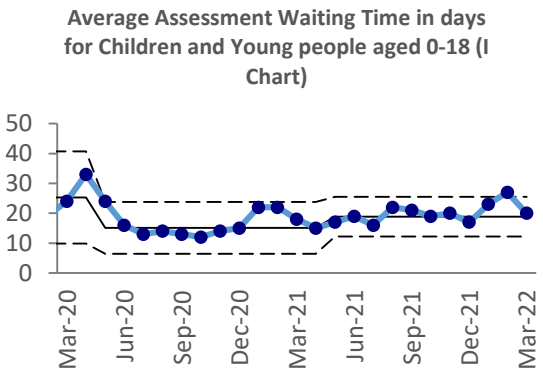
The percentage of service users with an advanced care plan has continued to increase in both Bedfordshire and East London. There has also been a rise in percentage of service users dying in their preferred place. The number of inappropriate referrals to the Intermediate Care Team has continued to reduce further over the last 3 months, which is encouraging. As highlighted previously, this is attributed to the Transfer of Care service, where staff proactively liaise with both Bedford and Luton and Dunstable Hospitals to identify appropriate referrals to expedite discharge from acute hospital wards.

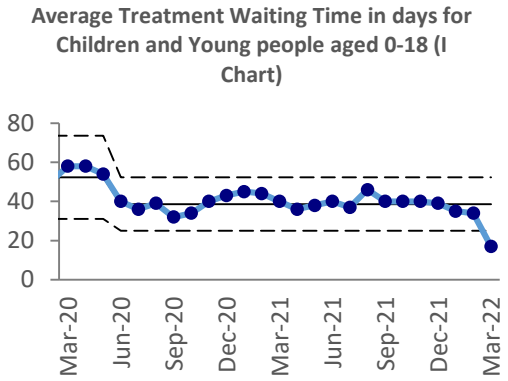
Perinatal Services are successfully capturing outcome measures and are exceeding the national (CQUIN) target of 40%. The services have reported an increase in the percentage of service users accessing the service from minority groups, owing to an improvement in the accuracy of demographic information being captured by new administrative processes. The number of women seen within 28 days and those receiving more than one contact is expected to increase as new staff members who have been recruited join the service. This data does not yet include the Ocean Service (Maternity Mental Health Service) which is provided in conjunction with an acute provider, and this is expected to show an increase in contact activity when this data is included.

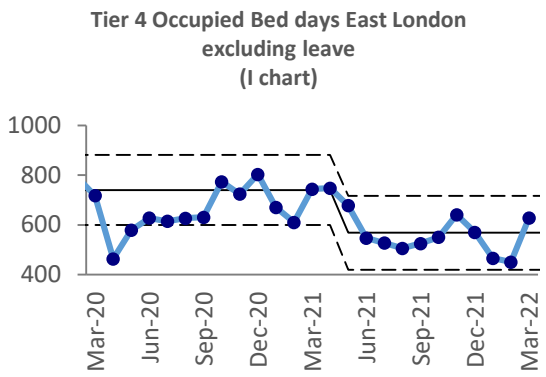
The number of service users with learning disabilities in a specialist placement outside of their borough for assessment and treatment has reduced slightly. All of these placements relate to service users who need specialist locked rehabilitation services, Assessment and Treatment units, or prison stepdown units that are commissioned centrally by NHS England.

Children and Young People









CAMHS continues to see an overall rise in the number of crisis and community referrals across most services. Services describe an increasing number of high-risk cases, which typically take longer to assess due to increased liaison with social care, schools and other partner agencies involved. The teams continue to assess service users in appropriate environments that suit them best with the aim of diverting people from A&E. Acute hospital teams are consistently accommodating in supporting young people with emotional needs. CAMHS continues to have a strong relationship with them and are investing fixed-term staff to help upskill their workforce. The teams have regular crisis huddles in partnership with acute hospital staff across the region to think about Tier 4 capacity and improve flow through the system. This initiative has been supported by developments in admission avoidance services.

In East London, CAMHS crisis services continue to experience significant demand. The team has managed to fully recruit to all vacancies however are continuously monitoring demand and forecasting how much more demand the team can manage. To support this, the teams are accelerating implementation of the Home Treatment Team in Newham, which needs to be in place next year to meet the Long Term Plan expectations.

Within the Eating Disorders service, the team has struggled more with recruitment. Only 50% of the roles have been substantively recruited to, with gaps filled through secondments, agency and locum staff. Additional funding has been provided by the North Central East London (NCEL) collaborative to develop an intensive pathway as an alternative to admission given some concerns about the effectiveness and experience of some service users with eating disorders when they are admitted to Tier 4.

Assessment times have increased while treatment times have decreased across CAMHS. Referrals for all services are higher than pre-pandemic levels. On average, Newham has twice as many young people waiting as the other two boroughs. The crisis service remains on hand to respond but several cases have deteriorated and required inpatient admission. The service continues to signpost service users where clinically appropriate to do so and is working closely with system partners in order to ensure that people's needs are met as soon as possible through the most appropriate service.

Newham CAMHS are currently prioritising their weekly access and flow working groups, adopting concepts and principles from other services and encouraging a shared-learning exercise to test new ideas. New funding is assisting teams in recruiting additional staff to increase capacity and further investment across Newham CAMHS home treatment has been approved for 12 months to strengthen community provision with intensive support teams to provide therapeutic support to young people and their families in their homes, allowing them to manage their illness and avoid admission or return home sooner than would otherwise be possible. Recruitment remains a barrier, with some posts proving difficult to fill. Services are continuing to think creatively in developing new roles.

In Bedfordshire, the teams are developing their GP offer and expanding on their school offer to enable better access to mental health support in the community. This system-working approach hopes to provide timely care to young people beyond the CAMHS system. CAMHS continues to meet national access targets despite the increasing demand.

Specialist Children and Young People Services (SCYPS) continue to see a reduction in their waiting list for the Autistic Spectrum Disorder (ASD) service, and aim to have reduced the waiting list to 400 by January 2023. Further investment has recently been received allowing the service to recruit a neurodevelopment nurse. The team is meeting the required number of appointments offered and the ratio of first/follow-up is improving, based upon children being diagnosed in two appointments. Areas of the pathway where there are delays for service users are due to checks and screening for other conditions, and the team is reviewing data processes to ensure that we are accurately capturing this data.

SCYPS Speech and Language Therapy waiting lists are slowly stabilising. The service continues to prioritise the Parent and Child sessions and will continue to do so for the next couple of months. Recently, Health Visitors have been trained by Public Health England to better identify children early on with possible social communication disorders. Consequently, they are making more referrals following the two-year checks. The service is also applying quality improvement to reduce waiting times from referral to treatment from 19 months to 6 months by January 2023.

The quality and experience indicators for SCYPS continue to highlight that 100% of parents and service users are satisfied with the service. As shown in the population health indicators 55% of children with neuro-disabilities are receiving annual reviews promptly. This indicator comprises of three pathways, all of which have seen improvements in the last 6 months. A review of the pathway with the largest cohort, has commenced.

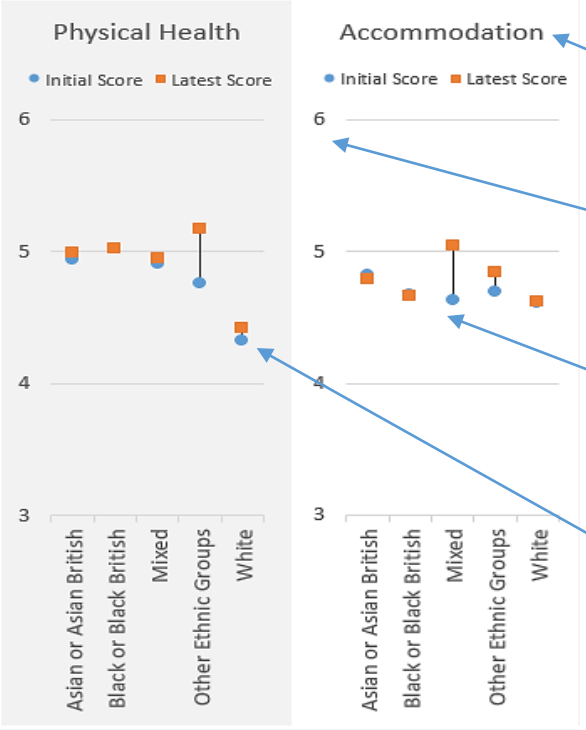
The number of Tier 4 occupied beds has seen an increase in occupancy. Collaborative work across the NCEL provider collaborative has enabled the service to manage this increased demand. The Evergreen Unit in Bedfordshire is set to open in September, and will reduce the number of young people admitted into adult wards.

Equity: Quality of life & Outcomes across inpatient services

The May 2022 performance report included an analysis of waiting times for adult community mental health and CAMHS through an equity lens. The analysis and findings have now been discussed with clinical directors, and shared with directorate management teams. We have also now built new business intelligence reports within PowerBI to allow teams to be able to look at their waiting list through the dimensions of age, gender and deprivation. A number of workshops are being run in the last two weeks of July to engage clinical teams with this new capability and show them how they are now able to view their waiting list through these lenses. Teams may then identify an opportunity to address an inequity that becomes apparent, and utilise support from people participation and quality improvement to understand this better and test out ideas to address. An example of a team that has done this successfully is the Tower Hamlets early intervention service, and the results from their work on improving access to psychology for people from black and minority ethnic communities are included in the quality report.

In this report, we will look at Dialog data for inpatients, helping us understand our quality of life patient-reported outcome measure through an equity lens. For adult inpatient services, we will look at whether certain patient groups report different levels of outcome scores than we might expect. We will look at the 8 quality of life domains in the Dialog outcome tool and review both the initial score and latest score for each patient with two or more scores during their inpatient stay. For this exercise we have considered all inpatient stays with 2 or more scores in the period 1st June 2019 to 31st May 2022.

How will we look at our data to help us answer this question?



The eight quality of life domains are titles at the top of the charts

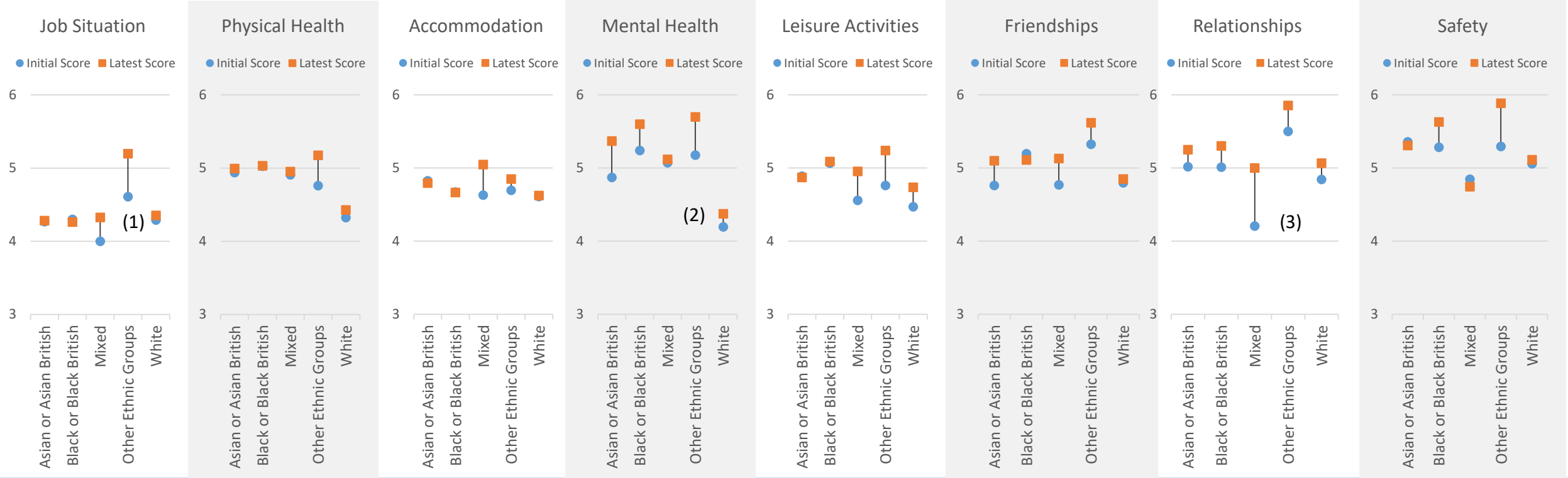
Each of the questions are rated using a Likert scale, with 1-3 representing dissatisfaction, 5-7 representing satisfaction, and 4 being neither satisfied or dissatisfied. The axis has been reduced from the range of 1-7 to better focus on the areas where the average scores lie.

The **blue circle** represents the average score at assessment and the **orange square** the average score at review. When the orange square is above the blue circle it represent as increase in the average satisfaction score from assessment to treatment. When the orange square is below the orange circle it represent as decrease in the average satisfaction score from assessment to treatment.

In this example, looking at the Physical Health domain, the White ethnicity group appears apart from the other ethnic groups with the lowest initial and latest score. The largest improvement in Physical health from initial to latest score can be seen in the Other Ethnic Groups.

Equity: Trustwide inpatient quality of life by ethnicity

Do we see any unusual variation in patient outcome scores by **ethnicity** across the 8 Quality of Life domains questions?
(scores of 1-3 represent dissatisfaction, and 5-7 explicit satisfaction with 4 in the middle)

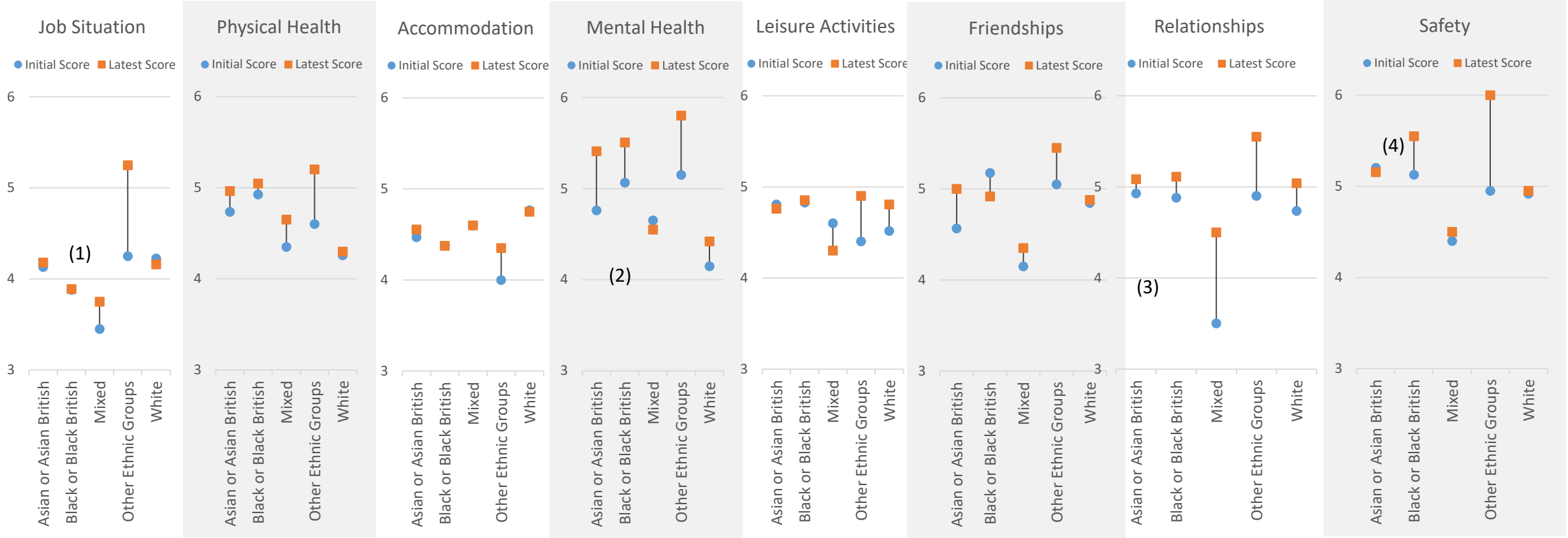


In terms of ethnicity, 44% of the service users in our sample were from White backgrounds, represented by 52 service users in Bedfordshire, 29 in Luton, 44 in City & Hackney, 10 in Newham and 70 in Tower Hamlets. 26% were from Black or Black British backgrounds, represented by 6 service users in Bedfordshire, 3 in Luton, 45 in City & Hackney, 5 in Newham and 59 in Tower Hamlets. 21% were from Asian or Asian British backgrounds, represented by 6 service users in Bedfordshire, 6 service users in Luton, 19 in City & Hackney, 8 in Newham and 56 in Tower Hamlets. 5% were from Mixed backgrounds, represented by 1 service users in Bedfordshire, 2 in Luton, 9 in City & Hackney, 1 in Newham and 10 in Tower Hamlets. Finally, 4% of service users were from Other Ethnic Groups, represented by 7 service users from City and Hackney, and 13 from Tower Hamlets. However, mixed and other ethnic groups can vary in their composition across different boroughs and may not necessarily be directly comparable or identical in different parts of the Trust.

(1) In Job Situation, highest satisfaction is found in the other ethnic groups, which also sees the biggest improvement in score.
(2) In Mental Health, the White ethnic group have the lowest satisfaction at both initial and latest score. The White and Mixed ethnic groups have a much lower improvement in score when compared to the Asian and Black groups.
(3) In Relationships, the Mixed ethnic group have the lowest initial satisfaction but also the highest improvement in score. Mixed group is made up from White & Black Caribbean, White & Black African, Mixed - White & Asian, Any other mixed background

Equity: London inpatient quality of life by ethnicity

Do we see any unusual variation in patient outcome scores by **ethnicity** across the 8 Quality of Life domains questions?
(scores of 1-3 represent dissatisfaction, and 5-7 explicit satisfaction with 4 in the middle)

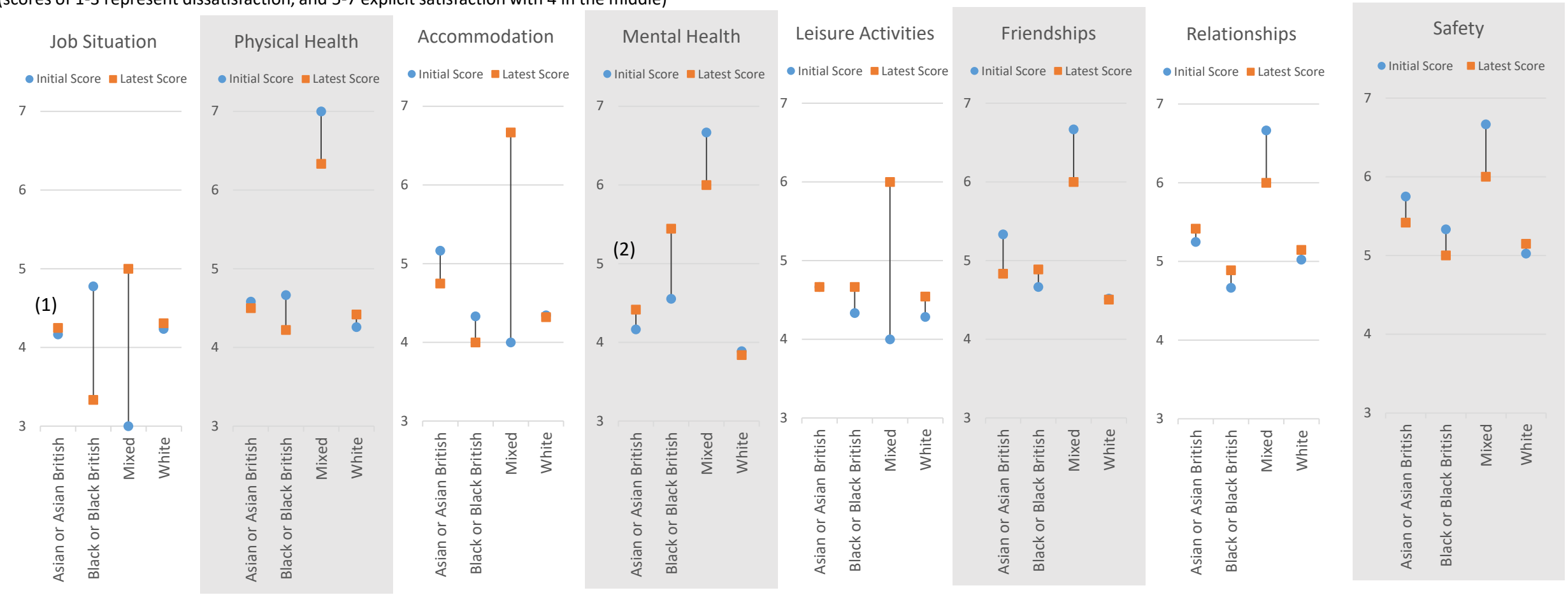


Sample sizes by ethnicity: White = 124, Black of Black British = 109, Asian or Asian British = 83, Mixed = 20, Other Ethnic Groups = 20

(1) In Job Situation, highest job satisfaction was found in other ethnic groups, which also saw the biggest improvement.
(2) In mental health, those from mixed ethnic groups were the only group that saw a decrease in their score.
(3) In relationships, those from mixed ethnic groups had the lowest initial score, but also saw the biggest improvement.
(4) In safety, those in other ethnic groups saw the biggest improvement in score

Equity: Bedfordshire & Luton inpatient quality of life by ethnicity

Do we see any unusual variation in patient outcome scores by **ethnicity** across the 8 Quality of Life domains questions?
(scores of 1-3 represent dissatisfaction, and 5-7 explicit satisfaction with 4 in the middle)



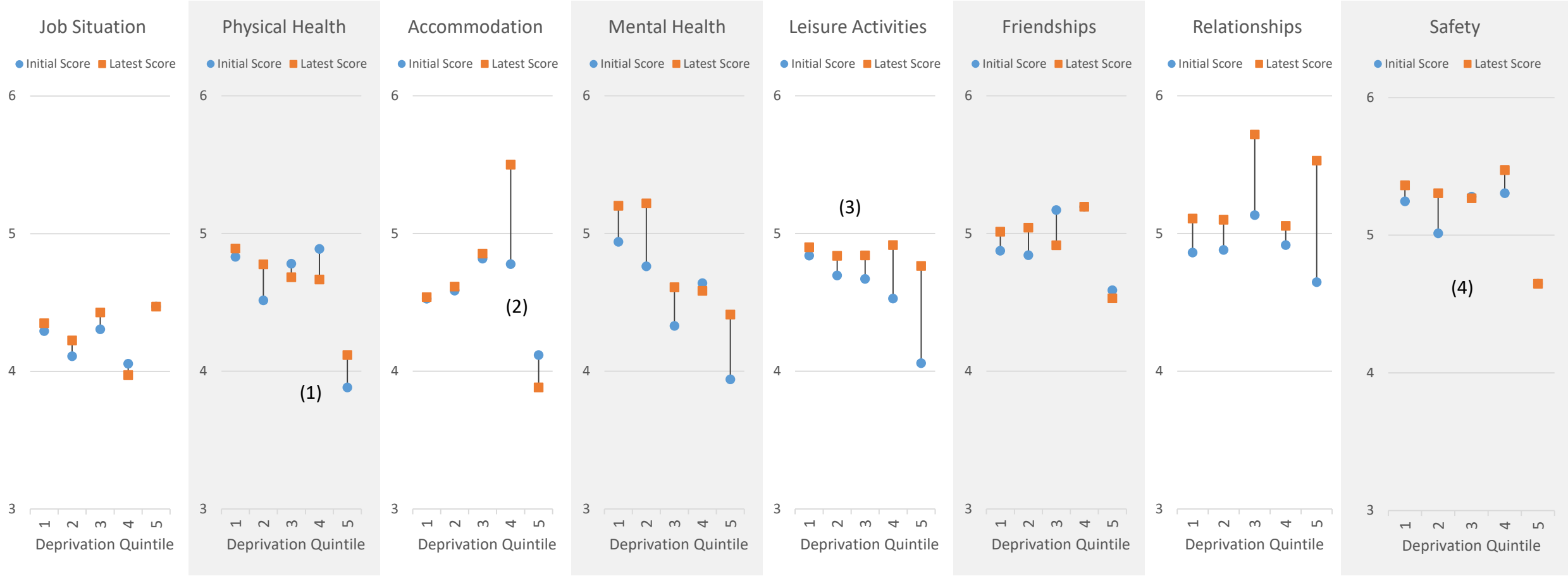
Sample sizes by ethnicity: White = 81, Black of Black British = 9, Asian or Asian British = 12, Mixed = 3

(1) In job situation, those from black or black British backgrounds were the only group that saw a deterioration in their score.
(2) In mental health, those from black or black British backgrounds saw the biggest improvement in score
Please note the mixed ethnicity group contains a small sample size (< 5)

Equity: Trustwide inpatient quality of life by deprivation quintile

Do we see any unusual variation in patient outcome scores by **deprivation quintile** across the 8 life domains questions?

(scores of 1-3 represent dissatisfaction, and 5-7 explicit satisfaction with 4 in the middle) (deprivation quintile 1 = most deprived areas, deprivation quintile 5 = least deprived areas)

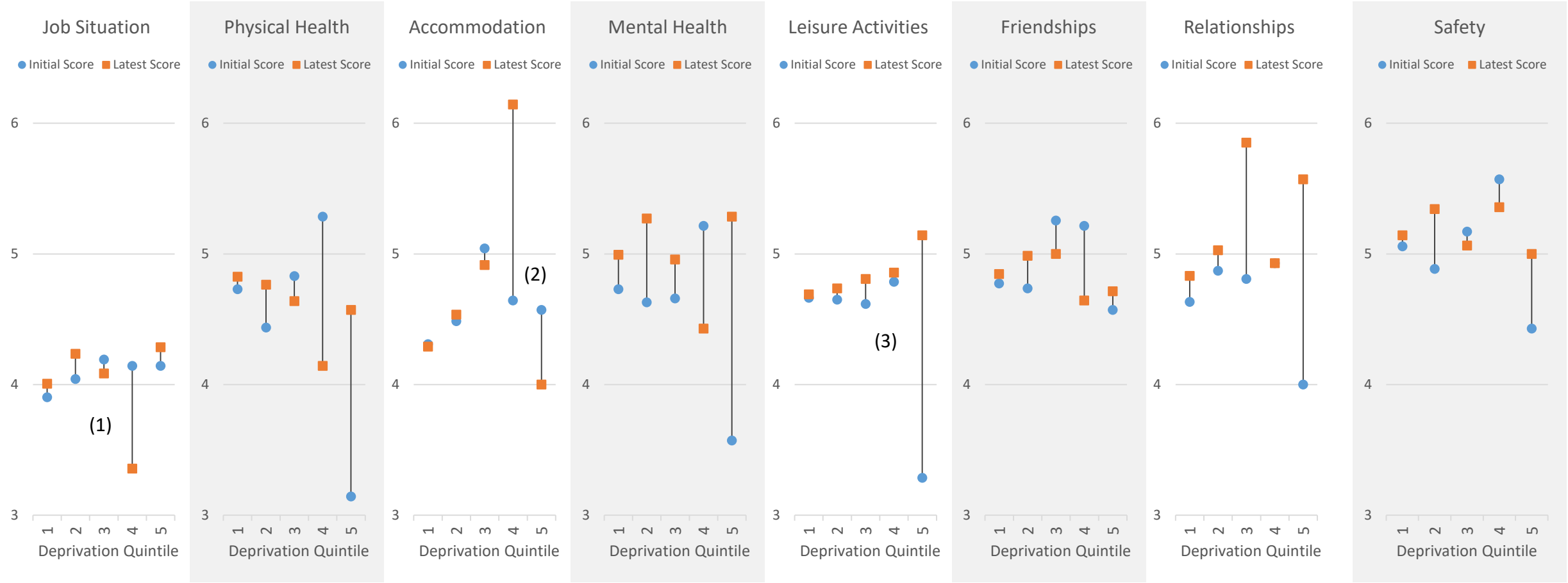


Sample size by quintile (Q): Q1 = 312, Q2 =210, Q3 = 82, Q4= 36, Q5 =17

(1) In physical health, although those living in the least deprived areas saw an improvement, their score remains the lowest of all quintiles.
(2) In accommodation, those living in deprivation quintile 4 saw the biggest improvement in their score, while those living in quintile 5 saw a decrease in their score.
(3) In leisure activities, the latest scores for all quintiles were more consistent with each other than initial scores.
(4) In safety, those living in the least deprived areas had the lowest score and saw no improvement.

Equity: London inpatient quality of life by deprivation quintile

Do we see any unusual variation in patient outcome scores by **deprivation quintile** across the 8 Quality of Life domains questions?
(scores of 1-3 represent dissatisfaction, and 5-7 explicit satisfaction with 4 in the middle) (deprivation quintile 1 = most deprived areas, deprivation quintile 5 = least deprived areas)



Sample size by quintile (Q): Q1 = 155, Q2 =140, Q3 = 47, Q4= 14, Q5 =7

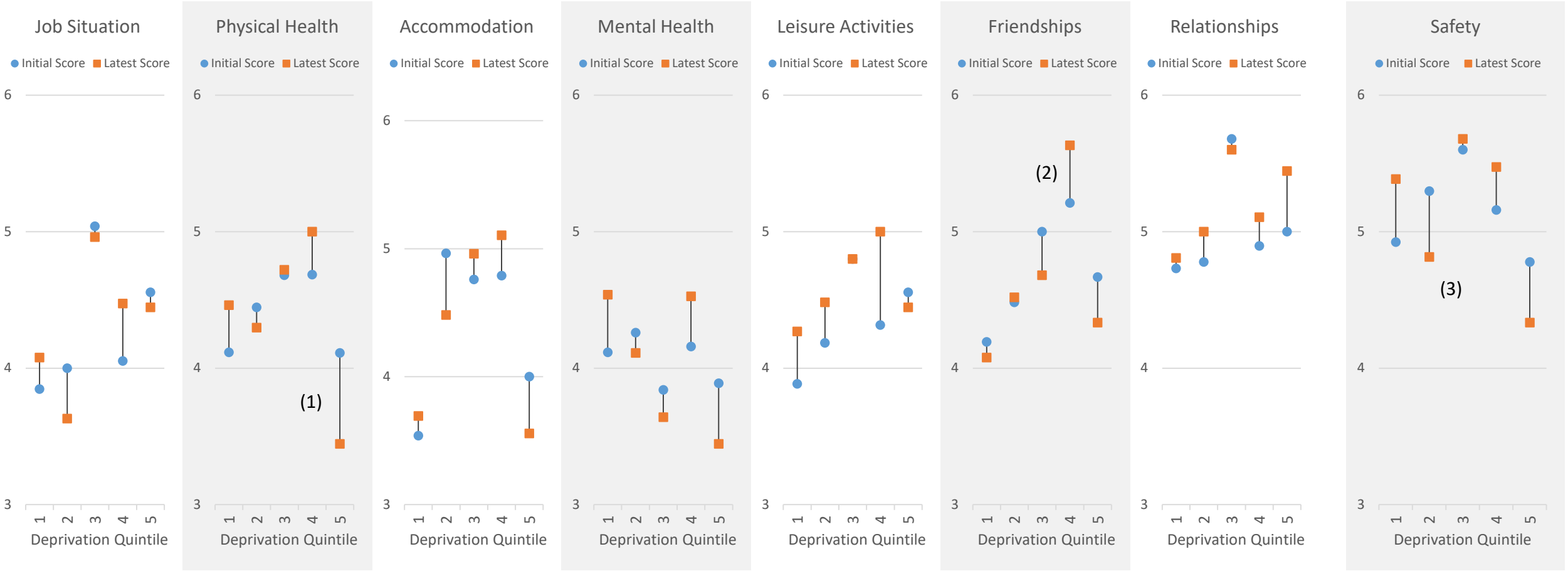
(1) In job situation, job satisfaction decreased for those living in deprivation quintile 4.

(2) In accommodation, those living in deprivation quintile 4 saw the biggest improvement in their score, while those living in quintile 5 saw a decrease in their score

(3) In leisure activities, those living in the least deprived areas saw the biggest improvement in their score.

Equity: Bedfordshire and Luton inpatient quality of life by deprivation quintile

Do we see any unusual variation in patient outcome scores by **deprivation quintile** across the 8 Quality of Life domains questions?
(scores of 1-3 represent dissatisfaction, and 5-7 explicit satisfaction with 4 in the middle) (deprivation quintile 1 = most deprived areas, deprivation quintile 5 = least deprived areas)



Sample size by quintile (Q): Q1 = 26, Q2 =27, Q3 = 25, Q4= 19, Q5 =9

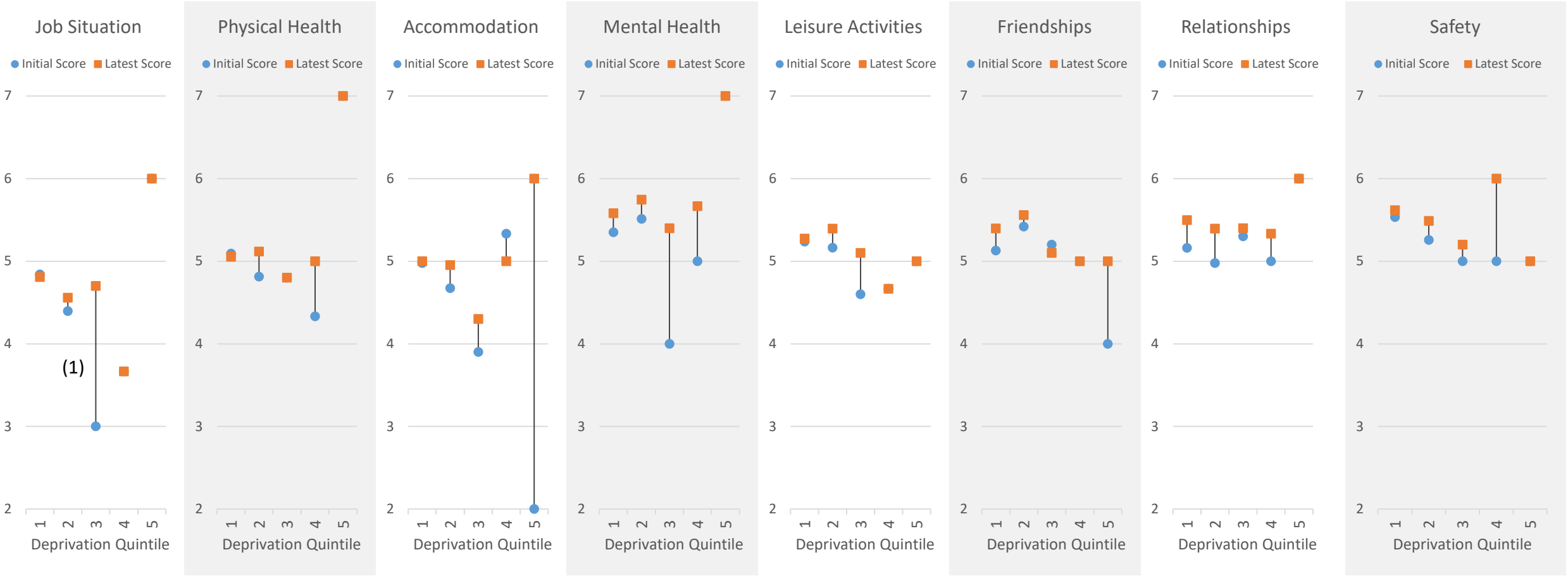
(1) In physical health, those living in the least deprived areas saw a deterioration in their score.

(2) In friendships, those living in deprivation quintile 4 had the highest score and saw the biggest improvement.

(3) In safety, those living in the least deprived areas felt the least safe and saw a deterioration in score.

Equity: Forensic inpatient quality of life by deprivation quintile

Do we see any unusual variation in patient outcome scores by **deprivation quintile** across the 8 Quality of Life domains questions?
(scores of 1-3 represent dissatisfaction, and 5-7 explicit satisfaction with 4 in the middle) (deprivation quintile 1 = most deprived areas, deprivation quintile 5 = least deprived areas)



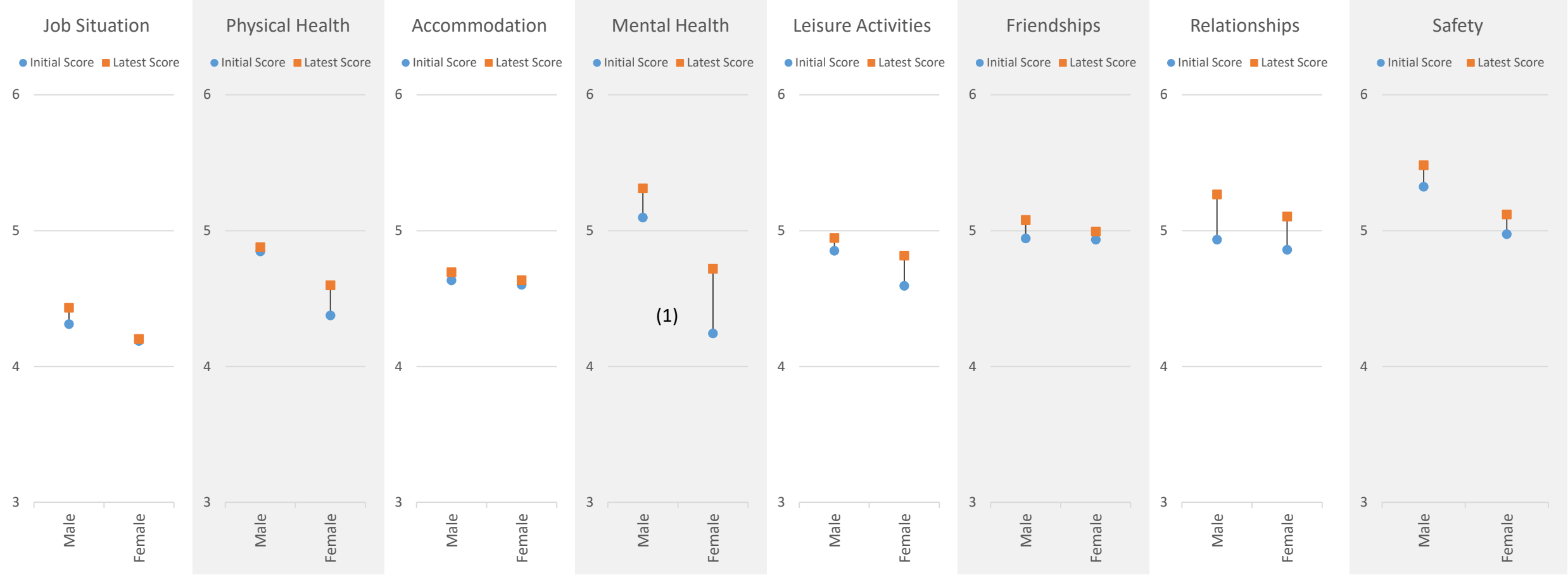
Sample size by quintile (Q): Q1 = 131, Q2 =43, Q3 = 10, Q4= 3, Q5 =1

(1) In job situation, those living in deprivation quintile 3 saw the biggest improvement in satisfaction.

Please note small sample sizes for deprivation quintile 4 and 5 (< 5)

Equity: Trustwide inpatient quality of life by gender

Do we see any unusual variation in patient outcome scores by **gender** across the 8 Quality of Life domains questions?
(scores of 1-3 represent dissatisfaction, and 5-7 explicit satisfaction with 4 in the middle)



Sample sizes: Male = 418, Female = 271

(1) In mental health, females had a lower initial and later score, but saw a bigger improvement than males.

In terms of gender, 46% of service users in our sample were male, represented by 19 service users in Bedfordshire, 31 in Luton, 58 in City and Hackney, 4 in Newham and 109 in Tower Hamlets. 54% of service users in our sample were female, represented by 47 service users in Bedfordshire, 10 in Luton, 71 in City and Hackney, 22 in Newham and 114 in Tower Hamlets.

Equity: London inpatient quality of life by gender

Do we see any unusual variation in patient outcome scores by **gender** across the 8 Quality of Life domains questions?
(scores of 1-3 represent dissatisfaction, and 5-7 explicit satisfaction with 4 in the middle)

Sample sizes: Male = 171, Female = 207

(1) In mental health, females had a lower initial and later score, but saw a bigger improvement than males.

Equity: Bedfordshire and Luton inpatient quality of life by gender

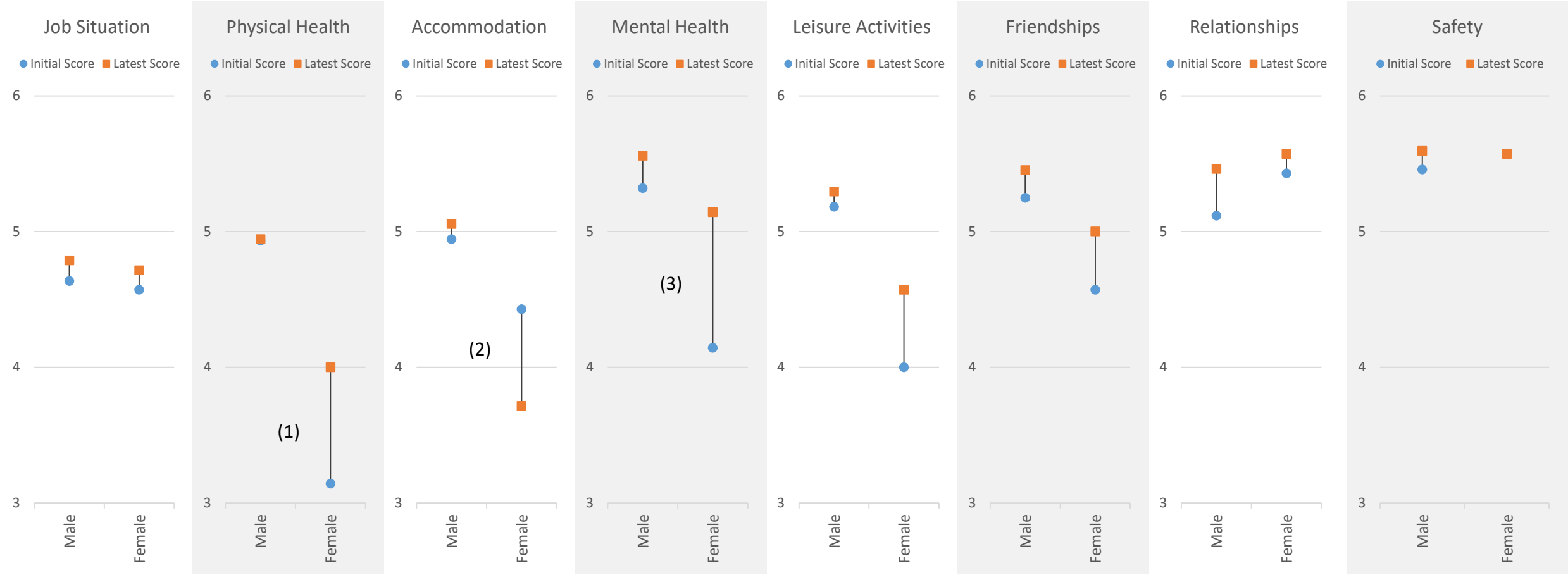
Do we see any unusual variation in patient outcome scores by **gender** across the 8 Quality of Life domains questions?
(scores of 1-3 represent dissatisfaction, and 5-7 explicit satisfaction with 4 in the middle)

Sample sizes: Male = 50, Female = 57

(1) In relationships, males had a lower initial score but also saw greater improvement in comparison with females
(2) Across relationships and leisure activities, males had lower initial and subsequent scores compared to females

Equity: Forensic inpatient quality of life by gender

Do we see any unusual variation in patient outcome scores by **gender** across the 8 Quality of Life domains questions?
(scores of 1-3 represent dissatisfaction, and 5-7 explicit satisfaction with 4 in the middle)



Sample sizes: Male = 197, Female = 7

Females have lower quality of life compared to men across 6 of the quality of life domains. There is improvement in 5 domains but a deterioration in satisfaction with accommodation.
In physical health, females saw the biggest improvement but still scored lower than males.
(1) In accommodation, females saw a deterioration in their score.
(2) In mental health, females saw the biggest improvement but still scored lower than males

Equity: What might this mean?

The equity analysis shows some interesting variations in quality of life scores by ethnicity, gender, and deprivation quartile across inpatient mental health services. However, it is important to recognise that there are some limitations with the dataset in terms of its size and representativeness. We should exercise caution when drawing conclusions about the effectiveness of one service over another, as the Dialog tool was not designed for that. For many inpatient services, Dialog is still relatively new and sample size varies considerably as wards continue to embed Dialog+ assessments and philosophy across all male and female wards in the Trust. There may be variation in the way Dialog assessments are completed by clinicians which might also impact scores. It is also worth noting, the task of a health organisation is not to achieve the same outcome for everyone. The task is to achieve the best possible outcome for everyone, which may vary among groups according to their specific needs and among individuals in those groups.

There are four key themes that seem to emerge from the data. Firstly, service users from a White ethnic background in both London and Bedfordshire & Luton had the lowest satisfaction with their mental health compared to service users from other ethnic backgrounds. The White and Mixed ethnic groups also see less improvement in their score compared to the Asian and Black groups. On the one hand this might suggest that the Trust is offering services in a more culturally sensitive way for some Black, Asian and Minority Ethnic (BAME) groups. The evidence base suggests that BAME groups are generally less satisfied with services, however, this appears not to be the case in the Trust, which is encouraging and positive. On the other hand, the data might imply that some white and mixed ethnic groups are doing less well than others, or that expectations vary between groups and that the expectations of white and mixed ethnic groups are not being met to the same extent. There may be cultural factors related to the social stigma associated with declaring mental health issues which might influence the scores between different groups. We know that certain geographies, such as Central Bedfordshire, have a predominantly white population, with limited transport infrastructure contributing to difficulties accessing services.

Interestingly, the baseline satisfaction of almost all ethnic groups was in the 4-5 range across most domains, including mental health. This seems unusual at the point of admission. Some ethnic groups may not perceive that they have a mental health issue, but may feel that their primary distress is related to socio-economic factors such as employment or accommodation rather than mental health. However, this baseline score might also indicate that there is a disparity between the service user perceptions of their needs, and their actual clinical presentation that necessitated admission.

The White ethnic group has the lowest physical health score and overall improvement in this domain. This might be explained by differences in GP attendance between different ethnic groups. It might be that the white ethnic group in our sample is more frequently engaged with their local GP and therefore does not need as much support. It may also be related to lower friendship scores when compared to other ethnic groups, which may indicate a lack of social capital, being more isolated and lonely, and not having as many motivating factors to encourage participation in physical activity. There is significant work underway in our Community Mental Health Teams and Primary Care Networks to focus on physical health and leisure opportunities in order to engage service users in meaningful activities such as joining cycle clubs, walking clubs, and other sports. Within Bedfordshire and Luton, teams are working closely with peer support workers, people participation and the voluntary sector to engage local citizens, understand needs and assets, and develop a range of physical health interventions.

Equity: What might this mean?

It should be noted that across Forensic services, the vast majority of service users are from Black and Mixed minority groups with very small numbers from white ethnic groups. The Forensic Black and Mixed minority group had some of the highest scores across the Trust, with better satisfaction scores across most quality of life measures. The main dissatisfaction theme related to employment opportunities and relationships. This is consistent with feedback from service users in local people participation forums and workshops, which have highlighted their desire for services to assist in maintaining positive relationships with family members and staff, to support their recovery journey. Most service users in forensics have previous been in prison, high security or medium security. The environment they arrive in at ELFT is very different, with greater access to activities, contact opportunities with family members and opportunities to develop life skills. This may explain why scores tend to be high, and overall improvement during the admission is lower.

Secondly, service users living in deprivation quintile 4 (the second least deprived areas) in London services saw a decline or no improvement in their job situation, physical health, mental health, friendships, relationships and safety. While the number is small (14 service users), the data suggests that this group of service users was among the more vulnerable groups, particularly in inner-city areas such as East London. One explanation might be that service users from more affluent areas have higher expectations and standards compared to those from more deprived areas. The vast majority of service users in this group in East London were from the Docklands, with smaller numbers living out of East London in areas such as Tooting, Wandsworth, Putney and Rainham. Anecdotal feedback from services has highlighted an increase in new presentations particularly from transient populations who have migrated to the country for employment purposes, who are well educated, and living in private rented accommodation. They do not have recourse to public funds, social capital, or well established networks to support them during periods of employment uncertainties or redundancy which in some stances has impacted on relationships and caused mental health problems. These factors have left this group particularly vulnerable during the pandemic. Local services also indicate that general anxiety disorders have become prevalent in this population, with more service users presenting with anxiety, low mood, low motivation and sleep deprivation. However, these service users are highly functional, with demanding careers and lifestyles, but often their subjective perceptions of distress tend to diverge from the objective assessment of outcomes. Service users who live outside of our catchment area may have been admitted to our inpatient beds temporarily, but are not usually living in our communities or accessing our community services. It is therefore important to recognise that their scores may differ because services will have less influence and control over their holistic needs and care provision.

The Docklands was a pioneer site for the Community Mental Health Transformation programme in Tower Hamlets. A new workforce and redesigned care pathways centred around neighbourhoods are now in operation. Health Care Assistants have been successfully recruited to perform physical health checks and are integrating these with weight loss, smoking cessation, and diet advice and support. New Mental Health practitioners are also in place and are offering a variety of social prescribing interventions to support this population.

Thirdly, service users living in deprivation quintile 5 (least deprived) in Bedfordshire & Luton saw a decline or no improvement in their job situation, physical health, accommodation, mental health, leisure activities, friendships and safety. While the numbers are small (9 service users), the factors might be similar for this group of services users as highlighted above. However, teams have reported that service users in this group are likely to have their own homes, are well educated, and likely to have fallen into financial or relationship difficulties during the pandemic which has resulted in mental heath issues. As they have more to lose, potentially higher expectations and less of a safety net compared to those in more deprived groups that have recourse to public funds, the impact can be more pronounced for this group of service users.

Equity: What might this mean?

Fourthly, when looking at difference in quality of life scores by gender, women treated in both London and Bedfordshire and Luton saw lower satisfaction for their mental health in both their initial and later scores compared to other domains, although they did see an improvement in scores. Bedfordshire and Luton also saw a small reduction in friendships and relationships scores, which might be related to the impact of reduced social interactions, family visits and other infection control restrictions initiated during the pandemic on the wards.

In exploring theories about why this might be the case, other contributory factors might be related to particular diagnoses and how this might impact they way service users perceive and report mental distress. According to national research, the incidence of schizophrenia is higher in men, who frequently attribute subjective distress to non-mental health factors. Complex emotional needs and personality disorders, on the other hand, are more common in women, who frequently attribute subjective distress to mental health concerns. Furthermore, national research suggests that men and women have different tolerance levels for mental health distress, with men feeling less comfortable expressing their struggles than women. Some services have anecdotally reported larger cohorts of service users with Emotionally Unstable Personality Disorder (EUPD), particularly in Bedfordshire and Luton, who are white females. This group often exhibits self-harm, violence and aggression, and erratic behaviour. As a result, the profile of mental health scores may differ because of the prevalence of different types of mental illness between male and females. A clinical pathway has been developed for service users with complex emotional needs, personality disorders and eating disorders. This will offer a range of community support, including trauma-orientated, structured long-term therapy, with the goal of prevention, early intervention and support in order to avoid crisis and inpatient admission. All staff are also being trained in trauma-informed care.

In Forensic services, the size of the female population is small and the care pathway is limited to one rehabilitation ward environment, compared to a variety of ward environments and care pathways for male service users. The improvement in mental heath scores was relatively greater than males. This suggests that, overall, most female service users have seen scores remain the same or improve across most of the quality of life measures including physical health, which is something the Trust has been committed to improving. The greatest areas of female dissatisfaction related to accommodation, employment, physical health and leisure activities, although scores for all these domains have shown improvement overall. For many inpatients, the main social interactions are with other service users and this is encouraged through weekly User Involvement Groups. Further improvements are also being made to the availability of physical health and leisure activities offer on the site. Paid employment opportunities are also being developed through partnership working with local charities. In terms of inpatient accommodation, there is a programme of estates work which includes adding additional communal bathrooms to our acute wards. As part of our Pursuing Equity programme, there is now a new quality improvement project focused on improving equity of access to physical activities for women at the John Howard Centre in the forensic service.

Appendices

Appendix 1 – System performance dashboard

Appendix 2 – Regulatory compliance against the system oversight framework

Appendix 1: System Performance dashboard - overview

Special cause variation (⇧ ⇩) and when it's of potential concern (⇧ ⇩)

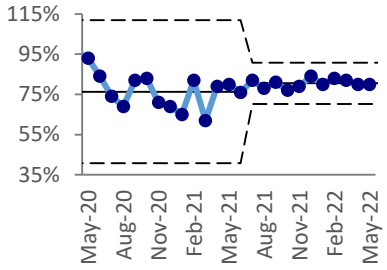
		Average	
People with substance misuse problems			
Service users reporting improvements in quality of life on discharge in Bedfordshire	Population Health	81%	
Service users in employment on discharge in Bedfordshire	Population Health	47.3%	⇧
Percentage of successful completions not re-presenting to service in Bedfordshire	Quality	32%	
Waiting times to treatment - average days wait in Bedfordshire	Quality	5.3	
Percentage of service users with drug problems across Mental Health services	Quality	15.3%	
Percentage of service users with Alcohol problems across Mental Health services	Quality	2.2%	
Children with complex mental health needs			
Service users presenting in crisis to our crisis pathway (monthly)	Population Health	247.4	⇧
Average Assessment Waiting Time (days) for Children and Young people aged 0-18	Population Health	18.9	⇧
Average Treatment Waiting Time (days) for children and young people aged 0-18	Population Health	46.5	
Carers and service users recommending our Community services	Quality	94.7%	
Children and young people aged 0-18 who have received one or more contacts (caseload)	Quality	5841	⇧
Admissions to adult facilities for services users under 18 years old (monthly)	Quality	3.1	
Tier 4 Occupied Bed days East London excluding leave (in month)	Value	568.4	⇧
Percentage of service users has paired Outcome Measures at discharge	Quality	76%	⇧
Average waiting time (days) for urgent referrals to CYP Eating Disorders services	Population Health	3.3	
Average waiting time (days) for routine referrals to CYP Eating Disorders services	Population Health	19.5	
Dementia			
Average wait (in weeks) from referral to diagnosis -18 week target	Quality	17.4	
Percentage of service users offered on-going post diagnostic support - 6 months after diagnosis	Population Health	95.5%	⇩
Dementia Diagnosis Rate	Quality	7.9%	
Average waiting time (in days) from referral to assessment	Population Health	142.5	
Percentage satisfaction with service, service users and carers	Quality	91.3%	
Children with complex health needs			
Percentage with complex neuro disability receiving a clinical review within past 12 months	Population Health	48.9%	⇧
Percentage of service users and parents satisfied with services – Friends and Family Test	Quality	98.4%	
Average weeks waited from Autism Spectrum Disorder referral to first appointment	Quality	108.5	⇩
Children receiving ASD diagnosis within 2 or less appointments	Value	75.5%	
People receiving end of life care			
Service users on End of Life Pathway (end of month)	Population Health	1,392	
Service Users referred to Continuing Healthcare as a fast track in month	Population Health	56.6	⇩
Percentage of service users with Care Plan in place (advanced) in East London	Quality	76.3%	⇧
Percentage of service users with Care Plan in place (advanced) in Bedfordshire	Quality	90.4%	
Percentage of service users who died in their preferred place of death	Value	73.8%	
People who are frail or who have multiple long term conditions			
Percentage of service users who have recorded a positive experience	Quality	98.6%	⇩
Rapid Response seen within 2 hour guideline (East London)	Quality	94%	
Number of Grade 2, 3 or 4 pressure ulcers (monthly)	Quality	83.3	
Promoting independent living - discharged within 6 wks. Bedfordshire	Quality	90%	
Percentage of inappropriate referrals into Intermediate Care - Bedfordshire	Value	12.5%	⇩

		Average	
People with common mental health problems			
Percentage of service users moving into recovery	Population Health	51.9%	⇩
Percentage access by minority groups	Population Health	35.7%	
Percentage of positive comments to PEQ	Quality/Experience	91.5%	
Average wait times to treatment (in weeks) from assessment	Quality/Experience	8.22	⇧
Average wait times to (in weeks) to assessment	Quality/Experience	0.9	
Number of people accessing IAPT services (in month)	Value	2,993	
People with a learning disability			
Average waiting times for new referrals seen (in weeks) for assessment	Population Health	7.5	
Percentage of service users that would recommend this service	Quality	91.9%	
Occupied bed days used in month by service with Learning Disability (Monthly)	Quality	210.9	
Number of specialist out of area inpatient placements (Monthly)	Value	1.9	
People with Severe Mental Illness			
Percentage of service users receiving Individual Placement Support – IPS	Population Health	12.4%	
Percentage of service users in employment	Population Health	6.3%	
Service users receiving NICE concordant care within 2 wks of referral (EIS services – face to face)	Population Health	68.7%	
Percentage of service users in settled accommodation	Population Health	45.6%	⇩
Percentage of service users followed-up within 72hours of discharge	Quality	74.7%	
Percentage of Inpatient service users with paired outcome measures showing improvement.	Quality	28.3%	
Psychological Therapy Service average wait times to (in weeks) to 1st assessment in East London	Quality	7.9	
Psychological Therapy Service average wait times to (in weeks) to treatment in East London	Quality	17.5	
Number of restraints reported per occupied 1,000 bed days (monthly)	Quality	19.7	⇧
Rate of physical violence incidents per occupied 1,000 bed days (monthly)	Quality	15.6	
Bed occupancy	Value	88.4%	⇧
Woman who are pregnant or new mothers			
Number of women receiving one + contact with specialist mental health services	Population Health	633	⇩
Number of service users seen in the month from minority communities	Population Health	41.3%	
Percentage of community perinatal service users seen within 28 days	Quality	86%	⇩
Percentage of patients undertaking Core10 showing improvement	Quality	54%	
Percentage of Service Users not attending their initial appointment	Value	18%	
Stable Long Term Conditions (East London)			
Average weeks waited for initial appointment with the foot health team		4.4	
Average weeks waited for face to face appointment with the Diabetes Service		19.2	
Average weeks waited for initial appointment with the MSK and Physiotherapy teams		7.7	⇧
Average weeks waited for initial appointment with the Continence Service		6	
Stable Long Term Conditions (Bedfordshire)			
Percentage of referral to treatment times within 11 weeks with the Continence Service		50%	⇩
Percentage of referral to treatment times within 11 weeks with the Speech and language therapy		75%	⇧
Percentage of referral to treatment times within 11 weeks with the Wheelchair Service		50.5%	
Percentage of referral to treatment times within 11 weeks with the podiatry team		66%	⇧
Percentage of referral to treatment times within 11 weeks with Physio		94.9%	⇩

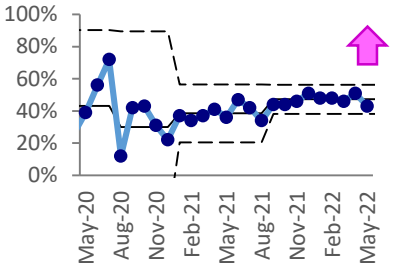
Appendix 1: System Performance dashboard Long Term Plan ( ) Special cause variation ( ) and when it's of potential concern ( )

People with substance misuse problems

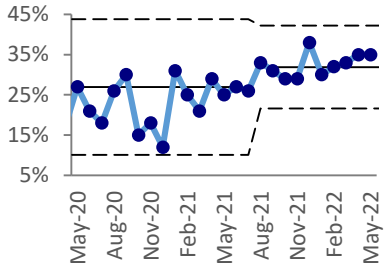
Reporting improvements in quality of life on discharge in Bedfordshire (I Chart)
Population Health



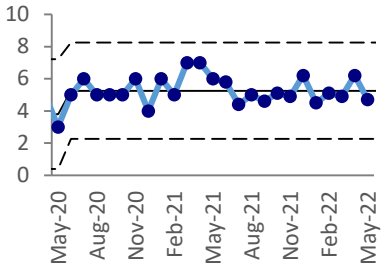
Service users in employment on discharge in Bedfordshire (I Chart)
Population Health



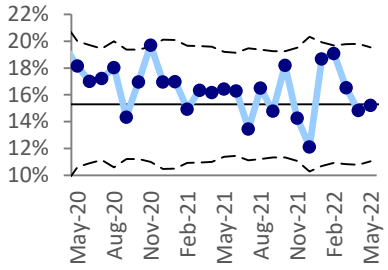
Successful completions not re-presenting to service in Bedfordshire (I Chart)
Quality



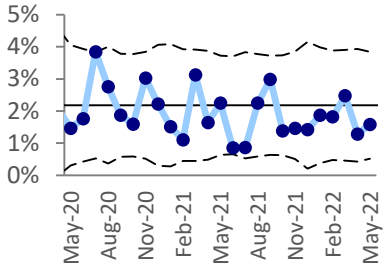
Average waiting time (days) to treatment in Bedfordshire (I Chart)
Quality



Service users with drug problems across Mental Health services (P Chart)
Quality

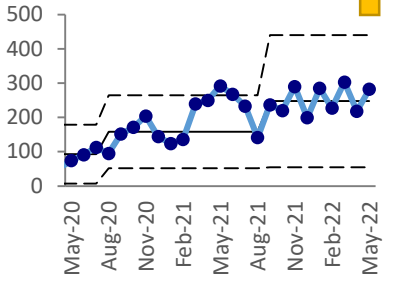


Service users with Alcohol problems across Mental Health services (P Chart)
Quality

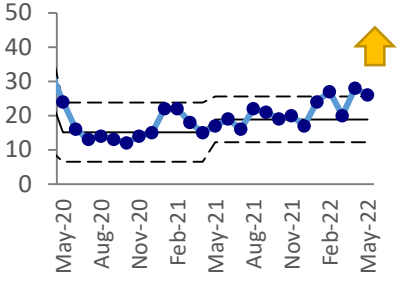


Children with complex mental health needs

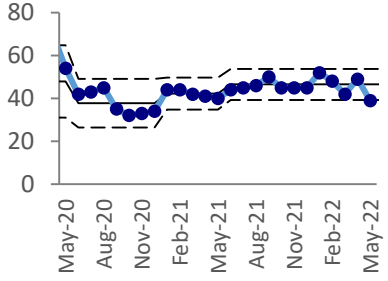
Number of service users presenting in crisis to our crisis pathway (I Chart)
Population Health



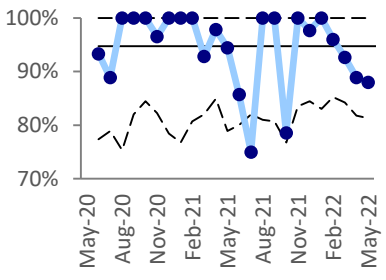
Average Assessment Waiting Time for Children and Young people aged 0-18 (I Chart) Population Health



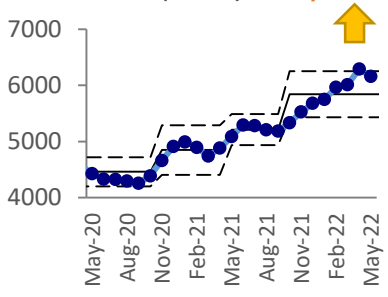
Average Treatment Waiting Time (Days) for Children and Young people aged 0-18 (I Chart) Population Health



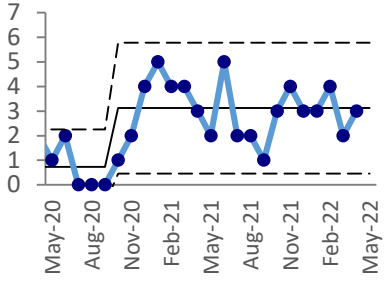
Carers and service users recommending our Community services (P chart)
Population Health



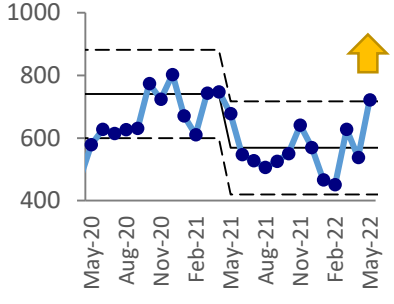
Children and young people who have received one or more contacts with mental health services (I Chart) Quality



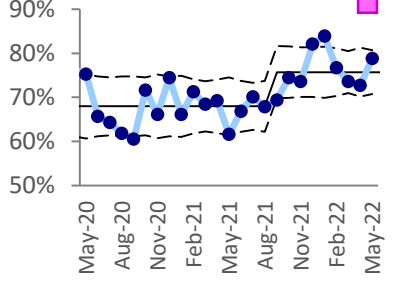
Admissions to adult facilities for services users under 18 years old
Quality



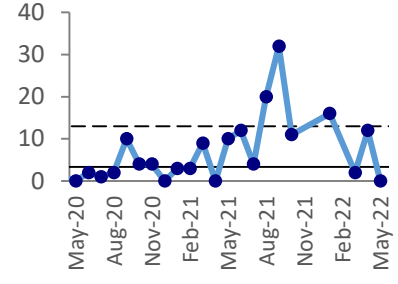
Tier 4 Occupied Bed days East London excluding leave (I chart)
Value



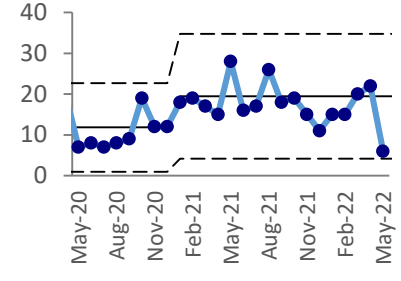
Percentage of service users that have paired Outcome Measures at discharge (P chart)
Quality



Average waiting time (days) for urgent referrals to CYP Eating Disorders services (I Chart)
Population Health (LTP)



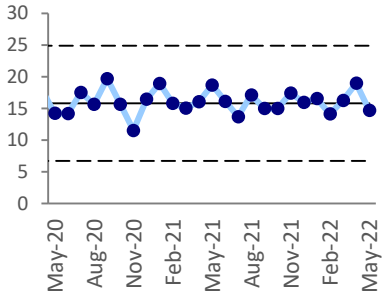
Average waiting time (days) for routine referrals to CYP Eating Disorders services Population Health (LTP)



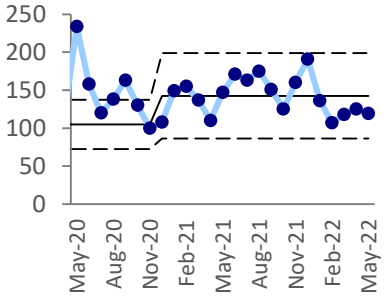
Appendix 1: System Performance dashboard Long Term Plan ( ) Special cause variation ( ) and when it's of potential concern ( )

People with dementia

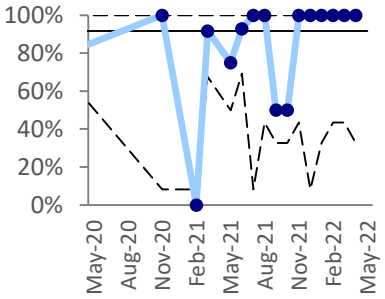
Average wait (in weeks) from referral to diagnosis (I chart) Quality



Average waiting time (in days) from referral to assessment (I chart) Population Health

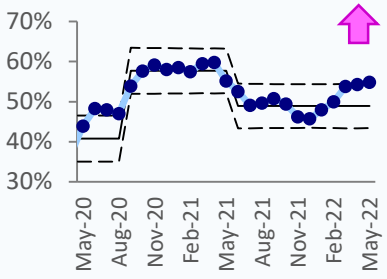


Percentage satisfaction with service, service users and carers (I chart) Quality

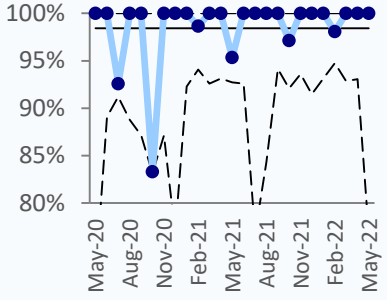


Children with complex health needs

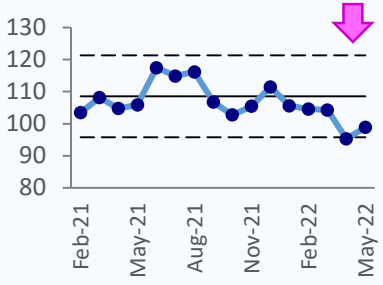
Complex neuro disability receiving a clinical review within past 12 m (P Chart) Population Health



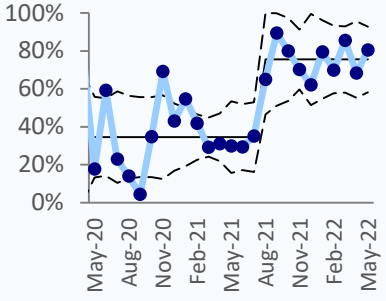
Percentage of service users and parents satisfied with services (P Chart) Quality



Average weeks waited from Autism Spectrum Disorder referral to first appt. (I chart) Quality

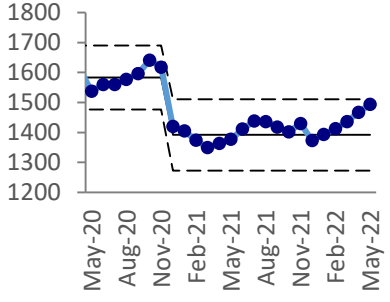


Children receiving ASD diagnosis within 2 appointments (P Chart) Value

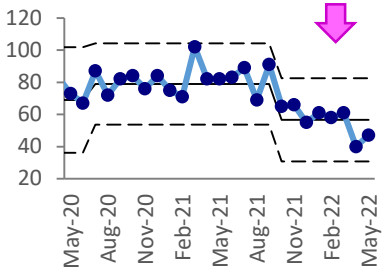


People receiving end of life care

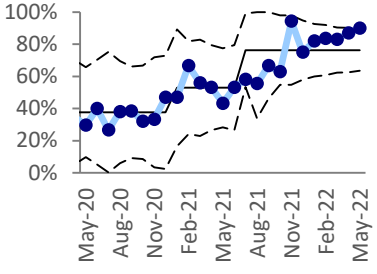
Service users on End of Life Pathway (I chart) Population Health



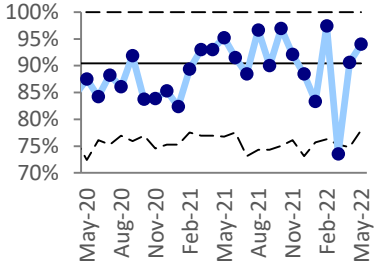
Service Users referred to Continuing Healthcare as a fast track in month (I chart) Population Health



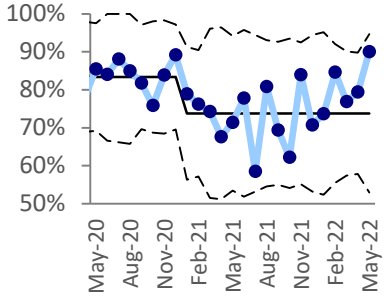
Service users with Care Plan in place (advanced) in East London (P Chart) Quality



Service users with Care Plan in place (advanced) in Bedfordshire (P Chart) Quality



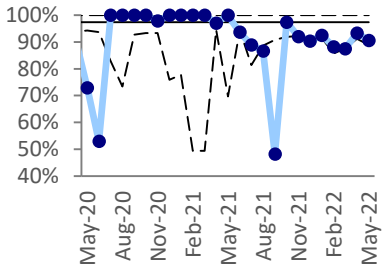
Service users who died in their preferred place of death (P Chart) Value



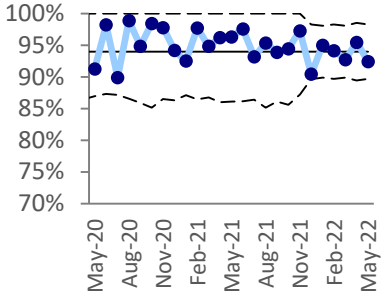
Appendix 1: System Performance dashboard Long Term Plan ( ) Special cause variation ( ) and when it's of potential concern ( )

People who are frail or have long term conditions

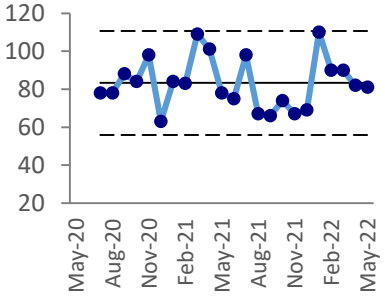
Percentage of service users who have recorded a positive experience (P chart) Quality



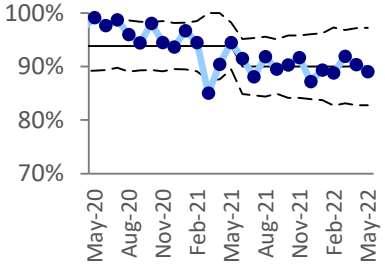
Rapid Response seen within 2 hour guideline (East London) (P Chart) Quality



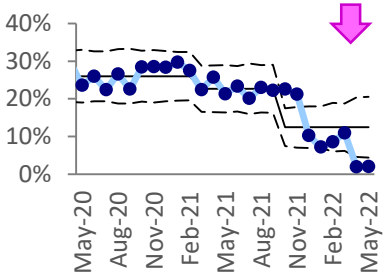
Number of Grade 2, 3 or 4 pressure ulcers non-inherited (I Chart) Quality



Promoting independent living - discharged within 6 weeks Bedfordshire(P Chart) Quality

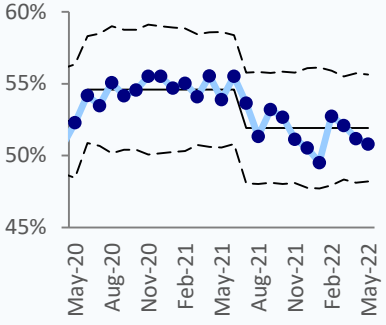


Number of inappropriate referrals into Intermediate Care - Bedfordshire (P Chart) Value

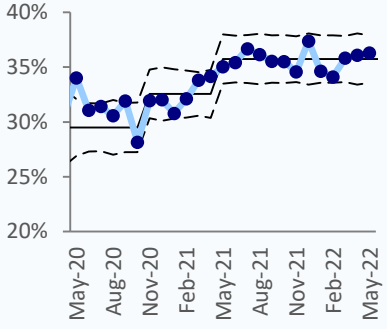


People with common mental health problems

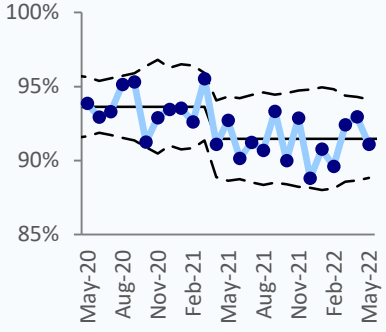
Percentage of service users moving into recovery (P Chart)



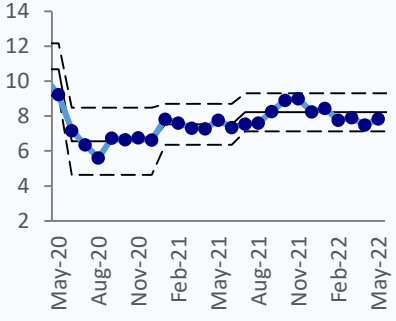
Percentage access by minority groups (P Chart)



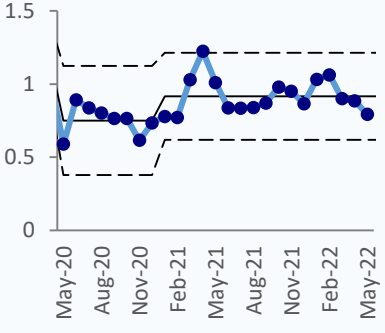
Percentage of positive comments to PEQ (P Chart)



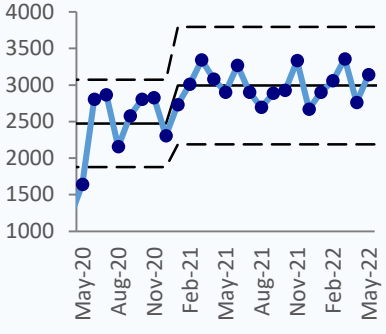
Average wait times to treatment (in weeks) from assessment (I Chart)



Average wait times (in weeks) to assessment (I Chart)

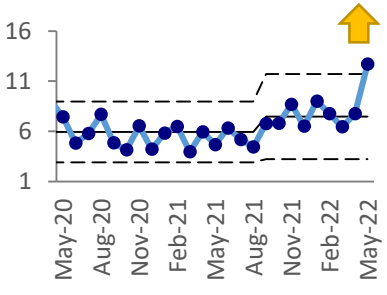


Number of people accessing IAPT services (I Chart)

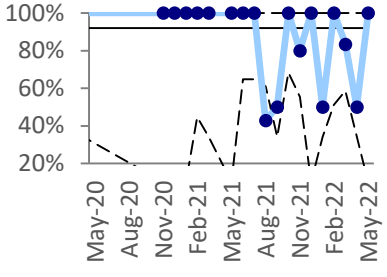


People with a learning disability

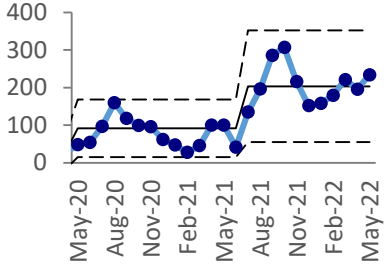
Average waiting times for new referrals seen (in weeks) for assessment (I chart) Population Health



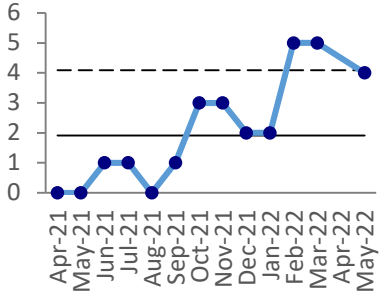
Percentage of service users that would recommend this service (P Chart) Population Health



Occupied bed days used in month by service users with Learning Disability (I Chart) Quality



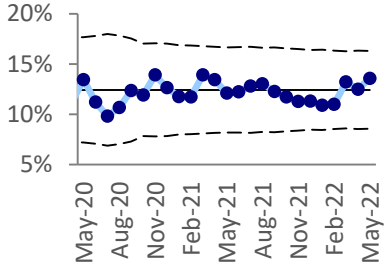
Total number of specialist out of area inpatient placements (I Chart) Value



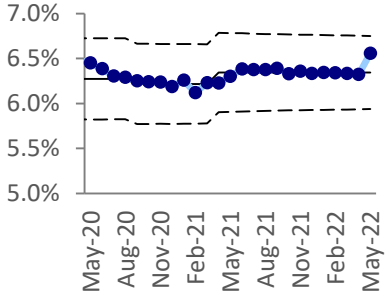
Appendix 1: System Performance dashboard Long Term Plan ( ) Special cause variation ( ) and when it's of potential concern ( )

People with Severe Mental Illness

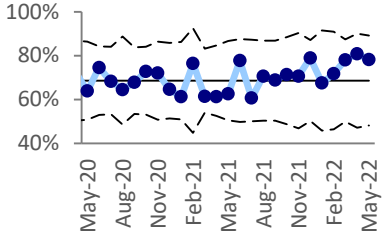
Percentage of service users receiving Individual Placement Support (P chart) Population Health



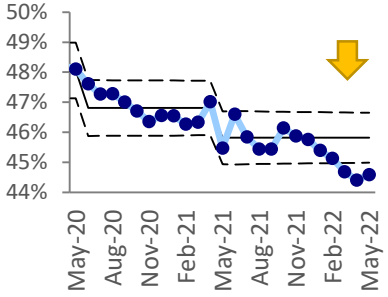
Percentage of service users in employment (P chart) Population Health



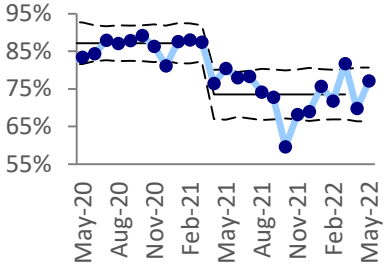
Service users receiving NICE concordant care within 2 wks of referral (EIS services – face to face) (P Chart) Population Health



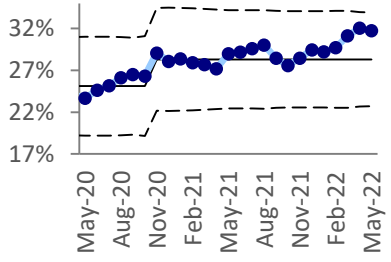
Percentage of service users in settled accommodation (P chart) Population Health



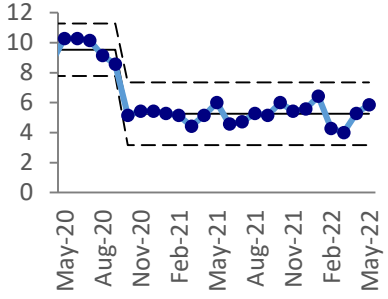
Percentage of service users followed-up within 72hours of discharge (p chart) Quality



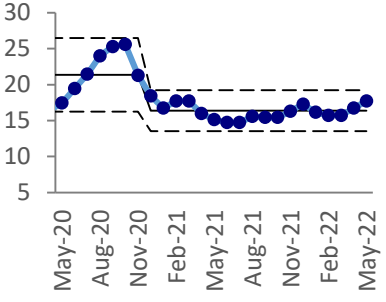
Inpatients with paired outcome measures showing improvement (P Chart) Quality



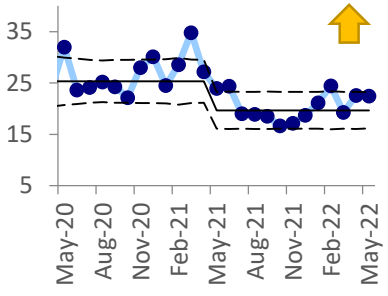
PTS average wait times to (weeks) to 1st assessment in East London (I chart) Quality



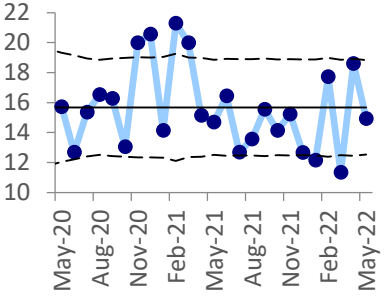
PTS average wait times (weeks) to treatment in East London (I chart) Quality



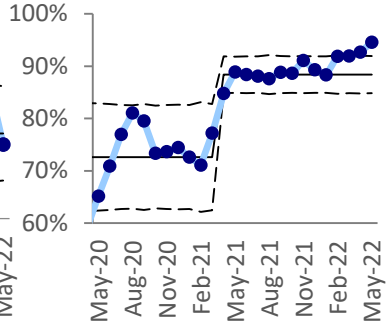
Number of restraints reported per 1,000 occupied bed days (P Chart) Quality



Rate of physical violence incidents per occupied 1,000 bed days (P Chart) Quality

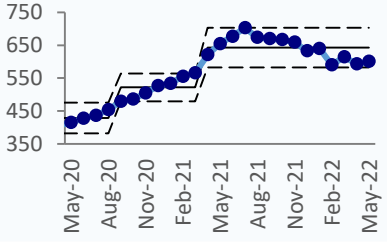


Bed occupancy (P' Chart) Value

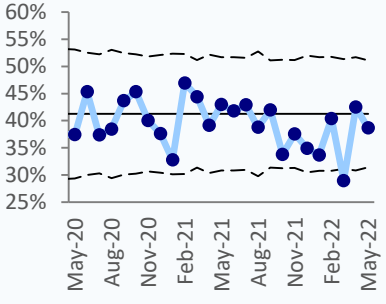


Woman who are pregnant or new mothers

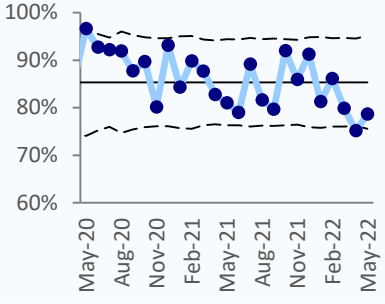
Number of woman receiving one + contact with specialist mental health services within 12 months (I Chart) Population Health



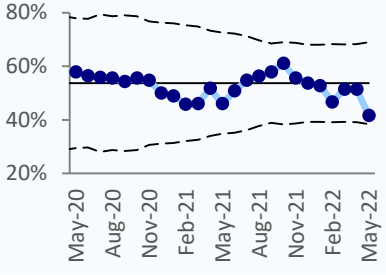
Service users seen in the month from minority communities (P Chart) Population Health



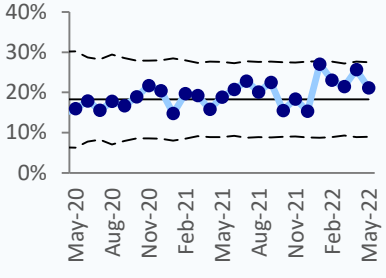
Percentage of service users seen within 28 days (I Chart) Quality



Percentage of patients undertaking Core10 showing improvement (P Chart) Quality



Percentage of Service Users not attending their initial appointment (P Chart) Quality

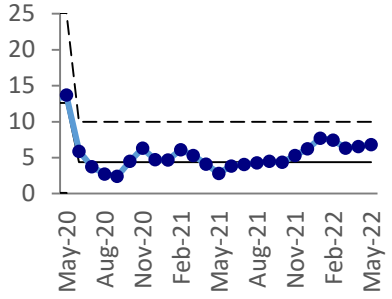


Appendix 1: System Performance dashboard

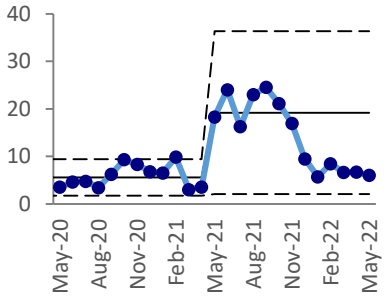
Special cause variation (⇧ ⇩) and when it's of potential concern (⇧ ⇩)

People with stable long term conditions (East London)

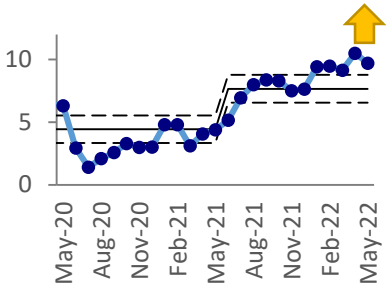
Average weeks waited for initial appointment with the foot health team (I Chart)



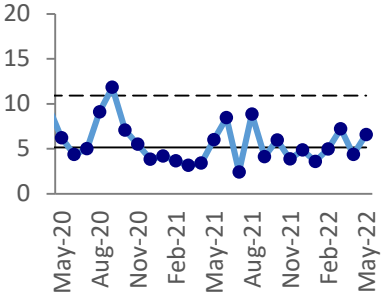
Average weeks waited for face to face appointment with the Diabetes Service (I Chart)



Average weeks waited for initial appointment with the MSK and Physiotherapy teams (I chart)

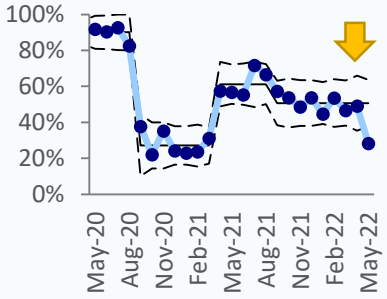


Average weeks waited for initial appointment with the Continence Service (I Chart)

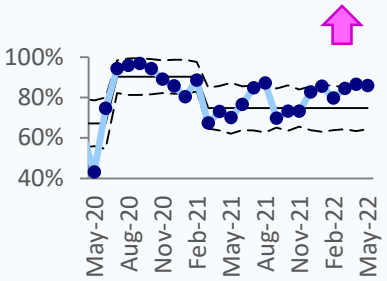


People with stable long term conditions (Bedfordshire)

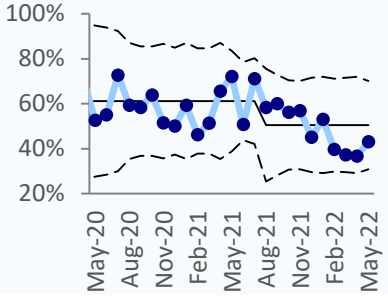
Referral to treatment times within 11 weeks with the Continence Service (P Chart)



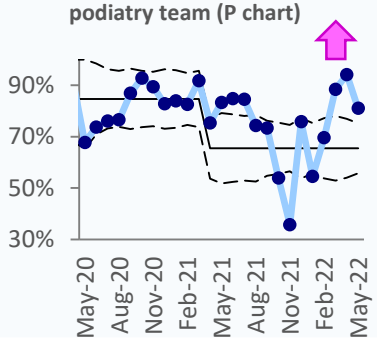
Referral to treatment times within 11 weeks Speech and language therapy (P chart)



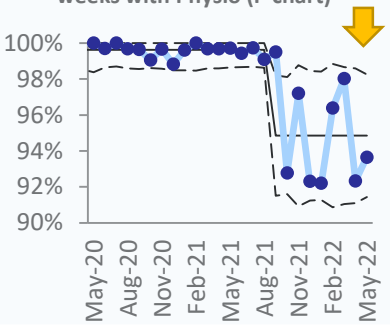
Referral to treatment times within 11 weeks Wheelchair Service (P chart)



Referral to treatment times within 11 weeks with the podiatry team (P chart)



Percentage of referral to treatment times within 11 weeks with Physio (P chart)



Appendix 2: Regulatory Compliance – System Oversight Framework (SOF)

NHS England and NHS Improvement have published a revised approach to NHS System Oversight in July 2022 to align with the vision set out for Integrated Care Systems. The table below provides a summary of the new indicators relevant to the Trust and current status. Some of the measures remain undefined so will be clarified over time. There are currently no areas of concern to bring to the Board's attention.

Oversight Theme	NHS Long Term Plan Area	Measure Name (metric)	Compliance Status	Comments
	Urgent and Emergency Care	Proportion of patients spending more than 12 hours in an emergency department		Further review underway
	Primary Care and Community Services	Proportion of Urgent Community Response referrals reached within two hours		
		Proportion of patients discharged from hospital to their usual place of residence		Further review underway
		Available virtual ward capacity per 100k head of population		Further review underway
	Mental health services	Number of children and young people accessing mental health services as a % of population		
		Proportion of people with severe mental illness receiving a full annual physical health check and follow -up interventions		
		Access rate for IAPT services		
		Access rates to community mental health services for adult and older adults with severe mental illness		
		Inappropriate adult acute mental health placement out -of-area placement bed days		
	Learning disabilities and autism	Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check		Further review underway
	Safe, high quality care	Summary Hospital -level Mortality Indicator		
		National Patient Safety Alerts not completed by deadline		
		Potential under-reporting of patient safety incidents		
		Overall CQC rating		
		Percentage of patients describing their overall experience of making a GP appointment as good		
		Acting to improve safety - safety culture theme in the NHS staff survey		
		Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate		
		Clostridium difficile infection rate		
		E. coli bloodstream infection rate		
		Antimicrobial resistance: appropriate prescribing of antibiotics and broad-spectrum antibiotics in primary care		

Appendix 2: Regulatory Compliance – System Oversight Framework (SOF)

Oversight Theme	NHS Long Term Plan Area	Measure Name (metric)	Compliance Status	Comments
Preventing ill Health	Reducing inequalities	Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities1		Further review underway
		Number of people receiving mechanical thrombectomy as a % of all stoke patients		
		Proportion of people with CVD treated for cardiac high-risk conditions		
		Proportion of diabetes patients that have received all eight diabetes care processes		
		Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled		
		Number of referrals to NHS digital weight management services per 100k head of population		
		Breast/Bowel/Cervical screening coverage - % patients across different age range screened in the last 30 months		
		Population vaccination coverage – MMR for two doses (5 year olds)		
		Proportion of patients who have a first consultation in a post -covid service within six weeks of referral		Further review underway
		Proportion of people over 65 receiving a seasonal flu vaccination		Further review underway
Leadership and Capability	Leadership	Aggregate score for NHS staff survey questions that measure perception of leadership culture		
		CQC well -led rating		

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REPORT TO THE TRUST BOARD IN PRIVATE
28 JULY 2022

Title	**Coroner Regulation 28 Report - Prevention of Future Deaths**
Author	Christina Helden, Interim Associate Director of Legal Affairs.
Accountable Executive Director	Dr David Bridle, Interim Chief Medical Officer

Purpose of the report

This report is intended to provide the Board with information about the circumstances of the sad death of Mr IC in so far as it relates to a Regulation 28 report **(the Report)** delivered by HM Coroner following the inquest. It is also intended to give assurance about the learning and actions taken in response to this by the Trust.

Summary of key issues

Mr IC was an in-patient on Globe Ward, Mile End Hospital. He was transferred to the Royal London Hospital **(RLH)** for physical health problems relating to a terminal cancer diagnosis. He was 'medically cleared' at RLH and transferred back to Topaz Ward at Newham Centre for Mental Health **(NCfMH)** over the weekend on 11 July 2021. Mr IC subsequently fell on 12 July 2021 and suffered a laceration to his head. He was taken to RLH A&E. He died at RLH due to complications related to his cancer.

At inquest, HM Coroner concluded that Mr IC's death resulted from natural causes (cancer).

He acknowledged that the Trust's Serious Incident **(SI)** Investigation identified several areas of learning. Nonetheless, HM Coroner delivered a Regulation 28 report **(the Report)** outlining further actions for the purpose of preventing future deaths. Specifically, his concern was that a falls assessment was not completed.

The Trust's SI review had found that a falls assessment did not take place, which was related to this having been a weekend transfer from a medical ward back to a mental health ward of someone with complex physical health problems. The action plan from the SI review focused on the issues surrounding such transfers, as this would rectify issues identified in the SI review around the lack of completion of NEWS 2 scores, falls assessment and instigating 15-minute observations following transfer.

The Trust has reviewed its policies that relate to falls and will be making updates accordingly.

This report provides an update on progress to address the shortcomings in these areas of practice – this includes the two key areas:

- New systems have been put in place at Newham Centre for Mental Health for complex weekend transfers from acute hospitals.

- The Trust Slips Trips and Falls Policy and Physical Health Care Policy are being reviewed and updated to ensure consistency in relation to falls assessments.

Strategic priorities this paper supports (please check box including brief statement)

Improved population health outcomes	☐	
Improved experience of care	☒	Safer, more effective care
Improved staff experience	☒	Clearer expectations and process for staff to follow
Improved value	☐	

Committees/meetings where this item has been considered

Date	Committee/Meeting
	None

Implications

Equality Analysis	There are no identified equality issues.
Risk and Assurance	This report summarises actions taken to respond to risk-related interventions and an assurance of the processes for safe practice and oversight
Service User/Carer/Staff	Delivery of safe reliable care is a priority for the Trust. Service users will benefit from timely completion of falls risk assessments when indicated on admission or transfer to inpatient wards, and from ensuring that transfers of people with complex health needs on weekends are as robust as possible.
Financial	There is no cost to the improvements that have been agreed.
Quality	The issues highlighted are related to patient safety. Patient safety is the cornerstone of high-quality health care.

Supporting documents and research material

a.
b.

Glossary

Abbreviation	In full
The Report	Regulation 28 Report
Serious Incident	SI
Newham Centre for Mental Health over	NCfMH
HM	Her Majesty's

1.0 Background/Introduction

1.1 Mr IC was a 53 year old man who was an in-patient on Globe Ward at Mile End Hospital. He was transferred to RLH for physical health problems relating to a terminal cancer diagnosis. He was 'medically cleared' at RLH and transferred back to Topaz Ward at NCfMH on the weekend on 11 July 2021. Mr IC subsequently fell on 12 July 2021 and suffered a laceration to his head. He was taken to RLH A&E. He died at RLH due to complications related to his cancer.

1.2 At inquest, HM Coroner concluded that Mr IC's death resulted from natural causes.

1.3 He acknowledged that the Trust's SI Investigation identified several areas of learning.

1.4 The SI review found that a falls assessment did not take place, which was related to this having been a weekend transfer back from a medical ward to a mental health ward of someone with complex physical health problems. The action plan from the SI review focused on the issues surrounding the transfer, with the view that this would rectify issues identified in the SI around the lack of completion of NEWS 2 scores, falls assessment and instigating 15-minute observations following transfer.

1.5 MH Coroner delivered the Report outlining further actions for the purpose of preventing future deaths. Specifically, his concern was that a falls assessment was not completed. The Matter of Concern in the Regulation 28 report stated:

"*On Sunday 11th July 2021, [Mr IC] was discharged from the hospital [Royal London Hospital] after treatment. The patient was discharged to a different mental health hospital [Newham Centre for Mental Health]. Upon arrival at the mental health hospital at 1600 hours, a review of the patients falls risk assessment was not undertaken. The following day, [Mr IC] suffered a fall whilst mobilising, unsupervised by staff. [Mr IC] sustained a serious laceration to the head*."

1.6 The Trust has reviewed its policies that relate to falls and will be making updates accordingly.

2.0 Serious Incident (SI) Investigation Evidence

2.1 *Serious Incident Findings*

2.2 HM Coroner heard oral evidence at inquest from the Trust's SI author and the Trust's Borough Lead Nurse for Newham that there were a series of systems issues surrounding Mr Cockfield's admission that led to missed opportunities in his care, including that a falls risk assessment did not take place within 24 hours as per the Trust's physical healthcare policy.

2.3 A summary of the Trust's SI review findings is as follows:

2.4 Mr IC was transferred from Royal London Hospital (RLH) to Topaz Ward at Newham Centre for Mental Health (NCFMH) over the weekend. A transfer was agreed for 11 July 2021 and he arrived on Topaz at 15:58 pm.

2.5 It is important to note that it is unusual for weekend transfers to take place for complex cases due to lower numbers of senior staff members on the wards at that time.

2.6 Upon arrival, Mr IC's admissions clerking was delayed as the records from Globe Ward, Mile End Hospital where he was an in-patient prior to his stay at RLH were not available for several hours which delayed the admissions process.

2.7 The SI review found that not all staff were aware of how to access records from other wards.

2.8 Mr IC was eventually admitted at 19:20 pm by a junior duty doctor. He completed comprehensive admission notes, although a NEWS 2 score was not completed.

2.9 Subsequently, a falls risk assessment was not completed within 24 hours of admission and 15-minute observations were not commenced.

2.10 Mr IC subsequently fell at 18:00 on 12 July 2021 and suffered a laceration to his head. He was taken to RLH A&E at 20:45pm.

2.11 The Trust's Serious Incident (SI) investigation identified the following missed opportunities: 1) A NEWS 2 score was not completed; 2) a falls risk assessment was not undertaken in line with the Trust's physical healthcare policy and 3) 15-minute observations were not commenced as per the ELFT observation policy.

3.0 *SI Actions*

3.1 The following actions were taken by the Trust to ensure that the learning from this incident was embedded into the Trust's policies and processes:

3.2 All weekend transfers of inpatients from acute hospitals now require senior management approval and a consultant-to-consultant handover. This ensures that there is a comprehensive management plan in place which is communicated to all staff in relation to out of hours transfers.

3.3 All Friday, Saturday and Sunday admissions are reviewed in a weekend huddle. The outcome is shared with on-call Consultant, to ensure that patients with complex health needs are reviewed by senior medical personnel during that time.

3.4 Regular interface meetings with Barts Health NHS Foundation Trust have been taking place between the Trust's Deputy Borough Lead Nurse and Newham University Hospital (NUH)'s Director of Nursing. They have developed a process for escalating urgent matters (including weekend transfers). A draft Standard

Operating Procedure will be ratified by September. Importantly, these meetings have already resulted in joint learning in other areas as well.

3.5 The psychiatric liaison team will cut and paste RLH physical health ward round information into the notes of complex patients so that pertinent physical health information is available immediately following transfer to mental health wards.

3.6 Current staff have been reminded that upon transfer back from an acute hospital, just like other new admissions, NEWS 2 scores must be undertaken in accordance with the ELFT admission policy. This has also been included in new staff inductions.

3.7 Staff have been reminded to undertake 15-minute observations upon transfer back from an acute hospital, just like other new admissions. This has been emphasized in induction and training. Observations audits are now undertaken on a weekly basis.

3.8 Daily Multi-Disciplinary Team huddles on the adult mental health wards in Newham have been opened to Occupational Therapists to ensure that falls risk assessments are being undertaken in more complex cases. There is a daily process of monitoring actions from the huddles which ensures the completion of the falls assessments that were identified to be undertaken.

3.9 The learning identified in this case has been shared with the other directorates to ensure that any changes that were relevant for their local arrangements for weekend transfers could be implemented. The Trust-wide Patient Safety Forum will review that those were implemented as needed.

3.10 This range of actions has helped to robustly address the issues surrounding complex weekend transfers from medical wards.

4.0 *Additional Actions*

4.1 As a consequence of HM Coroner's specific concern about the falls assessment not being completed, the Trust is reviewing its Physical Health Care Policy and its Slips, Trips and Falls Policy.

4.2 We have identified that some of the information in the two policies is inconsistent. Whilst the former states that if there are concerns about mobility on admissions a full moving and handling assessment should be completed and a falls risk assessment undertaken within 24 hours, the latter notes that only those older adults and those in younger age groups who are identified at risk of falls should be offered a falls risk assessment (with no specified timeframe).

4.3 Consequently, different staff members may have different understandings of when a falls risk assessment should be completed.

4.4 The Trust's Director of Nursing for London Mental Health is reviewing and updating these policies within the usual governance frameworks for doing so. Going forward, they will provide clear and consistent guidelines for completing

assessments for adult service users including timeframes clarifying all patients who require a falls assessment within 24 hours of arrival on a mental health ward and will also highlight special cases, where it should be done within a shorter time period. This will be completed by September 2022. Relevant communication about this update, along with its incorporation into the physical health training sessions for nursing staff on adult mental health wards and local audits, is expected to secure further improvements in this area across the Trust.

5.0 *Action being requested*

5.1 The Board is asked to consider whether appropriate assurance has been provided

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REPORT TO THE TRUST BOARD IN PUBLIC

28 JULY 2022

Title	Progress Report: Refreshed ELFT People Plan
Author	Associate Directors of People and Culture
Accountable Executive Director	Tanya Carter, Chief People Officer

Purpose of the report

The purpose of the report is to update the Trust Board on the progress against the ELFT People Plan. This new format aims to set out any updates ordered by the four priority areas within the People Plan:

- New Ways of Working
- Looking After our People
- Belonging in the NHS
- Growing and developing for the Future.
- Other general updates – that don't fit within the four priority areas.

This paper aims to provide the board with assurance in terms of the areas of concerns, mitigating actions and progress across some people metrics.

Committees/meetings where this item has been considered

Date	This paper has not previously been discussed.

Key messages

New Ways of Working - Resourcing

We have seen an increase in recruitment activity from 493.55 adverts in April 2022 to 572.55 in May 2022. There has also been an increase in offers from 269.97 in April to 313.84 in May 2022. In terms of time to hire the trust target was 41.1 days in January 2022 reducing to 37.7 in April 2022. However, there are some pockets where the time to hire is above this target.

The Recruitment and Retention group continues to make progress. There have been focussed efforts such as within Specialist Children and Young (SCYPS) that has resulted in a reduction from a vacancy rate of 40.9% to 21.8%.

The Trust has continued to develop its wellbeing offer. A wellbeing survey was undertaken and there were responses from 868 employees. A key theme from the survey is that there is a greater focus on women's health issues.

Wellbeing

Significant work has gone into the review of mileage rates paid, and these have increased from 3,500 miles paid at 54p per mile to 10,000 miles paid at 64p per mile until 30th September 2022. In addition, there is a regular user allowance (£50) that has been agreed for individuals driving over 3,500 miles per year. The position regarding lease cars drivers is still being clarified as it is very complex, and we wish to avoid any unintended consequences.

The bicycle milage rate has also been increased from 20p per mile to 30p per mile. The Trust have explored increasing the number of pool cars both petrol and electric cars. The Trust are also trying to obtain fuel cards to help to manage this.

Engagement
The latest NQPS results are for the first quarter of 2022/2023. Our staff engagement score has been well maintained with a score of 7.12.

Preparations are underway for the 2022 National Staff Survey. Planning is underway for the 2022 Staff Awards ceremony. The ceremony takes place at the Troxy Theatre in East London on 20th October 2022.

People Relations
In June 2022, there were 62 disciplinary cases, 19 dignity at work cases, 18 grievance cases, 10 capability cases, 1 medical disciplinary case and 1 whistleblowing case.

Growing and Developing for the future
The ELFT Learning Academy has been developed to incorporate appraisals, which launched on 19 July 2022 and the window closes on 31 October 2022.

Following the implementation of the new Learning Management System also known as ELFT Learning Academy (ELA), statutory and mandatory training reporting was delayed as we sought to address some data quality issues post transfer to the new system. Compliance reporting re-started in July. The Trust is currently reporting a compliance level of 79.28% (as of 20/07/2022) against a target of 90%. There are still some data quality issues to resolve with leavers and staff on maternity leave still showing in the data and we continue to address these issues. Actions are ongoing to improve compliance.

Strategic priorities this paper supports

Improved population health outcomes	☒	We have taken a population health approach to our staff wellbeing as many members of staff live and or work within the boroughs that we provide services in.
Improved experience of care	☒	Research shows that if staff are engaged then they will be able to provide better care to patients and service users.
Improved staff experience	☒	The approach to improvement sets out in this paper are designed to directly improve staff experience.

Improved value	☒	There is a strong evidence base that engaged staff are healthier and more productive at work and, therefore, contribute to value for money

Implications

Equality Analysis	The Trust's action plan is designed to improve equality through the reduction in variation between different staff groups.
Risk and Assurance	If staff are not engaged at work, there is a clear risk that patient care will be adversely affected.
Service User/ Carer/Staff	As above, the work in this area is designed to improve staff experience. Evidence shows a clear link between staff experience and patient care.
Financial	Evidence shows that high staff engagement is strongly correlated with low sickness absence levels, which has a financial benefit to the Trust.
Quality	Evidence shows a clear link between staff satisfaction and patient care.

Background

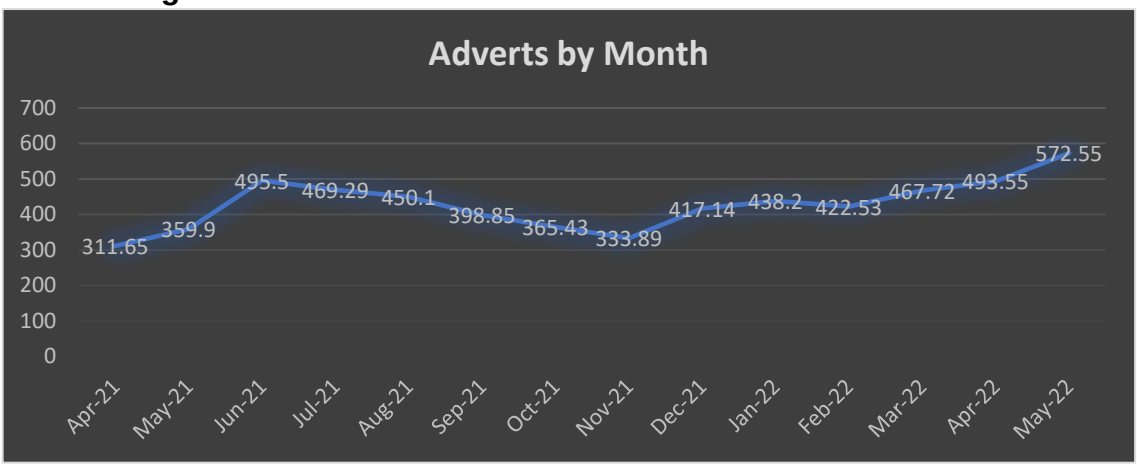
1.1. The refreshed ELFT People Plan was published in May 2022 in support of the Trust's refreshed Strategy. This paper sets out to provide assurance as well as a progress report on the delivery against the ELFT People Plan. The Trust's four key people priorities are:

- New Ways of Working
- Looking After our People
- Belonging in the NHS
- Growing and developing for the Future.
- Other General P&C Updates

These updates also translate in the Board Assurance Framework (BAF) in terms of BAF risks 5 and 6.

2. New Ways of Working

2.1 Resourcing



Recently there has been a spike in number of adverts by 16% published in May compared to previous month.

There has also been an increase in the number of posts offered. Of these 26% were made to Nursing groups, 23% additional clinical services and 19% Allied Health Professionals (AHP).

2.2 Time to Hire

The Trust's time to hire target is 43 days from the point of advert to pre-employment checks. This is currently being achieved, with some improvement over the last five months. The table below shows the time to hire by Directorate:

	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Bedford Level 2	39.7	44.8	46.0	49.0	44.0
Bedfordshire CHS Level 2	31.6	35.4	43.5	46.2	42.7

City & Hackney Level 2	45.2	45	42.0	40	34.91429
Community Services - Tower Hamlets Level 2	48.4	34.8	43.1	42.6	27.0
Corporate Level 2	37.7	42.9	35.9	33.2	39.1
Forensic Services Level 2	40.3	36.3	35.4	32.4	43.3
Luton Level 2	28.6	36.8	47.3	22.1	41.8
Newham CHS Level 2	40.9	40.5	45.2	40.3	43.1
Newham Level 2	60.2	56.3	37.6	43.6	49.7
Primary Care Level 2	35.4	36.4	37.9	47.9	29.3
Specialist CHS Level 2	47.1	54.3	37.1	21.8	25.7
Specialist Services Level 2	38.6	36.1	40.7	37.1	34.5
Tower Hamlets Level 2	40.7	29.9	27.5	41.7	34.7
Average	**41.1**	**40.7**	**39.9**	**38.3**	**37.7**

There is variation in achieving this target, driven by reasons that include:

- Managers sometimes not shortlisting in a timely manner.
- Delayed response times candidates and/or recruitment colleagues.
- Delayed responses times from referees.

In terms of next steps in improving the recruitment system, a pilot is now underway between Resourcing, Finance and Specialist Services to trial budget authorisation functionality within the recruitment system. If this is successful, this will be rolled out Trustwide.

3. Recruitment & Retention

3.1. The Recruitment and Retention group continues to make progress. A number of approaches are being used to tackle particular recruitment challenges.

3.2. For example, there have been focussed efforts within Specialist Children and Young People's Services (SCYPS) including a targeted recruitment campaign. These have led to 80% of advertised posts being filled. Key elements of this approach have included work to refresh advertisements, specific on line recruitment, and 'good news' stories to create a 'Human Factor'. Specific work with managers also led to changes in behaviour from recruiting managers, with candidates reporting that line managers were easily available to discuss opportunities prior to applying. New roles were also created so that staff were recruited as Band 5 with a development programme to build competencies to Band 6 level. This approach is now being shared with teams more widely across the Trust.

3.3. There has been similar success with specific recruitment to the Coburn Unit, and there as other similar targeted campaigns for:

- Crisis Teams

- Community Health Services Bedfordshire Community Careers Week- Recruitment Event for Newly Qualified Launch July 2022 https://www.elft.nhs.uk/news/community-careers-week
- Recruitment Campaign Bedfordshire; Psychiatry/ CAMHS Luton and Bedfordshire and London Medical roles working groups

3.4 International recruitment is also continuing and 18 posts have been offered as part of the Capital Nurse scheme. Of these 18 people, 4 have started in post, 2 are awaiting visa clearance and 10 are awaiting pre-employment checks clearance. In addition, in the past 12 months we have recruited circa 30 overseas applicants on the Skilled Workers scheme.

3.5 There are a range of other approaches that the Trust continues to use to support the increasing levels of recruitment that are taking place. These include:

- Joint working internally and externally across ICS's
- Role redesign and role mix for improved job offer and attractive roles
- Increasing Pre-Registration and Post-Graduate opportunities
- Developing Careers opportunities for schools
- Refer a friend bonus
- Revised staff benefits and relocation package
- Solidifying the Resourcing team and Develop Resourcing Partner roles to support recruitment activity.

3.6 Workforce Planning. A detailed piece of work has been undertaken to support our workforce planning efforts. This has identified a number of key drivers to support improved workforce planning and recruitment. These are:

- Attraction strategies
- The Recruitment Policy and process
- Systems working
- Workforce redesign.

The driver diagram that captures this work is attached as appendix 1.

4. Looking After our People

4.1 A wellbeing survey was undertaken with 868 responses and over 1500 qualitative comments were submitted. As well as general issues around cost of living, a key finding in the survey was that staff would like some additional focus on women's health issues.

4.2 In response to this survey, and general concerns about staff wellbeing and the cost of living, the Trust has put in place a number of responses. For example, free sanitary products for staff to donate and use is being piloted within the Newham locality to help combat the financial burden of these products for staff and patient users. This initiative aims to help de-stigmatise and raise awareness for women's health issues such as period poverty.

4.3 The Trust has also established support for staff to maximise their financial resources such as money management workshops. These will be facilitated by the team at Bromley-By-Bow that currently run workshops for the community. The workshops aim to equip staff with the ability to create secondary streams of income, how to navigate energy bills and understand their psychological relationship with money to empower staff to maximise their income and make more informed financial choices. The topics set to be covered are listed below:

- A psychological understanding of our own attitudes and behaviours towards money
- How to do a budget and why it's helpful to do this regularly, including how to build financial resilience through manageable regular saving.
- Prioritising bills and understanding the consequences of non-payment/accumulating debt
- Borrowing/credit- make informed decisions by understanding how different lenders work
- Managing energy costs- exploring switching, tariffs and energy saving measures
- Reviewing expenditure and identifying opportunities to reduce it and free money saving apps
- Income maximisation- exploring eligibility for benefits, grants, financial support.

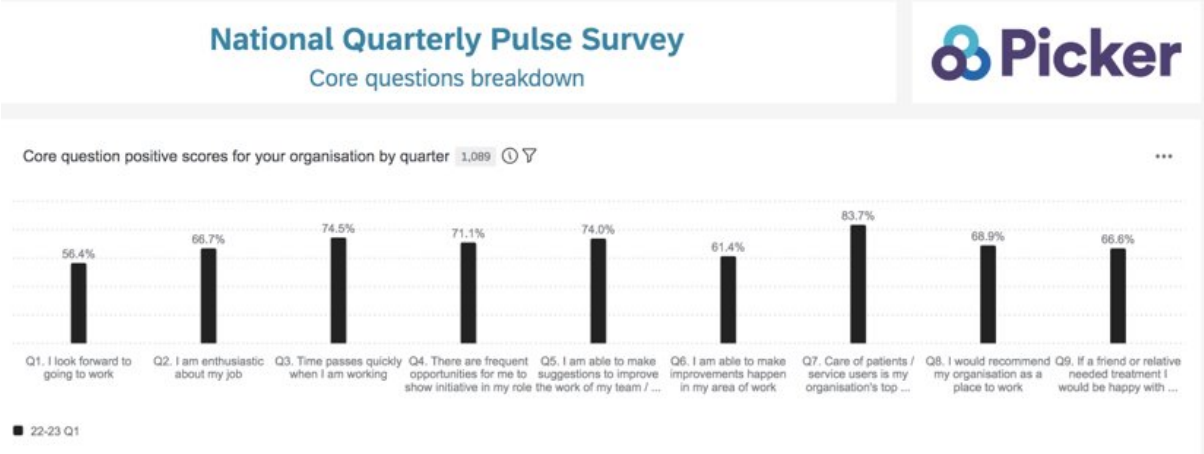
4.4 The Trust has also reviewed mileage rates, given the financial pressures caused by the rising price of fuel. The mileage limit has increased from 54p to 61p for miles up from 3,500 miles to 10,000 miles. For mileage over 10,000 miles, 20p per mile is payable. A £50 regular car user allowance will also be paid to staff who claim over 3,500 miles. These changes will be back dated to 1 April 2022 and reviewed by 30 September 2022.

4.5 Staff who use their bicycle to travel across our system also see an increase to 30p per mile.

4.6 We continue to work through the impact on staff who drive lease cars and the Trust has explored increasing the number of (electric) pool cars to reduce the need for staff to use their own vehicles whilst at work.

4.7 **National Quarterly Pulse Survey (NQPS).**

The latest survey results have been produced and relate to the first quarter of 2022/23. The response rate to the survey was 11% (compared to an NHS average of 19%). Our staff engagement score has been well maintained with a score of 7.12.

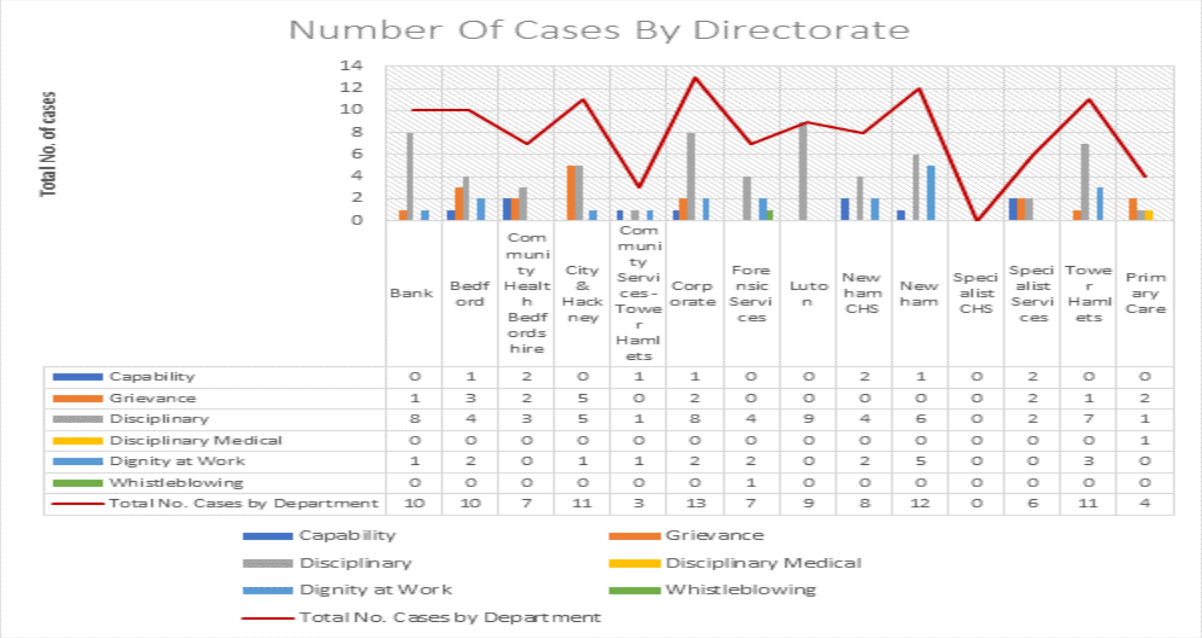


4.8 **2022 Staff Awards.**

Planning is underway for the 2022 Staff Awards ceremony. The ceremony takes place at The Troxy on 20th October 2022. Nominations opened in June and close on 31st July 2022. We have received over 100 award nominations and are encouraging further nominations.

4.9 People Relations

In June 2022, there were 62 disciplinary cases, 19 dignity at work cases, 18 grievance cases, 10 capability cases, 1 medical disciplinary case and 1 whistleblowing case. The following chart shows the number of people relations cases by directorate.



	Bank	Bedford	Community Health Bedfordshire	City & Hackney	Community Services - Tower Hamlets	Corporate	Forensic Services	Luton	Newham CHS	Newham	Specialist CHS	Specialist Services	Tower Hamlets	Primary Care
Capability	0	1	2	0	1	1	0	0	2	1	0	2	0	0
Grievance	1	3	2	5	0	2	0	0	0	0	0	2	1	2
Disciplinary	8	4	3	5	1	8	4	9	4	6	0	2	7	1
Disciplinary Medical	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Dignity at Work	1	2	0	1	1	2	2	0	2	5	0	0	3	0
Whistleblowing	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Total No. Cases by Department	10	10	7	11	3	13	7	9	8	12	0	6	11	4

4.7 COVID-19

The Trust continues to focus on supporting staff across the Trust in responding to the ongoing challenges of COVID-19.

4.7.1 Long Covid

Staff are supported by a monthly long covid monthly support group, as well as a weekly catch-up call which is run by members and a doctors long covid support group with colleagues in North East London Foundation Trust (NELFT).

4.7.2 The Trust has also received notification that sick pay rules for those who are affected by COVID and Long COVID have been changed. This means that COVID related sickness will now be managed through the usual sickness absence processes. The Trust is working with those affected and Staffside colleagues to implement this change to requirements in a way that best supports our colleagues who have been particularly affected by both COVID and long COVID.

4.7.3 The lead employer arrangements that have supported the North East London ICS vaccination campaign to date are planned to continue as the booster vaccination campaign begins, albeit with a lower volume of staff required.

4.8 Leadership

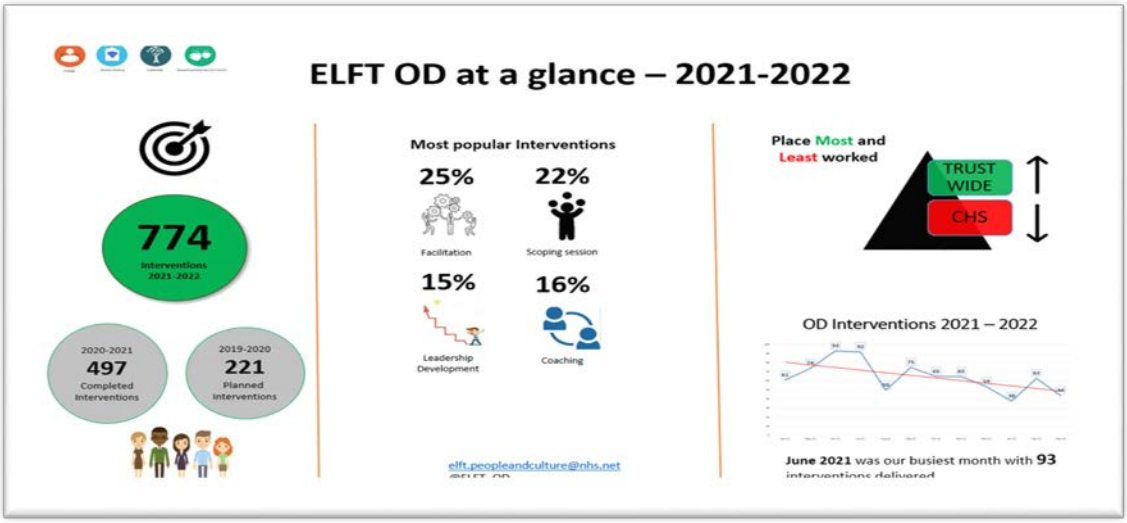
The following programmes are active for staff who wish to support their leadership development:

- Senior Clinical Leaders Programme

- ELFT Lead
- Stepping into Leadership
- Senior Leaders Forum
- Two Masterclasses are planned in September on the topic of systemic leadership.

4.9 OD Activity

Since the start of the financial year, 178 interventions have been undertaken. The following infographic shows the OD team's activity in June 2022.



4.9.1 Post-Incident Support

Systemic Psychotherapist Beverly Clarke joined the team in April 2022 to scope best practice in the Trust for support offered after a serious incident has taken place. Beverly has visited many services, corporate and professional leads and further updates on her findings will be provided at a later date.

5 Belonging in the NHS

5.1 **Equalities.** The Trust Equalities plan is currently under review, and a draft will be presented at the September Board meeting. Work is also ongoing to update the Trust Equality Diversity System requirements, and to collect data for the Workforce Disability Equality Standard (WDES) submission that is due on 31st August 2022. The Trust is exploring opportunities related to the WDES Innovation Fund that aims to develop programmes of work that improve the lives of Disabled staff. £10,000 will be awarded to 8 Trusts for a piece of work that will improve performance against one of the WDES metrics before March 2023.

5.2 Flair Pilot.

It has been agreed that the Trust will undertake a pilot using a product called Flair which will focus on a questionnaire on the current areas:

- Racial diversity;
- Racial inclusion;
- Racial awareness including situational judgement.
- Racist behaviours.

Following the survey, the Trust will receive a dashboard and recommendations to support the Trust in its Equality, Diversity and Inclusion journey. This is a two-year pilot which is due to be launched in August 2022 and will be sent to all staff. This is the next step in the Trust's journey to become and anti-racist and multi-cultural organisation.

5.3 Freedom to Speak Up (FTSU)

In the period 1st May – 30th June, the highest reported theme for concerns raised was Processes/Organisational Structure/Other. There was a notable increase in concerns relating to bullying and harassment and patient safety. These relate to two areas in particular: Tower Hamlets Crisis Team (patient safety) and Tower Hamlets Community Health Services (bullying and harassment). Concerns in Tower Hamlets Crisis Team related to the work area not being conducive to the service, fire evacuation procedures, staff development and training, operational policy and access to medics. All concerns raised were escalated to Service Directors and/or HR as appropriate to the nature of the concern raised. There is specific work in the two services identified to understand and address the concerns that have been raised.

The Freedom To Speak Up Guarding (FTSUG) continues to deliver FTSU awareness training at Trust Induction monthly and also on a team basis virtually and face-to-face. A lunch and learn session and FTSU Champion recruitment drive took place at East Ham Care Centre on May 13th 2022

The four tables below show concerns raised during the period 1st May – 30th June. Firstly, **FTSU concerns raised by theme** below shows an increase of eight staff raising concerns is noted compared with the last reporting period (March & April 2022). Processes/Organisational Structure/Other increased again this reporting period and most were raised in relation to the Tower Hamlets Crisis Response Team. Other concerns of this nature were related to line management; an SI case presentation and experience in incidents where people felt 'sidelined' or disrespected in their role.

FTSU Concerns Raised - Data by Themes	1st January to 28th February 2022	1st March to 30th April 2022	1st May to 30th June 2022
Patient Safety/Quality of Care	1	5	12
Bullying/Harassment/Negative Behaviours	7	3	11
***Worker safety**	4	0	1
Processes/Organisational Structure/ Other	12	14	15
COVID-19 related	2	0	0
Others	0	0	0
Unknown	0	0	0
****Total number of themes**	**26**	**22**	**39**
Total Number of staff raising concern	**20**	**17**	**25**
Number of concerns raised anonymously	**1**	**0**	**0**
***Disadvantageous and/or demeaning treatment as a result of speaking up	**0**	**0**	**0**

(***Worker safety** added as a category by the National Guardian Office as of July 2021. ****Total number of themes** *does not always correspond* with the total number of staff raising concern, one staff concern can relate to multiple themes. *** The term '**detriment'** now replaced with '**disadvantageous and/or demeaning treatment'**).

The next table shows **FTSU concerns raised by Directorate.** The most notable increases in FTSU concerns are from Community Health Services Tower Hamlets, which were around bullying/harassment/negative behaviours, and Tower Hamlets Mental Health, which were mostly around issues raised within the Tower Hamlets Crisis Response Team.

FTSU Concerns Raised - Data by Directorate	1st January to 28th February 2022	1st March to 30th April 2022	1st May to 30th June 2022
Bedfordshire	7	0	0
City & Hackney Services	0	3	0
Community Health Services - Bedfordshire	0	0	1
Community Health Services - Newham	1	7	1
Community Health Services - Tower Hamlets	0	2	9
Corporate Services	3	1	0
Forensic Services	1	1	0
Luton	0	0	0
Newham	0	1	0
Primary Care Directorate	2	0	0
Specialist Services	0	2	2
Tower Hamlets Mental Health	6	0	12
UNKNOWN	0	0	0
TOTAL	**20**	**17**	**25**

The next table shows **FTSU Concerns by Professional Group**. The highest increase is from Registered Nurses and Midwives and Other, which corresponds with the rise in reporting from CHS Tower Hamlets and Tower Hamlets Mental Health.

FTSU Concerns Raised - Data by Professional Group	1st January to 28th February 2022	1st March to 30th April 2022	1st May to 30th June 2022

Administration, Clerical & Maintenance/Ancillary	10	2	5
Allied Health Professionals	2	9	1
Corporate Services	1	1	0
Medical and Dental	0	0	1
Registered Nurses and Midwives	1	2	10
Nursing Assistants or Healthcare Assistants	0	1	0
Social Care	0	1	1
Not Disclosed	1	0	1
Other	5	1	6
TOTALS	**20**	**17**	**25**

(The NGO definition or 'Other' is: 1) Can include any professional group that does not fit with any other professional group category. 2) Can also include volunteers working in charity shops, fundraisers and similar. 3) Also includes Student Nurses).

The final table shows **FTSU concerns raised - by Professional Level.**

FTSU Concerns Raised - Data by Professional Level	**1st January to 28th February 2022**	**1st March to 30th April 2022**	**1st May to 30th June 2022**
Worker	12	12	22
Manager	7	5	3
Senior Leader	0	0	0
Not Disclosed	1	0	0
TOTALS	**20**	**17**	**25**

(The NGO definitions are **Worker**: A worker can be any individual working in any capacity in an organisation, including volunteers, contract staff, bank/agency staff etc. **Manager**: By 'manager', we mean a line manager or anyone with managerial responsibility. **Senior Leader**: This category should be applied to Board-level or equivalent workers).

5.4 Whistleblowing.

There is currently one whistleblowing case citing concerns about patient care, leadership challenges and leadership effectiveness. The Trust were already aware of some of these issues and the OD team have been providing support to the affected team and individuals. An external reviewed has been appointed to conduct a review and to build on some of the work to date.

6 Growing and Developing our People

6.1 Health Education England (HEE) – Quality Visits. Two HEE quality visits took place where HEE education leads met with trainees based at the Coburn Unit, Tower Hamlets and Forensics. Overall, the visits were positive. One theme that emerged was trainees' confidence and ability to carry out physical examinations and respond to medical emergencies in a psychiatric setting. Plans are in place to address the training gap and expectations at induction, with liaison with relevant subject matter experts.

6.2 Medical Appraisal Compliance.

As the pressure of the GMC suspension of appraisals and revalidation during the Covid-19 pandemic, diminishes and we begin to return to normal working there has been a greater focus on the appraisal compliance figures. Our last set of data reported 83% appraisal compliance. This has decreased slightly to 75.8% and we continue to focus on this to ensure an improved position in the next quarter.

6.3 Appraisal (Agenda for Change Staff).

The L&D team have been reviewing the appraisal cycle for 2022. This year's appraisal will be housed on Learning Management System also known as the ELFT Learning Academy.

Managers will be able to select their appraisee as well as to delegate appraisal to another senior manager if necessary.

The main change in the reviewed Appraisal process is as follows:

- More conversational
- Simpler
- Removal of unrequired information requests
- Embedded in the ELFT Learning Academy
- Suggested maximum of 4 objectives, (including PDO)
- Linked to supervision – language, style approach of proposed supervision system

The new Appraisal guidance and training was launched on the 19 July 2022. This includes recorded webinars made available on ELA and training sessions on zoom for appraisers and appraisees alike.

6.4 Statutory and Mandatory Training.

Following the launch of the ELFT Learning Academy (ELA), in February 2022, we continue to see increase in the number of staff completing training on the system. However, we continue to experience some data quality issues and continue to work with external providers and data warehouse colleagues to address these. These relate primarily to data relating to leavers and staff on maternity leave. The Trust is currently reporting a compliance level of 79.28% (as of 20/07/2022) against a target of 90%.

6.5 Organisational Changes

Currently there are 10 organisational changes in progress affecting 130 staff, possibly resulting in 9 redundancies. The reasons for the changes range from the reconfiguration of a service to the closing of a service as well as transfers in to, or out of ELFT under Transfer Under Employment Protection of Employment (TUPE).

7 Other General Updates

7.1 The P&C team celebrated International HR Day on 20 May 2022 at an away day. Over 120 P&C colleagues came together, and for some, this was the first time that they had met many colleagues. This was an opportunity to celebrate, reflect on the previous two and a half years and then set the vision and priorities for the coming year.

7.2 The P&C team have been shortlisted for the Healthcare People Management Awards (HPMA) for HR team of the year and the award ceremony is in September 2022.

7.3 An awayday for the Joint Staff Committee took place on 1 July 2022. It was a productive session focusing on how Staffside and management would work more effectively in partnership to deliver the People Plan in support of the Trust strategy.

7.4 We have facilitated the third and final #InclusiveHR session. The sessions focused on positive experiences within P&C in relation to career opportunities, less positive experiences, and solutions to these.

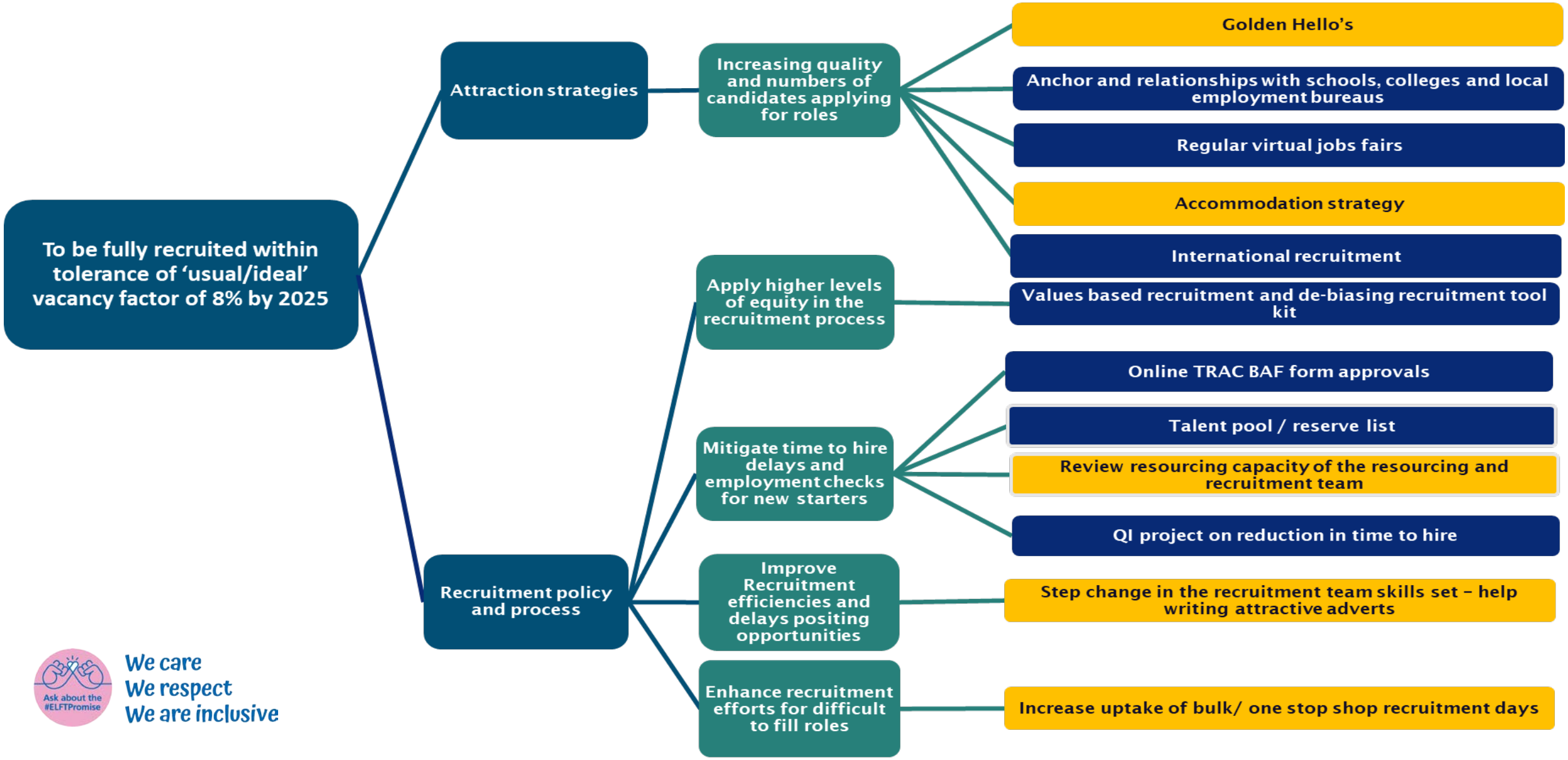
8 Recommendations

8.1 That Board are asked to CONSIDER the assurance provided and CONSIDER any other assurance that is required.

WORKFORCE PLAN DEVELOPMENT DRIVER

PART 1 OF 2

NHS
East London
NHS Foundation Trust



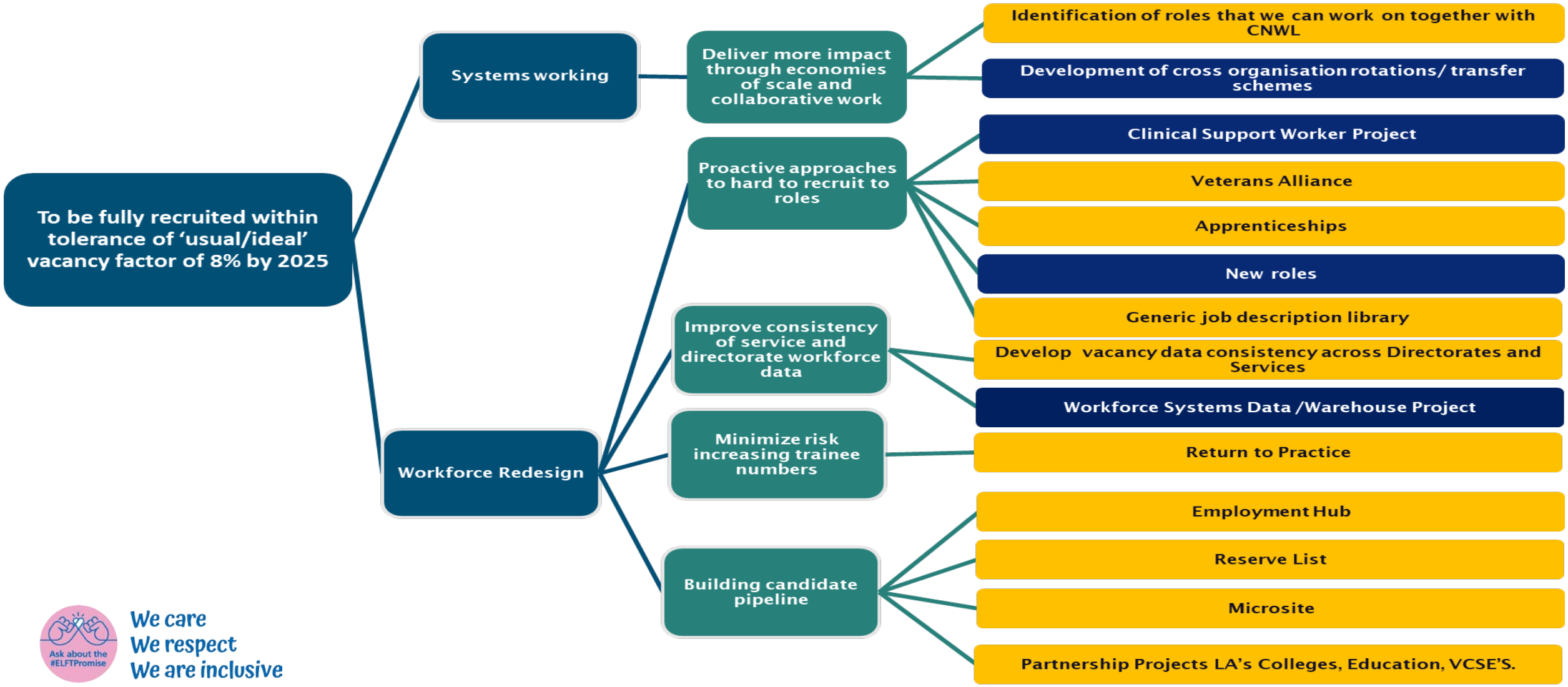
Ask about the #ELFTPromise

We care
We respect
We are inclusive

WORKFORCE PLAN DEVELOPMENT DRIVER

PART 2 OF 2

NHS
East London
NHS Foundation Trust



Ask about the #ELFTPromise

We care
We respect
We are inclusive

NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
28 July 2022

Title	Safer Staffing 6 Monthly Review of In-patient mental health nurse staffing levels and community health Nursing provision.
Author/Role	Claire McKenna - Director of Nursing (Mental Health) Ruth Bradley - Director of Nursing (Community Health Service) John Peers Safer Staffing Lead
Accountable Executive Director	Lorraine Sunduza – Chief Nurse / Deputy CEO

Purpose of the report

This is the tenth report to inform the Board on the steps taken to meet the expectations detailed in the guidance produced by the Chief Nursing Officer and the National Quality Board, 'How to Ensure the Right People with the Right Skills are in the Right Place at the Right Time: A guide to Nursing, Midwifery and Care Staffing Capacity and Capability (2013).

The report relates to all inpatient ward nursing staffing and Community Health Nursing staffing. This is in line with a requirement to provide the Board with a report outlining the assurance and issues related to safe nurse staffing levels at six monthly intervals. This report to the Board summarises the results of the Trust monitoring of staffing levels across all mental health and continuing care wards and covers the 6-month period from Nov 2021 to April 2022.
In relation to inpatient wards, it gives assurance that:

- Staffing levels that reach the Trust standard are being achieved in inpatient wards. On occasions where this is not the case, there are mitigations that have been put in place. Recruitment is also taking place in areas of particular challenge.
- The hours of care per patient have not been adversely affected over the last two years.
- That the demands of acuity on ELFT wards suggest the need for staffing levels that are reflected in those for which the Trust's inpatient wards are established.

It also includes a status report on recruitment & retention challenges and responses across community health services.

11 of the 53 wards showed variance in fill rate with immediate actions taken at the time by the managers.

Covid related absences continue to have an impact on safer staffing levels. Services have remained flexible in use of resources to respond to the fluctuating impact based on community prevalence of COVID-19 in the community.

Regular rota and establishment reviews inform planned and actual staffing decisions. All services have mitigation actions they follow to manage unplanned absences up to and including business contingency plans.

There are no recommended changes to the inpatient staffing levels currently. This may change as further guidance is issued. The ward staffing information is published monthly on the NHS Choices and Trust Website

The Board is asked to NOTE the assurance provided and **CONSIDER** if further sources of assurance are required.

Strategic priorities this paper supports

Improved population health outcomes	☐	
Improved experience of care	☐	The right staffing numbers to meet the service user needs and respond accordingly.
Improved staff experience	☐	The right staff numbers create an environment where staff can safely practice and deliver high quality care
Improved value	☐	The right staffing resources reduces the need for agency and promotes consistency of practice.

Implications

Equality Analysis	The Trust has a duty to promote equality in the recruitment of the nursing workforce.
Risk and Assurance	The following clinical risks are associated with inadequate nursing and care staffing capacity and capability: Inadequate staffing numbers compromise safe and compassionate care. Poor monitoring of staffing capacity and capability can give rise to unacceptable patterns of inadequate staffing Not having the right skill mix in clinical environments can place unacceptable, additional demands upon staff and give rise to unsafe and ineffective care. If staff feel unable to speak out, then potentially unsafe staffing levels go undetected and reported and steps to maintain patient safety not be taken as required.
Service User/Carer/Staff	Inadequate staffing numbers compromise safe and compassionate care.
Financial	Poor monitoring of staffing capacity and capability can give rise to unacceptable patterns of inadequate staffing
Quality	Not having the right skill mix in clinical environments can place unacceptable, additional demands upon staff and give rise to unsafe and ineffective care.

Meetings where this item has been considered

Date	Committee/Meeting

Supporting documents and research material

a. Reference: How to Ensure the Right People with the Right Skills are in the Right Place at the Right Time: A guide to Nursing, Midwifery and Care Staffing Capacity and Capability(National Quality Board 2013)
b. Mental Health Staffing Frame work https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/06/mh-staffing-v4.pdf

c. Safe, sustainable and productive staffing in district nursing services (National Quality Board 2018)

https://improvement.nhs.uk/resources/safe-staffing-district-nursing-services/

Glossary

Abbreviation	In full
CHPPD	Care Hours Per Patient Day
CAMHS	Child and Adolescent Mental Health Services
NQB	National Quality Board
MHOST	Mental Health Optimum Staffing Tool

1.0 Background

1.1 Further to the Robert Francis Report (2013), the National Quality Board (NCB) have published guidance that sets out the expectations of commissioners and providers for safe nursing and midwifery staffing, in order to deliver high quality care and the best possible outcomes for service users.

1.2 In July 2016 the NQB issued a follow up paper "*Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. Safe sustainable and productive staffing"* which outlines an updated set of NQB expectations for Nurse staffing within Acute Trusts.

2.0 Analysis of Trust Results, Planned vs Actual staffing.

2.1 There are three main ways in which staffing levels are assessed in order to inform judgements about whether sufficient staff are in place to deliver good quality care. These are: the Average Fill rate (**Table 1),** the Care Hours per Patient Day (**Table 2)** and the MHOST (Mental Health Optimum Staffing Tool) (**Table 3**)

2.2 The **Average Fill rate** (Table 1) identifies whether or not the Trust standard of a minimum of two registered nurses per shift on every ward is being achieved. It also identifies if wards were able to mitigate a failure to achieve this either by increasing health care support workers numbers to offset the reduced registered nurse numbers or through other means. In most areas there is a reliance on existing staff covering shortfalls by doing additional bank hours. Luton and Bedfordshire wards are the only inpatient area that use agency staff cover to ensure safer staffing levels.

2.3 Newham, Tower Hamlets and Luton and Bedfordshire Working Age inpatient services showed below expected fill rates for Registered Mental Health Nurses (RMN) in a number of wards. However, these shortfalls were balanced with above expected staff levels of Health Care Assistant (HCA) fill rates. RMN shortfalls were also covered by the Ward Manager, Matron and Duty senior nurse cover, by moving staff around the unit or booking agency or bank staff. Two wards (Onyx ward and Roman ward) showed one month where the staffing numbers were not balanced out by additional HCA hours due to challenges obtaining bank or agency.

2.4 Galaxy ward – CAMHS Child and Adolescent Mental Health Services) (showed 3 months of below expected levels for RNs on shift, this was mitigated by Matron and Ward Manager cover and the duty senior nurse basing themselves on the ward out of hours. The overall staffing level was high for support worker input. This was due to

increased levels of observations and acuity which meant that the overall staffing levels were increased. Galaxy ward have now successfully recruited 90% of their Registered Nurses which from April 2022 started to have a positive impact on staffing levels.

2.5 Brick Lane, Tower Hamlets working age reported two consecutive months of staffing challenges as a result of a combination of factors: Vacancies, high acuity, short notice absences and the unavailability of bank staff due to Trust wide seasonal high demand. However, recent recruitment has helped address this.

2.6 There have also been some challenges on Fothergill ward. In part this reflects a number of retirements amongst the staff group on this ward, and some challenges with recruitment of staff to work with this client group of older adults. As part of the Trust response to this, a number of rotational posts have been created offering newly registered nurses exposure to this setting. This builds on the work that the Trust is already doing with universities to ensure that newly qualified students are recruited onto the Trust establishment. The Trust currently employs over 90% of the mental health nursing students from the affiliated universities and we are working with them to increase this further.

Table 1 Average Fill rates based on funded establishments are recorded as Green indicates above 90%, Amber 80-90% and Red Below 80%.

Ward	Nov	Dec	Jan	Feb	March	April
Newham						
Emerald	Day RMN 82% HCA140%	Day RMN88% HCA 134%				
Ruby Triage					Day RMN 88% HCA 91%	
Opal					Day RMN 101% HCA 86%	
Roman			Day RMN 76% HCA 93%			
Tower Hamlets						
Brick Lane					Day RMN 68% HCA 90%	Day RMN 81% HCA 119%
Lea		Day RMN 85% HCA 106%		Day RMN 121% HCA 88%		
Millharbour		Day RMN 85% HCA 113%				
Roman		Day RMN 80%				

		HCA 96%				
Rosebank					Day RMN 120% HCA 74%	
Luton and Bedford						
LU Crystal	Day RMN 88% HCA 121%					
Townsend Court						Day RMN 87% NHC 90%
Fothergill Ward	Day RN 85% RN 120%					Day RN 68% HCA 130%
Onyx					Day RMN 63% HCA 79%	
Coborn Adolescent Unit						
Galaxy		Day RMN 81% HCA 265%		Day RMN 86% HCA 329%	Day RMN 84% HCA 263%	
Hackney						
Mother and Baby Unit						Day RMN82% HCA151%

3.0 Care Hours Per Patient Day (CHPPD)

3.1 CHPPD (Table 2) was developed, tested and adopted to provide a consistent way of recording and reporting deployment of staff on inpatient wards. It's calculated by dividing the total registered nurses and healthcare support worker hours in a 24hr period by the daily count of patients in beds at 23:59.

3.2 The ELFT CHPPD Average 2018/19 (pre pandemic) and Jan 2022 to April 2022 is shown in Table 2. Whilst there are variations between Trusts based on shift patterns, site size & location and the skill mix of nursing teams, there has been no significant reduction in care hours per patient in 2022. Indeed, some areas show an improvement on this measure. Particularly in intensive care units (the PICU wards and Galaxy ward), this measure can be particularly driven by levels of acuity leading to additional staffing for observations that makes comparison difficult.

3.3 As yet, there is no national guidance on appropriate ranges of hours to use as a formal benchmark. However, this data does indicate that input for service users on inpatient wards has not been significantly impacted by vacancy rates and ongoing Covid sickness in 2022.

Table 2

PICU	2018/19 Average	*Jan 22*	*Feb 22*	*March 22*	*April 22*
Bevan	10.1	8.8	9.7	9.7	9.3
Millharbour	12.4	13.2	11.9	14.4	14.3
Rosebank	19.9	12.9	11.6	8.6	12.2
Jade PICU	15.4	14.7	13.3	18.1	13.9
London Crystal	11.4	10.5	10.7	11.5	11.1

Admission

City & Hackney

Brett	6.1	7	7	5.6	6.7
Conolly	6.2	5.9	6.3	7	5.8
Gardner	5.5	5.4	5.4	6.1	5.3
Joshua Ward	5.6	6	6.5	6.5	6.6
Ruth Seifert	6.6	6.9	7	9	7.9

Tower Hamlets

Brick Lane	5.3	6.4	6.4	6.3	6.8
Globe	4.8	6.2	6.8	5.6	7.1
Lea	5.1	6.7	6.4	5.1	6.2
Roman	5.2	7.1	7.1	6.3	6.8

Newham

Emerald	6.4	7.9	6.5	8.1	11
Ivory	9.8	8.2	8.5	14.8	10.1
Opal	5.4	6.2	5.9	6.7	6.1
Sapphire	6.5	7.7	8.5	8.3	7.5
Topaz	5.8	6.5	6.6	5.7	6.6
Ruby/Triage	10.7	8.4	8.3	8.6	10.7

Bedford & Luton

Onyx	6.8	5.8	6.8	6.5	7.6
Coral	6.5	9.8	10	11.5	9.8
(LU) Crystal Ward	8.5	6.5	7.9	8.2	closed
Bed Ash	6.7	7	5.9	6.5	6.3
Townsend Court	6.8	10.8	6.8	7	7.3
Willow	7.6	5.4	9.6	6.6	10.2

Forensics

Aldgate	closed	5.4	14.3	10.8	12.4
Bow	8.1	7.2	8.8	7.9	9.1
Broadgate	5.9	6.7	7.5	5.8	6.9
Butterfield	5.8	7.8	5.3	5.4	5.7
Clerkenwell (LD)	9.1	8.9	13.9	11.3	14.8
Clissold	5.6	9.9	5.4	5.2	5.3
East India(DSPD)	8.3	10.5	11.3	8.1	11
Hoxton	5.9	5.3	5.8	5.1	5.5
Limehouse	5.6	5.6	5.8	5.7	5.5
Loxford	5.4	5	5.2	4.9	5.6
Ludgate	6.1	6.8	7.3	6.6	8.3
Morrison	6.4	10.6	6.7	5.8	6.5
Shoreditch(LD)	8.6	11.8	12.5	13.3	13
Victoria	5.5	5.9	5.6	6.4	5.9
Westferry (PICU)	14.2	12.2	14.7	12.5	14.9
Woodberry	7.5	8.7	8.7	7.9	8.3

MHCOP

Columbia	7.7	7.5	7.4	4.1	7.2
Leadenhall	6.3	6.4	7.1	5.9	6.6
Poplars	8.3	6.5	6.6	7.8	7
Sally Sherman	12.8	9.2	10.4	11.6	10.9
Fountains Court	8.5	14.6	10.7	12.4	10.8

Specialist

Margaret Oates (M&B)	16.4	21.1	16.9	19.9	14.4
Cedar House	6.1	3.5	6.3	6	6.1
Fothergill	7.9	16.9	9.5	19.1	7.5

CAMHS

Coborn Acute	11.5	8	14.9	13.3	15.3
Coborn Picu	26.1	5.9	NA	25.6	26
Coborn-Galaxy Ward	18.2	25.9	35.2	23	34.1

4.0 Mental Health Optimum Staffing Tool

4.1 The MHOST (Table 3) is a further tool that has been developed to help mental health staff measure patient acuity and dependency to inform evidence-based decision making on staffing and workforce. It is used under licence from Imperial College Innovations Ltd. It aims to determine what levels of staff are required in order to provide good quality care, given the levels of acuity on the ward at the time.

4.2 The tool is based on five acuity and dependency levels for each mental health in-patient specialty. Each acuity and dependency level has an associated descriptor to enable clinical staff to score patients receiving care in their ward. Data is collected on every patient in participating wards/units at 1500 hrs, daily for at least 20 days. Where the tool is deemed appropriate each ward has completed three sets of data collection. The data is then used to produce the indicated whole time equivalent staffing required.

4.3 For ELFT, the tool suggests that the following staffing levels (wtes) are required (as compared to national averages for different types of ward).

Table 3

Adult Mental Health Admission

National Average	Trust Average
Day 7.5	5.98
Night 3.5	2.54

Psychiatric Intensive Care Unit

National Average	Trust Average
Day 7	8.64
Night 3	4.91

Forensic

National Average	Trust Average
Day 7.4	5.22
Night 3.4	1.75

Older Adults

National Average	Trust Average
Day 7	6.8
Night 3.3	2.8

**The national average includes Allied Health Professional Hours worked, within ELFT AHP hrs are not recorded as being attached to individual wards, professional judgement is applied when reviewing specialist/specific areas.*

4.4 Using this tool as a basis for reviewing whether or not staffing levels are set at the required level, the Trust can provide good assurance that these staffing levels are reflected in planned staffing levels on a shift by shift basis. There is further work to do to fully integrated Allied Health Professional data into Trust data to enable this tool to be used to its fullest potential in providing assurance about effective staffing levels.

4.5 Taken together, these results give assurance that:

- Staffing levels that reach the Trust standard are being achieved in inpatient wards. On occasions where this is not the case, there are mitigations that have been put in place. Recruitment is also taking place in areas of particular challenge.
- The hours of care per patient have not been adversely affected over the last two years.
- That the demands of acuity on ELFT wards suggest the need for staffing levels that are reflected in those for which the Trust's inpatient wards are established.

5.0 Community Health Services Nursing

5.1 Safer staffing data NHSE/I – a Safer Staffing tool has been developed for Community nursing as part of the National Community Nursing Plan. The tool focuses on demand, capacity and patient dependencies. ELFT community services participated as one of the original national pilot sites for the design of the tool, and this process reported that 'safer staffing' levels were of good skill mix where patient and staff safety were evident. The report demonstrated that safe care was being delivered despite the increased complexity and dependency of patients as a result of the recent pandemic and new models of care within the community. Post pilot the tool is being fine-tuned to include some of the user feedback, (for example, adding in clinic work carried out by community nurses).

5.2 Data collection took place in May 2022 and is due to be repeated in November 2022. Staff assessed the patients they visited each day for up to seven days, including evenings and weekends. Patients were placed into four categories ranging from low- to high-dependency/acuity, i.e., Cat.1 to Cat.4. Table 4 below summarises ELFT's visit rate and case mix.

Table 4: Dependency/Acuity and Caseload
Key: *Cat. 1* = independent; *Cat. 2* = low-medium; Cat*. 3* = medium-high; *Cat. 4* = dependent; *WI* = workload index.

	A	B	C	D	E	F		G
	Locality	*Patients per staff member*	*Cat.1 %*	*Cat.2%*	*Cat.3%*	*Cat.4%*	*Clinics*	*WI*
1	England pre-Covid	6.72	12.6	35.6	37.5	14.4	0.32	1.1
2	England Covid Era	7.27	37	30.6	25.4	6.9	0.12	1.12
3	ELFT All	7.75	27	36.1	27	8.6	0.21	1.19
4	BCHS	7.35	43.2	34.4	17.9	4.6	0.14	1.24
5	Tower Hamlets	8.01	4.6	39.5	41.8	14.1	0	1.25

5.3 The findings from this work suggest that England's pre-covid community patients leant towards middle dependency/acuity (Table 4, D1 and E1), which suggests that dependent/acute patients are not being admitted to hospital and shows that significant acute and long-term care is shifting from hospital to community.

5.4 During the pandemic there was a marked increase in lower dependency/acuity patients on the caseload; this is explained by the reduction in clinic sessions normally attended by less dependent/acute patients who, consequently, needed to receive a home visit (Row 2). The data does suggest that, one element of the work to restore services after the impact of COVID will need to focus on ensuring that as many more dependent patients are cared for at home as was the case before the pandemic.

5.5 During the pandemic ELFT staff visited, overall 7.75 patients per practitioner per day, slightly above the England average at 7.27 patients visited per practitioner per day. (Col. B, Row 2). Taken alongside the Workload Index rating, this data does suggest that nursing staff within Community Health services in the Trust are working at a higher intensity that elsewhere in the country.

5.6 Community Health Services also monitor vacancy rates as part of their work on safer staffing. Between January – April 2022, Community Health Services report an overall vacancy rate of 13 %. This is driven partly by leavers, but also by an increase in workforce establishment for new services as part of the national community programme. The current vacancy rates for Registered Nurses and Healthcare support workers are:

- All CHS – 13%
- Bedfordshire – 15 %
- Newham – 12 %
- Tower Hamlets – 16.50 %

5.7 Although Bedfordshire CHS has the second highest vacancy rate these continue to be concentrated in the North and the South Community teams. The considerable distance between primary care homes restricts the flexibility of cross cover on a day-to-day basis.

5.8 Each CHS locality service has a Recruitment action plan led by the Lead Nurse. They use Bank and Agency Nurses to cover short and long term gaps. Bank nurses are invariably internal Nursing staff from within the same service and not sole Bank employees. To have continuity we offer the agency shifts as a line with regular reviews of agency use as we continue recruitment to substantive posts. Bedfordshire Community Health Services have also been the first service in the Trust to welcome international nurses as part of current initiatives on international recruitment.

6.0 Conclusion

6.1 The different ways of assessing inpatient staffing levels do indicate that ELFT wards are appropriately staffed, and that, where there are challenges in specific areas there are mitigations that are put in place. Community Health Services data indicates that ELFT nurses are working at a higher intensity than elsewhere in the country. Further data to inform this picture is due to be collected in November 2022. In the meantime, the Trust is continuing to focus on recruitment and retention of nursing and healthcare assistant staff across the range of services that are included in this review.

7.0 Action being requested

7.1 The **Board is asked to NOTE** the assurance provided and **CONSIDER** if further sources of assurance are required.

NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
28 July 2022

Title	Finance, Business and Investment Committee (FBIC) 19 July 2022 – Committee Chair's Report
Committee Chair	Aamir Ahmad, Non-Executive Director, chair of the meeting on 19 July 2022
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 Finance, Business and Investment Committee (FBIC) meeting held on 19 July 2022.

Key messages

Finance Report Month 2

- A better than plan position of £1.1m deficit at the end of M2 at net deficit of £805k
- M3 figures are, however, reporting a year to date deficit of £1.8m which takes into account a release for hyper-inflation in addition to normal spend, and re-phasing of the c£4m FV gap
- Contracts with NHS commissioners are being finalised following which funding will be devolved to local budgets
- A 0.6% convergence target has been included against Trust income with no current agreed mitigation
- The Trust continues to be in Segment 1 (no specific support needs – maximum autonomy, minimum risk) of the NHS Oversight Framework.

Financial Planning Update

- Revised Trust and ICB planning submissions made 20 June 2022 with key changes being the move from a £1.9m deficit to a break even plan, driven by new funding of £2.7m for hyper-inflation
- Evidence of hyper-inflation over the course of the financial year will be gathered to ensure the Trust's performance against plan can be tracked; a review of the Trust's additional inflation costs and associated impact to be presented at a future meeting for assurance
- Income continues to be received based on H2 of 2021-2022 block values rather than contract values which are still in draft form
- The impact of Agenda for Change and other pay awards are expected to funded within tariff
- Work is ongoing with ICBs to allocate new investments to directorates ahead of M4 with the awareness that recruitment can be made against these
- Expectation, however, that the Trust will achieve a break even position at year end.

Financial Viability Update

- £11.23m schemes identified many of which commence later in the year, achieving full year effect of just under £8m; work continues to address the identification of schemes for the £3.77m gap
- M3 achieved £553k against a plan of £2.68m due in part to slippage on one clinical transformation scheme and also related to delays in finalising income contracts
- Sessions being held in September with directorates to focus understanding of their plans, progress, milestones, barriers and future plans
- Robust quality impact assessments are undertaken around clinical care and staff experience for relevant schemes.

Agency Expenditure

- Positive progress with agency spend continuing to decrease
- Work on university pipelines and international recruitment should start to demonstrate cost reduction benefits in agency nursing staff by year end

- Anticipated that there will be a return to report on agency spend compared to ceiling with a possible agency cap to be introduced during 2022-2023.

Capital and Estates

- Estates environment strategy refresh is progressing with completion anticipated in September 2022
- Estates CQC action plan is embedded as part of the holistic Trust-wide action plan
- Capital plan has been adjusted to reflect available CDEL allocation; the reduced allocation will create a number of challenges for in year requests
- In the event that the Trust receives additional funding sources, a list of additional fully costed projects is ready to be progressed at short notice
- Robust procedures are in place to counter risks to deliverability related to issues such as late funding, affordability and hyper inflation
- Environment Action Groups have been established for each inpatient facility which are collaborative forums between partners, clinicians, service users and the supply chain to improve the quality of inpatient environments with specific action plans for each unit.

Board Assurance Framework: Improved Value – Risks 7 and 8

- **Risk 7:** *If the Trust's approach to value and financial sustainability are not embedded, this may impact on the achievement of the Trust's financial, service delivery and operational plans*
    - Enhancing oversight at the Service Delivery Board with a more detailed report and discussions
    - Development of additional structured support for directorates to work on assessing their FV plans and associated resource implications
- **Risk 8:** *If the Trust fails to robustly implement and embed infrastructure plans including digital and estates, this will adversely impact on our service quality and delivery, patient care and carer experience, and our ability to transform services in line with our aspiration to be a leader in both of our ICSs*
    - Improvements made across all areas of the risk with associated mitigating actions
    - Risk levels expected to decrease as action and delivery plans take effect
- The Committee:
    - Requested that in future incremental reductions to risk score 8 are implemented to reflect the success of the mitigating actions as they occur, rather than awaiting whole plan delivery
    - Agreed there are no changes to the current risk scores for both risks 7 and 8
    - Agreed that appropriate controls are in place and operating effectively

Digital Strategy & UKCloud Update

- Good progress made with the digital strategy including the appointment of a cyber security officer
- UKCloud migration is progressing in line with the plan; and major deliverables affected by the migration are also now back on track
- VDI and integration engine will be accelerated once the new Cloud system is in place
- Significant developments around digital clinical transformation
- Digital people participation team undertaking excellent work around the adoption of digital with service users and are leading the NEL ICB Patients Know Best (PKB) people participation roll out, and have been pivotal in Patient Held Record in NEL with the Trust being an early adopter

Previous Minutes

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

NHS
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REPORT TO TRUST BOARD
28 July 2022

Title	Finance Report Month 3
Author	Matthew Hart, Deputy Director of Finance
Accountable Executive Director	Samanthi Gibbens, Interim Chief Finance Officer

Purpose of the report

This paper highlights financial performance to 30th June 2022.

Committees/meetings where this item has been considered

Date	Committee/Meeting

Key messages

Summary of Performance:

- Operating surplus (EBITDA) to end of June 2022 of £5,749k compared to budget operating surplus of £6,672k.
- Net deficit of £1,810k (1.4%) compared to planned net deficit of £1,070k (0.9%).
- Year to date net deficit is adverse against plan by £739k.
- The Trust expects to breakeven in line with plan at year-end.
- NHS Improvement (NHSI) risk rating is now under the new Segmentation framework. The Trust has been notified it is in Segment 1 (Maximum autonomy, minimum risk).
- Cash balance on 30th June 2022 of £120.4m.

Strategic priorities this paper supports

Improved Population Health Outcomes	☒	Delivering financial balance aids the Trust in maintaining control in decision making.
Improved Experience of Care	☒	Delivering financial balance aids improving service user satisfaction and experience of care.
Improved Staff Experience	☒	Delivering financial balance aids improving staff experience.
Improved Value	☒	This is a key requirement to ensure that the Trust delivers value for money and is not in breach of its Foundation Trust provider licence.

Implications

Equality Analysis	Financial sustainability aids the organisation in being able to address and adequately resource equality issues within the services we deliver
Risk and Assurance	NHS Improvement (NHSI) risk rating places the Trust in segment 1, there are however risks around the use of temporary staff and achieving the Trusts financial Viability target

Service User/Carer/ Staff	Delivering against the Trusts financial metrics supports the investment in services for the benefit of our staff, service users and carers
Financial	As stated in the report.
Quality	Delivering our services in a financially sustainable way enables continuous investment in improving the quality of our services.

1 Background/Introduction

1.1 This paper highlights financial performance for the financial period ended 30th June 2022.

2 Executive Summary

- Operating surplus (EBITDA) to end of June 2022 of £5,749k compared to budget operating surplus of £6,672k.
- Net deficit of £1,810k (1.4%) compared to planned net deficit of £1,070k (0.9%) to the end of June 2022.
- Year to date net deficit is adverse against plan by £739k.
- The Trust expects to breakeven in line with plan at year-end.
- The Trust risk rating is notified as in Segment 1 (maximum autonomy, minimum risk) under the NHS Improvement (NHSI) Segmentation framework.
- Cash balance on 30th June 2022 of £120.4m.

3 Financial Framework

3.1 The initial Trust planning submission was made on 17th March 2022 with a second iteration on 26th April 2022.

3.2 Final revised Trust and ICB submissions were made on 20th June 2022 setting out income and expenditure assumptions across the ICB for the financial year, and is the plan against which Month 3 is reported.

3.3 I&E planning in line with ICB submissions is now based on a breakeven Trust position for 2022/23 (i.e. net surplus of zero). The planning assumption assumes income and expenditure resulting from hyper-inflation above that included in national tariff uplifts of £2.7m.

3.4 The Trust have an initial allocation of £4.5m to support continuing out of envelope COVID expenditure.

3.5 Expenditure budgets have been uploaded based on work completed by finance teams. Further cost pressures are being considered on a case by case basis.

3.6 Contracts with NHS commissioners are in the final stages of being agreed and funding for new investment is in the process of being devolved to local budgets. Directorates can recruit into posts supported by confirmed new investment while this process is ongoing.

3.7 A 0.6% convergence target (£986k) has been included against Trust income within current NEL ICS plans, resulting from national funding changes.

3.8 Discussions took place with ICS partners as to the rationale for applying this against Mental Health services, which are subject to the Mental Health Investment Standard (MHIS), with NEL taking the approach of applying convergence to the MH services, where a neighbouring ICB has not. The Trust position is that the issue of convergence is in effect "over commissioning" and the system should jointly be deciding what to decommission rather than this be a further efficiency on provider budgets.

3.9 There is no agreed mitigation at present to reduce Trust expenditure budgets by 0.6% for these or other services not covered by MHIS (e.g. Community Health) and this presents a risk to delivery of the plan. Discussion is currently taking place with the ICB Commissioners to recognise non-recurrent and recurrent measures for addressing this.

4 Summary of Performance to 30th June 2022

4.1 Financial performance is summarised in the table below:

	YTD Jun-22			Annual	YTD May-22	Change
	Budget	Actual	Variance	Budget	Variance	+/-
	£000	£000	£000	£000	£000	£000
Operating Income	138,789	138,850	60	549,111	495	(435)
Operating Spend	(132,117)	(133,101)	(984)	(518,141)	(349)	(636)
Operating Surplus (EBITDA)	**6,672**	**5,749**	**(924)**	**30,969**	**147**	**(1,070)**
Interest Receivable	60	244	184	240	104	80
Interest Payable	(661)	(661)	0	(2,644)	0	0
Depreciation	(5,930)	(5,930)	(0)	(23,719)	49	(49)
Public Dividend Capital	(1,332)	(1,332)	0	(5,328)	0	0
Net Surplus / (Deficit) before lease adjustments	**(1,190)**	**(1,930)**	**(739)**	**(481)**	**300**	**(1,039)**
Lease adjustments	120	120	0	481	0	0
Adjusted Net Surplus / (Deficit)	**(1,070)**	**(1,810)**	**(739)**	**0**	**300**	**(1,039)**

4.2 Financial Viability (FV) Programme

4.3 As a result of uploading the initial 2022/23 budgets, the Trust has an FVP requirement of £15.0m.

4.4 The opening FV balance includes £3.4m unidentified carried from previous years, £5.1m (1.1%) 2022/23 national efficiency assumption and an additional efficiency requirement required to meet other Trust cost pressures.

4.5 The FV plan has been rephased as part of the latest (June) plan submission. Identified plans are phased in line with planned delivery and the unidentified element of the plan is phased in equal 12ths across the year so as to not 'back-end' the risk.

4.6 The year-to-date target at Month 3 was £2,679k, with a reported delivery of £553k resulting in an adverse variance of £2,126k YTD. Delivery of the FVP is a key risk to delivery of the overall financial position and is a driver for the overall adverse variance against plan at Month 3.

4.7 A separate paper on financial viability is tabled and discussed at Finance Business and Investment Committee (FBIC) which includes further relevant detail of the programme and new work streams underway to improve FV delivery.

5 Key Highlights of Financial Performance to 30th June 2022

5.1 Operating income at Month 3 is reported as favourable against plan by £60k. A summary of the Trust income position is included in Table 1 below.

5.2 Month 3 income assumptions are based on submitted plans.

5.3 Budgets have now been included in respect of funding for hyper-inflation, and this is the main reason for the change in income variance between Month 2 and Month 3.

5.4 Table 1: Summary of Operating Income to 30th June 2022

	YTD Jun-22 Budget £000	YTD Jun-22 Actual £000	YTD Jun-22 Variance £000	Annual Budget £000	YTD May-22 Variance £000	Change +/- £000
Block Income						
CCGs	105,991	105,995	4	423,963	458	(454)
NHSE	2,518	2,518	0	10,070	0	0
Sub total	**108,508**	**108,512**	**4**	**434,033**	**458**	**(454)**
Cost and Volume Income						
Overseas Income	0	1	1	0	1	0
OATS / Spot Income	336	400	64	1,344	64	0
Sub total	**336**	**401**	**65**	**1,344**	**65**	**0**
SLA Income						
NCEL CAMHS Service (Lead Provider)	7,824	7,824	0	31,295	0	0
NCEL Forensic Service (BEH)	10,765	10,765	0	43,061	0	0
Services to other Trusts	2,070	2,072	2	8,279	0	2
Sub total	**20,659**	**20,661**	**2**	**82,635**	**0**	**2**
Workforce Allocation						
SIFT/MADEL/NMET R&D etc	**2,818**	**2,818**	**0**	**11,449**	**0**	**0**
COVID-19						
Vaccination Centre (London)	787	787	0	787	0	0
Vaccination Centre (Luton & Bedfordshire)	19	19	0	19	0	0
Vaccination Lead Employer	1,269	1,269	0	1,269	0	0
Sub total	**2,075**	**2,075**	**0**	**2,075**	**0**	**0**
Other Income						
Primary Care	598	598	1	2,390	(11)	12
CAMHS	10	10	0	38	0	0
Addiction Services	870	870	0	3,481	0	0
Community Services (Local Authority)	2,065	2,052	(12)	8,258	(17)	5
Other Income	182	182	0	726	0	0
Sub total	**3,723**	**3,712**	**(11)**	**14,893**	**(28)**	**17**
Deferred Income						
Deferred Income Released	670	670	0	2,682	(0)	0
Sub total	**670**	**670**	**0**	**2,682**	**(0)**	**0**
EBITDA Income	**138,789**	**138,850**	**60**	**549,111**	**495**	**(435)**

5.5 Operating Expenditure

The Trust is reporting an adverse variance of £984k against operating expenditure at 30th June 2022.

5.6 COVID-19

Where it has been possible to separately identify COVID-19 related expenditure, this has been charged to separate cost centre codes in each Directorate. The impact on each Directorate is shown in table 2a below and is adjusted for at summary level in Table 2b.

The surplus of income against expenditure may be repayable, however it is likely Covid-19 related costs may exist within Directorates, and not charged to the separate cost centre.

The national expectation has been that these costs should continue to decrease over the course of 2022/23. Whilst the response to COVID-19 is critical, containment of cost is needed.

Table 2a: COVID-19 Expenditure and Variance by Directorate

	YTD Budget £000	YTD Actual £000	YTD Variance £000
Mental Health Services			
Tower Hamlets	0	(55)	(55)
Newham	0	(67)	(67)
City & Hackney	0	(37)	(37)
Forensic Services	0	(30)	(30)
Specialist Services	0	0	0
Luton	0	(147)	(147)
Bedfordshire	0	(64)	(64)
Sub total	**0**	**(401)**	**(401)**
Community Health & Primary Care			
Newham CHS	0	(10)	(10)
Specialist CHS	0	0	0
Tower Hamlets CHS	0	0	0
Bedfordshire CHS	0	(96)	(96)
Sub total	**0**	**(107)**	**(107)**
Central COVID Budgets	(1,125)	(218)	907
Sub total	**(1,125)**	**(218)**	**907**
TOTAL (excluding vaccination centres and lead employer)	**(1,125)**	**(726)**	**399**

5.7 The Estates position is adversely impacted by the impact of variable Soft Facilities Management (FM) costs and other additional costs resulting from the recent Soft FM tender exercise. This is under discussion within the Executive Team and with Estates.

5.8 Corporate budgets continue to be significantly overspent in some areas. A process run by the Chief Finance Officer is ongoing to agree additional budget allocations, and a reserve is held to provide for these. Those agreed to be funded will be allocated budgets in Month 4 offset by savings proposed by the Executive Team to offset part of the cost pressures.

£1,250k has been released from reserves up to and including Month 3 to offset this.

5.9 A process is underway to apply budgets against new service developments. This is being completed later than usual to a significant degree because

annual planning was only completed on 20th June and contracts are only now being finalised. This will give Directorate teams visibility of their total budgets. This should not delay recruitment into newly funded posts and recruitment can progress while this process concludes.

5.10 Table 2b: Summary of Expenditure to 30th June 2022

	YTD Jun-22 Budget £000	YTD Jun-22 Actual £000	YTD Jun-22 Variance £000	Annual Budget £000	YTD May-22 Variance £000	Change +/- £000
Mental Health Services						
Tower Hamlets	(11,378)	(11,326)	51	(45,515)	114	(63)
Newham	(9,254)	(9,636)	(382)	(37,020)	(12)	(371)
City & Hackney	(10,194)	(10,510)	(316)	(40,780)	(161)	(155)
Forensic Services	(9,245)	(9,299)	(53)	(36,987)	27	(81)
Specialist Services	(14,685)	(14,484)	201	(58,747)	129	72
Luton	(6,336)	(6,307)	29	(25,348)	22	7
Bedfordshire	(12,964)	(13,024)	(61)	(51,862)	(78)	17
Less COVID-19 Costs	0	401	401	0	244	157
Sub total	**(74,056)**	**(74,186)**	**(130)**	**(296,258)**	**287**	**(417)**
Community Health & Primary Care						
Newham CHS	(6,626)	(6,387)	239	(26,506)	113	126
Specialist CHS	(1,772)	(1,722)	50	(7,090)	51	(1)
Tower Hamlets CHS	(3,729)	(3,575)	154	(14,919)	126	28
Bedfordshire CHS	(10,646)	(10,724)	(79)	(42,586)	(106)	28
Primary Care	(1,561)	(2,044)	(483)	(6,243)	(255)	(228)
Less COVID-19 Costs	0	107	107	0	98	9
Sub total	**(24,333)**	**(24,345)**	**(12)**	**(97,345)**	**27**	**(39)**
Commissioning						
NCEL Provider Collaborative	(8,494)	(8,494)	0	(33,977)	0	0
Sub total	**(8,494)**	**(8,494)**	**0**	**(33,977)**	**0**	**0**
Central Support Services						
Board / Members' Council	(778)	(824)	(46)	(3,114)	12	(58)
Director of Operations	(881)	(1,045)	(164)	(1,716)	(140)	(24)
Corporate Affairs	(200)	(260)	(60)	(800)	(25)	(35)
ICT	(2,121)	(2,126)	(5)	(8,485)	221	(226)
Business Develop Unit	(265)	(296)	(31)	(1,060)	25	(56)
Social Inclusion	(278)	(268)	11	(1,113)	0	10
Finance	(1,291)	(1,338)	(47)	(5,165)	(204)	157
Human Resources	(1,459)	(2,050)	(591)	(5,835)	(359)	(232)
Central Medical/Pharmacy	(2,010)	(1,999)	11	(8,039)	8	3
NMET	(796)	(769)	27	(3,185)	(22)	49
Central Nursing/MHA admin	(1,459)	(1,497)	(39)	(5,836)	(73)	34
Chief Quality Officer	(1,129)	(1,205)	(76)	(4,516)	(39)	(37)
Director of Integrated Care	(439)	(606)	(167)	(1,310)	(131)	(35)
R&D	(215)	(130)	85	(861)	90	(5)
AMPS	0	(1)	(1)	0	(1)	
Estates & Facilities	(6,530)	(7,955)	(1,424)	(26,122)	(643)	(781)
Central NHS SLAs	0	(0)	(0)	0	(62)	62
Less COVID-19 Costs	0	25	25	0	7	19
Sub total	**(19,851)**	**(22,342)**	**(2,491)**	**(77,156)**	**(1,336)**	**(1,155)**

	YTD Jun-22			Annual	YTD May-22	Change
	Budget	Actual	Variance	Budget	Variance	+/-
	£000	£000	£000	£000	£000	£000
Central COVID-19 Costs	(1,125)	(212)	913	(4,500)	754	159
Clinical Directorate COVID-19 Costs	0	(507)	(507)	0	(342)	(165)
Vaccination Centres	(806)	(806)	0	(806)	0	0
NEL Vaccination Lead Employer	(1,269)	(1,269)	(0)	(1,269)	0	(0)
Sub total	**(3,200)**	**(2,795)**	**405**	**(6,575)**	**412**	**(7)**
Reserves						
Development Reserve	(242)	0	242	(967)	0	242
Financial Viability	2,650	524	(2,126)	14,886	(958)	(1,168)
Pay/non pay reserve	(4,591)	(1,463)	3,128	(20,750)	1,220	1,908
Sub total	**(2,182)**	**(939)**	**1,243**	**(6,831)**	**262**	**981**
EBITDA Spend	**(132,117)**	**(133,101)**	**(984)**	**(518,141)**	**(349)**	**(636)**

5.11 NHSI Agency Ceiling

Total monthly agency expenditure has been consistently at or above 50% above the 2019/20 agency ceiling for at least the past 2 years. Medical agency expenditure is consistently above the ceiling calculated for that staff group.

National curbs on agency expenditure are being reintroduced. There remains a significant risk that the Trust would be 50% above our previous the agency ceiling on a cumulative basis.

The agency cap will apply again from July 2022 (Month 4), and the value of the Trust cap will be updated once this is notified by NHSI.

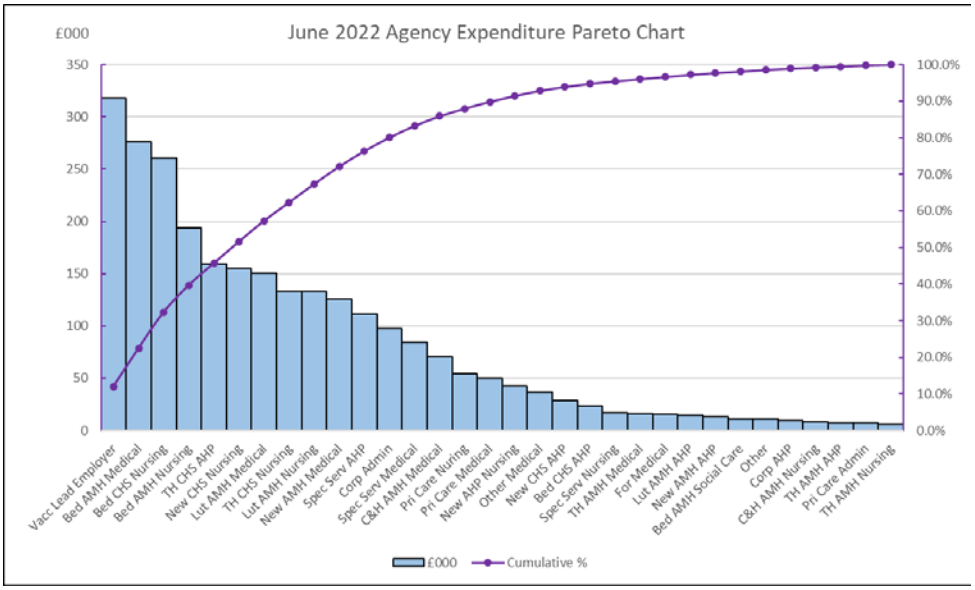
Services need to be particularly mindful that agency should only be considered as a short-term solution with substantive recruitment completed as quickly as possible.

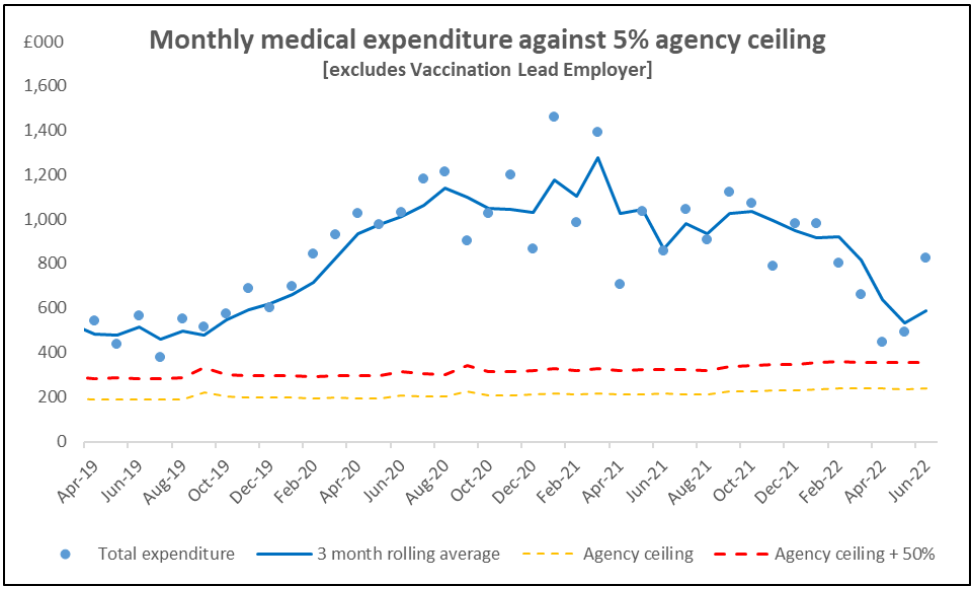
Agency expenditure is summarised in the charts below:

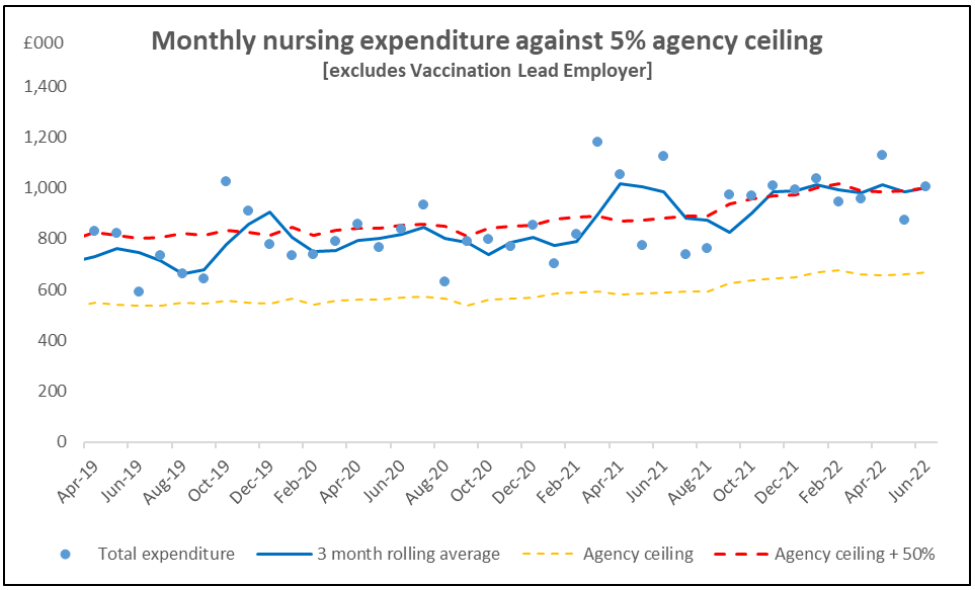
(a) Pareto Chart showing June 2022 agency expenditure by staff category and Directorate. Combinations with expenditure less than £10k in month are grouped under 'Other'.

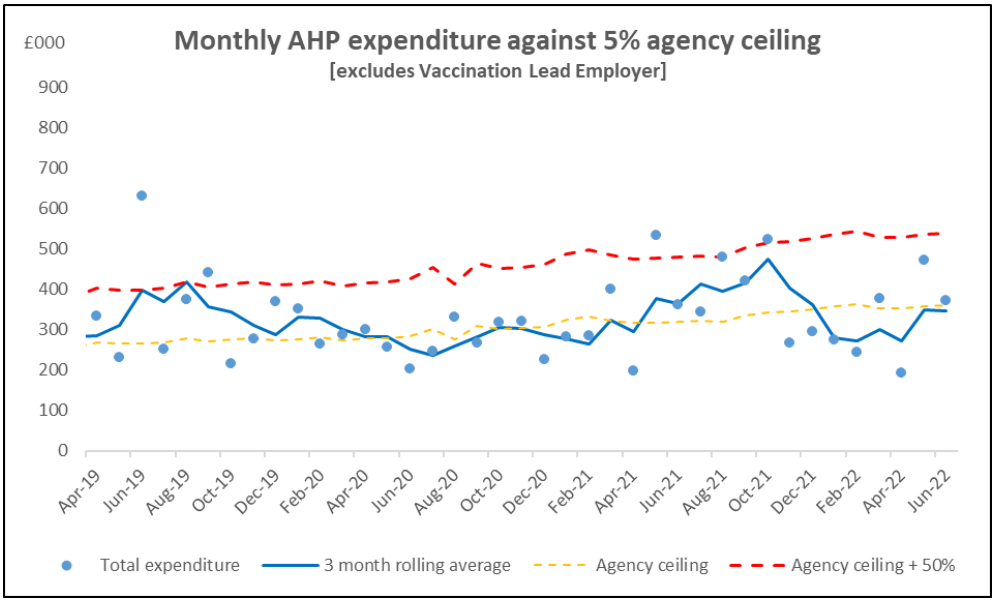
(b) Medical, Nursing and Allied Health Professional (AHP) expenditure run rates against a calculated 5% agency cap for these staff groups.

These charts exclude agency expenditure recorded under the Vaccination Lead Employer programme to present the underlying Trust position.


£000
June 2022 Agency Expenditure Pareto Chart
350
300
250
200
150
100
50
0
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Vacc Lead Employer
Bed AMH Medical
Bed CHS Nursing
Bed AMH Nursing
TH CHS AHP
New CHS Nursing
Lut AMH Medical
TH CHS Nursing
Lut AMH Nursing
New AMH Medical
Spec Serv AHP
Corp Admin
Spec Serv Medical
C&H AMH Medical
Pri Care Nuring
Pri Care Medical
New AHP Nursing
Other Medical
New CHS AHP
Bed CHS AHP
Spec Serv Nursing
TH AMH Medical
For Medical
Lut AMH AHP
New AMH AHP
Bed AMH Social Care
Other
Corp AHP
C&H AMH Nursing
TH AMH AHP
Pri Care Admin
TH AMH Nursing
£000
Cumulative %


£000
Monthly medical expenditure against 5% agency ceiling
[excludes Vaccination Lead Employer]
1,600
1,400
1,200
1,000
800
600
400
200
0
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jun-20
Aug-20
Oct-20
Dec-20
Feb-21
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22
Jun-22
Total expenditure
3 month rolling average
Agency ceiling
Agency ceiling + 50%


£000
Monthly nursing expenditure against 5% agency ceiling
[excludes Vaccination Lead Employer]
1,400
1,200
1,000
800
600
400
200
0
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jun-20
Aug-20
Oct-20
Dec-20
Feb-21
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22
Jun-22
Total expenditure
3 month rolling average
Agency ceiling
Agency ceiling + 50%



6 Forecast to March 2022

6.1 The plan is consistent with reporting a breakeven position per the June 2022 submission.

7 Conclusions

7.1 Reported net deficit at Month 3 is £1,810k, which is £739k adverse against plan.

8 Equalities

8.1 This paper has no direct impact on equalities.

9 Financial Implications

9.1 These are as stated in this report.

10 Risk

10.1 The NHSI risk rating is not currently being reported in the same way as before the COVID pandemic. Whilst agency spend is still monitored by NHSI, the Trust is currently in segment 1 (maximum autonomy, low risk). However, the high level of agency expenditure could adversely impact the Trust's overall risk rating at a later date if it is not reduced.

10.2 Delivery of a challenging FVP is critical to delivering the Trust plan and further work is required to develop schemes to meet the recurrent £15.0m target.

10.3 Hyper-inflation is assumed in the plan equal £2.7m, but this will need to be carefully monitored and documented through the year and will need to be reported within the ICS and as part of Trust returns to NHSI.

10.4 The NEL CCG 0.6% convergence target is unmitigated at present and presents a risk to delivery of the plan (see 3.9).

10.5 Barts Health have levied an increase Estates charge of £0.5m full year which is not funded in budgets and is being reported as an overspend at Month 3. These charges have been formally disputed and will require resolution.

10.6 The recent Soft FM tender exercise has resulted in additional unfunded variable pass-through and costs arising from additional service requests, amounting to a significant cost pressure. This is under discussion within the Executive Team and Estates team.

11 Actions Being Requested

11.1 The Service Delivery Board is asked to:

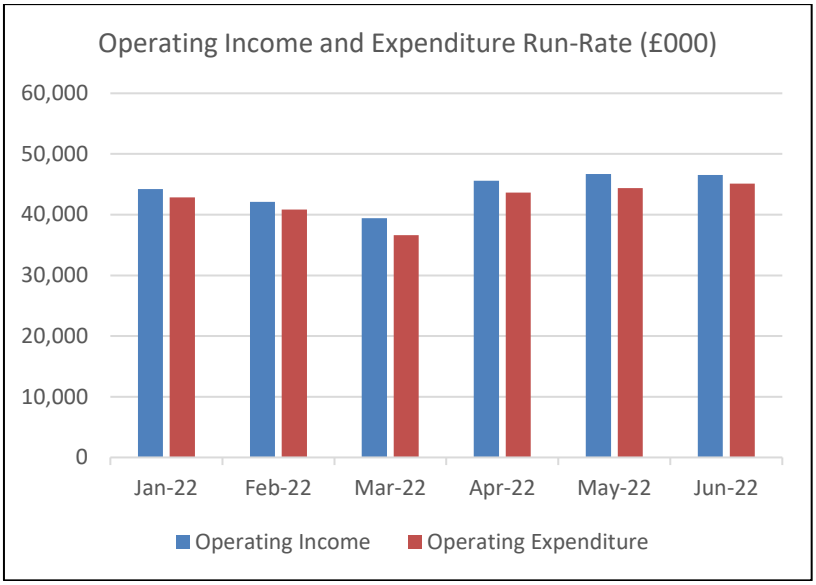
a. **RECEIVE** and **NOTE** the report
b. **NOTE** the assurance provided and **CONSIDER** if further sources of assurance are required

APPENDIX 1: SIX-MONTH INCOME AND EXPENDITURE RUN-RATE

OPERATING INCOME	Jan-22 £000	Feb-22 £000	Mar-22 £000	Apr-22 £000	May-22 £000	Jun-22 £000
Block Income						
CCGs	30,416	34,963	39,276	34,724	35,187	34,959
less funding returned to local CCGs	0	(7,500)	(7,500)			
CCGs COVID Funding	0	0	0	375	375	375
NHSE	1,100	1,534	1,259	839	839	839
Sub total	**31,516**	**28,998**	**33,034**	**35,939**	**36,401**	**36,173**
Cost and Volume Income						
Overseas Income	4	0	1	0	1	0
OATS / Spot Income	113	97	142	112	176	112
Sub total	**118**	**97**	**143**	**112**	**177**	**112**
SLA Income						
NCEL CAMHS Service (Lead Provider)	2,374	2,435	2,272	2,590	2,590	2,644
NCEL Forensic Service (BEH)	4,434	3,726	2,990	3,588	3,588	3,588
Services to other Trusts	669	807	688	690	690	692
Sub total	**7,478**	**6,968**	**5,950**	**6,868**	**6,868**	**6,925**
Workforce Allocation						
SIFT/MADEL/NMET R&D etc	**798**	**1,776**	**1,899**	**904**	**904**	**1,009**
COVID-19						
Vaccination Centre (London)	503	345	308	236	288	264
Vaccination Centre (Luton & Bedfordshire)	5	7	7	6	6	7
Vaccination Lead Employer	813	726	507	274	409	585
Sub total	**1,321**	**1,078**	**821**	**516**	**703**	**856**
Other Income						
Primary Care	195	409	306	195	190	213
CAMHS	10	3	3	3	3	3
Addiction Services	290	290	163	290	290	290
Community Services (Local Authority)	671	684	700	681	678	693
Other Income	61	61	61	61	61	61
Sub total	**1,227**	**1,448**	**1,233**	**1,231**	**1,222**	**1,259**
Deferred Income						
Deferred Income Released	1,769	1,769	(3,636)	0	447	223
Sub total	**1,769**	**1,769**	**(3,636)**	**0**	**447**	**223**
EBITDA Income	**44,226**	**42,135**	**39,445**	**45,569**	**46,723**	**46,558**

OPERATING EXPENDITURE	Jan-22 £000	Feb-22 £000	Mar-22 £000	Apr-22 £000	May-22 £000	Jun-22 £000
Mental Health Services						
Tower Hamlets	(3,833)	(3,768)	(4,246)	(3,664)	(3,799)	(3,864)
Newham	(3,239)	(2,939)	(3,497)	(3,219)	(2,949)	(3,468)
City & Hackney	(3,586)	(3,243)	(4,504)	(3,400)	(3,545)	(3,564)
Forensic Services	(3,255)	(4,228)	(3,394)	(3,109)	(3,018)	(3,171)
Specialist Services	(4,710)	(4,607)	(5,219)	(4,784)	(4,864)	(4,836)
Luton	(2,450)	(2,071)	(2,568)	(2,170)	(2,023)	(2,114)
Bedfordshire	(4,561)	(3,970)	(6,017)	(4,236)	(4,361)	(4,428)
Less COVID-19 Costs	313	333	177	164	80	157
Sub total	**(25,321)**	**(24,491)**	**(29,269)**	**(24,418)**	**(24,479)**	**(25,289)**
Community Health & Primary Care						
Newham CHS	(2,264)	(724)	(2,138)	(2,057)	(2,240)	(2,089)
Specialist CHS	(572)	(528)	(663)	(574)	(555)	(593)
Tower Hamlets CHS	(1,274)	(104)	(1,253)	(1,109)	(1,249)	(1,217)
Bedfordshire CHS	(4,272)	(3,630)	(3,892)	(3,566)	(3,616)	(3,542)
Primary Care	(604)	(696)	(651)	(672)	(621)	(751)
Less COVID-19 Costs	546	320	379	17	81	9
Sub total	**(8,441)**	**(5,363)**	**(8,217)**	**(7,961)**	**(8,200)**	**(8,184)**
Commissioning						
NCEL Provider Collaborative	(2,711)	(2,694)	(2,500)	(2,590)	(3,037)	(2,867)
Sub total	**(2,711)**	**(2,694)**	**(2,500)**	**(2,590)**	**(3,037)**	**(2,867)**
Central Support Services						
Board / Members' Council	(211)	(234)	(56)	(261)	(246)	(318)
Director of Operations	(130)	(190)	(279)	(189)	(123)	(733)
Corporate Affairs	(74)	(69)	(71)	(64)	(94)	(102)
ICT	(1,224)	(773)	(2,885)	(736)	(436)	(954)
Business Develop Unit	(90)	(128)	(173)	(65)	(86)	(144)
Social Inclusion	(90)	(116)	(64)	(98)	(87)	(82)
Finance	(456)	(482)	(422)	(452)	(556)	(330)
Human Resources	(607)	(610)	(765)	(674)	(652)	(724)
Central Medical/Pharmacy	(706)	(633)	(677)	(728)	(603)	(669)
NMET	134	(762)	(336)	(281)	(238)	(250)
Central Nursing/MHA admin	(168)	(860)	(1,974)	(379)	(584)	(534)
Chief Quality Officer	(1,058)	(643)	(618)	(385)	(405)	(415)
Director of Integrated Care	35	(213)	252	(155)	(298)	(153)
R&D	(109)	(28)	136	(28)	(25)	(77)
AMPS	(0)	(0)	(0)	(0)	(0)	(0)
Estates & Facilities	(3,918)	(3,813)	(4,024)	(2,343)	(2,630)	(2,981)
Central NHS SLAs	0	0	33	0	(62)	62
Less COVID-19 Costs	0	28	(18)	3	4	19
Sub total	**(8,673)**	**(9,528)**	**(11,941)**	**(6,836)**	**(7,121)**	**(8,386)**
Community Transformation	(619)	(630)	516			
Sub total	**(619)**	**(630)**	**516**	**0**	**0**	**0**
COVID-19						
Central COVID-19 Costs	(112)	(93)	(74)	(70)	17	(159)
Clinical Directorate COVID-19 Costs	(859)	(653)	(556)	(181)	(161)	(165)
Vaccination Centres	(508)	(352)	(327)	(241)	(294)	(271)

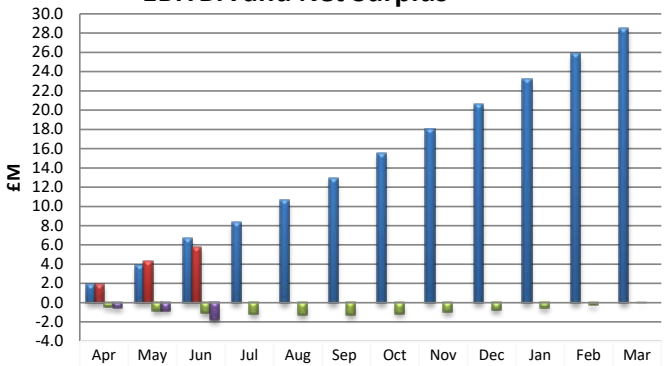
NEL Vaccination Lead Employer	(813)	(726)	(507)	(274)	(409)	(586)
Sub total	**(2,291)**	**(1,824)**	**(1,464)**	**(767)**	**(847)**	**(1,181)**
Reserves						
Development Reserve	3,814	(143)	559	(282)	(282)	565
Financial Viability	0	0	0	0	0	524
Pay/non pay reserve	8,209	(5,822)	8,501	(778)	(558)	(878)
Sub total	**12,023**	**(5,964)**	**9,060**	**(1,061)**	**(841)**	**211**
Other						
Other non-recurrent items	(6,800)	9,637	7,213	0	149	602
Sub total	**(6,800)**	**9,637**	**7,213**	**0**	**149**	**602**
EBITDA Spend	**(42,833)**	**(40,857)**	**(36,601)**	**(43,632)**	**(44,376)**	**(45,093)**



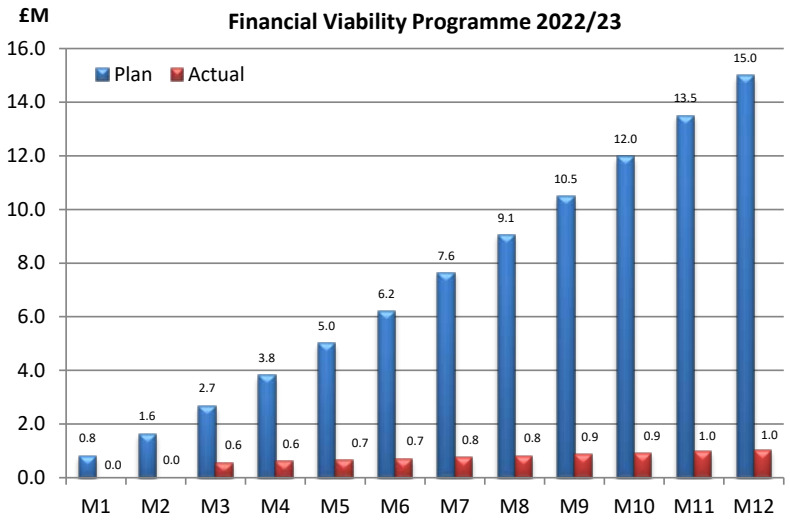
Financial Overview to Period Ending 30th June 2022

EBITDA AND NET SURPLUS

Reported	To 30/06/22 £m	To 30/06/22 %	Projection £m	Projection %	Plan £m	Plan %
EBITDA	5.7	4.1	28.5	5.1	28.5	5.1
SURPLUS	-1.8	-1.4	0.0	0.0	0.0	0.0

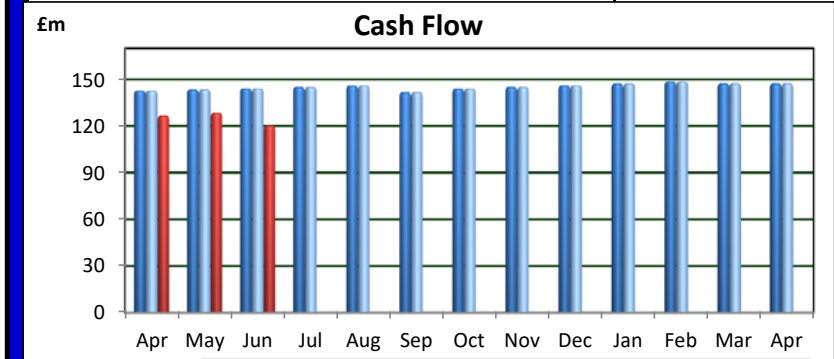


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
EBITDA Plan	1.9	3.9	6.7	8.3	10.6	13.0	15.5	18.1	20.6	23.3	25.9	28.5
EBITDA Actual	1.9	4.3	5.7									
Net Surplus Plan	-0.4	-0.9	-1.1	-1.2	-1.2	-1.3	-1.1	-0.9	-0.8	-0.5	-0.3	0.0
Net Surplus Actual	-0.5	-0.8	-1.8									

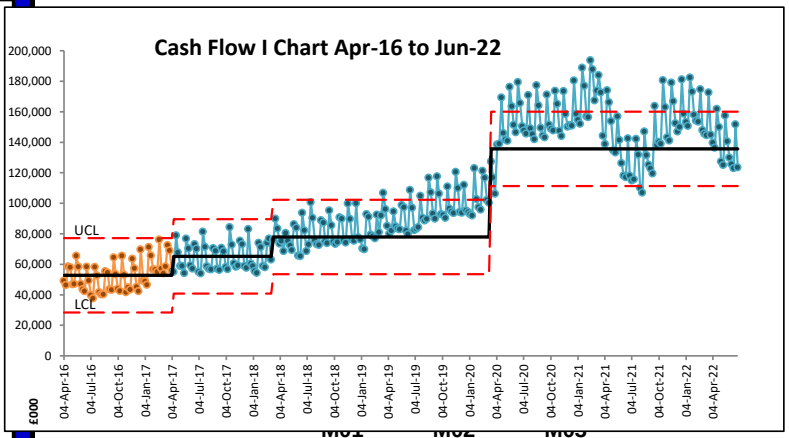


WORKING CAPITAL

		£m	Risk
Cash	: at Bank	120.4	
	: Short term deposits	0.0	
Short term	: Assets	154.4	
	: Liabilities	110.2	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Plan £M	143	144	144	145	146	142	144	145	146	147	149	148	148
Forecast £M	143	144	144	145	146	142	144	145	146	147	149	148	148
Actual £M	127	129	120										



	M01	M02	M03
DEBTOR DAYS	8	9	8
CREDITOR DAYS	23	19	21

RISKS AND RISK RATINGS

INCOME	£m
Total EBITDA Income	549.1
CCG	424.0
NHSE	10.1
Other	112.4
Deferred Income	2.7
INCOME RISK	LOW

EXPENDITURE

Financial Viability Prog.	HIGH
Expenditure Risk	HIGH

SEGMENTATION FRAMEWORK

SEGMENT	1

NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
26 May 2022

Title	Audit Committee 8 July and 14 July 2022 – Chair of the Meeting Report
Chair of the meeting	Anit Chandarana, Non-Executive Director
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 Extraordinary Audit Committee meeting held on 8 July 2022 and the Audit Committee held on 14 July 2022

Key messages

Audit Committee held on 14 July 2022

Annual Report and Accounts 2021-2022 including External Audit Report:

- Audit is largely completed with quality review process under way; this includes completion of enhanced procedures for the NAO group audit as the Trust is a sampled component this year
- Disclosure amendments and adjustments have been agreed and amended
- Progress being made on the three outstanding queries reported at the Extraordinary Audit Committee on 8 July 2022
- Assurance provided that the Trust will not have the same level of unadjusted errors to carry into the next year, and it is therefore anticipated that the materiality level will be approximately £1m
- The final annual report and accounts for 2021-2023 will be presented at the Trust Board in private in July 2022
- Assurance provided that the deficiencies identified from the 2020-2021 external audit have now been addressed.

Internal Audit Annual Report 2021-2022

Final internal audit annual report for 2021-2022 provided reasonable assurance: *the Trust has an adequate and effective framework for risk management, governance and internal control. Further enhancements have been identified to ensure that the framework remains adequate and effective.*

Waivers and Breach

- Breaches reported are predominantly around orders placed with requisitions being completed retrospectively
- Robust digital structures are being put in place to help with the learning around procurement processes and training for directorates is ongoing.

Counter Fraud Update

- Following the issue by NHS Counter Fraud Authority of a Fraud Prevention Notice in respect of card payment terminals, a review was undertaken to check if the risk posed a threat to the Trust; no concerns were raised and an opinion of substantial assurance was given
- Investigations into fraudulent entries on the National Immunisation & Vaccine System (NIVS) continue. Recommendations have been made to tighten up procedures at the Vaccination Centre to reduce the risk of further fraudulent entries being made and to reduce system weakness.

Board Assurance Framework: Deep Dive Risk 8 – Cyber Security Update

If the Trust's approach to value and financial sustainability are not embedded, this may impact on the achievement of the Trust's financial, service delivery and operational plans:

- Assurance received that the Cyber plan is on track following the challenges faced during the pandemic, maturing from a reactive to a strategic plan, and is expected to meet the requirement of new ICSs to have digital strategies in place across the system

- Cyber framework covers governance (context and leadership; organisational culture; evaluation and direction; compliance, audit and review) as well as management (security prevention; security detection; security incident response and recovery; measurement)
- Range of improvements have been made including the establishment of a Cyber team with the aim of aligning to and achieving ISO027001.

Governance Compliance Statements

- **NHSI Self Certification:** On the basis of the evidence provided on the Trust's compliance with NHS England's provider licence requirements, the Committee approved the self-certification statement for ratification by the Trust Board (attached at appendix 1)
- **Fit and Proper Persons Requirement:** The Committee received a report from the Trust Chair confirming compliance that the FPPR checks have been conducted for the period 1 April 2021-31 March 2022 and that all Board members satisfy the requirements (attached at appendix 2)
- **Modern Day Slavery and Human Trafficking Statement:** Having received appropriate assurance that the Trust is taking all steps to ensure modern day slavery and human trafficking is not taking place in our business, with staff or within the supply chain, the Committee approved the statement for ratification by the Trust Board and for publication on the Trust's website (attached at appendix 3)

Extraordinary Audit Committee held on 8 July 2022

The focus of discussions was on the progress of the drafting and external audit of the Trust's Annual Report and Accounts for 2021-2022.

External Audit

- An interim set of accounts submitted to NHSE as June deadline was missed due to late queries
- There were three further queries raised by the external auditors which are currently being responded to by the Trust, and which will require review by the auditors
- Requested a report on the query in relation to Loss of Office Payments
- External audit report on unadjusted audit differences reviewed and areas for adjustment and non-adjustment on the accounts agreed, noting there would be no impact on overall income and expenditure
- The decisions made by the Board for the 2020-2021 accounts have had an accumulative impact for this year

Annual Accounts

- The reported position agreed, pending ongoing work as reported above, and anticipated being able to sign off the accounts at the Audit Committee on 14 July 2022.

Annual Report

- Report agreed pending final outcome of the queries raised as reported under External Audit above, noting the Board has been sighted on two versions of the draft annual report.

Approval Process

- An extraordinary Audit Committee meeting to be arranged at end of August to allow for the completion of the external auditors' value for money report with the aim of being able to lay the annual report and accounts before Parliament in early September, and therefore to present at the planned Trust's Annual Members Meeting on 11 October 2022
- Plans are in place to mitigate any timing issues, with options for presenting the annual report and accounts and external auditors report at planned meetings in October and November
- External auditors to undertake a detailed review of the external audit process this year particularly in respect of challenges with completing to the previously agreed timeframe, a repeat of the previous year's experience.

Previous Minutes: The approved minutes of the previous Audit Committee meeting are available on request by Board Directors from the Director of Corporate Governance.

(APPROVED by Audit Committee and subject to ratification by Trust Board)

NHS
East London
NHS Foundation Trust

NHS PROVIDER LICENCE SELF-CERTIFICATION 2021-2022

General Condition 6, Continuity of Service 7 and Condition FT4

The Board of Directors at its meeting on 28 July 2022 reviewed and agreed the NHS Provider Licence Self-Certification statements for 2021-2022 as set out below.

1 General Condition 6: Systems for Compliance with Licence Conditions

1.1 ***Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the financial year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution.***

1.2 In making the above declaration, the main factors which have been taken into consideration include:

- The Trust believes that the best service improvements are those were our service users, the wider public and key stakeholders work together to coproduce services based on the health and care needs of our local population. Strong integrated governance arrangements are therefore paramount as we work in a much more integrated way to improve care for our residents, population and service users
- The Trust's capacity to manage risk has been tested during the year with the ongoing impact of the pandemic and processes in place have enabled an appropriate response to the emerging risks. The Trust established effective operational and corporate governance arrangements to respond to the continued challenges associated with Covid. The Trust continued with the Gold, Silver and Bronze Command structure to support the ongoing response, to provide leadership in managing the situation, monitoring progress and identifying solutions to problems with a focus on service users, service impacts, staff, risks and recovery. The Command structure ensured strategic, tactical and operational risks were identified, and individual risks on the Board Assurance Framework were regularly reviewed by the lead Executive Director and updates provided at each lead Board committee meeting. During the year there was a specific focus on the impact of the pandemic, and the controls and actions were updated to reflect the Trust's response to the crisis. An additional risk was added to the BAF in July 2021 to reflect the Trust's commissioning and lead provider responsibilities and the impact of not effectively managing these on the quality and experience of care for our service users and patients. Assurance continued to be provided to the NEDs via Audit Committee, FBIC, QAC and Board meetings
- The annual governance statement in the Trust's annual report for 2021-2022 describes the Trust's system of internal control and the processes in place to identify, evaluate and manage operational risks and risks to the achievement of the Trust's strategic objectives. Key elements of this system include the Trust's Risk Management Framework and approach to Board assurance; the Board committee structure and the committees' role in risk management; the approach to quality assurance and quality improvement; and the Trust's performance management framework. The annual governance statement also describes the steps taken to adapt the Trust's governance structures both in response to the pandemic and in returning to 'business as usual'
- No significant internal control issues, or risks to compliance with the provider licence or the requirements imposed under the NHS Acts, have been identified during 2021-2022. The Trust continues to account for the conditions of both in the delivery of its healthcare services

- The Trust has received the Head of Internal Audit opinion on the effectiveness of the Trust's system of internal control, including its approach to risk management. The overall opinion was that "*the Trust has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective*"
- The Trust has regard to the provisions contained within the NHS Constitution, and the rights of patients, service users and staff, through the formulation and adoption of Trust policies and procedures, its approach to service delivery and its governance structures
- The Trust's approach to ensuring continued compliance with the CQC standards and regulatory requirements. The Trust was rated as 'Outstanding' overall for a third consecutive time by the CQC following a comprehensive well-led inspection in 2021 as well as for being 'well-led': "*the leadership, governance and culture (at the Trust) were used to drive and improve the delivery of high-quality person-centred care*". The Trust has continued with the CQC preparedness programme and the monitoring of action plans in response to inspections

2 Continuity of Service Condition 7: Availability of Resources

2.1 ***After making enquiries, the Directors of the Licensee have a reasonable expectation that the Licensee will have the required resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.***

2.2 In making the above declaration, the main factors which have been taken into consideration include:

- The Board discusses and approves the Trust's strategic and annual plans (and budgets) taking into account the views of the Council of Governors
- Trust sets its budget on an annual basis and actively manages and monitors its financial position, resource levels, quality and performance on a regular basis during the year through routine performance reporting to the Board and its committees, with scrutiny and oversight by the Executive Team and through local structures
- The Board's finance and performance reports provide assurance to the Board on the delivery of the Trust's strategy and Trust-wide performance, finance and compliance matters, and seeks to demonstrate how the Trust is improving the quality of life for all we serve
- Performance and quality review meetings assess each directorate's performance across a full range of financial and quality metrics that, in turn, forms the basis of the monthly performance, quality and compliance report to the Trust's Service Delivery Board
- The Executive team, the Board and its standing committees continued to meet during the year in line with their forward plans, maintaining control of decision-making and oversight of risk and performance
- The Trust continues to embed a value and financial sustainability programme
- Although the Board is unable to sign off the annual accounts for 2021-2022 in line with the June submission deadline due to a few late queries from the external auditor, assurance has been provided that there is nothing material that would affect the Trust as a going concern. The Board therefore has a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. The view is supported by a cash balance at as 31 March 2022 of £143m. For this reason, the Trust continues to adopt the going concern basis in preparing the accounts. It is expected that the annual report and accounts will be submitted to NHSE by 9 September 2022 deadline
- For the financial year ending 31 March 2022, the financial funding mechanisms designed by NHSE continued to provide funding for the Covid response and a level of operational income to achieve at least a financial break-even position as in the previous

financial year. The Finance and Use of Resources metrics were temporarily replaced by a requirement for providers and systems to meet their financial targets. In addition, there was a requirement for Integrated Care Systems to deliver financial balance. The financial performance of the Trust was therefore an integral part of ensuring this requirement could be met and at year end the Trust met its key financial target reporting a £1.8m surplus (on an adjusted control account basis) as part of the North East London ICS.

3 Condition FT4: Corporate Governance Statement

3.1 ***The Board of Directors confirmed compliance with Condition FT4: Corporate Governance Statement for 2021-2022 as set out in the table below***

3.2 *The table includes potential risks to not meeting the requirements as well as the mitigating actions*

Corporate Governance Statement	Response, Potential Risks and Mitigating Actions
1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS	**Response: CONFIRMED** • The Trust has in place effective corporate governance systems and controls • A detailed explanation about the Trust's corporate governance systems is set out in the Trust's annual governance statement and in other parts of the Trust's annual report 2021-2022 • The Board gains assurance through regular scrutiny of its effectiveness through its committees and particularly the Audit Committee • CQC rated the Trust 'Outstanding' overall following a comprehensive well-led inspection as well as for the well-led domain • An independent well-led external review undertaken by Deloitte during 2021 which confirmed the Trust exhibits several characteristics of an 'Outstanding' Trust and is an exemplar in areas including people participation, QI, Governor engagement and is seen as a strong system player. The Board displays many traits associated with a unitary Board and has an innovate committee structure and use of the BAF at both Board and committees **Risk:** If the governance framework and supporting structures are not fit for purpose adversely affecting good corporate governance and decision making **Mitigating Actions:** • A review of Board committee structure, the terms of reference and information flow to and between committees and the Board ongoing to ensure it remains fit for purpose reflecting the changes to the Trust service provision and in preparation for ICSs • Governance development plan being developed to bring together a range of actions from both internal and external inspections and assessments or are identified as being required to support/enhance the systems and processes to ensure effective governance arrangements at the Trust • Annual review of compliance with NHSE/I *Code of Governance* (best practice in corporate governance)

	• Trust's internal audit function which reports to Audit Committee on the effectiveness of internal controls and provides recommendations for improvements
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	**Response: CONFIRMED** • Board is fully briefed as guidance becomes available • During 2021-2022, guidance related to NHS response to Covid was managed through the Gold and local command structure • Regular updates provided by internal auditors at Audit Committee • Membership of NHS Providers and NHS Confederation **Risk:** If Board Directors are unaware of guidance in a timely manner this could affect the Trust's compliance status **Mitigating Actions:** • On the release of new guidance a review will be undertaken by relevant teams (e.g. legal, MHA, finance, corporate governance, etc) to identify any actions required; updates will be provided to the relevant committees/Board as appropriate • Director of Corporate Governance and other Trust teams undertake horizon scans and are included on relevant review groups and circulation lists including NHSE/I and NHS Providers, to ensure early notification • Annual review of compliance with NHSE/I *Code of Governance* (best practice in corporate governance) in preparation for annual report disclosures
3. The Board is satisfied that the Trust has established and implements: a. Effective Board and committee structures b. Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees c. Clear reporting lines and accountabilities throughout its organisation	**Response: CONFIRMED** • The Trust has an effective governance structure in place which is reviewed annually alongside the terms of reference of committees which set out the roles and responsibilities of the committees as delegated by the Board • The work of the Committees are reported to the Board via regular assurance reports • The Trust works within a framework that devolves responsibility and accountability throughout the organisation through robust service delivery arrangements. There are clear structures with clear responsibility and accountability below Director level • Job descriptions and other key governance documents, such as the Standing Financial Instructions (SFIs), Scheme of Reservation & Delegation (SoRD), etc set out in detail the accountabilities across the Trust • On the outset of Covid the Trust embedded a Gold Command structure, agendas and discussions at Committee meetings were adapted to reflect the management and assurance of operations during the pandemic. The Board Assurance Framework (BAF) continued to reflect the impact of Covid and the risks in achieving the Trust's strategic priorities, and the mitigating actions and controls that have been put in place • The quality governance framework has been critical to the Trust's safe and effective response to the demands of the pandemic **Risk:** If the Trust's governance framework and supporting structures are not fit for purpose and/or responsive will adversely affect good corporate governance and decision making

	Mitigating Actions: • A review of Board committee structure, the terms of reference and information flow to and between committees and the Board being undertaken to ensure it remains fit for purpose reflecting the changes to the Trust service provision and in preparation for ICSs • Review Trust's SoRD and SFIs • Developing organisational structure charts to provide clarity on areas of responsibility and reporting lines • Governance development plan being reviewed and strengthened to bring together a range of actions that are in place or are identified as being required to support/enhance the systems and processes to ensure effective governance arrangements at the Trust • Trust's internal audit function which reports to Audit Committee on the effectiveness of internal controls and provides recommendations for improvements
4. The Board is satisfied that the Trust has established and effectively implements systems and/or processes:	**Response: CONFIRMED**
• To ensure compliance with the duty to operate efficiently, economically and effectively	• Point 3 above applies • The Trust's system of internal control is based on ongoing processes designed to identify and prioritise the risks to the achievement of the Trust's strategy and strategic priorities, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically • Executive team has responsibility for overseeing the day to day operations of the Trust and for ensuring that resources are being used economically, efficiently and effectively
• For timely and effective scrutiny and oversight by the Board of the Trust's operations	• The Board and its committees meets on a bi-monthly basis and holds extraordinary meetings where time sensitive items are considered. The meetings receive reports, information and data relating to finance, performance and quality, allowing time for scrutiny and challenge • Board Committees have a programme of deep dives scrutinising risks and mitigations within their areas of responsibility • The Trust has a BAF and Corporate Risk Register (CRR) as part of its Risk Management Framework which set out the high level risks facing the organisation, and the ways in which these are identified, monitored and mitigated. These were updated to reflect the impact of pandemic on the Trust's ability to achieve its strategic objectives and the mitigating actions and controls which have been put in place
• To ensure compliance with health care standards binding on the Trust including but not restricted to standards specified by the Secretary of State, CQC, NHS Commissioning Board and statutory regulators of health care professions	• The Trust was awarded an 'outstanding' rating following the CQC inspection in October 2021. The Trust continues to hold regular meetings with CQC • Trust has a clinical governance structure in place to manage health standards compliance • Health care provision is underpinned by policies, procedures and clinical guidelines based on NICE and best practice guidance • The Trust's quality assurance team leads on understanding the quality of care that we provide and aspire to, identifying gaps

	and work towards addressing these, e.g. through service user led accreditation, clinical audits, Board walkrounds • Trust has a range of subject matter experts who provide guidance and advice in their professional areas • Trust staff are members of relevant networks and work collaboratively with system partners • Professional registration for clinical staff is closely monitored ad revalidation carried out in line with regulations for health care professionals
• For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Trust's ability to continue as a going concern)	• The Trust has a finance function underpinned by policies and procedures overseen by the Chief Finance Officer • Board dedicates time to strategy, including financial strategy, at its Board development sessions and seminars • The Board's Finance, Business and Investment Committee meets bi-monthly to review financial performance, contracts, the capital programme, financial viability, etc • Appropriate finance controls and governance have been maintained during 2021-2022 and in continued response to the pandemic • The Trust's SoRD and SFIs provide clear limits on financial decision making including when Board approval is required for significant financial decisions • During 2021-2022, all decisions continued to be in line with the Trust's SoRD and SFIs • Trust has an internal audit programme aligned to key areas of potential financial and operational risk overseen by both the Quality Assurance and Audit Committees • Trust's constitution requires the Council to approve any significant transactions as defined in the constitution • A briefing session on the accounts for Governors is led by the Audit Committee chair and the Chief Finance Officer • The Trust met its control total in 2021-2022 (subject to audit)
• To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making	• The Trust has an informatics and business analysis function which links into all data systems to provide comprehensive reporting to the Board and its committees • The Trust has other systems in place such as patient electronic systems, incident reporting system, etc which allows other data to be presented to the Board and its committees • The Trust recognises the importance of having timely and effective monitoring reports using data as a fundamental requirement to support the delivery of safe and high quality care
• To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence	• The Trust's Risk Management Framework (which includes the BAF, CRR and Directorate Risk Register) enables informed management decisions in the identification, assessment, treatment and monitoring of risk • The Trust's BAF provides a structure for the effective and focused management of the principal risks in meeting the Trust's strategic priorities. It enables easy identification of the controls and assurances that exist in relation to the Trust's key objectives and the identification of significant risks. Each risk on the BAF is allocated to an executive lead and to a relevant Board committee. The lead committee reviews the relevant entries on the BAF at each meeting • Review of compliance with licence conditions included as part of governance development plan

• To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery	• Strategy refreshed during 2021, strategic priorities established and supporting frameworks developed • The Trust has an annual planning process that ensures future plans are developed and supported by appropriate engagement and approvals • Trust participates in system-wide working arrangements and collaborative working. Any plans developed as part of this process are scrutinised internally via the Executive team and Board's integrated Care & Commissioning Committee, as well as by external partners
• To ensure compliance with all applicable legal requirements	• The governance, risk and control processes in place ensure that the Trust remains compliant with all legal requirements • Executive oversight of legal requirements supported by relevant teams including finance, MHA, legal and corporate governance teams • Legal advice is sought when required
	Risk: If the Trust does not have effective governance (both corporate and clinical) arrangements in place, this may lead to poor oversight at Board level of risks and challenges; strategic objectives not being established or structures not in place to achieve those objectives; or appropriate structures and processes not in place to maintain the Trust's reputation and accountability to its stakeholders **Mitigating Actions:** • A review of Board committee structure, the terms of reference and information flow to and between committees and the Board being undertaken to ensure it remains fit for purpose reflecting the changes to the Trust service provision and in preparation for ICSs • Governance development plan being reviewed and strengthened to bring together a range of actions that are in place or are identified as being required to support/enhance the systems and processes to ensure effective governance arrangements at the Trust. Plan includes review of the Trust's SoRD and the BAF • Risk in respect of failure to maintain essential standards of quality and safety resulting in the provision of sub-optimal care and increases the risk of harm, is included on the BAF with the Chief Nurse as the lead Executive. Regular updates on mitigating actions are presented to the QAC
5. The Board is satisfied that the systems and/or processes referred to in para 4 (above) should include but not be restricted to systems and/or processes to ensure: a. That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided b. That the Board's planning and decision-making processes take	**Response: CONFIRMED** • Decision taken during 2021-2022 to recruit to a Joint Chair with NELFT • Annual performance reviews for Executive and Non-Executive Directors including the Chair and CEO – focusing on both individual objectives and contributions as well as those as a unitary Board • Annual succession planning discussions at Board's Appointments & Remuneration Committee (RemCo) and Council's Nominations & Conduct Committee (NomCo) • Trust commitment to quality and involving people who use our services to help us improve is core to the way the Trust works • Board has overview of the quality and safety of care provided across the Trust. Detailed reports are discussed at each Board meeting. The Board also receives presentations at each

timely and appropriate account of quality of care considerations c. The collection of accurate, comprehensive, timely and up to date information on quality of care d. That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care e. That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources f. That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate	meeting on quality improvement initiatives, people participation and patient stories • Quality assurance, quality improvement and co-production are an integral part of the Trust's strategy • The Board's QAC meets bi-monthly and provides overview and scrutiny of quality and safety within each directorate and across the Trust, reporting to the Board on assurances gained and any gaps. It also reviews clinical risks at each meeting • Trust's quality report provides a summary of the Trust's quality achievements and challenges, demonstrating how it meets its statutory and regulatory requirements as well as how it meets the expectations of its service users, carers, stakeholders, members and the public • Consideration was given to the Trust's approach to assurance regarding the quality of care and to utilising quality improvement to help test, learn and adapt through the pandemic. Many of our quality assurance processes were adapted to virtual methods, such as the service user-led accreditation programme. By the final quarter of 2020-2021, all quality assurance activities were operating as normal • Service users and carers, as well as the public and members' views are also represented by the Council of Governors. Whilst face to face activities were partially restricted during 2021-2022 the Board has remained engaged with the Council and members to take account of views from outside of the Trust • People participation structure to ensure that service users, carers and our local communities are actively involved in the planning, development, effective delivery and evaluation of all Trust services so that we can offer a better service for all • The Trust has established a People Participation Committee where service users and carers are involved in strategic decision making • Clear accountability for quality of care through the Chief Medical Officer, Chief Nurse and Chief Quality Officer • Trust actively works with its providers, voluntary and third sector through formal and informal mechanisms to foster and enable integrated care • Opportunity for staff to raise concerns through Freedom To Speak Up processes **Risk 1:** If the Board does not have sustained capability or expertise, this could impact on its ability to lead on the quality of care in the current climate **Mitigating Action 1:** Board composition and succession planning regularly reviewed by the Chair and RemCo to ensure skill mix and experience is appropriate and balanced **Risk 2:** If the Trust does not maintain essential standards of quality and safety, this may result in the provision of sub-optimal care and increases the risk of harm **Mitigating Action 2:** Patient Safety Director appointed to take forward the development of the patient safety framework that will provide an integrated approach to safety spanning the whole Trust, building on existing assets, culture and infrastructure to provide

	reliability and resilience, embed a 'just' culture and a culture of learning and safety management
6. The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence	**Response: CONFIRMED** • Trust recognises that providing high-quality inpatient and community-orientated health care to the communities we serve requires a highly skilled and motivated workforce • Board has a wide range of skills and experience with the majority of members having a medical, nursing or other health professional background. Non-Executive Directors have wide-ranging expertise and experience with backgrounds in health, primary care, finance, audit and regulation, business and organisational development, HR, global commercial, local government and third sector • The Board's RemCo and Council's NomCo oversee the recruitment processes for Executive and Non-Executive Directors respectively • Annual succession planning review to assess mix of skills and experience on the Board to ensure balance is maintained, and to ensure effective operation as a unitary Board • Rigorous and transparent recruitment process for new Board Directors includes testing against the values of the Trust and inclusion of stakeholder panels comprising of Governors, service users and carers, and external stakeholders • All Board Directors comply with the requirements of the Fit and Proper Persons Regulation and are appropriately qualified to discharge their functions effectively • All Board Directors and senior decision makers complete annual declarations of interest • Annual appraisal process supports effective succession planning through talent conversations • People plan priority areas include capacity and capability, leadership, collaborative working and staff engagement • Regular appraisals include discussions on staff's development and career aspirations • Continuous professional development of clinical staff, including medical staff, supports the delivery of high quality clinical services. The Trust has processes in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and re-validation requirements • Trust has various leadership and management development pathways in place • Given the national staffing challenges, it is even more important to recognise the link between positive staff experiences and the impact on patient care and is committed to ensuring that every member of staff feels valued and is able to contribute to the best of their ability • Pandemic particularly highlighted importance of the Trust's support and wellbeing offer for staff – covering emotional, physical and social wellbeing **Risk:** If the Trust does not have systems and processes to ensure Board Directors, managers, clinicians and staff are sufficient in number and qualified, this could affect the quality of service provision and decision making

	Mitigating Action: People plan includes actions to mitigate BAF risk if the Trust does not effectively attract, retain and look after staff wellbeing, there will be an impact on the Trust's ability to deliver the Trust's strategy

4 Training of Governors

4.1 ***The Board of Directors confirmed that, during the financial year most recently ended (2020-2021), it had provided the necessary training to its Governors as required under s151(5) of the Health and Social Care Act. This is to ensure that Governors are equipped with the skills and knowledge needed to undertake their role.***

Signed on behalf of the Board of Directors:

Eileen Taylor
Acting Chair
28 July 2022

Paul Calaminus
Chief Executive
28 July 2022

NHS
East London
NHS Foundation Trust

Modern Slavery and Human Trafficking Statement

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes the Trust's slavery and human trafficking statement for the financial year ending 31 March 2022. The statement sets out the steps that East London NHS Foundation Trust (ELFT) has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain, or in any part of our business during the year ending 31 March 2022.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. ELFT has a zero tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings, and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the business or our supply chain.

Our Commitment

We are fully aware of the responsibilities we bear towards our service users, staff and local communities. We aim to follow good practice and take all reasonable steps to prevent slavery and human trafficking.

We are committed to promoting a proactive and inclusive approach to equality in both employment and service provision which supports and encourages an inclusive culture which values diversity; this includes a commitment to building a workforce which is valued and whose diversity reflects the communities it serves, enabling the Trust to deliver the best possible healthcare services to the community.

We aim to design and provide services, implement policies and make decisions that meet the diverse needs of our service users and carers, the population we serve and our workforce ensuring that none are placed at a disadvantage.

We are guided by a strict set of ethical values in all of our business dealings and expect our suppliers to adhere to these same principles. We are committed to ensuring there is no modern slavery in any part of our business and, in so far as possible, require our suppliers to hold similar ethos.

We are committed to ensuring that all our staff are aware of the Modern Slavery Act 2015 and their safeguarding duty to protect and prevent any further harm and abuse when it is identified or suspected that an individual may be or is at risk of modern slavery and human trafficking.

We ensure modern slavery guidance is embedded into the Trust safeguarding policies. Staff are expected to report concerns about slavery and human trafficking, and management are expected to act upon them in accordance with our policies and procedures. Guidance on modern slavery and human trafficking – what it means, what are the types and who is affected, what to do if you suspect someone of being subjected to slavery, and further advice, support and resources – can be found on the Trust's intranet site.

We adhere to the National NHS Employment Checks/Standards this includes right to work in the UK, employees' UK address and factual references.

Due Diligence

To identify and mitigate the risks of modern slavery and human trafficking in our business and in our supply chain, we:

- Operate a robust recruitment and selection policy, including appropriate pre-employment checks reflecting the national NHS Employment Checks/Standards requirements on directly employed staff. Agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff, to safeguard against human trafficking or individuals being forced to work against their will
- Implement a range of controls to protect staff from poor treatment and/or exploitation which comply with all respective law as and regulations; these include provision of fair pay rates, fair terms of conditions of employment and access to training and development opportunities
- Consult and negotiate with Trade Unions/Staffside on proposed changes to employment, work organisation and contractual relations
- Have systems to encourage the reporting of concerns including a whistleblowing policy so that all staff know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals; and the promotion of our Freedom to Speak Up Guardian and Ambassadors
- Regular Freedom to Speak Up reports are provided to the Trust Board which includes an overview of the concerns raised by staff and the category they fall in to
- Have a standards of business conduct policy which explains the manner in which we behave as an organisation and about how we expect our staff and suppliers to act.

Our approach to procurement and our supply chain includes:

- Ensuring that our suppliers are carefully selected through our robust supplier selection criteria and processes
- Ensuring a human rights issue clause is included in specification and tender documents with a requirement for suppliers to have suitable anti-slavery and human trafficking policies and processes in place and that they comply with the provisions of the UK Modern Slavery Act (2015)
- Evaluate specifications and tenders with appropriate weight given to modern slavery and human trafficking points
- Encourage suppliers and contractors to take their own action and understand their obligations in their processes
- Uphold professional codes of conduct and practice relating to procurement and supply
- Trust staff must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.

Training

All staff have a personal responsibility for the successful prevention of slavery and human trafficking. Advice and training on modern slavery and human trafficking is available to staff through our safeguarding policies, procedures and training, and our safeguarding leads. Safeguarding training on identifying and supporting victims of modern slavery is mandatory for all staff via our online training system.

Confirmation

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

Eileen Taylor
Acting Chair
East London NHS Foundation Trust
28 July 2022

About the Organisation

ELFT provides mental health, community, primary care, wellbeing and inpatient services to young people, working age adults and older adults across the City of London, Hackney, Newham, Tower Hamlet, Bedfordshire and Luton. The Trust is recognised as a centre of excellence for innovation and improvement. Our extensive work in research and education has led to a number of pioneering health solutions, giving us a strong academic reputation. We have a workforce of over 6,800 staff and provide services from over 100 sites.

The Trust has achieved its third consecutive 'Outstanding' rating from the Care Quality Commission; the first community and mental health Trust to achieve this rating for a third time. The CQC found ELFT's overwhelmingly positive culture supported patients to achieve good outcomes.

Further information about ELFT can be found on our website: www.elft.nhs.uk

Annual Fit and Proper Persons Declaration 2022
28 July 2022

1 Introduction

1.1 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) [the Regulations] introduced a *fit and proper person requirement* (Regulation 5) for all Board Directors of NHS bodies. Its purpose is to ensure that the Trust is not managed or controlled by individuals who present an unacceptable risk to the organisation or to service users/patients.

1.2 Under the regulations the Trust has an obligation to ensure that all Board Director-level and VSM appointments meet the Fit and Proper Requirements (FPPR) and the regulations place a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director (or equivalent) or an Non-Executive Director (NED) under given circumstances.

1.3 The Trust's Fit & Proper Persons Policy specifies the scope of staff who are included as:

- NEDs including the Chair
- Executive Directors including the CEO
- Company Secretary
- Equivalent positions.

1.4 Compliance with the regulations is monitored and enforced by the CQC and forms part of the CQC 'well-led' assessment.

1.5 The Trust must demonstrate that it has appropriate systems and processes in place to ensure that all new appointees and current Directors are, and continue to be, 'fit and proper' to undertake the role.

1.6 Directors must meet certain criteria including that they are 'of good character'; have the qualifications, competence, skills and experience necessary for the relevant position; and are capable of undertaking the relevant position after any reasonable adjustments have been made. They must also not have been responsible for any serious misconduct and/or or mismanagement in the course of carrying on a regulated activity.

1.7 The Chair of the Trust has the ultimate responsibility to discharge the FPPR placed on the Trust to ensure that all relevant post-holders meet the 'fitness' test and do not meet any of the 'unfit' criteria, and has overall responsibility for compliance with FPPR.

1.8 The portfolio responsibilities in respect of CQC/well-led, HR (including FPPR) and corporate governance (including annual report) are assigned to three different individuals, namely the Chief Nurse, Chief People Officer and Director of Corporate Governance respectively. This strengthens the internal control system, and provides an additional check and balance in terms of the Chief Nurse & Deputy CEO's lead role in overall CQC responsibility.

1.9 There is an expectation of senior leaders to set the tone and culture of the organisation that leads to staff adopting a caring and compassionate attitude. The purpose of the FPPR is not only to hold Directors to account in relation to their conduct and performance but also to instil confidence in the public that the individuals leading NHS organisations are suitable to hold their positions.

2 Assurance Checks

2.1 The Chief People Officer and Director of Corporate Governance are responsible for undertaking an annual review of compliance on behalf of the Trust Chair, for bringing non-compliance to the attention of the Chair and/or SID, for an annual assurance report to be submitted to the Board and for inclusion in the Trust's annual report.

2.2 To provide assurance that the Trust meets the FPPR, it has in place the following processes to determine whether all new and existing Directors are and continue to be fit:

- A process to ensure that all new Board Director-level appointments are fit and proper as part of the recruitment process
- An annual process for regularly monitoring and reviewing the ongoing fitness of existing Directors to ensure they remain fit for their role, including consideration of serious mismanagement
- Principles for conducting investigations into concerns about the fitness of a Director
- A process for the right of appeal for Directors.

2.3 Pre-employment checks for all new appointments are undertaken in line with the NHS Employment Standards and include:

- Proof of identify
- DBS check undertaken at a level relevant for the post
- Occupational health clearance
- Evidence of the right to work in the UK
- Proof of qualifications where appropriate
- Checks with relevant regulators where appropriate
- Appropriate references
- Search of insolvency and bankruptcy register
- Search of Companies House register to ensure that no Board Director is disqualified as a Director
- Search of the Charity Commission's register of removed trustees.

2.4 The annual assurance checks consists of the following:

- All Directors are required to complete the FPPR self-declaration form annually; this declaration is also counter-signed by the Chair (to confirm that the annual checks have been completed) with the exception of his/her own which is signed by the Senior Independent Director; and retained on the individual's personal file
- The annual appraisal process provides an opportunity to discuss continued 'fitness' and in particular the 'good character' requirements to ensure that the Director continues to have the appropriate level of skill, experience and competence for the role. Discussions at appraisal also cover how the Director displays the Trust's values and behaviour standard including the leadership behaviour expected
- DBS checks at a level relevant for the post are repeated every three years in line with Trust policy
- Search of insolvency and bankruptcy register
- Search of Companies House register to ensure that no Board Director is disqualified as a Director
- Search of the Charity Commission's register of removed trustees
- Confirmation that Directors remain on the relevant professional register
- Annual and ongoing declarations of interest for all Board Directors.

3 Ongoing Fitness

3.1 During April 2022 and on appointment, Board Directors completed the annual Fit and Proper Persons Requirements self-declaration form.

3.3 The Trust Acting Chair reviewed the declarations and determined that the Directors continued to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Senior Independent Director reviewed the declarations for the Acting Chair and also determined that she continued to meet the FPPR requirements.

3.4 The completed declarations and the outcome of the searches are saved on personal files.

3.5 Revalidation of ongoing fitness is recorded as part of the appraisal process; and is reported to the Board's Appointments & Remuneration Committee for Executive Directors and to the Council's Nominations & Conduct Committee for Non-Executive Directors.

3.6 Directors are responsible for identifying any issues which may affect their ability to meet the statutory requirements and bringing these issues on an ongoing basis and without delay to the attention of the Trust Chair.

4 FPPR Reviews

4.1 Following the enquiries by BBC East into the qualification claims by a Board Director in 2021, a range of actions were agreed to strengthen the Trust's process and procedures underpinning the FPPR taking account of the learning. The Audit Committee, Appointments & Remuneration Committee and Trust Board were regularly updated through written reports during last year, and an updated report is also presented as a separate agenda item at the 14 July 2022 Audit Committee meeting.

4.2 As part of its well-led inspection, CQC undertook a sampled review of Directors' personal folders and in its findings reported that the Trust had strengthened the FPPR policy and procedures since the last inspection, and highlighting that the reviews did not just rely on Board members completing a self-declaration.

4.3 RSM undertook an internal audit in respect of the Trust's compliance with the FPPR as part of the 2021/2022 internal audit plan. The report acknowledged that the Trust has implemented a series of revisions to strengthen the requirements and control framework in place around FPPR, and that further actions were also planned. A reasonable assurance opinion was issued with three medium priority and two low priority recommendations for management action. This is also reported in the internal auditors report to the 14 July 2022 Audit Committee meeting.

4.4 A review of the Trust's compliance with the NHSE provider licence also included seeking evidence of compliance with the FPPR as required under Condition FT4 of the provider licence (i.e. that the Trust has complied with required governance standards and arrangements). No areas of concern were identified and there were four recommendations to strengthen compliance. A detailed report is also presented as a separate agenda item at the 14 July 2022 Audit Committee meeting.

4.5 The recommendations from both the internal audit review and the review of the NHS provider licence have been included in the FPPR action plan which was developed following the enquiries by BBC East into the qualifications claims by a Board Director in 2021 as mentioned in 4.1 above.

4.6 Good progress has been made with no outstanding actions, and that further actions have been identified to strengthen the process. It is proposed that updates are provided via the governance development plan.

5 Chair Assurance Statement

5.1 I confirm that, having considered all the matters outlined in the Regulated Activities Regulations, and all the information and documentary evidence provided to me, the Trust's Board Directors meet the FPPR and I am satisfied that there are no other grounds under which each individual would be ineligible to be appointed to or continue in the post.

6 Recommendation

6.1 The Board of Directors is asked to:

- **NOTE** the content of this report
- **RECEIVE ASSURANCE** that following the Fit and Proper Persons requirements checks for the financial year ending 31 March 2022, all Trust Board Directors satisfy the requirements.

NHS
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REPORT TO THE TRUST BOARD IN PUBLIC
28 July 2022

Title	ELFT Charity Committee 28 June 2022 – Committee Chair's Report
Committee Chair	Aamir Ahmad, Non-Executive Director and Chair of ELFT Charity Committee
Author	Forhad Ahmed, Programme Manager (ELFT Charity)

Purpose of the report

To bring to the Board's attention key issues and assurances discussed at the ELFT Charity Committee meetings held on 28 June 2022.

Key Messages

Healthier Wealthier Families

- An expression of interest submitted to the Charity in March 2022 to fund an innovative pilot in Newham and Tower Hamlets, with the aim of embedding advisers as part of routine maternal and child health services supporting the Marmot principles of tackling inequalities, specifically in giving every child the best start in life; and ensuring healthy standard of living for all (pay, income and financial support)
- An update was provided covering the development of a steering group with key partners, evaluation plan, sourcing other matched funding for the pilot, and planning for longer term funding
- Committee agreed supporting and committing partial funding to this project with the proviso that work is not commenced until full funding has been committed to
- This project is about changing lives on an ongoing basis and in addition to funding, its working will require system recognition and engagement.

Brand Development

- Initial branding concepts reviewed and wider views will be sought on the final options.

Equality Impact Assessment (EIAs):

- EIAs aim to ensure the charity funding allocation process is fair and does not present barriers to participation or disadvantage any protected groups from participation; and the purpose is to ensure informed decisions on funding allocation are made
- 22 funding requests totally £57,275 have been awarded to ELFT services including, for example, employment engagement activities and various activity sessions for patients and service users
- Work is being undertaken to provide a more detailed analysis on funding allocations to support with both monitoring and evaluation.

ELFT Charity Update on Current Developments

- The agreed communications plan has commenced including messages on applying for grants with a range of activities planned for the rest of the year
- Recent interest from services on applying for funding for projects that benefit our service users
- Finalising with Barts Charity on the deed of transfer for grants.

Risk Register

- Review of policy requirements undertaken and as a short-term solution need to clarify if there is an option to adopt Trust policies whilst the Charity's own policies are developed and in place
- The Committee requested the risk register includes information on the mitigating actions.

Income Generation Strategy: Refresh of the strategy being planned

Charity Promotion: Relaunch to be included at the Trustwide Members meeting in October where the theme is on 'tackling inequity'.

Previous Minutes: The approved minutes of the previous Charity Committee meeting are available on request by Board Directors from the Director of Corporate Governance.

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REPORT TO THE TRUST BOARD IN PUBLIC
28 July 2022

Title	People Participation Committee 16 June 2022 – Chair's Report
Committee Chair	Aamir Ahmad, Non-Executive Director and Committee Chair
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 People Participation Committee meeting held on 16 June 2022.

Key messages

Getting The Basics Right Priority

- Discussions covered clarifying what this involves and identifying the areas to work on and what the measures will be to know if these have been improved
- Communications, digital and medication were suggested areas for inclusion and information on patient satisfaction could also help with identifying areas of focus
- Range of suggestions including the expansion of service user led accreditation to drive culture change; and the importance of sharing good practice and identifying individuals to be champions; development and support of admin staff through alignment with the Trust-wide initiative on admin skills academy which will be coproduced
- QI to be used as the methodology for taking forward initiatives
- Important to maintain a focus on the 'basics' as well as driving new initiatives.

Update of Directorate PP Priorities: Learning Disabilities

- First PP lead appointed last summer
- Focus has been linking in with the Working Together Groups and with community based teams to encourage referrals to PP
- Range of projects in place including involving service users on service provision and identifying priorities; LD health needs assessments
- A challenge was to balance the risk of Covid if groups were held face to face against the risk of digital poverty amongst service users. Work is ongoing to find the right balance between co-production, consultation and engagement
- Other challenges include ensuring a cross section of service users and carers with varying skills are included; ensuring processes are inclusive of service users with learning disabilities when working to make system-wide changes
- Lessons so far include that people with learning disabilities are also sometime carers and so may need a great deal of support.

Trust-wide Working Together Group Priorities Update

- Although there are directorate progress reviews, consideration to be given to the most effective way to keep track of Directorate performance against the TWWTG priorities including achievements and challenges.

Trust-wide Employment Steering Group Update

- Good progress has been made including streamlining the onboarding process which is now as short as 5 weeks from interview compared to the previous 5-6 months; easier access to obtaining references for anyone joining the Trust via the lived experience route; more robust process in place with Occupational Health team resulting in a better understanding; specific individual placement service (IPS) for supporting people into employment
- The learning is being considered for wider application across the Trust.

Board Assurance Framework: Risk 3 – Improved Patient Experience
Risk 3 *If the Trust does not work effectively with patients and local communities in the planning and delivery of care, services may not meet the needs of local communities:*

- Range of actions being taken to manage and mitigate the risk including service user representation at NEL mental health collaborative decision-making and governance levels; ongoing work to enhance onboarding and infrastructure for PP team; continuing work on the implementation of the Use of Force Act (also known as Seni's Law) through the MHA implementation group with Board oversight via the Quality Assurance Committee
- Agreed no change to the risk score and that appropriate controls are in place and operating effectively.

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

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TWWTG priorities 2022-2023

Addressing Inequalities

- Make services accessible to all – ages, disabilities, gender, sexual orientation (all protected characteristics), for those who have English as a second language, BSL users, neurodiversity etc.

People Participation

- Celebrating People Participation success more visibly (Befriending etc.).
- Making the People Participation offer to service users and carers as early on in their treatment as possible.

Education

- The Trust to work towards developing more opportunities for service users and carers to further their education and/or to educate others.

Joint Working

- Developing thoughtful and meaningful engagement – hybrid working, face to face and virtual.
-

Care and Treatment

- Focusing on the barriers of care – getting the basics right (access, waiting times etc.).
- Develop more employment opportunities for people with lived experience of services.

Improving the Quality of Life

- Develop more options for people to improve their quality of life – creativity, healthy lifestyles etc.
- Develop more opportunities for ELFT to share and grow together – service users, staff and carers.

PP Team

Trust Board Forward Plan 2019-21 at July 2020

PART 1	Item	27/01/2022	24/03/2022	26/05/2022	20/06/2022	28/07/2022	29/09/2022	24/11/2022	26/01/2023	30/03/2023
Standing Items	Declarations of interests	✓	✓	✓		✓	✓	✓	✓	✓
	Minutes of previous meeting and action log	✓	✓	✓		✓	✓	✓	✓	✓
	Chair's Report	✓	✓	✓		✓	✓	✓	✓	✓
	Chief Executive's Report	✓	✓	✓		✓	✓	✓	✓	✓
	Patient/Staff Story	✓	✓	✓		✓	✓	✓	✓	✓
	Teatime Presentation to alternate between QI and People Participation Story:	✓	✓	✓		✓	✓	✓	✓	✓
	~ QI - Memory Service in Bedfordshire & Luton									
	~ QI - Identifying/tackling health and life equalites of our population									
	~ QI - Integrated Discharge Hub									
	~ QI - Global Health									
	~ QI - Reducing backlogs in Bedfordshire podiatry service									
	~ QI - TBC									
	~ Respect and Dignity (creating change)			✓			✓			
	~ PP - Medical Education									
	Forward Plan	✓	✓	✓		✓	✓	✓	✓	✓
Quality and Performance	Environment & Sustainability - Climate Emergency Declaration	✓								
	Excess Covid Deaths	✓							✓	
	Green Plan	✓							✓	
	Quality Report	✓	✓	✓		✓	✓	✓	✓	✓
	Patient Safety Report						✓	✓		
	Performance Report	✓	✓	✓		✓	✓	✓	✓	✓
	Inpatient Deaths						✓			
	Mortality Review Luton & Bedfordshire	AR							AR	
	Patient Safety (going forward)						✓			
	Prevention of Future Deaths Notice	✓	✓	✓		✓			✓	
	CQC	✓				✓				
	Mental Health Units (Use of Force) Act		✓							
	Core20PLUS5: approach to reducing health inequalities		✓							
	Waiting Times	✓							✓	
People	Clinical Workforce Report	✓				✓			✓	
	EDI									✓
	People Plan Updates:	✓	✓	✓		✓	✓	✓	✓	✓
	~ Workforce Race Equality Standard Report									
	~ Workforce Disability Equality Standard Report									
	Guardian of Safe Working Reports (quarterly and annual)					AR				
	Safe Staffing	✓				✓			✓	
	Staff Survey (inc in People Plan)		✓							
	Patient & Carer Race Equality Framework PCREF					✓				
Finance	Finance Report	✓	✓	✓		✓	✓	✓	✓	✓
	Financial Viability									
Governance	Annual Report and Accounts					✓	✓			
	Annual Reports:									

	~ Compass Wellbeing CIC Proposal and Annual Report	✓							✓	
	~ Internal Audit Plan		✓							✓
	~ NHS Self-Certification					✓				
	Feasibility Study of the Bedford Health Village			✓			✓			
	~ Board Assurance Framework									
	Estates Plan			✓		✓				
	Meeting dates for coming year						✓			
	Reporting Committees:									
	~ Reporting Committees Assurance Reports	✓	✓	✓		✓	✓	✓	✓	✓
	~ Review of Committee Terms of Reference						✓			
	Modern Day Slavery Statement						✓			

PART 2	Item	27/01/2022	24/03/2022	26/05/2022	20/06/2022	28/07/2022	29/09/2022	24/11/2022	26/01/2023	30/03/2023
Standing Items	Declarations of Interest	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Minutes of previous meeting and action log	✓	✓	✓		✓	✓	✓	✓	✓
	Emerging Issues - Internal and External:	✓	✓	✓		✓	✓	✓	✓	✓
	Trust Board Forward Plan	✓	✓	✓	✓	✓	✓	✓	✓	✓
Governance	Annual Accounts inc External Audit Report				✓					
	Annual Report				✓					
Strategy	Digital Strategy Update		✓							
	CQC and Well-Led		✓							
	System Working:									
	~ East of England Collaborative Update									
	~ NEL Collaboration		✓							
	~ System Working									
	~ NEL MH and Community Collaborative	✓	✓							

Acronyms

NHS East London NHS Foundation Trust

A

AfC	Agenda for Change
AGS	Annual governance statement
AHM	Associate Hospital Manager
AHP	Allied Healthcare Professional
ANA	Apprentice Nursing Associate
ANP	Advanced Nurse Practitioner

B

BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
BCF	Better Care Fund
BCHS	Bedfordshire Community Health Services Trust
BEH	Barnet, Enfield & Haringey Mental Health Trust
BLM	Black Lives Matter
BLMK	Bedfordshire, Luton & Milton Keynes

C

C&I	Camden & Islington NHS FY
CAMHS	Children & Adolescent Mental Health Services
CCG(s)	Clinical Commissioning Group(s)
CCT	Community Care Team
CDO	Chief Digital Officer
CEA	Clinical excellence awards
CEO	Chief Executive Officer
CFO	Chief Finance Officer
CHS	Community Health Services
CMHT	Community Mental Health Team
CMO	Chief Medical Officer
CN	Chief Nurse
CNWL	Central & North West London NHS FT
CoG	Council of Governors
COO	Chief Operating Officer
CPA	Care programme approach
CPD	Continuing professional development
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CQUIN	Commissioning for quality and innovation
CRHT	Crisis resolution and home treatment
CRR	Corporate Risk Register

D

Datix	Incidents complaints reporting management system
DBS	Disclosure and barring service
DD	Due diligence
DMT	Directorate Management Team
DNA	Did not attend
DoH DHSC	Department of Health & Social Care
DoLS	Deprivation of liberty safeguards
DRR	Directorate Risk Register

E

ED	Executive Director
EDI	Equality
EDS	Eating Disorder Service
EIS	Early Intervention Service
ELFT	East London NHS FT
EPUT	Essex University Partnership NHS TF
EMIS	Electronic patient record system
EoE	East of England
EPPR	Emergency preparedness

F

F2SU/ FTSU	Freedom To Speak Up
FBIC	Finance, Business & Investment Committee
FFT	Friends and family test
FOI	Freedom of information
FPPR	Fit and proper persons regulation
FT	Foundation Trust
FV	Financial viability

G

GDPR	General Data Protection Regulations

H

H1/H2	2021/2022 NHS finance regime
HCA	Healthcare Assistant
HCP	Healthcare Professional
HEE	Health Education England
HOSC	Health Overview and Scrutiny Committee

I

IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICCC	Integrated Care & Commissioning Committee
ICP	Integrated Care Partnership
ICP	Integrated care pathway
ICO	Information Commissioners Office
ICS	Integrated Care System
IG	Information governance
IPC	Infection prevention and control
IT	Information technology
ITT	Intention/invitation to tender

K

KLOE	Key line of enquiry
KPI(s)	Key performance indicator(s)

L

LA	Local authority
LCFS	Local Counter Fraud Service
LD	Learning Disabilities
LeDeR	Learning Disabilities Mortality Review
LTP	Long Term Plan
LWW	London living wage

M

MDT	Multi-Disciplinary Team
MHA	Mental Health Act
MHS	Mental Health Services
MOU	Memorandum of understanding

N

NCEL	North Central East London Provider Collaborative
NED	Non-Executive Director
NEET	Young people between the ages of 16 and 24 that are not in full time education, employment or training
NEL	North East London
NHSE	NHS England
NHSI	NHS Improvement
NHSEI	NHS England/NHS Improvement
NICE	National Institute for Clinical Excellence in Health
NMC	New models of care

O

OBC	Outline business case
OD	Organisational development
OOA	Out of area
OPEL	Operational Pressures Escalation Level

P

P&C	People & Culture
PALS	Patient Advice and Liaison Service
PC	Primary Care
PCSE	Primary Care Support England
PCN	Primary Care Network
PFI	Private finance initiative
PHSO	Parliamentary and Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PMO	Programme management office
PP	People participation
PPG	People Participation Group
PPL	People Participation Lead
PSW	Peer Support Worker

Q

QA	Quality assurance
QAC	Quality Assurance Committee
QI	Quality improvement
QIA	Quality impact assessment

R

RAID	Rapid assessment
RCA	Root cause analysis
RCP	Royal College of Physicians
RIO	Electronic patient record system
RLW	Real living wage
RTT	Referral to treatment
RVS	Respiratory syncytial virus

S

SCYPS	Specialist Child and Young Person Services
SEND	Special Educational Need and Disability
SI	Serious incident
SID	Senior Independent Director
SIRO	Senior Information Risk Officer
SLT	Senior leadership team
SJR	Structure judgement review
SOC	Strategic outline case
SOF	Single Oversight Framework
SOP	Standard operating procedure
SME	Small and medium-sized enterprises
SPA	Single point of access
SPOR	Single point of referral
SRO	Senior Responsible Officer
STEIS	Strategic executive information system
Systm One	Electronic patient record system

T

ToR	Terms of reference
TWWTG	Trust-wide Working Together Group

V

VCS	Voluntary and community sector
VCSE	Voluntary, community and social enterprise
VDI	Virtual desktop infrastructure
VfM	Value for money
VPN	Virtual private network
VSM	Very Senior Manager

W

WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTD	Working time directive
WTE	Whole-time equivalent
WTG	Working Together Group